UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

NOELLE LeCANN, KRISTIN SELIMO, and TANIA FUNDUK, on behalf of themselves and others similarly situated, Plaintiffs, v. THE ALIERA COMPANIES, INC., formerly known as ALIERA HEALTHCARE, INC., Defendant.	Civil Action File No. 1:20-cv-2429-AT

PLAINTIFFS' RESPONSE IN OPPOSITION TO DEFENDANT'S MOTION TO DISMISS OR COMPEL ARBITRATION

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Plaintiffs' claims arise from a scheme devised by Aliera to illegally sell and administer insurance plans under the misrepresentation that the plans are exempt from federal and state insurance laws, supposedly because Aliera works in conjunction with supposed healthcare sharing ministries ("HCSM"). Aliera seeks to compel arbitration based on a provision in Member Guides [Doc. 12-14] at 12, but its motion is misplaced for several reasons. Chief among them, arbitration requirements are illegal and unenforceable in insurance contracts under applicable law. O.C.G.A. § 9-9-2(c)(3); *McKnight v. Chi. Title Ins. Co.*, 358 F.3d 854, 857 (11th Cir. 2004).

To prevail on its motion, Aliera would have to establish that the health care plans at issue are ***not*** insurance, and in addressing that issue, the Court must "give to the party denying [the arbitration] agreement the benefit of all reasonable doubts and inferences that may arise." *Regan v. Stored Value Cards, Inc.*, 85 F. Supp. 3d 1357, 1360 (N.D. Ga. 2015). In fact, the record contains undeniable proof that the plans Aliera sold were "insurance," thus rendering the arbitration provision illegal.

Aliera neglects to mention either the controlling law on this issue or recent rulings against it involving the same plans and arbitration provision at issue here. *See Jackson v. The Aliera Cos.,* No. 2:19-cv-1281-BJR, 2020 WL 2733722 (W.D. Wash. May 26, 2020). In *Jackson,* Plaintiffs "sufficiently alleged that Trinity is an insurance company [and] the AlieraCare plans that Defendants created, marketed and sold are

insurance." *Id.* at *7. Therefore, since Washington prohibits arbitration provisions in insurance contracts, like Georgia, *Jackson* held that Aliera's "dispute resolution procedures are illegal." *Id.*

I. ALIERA'S PRODUCTS ARE INSURANCE.

A. *Why Aliera Wanted a Health Care Sharing Ministry.*

Aliera was incorporated and is operated by the Moses family – Timothy Moses, his wife Shelley Steele, and their son Chase Moses. Timothy Moses has been convicted of securities fraud and perjury, *United States v. Moses*, 1:04-cr-508-CAP-JMF (N.D. Ga.), and his probation was revoked for lying to the United States about his financial dealings and secret bank accounts. *Id.* at Doc. 150. Soon after his sentence was completed in April 2015, Moses undertook the scheme at issue here.[1]

The scheme is simple in concept. A for-profit company selling health care insurance is subject to extensive regulation by state laws. *See* O.C.G.A. §§ 33-1-1 *et seq*. In addition, the Patient Protection and Affordable Care Act ("ACA") strictly limits insurers' administrative costs and profits. At least 85% of premiums must go

[1] Shelley Steele incorporated Aliera Healthcare, Inc. in Georgia in 2016. (Ex. 1). Aliera began selling primary care medical home plans, which cover limited services and do not comply with the ACA if standing alone. *Aliera Healthcare, Inc. v. Anabaptist Healthshare, et al.*, No. 2018CV308981 (Fulton Super. April 25, 2019) (the "Fulton Injn.") at 4 (¶¶ 15–16) (Ex. 2), *aff'd,* 844 S.E.2d 268 (Ga. Ct. App. June 4, 2020); Receiver's Initial Report from the *Anabaptist* Litigation (Ex. 3) at 4 (¶ 5) (redactions by parties to *Anabaptist* litigation; unredacted version filed under seal).

to "reimbursement for clinical services provided to enrollees" plus "activities that improve health care quality."[2] 42 U.S.C. § 300gg-18(b)(1)(A)(i). By virtue of statutory exemptions, 26 U.S.C. § 5000A(d)(2)(B)(ii) & O.C.G.A. § 33-1-20, a legally qualified HCSM can operate outside these state and federal constraints. Because an HCSM must be a charitable 501(c)(3), however, its principals cannot take distributions, profits, or excessive compensation.[3] Moses sought to circumvent those limitations by combining a purported HCSM with Aliera and funneling the premiums to the for-profit Aliera and its principals. The scheme is completely illegal, however, because the entities Moses and Aliera used do not satisfy HCSM requirements, and the health care plans sold fall well within the legal definition of "insurance."

1. *Aliera's first HCSM effort*. In 2016, after his release from prison, Moses approached Anabaptist Healthshare ("Anabaptist"), which had functioned as an HCSM for a small 300-person Mennonite community in Virginia. Fulton Injn. at 2 (¶¶ 2, 5), 5 (¶¶ 18–20). Moses hoped to exploit Anabaptist's regulatory exemption to sell Aliera's products, and Anabaptist sought to "expand its HCSM nationwide" by

[2] Insurers spend less than 1% of premiums collected on "quality improvement." *See* Centers for Medicare & Medicaid Services, "The 80/20 Rule: How Insurers Spend Your Health Insurance Premiums" (Feb. 15, 2013) at 6, *available at* https://www.cms.gov/CCIIO/ Resources/Files/Downloads/mlr-report-02-15-2013.pdf. The "medical loss ratio" for "small market" insurers is 80%, rather than 85%. 42 U.S.C. § 300gg-18(b)(1)(A)(ii).

[3] 26 U.S.C. §§ 501(c)(3) & 5000A(d)(2)(B)(ii)(I); 26 C.F.R. § 1.501(c)(3)–1(f)(2)(ii)-(iv).

partnering with Aliera. *Id.* at 4-5. The Anabaptist board chair and director also personally stood to reap huge sums under a dubious "profit-sharing" arrangement[4] that would pay them each $2.50 per month for every enrolled member. *Id.* at ¶ 44. Aliera and Anabaptist entered into a contract providing for the creation of a new Anabaptist subsidiary, Unity Healthshare LLC ("Unity"), to serve as Aliera's HCSM. *Id.* at 6 (¶ 35); *see also* Ex. 4. Under the agreement, Aliera had exclusive authority to sell any and all health care products to Unity members; Unity had no right to sell any HCSM products. Ex. 2 at 7 (¶ 40). Aliera was responsible for "designing and implementing" all Unity plans, marketing them, cost sharing, and controlling the operation and general business banking of Unity. *Id.* (¶ 42). In short, as the Fulton County Superior Court later found, "[Anabaptist]/Unity delegated the administration of virtually all aspects of the Unity HCSM plans and plan assets to Aliera." *Id.* at 22.

Premiums were paid to Aliera, not Unity [Doc. 12-2] at 3, and the division of funds was heavily skewed in Aliera's favor and against the interests of the members, far out of line with ACA requirements that apply to nonexempt insurance. *See* Ex. 3

[4] *See supra* at 3 & n.3. While the payments here were technically "from" Aliera, that simply reflects how the parties papered their scheme. All premiums for Unity's HCSM products should have been the property of the non-profit, ACA-exempt Unity. *See, e.g.*, Fulton Injn. at 22 (monthly participation of members must be owned by the HCSM). In the Fulton County litigation, no party challenged the legality of the HCSM exemption of Anabaptist or Unity, of course, since an adverse ruling would have crushed their own interests as well as their adversary's.

at 14–18. Irregularities abounded in the operation of the Aliera-Unity business, including among others, Aliera's improper handling of Unity's finances; Aliera's inability to provide Unity with an accounting; Aliera's failure to segregate Unity funds; Aliera's assertion of ownership over Unity members accounts, which alone would preclude HCSM status; and Moses writing $150,000 of checks to himself from Unity's operating account without authorization. Fulton Injn. at 11–14, 22. Moses falsely represented to insurance regulators that funds related to Unity products were segregated, and he admitted that Aliera "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." *Id*. at 11–12 (¶¶ 67–70). Anabaptist terminated the agreement on August 10, 2018. *Id*. at 14 (¶70).

2. *Aliera's second HCSM effort*. With Unity gone and not even the pretense of an HCSM to use, Moses and Aliera created a new shell, Trinity Healthshare, Inc. ("Trinity"). On June 27, 2018, Aliera caused Trinity to be incorporated and installed William Thead III as CEO and sole employee. Ex. 5 at 5 (Item 2(a)), 7. Thead was a former Aliera employee and close friend of the Moses family who officiated Chase Moses' wedding. Fulton Injn. at 15–16 (¶ 94).

That Trinity is a mere shell operated, administered, and directed by Aliera solely to serve Aliera's purposes is apparent from the Management and

Administration Agreement executed by Aliera and Trinity on August 13, 2018. Ex. 6 at 12 ("Trinity Agreement"). The stated purpose was to allow Aliera to market "Trinity's healthcare sharing ministry programs" alongside Aliera's existing products, but in fact, no such Trinity HCSM programs existed because "Trinity currently ha[d] no members." *Id.* at 1. What Trinity did have was a pending 501(c)(3) application. *Id.* The Trinity Agreement gave Aliera full control over the business:

- Aliera is granted "an exclusive license to develop, market and sell" Trinity's purported HCSM plans to people "in the public markets who will acknowledge the standard of beliefs and other requirements as deemed necessary by Trinity, and agreed upon by Aliera." *Id.* at ¶ 1(a), (c).

- Aliera alone is "responsible for plan design (defining the schedule of medical services…), and pricing of the Plans," and Aliera has the right "at its sole discretion" to develop and manage non-insurance health care products and include them in Trinity's purported HCSM plans. *Id.* at ¶ 1(b).

- Aliera alone develops membership guidelines, determines which medical expenses are covered, and has total discretion to determine payment of claims. *Id.* at ¶¶ 1(a), (b). Aliera processes medical claims through a third-party administrator "which may be an affiliate of Aliera." *Id.* at ¶ 1(f).

- Aliera has exclusive authority "to accept any enrollment from members in the Plans in its sole discretion." *Id.* at ¶ 1(d). "Members who are enrolled in any Plan are permitted to change components of Plans as directed by Aliera," and Aliera can unilaterally substitute components of a member's plan "upon notice to the members of any Plan." *Id.*

- Trinity must use Aliera's auditor. Id. at ¶ 1(i).

- One-third of Trinity's Board of Directors can be current owners or employees of Aliera, and there is no restriction on Trinity board members being past Aliera employees or current Aliera family members or business associates. *Id.* ¶ 1(k).

- Aliera has a license to use all of Trinity's trademarks for marketing. Trinity, on the other hand, disavows any right to use Aliera IP. *Id*. at ¶ 2(a).

- Aliera has complete ownership of the Membership Roster developed through all sales, marketing, and enrollment efforts. Trinity is not even allowed "to contact" any plan members, nor can Trinity use any information in the Membership Roster "for any purpose" without prior written consent from Aliera. *Id*. at ¶ 1(d).

Members' premiums are paid to Aliera Healthcare, [Doc. 12-2] at 3, and 65% of the premiums are kept outright by Aliera. Ex. 7 at 21[5] (State of Washington Office of the Insurance Commission, Final Report (Apr. 8, 2019)) ("Washington Report"). *See* FED. R. EVID. 803(8)(A)(iii)). Of the 35% to Trinity, a further 54.2% of that goes to Aliera for expenses and commissions, with only 44.3% going for member medical expenses. *See also* Trinity Agreement at 14. In sum, 84% of each premium dollar goes to Aliera and only 16% to cover medical claims, Ex. 7 at 21, the opposite of the ACA's 15% limit on administrative costs and profit. *See supra* at 2-3.

B. *HCSM Requirements Have Been Ignored.*

Neither Unity nor Trinity conducted a legitimate HCSM in their dealings with Aliera. They simply provided a shell while Aliera ran and controlled everything from concept to creation to operation, with the money taken from members going to Aliera

[5] Citations to the Washington Report are to the pages of the PDF document being filed as Exhibit 7. They differ slightly from pagination in the Report itself because the title page and Executive Summary are separately numbered in the Report.

and, for the most part, remaining there. Even assuming arguendo that a legitimate HCSM can outsource some aspect of its operations without losing its HCSM status, this Court need not decide where a line might be drawn as to how much could be contracted out. Here, Aliera is the *entire* operation, controlling everything, including membership, premiums, and claims. Trinity and Unity simply provide a front for Aliera's illegal business.

HCSM status fails for several other reasons. Federal and state statutes spell out requirements for an entity to qualify as an HCSM, one of which is that the organization or its "predecessor" has been "in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously …since at least December 31, 1999."[6] 26 U.S.C. § 5000A(d)(2)(B)(ii)(IV). In Trinity's case, it had no conceivable status as an HCSM because it was not formed until 2018. At the time it was formed, it had no members, much less members "sharing" expenses, and it has no legitimate predecessor entity on whose experience it could rely to satisfy the December 31, 1999 cutoff. Presently, Trinity claims 1997 as the date since it or some unspecified predecessor has been continuously sharing

[6] The cutoff date "ensures that the ministries provide care that possesses the reliability that comes with historical practice. Second, it accommodates religious health care without opening the floodgates for any group to establish a new ministry to circumvent the Act." *Liberty Univ. v. Lew,* 733 F.3d 72, 102 (4th Cir. 2013).

medical expenses. *See* www.trinity healthshare.org/wp-content/uploads/Trinity HealthShareFederalDefinition2.pdf. Among other flaws in that argument, Trinity did not enter into the alleged contract until 2020, approximately two years after Trinity was formed. *See* https://www. trinityhealthshare.org/2020/01/trinity-healthshare-announces-agreement-with-faith-driven-life-church/. Even if Trinity's shell contract could somehow make Trinity an HCSM prospectively, it would be irrelevant prior to 2020, as Trinity was admittedly not sharing "continuously and without interruption" prior to that date.[7]

Neither do Unity, Trinity, or Aliera satisfy the faith-based requirement of HCSMs. Prior to its association with Moses and Aliera, Anabaptist had operated within a small, closely knit religious community of the same faith, but that was all abandoned with the creation of Unity and the partnership with Aliera. To be an HCSM, an entity must be "faith-based" and "[l]imit its participants to those who are ***of a similar faith.***" O.C.G.A. § 33-1-20(a)(1) (emphasis added). But Unity was designed just to capture the maximum number of people possible across the United

[7] Trinity's attempted historical justifications for HCSM status in its defense before the Washington Insurance Commissioner were laughable. Ex. 7 at 23. For example, Trinity argued that it should receive HCSM status because some Baptist churches had been "sharing" since the 1600's. *Id.*

States. The shared Mennonite faith was gone, replaced by a set of "principles" that were so general they could include anyone. [Doc. 12-5] at 11.

Members are not screened for religious tenets or beliefs. They are just presented with a "statement of beliefs" that is secular and generic, not even referring to Christianity[8] (let alone any particular Christian sect) or any other religion. *See, e.g.,* https://www.trinityhealthshare.org/about/statement-of-beliefs/. Trinity marketing material acknowledges it does not adhere to the "same faith" requirement in the following Q&A: **"**Can different faiths enroll in Trinity HealthShare? Yes!" https://www. calhealth.net/Secular-non-religious-health-sharing-plan.htm#different-faiths The advert goes on to say: "Whether Christian, Jewish, Muslim, or non-denominational, there's just a statement of belief that's required with Trinity HealthShare health plans. Technically, you don't need a specific faith to qualify." Trinity's "statement of beliefs" is described as just saying "that a person can practice their belief in their own way." *Id.* Sales training materials confirm that the plans are available to members of any faith or members of no faith at all. Ex. 7 at 13–14.[9]

[8] The HCSM concept has a Christian origin, sometimes attributed to the statement that Christians should "[b]ear one another's burdens" in Epistle to the Galatians, Verse 2, Ch. 6.

[9] Those materials acknowledge that agreement to the stated vague "beliefs" is a mere pro forma step. Defendant's sales agents are instructed that the "beliefs" are "basically...saying that you believe in a higher power…. It does not… matter as long as we all believe that there is a higher

The Trinity Agreement directs Aliera to "sell the HCSM plans to individuals in the public markets" so long as members "acknowledge" a "standard of beliefs." Ex. 6 at 2 ¶ 1(a). Since Trinity had *no* members at the time, by definition its members had no common or similar faith, and any beliefs it might later come up with required *Aliera's* approval. *Id.* Movant is left having to argue that a supposedly faith-based sharing ministry can have its faith dictated by a for-profit entity whose only apparent "faith" is self-enrichment.

Following the traditional operation of an HCSM, Georgia law requires that HCSM plan members actually share one another's burdens based on need and a member's present ability to help. A legal HCSM is "facilitator among participants" that "matches" "participants who have…medical needs" with "other participants with the present ability to assist those with…medical needs."[10] O.C.G.A. § 33-1-20(a)(2). The Aliera-Trinity-Unity plans do not operate at all like that. ***Mandatory*** monthly premiums are based on the plan and the member's plan coverage. The "present ability to assist those with needs" is no factor. If a member loses her/his job or is otherwise

power and we're all living our life that the best way that we possibly can." Sales materials further present the plans as "guaranteed issue." Ex. 7 at 13.

[10] Neither Aliera nor the other entities "facilitate" the transfer of any funds between members as required by law. Aliera receives monthly payments directly from members; Aliera determines what if anything to pay on claims; and on those occasions when Aliera approves some payment, payment goes from the entity, not from members based on their "present ability to assist."

financially incapable of paying their premium, they are terminated. *E.g.,* [Doc. 12-5] at 10; [Doc. 12-6] at 20; [Doc. 12-8] at 13; [Doc.12] at 13; [Doc. 12-13.] at 20. Neither has Aliera ever complied with the requirement that it, as the operator of the supposed HCSM, "provide a written monthly statement to all participants that lists the total dollar amount of qualified needs submitted to the [HCSM], as well as the amount actually published or assigned to participants for their contribution." O.C.G.A. § 33-1-20(a)(5).

C. *Aliera's Plans Are "Insurance."*

State laws throughout the country define "insurance" broadly. Insurance is a "contract which is an integral part of a ***plan for distributing individual losses*** whereby one undertakes to indemnify another or to pay a specified amount or benefits upon determinable contingencies." O.C.G.A. § 33-1-2(4) (emphasis added). Similarly, both "the Treasury Department and the IRS have interpreted 'insurance' broadly over the years," as recognized in recently proposed HCSM rules. *See* Certain Medical Care Arrangements, 85 Fed. Reg. 35398, 35400 (June 10, 2020).

Aliera contends its plans are not insurance because they disavow that they are insurance [Doc. 12-1] at ¶¶ 8–9, 13–14, 19–20, 26–27, 31–32. Aliera also calls members' required premiums "voluntary contributions" and refers to a "share box"

contrivance to imply that "voluntary sharing" occurs.[11] But the operation of the plans – not self-serving labels or disclaimers – determines whether they are insurance. *See, e.g.*, O.C.G.A. § 33-1-2(5) ("insurer" is "any person …who issues insurance…***by whatever name called***") (emphasis added). *See Jackson, supra*.

The most detailed judicial analysis of these issues is by *Commonwealth v. Reinhold*, 325 S.W.3d 272 (Ky. 2010). *See also Scott v. Louisville Bedding Co.*, 404 S.W.3d 870, 877 (Ky. Ct. App. 2013). *Reinhold* addresses and rejects every argument Aliera might make in its defense. In that case, Kentucky challenged the HCSM status of Medi-Share. As here, Medi-Share's plan documents "disclaimed any liability for members' medical expenses and guaranteed payment of no claims." *Id*. at 276. They also stated that (1) "a Medi-Share contract is not an insurance policy" and that it is not "a substitute for an insurance policy;" (2) plans were not "issued by an insurance company, nor offered through an insurance company;" (3) payment of "your medical bills is strictly voluntary" and "you are responsible for payment of your own medical bill;" and (4) "all money [to pay for healthcare expenses] comes from the voluntary giving of Members, not from the Christian Care Ministry, and the Christian Care

[11] A portion of premiums collected are perfunctorily accounted as "share box" funds before Aliera disburses them. The Member Guides do not mention share box operation or accounting, but it is mentioned briefly in Trinity's (extremely misleading) YouTube explanation, which states that funds assigned to a member's share box are "used to pay for another member's eligible medical expenses." Ex. 8 at 24–26. There is no actual HCSM voluntary sharing.

Ministry is not liable for the payment of any medical bills." *Id*. at 274. In the face of how the plans operated in substance, none of those disclaimers or characterizations worked. Medi-Share's plans were insurance:

> It is immaterial, or at least not controlling, that the term "insurance" nowhere appears in the contract the nature of which is to be determined; indeed, the fact that it states that it is not an insurance policy is not conclusive, and a company may be found to be engaged in an insurance business even though it expressly disclaims any intention to sell insurance.…The nature of a contract as one of insurance depends upon its contents and the true character of the contract actually entered into or issued—that is, whether a contract is one of insurance is to be determined by a consideration of the real character of the promise or of the act to be performed, and by a consideration of the exact nature of the agreement in light of the occurrence, contingency, or circumstances under which the performance becomes requisite, and not by what it is called.

Id. at 277. The court noted that the hallmark of "insurance" in the United States is the shifting of risk, *id.* at 276 (citing *Grp. Life & Health Ins. Co. v. Royal Drug Co*., 440 U.S. 205 (1979)), and it found that Medi-Share's plans did just that:

> The "commitment" contract…obligates Medi-Share members to pay their monthly "share" by the first of each month because their "fellow believers in Christ" *rely* upon that payment to satisfy their medical needs. In return for paying their monthly "share," Medi-Share members remain eligible to receive payment for their medical needs through the program. This process clearly shifts the risk of payment for medical expenses from the individual member to the pool of sub-accounts from which his expenses will be paid. Thus, regardless of how Medi-Share defines itself or what disclaimers it includes in its literature, in the final analysis, there is a shifting of risk.
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> . . .
>
> Medi–Share argues, however, that the disclaimer in the "commitment" contract which states that Medi–Share takes no responsibility for the

> payment of the members' medical bills indicates that no risk shifting occurs. Nevertheless, this disclaimer, while perhaps shielding Medi–Share from any liability for its members' medical bills, does not overcome the fact that through the Medi–Share program the individual members pool resources together to distribute the risk of major medical bills amongst each other. As previously stated, one cannot change the nature of an insurance business by simply declaring in the contract that it is not insurance.

Id. at 277–78.

The Aliera-Trinty-Unity "HCSM" plans and plan documents mimic the Medi-Share program in *Reinhold*. Indeed, the only significant distinctions between the ventures are that the American Evangelistic Association and its Christian Share Ministry in *Reinhold* were legitimate religious organizations, not a scheme created to take money from unsuspecting victims; and the *Reinhold* entity took only a small portion of the total revenue to cover its expenses, 325 S.W.3d at 275 n.4, rather than funneling most of the premiums into a for-profit company as Aliera does.

Plaintiffs' Complaint details how and why Aliera's Unity and Trinity plans are insurance. [Doc. 1] at ¶¶ 1, 3, 5, 9, 19, 26, 34, 56, 75, 82(a), 83(e), 85, 90, 92, 96(c) & (d), 101, 114, 115–121, 126, *passim*. And even without discovery, the current record overwhelmingly confirms those allegations. Among other things:

- Defendant's plans are marketed as "health care" plans, Ex. 7 *passim*, and other terms are used that are "insurance terms." *Id.* at 12. *See also* O.C.G.A. § 33-20-3(3) (Insurance Code defining "health care plan").

• Before one can enroll in an HCSM plan administered by Aliera, one must go through a typical insurance underwriting process. *See, e.g.,* [Doc. 12-5] at 17; [Doc. 12-6] at 17.

• Defendant uses a "metals nomenclature" like insurance plans under the ACA – namely, "bronze," "silver," or "gold." [Doc. 12-5] at 34–39; [Doc. 12-6] at 36–40; *see also* 42 U.S.C. § 18022(d)(1). Aliera also "follows CMS… guidelines for recommended preventative care required by the ACA." [Doc. 12-2] at 5.

• Medical benefits for health-related contingencies depend on the plan, with greater coverage corresponding to higher premiums. *See, e.g.,* [Doc. 12-2] at 5, 8; [Doc. 12-5] at 18-21; https://www.trinityhealthshare.org/about/.

• The Member Guides speak repeatedly of plan ***coverage***, again connoting insurance. *See, e.g.,* [12-5] at 6 ("As part of our solution, the plans ***cover*** medical services recommended by the USPSTF and outlined in the ACA for preventive care.") (emphasis added); [12-6] at 4 (same); [Doc. 12-5] at 13–14 (explaining that all three levels of AlieraCare plans have unlimited primary care and urgent care visits); [Doc. 12-6] at 12, 14 (same).

• Trinity's YouTube explanation represents that, if a medical expense is covered by a member's plan, the expense ***will*** be paid. "Eligibility for payment is…determined by a third-party administrator based on membership guidelines. If eligible, the share request is fulfilled." Ex. 8 at 34-37.

• The plans provide coverage for medical expenses like regular insurance plans, including for primary care visits, specialty care visits, hospitalization, emergency room, prescription drugs, labs, preventive care, urgent care, hospice, maternity, and x-rays. [Doc. 12-5] at 34-39; [Doc. 12-6] at 36–41.

• A member's "monthly contribution" is indistinguishable from an insurance "premium." There is nothing about it that is either "voluntary" or a "contribution." Any failure to pay terminates coverage. *Supra* at 11-12.

• The plans require a member to pay a deductible, labeled a "Member Shared Responsibility Amount" ("MSRA"). [Doc. 12-5] at 21, 27, 34–39; [Doc. 12-6] at 21, 27, 36–40.

> • After the MSRA is paid, medical bills are supposed to be paid in accordance with a benefits booklet or member guide for the selected program. [Doc. 12-5] at 34–36; [Doc. 12-6] at 38–43.
>
> • As with regular health care insurance, the plans require pre-authorization of certain non-emergency surgeries, procedures, or tests, as well as for certain types of cancer treatments. [Doc. 12-5] at 32–33; [Doc. 12-6] at 31.
>
> • Payments are made by Defendants directly to providers for covered benefits. *See*, *e.g.*, [Doc. 12-5] at 15 (noting that once the member's deductible ("MSRA") has been reached, payments will be "reimbursed directly back to the providers and hospital facilities"); [Doc. 12-6] at 15 (same). Such payments again reflect insurance risk-sharing and risk-distributing.

Like the plans in *Reinhold*, Defendant's plans function like insurance. While Georgia appellate courts have not decided an HCSM-insurance case like *Reinhold*, what constitutes insurance is very uniform among the states, and Kentucky law is the same as Georgia's in this regard. *See* K.R.S. § 304.1-030. In Georgia, as in *Reinhold,* a plan is insurance where risk-shifting occurs by "distribut[ing] individual losses among a large group of purchasers." *Love v. Money Tree, Inc.*, 279 Ga. 476, 478 (2005). And like Medi-Share, Aliera's "process clearly shifts the risk of payment for medical expenses from the individual member to the pool of sub-accounts from which his expenses will be paid. Thus, regardless of how [Aliera] defines itself…, in the final analysis, there is a shifting of risk" that constitutes insurance. 325 S.W. 3d at 277. That Aliera itself "takes no responsibility for the payment of the members' medical bills…, does not overcome the fact that through the [Aliera] program the

individual members pool resources together to distribute the risk of major medical bills amongst each other." *Id*. at 278.

D. *Rulings of State Agencies Confirm That Aliera's Products Are Not Protected by Their Contrived HCSM Relationships.*

States that have examined Aliera have found it to be selling insurance illegally, not bona fide HCSM plans. The Washington Report is a detailed 35-page analysis and executive summary about Aliera's products and business practices. It concludes that Trinity "does not meet the statutory definition of an HCSM" under Washington or federal laws; that Trinity was "acting as an unauthorized insurer;" and that Aliera's "advertisements on behalf of Trinity are deceptive and have the capacity and tendency to mislead or deceive consumers…." Ex. 7 at 2.

The Washington Report includes the following findings: (1) Trinity did not qualify as an HCSM because it failed the 1999 operating requirement; (2) Trinity lacked a religious conviction, the religious tenets in its bylaws were simply for show, and even those were not followed; (3) Aliera's training materials do not meaningfully address any religious points, and employees are instructed that Aliera's plans are "guaranteed issue;" (4) training materials direct Aliera's sales agents not to ask prospective customers religious questions that might raise an issue, and to tell prospects that Aliera is "not going to at all make it where [you can't] become a

member of the plan." Ex. 7 at 2–3, 8, 13. Sales agents are told that the "statement of beliefs" is broad enough that "we all" believe in them. *Id.* at 14.

The Texas Attorney General filed suit against Aliera for illegally selling unapproved insurance. Ex. 9. In its petition, the State asserted that:

> The Defendant Aliera Healthcare, Inc., is engaged in the business of insurance in this State without a license.... 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."

Id. at 1. The Texas determination was based on Aliera's representations not just to consumers, but also state regulators. *Id.*

In August 2019, Colorado ordered Aliera to cease and desist selling plans there because they constituted illegal, unauthorized insurance. Ex. 10. The Colorado Division of Insurance found that Aliera's conduct was "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." *Id.* at 4 ¶33. The purported HCSM plans "constitute insurance products." *Id.* at 4 ¶ 30.

Connecticut likewise sanctioned Aliera for selling insurance illegally. Ex. 11. That state's cease and desist order rejected Aliera's claim that its plans qualified as HCSM plans because Aliera and Trinity "do not limit the marketing of their products

to individuals holding any particular religious beliefs," and further because "[n]either Aliera nor Trinity have been in operation and continuously sharing members' health care costs since at least December [3]1, 1999." *Id.* at 2–3, ¶¶ 2 & 5. The plans are "insurance" because they "include an agreement to pay a sum of money, provide services or any other thing of value on the happening of a particular event or contingency, i.e. sickness or injury, or to provide indemnity for loss in respect to a specified subject by specified perils – indemnify their members for costs incurred for medical expenses – in return for consideration." *Id.* at 7, ¶ 17.

The Maryland Insurance Administration (MIA) and Aleira entered into a consent order in April 2018 which stated that the supposed HCSM operated by *Aliera* did not meet the requirements for religious exemption. Notwithstanding the 2018 consent order, Aliera continued to market HCSM plans in Maryland, prompting the MIA to issue an order on February 27, 2020 that stated, in part:

> [Aliera's] failure to comply with the terms of a consent order and its continued solicitation of memberships in an unauthorized insurance plan demonstrates that it does not meet the standard of trustworthiness and competence required of an insurance producer.

https://insurance.maryland.gov/Pages/newscenter/NewsDetails.aspx?NR=2020249.

"Concerned about potential fraudulent or criminal activity on the part of Aliera," the New Hampshire Insurance Commissioner issued a cease and desist order against Defendant in October 2019 that prohibited it from selling its health insurance

products in that state. Exs. 12 & 13. The Commissioner "determined that Trinity does not meet the legal definition of an HCSM," and that as a result, "Aliera, through its relationship with Trinity, is operating as an unauthorized insurer in the state of New Hampshire." Ex. 13 at 2, ¶ 15.

II. ARBITRATION IS NOT REQUIRED IN THIS CASE

Aliera contends that this case should be sent to arbitration and that an arbitrator should decide all arbitrability questions [Doc. 12-14] at 26, but Aliera ignores controlling law that dictates the opposite conclusion.

A. *Motions to Compel Arbitration Generally.*

"[A] party cannot be required to submit to arbitration any dispute which he has not agreed so to submit." *AT&T Techs., Inc. v. Comcn. Workers of Am.*, 475 U.S. 643, 648 (1986). Before a court can compel arbitration, the movant must establish

> that (a) the plaintiff entered into a written arbitration agreement that is enforceable "under ordinary state-law" contract principles and (b) the claims before the court fall within the scope of that agreement. *See* 9 U.S.C. §§ 2–4; *see also Paladino v. Avnet Computer Tech. Inc.,* 134 F.3d 1054, 1056 (11th Cir. 1998).

Lambert v. Austin Indus., 544 F.3d 1192, 1195 (11th Cir. 2008). In determining whether arbitration is required here, several issues must be decided. First, applying Georgia contract law, did the parties actually agree to submit any claims to arbitration? Second, is the arbitration provision Aliera relies upon legal and

enforceable? And third, are the claims encompassed by that arbitration provision? The Court need not address this last question in light of the answers to the first two.

Aliera's contention that this Court cannot even decide if there is a legal arbitration provision is incorrect. Certain "gateway" questions of arbitrability can be assigned to an arbitrator, but only if the parties clearly agreed to do so. If the parties did not specifically

> agree to submit the arbitrability question itself to arbitration, then the court should decide that question just as it would decide any other question that the parties did not submit to arbitration, namely, independently. [This] flow[s] inexorably from the fact that arbitration is simply a matter of contract between the parties; it is a way to resolve those disputes—but only those disputes—that the parties have agreed to submit to arbitration.

First Options of Chi., Inc. v. Kaplan, 514 U.S. 938, 943 (1995). There is a heavy presumption against such delegation. *Id*. at 944–45. "Courts should not assume that the parties agreed to arbitrate arbitrability unless there is 'clear and unmistakable evidence' that they did so." *Id*. at 944 (citations omitted).

Where there has been maximum delegation to an arbitrator, including explicit authority to pass on "arbitrability," a court must still determine the fundamental prerequisites to arbitration, including the legality of the provision:

> An agreement to arbitrate a gateway issue is simply an additional, antecedent agreement the party seeking arbitration asks the federal court to enforce, and the FAA operates on this additional arbitration agreement just as it does on any other. The additional agreement is valid under § 2

> "save upon such grounds as exist at law or in equity for the revocation of any contract…."
> . . .
> ***If a party challenges the validity under § 2 of the precise agreement to arbitrate at issue, the federal court must consider the challenge before ordering compliance with that agreement under § 4***.

Rent-A-Center, West, Inc. v. Jackson, 561 U.S. 63, 70, 71 (2010) (emphasis added). Even where arbitrability is delegated, "[t]o be sure, before referring a dispute to an arbitrator, the court determines whether a valid arbitration agreement exists. *See* 9 U.S.C. § 2." *Henry Schein, Inc. v. Archer and White Sales, Inc.*, ___ U.S. ___, 139 S. Ct. 524, 530 (2019); *Nebraska Machinery Co. v. Cargotec Solutions, LLC,* 762 F.3d 737, 741 n.2 (8th Cir. 2014) (even with delegation, court must determine "whether the arbitration agreement itself is valid"). Aliera's delegation contention "puts the cart before the horse." *Id*.

B. *The Arbitration Provision And The "Delegation" Provision, To The Extent There is One, Are Illegal and Void.*

Whether an arbitration agreement has been formed by the parties, whether it applies to the particular case, and whether it is legally enforceable are determined by state law. "[S]tate law… is applicable to determine which contracts are binding under § 2 and ***enforceable*** under § 3." *Arthur Andersen LLP v. Carlisle*, 556 U.S. 624, 630-31 (2009) (emphasis added); *First Options*, 514 U.S. at 944. Under Georgia law, arbitration provisions like the one here are illegal, void, and unenforceable. O.C.G.A.

§ 9-9-2(c)(3).[12] "Arbitration clauses…are impermissible in contracts between insurers and insureds." *McGowan v. Progressive Preferred Ins. Co*., 281 Ga. 169, 172–73 (2006); *Lawson v. Life of the S. Ins. Co*., 648 F.3d 1166, 1169 n.1 (11th Cir. 2011); *Love v. Money Tree, supra*. Because Georgia's anti-arbitration statute "regulates the business of insurance," it is preserved from FAA preemption by the McCarran-Ferguson Act. *Love*, 279 Ga. at 476; *Continental Ins. Co*., 255 Ga. App. at 447–48 (statute regulates insurance because, among other things, it "transfer[s] or spread[s] risk by preserving the possibility of a jury verdict"):

> § 9–9–2(c)(3) is a law enacted to regulate the business of insurance within the meaning of the McCarran–Ferguson Act. Thus, § 9–9–2(c)(3) is excepted from preemption by the Federal Arbitration Act.

McKnight, 358 F.3d at 858–59 (citations omitted).

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[12] Georgia law governs this question no matter where a Plaintiff or class member resides. Trinity's arbitration provisions state that "any arbitration shall be held in Atlanta, Georgia, and conducted … subject to the laws of the State of Georgia." [Doc. 12-1 at 14]. Even were that not the case, the rule of *lex fori* dictates that the forum state's law determines the applicability of arbitration. *Continental Ins. Co. v. Equity Residential Props. Trust*, 255 Ga. App. 445, 445 (2002) (arbitration provision invalid under Georgia law even though insured was Illinois resident and contract stipulated that Illinois law would apply). The same result is required by public policy:

> § 9–9–2(c)(3) establishes the public policy of Georgia that insureds shall not be compelled…to give up their common law right to access to the courts to resolve disputes arising under the contract. Georgia courts will not enforce a contractual provision choosing the law of another state where to do so would contravene the public policy of Georgia. As the procedural law and public policy of Georgia, [§ 9–9–2(c)(3)] appl[ies] in this case.

255 Ga. App. at 446 (citations omitted).

To the extent Aliera contends that reference in a Member Guide to arbitration by the American Arbitration Association ("AAA") might somehow "overrule" those authorities and require delegation of this threshold issue to an arbitrator [Doc. 12-14] at 16, Aliera is mistaken. The Supreme Court's *Rent-A-Center* and *Schein* decisions require a court to decide, before reference to an arbitrator, whether a valid arbitration agreement exists if a party specifically challenges the arbitration agreement and any delegation provision. Here, in addition to challenging the validity and applicability of the arbitration provision, Plaintiffs specifically deny that there is any agreement by the parties to delegate gateway enforceability issues to arbitration, much less the required "clear and unmistakable" proof of delegation.[13] Even if there were a clear written agreement to that effect, O.C.G.A. § 9-9-2(c)(3) would render it an illegal

[13] Even if AAA rules were "incorporated" in an agreement between the parties here, nothing in those rules *requires* delegation of gateway arbitrability. The rule simply *authorizes* arbitrators to decide those issues when the parties agree to do so. *See, e.g.*, AAA Consumer Arbitration Rule R-14 (arbitrator has "the power to rule…on the validity of the arbitration agreement"). That does not constitute an "agreement" by the parties that arbitrability is delegated, much less the required "clear and unmistakable" proof of such delegation. *First Options*, 514 U.S. at 944. While some courts under other facts have treated AAA rules as constituting delegation, *see, e.g., Terminix Int'l Co., LP v. Palmer Ranch Ltd. P'ship*, 432 F.3d 1327, 1332 (11th Cir. 2005), their rationale cannot be justified based on the language of the AAA rules, nor does it survive the Supreme Court's decision in *Schein, supra*. There, in the face of the same AAA argument, 139 S.Ct. at 528, the Supreme Court declined to hold that the parties had agreed to delegation of arbitrability because courts "should not assume that the parties agreed to arbitrate arbitrability unless there is clear and unmistakable evidence that they did so." *Id.* at 531. Plaintiffs would also note the blatant conflict of interest in allowing an arbitrator to determine whether s/he has jurisdiction over a case. Arbitrator's fees dwarf the kind of financial interests the Supreme Court has long condemned as intolerable for judicial officers. *Ward v. Village of Monroeville*, 409 U.S. 57 (1972); *Tumey v. Ohio*, 273 U.S. 510 (1927).

nullity, and it would be this Court's responsibility to decide that issue pursuant to the FAA. *See* 9 U.S.C. § 4 (court must be "satisfied that the making of the agreement for arbitration or the failure to comply therewith is not in issue"). *Minnieland Private Day School, Inc. v. Applied Underwriters Assurance Co.*, 867 F.3d 449, 455–56 (4th Cir. 2017) (court decides legality of arbitrability delegation where challenged); *In re Van Dusen*, 654 F.3d 838, 843–45 (9th Cir. 2011). *See also Lavigne v. Herbalife, Ltd.*, ___ F.3d ___, 2020 WL 4342671 (11th Cir. 2020) (court decided whether there was an enforceable agreement and whether equitable estoppel applied, notwithstanding AAA delegation provision).

The dispute resolution provisions relied upon by Aliera also violate the Affordable Care Act, which prohibits requiring an insured to go through more than one level of internal appeal to resolve a claim. 42 U.S.C. § 300gg-19(a)(1); 45 C.F.R. § 147.136(b)(3)(ii)(G). The Dispute Resolution and Appeal section of the Member Guide that Aliera relies on includes four levels of internal appeal, plus mediation, plus arbitration. *E.g.*, [Doc. 12-1] at 12–13. As Judge Rothstein ruled in *Jackson*, since the multi-stage Dispute Resolution and Appeal process is illegal, each and every one of its parts, including the fifth part (section E) that addresses Mediation and Arbitration, is illegal and unenforceable:

> Because Trinity's dispute resolution procedures clearly require more than "one level of internal review before issuing a final determination"

> and binding arbitration that deprives the Court of the jurisdiction of this action, the Court finds that Plaintiffs have sufficiently pled that Trinity's dispute resolution procedures are illegal under the Washington insurance law. *See* WAC 284-43-3110(7);[14] RCW 48.18.200(b).

Jackson, 2020 WL 2733722 at *7.

C. *No Arbitration Agreement Exists That Covers Plaintiffs' Claims.*

The illegality of the arbitration provision and any possible arbitrability delegation language, is fatal to Aliera's motion, but for completeness, Plaintiffs will address other defects in Aliera's position.

1. *What language would apply, if any?* While Aliera asserts there is a "binding arbitration clause" [Doc. 12-4] at 17 and has submitted certain Guides that include the term "binding arbitration," *e.g.*, [Doc. 12-5] at 18, it neglects to mention contrary language in other documents provided to members. For example, *Trinity HealthShare Plan Review, Rates, and Enrollment* states that the ***entire*** membership agreement is ***nonbinding***: "This membership is not a legal binding agreement…." Ex. 14 at 11. Enrollment documents similarly state: "This is not a contract" and "Enrollment in the ministry sharing program is not a contract." [Doc. 12-7] at 5. Furthermore, some versions of the Member Guides have no arbitration provision, *see,*

[14] WAC 284-43-3110(7) includes the same kind of prohibition against multiple level appeals as does the ACA. (Footnote added).

e.g., Ex. 14, creating a question as to what, if any, would apply to the claims against Aliera here. Consistent with that fact, Aliera cites to no mediation or arbitration provisions while Plaintiff Selimo was a Trinity member during 2019-2020. [Doc. 12-1] at 16 ¶ 23.

Unity Guides for Plaintiffs Selimo and Funduk refer to arbitration not by the AAA, but by the Rules of Procedure for Christian Conciliation of The Institute for Christian Conciliation. [Doc. 12-1] at 17, 20. Those rules leave the scope of arbitration to the parties' agreement at the time of arbitration, and there is no hint of an arbitrability delegation:

> At the outset of arbitration, the parties shall describe the issues and desired remedies that they wish the arbitrators to consider. The arbitrators shall consider only those issues that are consistent with the parties' original arbitration or mediation/arbitration agreement, or which are contemplated by an earlier contract between the parties that contains a conciliation clause.

Ex. 15 at Rule 25. Aliera itself cannot even figure out which of the many versions of the Member Guides and arbitration, or non-arbitration, provisions would apply to the claims here. Movant has submitted five different versions (Selimo's non-provision being a sixth) [Doc. 12-1] at 9-24, but does not suggest which one would apply to the present claims, apparently throwing it up to the Court to conjure an answer.

2. *Aliera is not a party to any arbitration agreement*. Because Aliera is not a party to any arbitration provision, it wrongly contends that it should be read in

because the provision it cites addresses disputes with Trinity or "its associates, or employees." [Doc. 12-14] at 14.[15] The Eleventh Circuit has ruled against construing arbitration provisions to include a non-named party under stronger facts than Aliera relies on here. *See, e.g.*, *Lawson*, 648 F.3d at 1171-72; *Herbalife*, 2020 WL 4342671 at *4. "Associates" here clearly means *individuals* associated with Trinity, such as those who might handle the first-level telephonic appeals, the "three Trinity HealthShare officials" on the second-level internal resolution committee, members selected to the third-level external resolution committee, or the medical expense auditor or panelists at the final appeal level. [Doc. 12-1] at 11-12.

Aliera cites the Merriam-Webster definition of "associate" as encompassing "business associates," but every one of the examples referenced refers to *individual* associates such as "employee," "worker," "partner," and "colleague." [Doc 13] at 19. None references other *business* entities. https://www. merriam-webster.com/dictionary/associate. From both the context of the agreement and the dictionary definition, it is clear that "associates" refers to Trinity's employees and other *individual* associates, not Aliera.

[15] Aliera complains that Plaintiffs did not sue Trinity and Unity, supposedly as an additional way to avoid arbitration. [Doc. 12–14] at 11. A plaintiff is the "master of her complaint," *Holmes Group, Inc. v. Vornado Air circulation Syst., Inc.*, 535 U.S. 826, 831 (2002), and the reasons for suing Aliera in this case are obvious. Aliera conceived, created, and operated the scheme at issue using the two shells, and the illegally collected premiums are funneled to Aliera.

Furthermore, Aliera itself wrote the arbitration provision pursuant to its plenary authority to develop Unity and Trinity documents and administer the plans. *Supra* at 4-6. It is inconceivable that Aliera, as the author of the Member Guides, intended to include itself in the arbitration provision, but did not mention its own name. Aliera should not be allowed to rewrite the provision now. The provisions Aliera cites are also telling because, by their own terms, they do not even contemplate an award against Aliera. They speak only of the possibility of "the arbitrator render[ing] a judgment in favor of" Unity or Trinity HealthShare." [Doc. 12-1] at 9, 14.

Under Georgia law, if the language of an insurance policy is clear and unambiguous, the contract must be enforced according to its plain terms." *Ace Am. Ins. Co. v. Wattles Co.*, 930 F.3d 1240, 1252 (11th Cir. 2019). But if a policy is ambiguous, "it is construed strictly against the insurer/drafter and in favor of the insured." *Id.*; *see also* O.C.G.A. § 13-2-2(5). At most, the contract here is ambiguous and must be construed against the insurer and in favor of Plaintiffs.

3. *Plaintiffs' claims are not covered by the provisions*. The Dispute Resolution and Appeal procedure Aliera relies on does not encompass the claims here. Rather, the procedure is a means to resolve "differences of opinion" regarding medical claim "determinations." [Doc. 12-1] at 7, 12, 15, 19, 23. If a member disagrees with "a determination," s/he may appeal that determination. *Id.* After a telephonic attempt

to resolve the determination, the member may submit a written appeal that addresses any "incomplete or incorrect" information on which Trinity relied, the manner in which Trinity "misinterpreted the information already on hand," and how Trinity "applied incorrectly" its "HealthShare Guidelines." *E.g., id* at 20. At each of the next two levels of appeal, the procedures speak of reviewing ***medical*** – and only medical – documentation. *Id.* at 24. The final appeal stage utilizes "a medical expense auditor" and a decision is made "unless additional ***medical*** documentation is required to make an accurate decision." *Id.* at 24. The scope of mediation and arbitration is the same as for the individual claims and appeals, as those latter stages arise only "[i]f the aggrieved sharing member disagrees with the conclusion of the Final Appeal Panel." *Id.* Were this not clear enough, mediation and arbitration are expressly limited to claims "arising out of the Sharing Guidelines." *Id.*

Plaintiffs' claims here bear no relation to individualized medical claims that could fall within the Dispute Resolution and Appeal procedures, if they were otherwise applicable and enforceable. The crux of Plaintiffs' claims is that Aliera sold Plaintiffs and the Class health care plans as purported HCSM plans that were actually illegal insurance contracts and that Aliera illegally funneled premiums into its own pockets. Those claims, and the specific legal basis set out in the various counts of the Complaint for those claims, would remain even if Aliera and its pseudo-HCSMs had

scrupulously paid every claim in accordance with the guidelines. Even Count III of the Complaint (Breach of Contract and Breach of Covenant of Good Faith and Fair Dealing) is not based on "breaches" of the guidelines. Indeed, allegations regarding Aliera's bad faith refusal to pay medical claims is based on more than the language of the guidelines because, as Aliera notes, they disavow any obligation to pay any claim. [Doc. 12-14] at 3–4. Plaintiffs' contract claim is more of a quasi-contract claim arising from Aliera's breach of the legal duties imposed upon it by law. *See* Complaint [Doc. 1] at 46 ¶¶ 172-75.

Of course, *if* there were a legal and enforceable arbitration provision, *if* Aliera were a party, and *if* one of Plaintiffs' claims were subject to arbitration, Plaintiffs' other claims would still remain before the Court. *KPMG LLP v. Cocchi*, 565 U.S. 18, 19 (2011); *Klay v. All Defendants*, 389 F.3d 1191 (11th Cir. 2004).

4. *Equitable estoppel*. Equitable estoppel is irrelevant since the arbitration provision is illegal, but Plaintiffs will briefly address the issue since Aliera has done so. Equitable estoppel, which was created and is determined by courts, allows for arbitration by some parties not explicitly mentioned in an arbitration provision, but equitable estoppel cannot change the clearly discernable intent of the parties because of the cardinal rule that "a party cannot be required to submit to arbitration any dispute

which he has not agreed so to submit." *AT&T Techs., Inc.*, 475 U.S. at 648. Here, the intent *not* to include Aliera in the provision is unmistakable, *supra* at 29-30.

The cases relied upon by Aliera do not support a different result. "In all cases, the lynchpin for equitable estoppel is equity, and the point of applying it to compel arbitration is to prevent a situation that would fly in the face of fairness." *Bahamas Sales Assoc., LLC v. Byers*, 701 F.3d 1335, 1342 (11th Cir. 2012).[16] Aliera's position is divorced from equity. Equitable estoppel never applies just because there are connections between a contract with an arbitration provision and a plaintiff's claims:

> [I]t is not enough that the alleged misconduct is somehow connected to the obligations of the underlying agreements; the misconduct must "be *founded in* or *inextricably bound up with*" such obligations.
> . . .
> Moreover, in deciding whether equitable estoppel is appropriate, we must remember the purpose of the doctrine, which is to prevent the plaintiff from "hav[ing] it both ways." …"[T]he signatory 'cannot, on the one hand, seek to hold the non-signatory liable pursuant to duties imposed by the agreement, which contains an arbitration provision, but, on the other hand, deny arbitration's applicability because the defendant is a non-signatory."

Herbalife, 2020 WL 4342671 at *6 (citations omitted). As just shown, Plaintiffs' claims are far afield of those requirements for equitable estoppel. Plaintiffs are not in

[16] This, too, is an issue for the Court to resolve, not an arbitrator, because equitable estoppel speaks directly to the existence of an agreement to arbitrate. *Autonation Fin. Servs. Corp. v. Arain*, 264 Ga. App. 755, 755–57 (2003) (even where arbitration clause incorporated reference to AAA rules, question whether non-signatory could invoke arbitration was properly decided by the court).

any way trying to "have it both ways."

III. MEDIATION IS NOT A PREREQUISITE TO THIS ACTION

Aliera contends that this case should be dismissed because there was no pre-suit mediation. There are many flaws in that contention, one being that nothing in the Membership Guides or any other plan document requires that there be mediation before ***filing a civil action*** in this or any other court. Moreover, had there been some such requirement, it would be illegal, and it would also be unenforceable because of Aliera's bad faith in "response" to Plaintiffs' prior efforts to address claim issues. Complaint [Doc. 1] at ¶¶ 12-17, 22-24, 29-31, 109-13.[17] Dismissal would also be inappropriate regardless. This Court can always order mediation if required or desired, but if that were to occur, the case would be stayed pending mediation, not dismissed.

A. *Plaintiffs Have Not Failed to Satisfy a Condition Precedent to Suit.*

Aliera asserts that Plaintiffs failed to comply with the "condition precedent contained in their Unity and Trinity Member Guides" to mediate their claims [Doc. 12-14] at 15, but the Member Guides do not designate mediation as a condition precedent to anything, much less to filing this action. Under Georgia law, not every

[17] Georgia law has long held that insurers' failure to process claims in good faith excuse insureds from pre-suit procedures like submitting proof of loss. *Aetna Cas. & Sur. Co. v. Sampley,* 108 Ga. App. 617 (1963). Notably, Aliera's conduct in this regard continued right up to filing of this action, as it never responded – much less mentioned mediation – to Plaintiffs' pre-suit demand letter. Ex. 16.

contractual requirement is a "condition precedent." To the contrary, as this Court has previously explained, such conditions are disfavored:

> In Georgia, a party must perform a condition precedent in order for the contract to become binding on the other party. O.C.G.A. § 13-3-4. Put another way, "[a] condition precedent is one which must be performed before any right to be created thereby accrues." *Brogdon ex rel. Cline v. Nat'l Healthcare Corp.*, 103 F. Supp. 2d 1322, 1335 (N.D. Ga. 2000) (quoting *Wolverine Ins. Co. v. Sorrough*, 122 Ga. App. 556, 177 S.E.2d 819, 822 (1970)). Parties can create conditions precedent "by language such as 'on condition that,' 'if' and 'provided,' or by explicit statements that future events are to be construed as conditions precedent." *Choate Constr. Co. v. Ideal Elec. Contractors, Inc.* 246 Ga. App. 626, 541 S.E.2d 435, 438 (2000). ***But Georgia law does not favor interpreting a contract to find a condition precedent; thus, "[i]f the contract's terms are clear and unambiguous and do not clearly establish a condition precedent, [courts] cannot construe the contract to create one."*** *Id.*

Ralls Corp. v. Huerfano River Wind, LLC, 27 F. Supp. 3d 1303, 1323–24 (N.D. Ga. 2014) (emphasis added).

Here, none of the dispute resolution clauses that Aliera relies on contains language suggesting that mediation is a condition precedent to the commencement of litigation. *See* [Doc. 12-1] at 9-24. They simply state that arbitration is to follow mediation, something that falls well short of the language in *Ralls* that is necessary to create a condition precedent. *See*, *e.g.*, *Plantation Pipeline Co. v. Stonewall Ins. Co.*, 335 Ga. App. 302, 312–13 (2015) (notice provision in insurance policy requiring insured to provide prompt notice of claims did not create a condition precedent).

This case differs markedly from the cases on which Aliera relies. In *Woods v. Holy Cross Hospital*, 591 F.2d 1164, 1169 n.7 (5th Cir. 1979), a Florida statute requiring pre-suit mediation of medical malpractice claims had been construed as creating "a condition precedent to the jurisdiction of any court in a medical malpractice-based action." *Woods* says nothing about whether the language in Defendant's Guides creates a condition precedent. In *Houseboat Store, LLC v. Chris-Craft Corp.*, 302 Ga. App. 795, 799 (2010), the court was not called upon to decide whether the dispute-resolution clause made mediation a condition precedent, as the parties agreed on the issue. Like the notice provision in the insurance contract addressed in *Plantation Pipeline*, the mere mentioning of mediation in the Member Guides does not make mediation a condition precedent to anything.

B. *If There Were a Mediation Requirement Here, It Would Be Unenforceable as a Matter of Law.*

Aliera's argument relies on a Dispute Resolution and Appeal procedure in some of the Members Guides, but as shown *supra* at 26-27, that multistage procedure is illegal under both the ACA and Georgia law. For the same reasons, any mediation requirement would be illegal here. As Judge Rothstein ruled in *Jackson,* the dispute procedures are illegal both in their individual requirements and together.

IV. CONCLUSION

For the foregoing reasons, the Court should deny Defendant's Motion To Dismiss Or Compel Arbitration and allow this case to proceed on the merits of Plaintiffs' claims.

Respectfully submitted this 14th day of August 2020.[18]

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[18] Pursuant to Local Rule 7.1(D), undersigned counsel certifies that this filing has been prepared with one of the font and point selections approved by the Court in Local Rule 5.1(C).

CERTIFICATE OF SERVICE

I hereby certify that on the date below, I served a true and correct copy of PLAINTIFFS' RESPONSE IN OPPOSITION TO DEFENDANT'S MOTION TO DISMISS OR COMPEL ARBITRATION by filing the same using the Court's CM/ECF system, which will automatically serve all counsel of record.

Dated this 14th day of August, 2020.

/s Jennifer K. Coalson

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STATE OF GEORGIA

Secretary of State

Corporations Division
313 West Tower
2 Martin Luther King, Jr. Dr.
Atlanta, Georgia 30334-1530

CERTIFICATE OF AUTHORITY

I, Brian P. Kemp, the Secretary of State and the Corporation Commissioner of the State of Georgia, hereby certify under the seal of my office that

Aliera Healthcare, Inc.

a **Foreign Profit Corporation**

has been duly formed under the laws of **Delaware** and has filed an application meeting the requirements of Georgia law to transact business as a **Foreign Profit Corporation** in this state.

WHEREFORE, by the authority vested in me as Secretary of State, the above **Foreign Profit Corporation** is hereby granted, on **04/28/2016**, a certificate of authority to transact business in the State of Georgia as provided by Title 14 of the Official Code of Georgia Annotated. Attached hereto is a true and correct copy of said application.

WITNESS my hand and official seal in the City of Atlanta
and the State of Georgia on 06/28/2016

Brian P. Kemp
Secretary of State

APPLICATION FOR CERTIFICATE OF AUTHORITY

Electronically Filed
Secretary of State
Filing Date: 4/28/2016 12:10:06 PM

BUSINESS INFORMATION

CONTROL NUMBER	16061258
BUSINESS NAME	Aliera Healthcare, Inc.
BUSINESS TYPE	Foreign Profit Corporation
EFFECTIVE DATE	04/28/2016
HOME JURISDICTION	Delaware
NAME IN HOME STATE	Aliera Healthcare, Inc.
DATE OF FORMATION IN HOME JURISDICTION	12/18/2015
COMMENCEMENT DATE IN GEORGIA	04/01/2016

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AUTHORIZER INFORMATION

AUTHORIZER SIGNATURE	Shelley Steele
AUTHORIZER TITLE	Incorporator

Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "ALIERA HEALTHCARE, INC." IS DULY INCORPORATED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL CORPORATE EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE TWENTY-EIGHTH DAY OF APRIL, A.D. 2016.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL REPORTS HAVE BEEN FILED TO DATE.

AND I DO HEREBY FURTHER CERTIFY THAT THE FRANCHISE TAXES HAVE BEEN PAID TO DATE.

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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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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. I Hon. Alice D. Bonner

RECEIVER'S INITIAL REPORT

Marshall Glade, not individually, but as Court-appointed Receiver ("**Glade**" or "**Receiver**") to oversee the legacy Unity Health Care Sharing Ministry ("**HCSM**") plans and to oversee all Unity HCSM plan assets during the pendency of the litigation between the parties pursuant to O.C.G.A § 9-8-1 and the April 25, 2019 Order entered by this Court appointing Glade as Receiver (the "**Order**"), files this initial report. The purpose of the initial report is to provide the Court and all interested parties with a description of the nature of the Receiver's activities, investigations, analysis, observations, and recommendations to date.

Table of Contents

1.0 Introduction

1. On April 25, 2019 the Superior Court of Fulton County Business Case Division (the "**Court**") appointed Glade as the Receiver to oversee Unity HCSM plans and plan assets.

2. To assist in his work, the Receiver retained the services of GlassRatner professionals. The Receiver, along with other GlassRatner professionals, met on numerous occasions with individuals familiar with Unity's financial processes and other affairs and reviewed various relevant documents.

3. The Receiver's duties and responsibilities as set forth in the Court's April 25, 2019 Order are as follows[1];:

   a) *"Oversee the legacy Unity HCSM plans and to oversee all Unity HCSM plan assets during the pendency of this litigation."*

   b) *"Receiver shall have complete access to 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."*

   c) "*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 Unity HCSM component of member plans.*"

   d) "*Receiver shall have all financial access and audit rights necessary to confirm the proper allocation, as well as payment of claims and expenses".*

   e) *"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."*

   f) *"Receiver also has review and audit rights with respect to Aliera's administration of Unity HCSM Claims to ensure Aliera is administering the members' plans and paying member claims consistently with the plan documents."*

4. The analyses performed, and to be performed, by the Receiver will require the scrutiny of financial information. GlassRatner is not a public accounting firm. While our work may involve

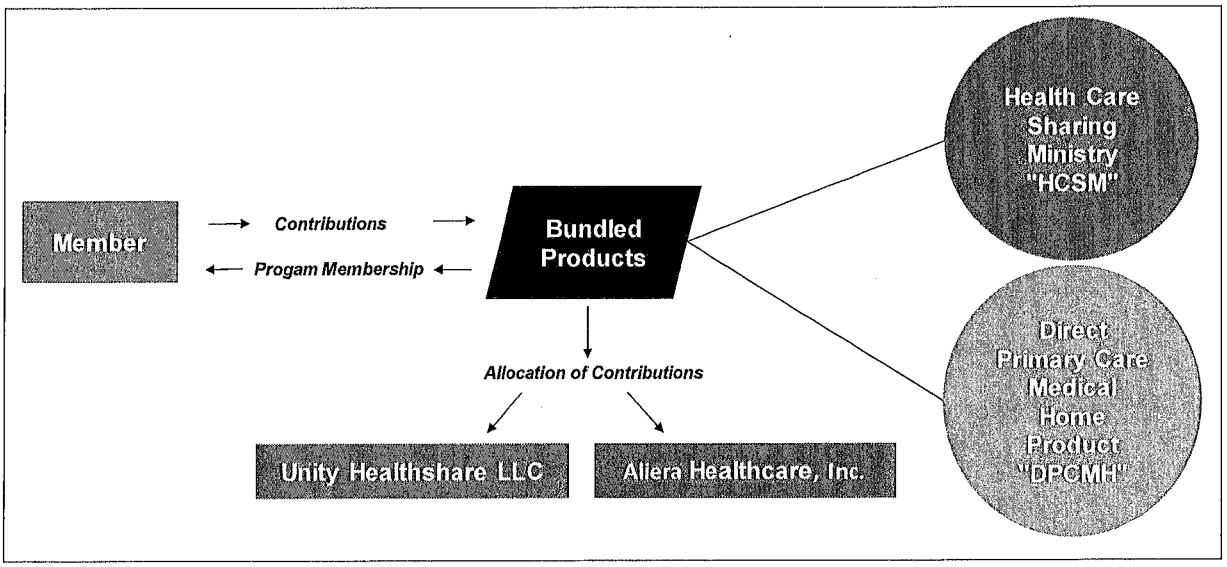
[1] Page 29 – 30 of Order Entering Interlocutory Injunction and Appointing Receiver (**Appendix 1**)

analysis of accounting records, it does not include an *audit* or *review* of existing records in accordance with generally accepted auditing standards or standards for review engagements[2].

2.0 Executive Summary

5. In 2016, Aliera approached Anabaptist Healthshare ("**AHS**") about developing a business relationship. Aliera sold a direct primary care medical home product ("**DPCMH**") which focuses on preventative and primary care. AHS sold an HCSM product, which is an alternative to traditional insurance products where members of similar religious/faith beliefs share in the health care costs of its members. Aliera proposed combining its DPCMH product with the HCSM product for the benefit of a comprehensive offering to the public, as illustrated in **Chart 1** below. The HCSM product was to be offered by Unity Healthshare, LLC, a wholly-owned subsidiary of AHS.

Chart 1



6. In February 2017, AHS and Aliera signed an agreement authorizing Aliera to sell the combined DPCMH and HCSM product and administer the plans.

7. As part of the Receiver's Order, we have examined Unity's books and records maintained by Aliera in order to assess the operating financial results from January 1, 2017 through June 30,

[2] An ***Audit*** is an independent examination of accounting and financial records and financial statements to determine if they conform to the law and to generally accepted accounting principles (GAAP). A ***Review*** is a service under which the accountant obtains limited assurance that there are no material modifications that need to be made to an entity's financial statements for them to be in conformity with the applicable financial reporting framework, such as GAAP.

2019. GlassRatner focused its efforts on examining and analyzing member payments, management fees, healthcare sharing expenses, financial results and development of a plan termination.

8. The documents relied upon for our analysis included bank statements, QuickBooks files, the member database, a healthcare sharing expense register, management fee calculations, contribution fee allocations and other supporting documentation.

9. Per the Court's Order, 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*"[3]. Aliera controlled and managed all cash receipts and disbursements. Depending on the operating results of the HCSM component, Aliera would either owe funds to Unity or Unity would owe funds to Aliera. For example, if the operating results of the HCSM component resulted in Net Assets (i.e. Unity contributions less Unity disbursements) of $10 million, Aliera would owe $10 million to Unity. By contrast, if the operating results of the HCSM component resulted in a Net Deficit (i.e., Unity disbursements exceed Unity contributions) of $10 million, Unity would owe $10 million to Aliera. Based on our procedures and analyses to assess the financial performance of the Unity component, we made the following observations:

   a) **Aliera Commingled Funds** – Aliera used a single bank account in which they commingled funds related to its business venture with Unity and their non-Unity related interests with other partners. All Unity and non-Unity member payments were deposited into a single bank account exclusively controlled by Aliera.

   b) **Unreliable and Incomplete Unity Financial Statements** – Our review of the internal unaudited financial statements and supporting documentation showed errors associated with Aliera's accounting for member payments, fee applications and management fees. Accordingly, we were unable to rely on the financial statements produced by Aliera.

   c) **Scenario Analysis of Financial Results** – Due to the lack of reliable financial statements, GlassRatner developed schedules to calculate the actual financial performance. The underlying data provided by Aliera allowed GlassRatner to analyze the performance of the Unity HCSM plans. We noted the Agreement did not expressly allocate the percentage of member payments associated with the Aliera DPCMH

[3] Order Entering Interlocutory Injunction and Appointing Receiver, page 29.

component and the percentage of member contributions associated with the Unity HCSM component. The proper allocation is a dispute between the parties that is before the Court in this litigation. The Agreement also did not expressly state that Unity would be responsible for expenses associated with the third-party administrator, whether such expenses are to be allocated, and if so, the allocation of such expenses. The disputed issues have a material impact on the financial results of Unity.

10. Accordingly, GlassRatner calculated the financial performance under two scenarios to allocate member payments, management fees and the third-party administrator fees (see Table 1 below). **Scenario A** summarizes the financial results based on the allocation of member payments and third-party administrator expenses currently asserted by Aliera. **Scenario B** summarizes the financial results based on the allocation of member payments and third-party administrator expenses currently asserted by Unity. The allocation assumptions are as follows:

    i. **Scenario A** assumes **35%** of the monthly payments for the bundled products are allocated to Unity and the entire third-party administrator fee is a Unity expense;

    ii. **Scenario B** assumes **68%** of the monthly payments for the bundled products are allocated to Unity and the third-party administrator fee is not a Unity expense;

    iii. Both Scenario's include an adjustment of the allocations related to Unity-only products and the application fees; and

    iv. The two parties dispute how the management fee described in Section 4 of the Agreement should be calculated. Both scenarios calculate the management fee in the same way. A change in the allocations affects the management fee calculations. For example, an increase in Unity allocations results in an increase in the management fee payable from Unity to Aliera.

Table 1

Unity Scenario Analysis on Financial Results (January 1, 2017 to June 30, 2019)			
Description	**Scenario A**	**Scenario B**	**Difference**
Total Member Contributions and Application Fees	$ 113,806,092	$ 203,913,734	$ (90,107,642)
Aliera Portion of Claims Expense [1]	34,548,794	34,548,794	-
Total Contributions	**$ 148,354,885**	**$ 238,462,528**	**$ (90,107,642)**
Less: Claim Disbursements	142,306,443	131,505,056	10,801,386
Contributions in Excess of Claims	**$ 6,048,443**	**$ 106,957,471**	**$ (100,909,029)**
Less: Aliera Management Fee Per Contract Terms	13,166,442	27,747,332	(14,580,891)
Unity-Component Performance	**$ (7,117,999)**	**$ 79,210,139**	**$ (86,328,138)**

Notes

[1] 100% of claims expense for the bundled product are recorded on the Unity general ledger. According to Aliera, approximately 68% of the 2018 medical claims (in dollars) relates to the HCSM portion of the offering. As an offset to this additional expense recorded on the Unity general ledger, an equal amount has been allocated to Unity as additional revenue.

11. As illustrated above in Table 1, there is an $86 million variance between the operating results using **Scenario A** compared to **Scenario B**. In summary, for every 5% change in allocation from Aliera to Unity there is approximately an $11.4 million improvement to Unity's financial performance.

12. Receiver also is in the process of reviewing records regarding Aliera's administration of the payment of Unity members' requests to share medical expenses. The Receiver will review these records and processes to confirm that Aliera is administering the Unity HCSM plans in accordance with the plan documents.

Next Steps

13. The Receiver plans to analyze the operating results post-June 2019 and will incorporate those results into an updated version of the scenario analyses.

14. The Receiver will continue to work with Aliera and Unity to develop a specific recommendation on the amount of funds to segregate, if necessary.

15. After a resolution has been reached regarding the scenario analysis variances, GlassRatner and Aliera will require at least 30 to 45 days to prepare financial statements in accordance with GAAP.

16. The plan is currently operating at a loss and has been operating at a loss for the past few months as the number of existing members has significantly declined, new members could not be added, and the average cost of the sharing request has increased. Unity and Aliera, with approval from the Court, agreed to terminate the plan as of November 18, 2019. The members have until February 15, 2020 to submit any healthcare expenses.

17. In the interim, Aliera has agreed to fund an escrow account for the expected value of the healthsharing expenses to be processed through the final healthcare expense submission date (February 15, 2020). Aliera estimates that from October 15, 2019 through the final payment, [redacted] of medical expenses will be processed. The [redacted] of medical expenses will be deposited from an anticipated [redacted] in member contributions and [redacted] from Aliera into a separate bank account to which the Receiver will have access and oversight.

3.0 Background

18. In 2016, Aliera approached Anabaptist Healthshare ("AHS"), who is the sole owner of Unity, about developing a business relationship. Aliera sold a direct primary care medical home product ("DPCMH") which focuses on preventative and primary care. Anabaptist sold an HCSM product which is an alternative to traditional insurance products where members of similar religious/faith beliefs share in the health care costs of its members. Aliera proposed combining this DPCMH product with the HCSM for the benefit of a comprehensive offering to the public. In addition, Aliera would "*develop networks, distribution channels, provide plan management and benefit coordination for health care services…throughout the United States*".[4] In November 2016, Anabaptist created Unity Healthshare, LLC to partner with Aliera to offer the combined side-by-side product.

19. In February 2017, the two parties executed an Agreement between Anabaptist Healthshare, Unity Healthshare LLC and Aliera Healthcare, Inc. (the "Agreement"), which is attached to this Report in **Appendix 2**[5]. The Agreement established the following:

    a) AHS and Aliera will partner together and enable Aliera to market and sell the two non-insurance products (i.e. the DPCMH and HCSM products) to the public[6];

[4] Page 1 of Agreement between Anabaptist Healthshare and Aliera Healthcare, Inc. dated February 2017. [GR_000358].
[5] Agreement between Anabaptist Healthshare and Aliera Healthcare, Inc. dated February 2017. [GR_000358 – 365].
[6] "*Public markets means persons who will acknowledge the standard of beliefs and other requirements as deemed necessary by AHS*", page 2 of the Agreement. [GR_000359].

b) AHS and Unity will market products through Aliera using their DPCMH model of care, network, administration, call center, marketing, enrollment portal and other related services;

c) AHS is granting Aliera an exclusive license to sell and distribute the Unity products to the public markets;

d) During the term of the Agreement, Aliera will remain the sole and exclusive healthcare company allowed to market and sell health care products;

e) Aliera is "*entitled to retain the first monthly membership fee. 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 per member per month ("PMPM") as payment for its services*";[7]

f) Unity will establish a ministry fund to further their charitable direction, which will receive the following:

   i. $2.00 PMPM; and

   ii. $25.00 for each one-time application fee per membership.

g) Eldon Hochstetler and Tyler Hochstetler, who are Anabaptist Healthshare, Inc. officers, will each receive $2.50 per enrolled member in Unity Healthshare per month. This fee ($5.00 PMPM in total) shall be incurred by and paid by Aliera each month; and

h) Aliera will design and implement all cost sharing plans, marketing materials, operational controls and general business banking for Unity and it's Healthshare operations.

The contract terms are further discussed in the Court's April 25, 2019 Order.

20. The Unity and Aliera products were marketed together to the general public and required only one contribution to be paid by the member. Aliera collected the payment from each member and then allocated a portion of the payment between Aliera and Unity. **However, the Agreement does not specify any agreed upon allocation of the monthly member payments. The proper allocation was a disputed issue between the parties during their relationship and it remains a disputed issue before the Court in the litigation.** Aliera and Unity have materially different perspectives on what the allocation of member contributions should be. As a result, this is by far the largest issue affecting the financial results.

[7] Section 4 of Agreement between Anabaptist Healthshare and Aliera Healthcare [GR_000359-GR_000360]

21. Aliera has recently informed the Receiver that certain members made two separate payments – one for the Aliera DCPMH product and one for the Unity HCSM product. Aliera has represented this occurred from November 2016 through July 2017. Further analysis will need to be performed to assess the impact, if any conclusions.

22. In August 2018, after failed mediation with Aliera, AHS/Unity terminated the Agreement. However, Aliera has continued to administer the plans subject to a temporary restraining order, which was issued in December 2018. After extensive on-going litigation between the parties throughout early 2019, the Receiver was appointed on April 25, 2019.

4.0 Receiver's Activities

23. Since the Appointment of the Receiver, Glade and his professionals made information requests to Aliera's counsel to facilitate the efforts described herein. The Receiver and his team continually met with Aliera and Unity representatives to carry out the Receiver's duties and responsibilities. GlassRatner relied upon these meetings and the review of documents (see **Appendix 3** for further details) in order to develop this initial report.

24. The Aliera team present in a majority of meetings and conference calls were:

    a) James F. Butler III, Vice President of Finance;

    b) Ella Bikeeva, Controller; and

    c) Aliera Counsel (Bondurant Mixson & Elmore LLP).

25. A series of meetings also took place with Unity counsel represented by Alston & Bird LLP.

26. In order to meet the Receiver's responsibilities as outlined above, GlassRatner performed the following procedures:

4.1 Member Payments

a) Examined the Aliera maintained Wells Fargo depository bank account statements from inception through June 2019[8].

b) Analyzed the Unity QuickBooks file maintained by Aliera from inception through June 2019;

[8] GR_001815 – GR_001822, GR_000867 – GR_001283,GR_001301 – GR_001409

c) Performed a reconciliation of the bank statements (noted above) to the member database file;

d) Performed a reconciliation of the member database file to the supporting accounting records;

e) Obtained an understanding of how payments are processed and accounted for; and

f) Analyzed the allocation percentages applied to Aliera and Unity regarding the shared products along with the necessary supporting documentation.

4.2 ***Management Fees***

a) Reviewed the Agreement between Aliera and Unity (defined below) to understand the financial terms of the management fee;

b) Obtained an understanding and analyzed the management fees as calculated by Aliera; and

c) Re-calculated the management fee per the language of the Agreement as follows: *"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 UHS ("Unity') expense. Thereafter, any succeeding month(s) which the membership is continued, Aliera shall be entitled to retain $25 PMPM as payment for its services."*[9]

d) As noted previously, the parties dispute how the management fee described in Section 4 of the Agreement should be calculated.

4.3 ***Healthcare Expenses***

a) Reconciled the healthcare expenses to the accounting records;

b) Gained an understanding of the allocation of healthcare expenses between the DPCMH and HCSM products (defined below);

c) Reviewed the third-party claims administrator agreement and reconciled the financial terms outlining the fee structure; and

d) Refer to **Appendix 4** for further discussion on our procedures performed.

[9] Section 4 of Agreement between Anabaptist Healthshare and Aliera Healthcare [GR_000359-GR_000360]

4.4 Scenario Analysis of Financial Results

a) Gained an understanding of the disputed business terms and their respective financial impact; and

b) Compiled a preliminary scenario analysis of financial results.

4.5 Development of Plan Termination

a) Facilitated an agreement of terms between Aliera and Unity regarding the termination of membership plans; and

b) Established procedures to verify adequate funds are available and segregated in order to fund the qualifying healthcare expenses run-out.

5.0 Receiver's Preliminary Observations & Analysis

27. Per the Receiver's Order, 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*"[10]. Aliera controlled and managed all cash receipts and disbursements. Depending on the operating results of the HCSM component, Aliera would either owe funds to Unity or Unity would owe funds to Aliera. For example, if the operating results of the HCSM component resulted in net assets (i.e. contributions less disbursements) of $10 million, Aliera would owe $10 million to Unity. By contrast, if the operating results of the HCSM component resulted in a Net Deficit (i.e., Unity disbursements exceed Unity contributions) of $10 million, Unity would owe $10 million to Aliera. While performing our procedures to determine the Unity operating results we noted the following observations:

5.1 Commingled Funds

28. Aliera maintained a single bank account in which they commingled funds related to their business venture with Unity as well as their non-Unity related interests with other partners. All Unity and non-Unity member payment were deposited into a Wells Fargo bank account (ending [redacted]) exclusively controlled by Aliera.

[10] Order Entering Interlocutory Injunction and Appointing Receiver, page 29.

29. These member contributions are tracked within Admin123, a customer database software administered by Aliera. The database tracks customer information such as address, date of birth, date of enrollment, payment timing, payment method, etc.

30. The member payments recorded to the Admin123 Files fit into one of six categories – Bundled Products, Unity Non-Bundled Products, Unity Dental and Vision Products, Aliera Product Ryders, Application Fees and Products not associated with the Unity - Aliera platform. Refer to **Appendix 5** for further description of these products.

31. GlassRatner reconciled the [redacted] in bank statement deposits for the period January 1, 2017 through June 30, 2019 to the Admin123 files. Refer to **Appendix 6** for our Reconciliation Schedule.

32. From review of the Admin123 files, GlassRatner determined [redacted] was received for the Unity – Aliera platform. Refer to **Appendix 7** for our Schedule of Contributions by Product.

33. Additional procedures were required by GlassRatner in order to account for and manage the commingling of not-for-profit (Unity), for-profit (Aliera), and non-Unity payments. Refer to **Appendix 8** for a summary of additional procedures performed to understand and validate the data in the Admin123 files.

5.2 Unreliable and Incomplete Unity Financial Statements[11]

34. The Unity financial statements, as prepared by Aliera, are unreliable and inaccurate. They contained the following errors for which we made adjustments with the input and assistance of Aliera's financial team.

5.2.1 Member Payments / Application Fees

35. [redacted] of Unity-only products were sold, of which Aliera only recorded [redacted] as Unity contributions. GlassRatner identified that an additional [redacted] in contributions should be recognized as Unity member contributions.

[11] James Butler, VP of Finance, and Ella Bikeeva, Controller, were not hired until mid-2018 in the midst of significant growth (as evidenced by the $85.7 million revenue increase from 2017 to 2018). Shortly thereafter, litigation commenced between Unity and Aliera, which placed additional strain on Aliera's resources. Given this situation, it is not uncommon for a company to be faced with these types of issues associated with financial reporting. The Aliera accounting and finance team have been cooperative in assisting us in the execution of our procedures.

36. [redacted] of Aliera Product Riders were sold, of which Aliera recorded [redacted] as Unity contributions. None of the [redacted] should have been recognized as Unity contributions, but instead should be recognized as Aliera-only revenue.

37. Based on Aliera's methodology (which is contested by Unity), member payments for bundled products would be allocated **35%** to Unity and **65%** to Aliera. GlassRatner's review of the bundled product determined only **32.5%** was allocated to Unity. Adjusting this percentage to **35%** results in an additional [redacted] in Unity-related member contributions.

38. Per the Agreement, Unity should have been allocated $25 revenue for each application fee, with the balance retained by Aliera[12]. GlassRatner recalculated the allocation of application fees and determined the Unity application fee revenue was overstated by approximately [redacted], such that Aliera should have received [redacted] more in revenue.

5.2.2 Management Fees

39. The management fee paid to Aliera is calculated on a per member basis, as follows[13]:

    a) 1st monthly membership payment;

    b) 2nd monthly membership payment with the caveat that it is "*to be used if necessary for Aliera or Unity expenses*"; and

    c) 3rd monthly payment and thereafter at $25 per month.

40. GlassRatner calculated the management fees based on the language outlined in the Agreement described above. Our management fee calculation was materially different than Aliera's calculation primarily due to Aliera's methodology which included a $25 fee on the 1st and 2nd payments for select products[14], instead of the full monthly contribution.

41. The net effect of the methodology difference between Aliera's management fee calculation and GlassRatner's calculation is significant, which if applicable, would result in **$13.2 million** more in fees owed to Aliera as shown in **Table 2** below. This is a disputed issue between the parties.

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[12] Per Paragraph 7(d) of the Agreement between Anabaptist Healthshare and Aliera Healthcare [GR_000358 – 365].
[13] Refer to Section 3.2 of the Agreement [GR_000360 – 361].
[14] Product ID's: 17460, 17461, 17462, 17113, 17115, 17117, 20662, 20725, 20726, 17476, 17478, 17480, 16916, 17108, 17109, 17184, 17185, and 17186.

Table 2

Management Fee Calculation								
2017		2018		Jan. - Jun. 2019		Total		
Aliera[1]	Contract	Aliera[1]	Contract	Aliera[1]	Contract	Aliera	Contract	Variance
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	$ 13,166,442

Notes
[1] The management fee shown above does not reconcile to Aliera's books and records as their calculations evolved as a result of on-going discussions.

5.3 Scenario Analysis of Financial Results

42. Due to the lack of reliable financial statements, GlassRatner developed schedules to calculate the actual financial performance. The underlying data provided by Aliera allowed GlassRatner to analyze the performance of the Unity HCSM plans. We noted the Agreement did not expressly allocate the percentage of member payments associated with the Aliera DPCMH component and the percentage of member contributions associated with the Unity HCSM component. The proper allocation is a dispute between the parties that is before the Court in this litigation. The Agreement also did not expressly state that Unity would be responsible for expenses associated with the third-party administrator, whether such expenses are to be allocated, and if so, the allocation of such expenses. The disputed issues have a material impact on the financial results of Unity.

43. Accordingly, GlassRatner calculated the financial performance under two scenarios to allocate member payments, management fees and the third-party administrator fees. **Scenario A** summarizes the financial results based on the allocation of member payment and third-party administrator expenses currently asserted by Aliera. **Scenario B** summarizes the financial results based on the allocation of member payments and third-party administrator expenses currently asserted by Unity.

44. The Scenario analyses use the following assumptions:

a) Member Payment Allocations:

i. **Scenario A** assumes **35%** of the monthly payments for bundled products are allocated to Unity based on Aliera's research and conclusions they believe are supported by the Brady Ware market study report that is discussed below in paragraph 46; and

ii. **Scenario B** assumes **68%** of the monthly payments for bundled products are allocated to Unity based on the split of healthcare expenses between the DPCMH and HCSM components. Further discussion regarding this can be found in paragraph 47 below.

b) Third-Party Administrator Fee (HealthScope):

i. **Scenario A** assumes the administrator fee is exclusively a Unity expense; and

ii. **Scenario B** assumes the tasks performed by the third-party administrator are part of the scope of services provided by Aliera in earning their management fee, so as a result, the administrator fee should not be a Unity expense and be solely incurred by Aliera.

45. The variance between the two scenarios is **$86.3 million** as illustrated previously in **Table 1**. **Table 3** below provides additional details relating to the impact of Aliera and Unity's respective allocation positions.

Table 3

Unity Scenario Financial Results (January 1, 2017 to June 30, 2019)			
Description	Scenario A $	Scenario B $	Difference $
Cash Receipts			
Bundled Products	[redacted]	[redacted]	$ (90,107,642)
Unity Only Products			-
Unity Portion of Member Share Contributions[1]			**$ (90,107,642)**
Unity Portion of Application Fees[2]			-
Aliera Portion of Claims Expense[3]			-
Total Cash Receipts			**$ (90,107,642)**
Cash Disbursements			
Claims Expense[3]			$ -
Claims TPA Expense[4]			11,356,988
Management Fees Per Aliera Calculation[5]			(555,601)
Other Misc. Expenses[6]			-
Accrued Claims Estimate[7]			-
Total Cash Disbursements			**10,801,386**
Net Receipts and Disbursements			**$ (100,909,029)**
Less:			
Additional Management Fee Per Contract Terms[5]			(14,580,891)
Net Receipts and Disbursements After Management Fee Per Contrac	**$** [redacted]	**$** [redacted]	**$ (86,328,138)**

Notes

[1] For bundled products, Scenario A was calculated as 35% of the monthly contribution (65% allocated to Aliera). Scenario B was calculated as 68% of the monthly contribution (32% allocated to Aliera). Any stand alone Unity product was calculated as 100% Unity. Note - parties dispute the appropriate monthly contribution splits.

[2] Per Agreement Between Anabaptist Healthshare and Aliera Healthcare ("Agreement") (Bates GR_000362) $25 per application fee is allocated to Unity, remainder is retained by Aliera.

[3] All expenses related to claims for the bundled product are presented on the Unity financial statements. This includes the 32% of claims that relate to the Aliera portion of the bundled product. As an offset to this additional expense on the Unity financials, an equal amount has been allocated to the revenue side.

[4] Expense related to third-party claims administrator, HealthScope. Scenario A represents 100% of the HealthScope expense with no allocation to Aliera. Scenario B represents 0% of the HealthScope expense allocated to Unity with 100% allocated to Aliera. The parties dispute how the expenses associated with Healthscope should be allocated between the parties.

[5] Aliera calculated their management fee differently than the fees agreed upon in the Agreement. If Aliera calculated the management fee based on GlassRatner's understanding of the terms of the agreement, an additional [redacted] in fees would be owed to Aliera.

[6] Other miscellaneous expenses such as rent, legal and accounting fees, and wages allocated specifically to Unity.

[7] This represents an estimate of incurred but unpaid outstanding claims owed as of 6/30/19.

5.3.1 Allocation of Member Payments for Bundled Products

46. Aliera proposes an allocation for the bundled products payments of 35% to Unity and 65% to Aliera (**Scenario A**). For example, if a member pays $400, then $140 would be allocated as a member contribution to the Unity plan and the remaining $260 would be retained by Aliera[15]. The rationale for this split of member share contributions is based on an HCSM industry analysis performed by Brady Ware & Schoenfeld, Inc. (which was commissioned by Aliera)[16]. The Brady Ware Report summarized purported market data related to comparable products. Aliera relied on the Brady Ware Report estimates to support their allocation position of 35%.

47. **Scenario B** is an allocation of the bundled product payments of **68%** to Unity and **32%** to Aliera. For example, if a member pays $400, then $272 would be a member contribution to the Unity plan and the remaining $128 would be retained by Aliera[17]. The rationale for this split of the member share payments is based on the healthcare expenses, where the allocation of the contributions would match the actual medical expenses of the Aliera and Unity products. According to Aliera, approximately **68%** of the 2018 medical expenses (in dollars) relates to the HCSM portion of the offering; therefore, Unity believes it should receive **68%** of member contributions for bundled products to pay these expenses. Depending on which allocation is utilized, the Unity membership contribution could be either **$112 million** (**Scenario A**) or **$202 million** (**Scenario B**), a difference of **$90 million**.

5.3.2 Management Fees

48. Ultimately, the member payment allocations have a significant effect on the management fee. For example, assuming a monthly payment of $400 and an allocation to Unity of **35%**, then Aliera would be eligible to retain $140 per month for the first two months. If that same $400 payment is allocated **68%** to Unity, Aliera would be eligible for a management fee of $272 per month for the first two months. As previously shown in **Table 3**, based on these adjustments the variances in the management fee calculation is as much as **$14.6 million**. As noted above, the allocation issue and the amount of the management fee are disputed issues between the parties.

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[15] $400 x .35 = $140. $400 - $140 = $260

[16] Brady Ware Analysis of Healthcare Plan Pricing dated March 8, 2019, with an effective date of October 31, 2018 (the "**Brady Ware Report**") [GR_000322 – 000342].

[17] $400 x .68 = $272. $400 - $272 = $128.

5.3.3 TPA Expense – HealthScope

49. Another disputed item relates to the claims TPA expense. These are fees paid to HealthScope for administering the healthcare expenses. Aliera proposes the full expense should be allocated to the Unity books, consistent with how Aliera recorded the expense on the general ledger. Unity contends that the tasks performed by HealthScope are included in the responsibilities of the manager (Aliera) as defined in the Agreement. Therefore, this expense should be borne exclusively by Aliera. This dispute results in a **$11.3 million** variance between the two parties.

6.0 Next Steps

6.1 Determination of Funds in Aliera's Possession Corresponding to Unity HCSM

50. The net receipts and disbursements represent the net assets of the Unity HCSM plan; however, this does not equate to the amount of dollars held by Aliera corresponding to the Unity HCSM plan (amounts owed from Aliera to Unity). When calculating the final amounts owed from Aliera to Unity, we need to take into account the **$4.6 million** of cash frozen and controlled by Unity in August 2018. These dollars will need to be offset from any net assets calculation to determine the true dollars owed from Aliera to Unity.

51. Based on the size of the **$86 million** variance between the operating results under **Scenario A** and **Scenario B**, the Receiver is unable to make a specific recommendation on the amount of funds to segregate at this time. For every 5% change in allocation from Aliera to Unity there is approximately an **$11.4 million** increase to Unity's net cash receipts.

52. The Receiver plans to analyze the operating results post-June 2019 and will incorporate those results into an updated version of the scenario analyses.

53. Additionally, the Receiver will continue to work with Aliera and Unity to develop a specific recommendation on the amount of funds to segregate, if necessary.

6.2 Preparation of GAAP Financial Statements

54. After a resolution has been reached regarding the scenario analysis variances, GlassRatner and Aliera will require at least 30 to 45 days to prepare financial statements in accordance with GAAP. Once the GAAP financial statements are finalized, a financial statement audit can

commence. When the audit is complete, Unity will be able to submit the appropriate documents in connection with its status as a non-profit entity.

55. The Receiver has and will continue to speak with the parties to attempt to negotiate a compromise and settlement of the terms of the Agreement that are in dispute.

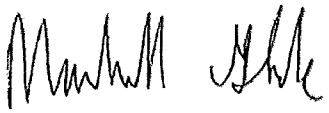
6.3 Plan Termination and Segregation of Funds

56. The plan is currently operating at a loss and has been operating at a loss for the past few months as the number of existing members has significantly declined, new members could not be added, and the average cost of the sharing request has increased. There is no ability to sign up new members so the plan will continue to operate at a loss. Therefore, Unity and Aliera, with approval from the Court, agreed to terminate the plan as of November 18, 2019. The members will have until February 15, 2020 to submit any healthcare expenses.

57. In the interim, Aliera has agreed to fund an escrow account for the expected value of the medical expenses to be processed through the final submission date (February 15, 2020). Aliera projected from October 15, 2019 through the final payment, [redacted] of medical expenses to be processed. The [redacted] of medical expenses will be funded through [redacted] in anticipated member contributions and [redacted] into an account which the Receiver will have access and oversight. In addition, the Receiver will be provided the weekly HealthScope funding requests. The combination of account access and the HealthScope funding requests will allow the Receiver to ensure all eligible remaining claims will be paid and determine if the escrow is appropriately funded.

Respectfully Submitted,

Marshall Glade, Receiver

By: 

Marshall Glade
GlassRatner Advisory & Capital Group LLC
3445 Peachtree Road
Suite 1225
Atlanta, GA 30326

November 22nd, 2019

AGREEMENT BETWEEN
ANABAPTIST HEALTHSHARE & ALIERA HEALTHCARE

This Agreement, hereinafter the ("**Agreement**") is entered into as of the first day of February, 2017 the ("**Effective Date**") by and between Aliera Healthcare, Incorporated, a Delaware corporation located at 5901 B Peachtree Dunwoody Road, Suite 200, Atlanta, Georgia 30328 ("**Aliera**") and Anabaptist HealthShare a "not for Profit" 501(c) (3) faith based ministry, located in Aroda, Virginia, ("**AHS**"). Unity HealthShare, LLC a "not for Profit" subsidiary of AHS with its situs in Aroda, Virginia (**UHS**). ALIERA and AHS are sometimes referred to collectively as the "**Parties**" and each individually as a "**Party**".

Whereas, ALIERA develops networks, distribution channels, provides plan management and benefit coordination for health care services, along with Employer, Employee and individual healthcare coverage products and services throughout the United States. Aliera Healthcare's Health plans are **NOT** insurance products and cannot be bundled with other insurance products into one price or product offering. (the "**ALIERA Products**");

Whereas, AHS seeks to develop benefit programs for members including healthcare service benefits, and AHS understands the products presented by ALIERA will be offered with AHS's permission to market and sell to AHS and UHS members, as part of this cooperative agreement.

Whereas, the ALIERA products are **NOT** insurance and cannot be bundled with insurance. AHS will advise its members that the Health Care products are not insurance, but do qualify for the tax exemption under IRS code, to avoid tax penalties.

Whereas, 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 UHS members. Members who wish to purchase the AHS non-insurance Health Share product will agree to become members of the faith and lifestyle based healthcare cost sharing membership, and understand to not identify the two part medical services offerings as insurance, rather as ("**Non-Insurance**") non-insurance based product.

Whereas, AHS and its subsidiary, UHS, wish to market products through ALIERA, using 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 UHS do hereby contract with ALIERA to provide said services, in accordance with the terms and conditions contained herein.

Whereas, AHS and ALIERA have previously entered into a Memorandum of Understanding (MOU) and have been operating in concert to improve cooperative operations between the organizations and now entered into this Agreement, to formalize the terms, conditions and responsibilities of the parties to this agreement as originally outlined in the 'MOU' as referred to herein.

Whereas, AHS and UHS wish to make available the two part offering healthcare products to ALIERA members via call centers, general agencies, field agents, and brokers. ALIERA shall not permit brokers, field agents, general agencies or call centers to bundle any insurance products with any AHS or UHS product opportunities.

Whereas, AHS has formed a not for profit subsidiary known as Unity HealthShare, LLC, in the State of Virginia (UHS). It is agreed that as part of this agreement, AHS will fully empower and authorize Unity HealthShare, LLC to contract with ALIERA to provide UHS, with the same benefit programs for members including healthcare service benefits which are part of this agreement.

Whereas, AHS is granting ALIERA an exclusive license to sell and distribute UHS products to the public markets (*public markets means persons who will acknowledge the standard of beliefs and other requirements as deemed necessary by AHS*) via all distribution channels and shall not permit brokers, agencies or call centers outside of ALIERA or its affiliates to promote any products or any other AHS or UHS opportunities. However, Eldon Hochstetler and Tyler Hochstetler (and other directors, officers, and agents) may operate and manage the parent ministry named "Anabaptist HealthShare," at its expense and may enroll (i) employees and employers of Anabaptist and (ii) other local members of the Anabaptist community in the parent HealthShare program.

Whereas, The Parties have agreed to enter this final Agreement for the purposes of being able to deliver the two part offering (UHS & ALIERA) healthcare cost sharing products.

NOW, THEREFORE, in consideration of the foregoing and the mutual promises and conditions contained herein, ALIERA, UHS, and AHS agree as follows:

1.

1.1 Promptly after the Effective Date and from time to time during the Term, ALIERA will provide to AHS its health care product offerings listed on attached ***Exhibit A*** solely for use as set forth in this Agreement. ALIERA may update the list of product offerings on the attached ***Exhibit A*** by providing AHS with an update from time to time.

1.2 Subject to the terms and conditions of this Agreement, during the Term, AHS hereby grants for itself, Unity HealthShare, LLC, and ALIERA a U. S. wide, royalty-free, non-transferable, exclusive, license, which may not be sub-licensed without expressed written approval of AHS. AHS may market and sell the HealthShare products offerings to members of AHS its employees and staff.

1.3 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.

1.4 AHS and ALIERA agree that a copy of the Official Unity HealthShare Guidelines "AlieraCare 5000, 7500, 10000 for 2016" and any subsequent amendments thereto, describing HealthShare offerings to be marketed and sold by Unity HealthShare, LLC, are by reference included into and made a part of this Agreement. Likewise, the letter from the Centers for Medicare and Medicaid Services (CMS) dated July14, 2015 addressed to Anabaptist HealthShare, which establishes its status as a charitable 501(c)(3) and under IRC § 5000A(d)(2)(ii)(I) – (V), and under Section 1311(d)(4)(H) of the Affordable Care Act, exempting members from the "shared responsibility payment" under the Act, is included into and made a part of this Agreement.

2. Representations and Warranties, Limitations & Indemnification

2.1 Each Party represents and warrants to the other that (i) it has the full right and power and is free to enter into and fully perform this Agreement; (ii) neither the execution or delivery of this Agreement, nor such Party's performance of any obligations under this Agreement, will conflict with or violate any other license, agreement or commitment by which such Party is bound; and (iii) it will perform its obligations under this Agreement in a professional, diligent and competent manner and comply with all applicable laws and regulations. ALIERA further represents and warrants to AHS that the ALIERA products do not infringe any intellectual property right of any

third party.

2.2 ALIERA represents and warrants it will use commercially reasonable efforts to ensure the ALIERA offerings provided to AHS will be provided to its members under the exemption provided by Section 5000A(d)(2)(B)(ii)(I) – (V) of the Internal Revenue Code and 45 CFR part 155 (Certificate of Exemption) 45 CFR 155 sub-part G of the PPACA. ALIERA further represents and warrants that the essential medical services being offered under its Direct Primary Care Medical Home (DPCMH) are recognized as not being insurance, as defined in the Affordable Care Act at Section 1301 (A) (3), 16.

2.3 ANY AND ALL WARRANTIES OR REPRESENTATIONS OR CONDITIONS, WHATSOEVER, EXPRESS OR IMPLIED, ORAL OR WRITTEN, ARE MADE IN LIEU OF ANY IMPLIED WARRANTIES OF MERCHANTABILITY AND FITNESS FOR A PARTICULAR PURPOSE.

2.4 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 LIABLE TO THE OTHER PARTY FOR ANY INCIDENTAL, CONSEQUENTIAL, 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.

3. Termination

3.1 This Agreement will commence on the Effective Date and will remain in effect perpetually after the execution date of this agreement, 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.

3.2 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.

4. Administrative Fees

AHS, UHS, and ALIERA have agreed to apportion the membership enrollment fees associated with signing new HealthShare members for health care services as follows: 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 UHS expenses. Thereafter, any succeeding month(s) which the membership is continued, ALIERA shall be entitled to retain $25.00 PMPM as

payment for its services.

5. Indemnification

EACH Party, an ("**Indemnifying Party**") agrees to indemnify and hold harmless, and pay the reasonably related costs and fees of the other Party, its corporate affiliates, and their respective officers, directors, employees, agents, shareholders, representatives and independent contractors (each an "**Affected Party**"), from and against any unaffiliated third party claims that arise out of or in connection with any actual or alleged breach of this Agreement by the Indemnifying Party, provided that (a) the Affected Party shall promptly notify the Indemnifying Party of such claim; (b) the Indemnifying Party shall have the sole and full control over the defense, proceedings and settlement against the third party claimant.

6. Confidential Information

As used in this Agreement, "Confidential Information" means: (a) any trade secrets and/or other non-public information, in print or electronic form or disclosed orally, that is designated as confidential or that, given the nature of the information or the circumstances surrounding its disclosure, reasonably should be considered as confidential, including, without limitation, non-public information relating to either Party's products, services, customers, web sites, product plans, designs, costs, prices or names, finances, marketing plans, business opportunities, personnel, research, development or know-how; and (b) the existence, terms and conditions of this Agreement. "Confidential Information" does not, however, include information that: (i) is or becomes generally known to the public or available by publication, commercial use or otherwise through no fault of the receiving Party; (ii) is known and has been reduced to tangible form by the receiving Party prior to the time of disclosure and is not subject to restriction on disclosure; (iii) is independently developed by the receiving Party without the use of the other Party's Confidential Information; (iv) is lawfully obtained from a third party that has the right to make such disclosure; or (v) is made generally available by the disclosing Party without restriction on disclosure. Each Party will protect the other's Confidential Information that it receives in connection with this Agreement from unauthorized dissemination and use with the same degree of care that such Party uses to protect its own like information and in no event using less than a reasonable degree of care. Neither Party will use the other's Confidential Information for purposes other than those necessary to directly further the purposes of this Agreement. Except as expressly provided in this Agreement, neither Party will disclose to third parties the other's Confidential Information without the prior written consent of the other Party.

Except as expressly provided in this Agreement, no ownership or license rights are granted to any Confidential Information. The other provisions of this Agreement notwithstanding, either Party will be permitted to disclose the Confidential Information to its employees or outside legal and financial advisors on a need to know bases, and to the extent required by applicable laws; provided however, that before making any such required filing or disclosure, the disclosing Party will first give written notice of the intended disclosure to the other Party and cooperate in seeking to obtain any available confidential treatment for the same. Without limiting the generality of this Section 4.1, neither Party will issue any press release or make any other public disclosure regarding this Agreement or its terms without the other Party's prior written consent.

6. Disputes

In the event of any disputes under this Agreement as to any matter, term, provision or covenant contained herein, the meaning of any term or provision, the breach of or default of any provision or covenant of this Agreement, and/or the enforcement of any provision or covenant of this Agreement; the parties agree to attempt

in good faith to resolve such dispute or conflict by first meeting within 30 days by representatives of each party with authority to resolve such dispute. In the event the representatives are unable to resolve the dispute then the parties will submit the dispute to an agreed mediator in a neutral mutually convenient location to assist them in attempting to resolve the dispute. Such mediation shall be conducted not more than 30 days after the original meeting of the party representatives. If the mediation is unsuccessful the parties may then pursue the issues of the dispute and its resolution in the State or Superior Court of Fulton County, Georgia.

This Agreement will be governed by the laws of the State of Georgia, excluding that body of law known as conflict of laws. The exclusive jurisdiction and venue of any action with respect to the subject matter of this Agreement shall be the State or Superior Courts of the State of Georgia, Fulton County or the United States District Court for the Northern District of Georgia and each of the parties hereto submits itself to the exclusive jurisdiction and venue of such courts for the purpose of any such action.

7. Miscellaneous

a) AHS agrees that it will prepare and file as necessary, amendments to the Anabaptist HealthShare, Not for Profit 501(3)(c) By-Laws to facilitate the intent and purpose of this Agreement. AHS has notified the Centers for Medicare and Medicaid (CMS) that it has formed a subsidiary named Unity HealthShare, LLC.

b) The Board of Directors currently consists of Eldon Hochstetler, Tyler Hochstetler, Tim Moses, and Alex Cardona. The Board will mutually agree on a fifth Board member.

c) ALIERA recognizes the need for offices for AHS to operate the health share business. It is agreed ALIERA and AHS will seek suitable office space conveniently located in Virginia nearby AHS's existing location and pay for same from monies funded by ALIERA directly or revenues derived from new membership fees.

d) AHS and ALIERA agree that: (i) UHS will escrow $2.00 PMPM from each new membership application into a "ministry fund" to be administered directly by AHS and be used as it deems most appropriate to further the charitable direction it wishes to share the charitable funds; (ii) UHS agrees to further deposit into escrow $25.00 from each *one-time* application fee per membership to be used as it deems most appropriate to further the expressed intent of the ministry and allow AHS to cover administration and related costs associated with maintaining, improving and growing its health share ministry.

e) ALIERA agrees to fund AHS up to but not to exceed $1,000 for costs directly associated with the creation and filing of a new Section 501(3)(C) "health share charitable organization" to be known as Unity HealthShare, LLC. To assist AHS creating a separate entity to continue providing healthcare services to all existing members with their needs and any new members added by ALIERA. It is understood that existing members may choose to purchase any new products being offered at the same price as new members, if they choose to add to their existing health share services.

f) Eldon Hochstetler and Tyler Hochstetler will each receive $2.50 per enrolled member in Unity HealthShare, per month, for as long as Unity HealthShare is operating, and regardless of how many members enroll in Unity HealthShare. This is a profit-sharing arrangement with ALIERA. This fee ($5 total per member, per month) shall be paid by ALIERA monthly to Eldon Hochstetler and Tyler Hochstetler based on total enrolled membership in Unity HealthShare. Eldon Hochstetler and Tyler Hochstetler shall have access to the Unity HealthShare member database at all times. ALIERA will fund additional staff as agreed upon by each Party, for their services, the terms of which are open to be reassessed and renegotiated in good faith, each successive year

g) ALIERA will design and implement all cost sharing plans, marketing materials, operational controls and general business banking for UHS for its operation of Unity HealthShare, subject to access and approval by the AHS Board of Directors.

h) Eldon Hochstetler and Tyler Hochstetler, and their assigns and successors, have the authority to terminate this

Cooperative Agreement and recover the CMS HCSM exemption if this Agreement is not followed. The CMS HCSM exemption will not be used by ALIERA in any capacity other than as Unity HealthShare.

i) The relationship of the Parties is that of independent contractors. This Agreement does not give either Party the power to direct the day to day activities of the other, constitute the Parties as partners, joint ventures', co-owners or principal-agent, or allow either Party to create or assume any obligation on behalf of the other Party.

j) Neither Party shall be entitled to assign, subcontract or otherwise dispose of its rights and be released from its obligations under this Agreement without the prior written consent of the other Party. Notwithstanding the foregoing, AHS may assign this Agreement to a person or entity that controls, is controlled by, or is under common control with AHS. AHS agrees to provide ALIERA with at least 60 days' prior written notice in the change of ownership, control, substantial change in management or management rules and regulation of operations.

k) If any provision of this Agreement is determined by a court to be unenforceable, then the parties shall deem the provision to be modified to the extent necessary to allow it to be enforced to the extent permitted by law, or if it cannot be modified, the provision will be deleted from this Agreement, and the remainder of the Agreement will continue in effect.

l) 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, UHS, and ALIERA whether oral or in writing. This Agreement may be executed in counterparts, including by facsimile, each of which will be deemed an original and all of which together will be deemed to be one and the same instrument.

IN WITNESS, WHEREOF, the Parties have caused this Agreement to be executed as of the Effective Date by their duly authorized representatives.

Aliera Healthcare, Inc.:

By: _____

Name: _____

Title: Exec. Dir.

Date: 2/1/2017.

Contact Information:

Address:5901- B Peachtree Dunwoody Road
Suite 200
Atlanta, Georgia, 30328
Telephone: 844-834-3456

Fax:

e-mail: ssteele@alierahealthcare.com

Anabaptist HealthShare

By: _____

Name: Eldon Hochstetler

Title: Director

Date: 2/1/2017

Contact Information:

Eldon Hochstetler
Anabaptist HealthShare
1552 Elly Road
Aroda, Virginia 22709
540-717-2115

Unity HealthShare, LLC

By: 

Name: Tyler Hochstetler

Title: Director

Date: 2/1/2017

Contact Information:

Tyler Hochstetler, Esq.
1552 Elly Road,
Aroda, VA 22709

EXHIBIT A
HCSM Offerings

See Attached

efile GRAPHIC print - DO NOT PROCESS | As Filed Data - | DLN: 93493319214069

Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)

▶ Do not enter social security numbers on this form as it may be made public

▶ **Go to *www.irs.gov/Form990* for instructions and the latest information.**

OMB No 1545-0047

2018

Open to Public Inspection

A For the 2019 calendar year, or tax year beginning 06-26-2018 , and ending 12-31-2018

B Check if applicable
- ☑ Address change
- ☐ Name change
- ☑ Initial return
- ☐ Final return/terminated
- ☐ Amended return
- ☐ Application pending

C Name of organization
TRINITY HEALTHSHARE INC

Doing business as

Number and street (or P O box if mail is not delivered to street address) | Room/suite
5901 PEACHTREE DUNWOODY RD NO C-160

City or town, state or province, country, and ZIP or foreign postal code
ATLANTA, GA 30328

D Employer identification number
83-1050344

E Telephone number
(404) 401-1748

G Gross receipts $ 8,231,106

F Name and address of principal officer
WILLIAM H THEAD III
5901 PEACHTREE DUNWOODY RD C-160
ATLANTA, GA 30328

H(a) Is this a group return for subordinates? ☐ Yes ☑ No

H(b) Are all subordinates included? ☐ Yes ☐ No
If "No," attach a list (see instructions)

H(c) Group exemption number ▶

I Tax-exempt status ☑ 501(c)(3) ☐ 501(c) ( ) ◀ (insert no) ☐ 4947(a)(1) or ☐ 527

J Website: ▶ WWW TRINITYHEALTHSHARE ORG

K Form of organization ☑ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation 2018

M State of legal domicile DE

Part I Summary

1 Briefly describe the organization's mission or most significant activities
THROUGH GOD'S GUIDANCE, BRING TOGETHER PEOPLE OF A COMMON SET OF RELIGIOUS BELIEFS FOR THE PURPOSE OF VOLUNTARILY SHARING ONE ANOTHER'S MEDICAL EXPENSE BURDENS AND SO FULFILL THE LAW OF CHRIST

Activities & Governance

2	Check this box ▶ ☐ if the organization discontinued its operations or disposed of more than 25% of its net assets		
3	Number of voting members of the governing body (Part VI, line 1a)	3	2
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	1
5	Total number of individuals employed in calendar year 2018 (Part V, line 2a)	5	1
6	Total number of volunteers (estimate if necessary)	6	0
7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	0
b	Net unrelated business taxable income from Form 990-T, line 34	7b	0

Revenue

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)		0
9	Program service revenue (Part VIII, line 2g)		8,231,106
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)		0
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)		0
12	Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)		8,231,106

Expenses

13	Grants and similar amounts paid (Part IX, column (A), lines 1–3)		67,000
14	Benefits paid to or for members (Part IX, column (A), line 4)		0
15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)		57,155
16a	Professional fundraising fees (Part IX, column (A), line 11e)		0
b	Total fundraising expenses (Part IX, column (D), line 25) ▶0		
17	Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)		8,954,281
18	Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25)		9,078,436
19	Revenue less expenses Subtract line 18 from line 12		-847,330

Net Assets or Fund Balances

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)		7,690,460
21	Total liabilities (Part X, line 26)		8,537,790
22	Net assets or fund balances Subtract line 21 from line 20		-847,330

Part II Signature Block

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge

Sign Here

****** 2019-11-15
Signature of officer Date

WILLIAM H THEAD III CHAIRMAN
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
		2019-11-15		P00292964

Firm's name ▶ WINDHAM BRANNON PC — Firm's EIN ▶ 58-1763439

Firm's address ▶ 3630 PEACHTREE RD NE SUITE 600 ATLANTA, GA 30326 — Phone no (404) 898-2000

May the IRS discuss this return with the preparer shown above? (see instructions) ☑ Yes ☐ No

Part III **Statement of Program Service Accomplishments**

Check if Schedule O contains a response or note to any line in this Part III . . . . . ☐

1 Briefly describe the organization's mission

THROUGH GOD'S GUIDANCE, BRING TOGETHER PEOPLE OF A COMMON SET OF RELIGIOUS BELIEFS FOR THE PURPOSE OF VOLUNTARILY SHARING ONE ANOTHER'S MEDICAL EXPENSE BURDENS AND SO FULFILL THE LAW OF CHRIST

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? . . . . . ☐ **Yes** ☑ **No**

If "Yes," describe these new services on Schedule O

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? . . . . . ☐ **Yes** ☑ **No**

If "Yes," describe these changes on Schedule O

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses Section 501(c)(3) and 501(c)(4) organizations are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported

4a (Code) (Expenses $ 8,991,419 including grants of $ 67,000) (Revenue $ 8,231,106)

See Additional Data

4b (Code) (Expenses $ including grants of $) (Revenue $)

4c (Code) (Expenses $ including grants of $) (Revenue $)

4d Other program services (Describe in Schedule O)

(Expenses $ including grants of $) (Revenue $)

4e **Total program service expenses** ▶ 8,991,419

Part IV Checklist of Required Schedules

			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? *If "Yes," complete Schedule A*	1	Yes	
2	Is the organization required to complete *Schedule B, Schedule of Contributors* (see instructions)?	2		No
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I*	3		No
4	**Section 501(c)(3) organizations.** Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? *If "Yes," complete Schedule C, Part II*	4		No
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? *If "Yes," complete Schedule C, Part III*	5		No
6	Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? *If "Yes," complete Schedule D, Part I*	6		No
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? *If "Yes," complete Schedule D, Part II*	7		No
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D, Part III*	8		No
9	Did the organization report an amount in Part X, line 21 for escrow or custodial account liability, serve as a custodian for amounts not listed in Part X, or provide credit counseling, debt management, credit repair, or debt negotiation services? *If "Yes," complete Schedule D, Part IV*	9		No
10	Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? *If "Yes," complete Schedule D, Part V*	10		No
11	If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable			
a	Did the organization report an amount for land, buildings, and equipment in Part X, line 10? *If "Yes," complete Schedule D, Part VI*	11a		No
b	Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VII*	11b		No
c	Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VIII*	11c		No
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part IX*	11d		No
e	Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X*	11e	Yes	
f	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? *If "Yes," complete Schedule D, Part X*	11f	Yes	
12a	Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI and XII*	12a	Yes	
b	Was the organization included in consolidated, independent audited financial statements for the tax year? *If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional*	12b		No
13	Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E*	13		No
14a	Did the organization maintain an office, employees, or agents outside of the United States?	14a		No
b	Did the organization have aggregate revenues or expenses of more than $10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at $100,000 or more? *If "Yes," complete Schedule F, Parts I and IV*	14b		No
15	Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or other assistance to or for any foreign organization? *If "Yes," complete Schedule F, Parts II and IV*	15		No
16	Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or other assistance to or for foreign individuals? *If "Yes," complete Schedule F, Parts III and IV*	16		No
17	Did the organization report a total of more than $15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? *If "Yes," complete Schedule G, Part I* (see instructions)	17		No
18	Did the organization report more than $15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II*	18		No
19	Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III*	19		No
20a	Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H*	20a		No
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b		
21	Did the organization report more than $5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II*	21	Yes	
22	Did the organization report more than $5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III*	22		No

Part IV **Checklist of Required Schedules** *(continued)*

			Yes	No
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? *If "Yes," complete Schedule J*	**23**		No
24a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than $100,000 as of the last day of the year, that was issued after December 31, 2002? *If "Yes," answer lines 24b through 24d and complete Schedule K If "No," go to line 25a*	**24a**		No
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	**24b**		
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	**24c**		
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	**24d**		
25a	**Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L, Part I*	**25a**		No
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? *If "Yes," complete Schedule L, Part I*	**25b**		No
26	Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? *If "Yes," complete Schedule L, Part II*	**26**		No
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? *If "Yes," complete Schedule L, Part III*	**27**		No
28	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions)			
a	A current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	**28a**		No
b	A family member of a current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	**28b**		No
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? *If "Yes," complete Schedule L, Part IV*	**28c**		No
29	Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M*	**29**		No
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	**30**		No
31	Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I*	**31**		No
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II*	**32**		No
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301 7701-2 and 301 7701-3? *If "Yes," complete Schedule R, Part I*	**33**		No
34	Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1*	**34**		No
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	**35a**		No
b	If 'Yes' to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? *If "Yes," complete Schedule R, Part V, line 2*	**35b**		
36	**Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2*	**36**		No
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? *If "Yes," complete Schedule R, Part VI*	**37**		No
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? **Note.** All Form 990 filers are required to complete Schedule O	**38**	Yes	

Part V **Statements Regarding Other IRS Filings and Tax Compliance**

Check if Schedule O contains a response or note to any line in this Part V ☐

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096 Enter -0- if not applicable	**1a**	0		
b	Enter the number of Forms W-2G included in line 1a *Enter -0-* if not applicable	**1b**	0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	**1c**			

2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	**2a**	1		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? **Note.** If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)			**2b**	Yes
3a	Did the organization have unrelated business gross income of $1,000 or more during the year? . . .			**3a**	No
b	If "Yes," has it filed a Form 990-T for this year? *If "No" to line 3b, provide an explanation in Schedule O* . . .			**3b**	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? . .			**4a**	No
b	If "Yes," enter the name of the foreign country ▶ _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR)				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . .			**5a**	No
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?			**5b**	No
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?			**5c**	
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions? . . .			**6a**	No
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?			**6b**	
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?			**7a**	No
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?			**7b**	
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?			**7c**	No
d	If "Yes," indicate the number of Forms 8282 filed during the year	**7d**			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?			**7e**	
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . .			**7f**	
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?			**7g**	
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?			**7h**	
8	**Sponsoring organizations maintaining donor advised funds.** Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?			**8**	
9a	Did the sponsoring organization make any taxable distributions under section 4966? . . .			**9a**	
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? . . .			**9b**	
10	**Section 501(c)(7) organizations.** Enter				
a	Initiation fees and capital contributions included on Part VIII, line 12 . . .	**10a**			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	**10b**			
11	**Section 501(c)(12) organizations.** Enter				
a	Gross income from members or shareholders	**11a**			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them)	**11b**			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?			**12a**	
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	**12b**			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state? **Note.** See the instructions for additional information the organization must report on Schedule O			**13a**	
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	**13b**			
c	Enter the amount of reserves on hand	**13c**			
14a	Did the organization receive any payments for indoor tanning services during the tax year?			**14a**	No
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O* . .			**14b**	
15	Is the organization subject to the section 4960 tax on payment(s) of more than $1,000,000 in remuneration or excess parachute payment(s) during the year? If "Yes," see instructions and file Form 4720, Schedule N			**15**	No
16	Is the organization an educational institution subject to the section 4968 excise tax on net investment income? If "Yes," complete Form 4720, Schedule O			**16**	No

Part VI **Governance, Management, and Disclosure** *For each "Yes" response to lines 2 through 7b below, and for a "No" response to lines 8a, 8b, or 10b below, describe the circumstances, processes, or changes in Schedule O See instructions*

Check if Schedule O contains a response or note to any line in this Part VI . . . . . ☑

Section A. Governing Body and Management

				Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	1a	2		
	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O				
b	Enter the number of voting members included in line 1a, above, who are independent	1b	1		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?		2	Yes	
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person?		3	Yes	
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?		4		No
5	Did the organization become aware during the year of a significant diversion of the organization's assets?		5		No
6	Did the organization have members or stockholders?		6		No
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?		7a		No
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?		7b		No
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following				
a	The governing body?		8a	Yes	
b	Each committee with authority to act on behalf of the governing body?		8b		No
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*		9		No

Section B. Policies (*This Section B requests information about policies not required by the Internal Revenue Code.*)

			Yes	No
10a	Did the organization have local chapters, branches, or affiliates?	10a		No
b	If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?	10b		
11a	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?	11a	Yes	
b	Describe in Schedule O the process, if any, used by the organization to review this Form 990			
12a	Did the organization have a written conflict of interest policy? *If "No," go to line 13*	12a	Yes	
b	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	12b	Yes	
c	Did the organization regularly and consistently monitor and enforce compliance with the policy? *If "Yes," describe in Schedule O how this was done*	12c	Yes	
13	Did the organization have a written whistleblower policy?	13		No
14	Did the organization have a written document retention and destruction policy?	14		No
15	Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?			
a	The organization's CEO, Executive Director, or top management official	15a	Yes	
b	Other officers or key employees of the organization	15b		No
	If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions)			
16a	Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?	16a		No
b	If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements?	16b		

Section C. Disclosure

17 List the States with which a copy of this Form 990 is required to be filed▶

18 Section 6104 requires an organization to make its Form 1023 (or 1024-A if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection Indicate how you made these available Check all that apply

☐ Own website ☐ Another's website ☑ Upon request ☐ Other (explain in Schedule O)

19 Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year

20 State the name, address, and telephone number of the person who possesses the organization's books and records
▶WILLIAM H THEAD III 5901 PEACHTREE DUNWOODY RD C-160 ATLANTA, GA 30328 (404) 401-1748

Part VII **Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors**

Check if Schedule O contains a response or note to any line in this Part VII . . . . . ☑

Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

1a Complete this table for all persons required to be listed Report compensation for the calendar year ending with or within the organization's tax year

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation Enter -0- in columns (D), (E), and (F) if no compensation was paid
- List all of the organization's **current** key employees, if any See instructions for definition of "key employee "
- List the organization's five **current** highest compensated employees (other than an officer, director, trustee or key employee) who received reportable compensation (Box 5 of Form W-2 and/or Box 7 of Form 1099-MISC) of more than $100,000 from the organization and any related organizations
- List all of the organization's **former** officers, key employees, or highest compensated employees who received more than $100,000 of reportable compensation from the organization and any related organizations
- List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than $10,000 of reportable compensation from the organization and any related organizations

List persons in the following order individual trustees or directors, institutional trustees, officers, key employees, highest compensated employees, and former such persons

☐ Check this box if neither the organization nor any related organization compensated any current officer, director, or trustee

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
(1) WILLIAM H THEAD III CHAIRMAN, DIRECTOR	40 00 0 00	X		X				51,923	0	0
(2) DAVID R THEAD SECRETARY, TREASURER, DIRECTOR	0 10 0 00	X		X				0	0	0

Part VII **Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees** *(continued)*

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
1b Sub-Total . . . . . ▶										
c Total from continuation sheets to Part VII**, Section A** . . . . ▶										
d Total (add lines 1b and 1c) . . . . . ▶								51,923	0	0

2 Total number of individuals (including but not limited to those listed above) who received more than $100,000 of reportable compensation from the organization ▶ 0

			Yes	No
3	Did the organization list any **former** officer, director or trustee, key employee, or highest compensated employee on line 1a? *If "Yes," complete Schedule J for such individual*	**3**		No
4	For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than $150,000? *If "Yes," complete Schedule J for such individual*	**4**		No
5	Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? *If "Yes," complete Schedule J for such person*	**5**		No

Section B. Independent Contractors

1 Complete this table for your five highest compensated independent contractors that received more than $100,000 of compensation from the organization Report compensation for the calendar year ending with or within the organization's tax year

(A) Name and business address	(B) Description of services	(C) Compensation
ALIERA HEALTHCARE INC 990 HAMMOND DRIVE SUITE 700 ATLANTA, GA 30328	MANAGEMENT	527,028

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 of compensation from the organization ▶ 1

Part VIII **Statement of Revenue**

Check if Schedule O contains a response or note to any line in this Part VIII . . . . . ☐

		(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514
Contributions, Gifts, Grants and Other Similar Amounts	**1a** Federated campaigns . . **1a**				
	b Membership dues . . **1b**				
	c Fundraising events . . **1c**				
	d Related organizations **1d**				
	e Government grants (contributions) **1e**				
	f All other contributions, gifts, grants, and similar amounts not included above **1f**				
	g Noncash contributions included in lines 1a - 1f $ _____				
	h Total. Add lines 1a-1f . . . . . ▶				

		Business Code				
Program Service Revenue	**2a** MEMBERSHARE CONTRIBUTI	524298	7,882,929	7,882,929		
	b MEMBERSHIP APPLICATION	524298	348,177	348,177		
	c					
	d					
	e					
	f All other program service revenue					
	g Total. Add lines 2a–2f . . . . ▶		8,231,106			

Other Revenue	**3** Investment income (including dividends, interest, and other similar amounts) . . . . . ▶				
	4 Income from investment of tax-exempt bond proceeds ▶				
	5 Royalties . . . . . ▶				

	(i) Real	(ii) Personal				
6a Gross rents						
b Less rental expenses						
c Rental income or (loss)						
d Net rental income or (loss) . . . . . ▶						

	(i) Securities	(ii) Other				
7a Gross amount from sales of assets other than inventory						
b Less cost or other basis and sales expenses						
c Gain or (loss)						
d Net gain or (loss) . . . . . ▶						

8a Gross income from fundraising events (not including $ _____ of contributions reported on line 1c) See Part IV, line 18 . . . . **a**					
b Less direct expenses . . . **b**					
c Net income or (loss) from fundraising events . . ▶					
9a Gross income from gaming activities See Part IV, line 19 . . . **a**					
b Less direct expenses . . . **b**					
c Net income or (loss) from gaming activities . . ▶					
10a Gross sales of inventory, less returns and allowances . . **a**					
b Less cost of goods sold . . **b**					
c Net income or (loss) from sales of inventory . . ▶					

Miscellaneous Revenue	Business Code				
11a					
b					
c					
d All other revenue					
e Total. Add lines 11a–11d . . . . . ▶					
12 Total revenue. See Instructions . . . . . ▶		8,231,106	8,231,106	0	0

Part IX **Statement of Functional Expenses**

Section 501(c)(3) and 501(c)(4) organizations must complete all columns All other organizations must complete column (A)

Check if Schedule O contains a response or note to any line in this Part IX . . . . . ☐

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraisingexpenses
1 Grants and other assistance to domestic organizations and domestic governments See Part IV, line 21	67,000	67,000		
2 Grants and other assistance to domestic individuals See Part IV, line 22				
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals See Part IV, line 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	53,183	26,591	26,592	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages				
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions)				
9 Other employee benefits				
10 Payroll taxes	3,972	1,986	1,986	
11 Fees for services (non-employees)				
a Management	527,028	527,028		
b Legal	41,558		41,558	
c Accounting				
d Lobbying				
e Professional fundraising services See Part IV, line 17				
f Investment management fees				
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)				
12 Advertising and promotion	630,735	630,735		
13 Office expenses				
14 Information technology				
15 Royalties . .				
16 Occupancy	20,811	10,405	10,406	
17 Travel				
18 Payments of travel or entertainment expenses for any federal, state, or local public officials .				
19 Conferences, conventions, and meetings				
20 Interest				
21 Payments to affiliates				
22 Depreciation, depletion, and amortization . .				
23 Insurance . . .				
24 Other expenses Itemize expenses not covered above (List miscellaneous expenses in line 24e If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O)				
a MEMBERSHARE REQUEST	7,526,855	7,526,855		
b MEMBERSHIP SHARING ADMI	97,716	97,716		
c HEALTHCARE NETWORK FEES	70,938	70,938		
d TELEMEDICINE	26,463	26,463		
e All other expenses	12,177	5,702	6,475	
25 **Total functional expenses.** Add lines 1 through 24e	9,078,436	8,991,419	87,017	0
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation Check here ▶ ☐ if following SOP 98-2 (ASC 958-720)				

Part X Balance Sheet

Check if Schedule O contains a response or note to any line in this Part IX . . . . . ☐

			(A) Beginning of year		(B) End of year
Assets	1	Cash—non-interest-bearing	0	1	850,207
	2	Savings and temporary cash investments		2	
	3	Pledges and grants receivable, net		3	
	4	Accounts receivable, net	0	4	5,176,341
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L		5	
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions) Complete Part II of Schedule L		6	
	7	Notes and loans receivable, net		7	
	8	Inventories for sale or use		8	
	9	Prepaid expenses and deferred charges	0	9	1,658,958
	10a	Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D — 10a			
	b	Less accumulated depreciation — 10b		10c	
	11	Investments—publicly traded securities		11	
	12	Investments—other securities See Part IV, line 11		12	
	13	Investments—program-related See Part IV, line 11		13	
	14	Intangible assets		14	
	15	Other assets See Part IV, line 11	0	15	4,954
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)	0	16	7,690,460
Liabilities	17	Accounts payable and accrued expenses	0	17	22,846
	18	Grants payable		18	
	19	Deferred revenue	0	19	2,774,029
	20	Tax-exempt bond liabilities		20	
	21	Escrow or custodial account liability Complete Part IV of Schedule D		21	
	22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons Complete Part II of Schedule L		22	
	23	Secured mortgages and notes payable to unrelated third parties		23	
	24	Unsecured notes and loans payable to unrelated third parties		24	
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17 - 24) Complete Part X of Schedule D	0	25	5,740,915
	26	**Total liabilities.** Add lines 17 through 25	0	26	8,537,790
Net Assets or Fund Balances		**Organizations that follow SFAS 117 (ASC 958), check here ▶ ☑ and complete lines 27 through 29, and lines 33 and 34.**			
	27	Unrestricted net assets		27	-847,330
	28	Temporarily restricted net assets		28	
	29	Permanently restricted net assets		29	
		Organizations that do not follow SFAS 117 (ASC 958), check here ▶ ☐ and complete lines 30 through 34.			
	30	Capital stock or trust principal, or current funds		30	
	31	Paid-in or capital surplus, or land, building or equipment fund		31	
	32	Retained earnings, endowment, accumulated income, or other funds		32	
	33	Total net assets or fund balances	0	33	-847,330
	34	Total liabilities and net assets/fund balances	0	34	7,690,460

Part XI Reconciliation of Net Assets

Check if Schedule O contains a response or note to any line in this Part XI . . . . . ☐

1	Total revenue (must equal Part VIII, column (A), line 12)	1	8,231,106
2	Total expenses (must equal Part IX, column (A), line 25)	2	9,078,436
3	Revenue less expenses Subtract line 2 from line 1	3	-847,330
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	0
5	Net unrealized gains (losses) on investments	5	
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	0
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	-847,330

Part XII Financial Statements and Reporting

Check if Schedule O contains a response or note to any line in this Part XII . . . . . ☑

			Yes	No
1	Accounting method used to prepare the Form 990 ☐ Cash ☑ Accrual ☐ Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O			
2a	Were the organization's financial statements compiled or reviewed by an independent accountant?	2a		No
	If 'Yes,' check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both ☐ Separate basis ☐ Consolidated basis ☐ Both consolidated and separate basis			
b	Were the organization's financial statements audited by an independent accountant?	2b	Yes	
	If 'Yes,' check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both ☑ Separate basis ☐ Consolidated basis ☐ Both consolidated and separate basis			
c	If "Yes," to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant?	2c	Yes	
	If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O			
3a	As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?	3a		No
b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits	3b		

Software ID:

Software Version:

EIN: 83-1050344

Name: TRINITY HEALTHSHARE INC

Form 990 (2018)

Form 990, Part III, Line 4a:

AS A 501(C)(3) NONPROFIT CHARITABLE ORGANIZATION, TRINITY HEALTHSHARE, INC , BROUGHT TOGETHER THOUSANDS OF PEOPLE WITH A COMMON SET OF BELIEFS FOR THE PURPOSE OF SHARING ONE ANOTHER'S MEDICAL EXPENSE BURDENS TRINITY UPHOLDS THE BIBLICAL COMMAND STATED IN GALATIANS 6 2 TO "BEAR ONE OTHER'S BURDENS, AND SO FULFILL THE LAW OF CHRIST " IN 2018, TRINITY FACILITATED THE VOLUNTARY SHARING OF $846,604 DOLLARS IN MONTHLY FINANCIAL GIFTS AMONG ITS 13,764 MEMBER HOUSEHOLDS TO PAY FOR 5,009 MEDICAL SHARING REQUESTS ADDITIONALLY, TRINITY ALSO DONATED $67,000 TO OTHER NONPROFIT CHARITABLE ORGANIZATIONS IN THE US

SCHEDULE A (Form 990 or 990EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.

▶ **Attach to Form 990 or Form 990-EZ.**

▶ **Go to *www.irs.gov/Form990* for the latest information.**

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
TRINITY HEALTHSHARE INC

Employer identification number
83-1050344

Part I Reason for Public Charity Status (All organizations must complete this part.) See instructions.

The organization is not a private foundation because it is (For lines 1 through 12, check only one box)

1 ☐ A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**

2 ☐ A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E (Form 990 or 990-EZ))

3 ☐ A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**

4 ☐ A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state _____

5 ☐ An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170 (b)(1)(A)(iv).** (Complete Part II)

6 ☐ A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**

7 ☐ An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II)

8 ☐ A community trust described in **section 170(b)(1)(A)(vi)** (Complete Part II)

9 ☐ An agricultural research organization described in **170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land grant college of agriculture See instructions Enter the name, city, and state of the college or university _____

10 ☑ An organization that normally receives (1) more than 331/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions—subject to certain exceptions, and (2) no more than 331/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975 See **section 509(a)(2).** (Complete Part III)

11 ☐ An organization organized and operated exclusively to test for public safety See **section 509(a)(4).**

12 ☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2).** See **section 509(a)(3).** Check the box in lines 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g

a ☐ **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization **You must complete Part IV, Sections A and B.**

b ☐ **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s) **You must complete Part IV, Sections A and C.**

c ☐ **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions) **You must complete Part IV, Sections A, D, and E.**

d ☐ **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions) **You must complete Part IV, Sections A and D, and Part V.**

e ☐ Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization

f Enter the number of supported organizations _____

g Provide the following information about the supported organization(s)

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1- 10 above (see instructions))	(iv) Is the organization listed in your governing document? Yes	(iv) No	(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
Total						

Part II **Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv), 170(b)(1)(A)(vi), and 170 (b)(1)(A)(ix)**

(Complete only if you checked the box on line 5, 7, 8, or 9 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grant ")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 **Total.** Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 **Public support.** Subtract line 5 from line 4						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a)2014	(b)2015	(c)2016	(d)2017	(e)2018	(f)Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income Do not include gain or loss from the sale of capital assets (Explain in Part VI)						
11 **Total support.** Add lines 7 through 10						

12 Gross receipts from related activities, etc (see instructions) **12**

13 **First five years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here** . . . . . ▶ ☐

Section C. Computation of Public Support Percentage

14 Public support percentage for 2018 (line 6, column (f) divided by line 11, column (f)) **14**

15 Public support percentage for 2017 Schedule A, Part II, line 14 **15**

16a **33 1/3% support test—2018.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

b **33 1/3% support test—2017.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

17a **10%-facts-and-circumstances test—2018.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ▶ ☐

b **10%-facts-and-circumstances test—2017.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ▶ ☐

18 **Private foundation.** If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ▶ ☐

Part III **Supporting Schedule for Organizations Described in Section 509(a)(2)**
(Complete only if you checked the box on line 10 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants ")					8,231,106	8,231,106
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 **Total.** Add lines 1 through 5					8,231,106	8,231,106
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						0
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of $5,000 or 1% of the amount on line 13 for the year						0
c Add lines 7a and 7b						0
8 **Public support.** (Subtract line 7c from line 6)						8,231,106

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
9 Amounts from line 6					8,231,106	8,231,106
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income Do not include gain or loss from the sale of capital assets (Explain in Part VI)						
13 **Total support.** (Add lines 9, 10c, 11, and 12)					8,231,106	8,231,106

14 **First five years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here** ▶ ☑

Section C. Computation of Public Support Percentage

15 Public support percentage for 2018 (line 8, column (f) divided by line 13, column (f))	15	
16 Public support percentage from 2017 Schedule A, Part III, line 15	16	

Section D. Computation of Investment Income Percentage

17 Investment income percentage for **2018** (line 10c, column (f) divided by line 13, column (f))	17	
18 Investment income percentage from **2017** Schedule A, Part III, line 17	18	

19a **33 1/3% support tests—2018.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

b **33 1/3% support tests—2017.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

20 **Private foundation.** If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions ▶ ☐

Part IV **Supporting Organizations**

(Complete only if you checked a box on line 12 of Part I. If you checked 12a of Part I, complete Sections A and B. If you checked 12b of Part I, complete Sections A and C. If you checked 12c of Part I, complete Sections A, D, and E. If you checked 12d of Part I, complete Sections A and D, and complete Part V.)

Section A. All Supporting Organizations

			Yes	No
1	Are all of the organization's supported organizations listed by name in the organization's governing documents? *If "No," describe in* ***Part VI*** *how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.*	1		
2	Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? *If "Yes," explain in* ***Part VI*** *how the organization determined that the supported organization was described in section 509(a)(1) or (2).*	2		
3a	Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? *If "Yes," answer (b) and (c) below.*	3a		
b	Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? *If "Yes," describe in* ***Part VI*** *when and how the organization made the determination.*	3b		
c	Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? *If "Yes," explain in* ***Part VI*** *what controls the organization put in place to ensure such use.*	3c		
4a	Was any supported organization not organized in the United States ("foreign supported organization")? *If "Yes" and if you checked 12a or 12b in Part I, answer (b) and (c) below.*	4a		
b	Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? *If "Yes," describe in* ***Part VI*** *how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.*	4b		
c	Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? *If "Yes," explain in* ***Part VI*** *what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes.*	4c		
5a	Did the organization add, substitute, or remove any supported organizations during the tax year? *If "Yes," answer (b) and (c) below (if applicable). Also, provide detail in* ***Part VI,*** *including (i) the names and EIN numbers of the supported organizations added, substituted, or removed, (ii) the reasons for each such action, (iii) the authority under the organization's organizing document authorizing such action, and (iv) how the action was accomplished (such as by amendment to the organizing document).*	5a		
b	**Type I or Type II only.** Was any added or substituted supported organization part of a class already designated in the organization's organizing document?	5b		
c	**Substitutions only.** Was the substitution the result of an event beyond the organization's control?	5c		
6	Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (i) its supported organizations, (ii) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (iii) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? *If "Yes," provide detail in* ***Part VI.***	6		
7	Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (defined in section 4958(c)(3)(C)), a family member of a substantial contributor, or a 35% controlled entity with regard to a substantial contributor? *If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).*	7		
8	Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? *If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).*	8		
9a	Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? *If "Yes," provide detail in* ***Part VI.***	9a		
b	Did one or more disqualified persons (as defined in line 9a) hold a controlling interest in any entity in which the supporting organization had an interest? *If "Yes," provide detail in* ***Part VI.***	9b		
c	Did a disqualified person (as defined in line 9a) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? *If "Yes," provide detail in* ***Part VI.***	9c		
10a	Was the organization subject to the excess business holdings rules of section 4943 because of section 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? *If "Yes," answer line 10b below.*	10a		
b	Did the organization have any excess business holdings in the tax year? *(Use Schedule C, Form 4720, to determine whether the organization had excess business holdings.)*	10b		

Part IV **Supporting Organizations** (continued)

			Yes	No
11	Has the organization accepted a gift or contribution from any of the following persons?			
a	A person who directly or indirectly controls, either alone or together with persons described in (b) and (c) below, the governing body of a supported organization?	11a		
b	A family member of a person described in (a) above?	11b		
c	A 35% controlled entity of a person described in (a) or (b) above? *If "Yes" to a, b, or c, provide detail in Part VI*	11c		

Section B. Type I Supporting Organizations

			Yes	No
1	Did the directors, trustees, or membership of one or more supported organizations have the power to regularly appoint or elect at least a majority of the organization's directors or trustees at all times during the tax year? *If "No," describe in* ***Part VI*** *how the supported organization(s) effectively operated, supervised, or controlled the organization's activities If the organization had more than one supported organization, describe how the powers to appoint and/or remove directors or trustees were allocated among the supported organizations and what conditions or restrictions, if any, applied to such powers during the tax year*	1		
2	Did the organization operate for the benefit of any supported organization other than the supported organization(s) that operated, supervised, or controlled the supporting organization? *If "Yes," explain in* ***Part VI*** *how providing such benefit carried out the purposes of the supported organization(s) that operated, supervised or controlled the supporting organization*	2		

Section C. Type II Supporting Organizations

			Yes	No
1	Were a majority of the organization's directors or trustees during the tax year also a majority of the directors or trustees of each of the organization's supported organization(s)? *If "No," describe in* ***Part VI*** *how control or management of the supporting organization was vested in the same persons that controlled or managed the supported organization(s)*	1		

Section D. All Type III Supporting Organizations

			Yes	No
1	Did the organization provide to each of its supported organizations, by the last day of the fifth month of the organization's tax year, (i) a written notice describing the type and amount of support provided during the prior tax year, (ii) a copy of the Form 990 that was most recently filed as of the date of notification, and (iii) copies of the organization's governing documents in effect on the date of notification, to the extent not previously provided?	1		
2	Were any of the organization's officers, directors, or trustees either (i) appointed or elected by the supported organization (s) or (ii) serving on the governing body of a supported organization? *If "No," explain in* ***Part VI*** *how the organization maintained a close and continuous working relationship with the supported organization(s)*	2		
3	By reason of the relationship described in (2), did the organization's supported organizations have a significant voice in the organization's investment policies and in directing the use of the organization's income or assets at all times during the tax year? *If "Yes," describe in* ***Part VI*** *the role the organization's supported organizations played in this regard*	3		

Section E. Type III Functionally-Integrated Supporting Organizations

1 Check the box next to the method that the organization used to satisfy the Integral Part Test during the year **(see instructions)**

- **a** ☐ The organization satisfied the Activities Test Complete **line 2** below
- **b** ☐ The organization is the parent of each of its supported organizations Complete **line 3** below
- **c** ☐ The organization supported a governmental entity Describe in **Part VI** how you supported a government entity (see instructions)

			Yes	No
2	Activities Test **Answer (a) and (b) below.**			
a	Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? *If "Yes," then in* ***Part VI identify those supported organizations and explain*** *how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities*	2a		
b	Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? *If "Yes," explain in* ***Part VI*** *the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement*	2b		
3	Parent of Supported Organizations **Answer (a) and (b) below.**			
a	Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? *Provide details in* ***Part VI.***	3a		
b	Did the organization exercise a substantial degree of direction over the policies, programs and activities of each of its supported organizations? *If "Yes," describe in* ***Part VI.*** *the role played by the organization in this regard*	3b		

Part V **Type III Functionally-Integrated 509(a)(3) Supporting Organizations**

1 ☐ Check here if the organization satisfied the Integral Part Test as a qualifying trust on Nov 20, 1970 (explain in Part VI) **See instructions.** All other Type III non-functionally integrated supporting organizations must complete Sections A through E

	Section A - Adjusted Net Income		(A) Prior Year	(B) Current Year (optional)
1	Net short-term capital gain	1		
2	Recoveries of prior-year distributions	2		
3	Other gross income (see instructions)	3		
4	Add lines 1 through 3	4		
5	Depreciation and depletion	5		
6	Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions)	6		
7	Other expenses (see instructions)	7		
8	**Adjusted Net Income** (subtract lines 5, 6 and 7 from line 4)	8		

	Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1	Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year)	1		
a	Average monthly value of securities	1a		
b	Average monthly cash balances	1b		
c	Fair market value of other non-exempt-use assets	1c		
d	**Total** (add lines 1a, 1b, and 1c)	1d		
e	**Discount** claimed for blockage or other factors (explain in detail in Part VI)			
2	Acquisition indebtedness applicable to non-exempt use assets	2		
3	Subtract line 2 from line 1d	3		
4	Cash deemed held for exempt use Enter 1-1/2% of line 3 (for greater amount, see instructions)	4		
5	Net value of non-exempt-use assets (subtract line 4 from line 3)	5		
6	Multiply line 5 by 035	6		
7	Recoveries of prior-year distributions	7		
8	**Minimum Asset Amount** (add line 7 to line 6)	8		

	Section C - Distributable Amount			Current Year
1	Adjusted net income for prior year (from Section A, line 8, Column A)	1		
2	Enter 85% of line 1	2		
3	Minimum asset amount for prior year (from Section B, line 8, Column A)	3		
4	Enter greater of line 2 or line 3	4		
5	Income tax imposed in prior year	5		
6	**Distributable Amount.** Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6		

7 ☐ Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions)

Part V **Type III Non-Functionally Integrated 509(a)(3) Supporting Organizations (continued)**

Section D - Distributions	**Current Year**
1 Amounts paid to supported organizations to accomplish exempt purposes	
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	
4 Amounts paid to acquire exempt-use assets	
5 Qualified set-aside amounts (prior IRS approval required)	
6 Other distributions (describe in **Part VI**) See instructions	
7 **Total annual distributions.** Add lines 1 through 6	
8 Distributions to attentive supported organizations to which the organization is responsive (provide details in **Part VI**) See instructions	
9 Distributable amount for 2018 from Section C, line 6	
10 Line 8 amount divided by Line 9 amount	

Section E - Distribution Allocations (see instructions)	**(i) Excess Distributions**	**(ii) Underdistributions Pre-2018**	**(iii) Distributable Amount for 2018**
1 Distributable amount for 2018 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2018 (reasonable cause required-- explain in Part VI) See instructions			
3 Excess distributions carryover, if any, to 2018			
a From 2013.			
b From 2014.			
c From 2015.			
d From 2016.			
e From 2017.			
f **Total** of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2018 distributable amount			
i Carryover from 2013 not applied (see instructions)			
j Remainder Subtract lines 3g, 3h, and 3i from 3f			
4 Distributions for 2018 from Section D, line 7 $			
a Applied to underdistributions of prior years			
b Applied to 2018 distributable amount			
c Remainder Subtract lines 4a and 4b from 4			
5 Remaining underdistributions for years prior to 2018, if any Subtract lines 3g and 4a from line 2 If the amount is greater than zero, explain in Part VI See instructions			
6 Remaining underdistributions for 2018 Subtract lines 3h and 4b from line 1 If the amount is greater than zero, explain in Part VI See instructions			
7 **Excess distributions carryover to 2019.** Add lines 3j and 4c			
8 Breakdown of line 7			
a Excess from 2014.			
b Excess from 2015.			
c Excess from 2016.			
d Excess from 2017.			
e Excess from 2018.			

Part VI **Supplemental Information.** Provide the explanations required by Part II, line 10; Part II, line 17a or 17b; Part III, line 12, Part IV, Section A, lines 1, 2, 3b, 3c, 4b, 4c, 5a, 6, 9a, 9b, 9c, 11a, 11b, and 11c, Part IV, Section B, lines 1 and 2, Part IV, Section C, line 1, Part IV, Section D, lines 2 and 3, Part IV, Section E, lines 1c, 2a, 2b, 3a and 3b, Part V, line 1, Part V, Section B, line 1e, Part V Section D, lines 5, 6, and 8, and Part V, Section E, lines 2, 5, and 6. Also complete this part for any additional information. (See instructions)

Facts And Circumstances Test

990 Schedule A, Supplemental Information

Return Reference	Explanation
PART III, SHORT YEAR EXPLANATION	THE ORGANIZATION WAS INCORPORATED ON JUNE 26, 2018 THEREFORE THE DATA REPORTED FOR 2018 IS FOR A SHORT YEAR BEGINNING ON THAT DATE

SCHEDULE D (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

▶ Complete if the organization answered "Yes," on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.
▶ Attach to Form 990.
▶ Go to www.irs.gov/Form990 for the latest information.

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
TRINITY HEALTHSHARE INC

Employer identification number
83-1050344

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.

Complete if the organization answered "Yes" on Form 990, Part IV, line 6.

		(a) Donor advised funds	(b) Funds and other accounts
1	Total number at end of year		
2	Aggregate value of contributions to (during year)		
3	Aggregate value of grants from (during year)		
4	Aggregate value at end of year		

5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? ☐ Yes ☐ No

6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? ☐ Yes ☐ No

Part II Conservation Easements. Complete if the organization answered "Yes" on Form 990, Part IV, line 7.

1 Purpose(s) of conservation easements held by the organization (check all that apply)

☐ Preservation of land for public use (e g , recreation or education)
☐ Preservation of an historically important land area
☐ Protection of natural habitat
☐ Preservation of a certified historic structure
☐ Preservation of open space

2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year

		Held at the End of the Year
a	Total number of conservation easements	2a
b	Total acreage restricted by conservation easements	2b
c	Number of conservation easements on a certified historic structure included in (a)	2c
d	Number of conservation easements included in (c) acquired after 7/25/06, and not on a historic structure listed in the National Register	2d

3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ▶ _____

4 Number of states where property subject to conservation easement is located ▶ _____

5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? ☐ Yes ☐ No

6 Staff and volunteer hours devoted to monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ▶ _____

7 Amount of expenses incurred in monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ▶ $ _____

8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)? ☐ Yes ☐ No

9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.

Complete if the organization answered "Yes" on Form 990, Part IV, line 8.

1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items

b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items

(i) Revenue included on Form 990, Part VIII, line 1 ▶ $ _____

(ii) Assets included in Form 990, Part X ▶ $ _____

2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items

a Revenue included on Form 990, Part VIII, line 1 ▶ $ _____

b Assets included in Form 990, Part X ▶ $ _____

Part III **Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets** *(continued)*

3 Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply)

- **a** ☐ Public exhibition
- **b** ☐ Scholarly research
- **c** ☐ Preservation for future generations
- **d** ☐ Loan or exchange programs
- **e** ☐ Other

4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII

5 During the year, did the organization solicit or receive donations of art, historical treasures or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? ☐ **Yes** ☐ **No**

Part IV **Escrow and Custodial Arrangements.**
Complete if the organization answered "Yes" on Form 990, Part IV, line 9, or reported an amount on Form 990, Part X, line 21.

1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? ☐ **Yes** ☐ **No**

b If "Yes," explain the arrangement in Part XIII and complete the following table

	Amount
c Beginning balance	**1c**
d Additions during the year	**1d**
e Distributions during the year	**1e**
f Ending balance	**1f**

2a Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability? . . . ☐ **Yes** ☐ **No**

b If "Yes," explain the arrangement in Part XIII Check here if the explanation has been provided in Part XIII . . . . ☐

Part V **Endowment Funds.** Complete if the organization answered "Yes" on Form 990, Part IV, line 10.

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance					
b Contributions . . .					
c Net investment earnings, gains, and losses					
d Grants or scholarships . . .					
e Other expenditures for facilities and programs . . .					
f Administrative expenses					
g End of year balance					

2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as

- **a** Board designated or quasi-endowment ▶
- **b** Permanent endowment ▶
- **c** Temporarily restricted endowment ▶

The percentages on lines 2a, 2b, and 2c should equal 100%

3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by

	Yes	No
(i) unrelated organizations	**3a(i)**	
(ii) related organizations	**3a(ii)**	
b If "Yes" on 3a(ii), are the related organizations listed as required on Schedule R?	**3b**	

4 Describe in Part XIII the intended uses of the organization's endowment funds

Part VI **Land, Buildings, and Equipment.**
Complete if the organization answered "Yes" on Form 990, Part IV, line 11a. See Form 990, Part X, line 10.

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land				
b Buildings				
c Leasehold improvements				
d Equipment				
e Other				
Total. Add lines 1a through 1e *(Column (d) must equal Form 990, Part X, column (B), line 10(c))* . . ▶				0

Part VII **Investments—Other Securities.** Complete if the organization answered "Yes" on Form 990, Part IV, line 11b. See Form 990, Part X, line 12.

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation Cost or end-of-year market value
(1) Financial derivatives		
(2) Closely-held equity interests		
(3) Other		
(A)		
(B)		
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
Total. *(Column (b) must equal Form 990, Part X, col (B) line 12)* ▶		

Part VIII **Investments—Program Related.** Complete if the organization answered 'Yes' on Form 990, Part IV, line 11c. See Form 990, Part X, line 13.

(a) Description of investment	(b) Book value	(c) Method of valuation Cost or end-of-year market value
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
Total. *(Column (b) must equal Form 990, Part X, col (B) line 13)* ▶		

Part IX **Other Assets.** Complete if the organization answered 'Yes' on Form 990, Part IV, line 11d See Form 990, Part X, line 15

(a) Description	(b) Book value
(1)	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col (B) line 15)* ▶	

Part X **Other Liabilities.** Complete if the organization answered 'Yes' on Form 990, Part IV, line 11e or 11f. See Form 990, Part X, line 25.

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
MEMBERSHIP SHARING LIABILITY	5,740,915
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col (B) line 25)* ▶	5,740,915

2. Liability for uncertain tax positions In Part XIII, provide the text of the footnote to the organization's financial statements that reports the organization's liability for uncertain tax positions under FIN 48 (ASC 740) Check here if the text of the footnote has been provided in Part XIII ☑

Part XI **Reconciliation of Revenue per Audited Financial Statements With Revenue per Return**
Complete if the organization answered 'Yes' on Form 990, Part IV, line 12a.

1	Total revenue, gains, and other support per audited financial statements			1	8,231,106
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12				
a	Net unrealized gains (losses) on investments	2a			
b	Donated services and use of facilities	2b			
c	Recoveries of prior year grants	2c			
d	Other (Describe in Part XIII)	2d			
e	Add lines **2a** through **2d**			2e	0
3	Subtract line **2e** from line **1**			3	8,231,106
4	Amounts included on Form 990, Part VIII, line 12, but not on line **1**				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIII)	4b			
c	Add lines **4a** and **4b**			4c	0
5	Total revenue Add lines **3** and **4c.** (This must equal Form 990, Part I, line 12)			5	8,231,106

Part XII **Reconciliation of Expenses per Audited Financial Statements With Expenses per Return.**
Complete if the organization answered 'Yes' on Form 990, Part IV, line 12a.

1	Total expenses and losses per audited financial statements			1	9,078,436
2	Amounts included on line 1 but not on Form 990, Part IX, line 25				
a	Donated services and use of facilities	2a			
b	Prior year adjustments	2b			
c	Other losses	2c			
d	Other (Describe in Part XIII)	2d			
e	Add lines **2a** through **2d**			2e	0
3	Subtract line **2e** from line **1**			3	9,078,436
4	Amounts included on Form 990, Part IX, line 25, but not on line **1:**				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIII)	4b			
c	Add lines **4a** and **4b**			4c	0
5	Total expenses Add lines **3** and **4c.** (This must equal Form 990, Part I, line 18)			5	9,078,436

Part XIII **Supplemental Information**

Provide the descriptions required for Part II, lines 3, 5, and 9, Part III, lines 1a and 4, Part IV, lines 1b and 2b, Part V, line 4, Part X, line 2, Part XI, lines 2d and 4b, and Part XII, lines 2d and 4b Also complete this part to provide any additional information

Return Reference	Explanation
See Additional Data Table	

Part XIII **Supplemental Information** ***(continued)***

Return Reference	Explanation

Additional Data

Software ID:

Software Version:

EIN: 83-1050344

Name: TRINITY HEALTHSHARE INC

Supplemental Information

Return Reference	Explanation
PART X, LINE 2	THE ORGANIZATION QUALIFIES FOR THE TAX EXEMPT STATUS UNDER SECTION 501(C)(3) OF THE INTERN AL REVENUE CODE AS A NONPROFIT, CHARITABLE ORGANIZATION UNDER SECTION 501(C)(3), NONPROFI T ORGANZIATIONS ARE TAXED ONLY ON UNRELATED BUSNIESS INCOME AS DEFINED BY THE INTERNAL REV ENUE CODE THE ORGANIZATION HAD NO UNRELATED BUSINESS INCOME FOR THE PERIOD ENDED DECEMBER 31, 2018 TRINITY'S INCOME TAX RETURNS SINCE INCEPTION ARE SUBJECT TO EXAMINATION BY TAX AUTHORITIES, AND MAY CHANGE UPON EXAMINATION

Note: To capture the full content of this document, please select landscape mode (11" x 8.5") when printing.

Schedule I (Form 990)

Department of the Treasury
Internal Revenue Service

Grants and Other Assistance to Organizations, Governments and Individuals in the United States

Complete if the organization answered "Yes," on Form 990, Part IV, line 21 or 22.

▶ **Attach to Form 990.**

▶ **Go to *www.irs.gov/Form990* for the latest information.**

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
TRINITY HEALTHSHARE INC

Employer identification number
83-1050344

Part I General Information on Grants and Assistance

1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? . . . . . ☐ Yes ☑ No

2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States

Part II Grants and Other Assistance to Domestic Organizations and Domestic Governments.

Complete if the organization answered "Yes" on Form 990, Part IV, line 21, for any recipient that received more than $5,000 Part II can be duplicated if additional space is needed

(a) Name and address of organization or government	(b) EIN	(c) IRC section (if applicable)	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of noncash assistance	(h) Purpose of grant or assistance
(1) See Additional Data							
(2)							
(3)							
(4)							
(5)							
(6)							
(7)							
(8)							
(9)							
(10)							
(11)							
(12)							

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table . . . . . ▶ 5

3 Enter total number of other organizations listed in the line 1 table . . . . . ▶ 0

Part III **Grants and Other Assistance to Domestic Individuals.** Complete if the organization answered "Yes" on Form 990, Part IV, line 22
Part III can be duplicated if additional space is needed

(a) Type of grant or assistance	**(b)** Number of recipients	**(c)** Amount of cash grant	**(d)** Amount of noncash assistance	**(e)** Method of valuation (book, FMV, appraisal, other)	**(f)** Description of noncash assistance
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					

Part IV **Supplemental Information.** Provide the information required in Part I, line 2; Part III, column (b); and any other additional information.

Return Reference	**Explanation**
SCHEDULE I, PART I, LINE 2	GRANTS WERE GIVEN TO LONG ESTABLISHED LARGE 501(C)(3) PUBLIC ORGANIZATIONS AND DO NOT REQUIRE FURTHER REVIEW

Software ID:
Software Version:
EIN: 83-1050344
Name: TRINITY HEALTHSHARE INC

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
FAMILIES OF CHILDREN UNDER STRESS INC 3825 PRESIDENTIAL PKWY STE 103 ATLANTA, GA 30340	58-1577602	501(C)(3)	6,500				STRENGTHEN METRO ATLANTA FAMILIES
GEORGIA CANINES FOR INDEPENDENCE INC 1540 HERITAGE COVE ACWORTH, GA 30102	20-0572759	501(C)(3)	5,500				DEDICATED TO IMPROVING THE QUALITY OF LIFE OF PEOPLE LIVING WITH DISABILITIES

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
ST JUDES CHILDREN'S RESEARCH HOSPITAL 501 ST JUDE PL MEMPHIS, TN 38105	62-0646012	501(C)(3)	25,000				ASSISTANCE TO CHILDEN IN HOSPITAL CARE
CAMP KUDZU INC 5885 GLENRIDGE DR STE 160 ATLANTA, GA 30328	58-2449646	501(C)(3)	10,000				HELPING CHILDREN LIVING WITH TYPE 1 DIABETES

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
ATLANTA RONALD MCDONALD HOUSE CHARITIES INC 795 GATEWOOD RD NE ATLANTA, GA 30329	58-1295754	501(C)(3)	20,000				NURTURE THE HEALTH AND WELL BEING OF CHILDREN AND FAMILIES

SCHEDULE O (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

Complete to provide information for responses to specific questions on Form 990 or 990-EZ or to provide any additional information.
▶ Attach to Form 990 or 990-EZ.
▶ Go to *www.irs.gov/Form990* for the latest information.

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
TRINITY HEALTHSHARE INC

Employer identification number
83-1050344

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 2	WILLIAM H THEAD III AND DAVID R THEAD ARE SIBLINGS

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 3	TRINITY HEALTHSHARE, INC ENGAGED ALIERA HEALTHCARE, INC TO PROVIDE IT WITH A VARIETY OF MANAGEMENT SERVICES IN 2018, ALIERA WAS PAID $527,028 FOR THESE SERVICES IN 2019 TRINITY HEALTHSHARE, INC IS IN THE PROCESS OF RENEGOTIATING ITS CONTRACT WITH ALIERA HEALTHCARE, INC

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 8B	IN 2018, TRINITY HEALTHSHARE, INC HAD NO COMMITTEES IN PLACE THAT WOULD ACT ON BEHALF OF THE GOVERNING BODY

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 11B	THE FORM 990 IS PREPARED BY AN INDEPENDENT CPA FIRM WHICH SENDS A DRAFT RETURN TO COUNSEL AND THE BOARD OF DIRECTORS FOR REVIEW A MEETING BETWEEN ALL PARTIES IS SCHEDULED TO REVIE W THE TAX RETURN IN DETAIL ANY CHANGES DECIDED ON AT THIS MEETING WILL BE INCORPORATED IN TO THE FINAL RETURN BEFORE SUBMISSION TO THE IRS

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 12C	THE WRITTEN CONFLICT OF INTEREST POLICY IS REVIEWED ANNUALLY BY THE BOARD AND ANY RELEVANT PARTIES ADDITIONALLY, THE POLICY IS REVIEWED WITH ANY NEW BOARD MEMBER(S) OR KEY EMPLOYE E(S) UPON THEIR ADDITION TO THE ORGANIZATION

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 15A	THE BOARD OF DIRECTORS REVIEWED SALARY DATA FROM COMPARABLE INDUSTRY SOURCES, INCLUDING SI MILAR ORGANIZATIONS THE SALARY PAID WAS AT - OR IN MOST CASES WELL BELOW - INDUSTRY STAND ARDS

Return Reference	Explanation
FORM 990, PART VI, SECTION C, LINE 18	THE ORGANIZATION'S FORM 1023 AND FORM 990 ARE AVAILABLE UPON REQUEST

Return Reference	Explanation
FORM 990, PART VI, SECTION C, LINE 19	THE AUDIT WILL BE MADE AVAILABLE UPON REQUEST AND ON THE WEBSITE

Return Reference	Explanation
FORM 990, PART VI, LINE(S) 13 AND 14	THE ORGANIZATION WAS FORMED, INCORPORATED, AND BEGAN OPERATIONS DURING 2018 IN NOVEMBER 2 019 THE BOARD OF DIRECTORS WAS IN PROCESS OF APPROVING AND IMPLEMENTING A WHISLEBLOWER AND DOCUMENT RETENTION AND DESTRUCTION POLICY

Return Reference	Explanation
FORM 990, PART VII, LINE 1A	DURING 2019 THE BOARD OF DIRECTORS WAS ACTIVELY SEEKING ADDITIONAL INDEPENDENT BOARD MEMBERS ON OCTOBER 23, 2019 A NEW BOARD MEMBER WAS ADDED TO TRINITY HEALTHSHARE, INC'S BOARD THE BOARD OF DIRECTORS WILL CONTINUE TO AGGRESSIVELY RECRUIT QUALIFIED AND INDEPENDENT BOARD MEMBERS

Return Reference	Explanation
FORM 990, PART XII, LINE 2C	THE 2018 AUDIT OVERSIGHT WAS PERFORMED BY ALIERA HEALTHCARE, INC AND TRINITY HEALTHSHARE' S BOARD OF DIRECTORS THE 2018 AUDIT FIRM SELECTION WAS PERFORMED BY ALIERA HEALTHCARE, IN C FOR 2019 THE AUDIT OVERSIGHT AND SELECTION WAS PERFORMED BY TRINITY HEALTHSHARE'S BOARD OF DIRECTORS

MANAGEMENT AND ADMINISTRATION AGREEMENT

This Management and Administration Agreement (the "**Agreement**") is effective as of August 13, 2018 (the ("**Effective Date**") by and between Aliera Healthcare, Inc., a Delaware corporation ("**Aliera**"). and Trinity HealthShare, Inc.. a Delaware nonprofit corporation ("Trinity"). Aliera and Trinity are sometimes referred to collectively as the "**Parties**," and each individually as a "**Party**".

WHEREAS, Aliera develops and markets healthcare products as an alternative to traditional health insurance, with some products containing a health care sharing ministry component:

WHEREAS, Aliera is a program manager for health care sharing ministry plans. responsible for the development of plan designs, pricing, and marketing materials, vendor management, and recruitment and maintenance of a national sales force to market plans, including accounting and management of sales commissions to authorized marketing representatives on behalf of the ministry;

WHEREAS, Aliera also provides administrative services that include system administration for both membership processing systems and member ShareBox databases. enrollment processing. billing and collection of monthly share amounts from health care sharing members. maintenance of membership records. management of third party administrators responsible for the processing of medical claims forms and determining sharing eligibility, and issuance of payment to members and providers, as well as providing and maintaining an inbound call center for member services, website development and maintenance, and usual and customary management functions such as Finance. Compliance. Human Resources. Marketing. Privacy. Data Security. and Information Technology;

WHEREAS, Trinity has filed the Form 1023 with the Internal Revenue Service (the "**IRS**") for recognition of exemption from federal income tax under section 501(c)(3) of the Internal Revenue Code, and wishes to enter into this Agreement allowing Aliera to include Trinity's healthcare sharing ministry program (the "**HCSM**") as a component of an existing healthcare plan which Aliera offers. or as a new healthcare plan which Aliera will offer, to the general public (any plan containing or consisting of the HCSM, a "**Plan**"). which Plans are listed on **Exhibit A** (as may be amended from time to time);

WHEREAS, Aliera has the exclusive right to design, market and sell the HCSM to its existing members and prospective members and to provide enrollment and other administrative services relating to the HCSM. and to market the Plans, which Plans will not include insurance products and cannot be bundled with insurance;

WHEREAS, Trinity currently 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 over 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.

NOW, THEREFORE, in consideration of the foregoing and the mutual promises and conditions contained herein, the Parties agree as follows:

1. Description of Services; Rights and Duties

a. Exclusive Rights. Trinity grants to Aliera an exclusive license to develop, market and sell the HCSM plans to individuals in the public markets who will acknowledge the standard of beliefs and other requirements as deemed necessary by Trinity, and agreed upon by Aliera. Aliera has the right to use all distribution channels for such marketing and sales; provided, however, that Aliera shall not permit brokers, field agents, general agencies or call centers to combine any insurance products with the HCSM.

b. Product Development. Aliera will be responsible for plan design (defining the schedule of medical services eligible for sharing), and pricing of the Plans. Aliera has the right, at its sole discretion, to develop and market the HCSM (the schedule of medical services eligible for sharing under the HCSM) with other non-insurance health care products that are developed and managed by Aliera as an "**Aliera Product**" and included in the same Plan. Aliera also has the sole right and discretion to determine whether a Plan also includes one or more Aliera Products.

c. Marketing. Aliera will (i) create any and all marketing materials used to market the Plans pursuant to this Agreement, and (ii) market and sell, through its authorized representatives, the Plans (the "**Services**"). Trinity authorizes Aliera and its authorized marketing representatives to discuss with potential members the prices, terms and conditions for the HCSM, and to provide explanations of the HCSM. Aliera, and its authorized marketing representatives will provide information to potential members regarding the faith and lifestyle requirements for the HCSM, as well as information necessary for potential members to understand that the Plans are not insurance.

d. Enrollment; Acceptance of Subscriptions of Members; Ownership of Membership Roster. Aliera (or its representatives or agents) will enroll new members in the Plans. Aliera is authorized to accept any enrollment from members in the Plans in its sole discretion. Aliera acknowledges and understands that, in order for members to qualify for participation in a healthcare sharing ministry, Aliera may only accept subscriptions from members who will acknowledge the standard of beliefs and other requirements as deemed necessary by Trinity and agreed upon by Aliera. 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.

e. Changes by Members. Members who are enrolled in any Plan are permitted to change components of Plans as directed by Aliera. Aliera is authorized, in its sole discretion, to transfer members to different Plans if members request such change in writing, and may substitute any component of a Plan, including the HCSM, upon notice to the members of any Plan. Aliera will notify Trinity when it has made a substitution of the HCSM component of a Plan at a member's request.

f. Medical Expense Processing. Aliera will enter into a third party administrative services agreement with a third party administrator, which may be an affiliate of Aliera (the "**TPA**"), pursuant to which the TPA provides account management and medical expense processing services for the Plans, as specifically described in such agreement. So long as such agreement or other similar agreement is in effect, Aliera shall have no obligation to provide account management and medical expense processing services for the HCSM. In addition, Aliera may engage other third party administrative service providers in connection with the Plans or this Agreement. In addition, Aliera may direct the TPA to use the services of other providers or service providers in order to enhance members' experiences, contain costs, or provide services that the TPA may not be qualified to provide.

g. Medical Expense Funding. Aliera and Trinity agree that each Party will distribute amounts to the ShareBox account for members to fund future member medical expense payments in accordance with **Exhibit B** attached hereto. The Parties may amend **Exhibit B** without amending this Agreement.

h. Financial Reporting. Trinity is responsible for providing and paying for accounting staff to support the financial operations necessary for the HCSM. Trinity hereby delegates this responsibility to Aliera, and Aliera agrees to provide such accounting staff and financial operations support, including monthly financial and membership reporting, audit support and Form 990 tax filing support as part of the Services.

i. Tax Filings; Audits. The Parties agree to have simultaneous Audits performed by the same mutually agreed upon audit firm for each calendar year end. This cooperation to engage certified public accountants and auditors is specifically encouraged to timely prepare and file Trinity's Form 990s and perform required audits relating to the HCSM, as required (including required time frames) under IRS rules applicable to 501(c)(3) organizations and health care sharing ministries. Each Party is responsible for its own expenses in connection with any tax filings or audits. Each Party shall make available to the certified public accountants and auditors, upon reasonable and advance request, all books and records required to be reviewed in connection with any tax filings or audits.

j. Compliance with Non-Profit Laws. Trinity has the sole responsibility to determine the requirements applicable to it as a non-profit organization.

k. Trinity Board. The board of directors of Trinity shall be selected by Trinity. At all times during the Term of this Agreement, no more than one-third of the board of directors of Trinity will consist of directors who are current directors, officers, employees, agents or stockholders of Aliera. Trinity has the sole responsibility and obligation to determine when board actions are required, and Aliera has no responsibility to assist or advise Trinity regarding any of its internal governance matters. Notwithstanding the foregoing, the Trinity board shall not take any actions that will cause it to violate this Agreement, Aliera's rights under this Agreement, or negatively affect the interests of the members of the Membership Roster.

2. **Intellectual Property**

a. License of Trinity Name. Trinity hereby grants to Aliera a non-exclusive, non-transferable, and non-sublicensable license to use Trinity's trademarks, logos, and other brand indicia (collectively, "**Brand Indicia**") of Trinity (the "**Trinity Marks**") during the Term, on or in connection with the marketing, promotion, advertising, and sale of the Plans. Upon reasonable written request from Trinity, Aliera will discontinue the display or use of the Trinity Marks or change the manner in which one or more Trinity Marks are displayed or used, provided that Aliera shall have no obligation to destroy existing inventory of materials as a result of a change in the Trinity Marks, but only to replace such inventory with the revised versions of the Trinity Marks when such inventory is depleted. Aliera acknowledges and agrees that any and all goodwill arising as a result of Aliera's use of the Trinity Marks shall inure to the benefit of Trinity, and Aliera acquires no rights in or to the Trinity Marks other than the license specifically set forth in this Agreement. Trinity shall not have a right or license to use the Aliera Brand Indicia.

b. Intellectual Property Defined. "**Intellectual Property**" means any and all methods, processes, procedures, inventions (regardless of patentability), ideas, designs, concepts, technique, discoveries, improvements, software code, algorithms, works of authorship, work product or moral rights, as well as any trademarks, service marks, copyrights, copyright applications, rights in copyrightable works, trade secrets, know-how and other confidential or proprietary information, patents, patent applications, any divisionals, continuations, continuations-in-part, reissues, extensions, or reexaminations thereof, and any other intellectual property rights or other proprietary rights in any country or jurisdiction throughout the world.

c. Background Intellectual Property. "**Background IP**" means any Intellectual Property conceived, developed, created or discovered prior to or outside the scope of this Agreement.

d. Trinity Intellectual Property. Subject only to the rights expressly granted in this Agreement, Trinity owns and shall retain ownership of all Trinity Background IP. In addition, subject only to the rights and licenses expressly granted in this Agreement, Trinity will solely own all right, title and interest in any Intellectual Property conceived, developed, created or discovered solely by Trinity personnel or contractors in the performance of this Agreement (the "**Trinity Intellectual Property**").

e. Aliera Intellectual Property. Subject only to the rights expressly granted in this Agreement, Aliera owns and shall retain ownership of all Aliera Background IP. In addition, subject only to the rights and license granted in this Agreement, Aliera will solely own all right, title and interest in any Intellectual Property conceived, developed, created or discovered solely by Aliera personnel or contractors in the performance of this Agreement (the "**Aliera Intellectual Property**"). Without limiting the foregoing, Aliera Intellectual Property shall specifically include all plan designs, marketing materials, plan concepts, pricing structure, the Membership Roster, software systems to manage said plans and all Intellectual Property associated with the plans designed and implemented by Aliera, even if said items bear the Brand Indicia or Trinity Marks. Neither the use of the Brand Indicia nor the Trinity Marks in the Aliera Background IP or the Aliera Intellectual Property will grant Trinity any rights in or to the Aliera Background IP or the

Aliera Intellectual Property other than the ownership in and to the Brand Indicia and the Trinity Marks that Trinity holds as Trinity Background IP.

f. Joint Intellectual Property. Trinity and Aliera will jointly own any and all Intellectual Property conceived, developed, created or discovered jointly by personnel or contractors of both Trinity and Aliera (the "**Joint Intellectual Property**"). Aliera and Trinity will coordinate with each other to determine whether it is appropriate to file for any intellectual property protections for the Jointly Developed Intellectual Property, and both Aliera and Trinity will each have the right to exploit the Jointly Intellectual Property without accounting to the other. provided that such exploitation does not violate other provisions of this Agreement.

g. No Other Licenses. For the avoidance of doubt, other than the express licenses granted by this Agreement, none of the Parties grant any rights or licenses to their Intellectual Property, by implication, estoppel, or otherwise, to the other Parties.

3. Revenue and Expenses; Payments

a. Revenues and Expenses. Trinity and Aliera have agreed to apportion the total revenues received from the member share contribution amounts and the vendor fees associated with the Plans in accordance with **Exhibit B** attached hereto, which may be amended from time to time as agreed to by the Parties (the "**Revenue and Expense Structure**"). For clarity, the Parties may amend the Revenue and Expense Structure by amending **Exhibit B** only. without amending this Agreement. No person who is a "disqualified person" under IRS rules and regulations will be paid any fees by the other Party.

b. Enrollment Fees. Trinity will receive $25 for each application to be paid from each member's enrollment fees (the "**Member Enrollment Fees**") in any of the Plans.

c. Member Payments. All 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. Aliera will 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, in accordance with the Revenue and Expense Structure and the Share Box Contribution, have been distributed by Aliera. Aliera will provide Trinity with a report within 15 days of the end of each month showing the amounts attributable in that month to the HCSM portion of the Plans, and the deductions made from such amounts in accordance with the Revenue and Expense Structure.

d. Payments. Pursuant 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. Aliera is authorized to make, or cause to be made, deposits into, and payments from, such Trinity banking accounts, in accordance with the Revenue and Expense Structure.

4. Representations and Warranties

Each Party represents and warrants to the other that (i) it has the full authority and power to enter into and fully perform this Agreement; (ii) neither the execution nor delivery of this Agreement, nor such Party's performance of any obligations under this Agreement, will conflict with or violate any other license, agreement or commitment by which such Party is bound; and (iii) it will perform its obligations under this Agreement in compliance with all applicable laws and regulations.

5. Termination

a. Term. This Agreement shall become effective on the Effective Date and shall continue in force until the fifth (5th) anniversary of the Effective Date (the "**Initial Term**"), and will automatically, without further action by either Party, renew for an additional five (5) years ("**Renewal Term**", and each Renewal Term together with the Initial Term, the "**Term**"), unless either Party delivers to the other Party written notice of its intent not to renew at least 270 days prior to the expiration of the Initial Term or the then current Renewal Term, as applicable.

b. Termination Upon Default. Either Party may terminate this Agreement, effective on written notice to the other party (the "**Defaulting Party**"), if the Defaulting Party:

i. Materially breaches this Agreement, and either such material breach is incapable of cure or, if curable, the Defaulting Party does not cure such breach within 30 days after receipt of written notice of such breach;

ii. Becomes insolvent or admits its inability to pay its debts generally as they become due, makes a general assignment for the benefit of creditors, voluntarily enters into an proceeding under any bankruptcy or insolvency law, becomes involuntarily subject to any such proceeding which is not dismissed or vacated within 45 days after filing, or has a receiver or similar agent appointed by order of any court of competent jurisdiction to take charge of or sell any material portion of its property or business; or

iii. Is dissolved or liquidated or takes any corporate action for such purpose.

c. Post-Termination Matters. Neither Party shall incur any liability to the other by reason of the termination of this Agreement or its non-renewal; provided, however, that the termination of this Agreement for any reason shall not terminate any rights, obligations or liabilities which either Party may accrue prior to such expiration or termination. Upon valid termination of this Agreement, all rights and authority granted hereunder shall immediately terminate (except as provided below), 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 as well as any and all materials bearing the Brand Indicia or containing the Intellectual Property of the other Parties. In the event of any termination of this Agreement, Sections 1(d), 7, 8 and 9 will survive in accordance with their terms.

d. Active Members. Upon termination of this Agreement in accordance with this Section, any existing member enrolled in a Plan will remain active and continue to be serviced by Aliera until the member requests cancellation of the Plan.

6. Indemnification & Limitations

a. Indemnification. Each party shall agree to defend, hold harmless and expeditiously indemnify the other party of and from any and all liability, claim, loss, damage, or expense arising from or in connection with the indemnifying Party's breach or violation of any representation, warranty or covenant contained in this Agreement (if such breach of representation, warranty or covenant is decided by a court of competent jurisdiction, arbitration or by admission of either party), including reasonable attorneys' fees and expert witness fees and other reasonable costs incurred in the defense of any legal proceeding asserting such a claim.

b. Limitations. EXCEPT FOR (i) A PARTY'S BREACH OF ITS CONFIDENTIALITY AND NON-SOLICITATION OBLIGATIONS SET FORTH IN SECTION 7 AND (ii) A PARTY'S INDEMNITY OBLIGATIONS SET FORTH IN SECTION 6, NEITHER PARTY WILL BE LIABLE TO THE OTHER PARTY FOR ANY INCIDENTAL, CONSEQUENTIAL, 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 7 (CONFIDENTIALITY AND NON-SOLICITATION OBLIGATIONS) OR EXCEPT AS PROVIDED UNDER SECTION 6 (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.

7. Confidential Information; Non-Solicitation

a. Confidential Information.

i. Definition. From time to time during the Term of this Agreement, either Party (in such capacity, the "**Disclosing Party**") may, but is not hereby obligated to, disclose or make available to the other Party (in such capacity, the "**Receiving Party**") proprietary information of the Disclosing Party, including information about its business, products and services, ownership structure, financial condition, operations, assets, liabilities, business plans, Aliera Intellectual Property, information that it deems a trade secret under applicable law, third-party confidential information in the Disclosing Party's possession or under its control, and other sensitive or proprietary information, and all notes, documents and other materials prepared by the Receiving Party that contain, reflect or are based upon any such information described above, in each case whether orally or in

writing, electronic or other form or media, and whether or not marked, designated or otherwise identified as "confidential" (collectively, "**Confidential Information**").

ii. Exclusions. Confidential Information shall not include information that, at the time of disclosure and as established by the Receiving Party by documentary evidence: (i) was already possessed by the Receiving Party prior to its being obtained in connection with the Services, free of other confidentiality obligations to the Disclosing Party, (ii) has become generally available to the public other than as a result of disclosure by the Receiving Party or any of its affiliates or representatives, or (iii) has become available to the Receiving Party on a non-confidential basis from a source other than the Disclosing Party, where the Receiving Party has no knowledge, after reasonable inquiry, that the source owes any confidentiality obligation to the Disclosing Party.

iii. HIPAA. Trinity acknowledges that Aliera may determine, with advice of counsel, that Aliera is subject to (i) the Health Insurance Portability and Accountability Act of 1996, and regulations promulgated thereunder, including the Privacy, Security, Breach Notification and Enforcement Rules at 45 CFR Parts 160 and 164, and any subsequent amendments or modifications thereto, and (ii) the HITECH Act, and regulations promulgated thereunder, and any subsequent amendments or modifications thereto (together, "**HIPAA**"). As such, Trinity shall not use PHI (as defined below) in any manner except for the purpose of performing functions, activities, or services pursuant to the Agreement; provided, however, that Trinity shall not use PHI in any manner that would constitute a violation of HIPAA if so used by Aliera. Trinity may use PHI: (i) for the proper management and administration of Trinity; (ii) to carry out the legal responsibilities of Trinity; or (iii) as required by 45 CFR § 164.103. "**PHI**" shall have the meaning set forth in 45 CFR § 160.103, including, without limitation, any information, whether oral, electronic or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an individual; (ii) the provision of health care to an individual; or (iii) the past, present or future payment for the provision of health care to an individual; and (iv) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

iv. Duties. The Receiving Party shall protect and safeguard the confidentiality of the Disclosing Party's Confidential Information with at least the same degree of care as the Receiving Party would protect its own Confidential Information, but in no event with less than a commercially reasonable degree of care; shall not use the Disclosing Party's Confidential Information, or permit it to be accessed or used, for any purpose other than to exercise the Receiving Party's rights or to perform its obligations under this Agreement; and shall not disclose any such Confidential Information to any person or entity, except to the Receiving Party's representatives who need to know the Confidential Information to assist the Receiving Party, or act on its behalf, to exercise its rights or perform its obligations under the Agreement.

v. Obligation for Representatives. The Receiving Party shall be responsible for any breach of this Section 7(a) caused by any of its representatives. At the Disclosing Party's written request, the Receiving Party shall promptly return, and shall require its

representatives to return to the Disclosing Party all copies, whether in written, electronic or other form or media, of the Disclosing Party's Confidential Information, or destroy all such copies and certify in writing to the Disclosing Party that such Confidential Information has been destroyed. The Disclosing Party's Confidential Information shall be protected throughout the Term of this Agreement and for five (5) years following termination of this Agreement.

b. Non-Solicitation. During the Term and for two (2) years after, each Party shall not, and shall not assist any other person to, directly or indirectly, recruit or solicit for employment or engagement as an independent contractor any person then or within the prior six (6) months employed or engaged by the other Party.

c. Remedies. In addition to all other remedies available hereunder or otherwise at law, each party may seek equitable relief (including injunctive relief) against the other party and its representatives to prevent the breach or threatened breach of Section 7 of this Agreement and to secure enforcement thereof, without need to prove actual damages or to post bond or other security.

8. Governing Law; Venue; Waiver of Jury Trial

This Agreement shall be enforced, governed and construed in accordance with the laws of the State of Georgia, without regard to its principles governing the conflict of laws. Any judicial proceedings brought by either Party hereto must be brought in either the state or (if jurisdiction can be acquired) federal courts located in Fulton County, Georgia, and each Party consents to such venue serving as the exclusive venue for any such actions.

THE PARTIES HEREBY IRREVOCABLY WAIVE ANY RIGHT THEY MAY HAVE TO A TRIAL BY JURY WITH RESPECT TO ANY ACTION DIRECTLY OR INDIRECTLY ARISING OUT OF, UNDER OR IN CONNECTION WITH THIS AGREEMENT.

9. Miscellaneous

a. No Joint Venture. The relationship of the Parties is that of independent contractors. This Agreement does not give either Party the power to direct the day to day activities of the other, constitute the Parties as partners, joint venturers, co-owners or principal-agent, or allow either Party to create or assume any obligation on behalf of the other Party.

b. Records. The Parties agree to maintain all documents and records relating to members in the Plans for the earlier of five (5) years following the (i) cancelation of such member's enrollment in any Plan, or (ii) termination of this Agreement. Each Party agrees to permit the other Party (at the requesting Party's sole expense) to have reasonable access, at reasonable times and in a manner so as not to unreasonably interfere with normal business operations, to such documents and records so as to enable each Party to prepare tax, financial or court filings or reports, to respond to court orders, subpoenas or inquiries, investigations, audits or other proceedings of governmental authorities and to prosecute and defend legal actions or for other like purposes.

c. Assignment. This Agreement will be binding upon and inure to the benefit of the successors and permitted assigns of the parties. No Party shall assign any of its rights or obligations under this Agreement without the prior written consent of the other Party, and any purported assignment by any Party in violation of this provision will be null and void. Notwithstanding the foregoing, a Party may assign this Agreement to a person or entity that controls, is controlled by, or is under common control with the Party. A Party agrees to provide the other Party with at least 60 days' prior written notice in the change of ownership, control, substantial change in management or management rules and regulation of operations.

d. Severability. If any provision of this Agreement is determined by a court to be unenforceable, then the parties shall deem the provision to be modified to the extent necessary to allow it to be enforced to the extent permitted by law, or if it cannot be modified, the provision will be deleted from this Agreement, and the remainder of the Agreement will continue in effect.

e. Entire Agreement. 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 Trinity, and Aliera whether oral or in writing.

f. Joint Negotiation. The Parties have participated jointly in the negotiation and drafting of this Agreement. The Parties contemplate that this Agreement will be construed as having been drafted jointly by the Parties, and no presumption or burden of proof will arise favoring or disfavoring any party based upon the authorship of any provision hereof. Trinity acknowledges that Aliera's legal counsel does not represent and has not represented Trinity in connection with, including the negotiation of, this Agreement, and that it had the opportunity to retain its own counsel in connection with this Agreement.

g. Notices. Any notice, request or consent required or permitted hereunder must be in writing and will be deemed to have been received when hand delivered, when sent by email or fax (upon electronic confirmation of error-free delivery), one day after being sent by nationally recognized overnight courier, costs prepaid, or three days after being sent by certified or registered U.S. mail, return receipt requested, postage prepaid, in any case addressed to the recipient at its contact information listed below (or at such other address as the applicable party may designate by notice hereunder to the other parties):

To: Trinity HealthShare, Inc.
5901 Peachtree Dunwoody Rd., Suite C 160
Atlanta, GA 30328
Attn: William H. Thead, III, Chairman

To: Aliera Healthcare, Inc.
990 Hammond Drive
Suite 700
Atlanta, Georgia 30328
Attn: Chase Moses, Executive Vice President

h. No Waiver. No failure or delay by any party to exercise any right under this Agreement will operate as a waiver of such right, and no single or partial exercise of any such right will preclude any other or further exercise of such right or the exercise of any other right.

i. Multiple Parts. This Agreement may be signed in counterparts, by facsimile and electronic signatures, and by signatures delivered electronically, each of which will be deemed an original and all of which together will constitute one instrument.

[SIGNATURE PAGE FOLLOWS]

IN WITNESS, WHEREOF, and intending to be legally bound hereby, the Parties have executed this Agreement under seal as of the date first written above.

ALIERA HEALTHCARE, INC.

By: _____

Name: Chase Moses
Title: Executive Vice President

TRINITY HEALTHSHARE, INC.

By: _____

Name: William Thead, III
Title: Chairman

EXHIBIT A

List of Plans

AlieraCare contains both Aliera and Trinity healthcare components

Interim Care contains both Aliera and Trinity healthcare components

CarePlus contains Trinity healthcare components only

Trinity Dental and Vision - contains Trinity healthcare components only

PrimaCare contains Trinity healthcare components only

AD&D - TBD

Critical Illness - TBD

Accident TBD

Hospital Indemnity - TBD

EXHIBIT B

Revenue and Expense Structure

Pursuant to that Management and Administration Agreement dated as of August 13, 2018, by and between Aliera and Trinity, the parties agree that the revenues received from the Plans, and the costs and expenses associated with the Plans, shall be allocated to each of Aliera and Trinity as set forth below or attached, until amended or changed by mutual agreement of the parties. Aliera will obtain a valuation from an independent appraiser to ensure the payments from Trinity to Aliera for Aliera's services under the Agreement are fair market value for purposes of Internal Revenue Service (IRS) rules and regulations governing excess benefit transactions in connection with non-profit organizations. Payments from Trinity to Aliera for reimbursement of vendor costs will not be considered payment of services to Aliera.

AlieraCare & InterimCare

Trinity acknowledges and agrees that Aliera will receive and retain 65% of the total member share contribution for each primary member of each of the AlieraCare and Interim Care plans (the "**Total Side by Side MSC**") for the Aliera components of each plan and as payment for the Services.

Trinity will receive 35% of the Total Side by Side MSC (the "**Trinity MSC**"). Trinity will reimburse Aliera, from such amount, the following fees in the following percentages for Aliera's payment of vendor cost for the AlieraCare and Interim Care plans, as well as distribute the following amounts to the ShareBox account to be used solely for member medical expense payments.

Program Expenses Side by Side Products	% of Trinity MSC
Aliera Mgmt Fee General Overhead Ops Labor Internal Sales	19.6%
Commissions	30.0%
TPA Fees	2.6%
Provider Network (Multi Plan)	1.2%
Telemedicine	0.8%
Total Reimbursement	54.2%
ShareBox Contribution Side by Side Products	% of Trinity MSC
ShareBox Member Reserve	44.3%

CarePlus

The Parties agree that Trinity will receive 100% of the total member share contribution for each primary member of each of CarePlus plans (the "**MSC**"), and potentially in the future, for the Hospital Indemnity, Critical Illness and AD&D Plans contemplated under Exhibit A . Trinity will reimburse Aliera, from such amount, the following fees in the following percentages for Aliera's payment of vendor cost for the CarePlus plans (and potentially in the future, for the Hospital

Indemnity, Critical Illness and AD&D Plans), as well as distribute the following amounts to the ShareBox account to be used solely for member medical expense payments.

Program Expenses Stand Alone products	% of MSC
Aliera Mgmt. Fee General Overhead Ops Labor Internal Sales	20.0%
Commissions	35.0%
TPA Fees	2.5%
Provider Network (Multi Plan)	1.2%
Telemedicine	1.0%
Total Reimbursement	59.7%
Share Box Contribution Stand Alone Products	% of MSC
Share Box Member Reserve	35%

PrimaCare

The Parties agree that Trinity will receive 100% of the total member share contribution for each primary member of each of PrimaCare (the "**PrimaCare MSC**"). Trinity will reimburse Aliera, from such amounts, the following fees in the following percentages for Aliera's payment of vendor cost for the PrimaCare plans, as well as distribute the following amounts to the ShareBox account to be used solely for member medical expense payments.

Program Expenses Stand Alone products	% of PrimaCare MSC
Aliera Mgmt. Fee General Overhead Ops Labor Internal Sales	30.0%
DPCMH Concierge Services	15.5%
Commissions	40.0%
TPA Fees	2.5%
Provider Network (Multi Plan)	1.2%
Telemedicine	1.0%
Total Reimbursement	90.20%
Share Box Contribution Stand Alone Products	% of PrimaCare MSC
Share Box Member Reserve	8.3%

Dental

The Parties agree that Trinity will receive 100% of the total member share contribution for each primary member of each of Dental plans (the "**Dental MSC**"). Trinity will reimburse Aliera, from such amount, the following fees in the following percentages for Aliera's payment of vendor cost for the Dental plans, as well as distribute the following amounts to the ShareBox account to be used solely for member medical expense payments.

Program Expenses Stand Alone products	% of Dental MSC
Aliera Mgmt. Fee General Overhead Ops Labor Internal Sales	30.0%
Commissions	40.0%
TPA Fees	2.5%
Provider Network (Multi Plan)	10%

Total Reimbursement	82.5%
Share Box Contribution Stand Alone Products	% of Dental MSC
Share Box Member Reserve	15%

Vision

Further, the Parties agree that Trinity will receive 100% of the total member share contribution for each primary member of the Vision plans (the "**Vision MSC**"). Trinity will reimburse Aliera, from such amount, the following fees in the following percentages for Aliera's payment of vendor cost for the Vision plans, as well as distribute the following amounts to the ShareBox account to be used solely for member medical expense payments.

Program Expenses Stand Alone products	% of Vision MSC
Aliera Mgmt. Fee General Overhead Ops Labor Internal Sales	30.0%
Commissions	40.0%
TPA Fees	2.5%
Provider Network (Vision Fees)	10%
Total Reimbursement	82.5%
Share Box Contribution Stand Alone Products	% of Vision MSC
Share Box Member Reserve	15%

State of Washington
Office of the Insurance Commissioner
Legal Affairs Division
Investigations Unit

Final Investigative Report
Cover Page Synopsis

OIC Case #: 1589861 **Final Report Date:** 04/08/2019
Related Cases: None **Date Complaint Received:** 09/11/2018

Name of Person or Entity under Investigation: (1) Aliera Healthcare, 5901 Peachtree Dunwoody Rd., Ste. 200, Atlanta, GA 30328. (2) Trinity Healthshare, 5901 Peachtree Dunwoody Rd., Ste 160, Atlanta, GA 30328

WAOIC License Number and Status: None

Representative for Person or Entity under Investigation: (1a) Aliera: Reba Leonard, Vice President Compliance and Regulatory Affairs (rleonard@alierahealthcare.com / 404-618-0602), 15301 Dallas Parkway, Ste 920, Addison, TX 75001; (1b) Aliera: Dwight Francis (Sheppard, Mullin, Richter & Hampton LLP), 2200 Ross Ave, Ste. 2400, Dallas, TX 75201; 430-391-7400, dfrancis@sheppardmullin.com; (2) Trinity: J. Joseph Guilkey (BakerHostetler), 200 Civic Center Drive, Ste. 1200, Colombus, OH 43215; 614-462-2697, jguilkey@bakerlaw.com

Complainant: Zack Snyder, Director of Government Affairs at Cambia Health Solutions; 1800 9th Ave, Seattle, WA 98101 (zach.snyder@cambiahealth.com, 206-332-5060).

Name of Insured (if different from complainant): N/A

Relationship to Insured: N/A

Allegation(s): (1) Trinity Healthshare does not meet the statutory definition of a HCSM under RCW 48.43.009 and Federal statute. If proven true, Trinity may be acting as an unauthorized insurer, in violation of RCW 48.05.030. (2) Aliera Healthcare's various advertisements on behalf of Trinity are deceptive and have the capacity and tendency to mislead or deceive consumers to believe they are purchasing insurance rather than a HCSM membership. If proven true, these could be violations of RCW 48.30.040, WAC 284-50-050 and 284-50-060.

Investigative Findings: Substantiated

Potential RCW's or WAC's Violated: RCW 48.05.030, RCW 48.30.040, WAC 284-50-050 and WAC 284-50-060

State of Washington
Office of Insurance Commissioner
Legal Affairs Division
Regulatory Investigations Unit

Final Investigative Report
Executive Summary

This investigation determined the following:

1. The allegation that Trinity Healthshare ("Trinity") does not meet the statutory definition of a HCSM under RCW and Federal statute is substantiated. Trinity is therefore acting as an unauthorized insurer, in violation of RCW 48.05.030.
2. The allegation that Aliera Healthcare's ("Aliera") various advertisements on behalf of Trinity are deceptive and have the capacity and tendency to mislead or deceive consumers to believe they are purchasing insurance rather than a HCSM membership, in violation of RCW 48.30.040, WAC 284-50-050 and 284-50-060, is substantiated.

RIU opened the investigation based on a complaint from an insurer, which forwarded an Aliera Healthcare ("Aliera") solicitation it obtained which sought to recruit agents to sell "healthcare" products. From previous RIU investigations, OIC is aware Aliera has acted as a marketer for health care sharing ministries ("HCSM"). A HCSM is an organization that is exempt from insurance regulation in Washington State (see RCW 48.43.009, which defers to 26 USC §5000A(d)(2)(B)(ii)) and exists to facilitate medical cost sharing between members in accordance with a specific set of religious and/or ethical beliefs.

During the course of the investigation the RIU gathered information regarding Aliera, Trinity and three other legal entities with a nexus to the Trinity-Aliera relationship. Based on this information, the RIU concluded:

1. The evidence indicates Trinity does not meet the definition of a HCSM because (1) its representations about the nature of its religious convictions to consumers, State

and Federal regulators are contradictory and in conflict with its own bylaws, (2) it has not been operating as a 501(c)(3) legal entity and sharing member medical needs continuously since December 31, 1999, and (3) evidence indicates Trinity was formed in 2018 for the express purpose of entering into a marketing agreement with Aliera.

Because the evidence indicates Trinity is not a HCSM, as defined by RCW and Federal statute, the laws concerning advertising for disability insurance likely apply to Trinity's HCSM products. Regardless of this finding, because these HCSM products mirror disability policies in their *function* (not the legal structure of the entity offering them), it is prudent to use disability advertising statutes to determine whether Trinity and Aliera are providing misleading or deceptive advertisements regarding HCSM products. Therefore, RIU determined the following:

2. The evidence indicates Aliera (1) failed to represent Trinity's actual Statement of Faith, as defined by Trinity's bylaws, (2) provided misleading training to prospective agents about the nature of the HCSM products, and (3) provided misleading advertisements to the general public and potential consumers that have the capacity or tendency to mislead or deceive consumers, based on the overall impression that these advertisements may be reasonably expected to create upon a person of average education.

State of Washington
Office of Insurance Commissioner
Legal Affairs Division
Regulatory Investigations Unit

Final Investigative Report
Investigative Findings

1. ALLEGATION

The Regulatory Investigations Unit ("RIU"), Office of the Insurance Commissioner ("OIC") opened this investigation after receiving a communication from Cambia Health Solutions "(Cambia") which expressed concerns that Aliera Healthcare ("Aliera") may be misrepresenting its products as insurance (Exhibit 1). Cambia provided a copy of a communication Aliera sent to prospective brokers, which read (in part):

> *This is an excellent opportunity for Aliera Healthcare to develop long-term, mutually-beneficial relationships with new brokers and agencies in the state of Washington and to build a strong Aliera presence in both the Group and Individual markets ... Aliera makes affordable quality healthcare accessible to those who are priced out of the current markets. Whether you're a business looking for affordable ACA-compliant plans, or an individual looking for ACA alternatives, Aliera Healthcare puts the power of choice back in your hands.*

From previous RIU investigations, OIC is aware Aliera has acted as a marketer for health care sharing ministries ("HCSM"). A HCSM is an organization that is exempt from insurance regulation in Washington State (see RCW 48.43.009) and exists to facilitate medical cost sharing between members in accordance with a specific set of religious and/or ethical beliefs. The Washington State insurance code defers to the Federal statute to define a HCSM [see RCW 48.43.009; cf. 26 USC §5000A(d)(2)(B)(ii)]. The Federal statue lists five criteria:

- *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.*

The OIC opened an investigation into both (1) Trinity Healthshare ("Trinity"), the HCSM behind many of Aliera's products, and (2) Aliera, Trinity's marketer. This investigation had two objectives:

- Does Trinity meets the statutory definition of a HCSM under WA law (RCW 48.43.009)? If it does not, it may be operating as an unauthorized insurer in violation of RCW 48.05.030.
- Do Aliera's various advertisements on behalf of Trinity mislead consumers to believe they are purchasing insurance, rather than a HCSM membership? If proven to be true, this could be a violation of RCW 48.30.040 and WAC 284-50-050 and 284-50-060.

The case was assigned to Investigator ("INV") Tyler Robbins.

2. LICENSING REVIEW

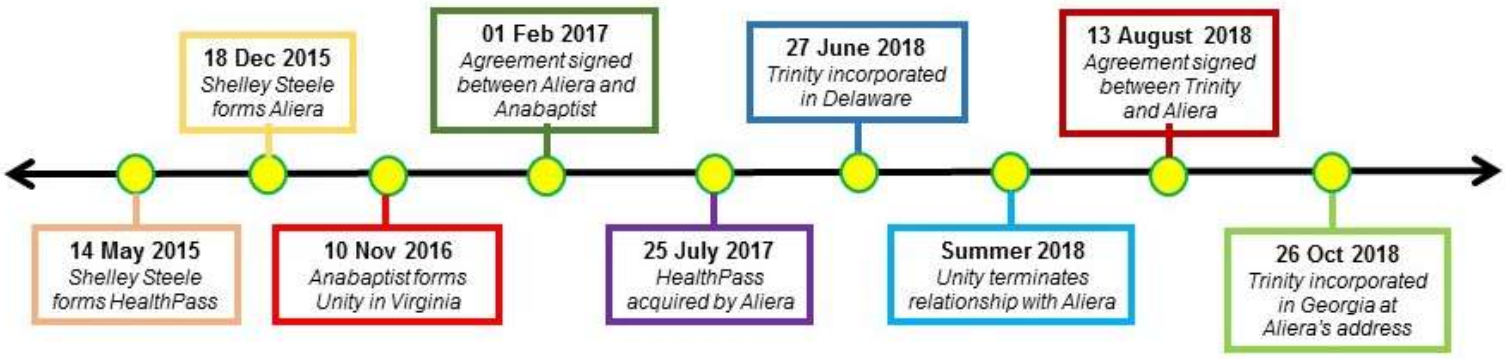
INV Robbins conducted a licensing check on Aliera through the National Association of Insurance Commissioners ("NAIC"), which disclosed Aliera has active producer's licenses in 36 states. It does not have a license in Washington (Exhibit 2). Trinity is not licensed with the NAIC or the OIC, because it purports to be a HCSM exempt from insurance regulation.

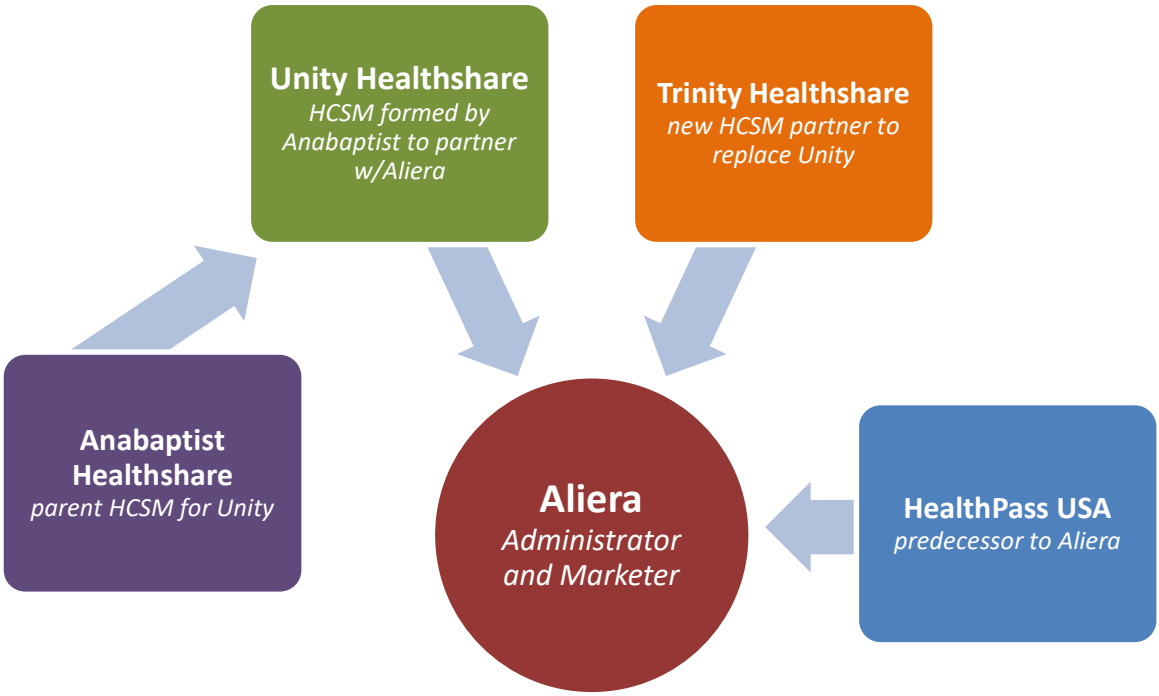
3. **NOTIFICATION OF INVESTIGATION**

On 10/01/2018, INV Robbins sent formal notices of investigation to both Aliera and Trinity, requesting a response to the allegations (Exhibit 3a). Throughout the course of the investigation, INV Robbins sent a follow-up notices to both Trinity (Exhibits 3b – 3c) and Aliera (Exhibit 3d), requesting further information.

4. **INVESTIGATION OF AND RESPONSE FROM PARTIES**

During the course of this investigation, RIU gathered information regarding five entities; Aliera, Trinity, Anabaptist Healthshare, Unity Healthshare and HealthPass USA. The relationship between these entities and a relevant timeline is below:





a. ALIERA HEALTHCARE

i. **Background**

The entity known as Aliera appears to have begun as a domestic stock corporation in the State of Delaware on 09/29/11 as an entity called, “OnSite Health Management, Inc.” (Exhibit 7b). Approximately 14 months later, it filed an amendment and changed its name to Aliera Healthcare, Inc. (Exhibit 7b, pg. 4). This Aliera entity (“Aliera #2”) appears to remain an active business entity in Delaware (Exhibit 7c), and has never registered in Georgia.

The Aliera entity that is the focus of this investigation (“Aliera”) was incorporated in the State of Delaware on 12/18/15 (Exhibits 4a and 4b) by Shelley Steele (Exhibit 4b, pg. 7). Its scope of business was “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 …” (Exhibit 4b, pg. 8). In 2017, the most recent year Delaware has on file, a man named Chase Moses appears on record as a director of the corporation (Exhibit 4b, pg. 9).

Aliera registered as a foreign corporation in the State of Georgia approximately four months later, on 04/28/16, with Shelley Steele as the CFO and CEO (Exhibit 4c). The business remains active in Georgia, where it maintains its offices (Exhibits 4d – 4e). In addition, an entity named “Aliera Healthcare of Georgia” registered as a domestic LLC in that state on 03/13/17 (Exhibit 4f) and remains active (Exhibit 4g). Shelley Steele was also the CEO of this entity.

On 07/25/17, a domestic Georgia entity named HealthPassUSA, LLC (“HealthPass”) merged with Aliera, which remained the surviving corporation (Exhibit 4h). HealthPass was organized as a domestic LLC on 05/14/15 by Shelley Steele (Exhibit 6a), the same individual who founded both Aliera entities (above). HealthPass also occupied the very

same address as Aliera later did throughout 2016 and 2017, until its merger (Exhibits 6b – 6c; compare to address in Exhibit 4b).[1]

ii. **Agent Training**

The Federal exemption for HCSMs is religious in nature. Indeed, the exemption is under a heading marked "religious exemptions."[2] However, Aliera's promotional material for consumers and its training material for new and prospective brokers fails to emphasize this point. The majority of the material never mentions the religious motivations that the Federal HCSM statute envisions prospective consumers would have. This potentially misleads both consumers *and* the prospective brokers who will market, solicit and sell the products to the religiously-motivated individuals whom the Federal statute envisions to be the HCSM's intended market.

1. Advertisements for prospective agents:

Aliera's advertisements for recruiting prospective agents to sell the HCSM products offer them the opportunity to sell "the next generation of Healthcare products" and suggests they can offer employers "a healthcare plan that saves money," (Exhibit 4i). The terms "healthcare" and "health plan" are insurance-specific terminology, defined by statute (see RCW 48.43.005 [26]). Moreover, the advertisement does not mention a religious or ethical component for the consumers.

Aliera's agent training portal[3] requires prospective agents to watch a series of three training videos, then take an assessment (Exhibit 4j). INV Robbins obtained both mp3 and mp4 copies of each video from the portal:

1. The address is 5901 Peachtree Dunwoody Road, Building B, Suite 200, Atlanta, GA, 30328.
2. See 26 USC 5000A(d)(2).
3. At the time of this report, the prospective agent portal was located at https://www.alierahealthcare.com/training-center/brokers-agents/ and accessed using the password "aliera2017."

2. Video #1:

The first video, entitled "Training Modules Aliera," is linked on the training site and hosted in an unlisted status on YouTube.[4] It consists of a narrator explaining four different plans; AlieraCare, PrimaCare, InterimCare and CarePlus, accompanied by informational charts. However, as Aliera disclosed (see response Exhibit 5a, below), each of these plans are Trinity HCSM products. However, this training video never mentions a religious motivation or caveat to agents-in-training (Exhibits 4k and 4l).

3. Video #2

The second video, entitled "Aliera Healthcare – Your ACA Solution,"[5] is just over four minutes long and is an advertisement oriented to consumers, even though it is an agent training tool. The narrator asks, "what if there was a way to get healthcare coverage that was affordable, and provides actual health care that you can use, without the added cost of co-pays, deductibles, and the high cost of insurance?" The narrator said "you bet there is!" and proclaimed, "Welcome to HealthPassUSA, from Aliera Healthcare!" It explains it's a "nationwide healthcare membership that provides you the minimum essential coverage required by the affordable care act," (Exhibits 4m and 4n, 00:10 – 00:45).

There is no mention of a religious component or motivation associated with the product. Indeed, the video specifically refers to the product as "HealthPassUSA," which is the non-HCSM entity Aliera acquired in 2017 (see Exhibit 4h). The narrator frames the product as a lower-cost alternative. He provides a hypothetical consumer named "Joe," who "can't afford traditional health insurance, but he needs healthcare for himself and his family," (Exhibit 4m, 1:40 – 1:50). The term "healthcare" is insurance language defined by statute.

4. The video is hosted at https://www.youtube.com/watch?v=ecEmZffiR-M/. If a video is "unlisted," it means it cannot be found unless the viewer has the link. This process is often used by video creators who want a video to remain confidential, disclosed only to certain viewers.
5. This video is also available at the Aliera training portal (see footnote #3, above), and on YouTube at https://www.youtube.com/watch?v=BaL1SH5jQ30.

4. Video #3:

The third video, entitled "Aliera Healthcare – How to Use Your Membership,"[6] is geared to consumers, not agents, even though it is an agent training tool. The narrator explains what "your myHealthPass membership" will cover, and explains how to decipher "your myHealthPass membership card." Again, this refers to a non-HCSM company Aliera acquired in 2017 (see Exhibit 4h). The narrator explains the card provides access to "healthcare services," and assures the viewer Aliera is his first stop for "your healthcare needs," (Exhibits 4o and 4p). Again, this is insurance language defined by statute.

5. Video #4:

The fourth video, entitled "How to Activate Your Membership," explains to a consumer how to activate his HealthPass membership.[7] Once again, this video is training for prospective agents on how to market, solicit and sell an HCSM product, yet Aliera brands the product after a non-HCSM company it acquired in 2017 (Exhibits 4q and 4r).

6. Assessment:

The Aliera agent training assessment, which all prospective brokers must successfully pass, asks a series of detailed questions about various Trinity HCSM products – none of which mention a religious motivation (Exhibit 4s). There is text at the end of the assessment, just above the "submit assessment" button, which expresses Trinity's five faith statements. The producer must attest he will be held responsible for communicating to consumers that the Trinity products are not insurance. However, the assessment *does not* require the producer to explain or advise the consumer of the alleged religious motivations behind the HCSM product.

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6. This video is available at Aliera's prospective agent training portal (see footnote #3, above) or on Vimeo at https://vimeo.com/177624500.
7. This video is also available at the Aliera training portal, or on Vimeo at https://vimeo.com/177625744.

7. Prospective Agent Training Video:

On 10/25/18, an unidentified Aliera trainer conducted a video seminar for prospective agents. The trainer apparently conducted this seminar for a marketer named America's Health Care Plan ("AHCP"),[8] which then posted the video to YouTube on 10/29/18 with the title "Aliera Healthcare Product Overview."[9] INV Robbins obtained mp3 and mp4 copies of this video (Exhibits 4t and 4u).

The trainer explained Aliera fills a need, because the market "doesn't really have anything that's affordable, and truly comprehensive. Our plans are very similar to what was in effect before the ACA came around. And so, all we did is take that wheel, make it a little bit better, and we put that back out in the market," (Exhibits 4t and 4u, 1:32 – 1:48).

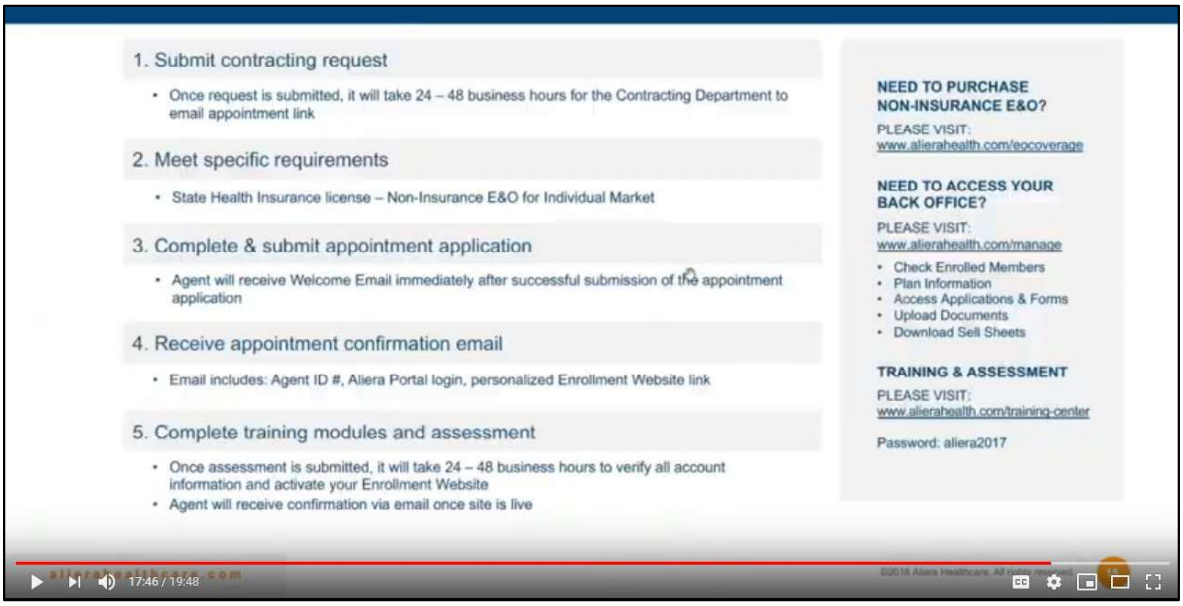
The narrator discussed various group coverage options, then transitioned to the "individual alternative market," which he described as "our bread and butter" which accounted for over 70% of Aliera's sales. Each of the branded plans in this category (below) are actually HCSM plans which Aliera markets on behalf of Trinity.[10]

8. See AHCP's website at http://www.ahcpsales.com/about-us/.
9. See the video at https://youtu.be/OjI5Ff1I2Ck.
10. See the signed agreement between Trinity and Aliera (Exhibit 5g, pgs. 3-18) and Aliera's response to the OIC (Exhibit 5a), discussed below.

The narrator said Aliera's "comprehensive plans" (which are HCSM products marketed by Aliera) "not only mirrors traditional insurance, but truly provide comprehensive healthcare for an individual," (Exhibits 4t and 4u, 8:20 – 8:33). The trainer referred to "InterimCare" as "our short-term medical plan," (Exhibits 4t and 4u, 10:50 – 11:05). The following graphic from the video (see Exhibit 4t, 08:36) captures the ambiguity in Aliera's representations:

The term "healthcare" is insurance language defined by statute, and the terms "comprehensive coverage," "short-term medical" and "individual market" are colloquial insurance terms widely used in the disability market and discussed in that context during Washington producer licensing training.

The graphic below, from the AHCP video, confirms this investigative report has now summarized the entire training pipeline for prospective Aliera agents who market, solicit and sell Trinity's HCSM plans to consumers. At no time during the entire training process for prospective agents is a religious motivation, ethic or caveat emphasized:



8. "Back Office" Enrollment Training for Agents

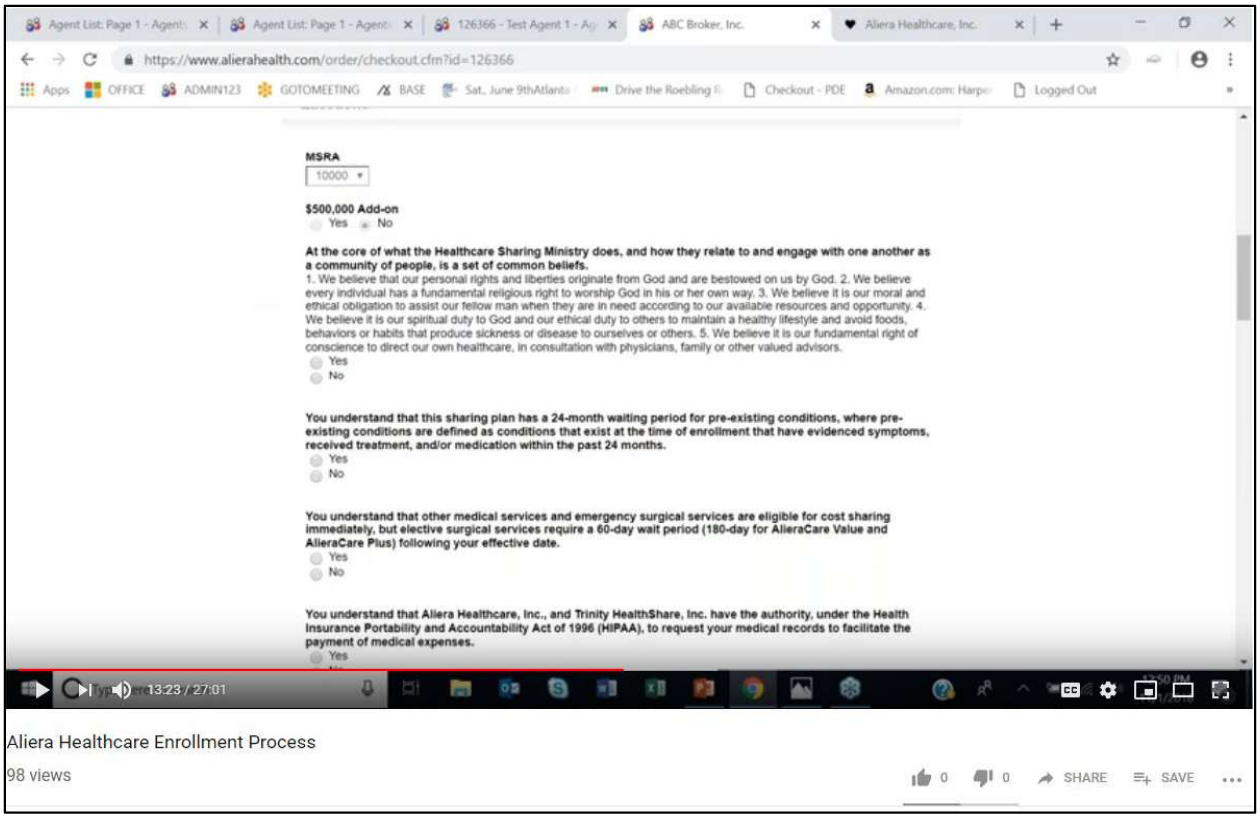
On 11/01/18, an unidentified Aliera trainer conducted a seminar for new or prospective agents about the "back office" functions of Aliera's agent portal. AHCP posted this video on YouTube the same day, with the title "Aliera Healthcare Enrollment Process."[11] INV Robbins obtained both mp3 and mp4 copies of this video (Exhibits 4v – 4w).

The trainer walks the viewer through how to enroll a new customer for an Aliera product, and eventually comes to a series of questions the agent must ask before completing the application. The trainer explains (Exhibits 4v and 4w, 11:45 – 12:05).

> *Then, of course, there's going to be questions. Now, it's guaranteed issue, so these questions are not knockout questions. They're not going to at all make it where you're not possible to, you know, become a member of the plan. So, there's no worries about that. Make sure to let the members know that.*

The consumer must respond positively to each question, and the first includes Trinity's statement of faith:

11. The video is available at https://youtu.be/PiwoaXt8Z78.



The trainer explains to the viewer what this means (Exhibits 4v and 4w, 12:25 – 13:25):

> *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.*

This is at odds with the Statement of Faith Trinity requires members to abide by, according to its own bylaws (see discussion, below).

iii. **Marketing**

1. Consumer Video

On 09/19/18, Aliera published a short promotional video on YouTube entitled, "Aliera Healthcare – A New Era in Healthcare Choices."[12] The video encourages the viewer to consider Aliera as a substitute for traditional medical insurance. The narrator explains Aliera is "redefining the healthcare experience" by "putting the power of choice back in your hands." The narrator never mentions a religious motivation, prerequisite or caveat in the advertisement. The video description reads, "Aliera is committed to redefining the healthcare experience for individuals, families, and employers, with innovative services and solutions that simplify the complexities of healthcare and unlock the freedom and power of choice." INV Robbins obtained both mp3 and mp4 copies of the video (Exhibits 4x and 4y).

2. "The Balancing Act"

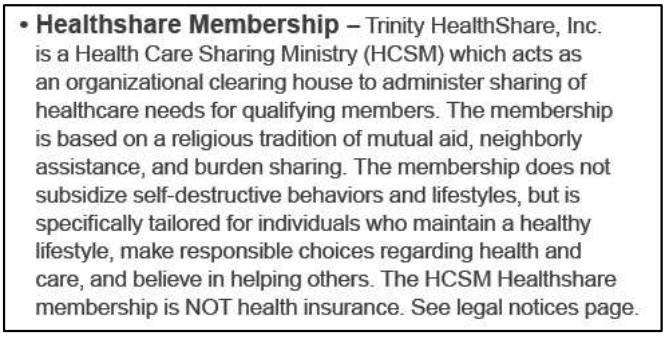
On 10/01/18, Aliera published a video of an appearance its Executive Vice President, Chase Moses ("Moses"), made on a Lifetime morning television program called *The Balancing Act.*[13] INV Robbins obtained mp3 and mp4 copies of the video (Exhibits 4z and 4aa). Moses explains, "Aliera has thrived in creating simple, affordable, quality healthcare solutions for anyone and everyone. And, whether you're an individual, whether you're family, or whether you're an employer, and we've done that through innovation," (Exhibits 4z and 4aa, 1:05 – 1:20). Moses went on to briefly describe each Trinity HCSM plan, and never mentioned the religious motivation or emphasis in the interview. He demonstrated the ease with which consumers can sign up for "individual plans" (i.e. HCSM plans) on the website.

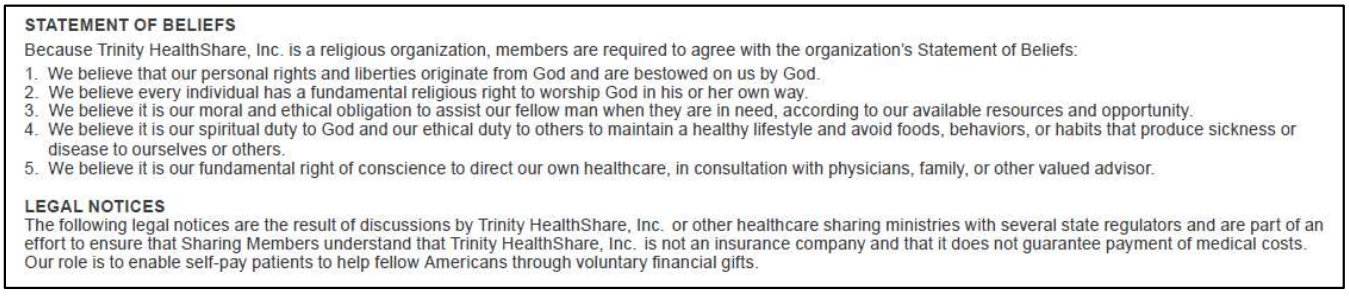
3. Literature:

12. The video is available at https://youtu.be/q8FyZmOla6c.
13. According to its website, *The Balancing Act* is "a daily morning show that brings cutting-edge ideas to today's on-the-go, modern woman to help balance and enrich her life every day," (retrieved from https://thebalancingact.com/about/). The video is available at https://youtu.be/I7aobwe3kZ4.

INV Robbins obtained brochures from Aliera's website regarding the various Trinity HCSM plans which Aliera offers (Exhibits 4ab – 4ae). Each brochure features a disclaimer which reads "This is NOT Insurance." A representative first paragraph, below, describes the nature of the plans (Exhibit 4ab, pg. 1):

The brochure also explains the following (Exhibit 4ab, pgs. 3, 11):





The “short-term healthcare” plan apparently mirrors “short-term medical” plans available in the disability market in certain jurisdictions. Aliera’s literature describes it as “a short-term comprehensive healthcare plan” (Exhibit 4ad, pg. 1) and does not mention a religious/ethical conviction. The dental and vision plan “gives you exactly what you need to maintain your overall dental health, whatever your budget or lifestyle” (Exhibit 4ae) and likewise does not mention a religious/ethical ethos. Aliera’s informational brochure for the CarePlus Advantage product explains it is “a catastrophic health plan that offers assistance with the cost of major medical expenses,” (Exhibit 4ac, pg. 1). It, too, does not mention a religious or ethical conviction. Each brochure contains legal disclaimers at the end which explain these are not insurance products; “[o]ur role is to enable self-pay patients to help fellow Americans through voluntary financial gifts.”

iv. **Responses from Aliera**:

On 10/22/2018, Aliera responded to the OIC on behalf of itself and Trinity (Exhibit 5a). The company explained (pg. 1):

> *Aliera is not a health care sharing ministry. Aliera is best described as an innovative healthcare organization offering members a comprehensive model of care. Aliera has entered into an exclusive agreement with Trinity Healthshare, Inc. to provide operational and marketing support in order that Trinity might grow to include people of faith from throughout the United States. Trinity’s board directs the activities of the sharing ministry through the issuance of sharing guidelines and through oversight of the servicing that Aliera provides to the sharing members on their behalf.*

The company related (Exhibit 5a, pg. 5):

> *Aliera provides exclusive operational and marketing support for Trinity. Trinity directs the activities of Aliera through the administration of the signed agreement, as well as the spiritual guidance for the ministry and its members.*

Aliera provided a copy of Trinity’s 501(c)(3) certificate, showing it is a non-profit entity (Exhibit 5b). It provided a list of five statements “that members must attest they agree with before they can be enrolled in a health care sharing plan offered by Aliera on behalf of

Trinity." Aliera explained consumers must attest they share in these beliefs, either in a recorded verification call or by electronic signature as part of the application process (Exhibit 5a, pg. 2).[14]

Regarding the WA state requirement that a HCSM must have been in continuous existence and sharing expenses since December 31, 1999, Aliera stated it disagreed with an interpretation that understood this language literally. The company explained (Exhibit 5a, pg. 3):

> *it seems reasonable that the* [Washington state] *definition would be applied in the same context as the U.S. Code, in that the five (5) elements described in the Code as the definition for Minimum Essential Coverage and the Individual Shared Responsibility Payment, not for the existence of the health care sharing ministry outside of that context, or to negate the fact that health care sharing ministry plans do not meet the definition of insurance.*

However, Aliera went on to state (Exhibit 5a, pg. 3):

> *Trinity derives its existence from the Baptist association of churches which have been in existence and continually sharing since the 1600 … The health care needs of the members of Trinity Healthshare, Inc., through its historical predecessor church association, have been shared for years ahead of the statutory demarcation point of December 31, 1999.*

The OIC asked for documents to support the contention that Trinity, or a predecessor organization, had been sharing expenses as a HCSM since at least December 31, 1999. Aliera replied, "Neither Aliera nor Trinity have access to predecessor Baptist association records, but the role of the Baptist church and its association of churches in assisting members has been documented historically since the 1600's," (Exhibit 5a, pg. 4).

Aliera explained that, in addition to the HCSM component it administers for Trinity, "Aliera also manages small employer self-funded health benefit plans," (Exhibit 5a, pg. 5). Aliera

14. See this process explained by a trainer in Exhibits 4v and 4w (discussed above).

bundles several non-insurance products with the HCSM elements to form different plans:[15]

Trinity product		Aliera product
AlieraCare	+	Telemedicine, discount prescription drugs, concierge services to locate "in-network" providers
PrimaCare	+	Telemedicine, discount prescription drugs, concierge services to locate "in-network" providers
InterimCare	+	Telemedicine, discount prescription drugs, concierge services to locate "in-network" providers
CarePlus	+	Telemedicine, discount prescription drugs, concierge services to locate "in-network" providers

The OIC inquired about Unity Healthshare ("Unity"), a HCSM for which Aliera had previously acted as a marketer and administrator. Aliera explained the Unity board "exercised its rights to terminate the administrative agreement with Aliera and transition their membership to another administrator," (Exhibit 5a, pg. 5).

The OIC asked Aliera to explain references to "in-network" in its plan materials, and the company explained it uses a MultiPlan network. "The MultiPlan PHCS network is managed by MultiPlan, and Trinity members who are seeking medical services are requested to utilize in-network providers in an attempt to manage the cost of health care expenses that will be requested for sharing," (Exhibit 5a, pg. 6). Aliera also provided copies of member guidelines for the four plans it offers (Exhibits 5c – 5f).

v. **Agreement Between Trinity and Aliera**

On 11/16/18, Aliera provided a copy of the signed agreement between itself and Trinity (Exhibit 5g) dated effective 08/13/18, which is approximately six weeks after Trinity incorporated as a domestic corporation in the State of Delaware. The agreement was signed by Moses (Aliera's Executive Vice President) and Trinity's CEO. The agreement explains (Exhibit 5g, §2-3):

15. The OIC created the following table from a written description Aliera provided.

WHEREAS, Aliera develops and markets healthcare products as an alternative to traditional health insurance, with some products containing a health care sharing ministry component;

WHEREAS, Aliera is a program manager for health care sharing ministry plans, responsible for the development of plan designs, pricing, and marketing materials, vendor management, and recruitment and maintenance of a national sales force to market plans, including accounting and management of sales commissions to authorized marketing representatives on behalf of the ministry;

The agreement states Trinity had filed to become a 501(c)(3) entity, and wanted Aliera to offer its HCSM plans (Exhibit 5g, pg. 3). Aliera was granted "exclusive license to **develop**, **market** and **sell** the HCSM plans to individuals in the public markets who will acknowledge the standard of beliefs and other requirements as deemed necessary by Trinity, and agreed upon by Aliera," (Exhibit 5g, pg. 4, §1a).[16] In addition, Aliera will "provide enrollment and other administrative services relating to the HCSM and to market the Plans, which Plans will not include insurance products and cannot be bundled with insurance," (Exhibit 5g, pg. 1).

The agreement also noted, "Trinity currently 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 over the 'Membership Roster,'" (Exhibit 5g, pg. 1; see also pg. 4, 1d). Aliera "may only accept subscriptions from members who will acknowledge the standard of beliefs and other requirements as deemed necessary by Trinity and agreed upon by Aliera," (Exhibit 5g, pg. 4, 1d).

Trinity delegates all financial accounting functions to Aliera (Exhibit 5g, pg. 5, 1h). No more than one-third of Trinity's board may be affiliated with Aliera (Exhibit 5g, pg. 5, 1k). In addition to the normal apportionment of fees, Trinity receives $25 for each application (Exhibit 5g, pg. 7, 3a). Aliera forwards all allotted fees to Trinity monthly, and controls a bank account established for that purpose (Exhibit 5g, pg. 7, §3c-d).

16. Emphasis mine.

The fee schedule shows Trinity retains virtually no funds; they largely return to Aliera for various purposes. One representative example follows (Exhibit 5g, pg. 16):

AlieraCare & InterimCare

Trinity acknowledges and agrees that Aliera will receive and retain 65% of the total member share contribution for each primary member of each of the AlieraCare and Interim Care plans (the "**Total Side by Side MSC**") for the Aliera components of each plan and as payment for the Services.

Trinity will receive 35% of the Total Side by Side MSC (the "**Trinity MSC**"). Trinity will reimburse Aliera, from such amount, the following fees in the following percentages for Aliera's payment of vendor cost for the AlieraCare and Interim Care plans, as well as distribute the following amounts to the ShareBox account to be used solely for member medical expense payments.

Program Expenses Side by Side Products	% of Trinity MSC
Aliera Mgmt Fee/General Overhead/Ops Labor/Internal Sales	19.6%
Commissions	30.0%
TPA Fees	2.6%
Provider Network (Multi Plan)	1.2%
Telemedicine	0.8%
Total Reimbursement	54.2%
ShareBox Contribution / Side by Side Products	% of Trinity MSC
ShareBox Member Reserve	44.3%

Aliera retains 65% of all fees outright, and Trinity receives the remaining 35%. However, as the example above makes clear, Trinity repays *from its 35%* (i.e. "from such amount") 54.2% of this total to Aliera for various reimbursements. The remaining 44.3% of the 35% Trinity received is placed into a reserve account for member medical expenses (Exhibit 8e, pgs. 7-8). In practical terms, the arrangement looks like this with a figurative total of $100:

	Less		Total
Money received from consumer			100.00
Less 65% to Aliera	- 65	=	35.00
*Less 54.2% **of the remaining 35%** reimbursed to Aliera*	- 18.97	=	16.03
*Less 44.3% **of the remaining 35%** placed in member expense reserve*	- 16.03	=	0.00

Trinity has a similar arrangement for its CarePlus, PrimaCare and dental and vision plans (Exhibit 5g, pgs. 16-18).

b. TRINITY HEALTHSHARE:

i. **Background:**

Trinity Healthshare registered as a domestic corporation in the State of Delaware on 06/27/18 (Exhibit 8a). Approximately four months later, on 10/26/18, Trinity registered as a foreign corporation in the State of Georgia, with William Thead as the CEO and David Thead as the CFO and Secretary (Exhibit 8b). Trinity provided an address that was nearly identical to that of Aliera, at 5901b Peachtree Dunwoody Road, Atlanta, GA 30328.[17] However, the address is likely false, as the RIU sent correspondence to it in November 2018 (mere weeks after Trinity incorporated in Georgia) which was returned as undeliverable (Exhibit 8c).

ii. **Responses:**

1. First Response

On 12/07/18, in response to the OICs notice (Exhibit 3b), Trinity replied (Exhibit 8d) via its attorney, J. Joseph Guilkey ("Attorney Guilkey"), who provided a letter written by Trinity's CEO, William Thead ("Thead"). In his letter, Thead explained "we are confident that Trinity meets the criteria listed in 26 USC § 5000A to be considered a health care sharing ministry." He explained Trinity was seeking a determination letter from the U.S. Department of Health and Human Services to that end, and believed such a letter would settle the matter (Exhibit 8d, pg. 1).[18] Thead explained that, regardless, Trinity does meet the definition of an insurer "because Trinity's operations do not shift risk to Trinity," (Exhibit

17. Only the suite number is different. Aliera is Suite 200 (Exhibit 4b), whereas Trinity is Suite 160c (Exhibit 8b).

18. HHS has informed the OIC it stopped issuing such determinations several years ago.

8d, pg. 2). Thus, Thead concluded, statutes regarding insurers are not applicable to Trinity.

Regarding whether Trinity had been operating continuously sharing member medical needs since at least 12/31/99, Thead stated his response was “contingent” on a determination from HHS. However, as HHS has told OIC, it has not provided such certifications for several years. RIU asked for more specifics about the history of any Trinity predecessor organization, as follows:

> *In its own response to the OIC, Aliera stated, "Trinity derives its existence from the Baptist association of churches which have been in existence and continually sharing since the 1600's." As you are likely aware, there is no single, monolithic "association of Baptist churches." This is in marked contrast to, for example, the Roman Catholic Church. Baptist churches exist in the free church tradition, which is marked by a quest for autonomy from the State and, to greater or lesser extent, from ecclesiastical bureaucracy in general. The context for this ecclesiology is the principle of soul liberty; more specifically Baptists own struggles against State churches in Europe and America during and after the Protestant Reformation. The Baptist tradition does not express itself as a monolithic denomination, but rather as a multi-layered patchwork of local, regional, national and inter-national cooperative networks (i.e. "associations") of independent churches, many of which (at all levels) are aloof from and do not maintain formal ecclesiastical ties with each other. Even beyond the association level, there are many independent Baptist churches worldwide which remain detached from all associations, and view them as infringing on the autonomy of a local church.*
>
> *In light of this context, please (1) provide more clarification on Aliera's representations … and (2) please explain how this representation satisfies the language of 26 USC §5000A.*

Trinity replied that it believed its forthcoming certification from HHS would address the issue, then remarked, “[w]e have concerns that interpreting the language of 26 USC §5000A too narrowly based on how one religion has historically organized itself could unintentionally discriminate against other religions,” (Exhibit 8d, pg. 3). It explained (Exhibit 8d, pg. 4):

> *The Baptist association of churches, formally in existence since the early 1600's, has provided for the health care needs of association members as a predecessor of Trinity. Thus, Trinity's predecessor church association does not have a rigid corporate form.*

Trinity also provided OIC a copy of the letter it sent to HHS, seeking official status as a HCSM. The letter explained why Trinity meets all five criteria of the Federal HCSM statute and, regarding the 12/31/1999 date, it largely echoed what it already provided to the RIU (Exhibit 8d, pg. 26):

> *Baptists and many other Christian denominations have been sharing in each other's medical expenses since the sixteenth century. They have not only shared medical expenses since before 1999, they have shared medical expenses since the 1600's. The Baptist association of churches has formally been in existence since the early 1600's.*

In the letter, Thead also stated that Trinity "seeks to provide no-cost or low-cost health care sharing for missionaries, volunteers, employees of nonprofit faith-based ministries, and other individuals who share in our Statement of Beliefs. It coordinates sharing support from within the Baptist community to make this possible," (Exhibit 8d, pg. 23).

2. Second Response

On 03/11/19, in response to OICs follow-up request (Exhibit 3c), Trinity responded to the OIC (Exhibit 8e). Trinity denied it was created for the express purpose of entering into a corresponding marketing agreement with Aliera. Instead, it was created to share member medical needs in accordance with its Christian beliefs. It acknowledged it had no HCSM members at the time of its signed agreement with Aliera (Exhibit 8e, pg. 4).

Trinity also acknowledged that, at the time of its signed agreement with Aliera, it intended that all HCSM members become Aliera customers and that Aliera retain ownership of the membership roster. In fact, Aliera has exclusive ownership rights to the membership roster, and Trinity cannot contact HCSM members unless Aliera grants permission. Even

if Trinity's agreement with Aliera is terminated, Aliera will continue to service these HCSM members (Exhibit 8e, pgs. 4-5).

Trinity acknowledged Aliera is contracted to perform all development, sales and marketing responsibilities, and that Aliera must communicate Trinity's faith and lifestyle requirements to potential HCSM consumers (Exhibit 8e, pgs. 5-6).

Trinity acknowledged Aliera is contracted to perform billing, collection and accounts payable services. Aliera collects member contributions and enrollment fees, makes required distributions to a Trinity bank account, and is a signatory on Trinity's bank accounts (Exhibit 8e, pg. 6).

Trinity explained one of its purposes was to remain faithful to its statement of faith. However, Trinity provided a copy of its bylaws (Exhibit 8e, pgs. 11-16), which contain an *explicitly Protestant* statement that would be considered a conservative, evangelical expression of the Christian faith and message (see bylaws, Art. II.4, in Exhibit 8e, pg. 4). However, this statement of faith is quite different from the more generic faith statements Trinity members must agree to in order to join the HCSM:

	Statement of Faith *from bylaws*		**Faith Statements** *from marketing and plan*
1	We believe the Bible alone is the inspired Word of God; therefore it is the final and only source of absolute spiritual authority.	*vs.*	We believe that our personal rights and liberties originate from God and are bestowed on us by God.
2	We believe in the triune God of the Bible. He is one God who is revealed in three distinct Persons – God, the Father; God, the Son; and God, the Holy Spirit.	*vs.*	We believe every individual has a fundamental religious right to worship God in his or her own way.
3	We believe in Jesus Christ was God in the flesh – fully God and fully man. He was born of a virgin, lived a sinless life, died on the cross to pay the penalty for our sins, was bodily resurrected on the third day, and now is seated in the heavens at the right hand of God, the Father.	*vs.*	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 that all people are born with a sinful nature and can be saved from eternal death only by grace alone, through faith alone, trusting only in Christ's atoning death and resurrection to save us from our sins and give us eternal life.	*vs.*	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 in the bodily resurrection of all who have put their faith in Jesus Christ. All we believe and do is for the glory of God alone.	*vs.*	We believe it is our fundamental right of conscience to direct our own healthcare in consultation with physicians, family, or other valued advisors.

As a result of Trinity's representation that it "coordinates sharing support **from within the Baptist community**"[19] to carry out its mission, the RIU asked Trinity whether it "intends to restrict membership to members of self-identified Baptist religious communities." Trinity explained the Federal HCSM statute does not require HCSM members "to rigidly adhere to a particular, in Trinity's case Christian, denomination." Indeed, Trinity stated "[f]undamentally, Trinity's Statement of Beliefs require members to believe in God," (Exhibit 8e, pg. 8).

This is incorrect; there are numerous self-identified Christian groups which could not sign Trinity's Statement of Faith from its bylaws. Rather, Trinity's Statement of Faith is an *explicitly Protestant* expression of the Christian faith and its bylaws state all HCSM members must adhere to it (see bylaws, Art. III.1; in Exhibit 8e, pg. 12):

ARTICLE III

MEMBERSHIP

Section 1. Age and Gender. Membership shall not be limited on the basis age or gender. Membership is limited to traditional believers who are volunteers, missionaries, or employees of nonprofit Trinity Healthshare, Inc. ministries, and those who prescribe to the Statement of beliefs at Article II, Section 4, and prescriptions for living a full, healthy and personally spiritual life as contained in the bible and holy writings.

However, the faith statements it actually asks members to agree to in its marketing materials and solicitations bears little resemblance to the Protestant Statement of Faith in its bylaws (see the table, above). Specifically, Trinity's conservative Statement of Faith from its bylaws expresses the following:

1. The statement affirms a Protestant understanding of the Bible as the "final and only source of absolute spiritual authority." This position is at odds with other

19. Emphasis mine.

Christian traditions which see the role of tradition, through the precedent of the teaching magisterium of the church, as a legitimate source of authority to interpret the Bible for the people.

2. The statement affirms God is triune, which identifies the God whom Trinity believes in to be an *explicitly monotheistic, Trinitarian* God. This position is at odds with other self-identified Christian groups or renewal movements which explicitly deny the doctrine of the Trinity, such as the Jehovah's Witnesses, the Church of Jesus Christ of Latter Day Saints, and the United Pentecostal Church International, etc.
3. The statement affirms an orthodox view of Jesus Christ as fully God and fully man, in broad agreement with the Council of Chalcedon (451 A.D.). It also affirms the virgin birth, Christ's sinless life, His literal death to atone for sins, His bodily resurrection, and His ascension to heaven to rejoin God the Father.
4. The statement also affirms people can only be saved from eternal death "by grace alone, through faith alone, trusting only in Christ's atoning death and resurrection to save us from our sins and give us eternal life." This is an *explicitly Protestant* interpretation of the doctrine of salvation, as evidenced by the terminology "grace **alone**, through faith **alone**, trusting **only** in Christ's atoning death …"[20] For example, these statements are at odds with the Roman Catholic Church's doctrine of salvation, both in its formal catechism and in the canons and decrees of the Council of Trent.
5. The statement explains Trinity believes in the literal, bodily resurrection "of all who have put their faith in Jesus Christ."

Trinity not only put forth an explicitly Christian statement of faith, but an *explicitly Protestant expression* of the Christian faith and message. This ethos seems to be contradicted by the broader, generic faith statements it obligates its members to agree to. Moreover, Trinity's bylaws state membership is limited to those who prescribe to the statement of faith *in its own bylaws* (see bylaws, Art. III.1; in Exhibit 8e, pg. 12), not the

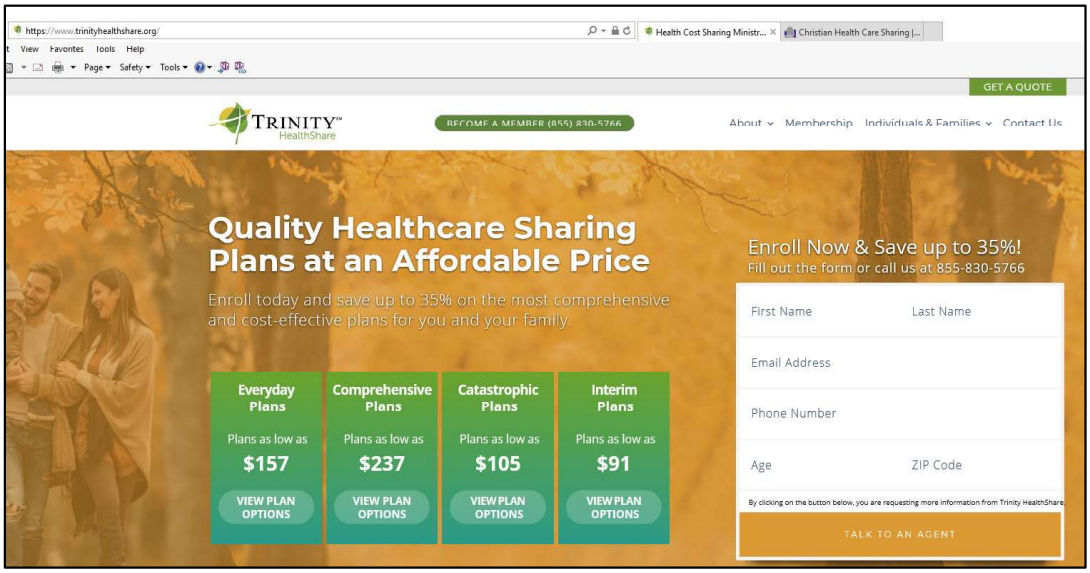
20. Emphasis mine. For further information on the "alone" and "only" statement bolded above, and the distinction between the historic Protestant and Roman Catholic understandings of salvation, see any public source discussion of the context of the "five solas" of the Protestant Reformation – even Wikipedia.

more generic faith statements that Aliera markets to consumers (Exhibit 8e, pg. 10). Trinity's claim that, in essence, it merely requires members to "believe in God" is incorrect.

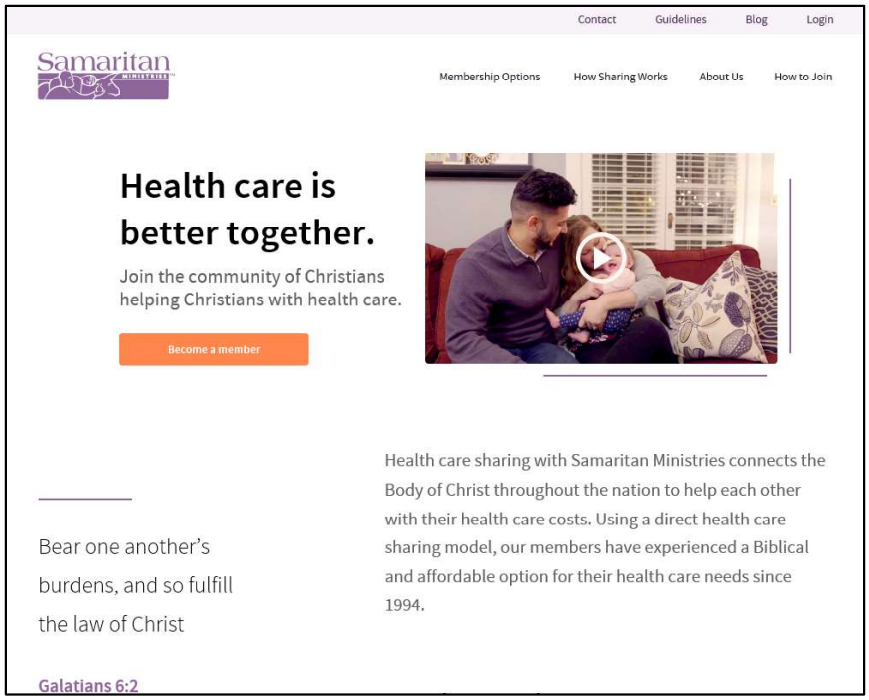
iii. **Website:**

Trinity's website, as it appeared on 01/24/19, emphasized the affordability of its plans for consumers (Exhibit 8f). It promotes "an alternative solution to the rising costs of health insurance without sacrificing on great healthcare." The site explains, "Trinity HealthShare is a unique healthcare sharing ministry (HCSM) because it offers membership to persons of all faiths and provides superior healthcare at a competitive price."

Below is a comparison between Trinity's webpage, and the more explicitly religious motivation of another HCSM:[21]



21. The image from Samaritan Ministries was captured from https://samaritanministries.org/.



Trinity's "Healthcare Cost Sharing Explained" page compares components of traditional health insurance and HCSMs. It explains, "Trinity Healthshare's medical cost sharing plans provide affordable and effective alternatives for those who believe in individual responsibility, healthy living, and caring for one another," (Exhibit 8g). It goes on, "Trinity HealthShare is a health care sharing ministry and bases its principles of health care upon sharing one another's burdens. With most medical cost sharing plans, individuals come together around a common religious or ethical belief, or both. Members must sign a statement of beliefs in order to join a health care sharing ministry."

On 09/14/18, the ministry's "FAQ" page explained, "becoming a member is simple; complete the membership application process online," (Exhibit 8h, pg. 3). It also related, "Trinity HealthShare welcomes members of all faiths who can honor the Statement of Beliefs, by which the Trinity HealthShare program operates," (Exhibit 8h, pg. 6).

c. ANABAPTIST HEALTHSHARE AND UNITY HEALTHSHARE:

i. **Background on Unity:**

During previous investigations, RIU learned Aliera formerly contracted with another HCSM, Unity Healthshare ("Unity"). RIU determined Unity was domiciled in Virginia, and obtained publically available documents from the Virginia Secretary of State regarding the entity (Exhibits 9b – 9e). Unity registered as a domestic Virginia corporation on 11/10/16 (Exhibit 9b, pgs. 2-3), and noted its records would be kept at an address identical to Aliera's, in Georgia (Exhibit 9b, pg. 4). RIU cannot find any record that Unity registered as a foreign corporation in the State of Georgia.

On 12/05/17, approximately three weeks after Unity was created, a press release appeared promoting touting Unity and explained the HCSM had the same operating relationship with Aliera that Trinity currently has (Exhibit 9e):

About Unity HealthShare

Unity HealthShare was established as a non-profit 501(c)(3) entity under the Anabaptist HealthShare organization. Members of health-sharing organizations share a common set of ethical or religious beliefs around health and community and further share in each other's medical expenses, unlike traditional health insurance. Aliera markets and sells Unity HCSM products alongside its non-insurance based products providing individuals ACA exemption.

In August 2018, Unity filed both a change of address and registered agent, and changed its name (Exhibits 9b – 9d). As of January 2019, Unity's website (www.unityhealthshare.com) automatically redirects to Trinity's website. Aliera explained that Unity's board terminated its agreement with Aliera (Exhibit 5a, pg. 5), which likely prompted Unity's address, resident agent and name changes.

From the documents RIU obtained during its four various investigations concerning Aliera while it was Unity's marketer, this investigation determined Unity had *precisely* the same generic "faith statements" as Trinity (Exhibits 9j – 9m). The following graphics demonstrate this (Exhibit 9j [pg. 2] from Unity, and Exhibit 5c [pg. 19] from Trinity, respectively):

- **HCSM Programs - Unity HealthShare (UHS) Statement of Beliefs**

At the core of what Unity HealthShare does, and how it relates to and engages with one another as a community of people, is a set of common beliefs.

UHS' Statement of Beliefs are 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 he/she is in need according to 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.

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.

Given that Trinity replaced Unity as Aliera's HCSM partner, their identical "faith statements" raises reasonable questions about whether Trinity was formed with the express purpose of entering into a marketing agreement with Aliera, and about the veracity of the *nature* (not the content) of its religious ethos.

ii. Background on Anabaptist

RIU queried the Virginia Secretary of State, which provided all documents it possessed regarding Anabaptist Healthshare ("Anabaptist"). The entity was incorporated as a

domestic Virginia corporation on 5/25/15 (Exhibit 9f, pg. 4). The same individual, Tyler Hochstetler, acted as the registered agent for both Anabaptist and Unity.[22]

In its 2018 annual report, Unity listed two Aliera executives as directors (Exhibit 9g). In May 2018, Chase Moses, Aliera's Executive Vice President, submitted Unity's Form 990 for calendar year 2016 (Exhibit 9h). The form explained Anabaptist's purpose was "to provide health care sharing support for the missionaries, volunteers, and employees of conservative Anabaptist ministries and businesses," (Exhibit 9h, pg. 2).

iii. **Agreement with Aliera**

Aliera provided RIU with a copy of its agreement with Unity (Exhibit 9i), which was signed on 02/01/17, approximately two months after Unity incorporated (Exhibit 9i, pg. 9). The agreement is similar to Trinity's, in that Unity gave Aliera exclusive license to sell and distribute Unity products (Exhibit 9i, pg. 4).

The agreement suggests Unity was formed as an HCSM for *the express purpose* of entering into this agreement with Aliera. It states that, "to facilitate the intent and purpose of this agreement," Anabaptist "has formed a subsidiary named Unity Healthshare, LLC," (Exhibit 9i, pg. 7). Aliera even agreed to reimburse Anabaptist up to $1,000 "for costs directly associated with the creation and filing of a new Section 501(3)(C) *[sic]* 'health share charitable organization' to be known as Unity Healthshare, LLC," (Exhibit 9i, pg. 7).

5. **REVIEW OF EVIDENCE OBTAINED**

a. DOES TRINITY MEET THE DEFINITION OF A HCSM?

The evidence indicates Trinity does not meet the definition of a HCSM because (1) its representations about its religious convictions are contradictory, (2) it has not been operating as a 501(c)(3) legal entity and sharing member medical needs continuously

22. Compare Exhibit 9f, pg. 7 and Exhibit 9a, pg. 4.

since December 31, 1999, and (3) evidence indicates Trinity was formed in 2018 for the express purpose of entering into a marketing agreement with Aliera.

i. **Religious convictions**

OIC's interest is not in the *content* of Trinity's religious ethic; its interest is in the veracity of the *nature* of Trinity's representations *about* this religious motivation. If Trinity and its members do not share a religious or ethical motivation, then it cannot be an HCSM. Trinity's contradictory representations about the *nature* of its religious ethic to State and Federal government agencies and to consumers indicates it either does not understand its religious motivation, or fails to communicate a consistent message about its religious ethic to State and Federal regulators and its own members.

In representations to HHS, the State of Delaware and the OIC, Trinity states it holds to an explicitly conservative, Protestant expression of the Christian faith. Moreover, its bylaws obligate its members to affirm this specific Statement of Faith. However, the faith statements in its marketing materials and solicitations are very different. Indeed, one Aliera-linked trainer explained to prospective agents who will sell the HCSM product, "[i]t 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 …"

Trinity incorrectly asserted the Statement of Faith in its bylaws, in essence, simply requires members to "believe in God." This is incorrect; the Statement of Faith requires members to believe in a *very particular expression* of the Christian faith and message. Indeed, they require members to believe in a *very particular* Trinitarian conception of God.

ii. **Legal status since December 31, 1999**

Trinity was incorporated in 2018, and the Federal statute says a HCSM must have been in *continuous* existence sharing member health needs *continuously* since 12/31/1999. Trinity suggests OIC is incorrect to interpret the 1999 date as binding. It acknowledges

its very recent formation date, but states its religious ethos reflects the Baptist tradition of sharing health needs, which dates to at least the 16th century.

However, evidence suggests Trinity was formed for the express purpose of entering into a marketing agreement with Aliera, which was precisely what happened with Aliera's previous HCSM partner, Unity. Trinity incorporated, signed an agreement with Aliera, and brought no HCSM consumers to the agreement. Moreover, it retains virtually no funds from sales, delegates all operations to Aliera, and even yields maintenance, ownership and access to the membership list to Aliera. Unity and Trinity even obligate its HCSM consumers to agree to the *exact same* generic faith statements.

iii. **Summary**

Because (1) it was formed as a legal entity after 12/31/1999 and evidence suggests Trinity was formed for the express purpose of entering into a marketing agreement with Aliera, and (2) Aliera made (and continues to make) numerous contradictory representations about the nature of its religious ethic to consumers, State and Federal regulators, (3) Trinity does not meet the definition of an HCSM, according to RCW 48.43.009. Therefore, Trinity is not exempt from insurance regulation and is acting as an unauthorized insurer (as defined by RCW 48.01.050) which offers a variety of unauthorized disability insurance plans (as defined by RCW 48.11.030), because it undertakes to indemnify a consumer or pay a specified amount upon a determinable contingency of bodily injury, sickness or other health-related matters (see RCW 48.01.040).

Aliera declined to provide detailed information to RIU about the number of Trinity's HCSM products it has sold and the total amount of funds collected (Exhibit 5h). RIU did not elect to then seek the information via a subpoena.

b. ARE ALIERA'S ADVERTISEMENTS ABOUT THE TRINITY HCSM OPTIONS FALSE OR MISLEADING?

The evidence indicates this allegation is substantiated.

i. **Legal basis for the determination**

Because the evidence indicates Trinity is not a HCSM, as defined by RCW and Federal statute, the laws concerning advertising for disability insurance likely apply to Trinity's HCSM products. Regardless of this finding, because these HCSM products mirror disability policies in their *function* (not the legal structure of the entity offering them), it is prudent to use disability advertising statutes to determine whether Trinity and Aliera are providing misleading or deceptive advertisements regarding HCSM products.

To that end, RCW 48.30.040 explains Trinity and Aliera cannot "knowingly make, publish, or disseminate any false, deceptive or misleading representation or advertising in the conduct of the business of insurance." According to WAC 284-50-050(1), the "format and content" of these disability insurance advertisements "shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive." The statute explains that such 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," (WAC 284-50-050[2]).

Likewise, WAC 284-50-060(1) relates that "[n]o advertisement shall omit information or use words, phrases, statements, references, or illustrations if the omission of such information or use of such … 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 consumer later receives plan documents to review "does not remedy misleading statements."

The OIC "shall" determine whether a particular disability advertisement "has a capacity or tendency to mislead or deceive" based on "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," (WAC 284-50-050[1]).

ii. **Advertisements are deceptive and misleading**

Evidence indicates Aliera's advertisements for Trinity's HCSM products are deceptive and misleading for both the selling agents and the consumers. The overall impression an average agent or consumer would likely receive from these advertisements and training tools is that the HCSM products are insurance:

- The agent training videos and assessment do not instruct prospective agents to convey the religious/ethical ethos which the RCW and Federal statute envision potential consumers will have. In fact, these tools use statutory and colloquial insurance terminology when describing the HCSM products to new agents who will sell them. This evidence therefore suggests the faith statements and disclaimer at the end of the agent assessment are *pro forma*.
- An Aliera consumer advertisement video promises that Aliera is "redefining the healthcare experience" by putting the "power of choice" in the consumer's hands (Exhibits 4x and 4y). An Aliera's executive explained on television that Aliera has created new "healthcare choices" through innovation (Exhibits 4z and 4aa, 1:05 – 1:20). The television host explained the Aliera executive was there to discuss "healthcare in America" (Exhibits 4z and 4aa, 0:00 – 0:50), and the executive described the HCSM plans for a national television audience without ever mentioning a religious/ethical motivation or caveat. This evidence suggests Aliera's HCSM disclaimers to consumers in its literature are *pro forma*.

In mid-2018, when Unity was Aliera's marketer, RIU received complaints from four consumers who stated the Aliera-contracted agent misrepresented the HCSM product as an insurance plan.[23] Since Trinity became Aliera's HCSM partner, RIU has received a similar complaint against Aliera in which the consumer alleged misrepresentation and explained he was solicited Trinity HCSM products along with actual insurance plans.[24]

23. See RIU cases 1560917, 1549758, 1539832 and 1546395. RIU opened each investigation to determine whether Aliera was selling insurance products without a license. Once it became apparent these complaints involved HCSM products, RIU closed each complaint as unsubstantiated. RIU did not make determinations about misrepresentation, because it determined it lacked jurisdiction over HCSM organizations.
24. See RIU case 1598492. The complaint did not cooperate with RIU or respond to requests for further information, and RIU did not open an investigation.

Another consumer related an agent claimed her physician and dentist were "in network," but later discovered this was incorrect.[25]

The evidence indicates Aliera (1) failed to represent Trinity's actual Statement of Faith, as defined by Trinity's bylaws, (2) provided misleading training to prospective agents about the nature of the HCSM products, and (3) provided misleading advertisements to the general public and potential consumers that have the capacity or tendency to mislead or deceive consumers, based on the overall impression that these advertisements may be reasonably expected to create upon a person of average education.

Conclusions

1. **The allegation that Trinity does not meet the statutory definition of a HCSM under RCW and Federal statute is substantiated. Trinity is therefore acting as an unauthorized insurer, in violation of RCW 48.05.030.**

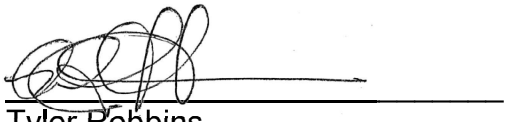
The allegation is substantiated because (1) Trinity's representations about its religious convictions are contradictory, (2) it has not been operating as a 501(c)(3) legal entity and sharing member medical needs continuously since December 31, 1999, and (3) evidence indicates Trinity was formed in 2018 for the express purpose of entering into a marketing agreement with Aliera.

2. **The allegation that Aliera's various advertisements on behalf of Trinity are deceptive and have the capacity and tendency to mislead or deceive consumers to believe they are purchasing insurance rather than a HCSM membership, in violation of RCW 48.30.040, WAC 284-50-050 and 284-50-060, is substantiated.**

The evidence indicates Aliera (1) failed to represent Trinity's actual Statement of Faith, as defined by Trinity's bylaws, (2) provided misleading training to prospective agents

25. See RIU case 1595064. RIU directed the consumer to work with Aliera's customer service to resolve the issue, and to contact OIC's Consumer Protection division for advocacy assistance, if necessary.

about the nature of the HCSM products, and (3) provided misleading advertisements to the general public and potential consumers that have the capacity or tendency to mislead or deceive consumers, based on the overall impression that these advertisements may be reasonably expected to create upon a person of average education.



Tyler Robbins
Investigations Manager

State of Washington
Office of Insurance Commissioner
Legal Affairs Division
Regulatory Investigations Unit

Final Investigative Report
Exhibits List

Exhibit 1	(09.11.2018) Initial Complaint
Exhibit 2	(12.10.2018) NAIC license details
Exhibit 3a	(10.01.2018) NoI to Aliera and Trinity
Exhibit 3b	(11.08.2018) NoI to Trinity
Exhibit 3c	(02.26.2019) Follow-up Request for Info to Trinity
Exhibit 3d	(01.30.2019) Follow-up request to Aliera
Exhibit 4a	(12.18.2015) Aliera's Home Registration with Delaware Secretary of State
Exhibit 4b	(01.10.2019) Aliera #1 Documents from Delaware
Exhibit 4c	(04.28.2016) Aliera's Registration with Georgia Secretary of State
Exhibit 4d	(03.20.2017) Aliera Healthcare 2017 Georgia Registration
Exhibit 4e	(01.10.2018) Aliera Healthcare 2018 Georgia Registration
Exhibit 4f	(03.13.2017) Aliera Healthcare of Georgia Formation
Exhibit 4g	(03.14.2018) Aliera of Georgia 2018 Registration
Exhibit 4h	(07.05.2017) HealthPass USA Merger with Aliera
Exhibit 4i	(09.14.2018) Aliera Brochure for Brokers
Exhibit 4j	(11.05.2018) Aliera training portal homepage
Exhibit 4k	(09.28.2018) Training Modules Aliera (video)
Exhibit 4l	(09.28.2018) Training Modules Aliera (audio)
Exhibit 4m	(2016) Aliera Healthcare - Your ACA Solution (from Aliera's broker training site)
Exhibit 4n	(2016) Aliera Healthcare - Your ACA Solution (video)
Exhibit 4o	(2016) How to Use Your HealthPass Membership (video)
Exhibit 4p	(2016) Aliera Healthcare - How to Use Your Membership (from Aliera's broker training site)
Exhibit 4q	(2016) How to Activate Membership
Exhibit 4r	(2016) How to Activate Your HealthPass Membership (video)

Exhibit 4s	(11.05.2018) Aliera Agent Assessment
Exhibit 4t	(10.29.2018) Aliera Healthcare Product Overview (video)
Exhibit 4u	(10.29.2018) Aliera Healthcare Product Overview
Exhibit 4v	(11.01.2018) Aliera Healthcare Enrollment Process (video)
Exhibit 4w	(11.01.2018) Aliera Healthcare Enrollment Process
Exhibit 4x	(09.19.2018) Aliera Healthcare - A New Era in Healthcare Choices (video)
Exhibit 4y	(09.19.2018) Alliera Healthcare A New Era in Healthcare Choices
Exhibit 4z	(10.01.2018) Aliera Healthcare featured on The Balancing Act, Lifetime TV (video)
Exhibit 4aa	(10.01.2018) Aliera Healthcare featured on The Balancing Act, Lifetime TV (mp3)
Exhibit 4ab	(2018) Aliera Comprehensive Care Brochure
Exhibit 4ac	(2018) Aliera CarePlus Advantage Brochure
Exhibit 4ad	(2018) Aliera Short-term Care Brochure
Exhibit 4ae	(2018) Trinity Dental and Vision Plan
Exhibit 5a	(10.22.2018) Aliera's First Response to OIC
Exhibit 5b	(10.01.2018) Trinity's 501(c)3 Certificate
Exhibit 5c	(2018) AlieraCare BSG Member Guide
Exhibit 5d	(2018) AlieraCare VPP Member Guide
Exhibit 5e	(2018) CarePlus Member Guide
Exhibit 5f	(2018) InterimCare Member Guide
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Exhibit 6b	(2016) HealthPass USA 2016 Annual Registrations in Georgia
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Exhibit 8a	(06.27.2018) Trinity HCSMs Home Registration with Delaware Secretary of State
Exhibit 8b	(11.01.2018) Trinity's Registration in Georgia
Exhibit 8c	(11.29.2018) Undeliverable Letter to Trinity
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Exhibit 9e	(12.05.2017) Press Release for Unity's New Website Launch
Exhibit 9f	(11.16.2018) Request to and Response from Virginia About Anabaptist HealthShare Docs
Exhibit 9g	(08.08.2018) Anabaptist Healthshare 2018 Annual Report
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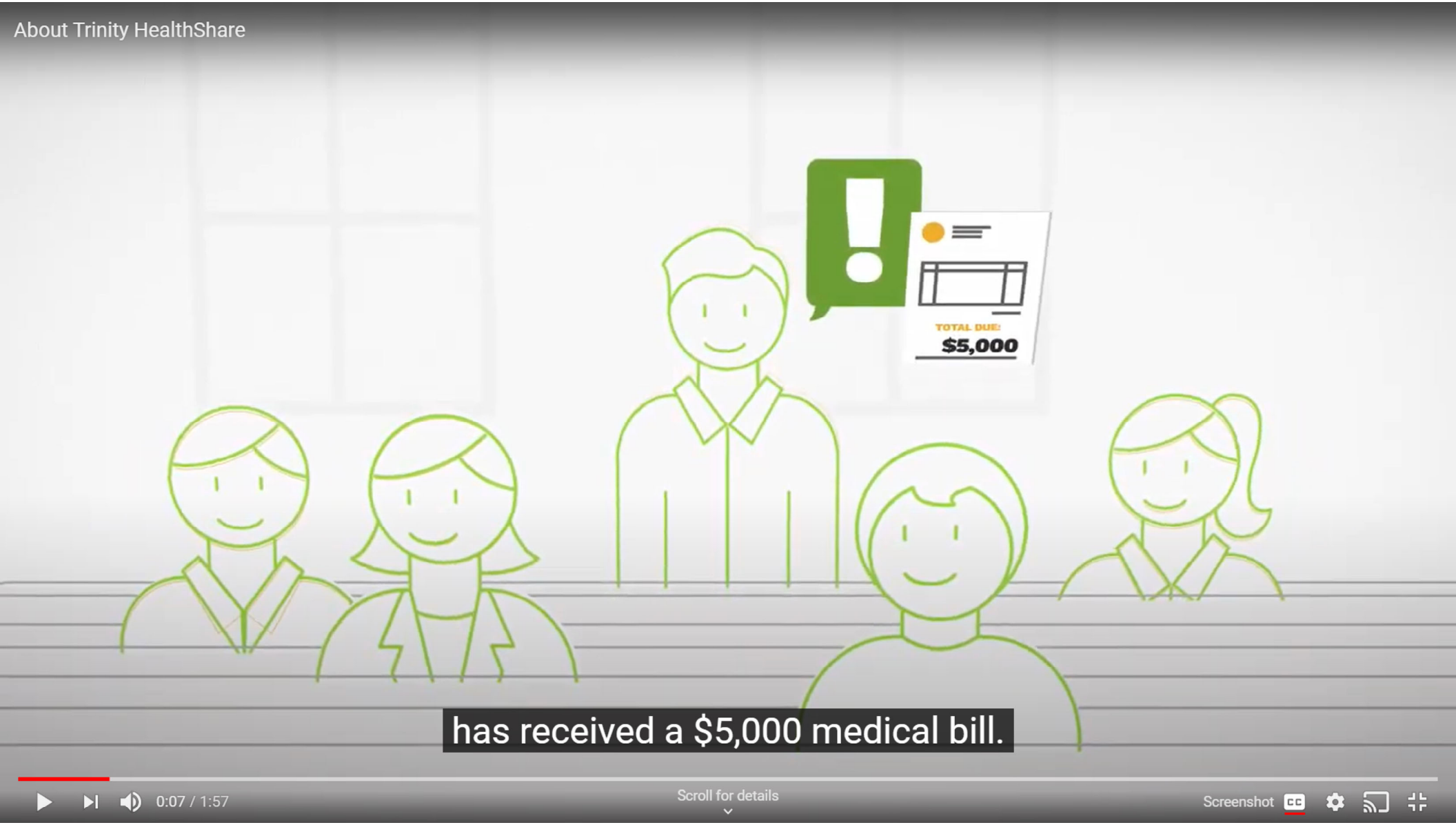
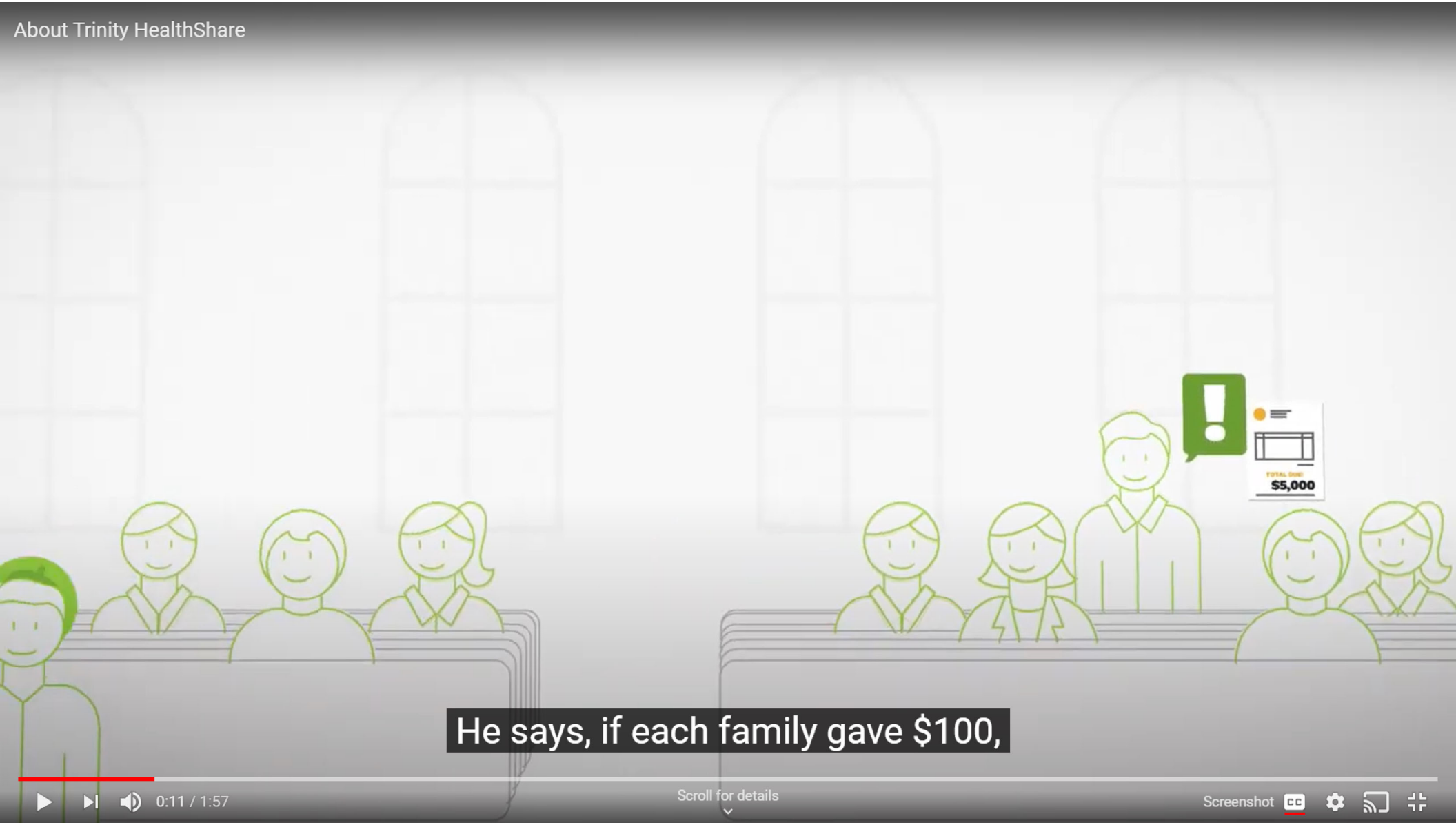
Exhibit 9l	(06.05.2018) 1549758 acknowledgment
Exhibit 9m	(06.05.2018) 1560917 acknowledgment

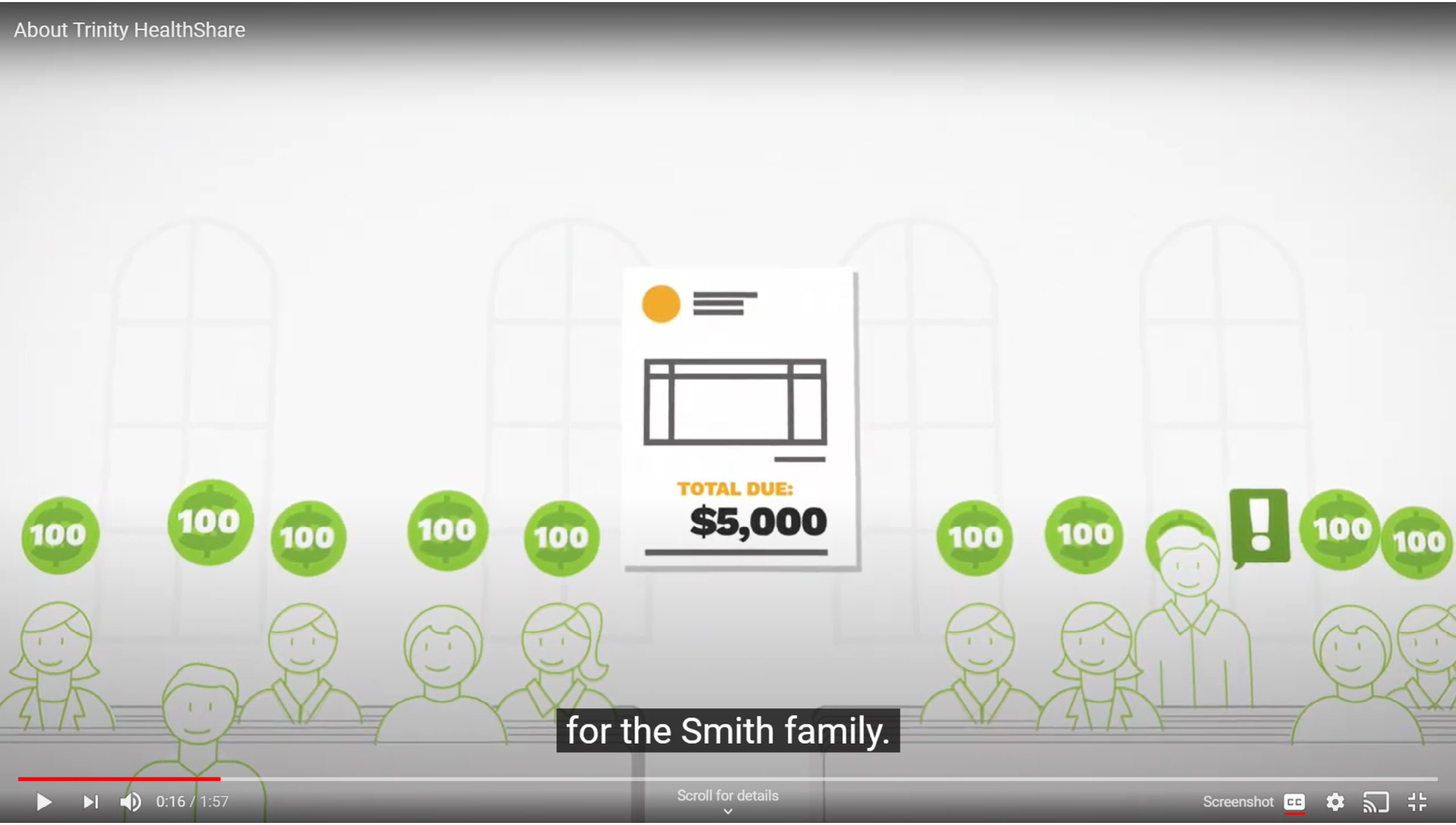

About Trinity HealthShare
Elder John
Elder Johnson stands up in church on Sunday
0:03 / 1:57
Scroll for details
Screenshot

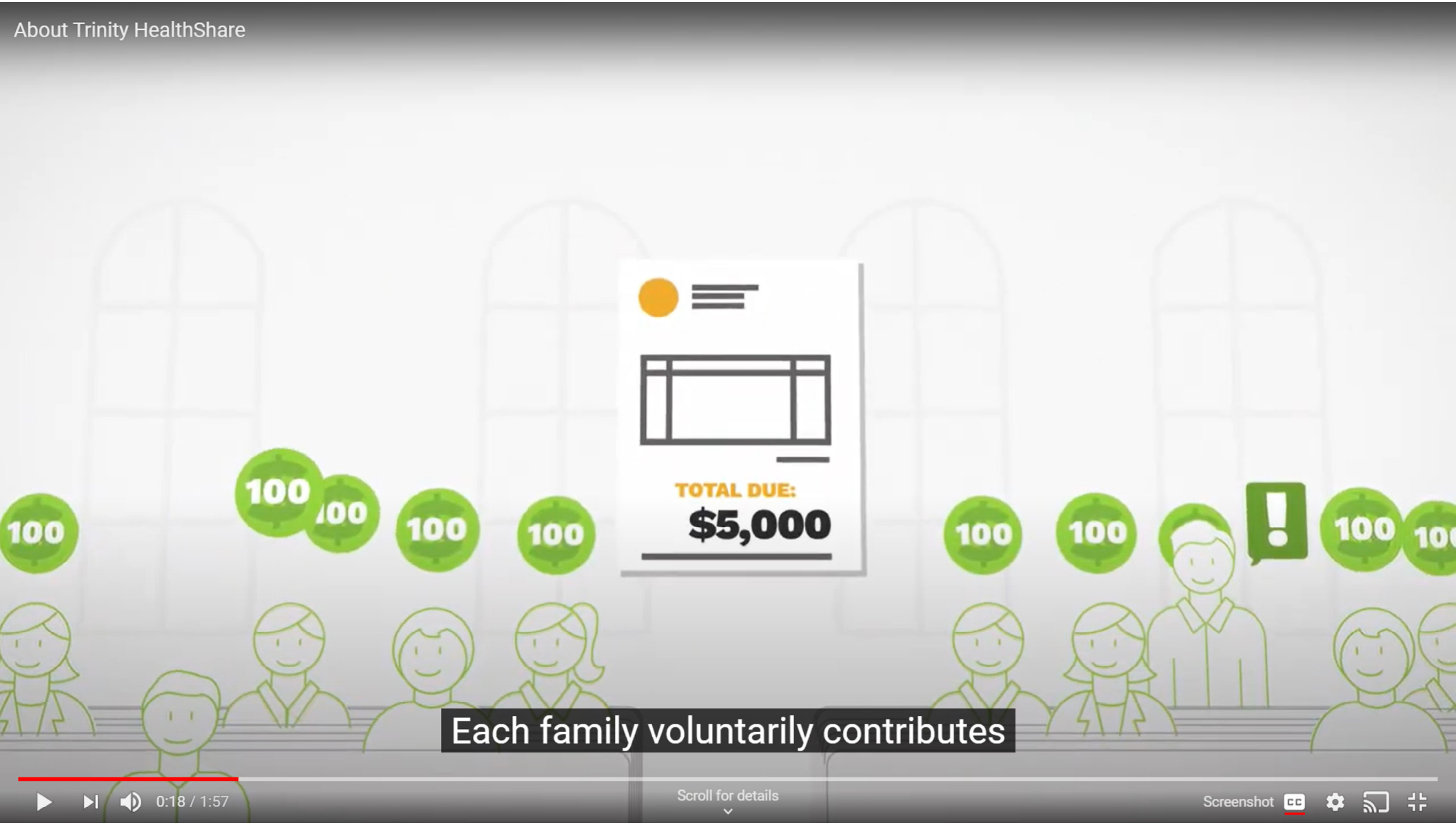

About Trinity HealthShare
and informs the congregation
that the Smith family
0:06 / 1:57
Scroll for details
Screenshot

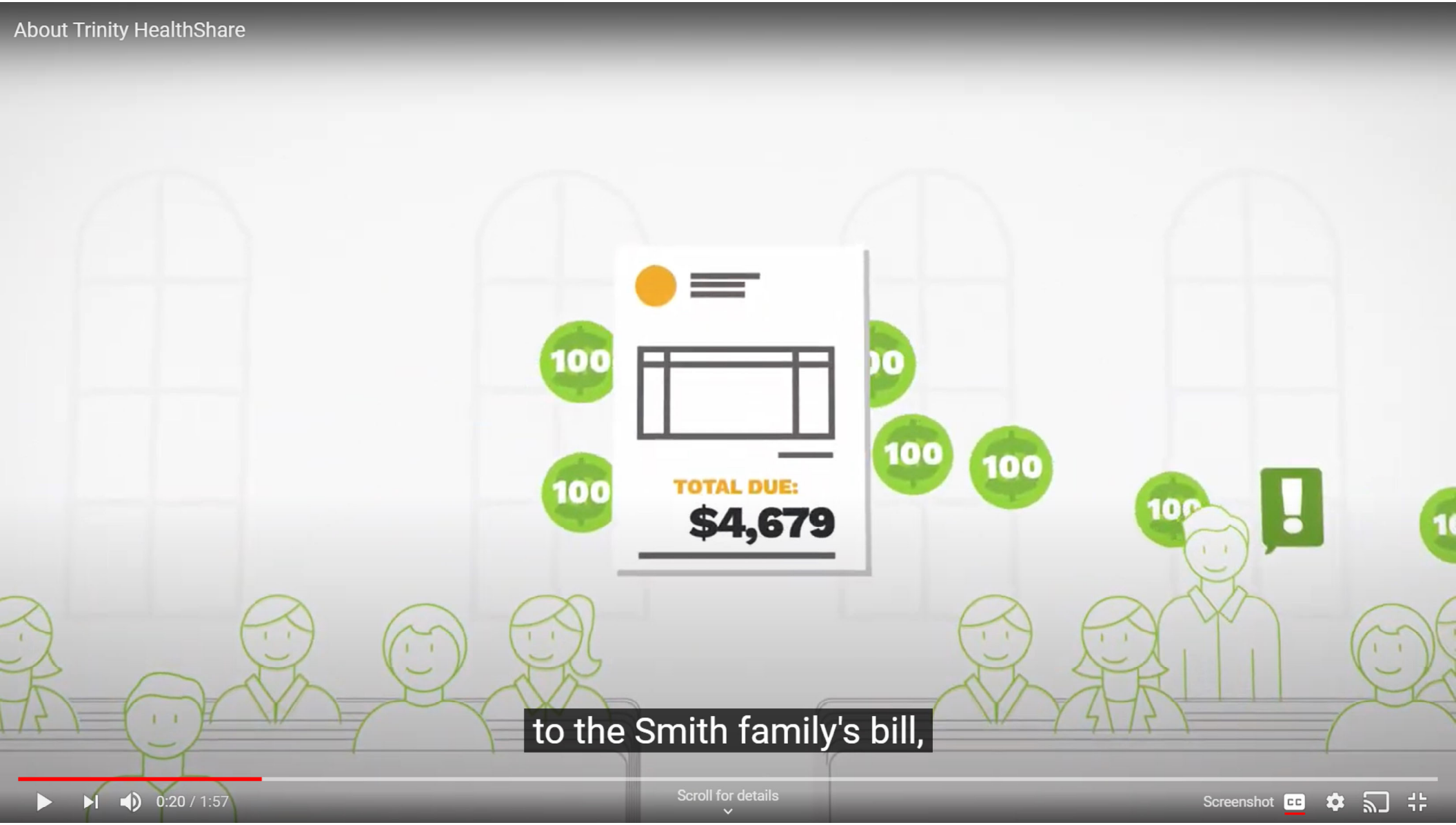

About Trinity HealthShare
TOTAL DUE:
$5,000
has received a $5,000 medical bill.
0:07 / 1:57
Scroll for details
Screenshot

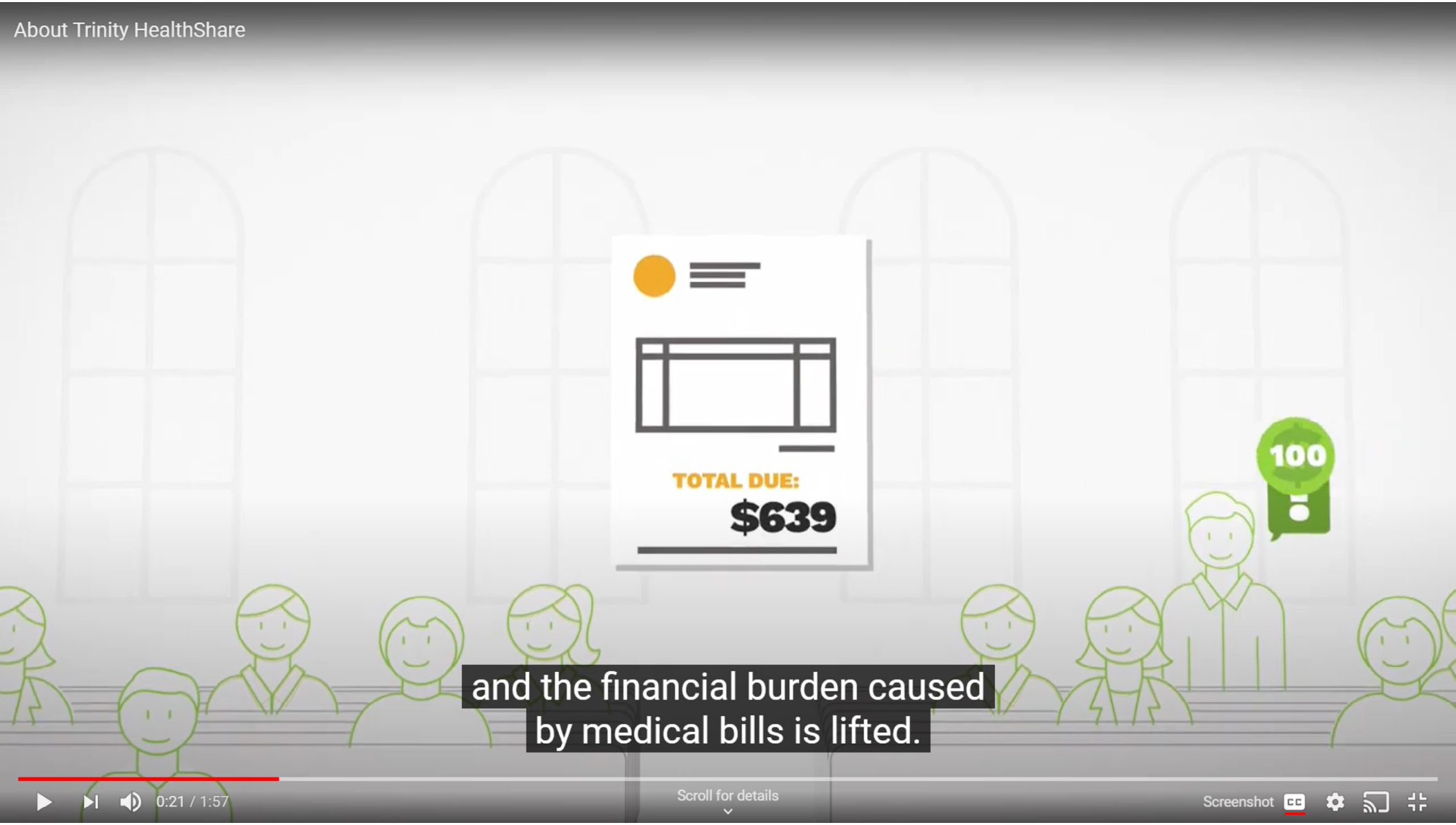

About Trinity HealthShare
$5,000
He says, if each family gave $100,
0:11 / 1:57
Scroll for details
Screenshot


About Trinity HealthShare
100
100
100
100
100
100
100
100
100
$5,000
we would be able to help
alleviate the financial burden
0:13 / 1:57
Scroll for details
Screenshot


About Trinity HealthShare
TOTAL DUE:
$5,000
100
100
100
100
100
100
100
100
100
for the Smith family.
0:16 / 1:57
Scroll for details
Screenshot

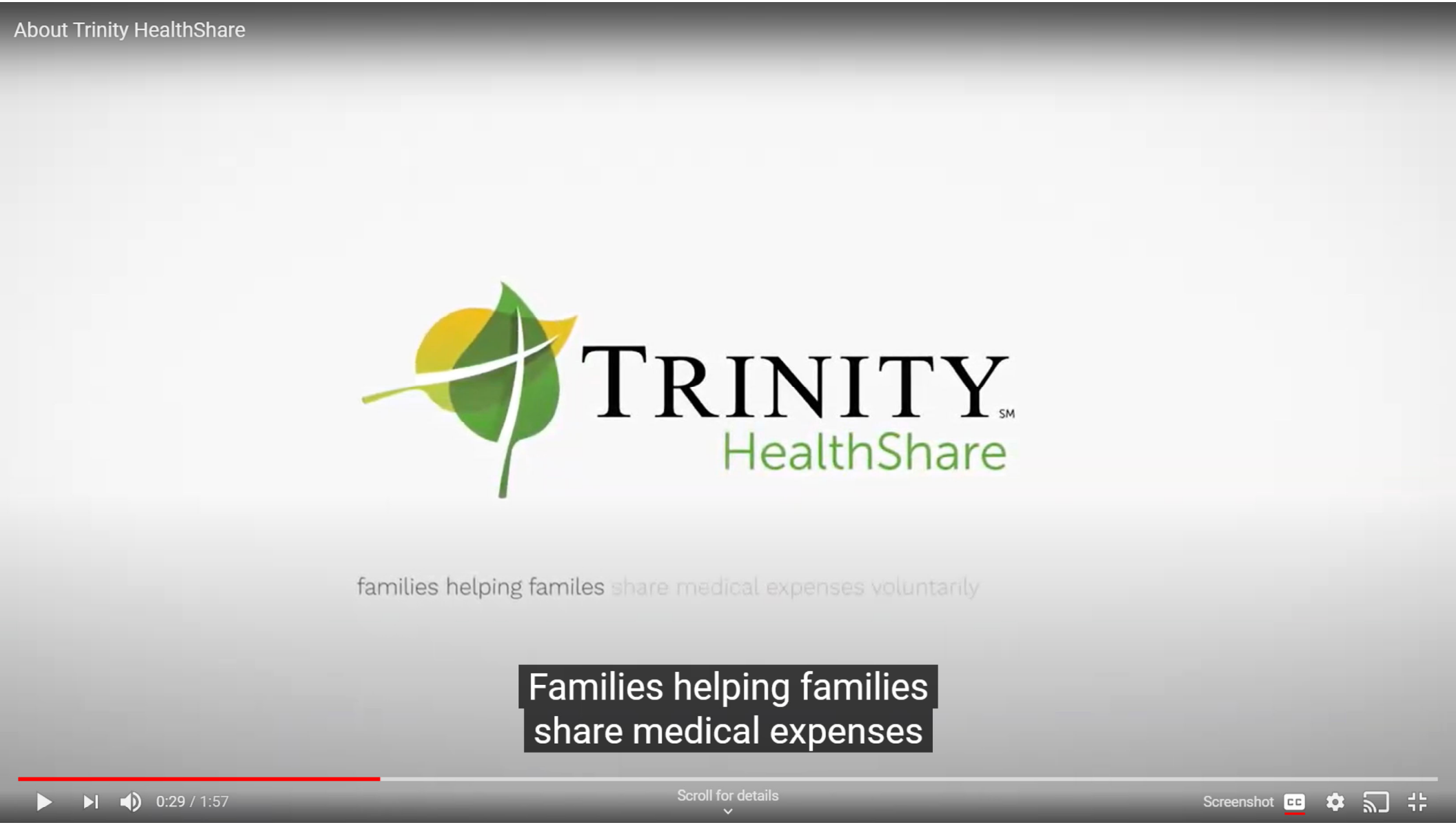

About Trinity HealthShare
TOTAL DUE:
$5,000
Each family voluntarily contributes
0:18 / 1:57
Scroll for details
Screenshot


About Trinity HealthShare
100
100
100
100
TOTAL DUE:
$4,679
to the Smith family's bill,
0:20 / 1:57
Scroll for details
Screenshot


About Trinity HealthShare
TOTAL DUE:
$639
100
and the financial burden caused
by medical bills is lifted.
0:21 / 1:57
Scroll for details
Screenshot


About Trinity HealthShare
Health Care Sharing
$0
That is health care sharing.
0:25 / 1:57
Scroll for details
Screenshot


About Trinity HealthShare
TRINITY
HealthShare
That is Trinity HealthShare.
0:27 / 1:57
Scroll for details
Screenshot


About Trinity HealthShare
TRINITY SM
HealthShare
families helping familes share medical expenses voluntarily
Families helping families
share medical expenses
0:29 / 1:57
Scroll for details
Screenshot


About Trinity HealthShare
TRINITY SM
HealthShare
families helping familes share medical expenses voluntarily with gifts.
voluntarily with gifts.
0:32 / 1:57
Scroll for details
Screenshot


About Trinity HealthShare
faithdriven
LIFE CHURCH
Affiliated with Faith Driven Life Church,
0:34 / 1:57
Scroll for details
Screenshot


About Trinity HealthShare
faithdriven
LIFE CHURCH
which is a member of the
Church of God in Christ,
0:37 / 1:57
Scroll for details
Screenshot

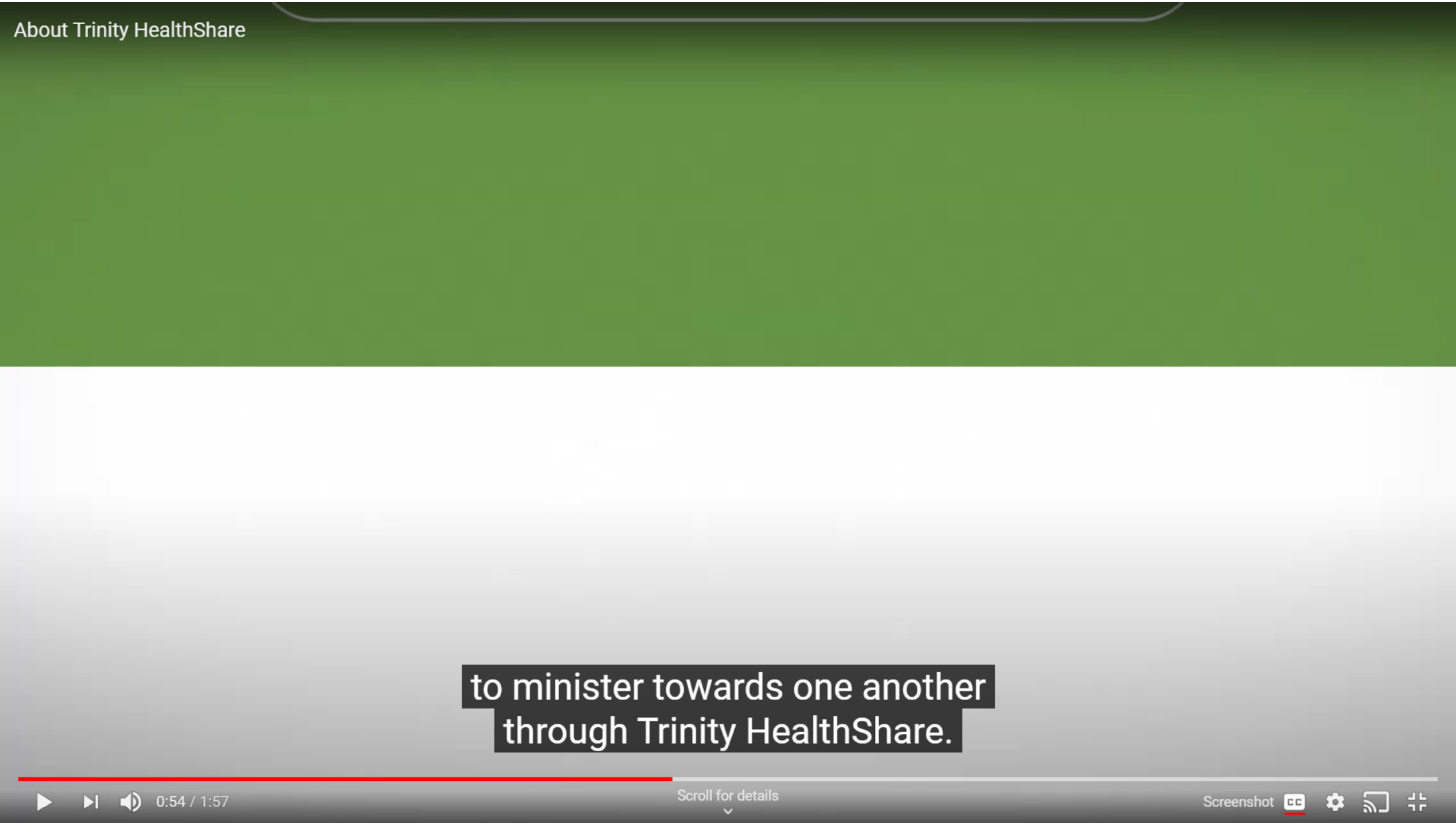

About Trinity HealthShare
faithdriven
LIFE CHURCH
THE SEAL OF THE CHURCH OF GOD IN CHRIST, INC.
ORGANIZED 1907
MEMPHIS, TENNESSEE
the largest African-American
Pentecostal denomination
0:39 / 1:57
Scroll for details
Screenshot


About Trinity HealthShare
faithdriven
LIFE CHURCH
THE SEAL OF THE CHURCH OF GOD IN CHRIST, INC.
ORGANIZED 1907
MEMPHIS, TENNESSEE
in the country,
0:42 / 1:57
Scroll for details
Screenshot

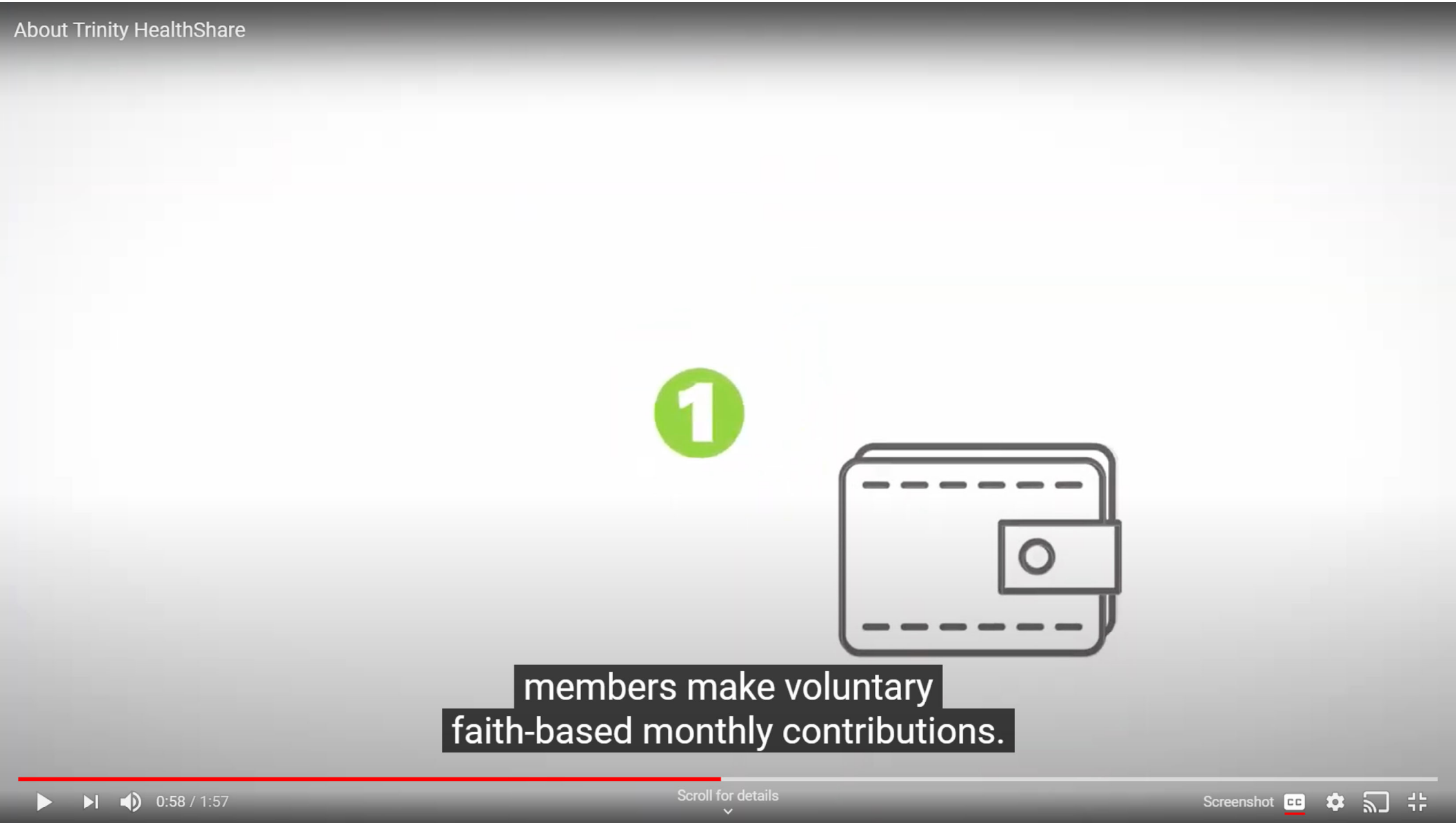

About Trinity HealthShare
faithdriven
LIFE CHURCH
THE SEAL OF THE CHURCH OF GOD IN CHRIST, INC.
ORGANIZED 1907
MEMPHIS, TENNESSEE
who have been sharing members'
needs since the 1990s,
0:43 / 1:57
Scroll for details
Screenshot

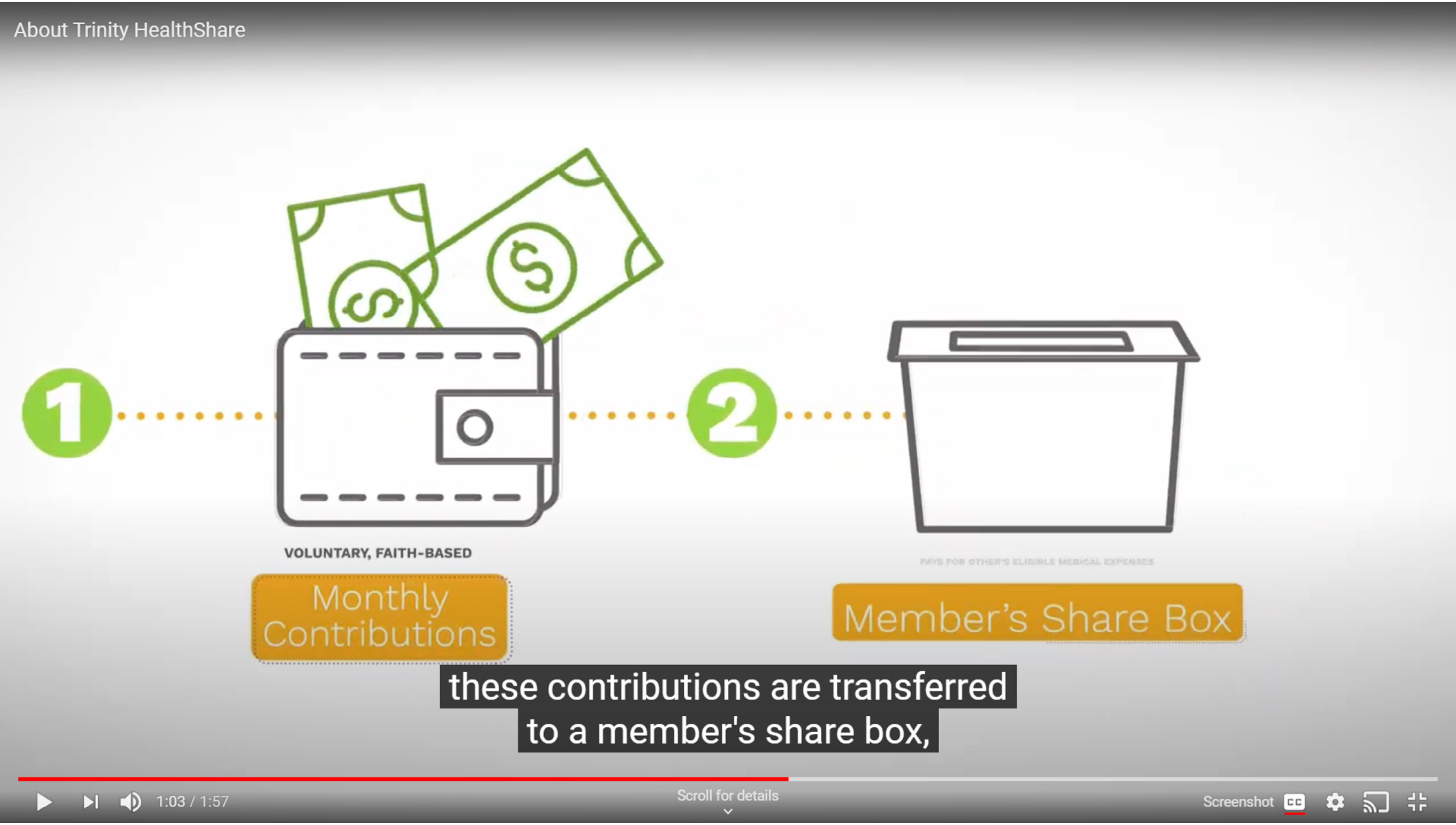

About Trinity HealthShare
faithdriven
LIFE CHURCH
THE SEAL OF THE CHURCH OF GOD IN CHRIST, INC.
ORGANIZED 1907
MEMPHIS, TENNESSEE
and is proud to uphold the
long-standing tradition
sharing member's needs since the 1990s
0:46 / 1:57
Scroll for details
Screenshot

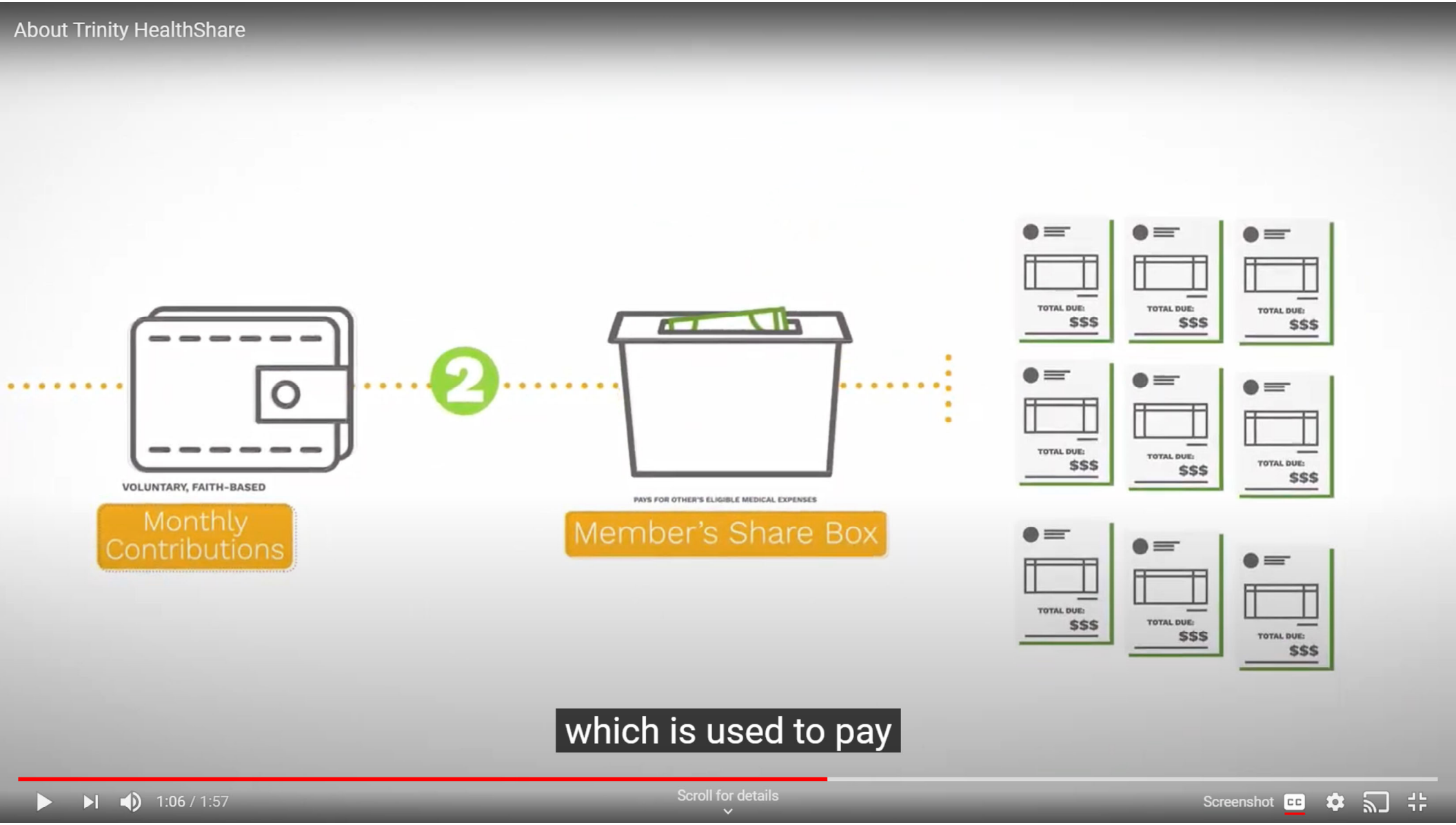

About Trinity HealthShare
faithdriven
LIFE CHURCH
THE SEAL OF THE CHURCH OF GOD IN CHRIST, INC.
ORGANIZED 1907
MEMPHIS, TENNESSEE
bringing people of faith together
of bringing people of faith together
0:49 / 1:57
Scroll for details
Screenshot

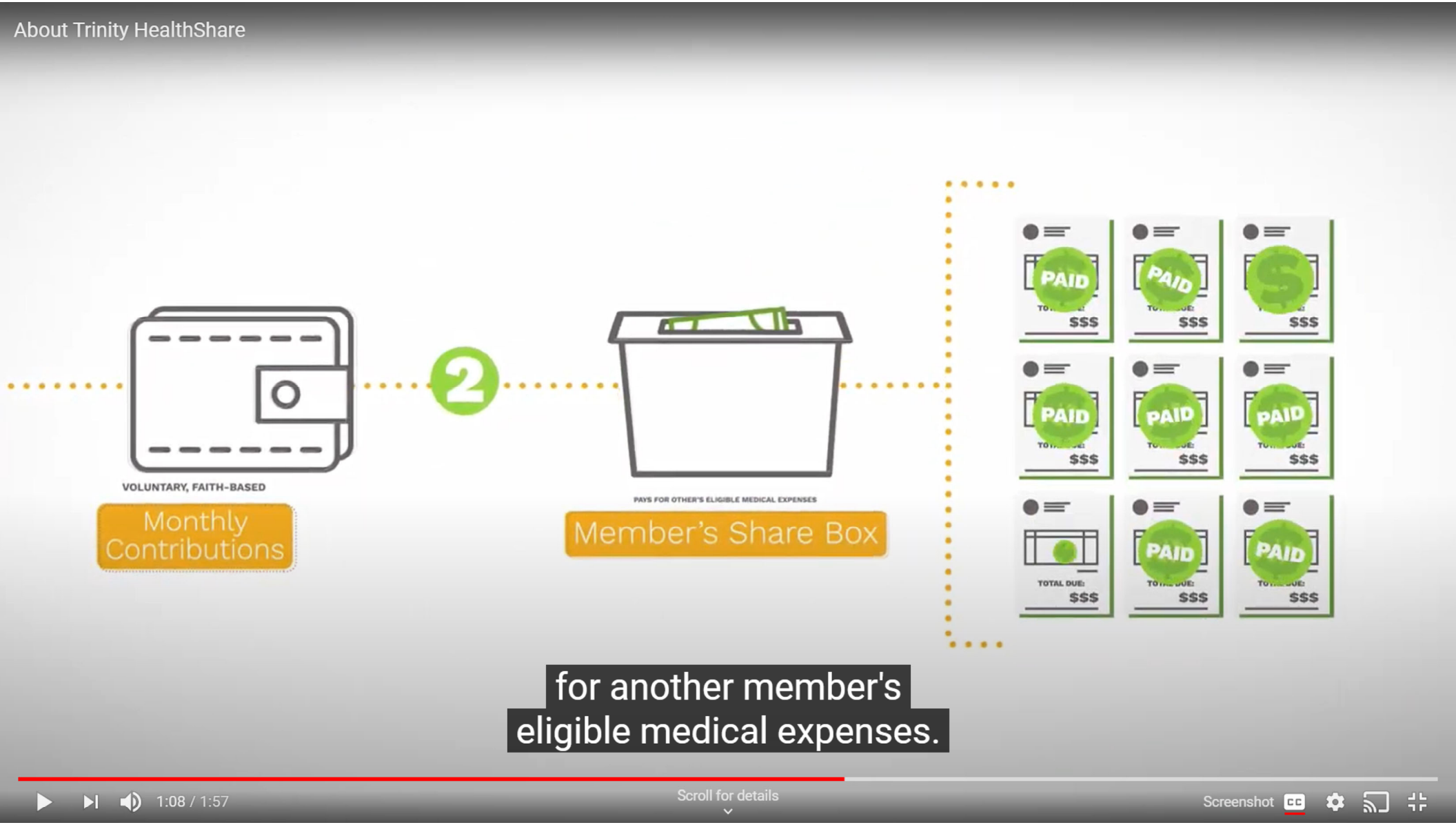

About Trinity HealthShare
to minister towards one another
through Trinity HealthShare.
0:54 / 1:57
Scroll for details
Screenshot


About Trinity HealthShare
How Do Members Share?
So how do members share?
0:55 / 1:57
Scroll for details
Screenshot

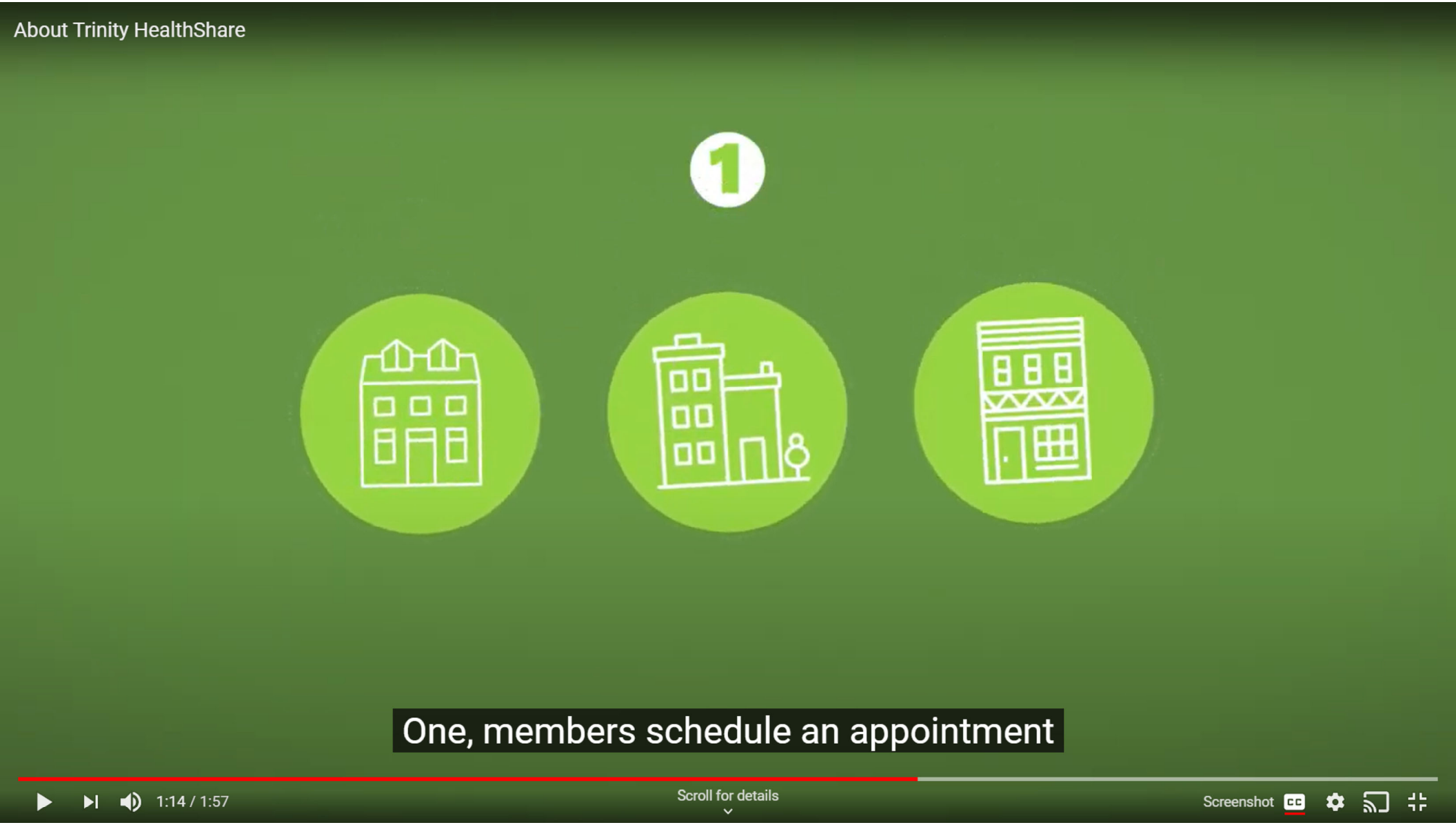

About Trinity HealthShare
1
members make voluntary
faith-based monthly contributions.
0:58 / 1:57
Scroll for details
Screenshot

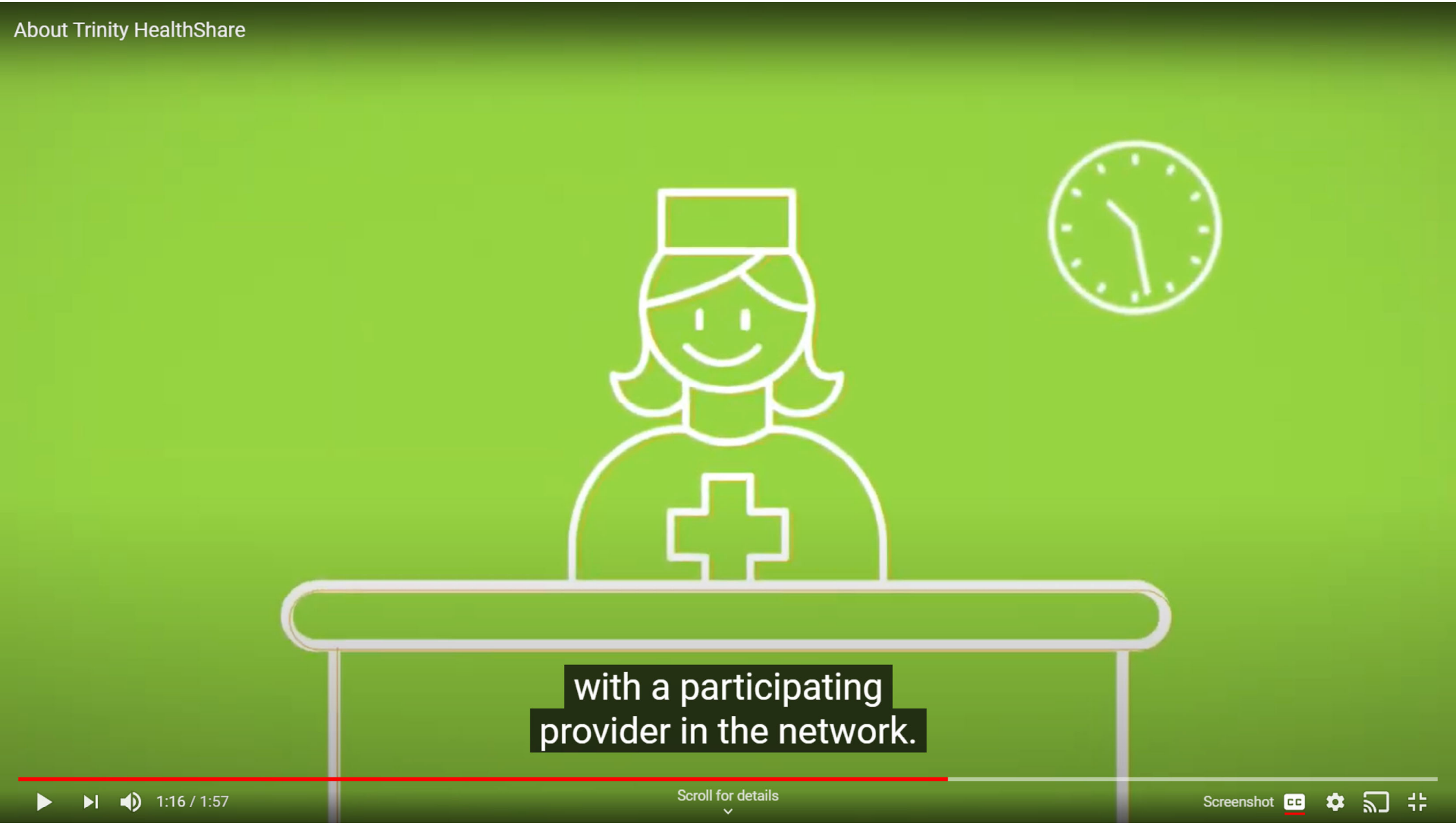

About Trinity HealthShare
1
2
VOLUNTARY, FAITH-BASED
Monthly Contributions
Member's Share Box
these contributions are transferred
to a member's share box,
1:03 / 1:57
Scroll for details
Screenshot

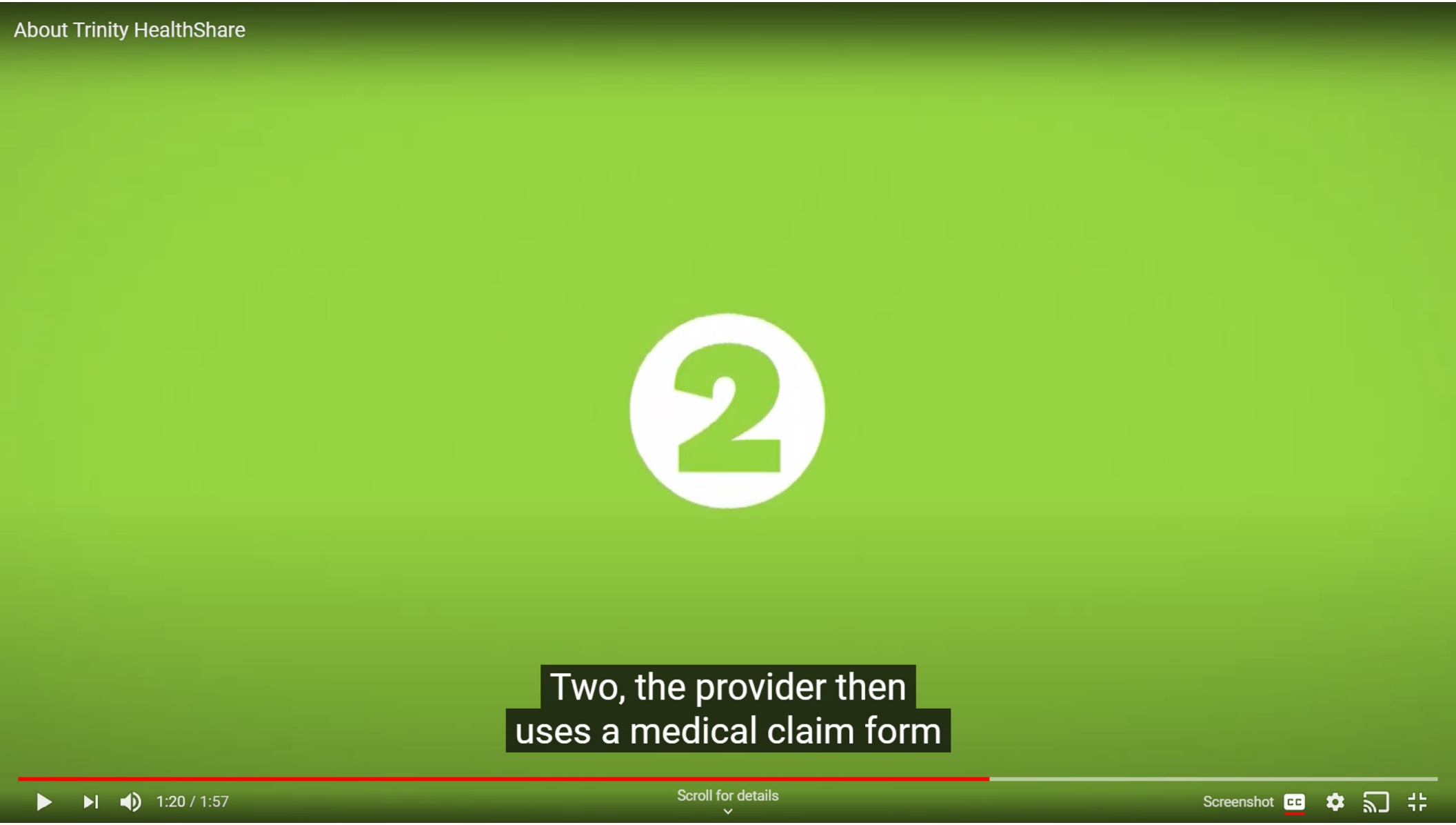

About Trinity HealthShare
2
VOLUNTARY, FAITH-BASED
Monthly Contributions
PAYS FOR OTHER'S ELIGIBLE MEDICAL EXPENSES
Member's Share Box
TOTAL DUE:
$$$
which is used to pay
1:06 / 1:57
Scroll for details
Screenshot

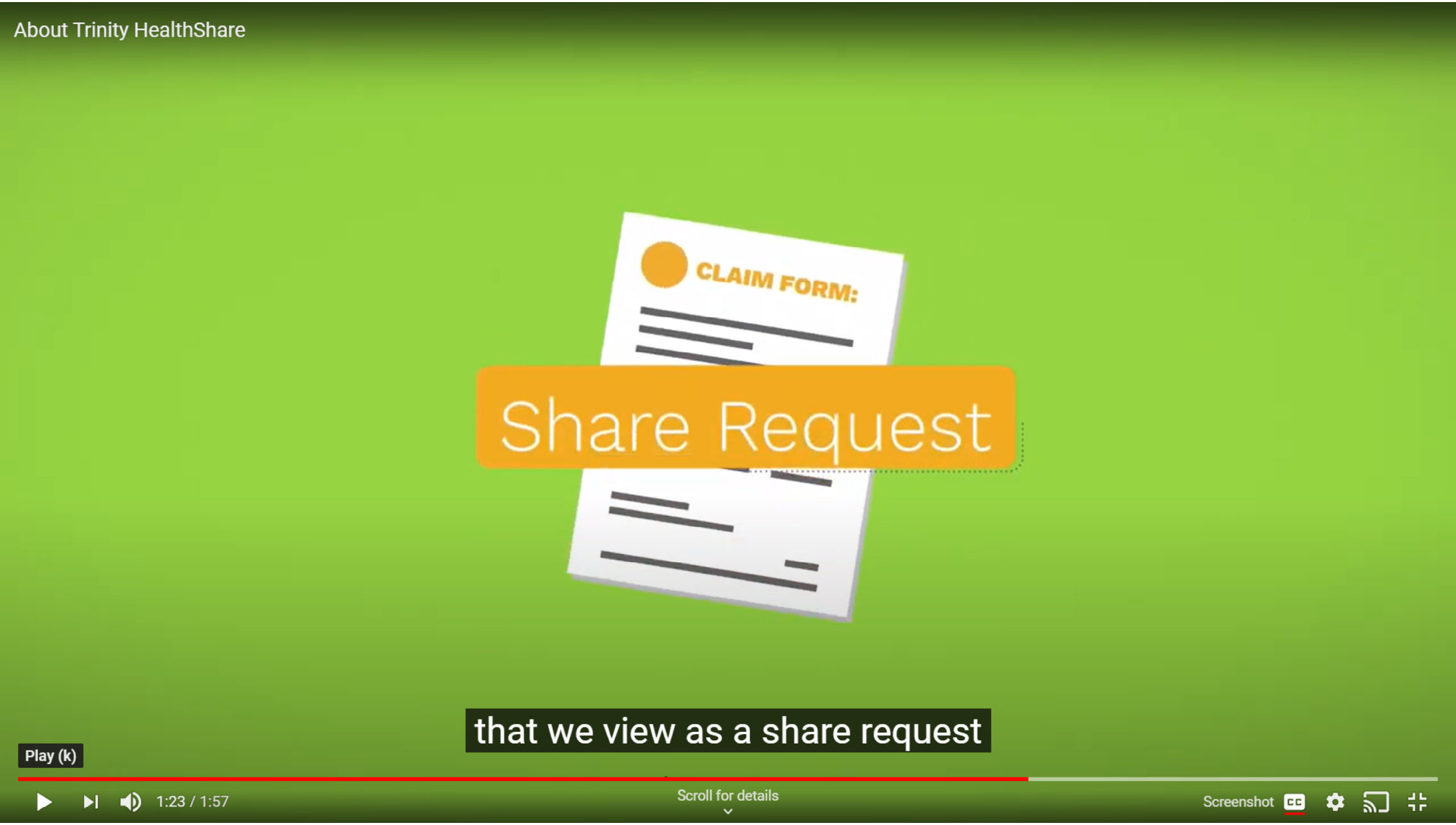

About Trinity HealthShare
VOLUNTARY, FAITH-BASED
Monthly Contributions
2
PAYS FOR OTHER'S ELIGIBLE MEDICAL EXPENSES
Member's Share Box
PAID
$$$
TOTAL DUE:
for another member's
eligible medical expenses.
1:08 / 1:57
Scroll for details
Screenshot

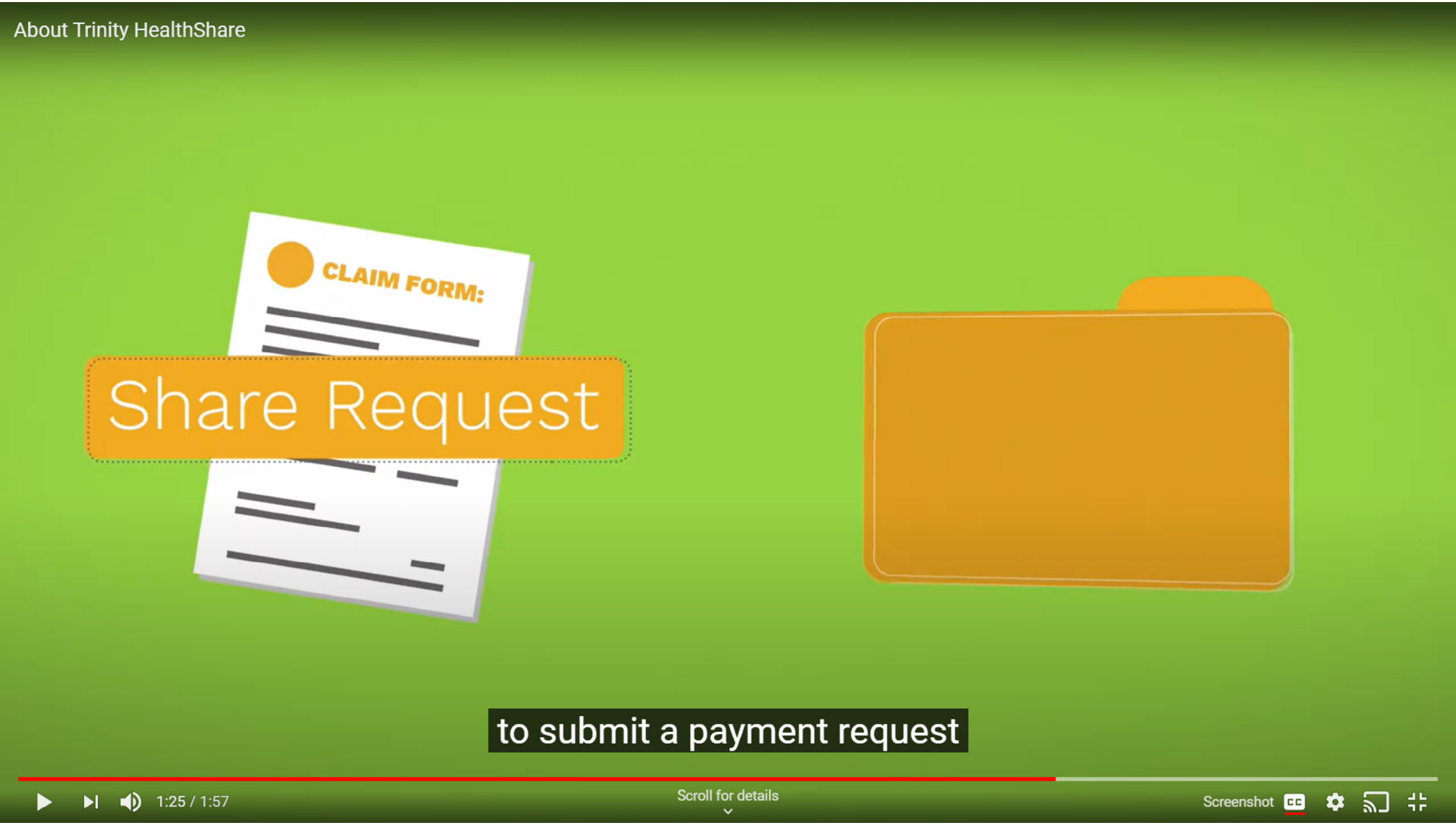

About Trinity HealthShare
How Do Members Present An Eligible Sharing Request?
How do members present an eligible sharing request?
1:10 / 1:57
Scroll for details
Screenshot

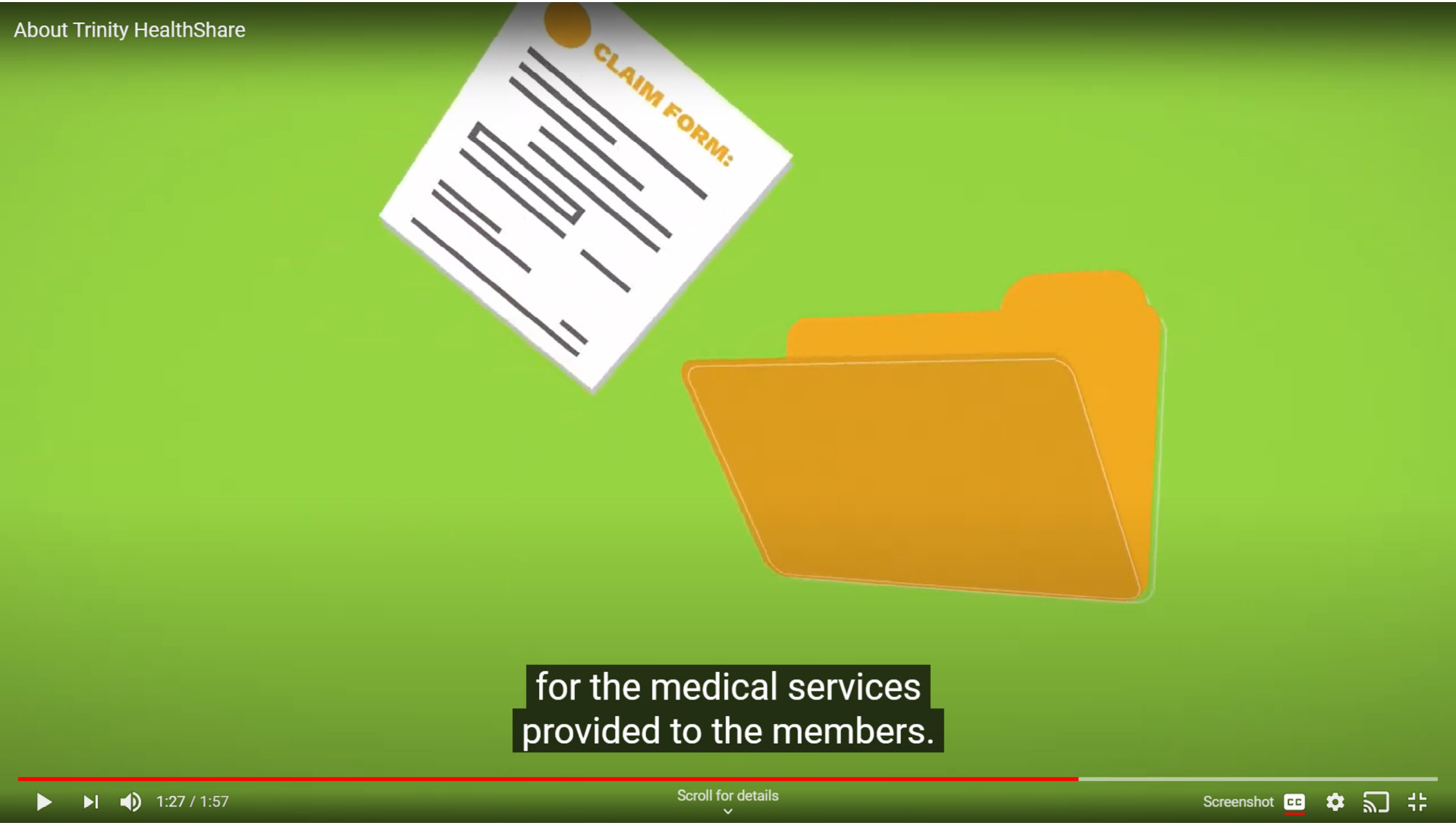

About Trinity HealthShare
1
One, members schedule an appointment
1:14 / 1:57
Scroll for details
Screenshot

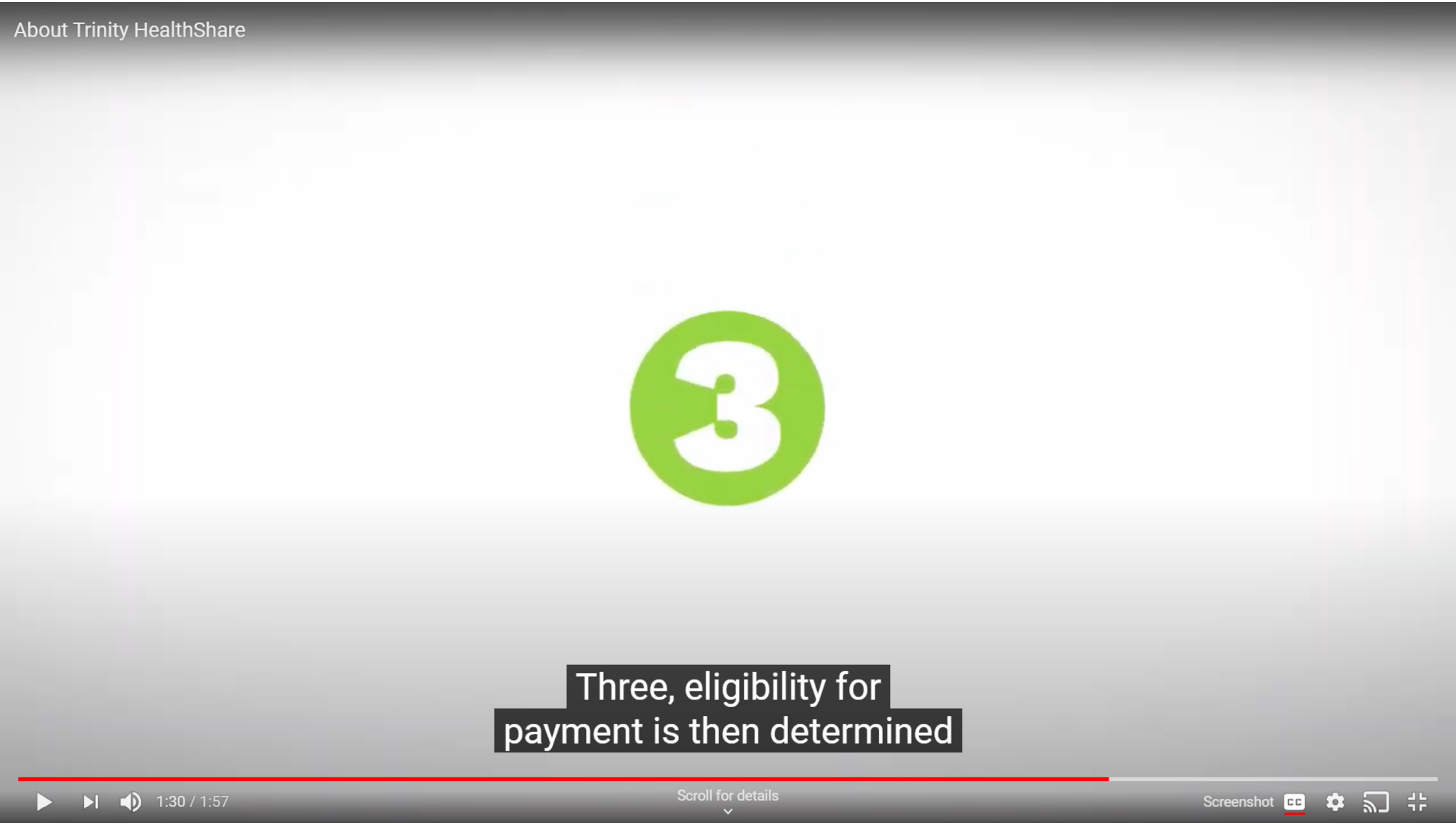

About Trinity HealthShare
with a participating
provider in the network.
1:16 / 1:57
Scroll for details
Screenshot


About Trinity HealthShare
2
Two, the provider then
uses a medical claim form
1:20 / 1:57
Scroll for details
Screenshot

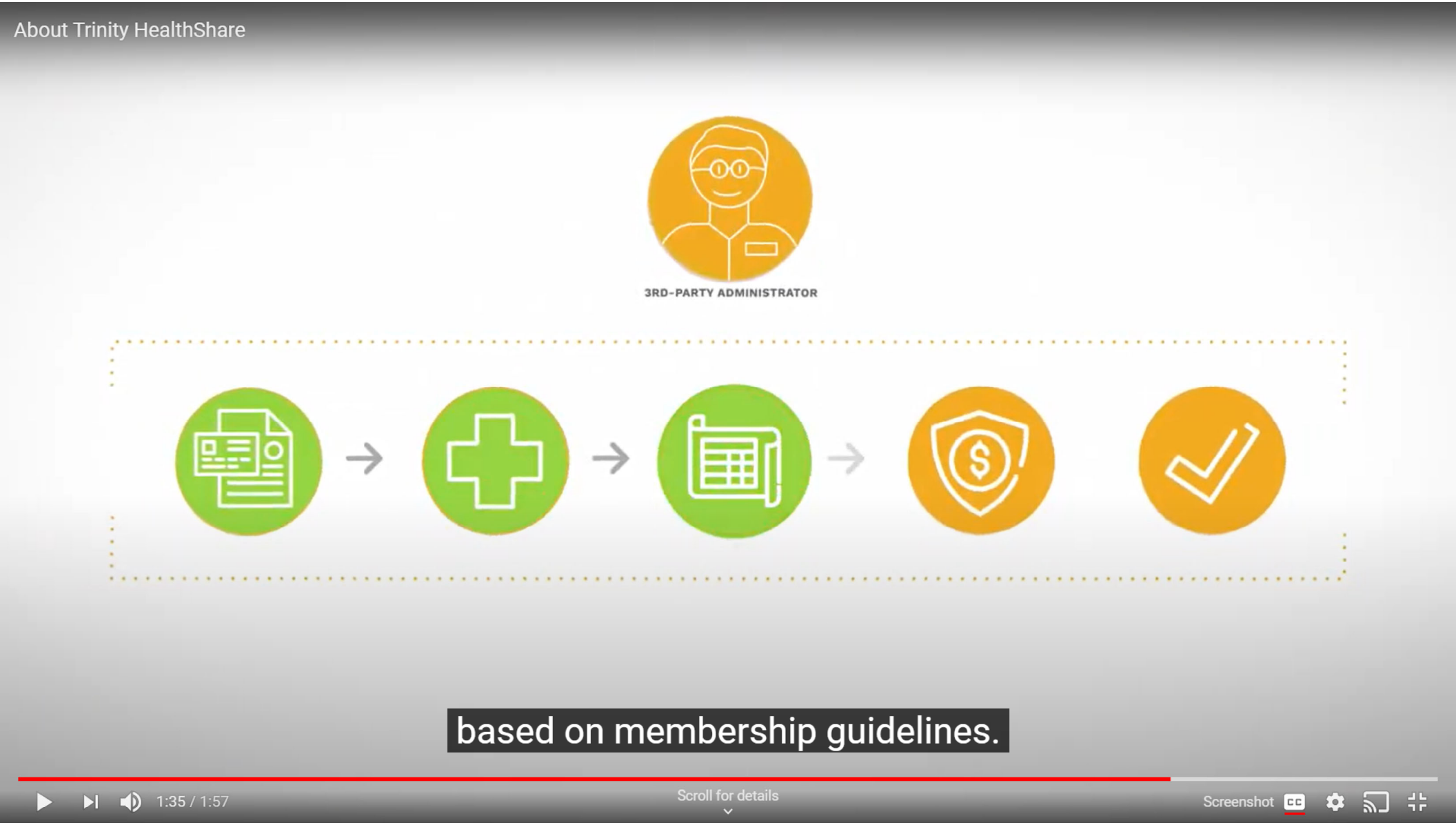

About Trinity HealthShare
CLAIM FORM:
Share Request
that we view as a share request
Play (k)
1:23 / 1:57
Scroll for details
Screenshot

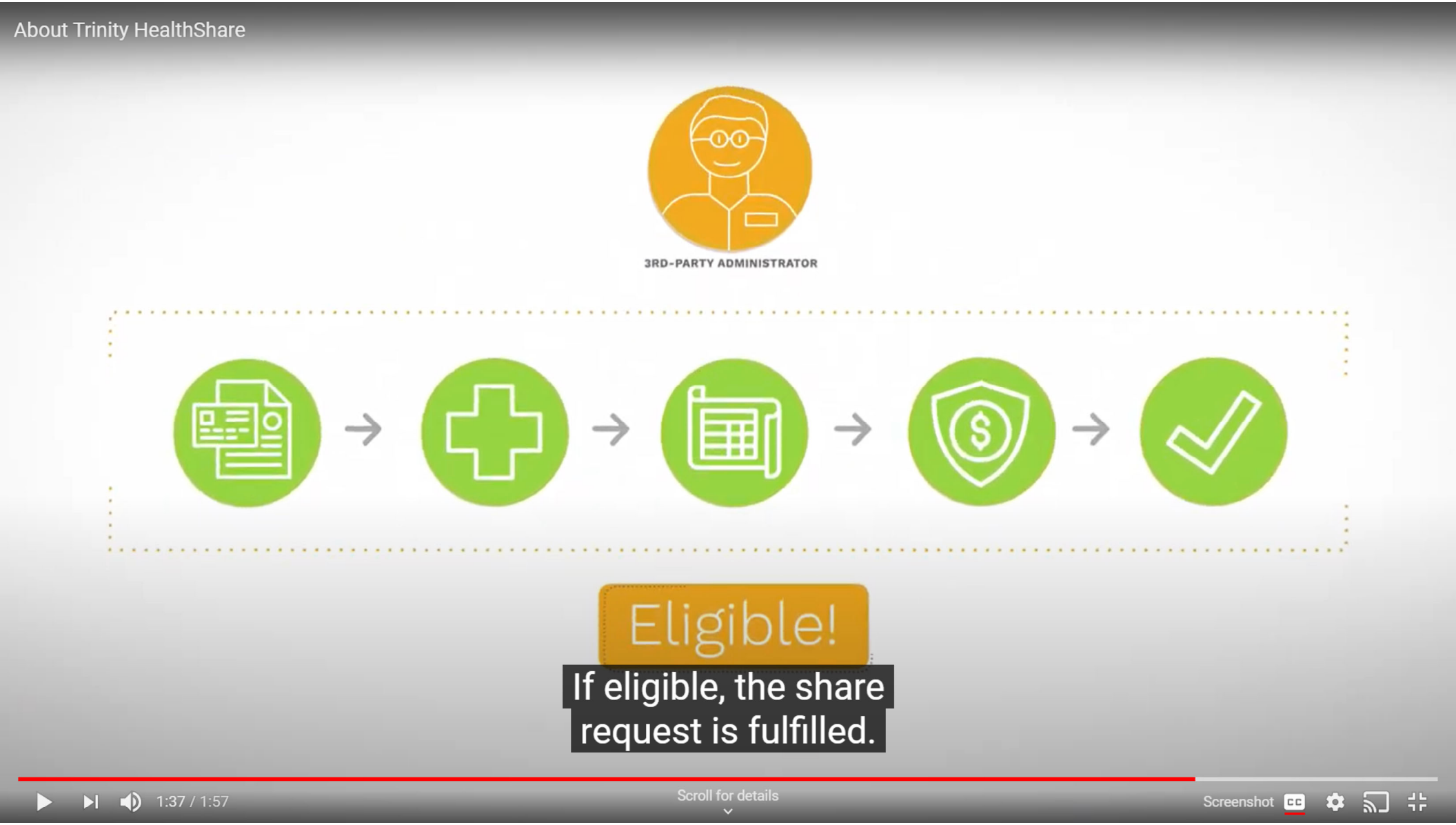

About Trinity HealthShare
CLAIM FORM:
Share Request
to submit a payment request
1:25 / 1:57
Scroll for details
Screenshot


About Trinity HealthShare
CLAIM FORM:
for the medical services
provided to the members.
1:27 / 1:57
Scroll for details
Screenshot


About Trinity HealthShare
3
Three, eligibility for
payment is then determined
1:30 / 1:57
Scroll for details
Screenshot

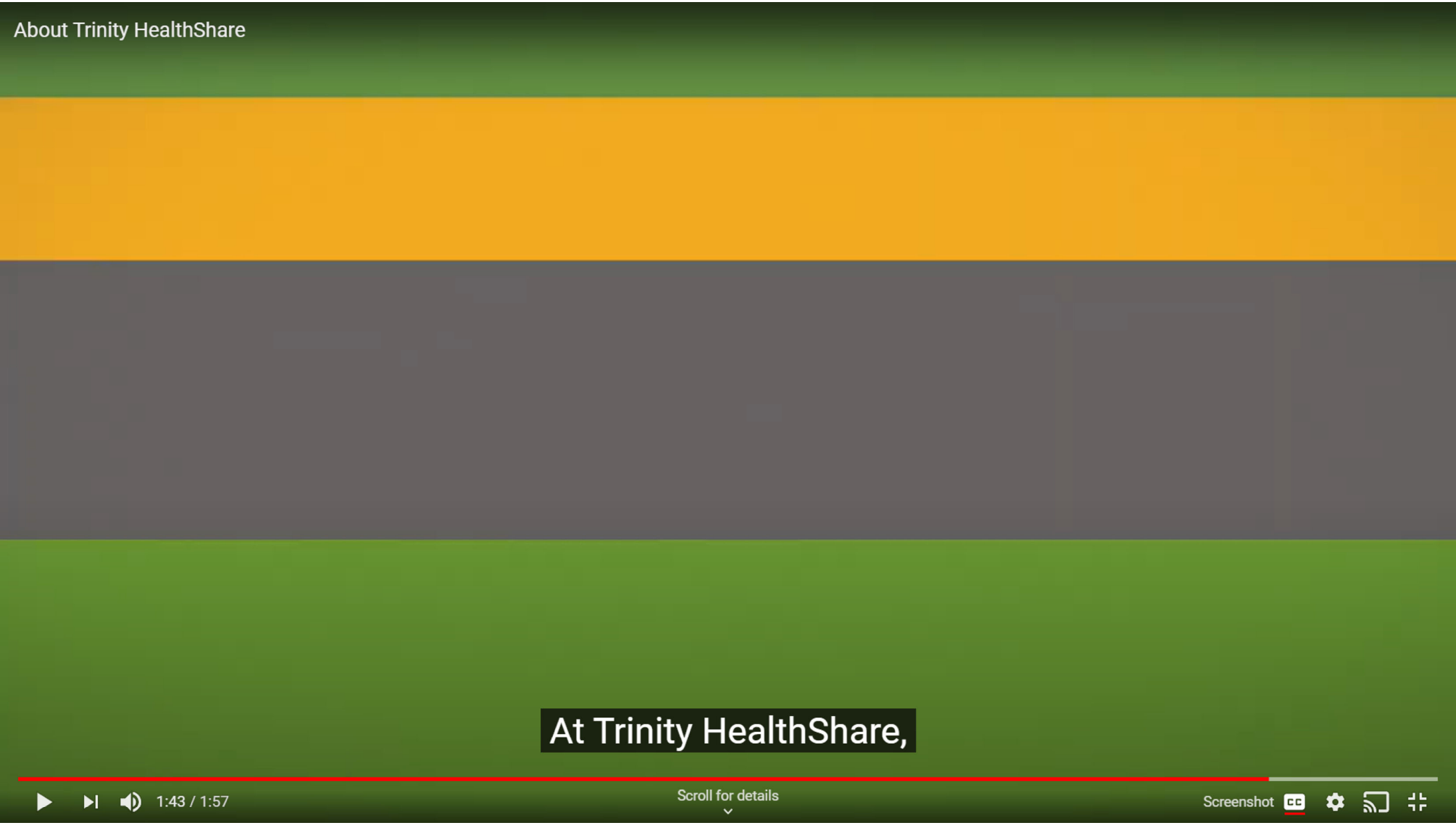

About Trinity HealthShare
3RD-PARTY ADMINISTRATOR
by a third-party administrator
1:33 / 1:57
Scroll for details
Screenshot


About Trinity HealthShare
3RD-PARTY ADMINISTRATOR
based on membership guidelines.
1:35 / 1:57
Scroll for details
Screenshot

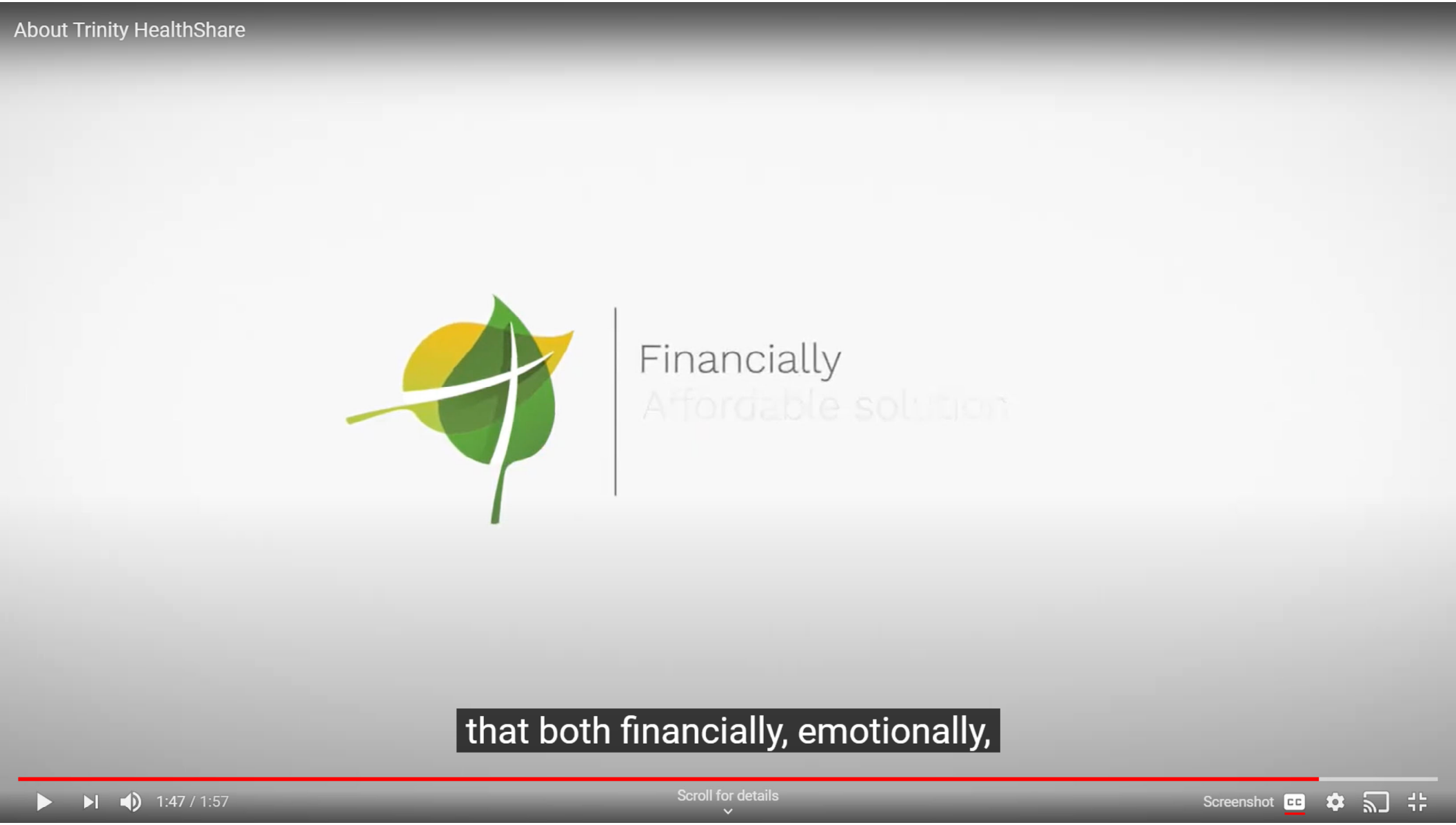

About Trinity HealthShare
3RD-PARTY ADMINISTRATOR
Eligible!
If eligible, the share request is fulfilled.
1:37 / 1:57
Scroll for details
Screenshot


About Trinity HealthShare
The Smith Family
So many Smith families are out there
1:40 / 1:57
Scroll for details
Screenshot


About Trinity HealthShare
The Smith Family
in need of assistance.
1:42 / 1:57
Scroll for details
Screenshot


About Trinity HealthShare
At Trinity HealthShare,
1:43 / 1:57
Scroll for details
Screenshot


About Trinity HealthShare
Affordable solution
we aim to share each
other's medical burdens
1:45 / 1:57
Scroll for details
Screenshot


About Trinity HealthShare
Financially
that both financially, emotionally,
1:47 / 1:57
Scroll for details
Screenshot


About Trinity HealthShare
Ministers to families
Spiritually
and spiritually ministers to families.
1:50 / 1:57
Scroll for details
Screenshot


About Trinity HealthShare
TRINITY SM
HealthShare
Exit full screen (f)
1:54 / 1:57
Scroll for details
Screenshot

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.

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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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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

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

STATE OF CONNECTICUT
INSURANCE DEPARTMENT

IN THE MATTER OF:	)	
	)	
THE ALIERA COMPANIES, Inc.	)	
	)	
and	)	Docket No. MC 19-109
	)	
TRINITY HEALTHSHARE, Inc.	)	
	)	
Respondents	)	

CEASE AND DESIST ORDER

The Insurance Commissioner of the State of Connecticut (hereinafter "the Commissioner") has cause to believe that the acts, practices, transactions, and course of business engaged in by The Aliera Companies, Inc. ("Aliera") and Trinity Healthshare, Inc. ("Healthshare") may be conducted in an illegal and improper way and that irreparable harm may be caused to the citizens of the State of Connecticut. As a result the issuance of the following Cease and Desist order appears warranted:

FINDINGS OF FACT

1.

The Aliera Companies, Inc. (hereinafter "Aliera") is a foreign entity organized under the laws of Delaware and acting as an insurer and as an insurance producer in the State of Connecticut with its principal place of business at 990 Hammond Drive, Suite 700, Atlanta, GA 30328. Trinity Healthshare, Inc. (hereinafter "Trinity") is a foreign corporation organized under the laws of

Delaware, first incorporated on or about June 27, 2018, which represent itself as a healthcare sharing ministry within the meaning of 26 USC §5000A. Aliera and Trinity ("hereinafter collectively referred to as "Respondents") are engaging in an insurance business and acting as insurers in the State of Connecticut by providing health insurance to Connecticut residents or persons authorized to conduct business in Connecticut.

2.

Neither Aliera nor Trinity have been in operation and continuously sharing members' health care costs since at least December 1, 1999, as required by 26 USC § 5000A(d)(2)(B).

3.

Since August 14, 2018 Aliera has been licensed in Connecticut as a producer agency, license No. 2571864, with authority to sell Life, Accident & Health, Credit and Travel insurance products, but is not authorized to engage in any other insurance business or to place coverage as an insurer in the state of Connecticut. Trinity does not hold any insurance license and is not authorized to transact any insurance business in the state of Connecticut.

4.

Respondents are soliciting and/or entering into health insurance contracts with residents of Connecticut or persons authorized to do business in Connecticut whereby Respondents, upon payment of a fee, agree to provide coverage for costs the members incur when receiving medical, dental, optical, hearing, vision and chiropractic services. In addition, Respondents purport to provide coverage for

prescription drugs, Medicare, short term health insurance and insurance for small businesses.

5.

Aliera represents that the products marketed on behalf of Trinity are not insurance, that it administers a faith-based cost sharing program on behalf of Trinity and that it provides assistance to individuals with common religious and ethical beliefs, when in fact the Respondents do not limit the marketing of their products to individuals holding any particular religious beliefs, but enroll in their program all individuals irrespective of faith and, through their marketing representatives, simply require that members enrolling in their program agree to a series of general belief statements, such as "helping others and/or maintaining a healthy lifestyle and avoid foods, behavior, or habits that produce sickness or disease to ourselves or others", or "believe that personal rights and liberties originate from God and are bestowed on us by God", or "believe that every individual has a fundamental religious right to worship God in his or her own way."

6.

Aliera's marketing materials promote individual and family coverage that includes primary care physician visits, pharmaceuticals, basic eye and hearing exams, both in- and out-patient procedures, extended hospitalizations, urgent care needs, labs and diagnostic procedures. Plans offered by Aliera come in gold, silver and bronze, using the same metal designations as insurance plans offered under the Affordable Care Act in the Connecticut Insurance Exchange.

7.

Encouraging the public to apply for coverage offering “lower rates”, “great coverage” and “no penalty”, Aliera’s website states that Aliera operates “like health insurance” by pooling members’ contributions to pay the providers directly, just like a regular insurance company, albeit at a premium 50 percent lower.

8.

A guide provided by Aliera to its members represents that Aliera Healthcare, Inc., in conjunction with Trinity Healthshare, LLC, creates a full range of services and benefits, including preventive care, episodic primary care, chronic maintenance, labs & diagnostics, telemedicine, including “specialty care hospitalization, surgery and emergency room treatment”. The guide represents that “Aliera Healthcare, in alliance with Trinity HealthShare, makes quality healthcare choices affordable for individuals and families”. In addition, the guide includes information about the coverages available, exclusions and limitations of coverage, lifetime or per incident maximum limits and amounts of deductible for each type of service, claims adjudication process and information about the use of provider networks.

9.

The Respondents market their plans to Connecticut consumers through licensed insurance producers and collect fixed monthly payments from their members, calculated on the basis of the coverage chosen, which vary in accordance with the type of plan applied for, the level of coverage, the number of family members enrolled and the underwriting characteristics of each member.

10.

At the present time, the Respondents have not applied for or received an insurance license from the Commissioner authorizing the Respondents to make or propose to make, as insurers, insurance contracts or to conduct in Connecticut, as principals, any insurance business, as defined in General Statutes § 38a-271 .

11.

General Statutes § 38a-272 prohibits any person or insurer from doing, directly or indirectly, any of the acts of an insurance business, as defined in General Statutes § 38a-271, unless authorized under the general statutes. General Statutes § 38a-41 prohibits any insurer or health care center from doing any insurance business or health care business in this state, except if authorized by the Commissioner.

12.

General Statutes § 38a-8 authorizes the Commissioner to administer and enforce all provisions relating to the insurance laws of our State, including the provisions of the Unauthorized Insurers Act, General Statutes § 38a-271 *et seq.* The Commissioner can, therefore, assert jurisdiction over, issue orders and/or commence administrative proceedings against, any person that, in violation of Connecticut law, provides the types of insurance coverage offered in this state by the Respondents.

13.

General Statutes § 38a-17 authorizes the Commissioner to order any insurer to discontinue any illegal or improper method of doing business if, in the opinion of the Commissioner, such insurer is in fact doing business in an illegal or improper way.

14.

General Statutes §§ 38a-481 and 38a-513 provide that no individual health insurance policy or group health insurance policy, respectively, shall be delivered or issued for delivery in this state until a copy of the form thereof and of the classification of risks and the premium rates have been filed with, and approved by, the Commissioner.

15.

The Respondents have never filed copies of the forms relating to the health insurance plans they offer in Connecticut or the premium rates applicable to the risk classification of the contracts they offer to the public.

16.

General Statutes § 38a-1 defines the term "insurance" as "any agreement to pay a sum of money, provide services or any other thing of value on the happening of a particular event or contingency or to provide indemnity for loss in respect to a specified subject by specified perils in return for a consideration. In any contract of insurance, an insured shall have an interest which is subject to a risk of loss through destruction or impairment of that interest, which risk is assumed by the insurer and such assumption shall be part of a general scheme to distribute losses among a large

group of persons bearing similar risks in return for a ratable contribution or other consideration."

17.

The products marketed by the Respondents include an agreement to pay a sum of money, provide services or any other thing of value on the happening of a particular event or contingency, i.e. sickness or injury, or to provide indemnity for loss in respect to a specified subject by specified perils - indemnify their members for costs incurred for medical expenses - in return for a consideration. As it relates to the contracts issued by the Respondents, members have an interest which is subject to a risk of loss through destruction or impairment of that interest, which risk is assumed by the Respondents as part of a general scheme to distribute losses among a large group of persons bearing similar risks in return for a ratable contribution or other consideration by each member.

CONCLUSIONS OF LAW

1.

The facts set forth in paragraphs 1 through 17 of the Findings of Fact herein show that the Respondents are subject to the jurisdiction of the Commissioner and are subject to all appropriate provisions of the Connecticut Insurance Code pursuant to General Statutes § 38a-271 *et seq.* Said facts further show that the Respondents have been acting, and are currently acting, as insurers and/or transacting the business of insurance in Connecticut without a subsisting certificate of authority in violation of General Statutes § 38a-272 and § 38a-41.

2.

The facts set forth in paragraphs 1 through 17 of the Findings of Fact herein show that the Respondents are acting as insurers in Connecticut by providing health insurance without first obtaining a certificate of authority from the Commissioner, in violation of General Statutes § 38a-41, and without having filed such health insurance products with the Commissioner and having obtained the Commissioner's approval prior to marketing such products, in violation of General Statutes §§ 38a-481 and 38a-513.

3.

The facts set forth in paragraphs 1 through 17 of the Findings of Fact herein constitute grounds for the Commissioner to issue an order directing the Respondents to immediately discontinue engaging in an insurance business in Connecticut whereby they provide Life, Accident & Health insurance or any other kind of insurance to Connecticut residents or persons authorized to do business in Connecticut.

4.

The facts set forth in paragraphs 1 through 17 of the Findings of Fact herein constitute grounds, pursuant to General Statutes § 38a-278, for the Commissioner to subject the Respondents to a monetary penalty of up to $50,000.00 for each and every act of violation of the Connecticut Insurance Statutes or any pertinent Rules and Regulations of the Connecticut Insurance Department, which amount may be increased by $2,500.00 for the first offense and by an additional $2,500.00 for each month during which any violation continued.

5.

The facts set forth in paragraphs 1 through 17 of the Findings of Fact herein give the Commissioner reasonable cause to believe that the Respondents have violated, are violating, and will continue to violate the insurance laws of Connecticut. The aforesaid facts also show that the Respondents have not committed merely technical violations, but have violated a basic tenet of public policy by transacting insurance in this State without a subsisting certificate of authority in violation of General Statutes §§ 38a-41 and 38a-272.

6.

The facts set forth in paragraphs 1 through 17 of the Findings of Fact herein give the Commissioner reasonable cause to believe that the probability of such continued violations constitutes a situation of imminent peril to the public welfare, and that the situation therefore imperatively requires immediate action.

7.

The facts set forth in paragraphs 1 through 17 of the Findings of Fact herein give the Commissioner reasonable cause to believe that the Respondents have violated Sections 38a-481 and 38a-513 of the Connecticut General Statutes by failing to file the rates and forms for the health insurance policies marketed in Connecticut and by failing to obtain prior approval from the Commissioner prior to marketing their insurance contracts in this state.

Pursuant to General Statutes § 38a-17, IT IS THEREFORE ORDERED by the Insurance Commissioner:

That the Respondents IMMEDIATELY CEASE AND DESIST from acting as insurers with respect to subjects of insurance resident, located or to be performed in this state, transacting an insurance business in Connecticut, or otherwise violating in any way the insurance laws of the State of Connecticut, except for payment on existing contracts of insurance or other obligations for business placed in our state, which payments are to be made for each claim without regard to any condition, exclusion or limitation contained in the contracts sold or any other defense.

IT IS FURTHER ORDERED:

That any and all licensed producers and any other representatives of the Respondents IMMEDIATELY CEASE AND DESIST from representing insurers that are not authorized to transact insurance in this state or assisting any person in the transaction of an insurance business in Connecticut without a proper license, or otherwise violating in any way the insurance laws of Connecticut, except for facilitating the payment of claims on existing contracts or other obligations for business placed in our state.

SO ORDERED this 2nd day of December, 2019.

Andrew N. Mais
Insurance Commissioner

FOR IMMEDIATE RELEASE: October 30, 2019

Contact: Eireann Aspell Sibley, communications director, (603) 271-3781, eireann.sibley@ins.nh.gov

Aliera Healthcare, Inc. Operating as an Unauthorized Insurance Company in New Hampshire

1,400 NH Residents with Aliera Healthcare Plans Need to Find New Health Insurance Options for 2020

CONCORD, NH – Today, Insurance Commissioner John Elias ordered Aliera Healthcare, Inc. and Trinity Healthcare, Inc. to immediately stop selling or renewing illegal health insurance in New Hampshire. Aliera also markets their products under the company name Ensurian. The 1,400 New Hampshire residents with these plans will need to find new health insurance options during the open enrollment period for plan year 2020 coverage.

Aliera, an unlicensed insurance company in New Hampshire, has been administering and marketing health coverage on behalf of Trinity Healthshare. Trinity represents itself as a health care sharing ministry, which would be exempt from state insurance regulation. A legal health care sharing ministry is a nonprofit organization in existence since December 31, 1999, whose members share a common set of ethical or religious beliefs and share medical expenses among members.

The Department's Consumer Services Division received dozens of complaints and concerns from consumers. Some people believed they were buying health insurance and did not know they had joined a health care sharing ministry. Many people discovered this when their claims were denied because their medical conditions were considered pre-existing under the plan, or were not covered because they were deemed inappropriate for a "Christian lifestyle."

"There are legitimate health care sharing ministries that offer coverage for their members, but Aliera and Trinity are not one of them," said Elias. "Unfortunately, we are seeing entities in the marketplace that are misleading consumers and finding ways to try to avoid insurance regulation. It is important for consumers to be cautious when they purchase health coverage and to reach out to the Department when they have questions or concerns."

The Department's investigation into Aliera and Trinity found that it fails to meet key federal and state requirements:

- Trinity was formed on June 27, 2018, with zero members. Federal and state law requires that health care sharing ministries be formed before December 31, 1999 and their members must have been actively sharing medical costs since then without interruption.
- 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. Trinity fails to establish that it is faith based and limit its membership to individuals who share a common set of ethical or religious beliefs.
- Aliera offers Trinity plans to individuals and employer groups. State law requires that health care sharing ministry plans only market and sell plans to individuals.

Both companies have 30 days from the issuance of the order to request a hearing.

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.

STATE OF NEW HAMPSHIRE
INSURANCE DEPARTMENT

In re: Aliera Healthcare, Inc. (dba The Aliera Companies, Inc.)

Docket No.: INS No. 20-014-EP

ORDER TO SHOW CAUSE AND NOTICE OF HEARING

The New Hampshire Insurance Department ("NHID") orders Aliera Healthcare, Inc. (dba The Aliera Companies, Inc.) to show cause why the New Hampshire Insurance Commissioner should not order the cease and desist of their operations in New Hampshire, suspend or revoke their business entity producer license and/or levy an administrative fine in the maximum amount allowed by law. In support of the Order to Show Cause and pursuant to RSA 541-A:31, RSA 400-A:3, RSA 400-A:17 *et seq.*, RSA 417:6, *et seq.* and Ins Part 200, the NHID states as follows:

STATEMENT OF FACTS

1. 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 markets, solicits and administers health plans in New Hampshire on behalf of Trinity Healthshare ("Trinity"). Prior to August 10, 2018 Aliera solicited 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.

5. Trinity was created in Delaware on June 27, 2018 by Aliera and its principals.

6. Trinity claims to be a Health Care Sharing Ministry[1] ("HCSM") that is exempt from insurance regulation in New Hampshire under RSA 126-V.

7. On August 13, 2018, Aliera and Trinity entered into a Marketing and Administration Agreement ("MAA"). Under the MAA, Aliera is the program manager for Trinity's HCSM plans, and as such is responsible for the development of plan designs, pricing, marketing, vendor management, recruitment and maintenance of a national sales force, and accounting and management of sales commissions on behalf of Trinity.

8. Aliera has the exclusive right to design, market and sell Trinity HCSM plans to its existing members and prospective members.

9. Per the MAA, Aliera also maintains ownership of the "Membership Roster" of all Trinity enrollees.

10. Aliera markets Trinity HCSM products to New Hampshire consumers as alternatives to traditional health insurance, and utilizes licensed resident insurance producers to sell Trinity's products within the state.

11. Approximately 1269 New Hampshire consumers have been sold Trinity products through Aliera.

12. On October 30, 2019, the New Hampshire Insurance Commissioner (the "Commissioner") ordered Aliera to cease and desist from the unauthorized business of insurance in the state of New Hampshire under Order to Cease and Desist INS No. 19-027-EP.

13. The NHID first opened an investigation into Aliera after receiving several consumer complaints regarding the alleged misrepresentations of healthcare insurance products.

14. These consumers agreed to pay a monthly amount to Aliera for which they were led to believe would cover specified healthcare expenses as included with the Membership Guidelines and marketing materials. Ultimately, Aliera and/or Trinity failed to pay the medical claims submitted by these consumers prompting them to the contact the NHID to facilitate a resolution.

15. Through the course the of the NHID's investigation, it was determined that Trinity does not meet the legal definition of a HCSM. Therefore, Aliera, through its relationship with Trinity, is operating as an unauthorized insurer in the state of New Hampshire

[1] The terms "healthcare sharing ministry" and "healthcare sharing organization" are used interchangeably within this Order.

APPLICABLE NEW HAMPSHIRE LAWS

16. RSA 405:1 states, "(no) insurance company not organized under the laws of this state shall do insurance business within the state unless it has obtained a license from the insurance commissioner authorizing it to do so."

17. NH RSA 406-B:3 further states that, "(no) unlicensed person or insurer shall directly or indirectly do any of the acts of an insurance business set forth in RSA 406-B:2 except as provided by and in accordance with the specific authorization of statute."

18. 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;
    f. Doing any kind of insurance business specifically recognized as constituting the doing of an insurance business within the meaning of the insurance statutes;
    g. Doing or proposing to do any business equivalent in substance to any of the foregoing in a manner designed to evade the provisions of the statutes; and
    h. Any other transactions of business in this state by an insurer. *See* RSA 406-B:2

19. New Hampshire law exempts health care sharing organizations from insurance regulation if they meet the requirements of RSA 126-V:1.

20. 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.

21. RSA 417:3, states that "(n)o person shall engage in this state in any trade practice which is defined in this chapter or determined pursuant to this chapter as an unfair method of competition or an unfair or deceptive act or practice in the business of insurance." Person means "any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyd's insurers, fraternal benefit society and any other legal entity, engaged in the business of insurance." *See* RSA 417:2, I.

22. RSA 417:4, I(h) defines an unfair and deceptive act or practice as, "misrepresenting, directly or indirectly, in the offer or sale of any insurance" by engaging in a "transaction, practice, or course of business which operates as a fraud or deceit upon the purchaser, insured, or person with policy ownership rights."

23. RSA 402-J:12, I provides that the specific misconduct enumerated under sections (a) through (m) are grounds for suspension or revocation of an already issued license and also grounds for levying a fine. RSA 402-J:12, I(h) specifically prohibits an insurance producer from, "(u)sing fraudulent, coercive, or dishonest practices, or demonstrating incompetence, untrustworthiness or financial irresponsibility in the conduct of business in this state or elsewhere."

LEGAL ALLEGATIONS and/or VIOLATIONS

24. To qualify as a HCSM under both IRS and New Hampshire law, an organization must be a registered 501(c)(3) organization whose members share a common set of religious or ethical beliefs and share medical expenses in accordance to those beliefs. A HCSM must also have been in operation and continuously sharing member health care costs since December 31, 1999.

25. Trinity cannot meet the exemption requirements of RSA 126-V:1, II, specifically, it has not been in existence continuously and has not been facilitating the sharing of medical expenses of participants without interruption since December 31, 1999.

26. Trinity has only been in existence for less to than two years, and had no members as of August 13, 2018, two months after it incorporated as a non-profit organization within the state of Georgia.

27. Further, no predecessor organization exists which Trinity's members were sharing medical costs.

28. 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. In a September 6,

2018 letter to the United States Department of Health and Human Services, Trinity states that its organization adopts strict Baptists teaching and beliefs. Trinity's bylaws also 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.

29. As Trinity does not meet the required legal elements to designate it as a HCSM under RSA 126-V, and is therefore not exempt from regulation, the acts as described in the above statement of facts demonstrate that Aliera,, through is marketing, solicitation and administration of Trinity products, is operating as an unlicensed insurance company in violation of RSA 406-B:3 and 405:1.

30. Further, by misleading consumers to believe that they are being enrolled in a valid healthcare sharing ministry which is exempt from regulation under RSA 126-V:1, Aliera has violated New Hampshire RSAs 417:3 and 417:4 I (h).

31. Finally, Aliera, as a licensed NH business entity producer is in violation of RSA 402-J:12, I (h) by using fraudulent, coercive, or dishonest practices, or demonstrating incompetence and/or untrustworthiness in the conduct of business in this state or elsewhere by promoting Trinity as a legitimate HCSM to New Hampshire consumers, when in fact it is not.

NEW HAMSPHIRE INSURANCE LAWS VIOLATED BY RESPONDENT

32. The NHID maintains that the Respondent violated RSA 403-B:3 and 405:1 for operating as an unlicensed insurance company in New Hampshire.

33. The NHID maintains that the Commissioner has the authority to levy a monetary penalty in accordance RSA 406-B:12.

34. The NHID maintains that the Respondent violated RSAs 417:3 and 417:4, I(h) for deceptively enrolling 1269 New Hampshire consumers into an invalid healthcare sharing ministry.

35. The NHID also maintains that the Commissioner has the authority to levy a monetary penalty in accordance with RSA 417:10 for each New Hampshire consumer who were enrolled by Aliera into a Trinity membership.

36. The NHID maintains that the Respondent violated 402-J:12, I(h) for enrolling 1269 New Hampshire consumers into an invalid healthcare sharing ministry.

37. The NHID maintains that the Commissioner has the authority to revoke the Respondent's New Hampshire insurance business entity license pursuant to NH RSAs 400-A:15, III, and 402-J:12, I(h).

38. The NHID maintains that the Commissioner has the authority to levy a monetary penalty in accordance with RSAs 400-A:15, III for each violation of 402-J:12, I(h).

39. The NHID reserves the right to amend this list of insurance laws violated by the Respondent upon reasonable notice to the Commissioner (or his designated Representative) and the Respondent.

PENALTY REQUESTED

40. In the event the Hearing Officer determines after evidentiary hearing that the NHID sustained its burden of proof with respect to the allegations of fact and violations of law outlined above, the NHID request that the Hearing Officer,

(i) Order Aliera to Cease and Desist soliciting invalid health care sharing ministry business within New Hampshire;

(ii) Levy an administrative fine in the amount of $10,000 as authorized by RSA 406-B:12;

(iii) Levy a fine in the maximum amount allowed by law for each violation of RSAs 417:3 and 417:4 I(h); and

(iv.) Pursuant to RSA 402-J:12, I and RSA 400-A:15, III, order the permanent revocation of the Respondent's New Hampshire business entity insurance producer license and levy an administrative fine in the maximum amount allowed by law.

NOTICE OF HEARING

41. An adjudicatory proceeding shall be commenced for the purpose of resolving the issues articulated above pursuant to RSA 541-A:31, RSA 400-A:17:6, *et seq.*, RSA 417:6, *et seq.*, and Ins 200. To the extent that the Department's rules do not address an issue of policy or procedures, the Department shall apply the N.H. Department of Justice Rules, Part 800.

42. The Respondent shall appear at Department **on a date to be determined in accordance with RSA 400-A:18, I**, at the Department's office located at 21 South Fruit Street, Suite 14, in Concord New Hampshire to participate in this adjudicatory proceeding and, if deemed appropriate, be subject to sanctions pursuant to RSA 402-J:12, I and RSA 400-A:15, III. Respondent's failure to appear at the time and place specified above may result in the hearing being held *in absentia* and sanctions may be imposed without further notice or an opportunity to be heard.

43. Michelle Heaton Esq. is appointed to act as Hearing Officer in this matter with all the authority within the scope of RSA 400-A:19 and Ins 203.01.

44. Linda Zalinskie shall serve as clerk to the Hearing Officer. The parties should direct all communications to Ms. Zalinskie, whose contact information is:

    Linda Zalinskie, Clerk
    New Hampshire Insurance Department
    21 South Fruit Street, Suite 14
    Concord, NH 03301
    Tel: (603) 271-2261
    Fax: (603)271-1406
    Email: linda.zalinskie@ins.nh.gov

45. The Respondent has the right to be represented by a lawyer in this proceeding. However, the Respondent shall bear the cost of retaining said lawyer. Should the Respondent elect to retain a lawyer, his lawyer shall file a Notice of Appearance with Ms. Zalinskie, and said lawyer should do so at the earliest possible date. A copy of the NHID's Notice of Appearance form is enclosed with this Order.

46. Any party may request a transcript of the proceeding. The party requesting a transcript of the proceedings shall file a written request for a certified court reporter with the Hearing Officer at least 10 days prior to the scheduled hearing date. The costs incurred for the services of a certified court reporter shall be borne by the requesting party.

47. Mary C. Bleier, Esq. and/or Joshua Hilliard, Esq. shall serve as staff advocates representing the interests of the NHID.

48. All routine procedural inquiries may be made by contacting Linda Zalinskie, Hearing Clerk, New Hampshire Insurance Department, 21 South Fruit Street, Suite 14, Concord NH 03301, (603) 271-2261, but that all other communications with the Hearing Officer and the Commissioner shall be in writing and filed as provided above. *Ex parte* communications are forbidden by statute and the Department's regulations.

49. A copy of this hearing notice shall be served upon Respondent by certified mail addressed to the mailing address on file with New Hampshire Insurance Department. *See*, RSA 400-A:14.

It is **SO ORDERED.**

NEW HAMPSHIRE INSURANCE DEPARTMENT

Date: 3/10/2020

Christopher Nicolopoulos,
Insurance Commissioner

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and accurate copy of the foregoing Order to Show Cause and Notice of Hearing was sent this date by first-class mail, postage prepaid, and by certified mail, return receipt requested, to Aliera Healthcare, Inc. 5901 Peachtree Dunwoody Rd. Ste C-160, Atlanta, GA 30328, this being his last mailing address on file with the Department.

Date: 3/10/2020 .

Mary C. Bleier, Esq.

MEMBER GUIDE

TRINITYCARE℠ EVERYDAY

TRINITY℠ HealthShare

THIS IS NOT AN INSURANCE PRODUCT

Welcome

Welcome to the Trinity family! Thank you for participating in our health care sharing community. We are committed to streamlining access to individual and family-focused health care services at each step along the continuum of care. Please take a few minutes to review and understand the information in this member guide.

While this member guide is not a contract and does not constitute an agreement, a promise to pay, or an obligation to share, it is provided to help you understand how your Trinity HealthShare (Trinity) program works, your responsibilities as a member of a Health Care Sharing Ministry (HCSM) and the guidelines associated with your Trinity program. The more informed you are, the easier it will be to understand which services may be eligible for sharing with your Trinity program, as well as any limitations, exclusions or requirements you should know about prior to receiving a medical service.

If you have any questions, *member services* is here to help with any of the following:

- General information
- Program management
- Monthly contributions
- Member Shared Responsibility Amount (MSRA)
- Find a network provider
- Eligibility for sharing
- Sharing requests
- Using your member portal

Trinity HealthShare programs are not available in AK, CO, CT, HI, MA, MD, ME, MT, ND, NH, OR, PA, PR, SD, TX, VT, WA, WY or Washington, D.C. Limitation subject to change without prior notice. Due to regulatory limitations regarding compensation, Trinity HealthShare programs will no longer be sold in Massachusetts or Pennsylvania.

Contact Member Services

Please contact member services Monday through Friday between 8am and 6pm ET.

Phone: 844-834-3456

Email: memberservices@trinityhealthshare.org

Online: TrinityHealthShare.org

Mail: PO Box 28220 | Atlanta, GA 30358

Quick Reference:

Billing/Payment Questions | 844-834-3456
Log in to your Member Portal:
TrinityHealthShare.org > Members > Member Portal

Share Request Questions | 844-834-3456
Log in to your Member Portal:
TrinityHealthShare.org > Members > Member Portal

FirstCall Telemedicine | 866-920-DOCS (3627)
FirstCallTelemed.com

Find a Network Health Care Provider
To find a network provider, go to TrinityHealthShare.org/network. Find the name of your program and click the logo next to it to start a provider search.

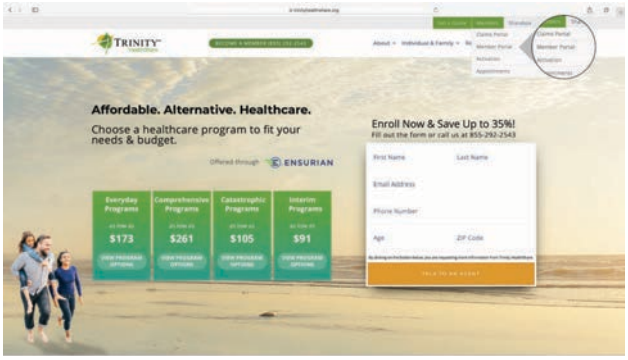
Rx Valet | 855-798-2538
RxValet.com

Getting Started

In order to maintain your privacy and provide a streamlined member experience, Trinity works closely with vendors to make digital registration and activation quick and easy. Please follow each of the steps below in order to gain access to all the services outlined in your program.

Step 1: Register for the Member Portal

Refer to your member portal to view/print a copy of your member ID card, request an address change, initiate a program change, add a dependent, review contribution history, manage share requests, and add or change your monthly contribution method.



1. Locate the 9-digit ID number on your ID card
2. Visit **TrinityHealthShare.org**
3. Click the green **Members** button on the top navigation bar
4. Select **Member Portal**
5. Click on **Need to Register?**
6. Complete the form and click **Register**

Step 2: Activate Your FirstCall Telemedicine Account

By establishing your telemedicine account, you have access to board-certified physicians 24/7, 365 days per year via phone or video chat.*

1. Go to **FirstCallTelemed.com**
2. Click on **Activate Now**
3. Follow the online instructions and provide the required information for the primary member, including medical history.
4. Set up minor dependents (17 years or younger) by clicking **My Family** on the top menu.
5. Follow the online instructions to provide the necessary information and complete each dependent's medical history.
6. Set up adult dependents (18 to 26 years). Adult dependents must set up their own account; follow steps 1-3 above.

After your FirstCall Telemedicine Account is active, consultations may be requested by

- Logging in to the member portal on **FirstCallTelemed.com**
- Calling **866-920-DOCS (3627)**

**If membership fees are not paid to date, members are not eligible to set up/use the telemedicine account.*

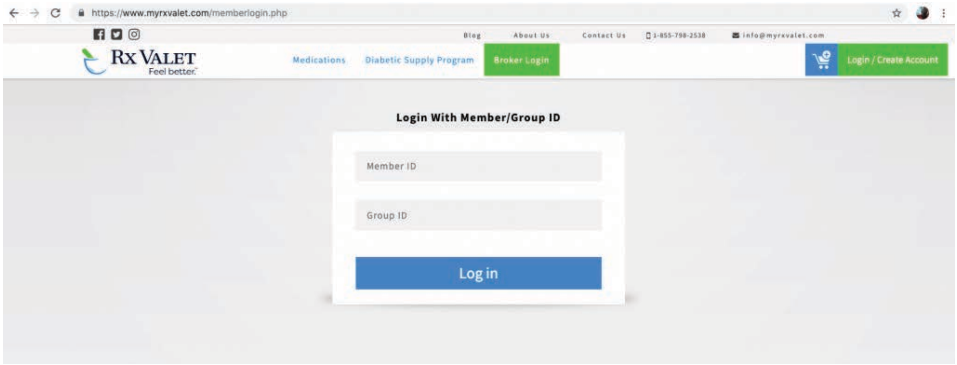
Step 3: Activate Your Rx Valet Account

This prescription discount program helps you save on prescription medications and diabetic testing supplies at most retail pharmacies. Save even more by choosing the home delivery option.*

1. Go to **RxValet.com**
2. Click **Login/Create Account**
3. Select **Member/Group ID**
4. Enter 9-digit ID number on your card
5. Enter the Group ID 2504

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. For added convenience, download the Rx Valet app on your smartphone. If you are experiencing an urgent situation and don't have time to set up your account, you can hand your member ID card to the pharmacist to see if an immediate discount can be applied. The discount may not be as great, so please set up your account when you have time.

**If membership fees are not paid to date, members are not eligible to set up or use the prescription discount account.*



Part I: How to Use Your Membership

Program Overview

This member guide contains the information you need to understand each of the services available with your program. Please review it carefully. We highly encourage you to contact FirstCall Telemedicine before seeking treatment elsewhere, unless you have a life-threatening emergency. Often times, telemedicine physicians can treat primary medical concerns — and you don?t even have to leave the comfort of your home! Refer to your member ID card or the *FirstCall Telemedicine* section of this member guide for more information. Also, remember to keep your member ID with you at all times and present it to providers before services are rendered.

Eligibility for Sharing

Trinity HealthShare reviews each sharing request for eligibility based on the services outlined in the member guides. Eligibility does not imply a promise to pay and each member is responsible for their own medical expenses at all times.

Services At A Glance

Trinity HealthShare programs provide access to a wide range of medical services that may be eligible for cost sharing. Your program includes the services below, but review the individual program details in this guide for specific cost-sharing services associated with your program tier.

* MSRA (member shared responsibility amount) is the amount members must pay out of pocket before medical expenses become eligible for sharing with other members

Find a Network Health Care Provider

Since network participation can change frequently, Trinity cannot guarantee provider participation in any networks. It is important to call the provider to verify participation in the network associated with your Trinity program prior to scheduling your appointment(s) and incurring medical expenses that may or may not be eligible for sharing.

- Start your provider search by visiting **TrinityHealthShare.org/network**
- Find the name of your program in the left-hand column of the chart
- Click the network logo next to it
- Search for a provider
- Call the provider you choose to ensure participation with Trinity HealthShare programs

If you need help, contact *member services* and a representative will be happy to help you identify a provider listed under the network associated with your program.

What Is a Member Shared Responsibility Amount (MSRA)?

The Member Shared Responsibility Amount, or MSRA, reflects the amount of personal responsibility and stewardship members are expected to demonstrate; in other words, the amount a member must pay before asking others in the program to share in the cost of medical expenses. It is important to recognize that some services (such as telemedicine, preventive services and prescription discounts) are available to members before the full amount of the MSRA is met. Expenses for other services, however, are not eligible for sharing until members pay the entire MSRA.

Services Eligible For Sharing Prior to Meeting the MSRA

The following sections outline the services that are generally eligible for sharing prior to meeting your MSRA.

FirstCall Telemedicine

Included with Contribution
No Consult Fee, Co-expense or MSRA Applies

FirstCall Telemedicine
FirstCallTelemed.com | 866-920-DOCS (3627)

FirstCall Telemedicine is a great option for immediate access to health care because it is included with your Trinity program's monthly contribution for members and their dependents, 24/7, 365 days per year. Trinity encourages members with access to

FirstCall Telemedicine to take advantage of the services it offers before seeking treatment elsewhere, unless you have a life-threatening emergency. FirstCall Telemedicine has board-certified physicians who can treat many primary medical concerns quickly and easily and who may prescribe some medications over the phone or using a secure internet connection/application. You don?t even have to leave the comfort of your home!

- At home, at work, or while traveling in the U.S., you or your dependents can speak to a board-certified telemedicine physician 24/7 via face-to-face internet consultation or by phone
- Telemedicine consultations are included with every program for members and dependents on the program
- 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 the expense of emergency room visits for non-emergency situations, waiting for an appointment, or driving to a local facility. Telemedicine providers can often treat conditions such as:
    - Cold and flu symptoms
    - Bronchitis
    - Allergies
    - Poison ivy
    - Pink eye
    - Urinary tract infections
    - Respiratory infections
    - Sinus problems
    - Ear infections

If the telemedicine physician recommends that you see your primary care physician (PCP) or that you visit an urgent care facility, refer to the *Find A Network Health Care Provider* section of this guide or contact *member services* and a representative will be happy to help you identify a provider listed under the network associated with your program.

Make sure to *Activate your FirstCall Telemedicine Account* as soon as your membership is active so you can use the service right when you need it.

Wellness & Preventive Care

When applicable, included with contribution.

No consult fee, co-expense or MSRA applies unless additional services are performed at the time of visit.

It's easier to stay healthy with regular wellness and preventive care. As part of your Trinity solution, your program may include many preventive care services with your monthly contribution. When applicable, there is no consult fee or obligation to reach the MSRA for the preventive care services listed below.

How to Use Wellness & Preventive Care Services

1. Members do not need to call FirstCall Telemedicine to schedule preventive care.
2. Present your member ID card and a photo ID when you arrive at your PCP.
3. If you have not activated your membership or if your monthly contributions are not current, the services will automatically be deemed ineligible for sharing.
4. Preventive health services must be appropriate for the member. If other medical needs are addressed during regular check-ups or preventive care visits, members are responsible for the non-preventive costs at the time of those visits.
5. Refer to the *Preventive Services Eligible for Sharing* list below.

Preventive Services Eligible for Sharing

A sampling of the preventive medical services included with your monthly contribution is listed below and subject to change without notice. Please refer to details within this guide for specifics about the services included with your program. Always verify eligibility before treatment or service is rendered.

- Abnormal Blood Glucose and Type 2 Diabetes Mellitus: Screening
- Asymptomatic Bacteriuria in Adults: Screening
- Bacterial Vaginosis in Pregnancy to Prevent Preterm Delivery: Screening
- BRCA-Related Cancer: Risk Assessment, Genetic Counseling, and Genetic Testing
- Breast Cancer: Medications for Risk Reduction
- Breast Cancer: Screening
- Breastfeeding: Primary Care Interventions
- Cervical Cancer: Screening
- Chlamydia and Gonorrhea: Screening
- Colorectal Cancer: Screening*
- Dental Caries in Children from Birth Through Age 5 Years: Screening
- Depression in Adults: Screening
- Depression in Adolescents: Screening
- Folic Acid for the Prevention of Neural Tube Defects: Preventive Medication

- Genital Herpes Infection: Serologic Screening
- Gestational Diabetes Mellitus, Screening
- Gynecological Conditions: Periodic Screening With the Pelvic Examination
- Healthful Diet and Physical Activity for Cardiovascular Disease Prevention in Adults With Cardiovascular Risk Factors: Behavioral Counseling
- Hepatitis B Virus Infection in Pregnant Women: Screening
- Hepatitis B Virus Infection: Screening, 2014
- Hepatitis C: Screening
- High Blood Pressure in Adults: Screening
- Human Immunodeficiency Virus (HIV) Infection: Screening
- Immunizations for Adults
- Immunizations for Children
- Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: Screening
- Latent Tuberculosis Infection: Screening
- Lung Cancer: Screening
- Motor Vehicle Occupant Restraints: Counseling
- Obesity in Children and Adolescents: Screening
- Ocular Prophylaxis for Gonococcal Ophthalmia
- Opthalmia Neonatorum: Preventive Medication
- Ovarian Cancer: Screening
- Perinatal Depression: Preventive Interventions
- Preeclampsia: Screening
- Rh(D) Incompatibility: Screening
- Rubella: Immunizations
- Sexually Transmitted Infections: Behavioral Counseling
- Skin Cancer Prevention: Behavioral Counseling
- Statin Use for the Primary Prevention of Cardiovascular Disease in Adults: Preventive Medication
- Syphilis Infection in Nonpregnant Adults and Adolescents: Screening
- Syphilis Infection in Pregnant Women: Screening
- Tobacco Smoking Cessation in Adults, Including Pregnant Women: Behavioral and Pharmacotherapy Interventions
- Tobacco Use in Children and Adolescents: Primary Care Interventions
- Vision in Children Ages 6 Months to 5 Years: Screening
- Vitamin Supplementation to Prevent Cancer and Cardiovascular Disease: Preventive Medication

**For adults ages 50-65, a colorectal screening (fecal occult blood test) may be eligible as a preventive service. A colonoscopy would be considered an outpatient surgical service and is not eligible as a preventive service. Cologuard is not eligible for sharing.*

Primary Care

Participating In-network Services
Value: 1 visit per year l $20 consult fee Plus: 3 visits per year l $20 consult fee Premium: 5 visits per year l $20 consult fee

Primary care is at the core of your Trinity program, and the Trinity HealthShare community considers it a key step in living a healthier lifestyle. Your program tier includes a specified number of visits every program year to a PCP, pediatrician or OB/GYN for primary care, sick care, chronic maintenance and general day-to-day medical care. A consult fee is required at each visit.

How to Use the Primary Care Service

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.
3. If your medical issue cannot be resolved after a no-fee consultation with the telemedicine doctor, visit the closest participating in-network primary care facility (refer to the *Find A Network Health Care Provider* section of this guide).
4. Present your member ID to the front office personnel when you arrive at your PCP's office. The provider's staff will contact the program to verify your eligibility status. If you have not activated your membership or if your monthly contributions are not current, the services will automatically be deemed ineligible for sharing.
5. A consult fee is due at the time of service. If x-ray services are required, there is a $25 dollar fee for the image read, which is your responsibility. Costs may be higher depending on your state and provider.

Urgent Care

Participating In-network Services
Value: not eligible Plus: 1 visit per year l $20 consult fee Premium: 2 visits per year l $20 consult fee

Urgent care centers provide walk-in, extended hour access for adults and children when illness is beyond the scope or availability of telemedicine or a PCP, but not life threatening as to warrant a trip to the emergency room. Your program network includes many participating urgent care facilities throughout the United States. Many Urgent Care facilities are open later than primary care offices and have some weekend hours with variable late-night weekends and holiday access. Often, no appointment is necessary, but you may choose to call ahead to plan your visit if you want to cut down on waiting room times.

Staff varies with each facility from board-certified doctors to nurse practitioners and medical assistants, who work together and independently to treat a wide range of common non-life-threatening illnesses and injuries which may include, but are not limited to:

- Accidents or Falls
- Back or Stomach Pain
- Chronic condition exams
- Cuts Requiring Stitches
- Earaches
- Flu, Sore Throat, Coughing, Congestion
- High Fever
- Mild-to-moderate Asthma
- Severe Abdominal Pain
- Sprains or Minor Broken Bones
- Vomiting, Diarrhea, Dehydration
- Wellness & preventive services including vaccines, screenings and more

How to Use the Urgent Care Service

1. If it is not a life-threatening emergency *(see definition below)*, 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, the telemedicine provider will advise you to locate the the closest participating in-network urgent care facility (refer to the *Find A Network Health Care Provider* section of this guide).
3. Present your member ID to the front office personnel when you arrive at urgent care. The urgent care staff will contact the program to verify your eligibility status. If you have not activated your membership or if your monthly contributions are not current, the services will automatically be deemed ineligible for sharing.
4. A consult fee is due at the time of service. If x-ray services are required, there is a $25 dollar fee for the image read, which is your responsibility. Costs may be higher depending on your state and provider.

Life-threatening Emergency. A potentially fatal injury or illness that if not treated immediately would lead to disability or death.

Emergency Room

Participating In-network Services
Value: full MSRA Plus: unlimited visits l $500 consult fee Premium: unlimited visits l $300 consult fee

Emergency room visits are eligible for cost sharing for life-threatening emergencies only. Life-threatening emergencies are defined as potentially fatal injuries or illnesses that, if not treated immediately, would lead to 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.

Emergency services are provided for stabilization or initiation of treatment of an emergency medical 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. Trinity HealthShare must be notified of all ER visits within 48 hours.

If you are experiencing a life-threatening emergency, call 911 or go to the emergency room. It is your responsibility to know which providers in your area are participating in the network associated with your program before a life-threatening emergency occurs. Please refer to the *Find A Network Health Care Provider* section of this guide or contact member services today and a representative will be happy to help you identify a provider listed under the network associated with your program.

If you are not experiencing a life-threatening emergency, you're encouraged to utilize telemedicine, visit your PCP, or go to an urgent care facility for treatment whenever possible. It is still important to call the provider to verify participation in the network associated with your Trinity program prior to scheduling your appointment(s) and incurring medical expenses that may or may not be eligible for sharing.

Emergency Room Limitations

- **Pre-existing Conditions.** Refer to *Pre-existing Conditions* section of this member guide for details.

Lab Work & X-rays

Participating In-network Services
Value: included at PCP Plus: included at PCP or urgent care Premium: included at PCP or urgent care

Any lab work or x-rays conducted by a participating in-network PCP, urgent care or specialist (Plus and Premium programs only) during an eligible routine visit are included. If x-rays are required, a $25 x-ray read fee will be due at time of service.

Imaging (CT scans, PET scans, MRIs), labs, x-rays and diagnostic imaging in an inpatient or outpatient hospital setting are eligible for cost sharing with a co-expense after MSRA has been met.

Neither lifestyle lab testing nor independent lab testing is eligible for sharing.

Prescriptions

Prescription Discount Program: included with contribution
No consult fee, co-expense or MSRA applies

Rx Valet can provide members with substantial prescription discounts, though savings may vary from month to month depending on the fluctuation of pricing by formularies. This prescription discount program* is available immediately upon enrollment. See the *Getting Started* section of this member guide to register with Rx Valet and start taking advantage of the savings.

Rx Valet 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 the Rx Valet live customer care team at **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
NPI: 1174830475

Fax: 888-415-7906
NCPDP: 4229971

**If membership fees are not paid to date, members are not eligible to set up or use the prescription discount program.*

Services Eligible for Sharing After Meeting the MSRA

The following sections outline the services available to you AFTER meeting the MSRA.

Service Eligibility Verification

Non-emergency Surgery, Procedure or Test. The member must contact *member services* to verify service eligibility for the following procedures or services prior to receiving them. Failure to comply with this requirement will render the service not eligible for sharing.

- Cardiac Testing, Procedures & Treatments
- EMG/EEG/EKG
- Infusion Therapy Within Facility
- Outpatient Surgical Procedures
- Radionuclide Imaging
- Occupational Therapy
- Ophthalmic Procedures
- Physical Therapy
- Sleep Studies (must be completed in one session)
- Speech Therapy (eligible for sharing under limited circumstances only)

Specialty Care

Participating In-network Services
Value: not eligible Plus: not eligible Premium: $75 After MSRA I If MSRA has not been met, member is responsible for a $75 consult fee in addition to the cost of the specialty care visit. This consult fee does not apply toward the MSRA.

For most everyday medical conditions, your primary care provider is your one-stop medical shop. However, there are cases when it's time to see a specialist who has received additional training and has been board certified for that specialty. For situations like these, your program may provide specialty care services at the cost of a consult fee to be paid at the time of service.

Trinity members are required to obtain a referral before visiting a specialist.
Without a referral, specialty visits are automatically deemed not eligible for sharing.

Specialty Care Limitations

- **Mental Health.** Everyday Premium members are eligible for $2,500 (max) for psychotherapy office visits and $1,000 (max) at outpatient facilities. Everyday Value and Plus programs do not include this service.
- **Occupational Therapy.** Everyday Value and Plus members receive up to six (6) visits total per program year at inpatient and outpatient facilities. Everyday Premium members receive up to six (6) visits total per program year at inpatient, outpatient *and* specialty facilities.
- **Physical Therapy.** Everyday Value and Plus members receive up to six (6) visits total per program year at inpatient and outpatient facilities. Everyday Premium members receive up to six (6) visits total per program year at inpatient, outpatient *and* specialty facilities.
- **Sleep Testing (overnight).** 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 will require *service eligibility verification*. Allowed charges will not exceed the usual, customary, and reasonable charges for the area.
- **Speech Therapy.** Everyday Value and Plus members receive up to six (6) visits total per program year at inpatient and outpatient facilities. Everyday Premium

members receive up to six (6) visits total per program year at inpatient, outpatient *and* specialty facilities. Service only eligible for sharing after a stroke.

Hospitalization & Surgical

Participating In-network Services for Inpatient/Outpatient Hospitalization and Surgery
All Tiers: after MSRA has been met, program shares 100% of eligible medical expenses

In order to help alleviate stress and strain during times of crisis or medical need, hospitalization, as well as many inpatient and outpatient surgery procedures are eligible for sharing after MSRA has been met.

1. Members are required to verify service eligibility for all hospitalization & surgical services/visits unless it is an obvious medical emergency. Please see the *Service Eligibility Verification* section of this guide for instructions.
2. Members are responsible to pay the MSRA before any cost sharing will be available. Once the MSRA has been reached in full, sharing will directly reimburse the providers and hospital facilities.
3. Several programs allow for fixed cost sharing in the emergency room.

Inpatient Limitations

- **Occupational Therapy.** Everyday Value and Plus members receive up to six (6) visits total per program year at inpatient and outpatient facilities. Everyday Premium members receive up to six (6) visits total per program year at inpatient, outpatient *and* specialty facilities.
- **Organ Transplant Limit.** Eligible medical expenses for 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. Medical expenses for multiple organ transplants will be considered on a case-by-case basis.
- **Physical Therapy.** Everyday Value and Plus members receive up to six (6) visits total per program year at inpatient and outpatient facilities. Everyday Premium members receive up to six (6) visits total per program year at inpatient, outpatient *and* specialty facilities.
- **Pre-existing Conditions.** Refer to *Pre-existing Conditions* section of this member guide for details.

- **Speech Therapy.** Everyday Value and Plus members receive up to six (6) visits total per program year at inpatient and outpatient facilities. Everyday Premium members receive up to six (6) visits total per program year at inpatient, outpatient *and* specialty facilities. Service only eligible for sharing after a stroke.

- **Surgical.** Non-life-threatening surgical services are not available for the first 60 days of membership for Everyday Premium programs and all other programs require a six (6) month waiting period. Surgical services do not include cosmetic surgery. Please verify service eligibility by calling Member Services before receiving any surgical services.

Outpatient Limitations

- **Mental Health.** Everyday Premium members are eligible for $2,500 (max) for psychotherapy office visits and $1,000 (max) at outpatient facilities. Everyday Value and Plus programs do not include this service.

- **Occupational Therapy.** Everyday Value and Plus members receive up to six (6) visits total per program year at inpatient and outpatient facilities. Everyday Premium members receive up to six (6) visits total per program year at inpatient, outpatient *and* specialty facilities.

- **Physical Therapy.** Everyday Value and Plus members receive up to six (6) visits total per program year at inpatient and outpatient facilities. Everyday Premium members receive up to six (6) visits total per program year at inpatient, outpatient *and* specialty facilities.

- **Pre-existing Conditions.** Refer to *Pre-existing Conditions* section of this member guide for details.

- **Sleep Testing (overnight).** 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 will require *service eligibility verification*. Allowed charges will not exceed the usual, customary, and reasonable charges for the area.

- **Speech Therapy.** Everyday Value and Plus members receive up to six (6) visits total per program year at inpatient and outpatient facilities. Everyday Premium members receive up to six (6) visits total per program year at inpatient, outpatient *and* specialty facilities. Service only eligible for sharing after a stroke.

- **Surgical.** Non-life-threatening surgical services are not available for the first 60 days of membership for Everyday Premium programs and all other programs require a six (6) month waiting period. Surgical services do not include cosmetic surgery. Please verify service eligibility by calling Member Services before receiving any surgical services.

Extended Continuum of Care

Trinity programs provide access to additional services to help ensure you get the care you need, when you need it.

Pre-existing Conditions

Value I Plus I Premium
Primary care, pediatric, OB/GYN, specialty care and urgent care services for pre-existing conditions are eligible for sharing consideration upon effective date. Otherwise, hospitalization, surgery and emergency room services for pre-existing conditions are eligible for sharing after a 24-month waiting period. On the 25th month of continuous membership, the pre-existing condition will no longer be subject to these cost-sharing limitations.

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, seizure, abnormal results from a test administered by a medical practitioner.

The following restrictions are only applicable to pre-existing conditions and do not affect normal sharing for other non-pre-existing related incidents, events, etc.

1. Chronic or recurrent conditions that have evidenced signs/symptoms and/or received treatment and/or medication within the past 24 months are not eligible for sharing during the first 24 months of membership.
2. Upon inception of the 25th month of continuous membership and thereafter, the conditions may no longer be subject to the pre-existing condition sharing limitations.
3. Appeals may be considered for earlier sharing in surgical interventions when it is in the mutual best interest of both the members and the membership to do so.

Cancer Care

TrinityCare Everyday Value I Plus I Premium
Health care services for new occurrences of cancer following enrollment are eligible for sharing after 12 months of continuous membership. Pre-existing or recurrences of cancer are not eligible for sharing. If previously diagnosed with cancer, members must be cancer-free for five (5) years before being considered eligible to share for new cancer occurrences.

Cancer sharing will not be available for individuals who have cancer at the time of or five (5) years prior to enrollment. If cancer existed outside of the 5-year time frame of a pre-existing lookback, the following must be met in the five (5) years prior to enrollment, 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.

Eligibility for Cancer Sharing Requests

For inpatient hospital admissions related to cancer of any type (e.g. breast, colorectal, leukemia, lymphoma, prostate, skin, etc.), the member must meet the following requirements in order for the admission to be eligible for sharing:

- 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 MSRA(s) has been assessed to the member for inpatient cancer hospitalization.
- Early detection provides the best chance for successful treatment and in the most cost-effective manner. Membership requires that all members age 40 and older receive appropriate screening tests every two years – mammogram or thermography and pap smear with pelvic exams for women and PSA testing for men. **Failure to obtain biennial mammograms and gynecological tests listed above for women or PSA tests for men will render future medical expenses for breast, cervical, endometrial, ovarian or prostate cancer ineligible for sharing.**

Cancer Limitations

- **Cancer.** Cancer sharing is limited to the Per Incident Maximum Limit of $150,000 for Everyday Value, $250,000 for Everyday Plus, $500,000 for Everyday Premium

when applicable.

Maternity

- **Maternity.** All Trinity Everyday tiers include sharing eligibility for prenatal maternity services immediately at the PCP or OB/GYN.
    - **Everyday Value and Plus**: Maternity delivery services are not eligible for cost sharing.
    - **Everyday Premium**: Offers some maternity services which may be eligible for cost sharing after the first ten months of continuous membership and after MSRA has been met. After MSRA, physician services for vaginal delivery are eligible for cost sharing up to $5,000, physician services for caesarean delivery are eligible for cost sharing up to $8,000, and most health care services related to complications of mother and child are eligible for cost sharing up to $50,000.
    - Hospitalization services for some maternity medical expenses are eligible for sharing at the program co-expense.

Mental Health

- **Mental Health.** Everyday Premium members are eligible for $2,500 (max) for psychotherapy office visits and $1,000 (max) at outpatient facilities. Everyday Value and Plus programs do not include this service.

Limits of Sharing

Total eligible medical expenses shared from member contributions are limited as defined in this section and as further limited in each section of this member guide, or in writing to the individual member.

- **Lifetime Limits.** $1,000,000: the maximum amount shared for eligible medical expenses over the course of an individual member's lifetime.
- **Ambulance**. Ground ambulance services to the nearest medical facility capable of providing the care needed to avoid seriously jeopardizing the sharing member's life or health are eligible for sharing and only subject to the program year maximum limit. Air ambulance services are eligible for sharing up to a $10,000 maximum sharing limit.
- **Cancer.** Cancer sharing is limited to the Per Incident Maximum Limit of $150,000 for Everyday Value, $250,000 for Everyday Plus, $500,000 for Everyday Premium when applicable.
- **Mental Health.** Everyday Premium members are eligible for $2,500 (max) for psychotherapy office visits and $1,000 (max) at outpatient facilities. Everyday Value and Plus programs do not include this service.
- **Maternity.** All Trinity Everyday tiers include sharing eligibility for prenatal

maternity services immediately at the PCP or OB/GYN.
    - **Everyday Value and Plus**: Maternity delivery services are not eligible for cost sharing.
    - **Everyday Premium**: Offers some maternity services which may be eligible for cost sharing after the first ten months of continuous membership and after MSRA has been met. After MSRA, physician services for vaginal delivery are eligible for cost sharing up to $5,000, physician services for caesarean delivery are eligible for cost sharing up to $8,000, and most health care services related to complications of mother and child are eligible for cost sharing up to $50,000.
    - Hospitalization services for some maternity medical expenses are eligible for sharing at the program co-expense.

- **Occupational Therapy.** Everyday Value and Plus members receive up to six (6) visits total per program year at inpatient and outpatient facilities. Everyday Premium members receive up to six (6) visits total per program year at inpatient, outpatient *and* specialty facilities.

- **Organ Transplant Limit.** Eligible medical expenses for 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. Medical expenses for multiple organ transplants will be considered on a case-by-case basis.

- **Physical Therapy.** Everyday Value and Plus members receive up to six (6) visits total per program year at inpatient and outpatient facilities. Everyday Premium members receive up to six (6) visits total per program year at inpatient, outpatient *and* specialty facilities.

- **Pre-existing Conditions.** Refer to *Pre-existing Conditions* section of this member guide for details.

- **Sleep Testing (overnight).** 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 will require *service eligibility verification*. Allowed charges will not exceed the usual, customary, and reasonable charges for the area.

- **Speech Therapy.** Everyday Value and Plus members receive up to six (6) visits total per program year at inpatient and outpatient facilities. Everyday Premium members receive up to six (6) visits total per program year at inpatient, outpatient *and* specialty facilities. Service only eligible for sharing after a stroke.

- **Surgical.** Non-life-threatening surgical services are not available for the first 60 days of membership for Everyday Premium programs and all other programs require a six (6) month waiting period. Surgical services do not include cosmetic surgery. Please verify service eligibility by calling Member Services before receiving any surgical services.

- **Other Resources.** Services available to the member from other sources such as

insurance, VA, Tricare, private grants, 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 those sources do not pay, the member is authorized to submit the excess medical expenses for sharing. Sharing of monthly contributions for a medical expense 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 medical expenses incurred on or after the membership effective date are eligible for sharing. 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, standard industry claim forms, a copy of the itemized bill(s) and medical records, if necessary.

Lifestyles or activities engaged in after the enrollment date that conflict with the Statement of Beliefs are not eligible for sharing. Medical expenses arising from any one of the following are not eligible for sharing, either:

1. Abortion Services
2. Acupuncture Services
3. Aqua Therapy
4. Biofeedback
5. Birth Control (female) Office Procedure
6. Birth Control (male) Elective Sterilization
7. Birth Control (male) Reversal of Sterilization
8. Cataracts, Contacts or Glasses
9. Chemical Face Peels
10. Chiropractic Services
11. Christian Science Practitioner
12. Cosmetic Surgery
13. CPAP Machines
14. Custodial Care Services
15. Dental Services
16. Dermabrasion Services
17. Doula or Midwife
18. Durable Medical Equipment
19. Education Services
20. Exercise Equipment
21. Experimental Drugs & Procedures
22. Extreme sports: Sports that voluntarily put an individual in a life-threatening situation
23. Gender Dysphoria
24. Genetic Testing
25. Home Health Care Services & Private Duty Nursing
26. Hospice Services

27. Hypnotherapy Services
28. Infertility Services
29. Lifestyle Lab Testing
30. Mammogram (3D)
31. Massage Therapy
32. Mental Health Services (Inpatient or Residential)
33. MILIEU Situational Therapy Services
34. Non-routine Hearing Exams & Hearing Aids
35. Ongoing Pain Management
36. Professional & Extreme Sports Injuries
37. Prosthetic Appliances
38. Self-inflicted Injury
39. Sexual Dysfunction Services
40. Sexual Transformation Services
41. Skilled Nursing Facility
42. Substance/Alcohol Abuse
43. TMJ Treatment
44. Vision Services
45. Wigs

PART II: How Your Health Care Cost Sharing Ministry (HCSM) Works

Membership

This is a voluntary program offered by Trinity Healthshare, Inc., a Health Care Sharing Ministry (HCSM). An HCSM is a group of individuals who share a common set of ethical or religious beliefs and voluntarily choose to share in the payment of their medical expenses in accordance with those beliefs, without regard to the state in which a member resides or is employed. Membership cannot be transferred to anyone other than the member and his/her eligible enrolled dependents.

Services are offered on a faith-based tradition of mutual aid, neighborly assistance, and burden sharing. Trinity is specifically tailored for individuals who maintain a healthy lifestyle, make responsible choices regarding health and care, and believe in helping others. As an HCSM, Trinity does not subsidize self-destructive behaviors or lifestyles. Trinity is **NOT** insurance and provides no guarantee to pay.

All Trinity HealthShare (Trinity) members are required to declare their acknowledgment of the Statement of Beliefs and to attest that they are of like mind with those beliefs.

Statement of Beliefs

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 he/she is in need according to 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.

Disclaimer; No Promise to Pay

Trinity HealthShare (Trinity) is a Health Care Sharing Ministry (HCSM), not an insurance company, and does not offer any insurance products or policies. As such, Trinity does not assume any risk for medical expenses and makes no promise to pay. Trinity offers voluntary participation in its HCSM programs, which are not governed by insurance laws.

Trinity does not provide a promise to pay or any guarantee of payment for medical expenses. Since Trinity does not assume the member's risk, the member is responsible for payment of his/her medical bills. Trinity does not guarantee that medical expenses will be shared by other members who utilize the health care

sharing services provided by Trinity.

Voluntary Participation

Trinity members are voluntary participants of an HCSM program. Enrollment, membership and participation in a Trinity HCSM program, such as the sharing of monetary contributions, is voluntary. Enrollment is not a contract. Members are free to withdraw participation at any time. Trinity requests a “monthly contribution” amount to be collected from members to facilitate the sharing of eligible medical expenses.

Guidelines

Trinity manages contributions by establishing the guidelines that generally define the sharing of eligible expenses between members of the Trinity HCSM (“Guidelines”), and more specifically defines the sharing of eligible expenses between members of each Trinity program outlined in the individual member guide(s) provided at the time of enrollment. The Guidelines and Trinity member guides are not contracts and do not constitute an agreement, a promise to pay, or an obligation to share.

The Guidelines are intended to ensure that every member has paid his/her own medical expenses as they are financially able before requesting others to share in the cost of remaining eligible medical expenses. The Guidelines generally define when a member is eligible for sharing requests, while individual member guide(s) detail what type of expenses may be eligible for sharing per program, including specific limitations, exclusions and requirements for sharing eligibility, so all members can expect a reasonable and equitable level of sharing. The amounts of sharing requests will be published monthly in a newsletter to members.

Trinity programs may exclude or have sharing limitations for pre-existing conditions. Members are required to fully disclose pre-existing conditions as part of their enrollment in Trinity programs. Trinity reserves the right, on behalf of members, to exclude sharing eligibility for any pre-existing conditions, whether disclosed at the time of enrollment or discovered after the effective date of membership. Furthermore, a member is not eligible for sharing when a member (i) receives care within the first 60 days of the program and cancels membership within 30 days of receiving medical care, except within the last 90 days of the membership term, or (ii) receives or requires surgery within the first 60 days of becoming a member, except in the case of an accident.

Trinity reserves the right to make updates to the Guidelines and member guides at any time on behalf of its HCSM program members. The Guidelines and member guides in effect at the time of service will supersede all previous versions of the Guidelines and member guides. Members will be notified of updates.

Sharing Requests and Use of Funds

After receiving an eligible sharing request from a member or a provider, Trinity HealthShare will assign the eligible expense(s) for sharing, less the amount of personal responsibility required, called the Member Shared Responsibility Amount (MSRA).

Voluntary “monthly contributions” are received from each member, each month. Up to 30% of membership contributions may be applied towards administration of Trinity HealthShare programs, charitable causes, or general overhead costs, not including marketing costs to grow the membership. Administrative costs are subject to change by Trinity HealthShare and may be applied towards other charitable causes or general overhead costs.

HCSM Tax Matters

Members should always consult with a tax professional to determine whether participation will have tax implications.

Individuals Helping Individuals

Contributors participating in the membership help individuals with their eligible medical expenses. Trinity HealthShare facilitates in this assistance, dispersing monthly contributions as described in the membership 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. 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 membership on his/her enrollment date, based on the criteria set forth in this guidebook and the membership enrollment form. If, at any time, it is discovered that a member did not submit a complete and accurate medical history on the membership enrollment form, a retroactive membership limitation, or a retroactive denial to his/her effective date of membership may be applied.

Enrollment, Acceptance and Effective Date. A person must submit a complete membership enrollment form and attest to the Statement of Beliefs. The membership begins on a date specified by Trinity HealthShare in writing to the member.

Dependent(s). The head of household’s spouse or unmarried child(ren), ages 26 and younger, who are the head of household’s dependent by birth, legal adoption, or marriage who is participating under the same combined membership. A dependent may participate under a combined membership with the head of household. 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.

A dependent who wishes to continue participating in the membership but no longer qualifies under a combined membership must apply and qualify for a membership based on eligibility criteria.

Financial Participation. Monthly contributions should 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 within 45 days, membership will become inactive as of the last day of the month in which a monthly contribution was received.

Any member who has a membership that has become inactive will be able to reinstate their membership under the terms as outlined by Trinity HealthShare in writing. A member will not be able to reinstate their membership if they have allowed their membership to become inactive a total of three times. Share requests occurring after a member's inactive account date but before they reapply will not be considered eligible for sharing.

Other Criteria. Children under the age of 18 may not qualify for their own membership.

When Available Shares are Less than Eligible Medical Expenses

In any given month, the available suggested share amounts may or may not meet the total amount of eligible medical expenses submitted for sharing. If a member's eligible bills exceed the available shares to meet those medical expenses, the following actions may be taken:

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

Refunds

If you cancel your membership within 10 days of the effective date of the membership, you are entitled to a full refund, including the one-time enrollment fee. Any cancellation requests processed more than 10 days from the scheduled billing date will NOT receive a refund, and the membership will remain active until the end of that billing period. Refunds will be processed as a credit to the same card or account provided for billing. Requests involving refunds payable by check may be delayed up to 30 business days.

Program Change/Switch Policy

Members wishing to switch to a program type other than that which they are currently participating may, at the discretion of Trinity HealthShare, be required to submit an Individual Program Change/Switch Form for review. Membership changes to an existing program or switches to a new program will only become effective on the applicable effective date after the new program enrollment has been evaluated for eligibility.

1. When switching from one annual program category to another (i.e. TrinityCare to CarePlus) your program will be reset as if it is a new enrollment. This rule does not apply when transitioning from an InterimCare program.
2. You are allowed to switch programs two times per membership year. The first program switch will not incur any additional fees; the second will incur an enrollment fee of the new program. Program switches are subject to a 30-day review and approval process.

Voluntary Termination Policy

Members of Trinity HealthShare programs may voluntarily terminate their membership at any time. Members wishing to discontinue participation in the program must complete a cancellation form including the reason for discontinuing participation in the membership.

Post-termination Sharing Policy

To ensure equitable sharing opportunities for all program participants, any share requests received within 60 days of a cancellation are subject to review by Trinity HealthShare, on behalf of program participants, for eligibility.

Contributors' Instructions & Conditions

By submitting monthly contributions, the contributor instructs Trinity HealthShare to share contributions in accordance with the membership guidelines. Each contributor designates Trinity HealthShare as the final authority for the interpretation of these guidelines. By participation in the membership, all members accept these conditions.

Dispute Resolution & Appeal

Trinity HealthShare is a voluntary association of like-minded people who come together to assist each other by sharing medical expenses without establishing legal obligations.

However, it is recognized that differences of opinion may 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 valid 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 (through the member services team) 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 disagreement and the relevant facts. Make sure the appeal addresses the following items:

1. What information in the determination is either incomplete or incorrect?
2. How do you believe the information already on hand has been misinterpreted?
3. Which provision in the Member Guide do you believe was 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.

Appendices

Appendix A: Abbreviations & Definitions

Many of the terms used in describing health cost sharing may be unfamiliar to those new to the programs and programs provided by Trinity. This section provides a quick and easy reference to help you understand the terms used in this guide and other program documents.

Abbreviations

- **ACA** Affordable Care Act
- **DEA** Drug Enforcement Administration
- **DME** Durable Medical Equipment
- **HCSM** Health Care Sharing Ministry
- **MSRA** Member Shared Responsibility Amount
- **PCP** Primary Care Provider
- **PPO** Participating Provider Organization

Definitions

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.

Co-expense: A stated percentage of medical expenses that the member is required to pay after the MSRA has been met. Cost sharing is not available for co-expense amounts, unless the out-of-pocket maximum is exceeded.

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

Consult Fee. A fixed dollar amount due from the member when a medical service is rendered.

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

Dependent(s). The head of household's spouse or unmarried child(ren), ages 26 and younger, who are the head of household's dependent by birth, legal adoption, or marriage who is participating under the same combined membership.

Eligible. Medical expenses that qualify for voluntary sharing of contributions from members in accordance with membership guidelines and subject to the sharing limits.

Effective Date. The date a member's membership becomes effective and medical expenses become eligible as sharing requests.

Enrollment Date. The date Trinity HealthShare receives a complete membership enrollment form.

Facility. A physical location that provides medical services, included but not limited to, primary care facilities, urgent care facilities, specialty care facilities, clinics, hospitals and ambulatory surgical centers.

Life-threatening Emergency. A potentially fatal injury or illness that if not treated immediately would lead to disability or death.

Member(ship) Guide. The document that contains the criteria used to determine eligibility for participation in the membership, application of membership limitations, and eligibility of medical expenses for sharing.

Member Shared Responsibility Amount (MSRA). The MSRA reflects the amount of personal responsibility and stewardship members are expected to demonstrate; in other words, the amount a member must pay before asking others in the program to share in the cost of medical expenses. See the *What is a Member Shared Responsibility Amount* section of this guide for more details.

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

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

Out-of-pocket Maximum. This is the most a member pays for eligible services in a program year. After a member pays the MSRA and co-expenses, the program shares 100% of eligible services up to the per-incident maximum or lifetime maximum limits. The out-of- pocket maximum does not include monthly contributions.

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, seizure, abnormal results from a test administered by a medical practitioner.

Share (Sharing) Request. A request submitted to Trinity HealthShare for eligible medical expenses to be paid by the membership.

Sharing Instructions. Instructions contained on the membership enrollment form outlining the order in which voluntary monthly contributions may be shared by Trinity HealthShare.

Trinity HealthShare. A 501(c)(3) non-profit organization that provides HCSM services to guide the cost sharing of member contributions for certain eligible health care expenses such as hospitalization, surgery and emergency room visits.

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

Appendix B : Terms, Conditions & Special Considerations

1. Keep your member ID card with you at all times and present it to all providers to confirm your status as a Trinity HCSM member.
2. Activate your program membership by following the instructions in this member guide.
3. Telemedicine. Set up your telemedicine account by following the instructions in the *Getting Started* section of this member guide. You will also receive the same instructions in an electronic welcome letter, as well as printed version in the mail.
    - Telemedicine is subject to state regulations and may not be available in certain states.
    - Telemedicine phone and face-to-face internet consultations are available 24/7/365.
    - Telemedicine does not guarantee that a prescription will be written.

Telemedicine providers do 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.

- Trinity telemedicine partners do not replace the primary care provider.

4. Durable Medical Equipment (DME) – i.e. crutches, etc. – is not included in your program. Members will be charged for DME at time of service.
5. Trinity HealthShare cannot guarantee a provider will accept a Trinity HCSM program if the member fails to contact *member services* before services are rendered. Member services representatives are available to confirm eligibility and answer your questions. Refer to the *Contact Member Services* section of this guide for phone numbers and hours of service.
6. Programs may vary from state to state. Providers may be added or removed from Trinity networks at any time without notice.
7. 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 services that are referenced in this guide.
8. Most network facilities are able to accommodate both urgent care and primary care situations.
9. While Trinity HealthShare offers access to one of the largest networks of providers in the country, some in-network providers may not participate Trinity HCSMs.

Disclaimer

After receiving an eligible sharing request from a member or a provider, Trinity HealthShare will assign the eligible expense(s) for sharing, less the amount of personal responsibility required, called the Member Shared Responsibility Amount (MSRA).

Voluntary “monthly contributions” are received from each member, each month. Up to 30% of membership contributions may be applied towards administration of Trinity HealthShare programs, charitable causes, or general overhead costs, not including marketing costs to grow the membership. Administrative costs are subject to change by Trinity HealthShare and may be applied towards other charitable causes or general overhead costs.

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 expenses related to your eligible medical expenses 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 expenses, or whether or not this membership continues to operate, you will remain financially liable for any and all unpaid medical expenses.

This is not a legally binding agreement to reimburse any member for medical expenses 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 expenses 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.

Disclosures

1. Trinity HealthShare, the Trinity HealthShare logo, and other program or service logos are trademarks of Trinity HealthShare, Inc. and may not be used without written permission.
2. Trinity HealthShare programs are NOT insurance. 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. Trinity HealthShare programs offer services only to members and dependents on your program.
4. Trinity HealthShare reserves the right to interpret the terms of this membership to determine the level of medical expenses shared by the HCSM membership.
5. This membership is issued in consideration of the member's enrollment form and the member's payment of a monthly fee as provided under these programs. Omissions and misstatements, or incorrect, incomplete, fraudulent, or intentional misrepresentation in your enrollment form may void your membership, and services may be denied.

Appendix C : Legal Notices

The following legal notices are required by state law, and are intended to notify individuals that health care sharing ministry programs are not insurance, and that the ministry does not provide any guarantee or promise to pay your medical expenses.

GENERAL LEGAL NOTICE

This organization facilitates the sharing of medical expenses but is not an insurance company, and neither its guidelines nor plan of operation is an insurance policy. Sharing is available for all eligible medical expenses; however, 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 or your provider receive any payments for medical expenses and whether or not this program continues to operate, you are always liable for any unpaid bills. This health care sharing ministry is not regulated by the State Insurance Departments. You should review this organization's guidelines carefully to be sure you understand any limitations that may affect your personal medical and financial needs.

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

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 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. 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.

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 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 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.

Virginia Code 38.2-6300-6301

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

Trinity HealthShare programs are not available in AK, CO, CT, HI, MA, MD, ME, MT, ND, NH, OR, PA, PR, SD, TX, VT, WA, WY or Washington, D.C. Limitation subject to change without prior notice. Due to regulatory limitations regarding compensation, Trinity HealthShare programs will no longer be sold in Massachusetts or Pennsylvania.

TRINITYCARE℠ EVERYDAY

TRINITY℠ HealthShare

PO BOX 28220 Atlanta, GA 30358
Toll Free 844-834-3456

Guidelines for Christian Conciliation

Version 2019/January

ICC Peace, LLC

Institute for Christian Conciliation™

306-N West El Norte Parkway #29

Escondido, CA 92026

www.iccpeace.com or www.instituteforchristianconciliation.com

844-707-3223

Guidelines for Christian Conciliation
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Part II—Rules of Procedure for Christian Conciliation[3]
Institute for Christian Conciliation™
Version 2019/January

[3] Part II – The *Rules of Procedure for Christian Conciliation* may be used independently of the *Guidelines for Christian Conciliation.* www.instituteforchristianconciliation.com.

agreement, the parties agree that the arbitrators may consider any information they received during mediation as though it were received during arbitration, in full compliance with the Arbitration Rules.

E. Whenever mediators are authorized to act as arbitrators pursuant to this Rule, the parties, after signing the appropriate documents, may either (1) summarize the information that was received during mediation, make closing statements, and then rest their cases; or (2) proceed to offer new information pursuant to the Arbitration Rules.

F. Whenever new arbitrators are appointed pursuant to this Rule, the arbitrators may not call the previous mediators as witnesses without the unanimous agreement of the parties and the mediators.

C. ARBITRATION RULES

25. Description of Issues and Remedies

At the outset of arbitration, the parties shall describe the issues and desired remedies that they wish the arbitrators to consider. The arbitrators shall consider only those issues that are consistent with the parties' original arbitration or mediation/arbitration agreement, or which are contemplated by an earlier contract between the parties that contains a conciliation clause.

26. Approval of Panel

At the outset of arbitration, the parties shall sign forms approving the appointment of the arbitrators. If the parties refuse or are unable to agree on arbitrators, arbitrators shall be appointed pursuant to Rule 10.

27. Oaths or Vows

Before proceeding with arbitration, each arbitrator may take an oath or vow of office. The arbitrators have discretion to require parties or witnesses to testify under oath or vow, provided that making an oath or vow does not violate the person's sincerely held religious beliefs. Oaths or vows may be administered by the arbitrators.

28. Pre-hearing Conferences and Preliminary Hearings

A. At the request of the parties or at the discretion of the Administrator, a preliminary conference with a case administrator and the parties may be scheduled to arrange for an exchange of information and the stipulation of uncontested facts to expedite the arbitration proceedings.

B. In large or complex cases, at the discretion of the arbitrators or the Administrator, a preliminary hearing may be scheduled with the arbitrators and the parties to arrange for the production of relevant evidence, to identify potential witnesses, to schedule further hearings, and to consider other matters that will expedite the arbitration proceedings.

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www.sfclasslaw.com

Stephen J. Fearon, Jr.
stephen@sfclasslaw.com

April 28, 2020

VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED

The Aliera Companies, Inc.
990 Hammond Drive
Suite 700
Atlanta, GA 30328

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

RE: NOTICE OF VIOLATION OF GEORGIA FAIR BUSINESS PRACTICES ACT

To The Aliera Companies, Inc. and Aliera Healthcare, Inc.:

My firm represents Noelle LeCann and Kristin Selimo, two unrelated individuals who owned or own purported Aliera Health Care Sharing Ministry policies (together, "Claimants").

Ms. LeCann owned an Aliera policy from 2018 until late 2019 and paid approximately $1,700 per month for family coverage for her and her spouse. Despite paying the required premiums and receiving a pre-authorization from Aliera, Aliera has refused to pay medical bills for a shoulder surgery that was performed on Ms. LeCann in 2019. Aliera also unreasonably delayed and protracted Ms. LeCann's attempts to resolve her claim dispute.

Ms. Selimo has owned an Aliera policy since January 2018 and has paid approximately $900 per month for family coverage for her, her spouse, and her two children. Despite paying the required premiums, Aliera has refused to pay medical bills relating to Ms. Selimo's pregnancy and her October 2019 labor and delivery, as well as medical bills for an emergency room visit for Ms. Selimo's daughter who had suffered a seizure. Despite assurances that the medical bills would be covered, Aliera has unreasonably delayed and protracted payment and the bills will soon be placed in collections.

I am writing under O.C.G.A. § 10-1-399(b) to describe unfair and deceptive business practices that Aliera has engaged in that violate the Georgia Fair Business Practices Act; to provide Aliera with a demand for relief that remedies the injuries that Aliera has caused Claimants and other policyholders/members; and to inform Aliera that if it does not provide the requested relief, Claimants are going to bring a class action claim under the Georgia Fair Business Practices Act against The Aliera Companies, Inc. and Aliera Healthcare, Inc. on behalf of themselves and the class of similarly situated policyholders described below.

A. Unfair and Deceptive Business Practices Prohibited by the Georgia Fair Business Practices Act

Aliera has engaged in a course of unfair and deceptive business practices while selling and managing Claimants' policies and other policies, including making misrepresentations, failing to disclose necessary information, and retaining an unconscionable amount of the premiums paid by policyholders to enrich Aliera and its owners. Aliera's deceptive and unfair business tactics have been described in litigation filed by Aliera's former business partner, orders issued by the court in that case, cease and desist orders and investigations by state regulators, and lawsuits filed by other policyholders.

1. Aliera's Misrepresentations

Aliera has made numerous misrepresentations regarding the nature of the policies in its offering materials, member guides, website, and on membership identification cards, including that:

- Aliera was an HCSM when it was not an HCSM and could not be an HCSM because it did not meet the legal requirements of an HCSM;
- The policies were *not* insurance when, in fact, the policies are illegal insurance contracts, and Aliera is not legally authorized to sell insurance;
- Premiums would be paid to cover policyholders' medical expenses when 80% or more of premiums were being retained by Aliera to benefit Aliera and its owners and executives;
- Claim issues could be resolved through a *legitimate* and *meaningful* dispute resolution process when that dispute resolution process was illegal and was intentionally designed to be a central part of Aliera's deceptive and unfair claims settlement practices and part of Aliera's scheme to misappropriate members' payments; and
- Many of the facilities and health care providers identified by Aliera in its materials do not have agreements with Aliera to provide medical services to Aliera's members.

2. Aliera's Omissions

Aliera failed to disclose information in offering documents and policyholder materials that policyholders needed to know when weighing purchasing Aliera's plans and making their healthcare choices and when deciding whether to continue paying premiums, including that:

- Aliera was created by Timothy Moses and his family for his and his family's benefit, and that Mr. Moses was a felon and had previously been convicted of securities fraud and perjury and had his parole revoked because he lied about his financial assets;
- Mr. Moses instructed his wife and son to run Aliera but made many of the decisions about Aliera's business and the plans;
- Aliera's former partner, Anabaptist Healthshare, severed its ties to Aliera and the Moseses after discovering that Aliera and Mr. Moses were lying and misappropriating funds for their own benefit;

- A number of courts, state regulators, and attorneys general have found Aliera is not a legal HCSM and have enjoined Aliera from selling illegal insurance in their respective states and/or have warned consumers against purchasing the plans;

- Because the policies are insurance, members are entitled to protections under federal and state laws that prohibit unfair claim settlement practices, multilevel internal appeals processes, and binding arbitration; and

- Aliera has engaged in a pattern and practice of delaying and denying claims.

3. Litigation and Regulatory Actions Across the Country Involving Aliera's Unfair and Deceptive Business Practices

Aliera's unfair and deceptive practices (including the deceptive and unfair practices of its owners) have been the subject of a slew of litigation and regulatory interventions by attorneys general and insurance commissioners.

Aliera formerly did business with Anabaptist Healthshare, Inc. but was sued by that company in Georgia after Anabaptist Healthshare uncovered evidence that Aliera was self-dealing and misappropriating funds from plan members. The Georgia court there issued an order appointing a receiver to provide oversight of Aliera's administration of Anabaptist Healthshare funds, making numerous findings supporting its decision, including that:

- Aliera demonstrated a lack of transparency with respect to the funds;

- Aliera held and controlled funds that were intended to be used to cover healthcare expenses and would not return those funds;

- Aliera lied to state regulators; and

- Mr. Moses lied and withheld information to Anabaptist and wrote checks to himself out of the partnership's operating account.

Numerous state regulators have sought to prevent Aliera from conducting business in their states. In April 2019, for example, the Washington Office of the Insurance Commissioner found: (1) that Aliera provided misleading training to prospective agents about the nature of its products; (2) that Aliera provided misleading advertisements to the general public and potential consumers;

and (3) that Aliera's plans did not meet the requirements for a Health Care Sharing Ministry under federal law and that Aliera was therefore acting as an unauthorized insurer. In May 2019, the Washington Insurance Commissioner issued a cease and desist order to Aliera preventing it from "[e]ngaging in or transacting the unauthorized business of insurance" in Washington.

Washington regulators are not alone in finding that Aliera acted illegally. Other regulators, including the New Hampshire Insurance Department, the Colorado Division of Insurance, the Connecticut Insurance Department, and the Attorney General for the State of Texas have issued orders preventing Aliera from conducting illegal insurance business within their states or have warned consumers against purchasing Aliera policies. Other states are investigating Aliera's deceptive and unfair business practices, including New York, where the New York Department of Financial Services received fifteen to twenty complaints from consumers regarding Aliera in 2019 and subpoenaed Aliera in January 2020 to determine whether Aliera misled consumers.

Aliera never revealed to policyholders and potential policyholders the cases and regulatory proceedings brought against it because Aliera and its owners wanted potential policyholders to continue purchasing policies and wanted current policyholders to continue paying premiums so that Aliera and its owners and executives could reap unjustifiable and unfair profits at the expense of its policyholders.

B. Description of Injuries and Demand for Relief from The Aliera Companies, Inc. and Aliera Healthcare, Inc.

Aliera's misrepresentations, omissions, and unfair practices have injured Claimants and current and former policyholders of Aliera Care; PrimaCare, InterimCare, CarePlus, Aliera DPCMH, Trinity HCSM, Aliera Healthcare, Trinity Healthcare, as well as Aliera dental and vision plans (the "Class"). If Claimants had known the truth about Aliera's misleading policies—including that the policies did not legally qualify as Health Care Ministry Sharing plans, that Aliera

was illegally selling insurance, and that Aliera was improperly delaying and denying claims and settling claim disputes—Claimants and the Class would not have purchased the plans, continued paying premiums, or sought medical treatment based on the false representation that premium payments would provide coverage for medical expenses (rather than being used to enrich Aliera and its owners). Every policyholder, including Claimants, depended on and trusted Aliera to provide truthful and complete information when Aliera marketed, sold, and managed the policies and to use premiums to pay medical expenses. Aliera betrayed those representations and that trust and lied and withheld information from its policyholders for its own profit.

To remedy Aliera's deceptive and unfair business practices, Claimants demand that The Aliera Companies, Inc. and Aliera Healthcare, Inc. provide the following relief to Claimants and the Class:

1. Refund all of the premiums paid by Claimants and the Class;

2. Pay the unreimbursed medical expenses incurred by Claimants and other Class members while they were participating in Aliera's plans;

3. Cease representing that Aliera's policies are part of a legal and legitimate Health Care Sharing Ministry;

4. Cease selling illegal insurance and instead comply with all applicable federal and state laws if Aliera seeks to continue operating its business;

5. Pay for credit rehabilitation for any Class members whose credit ratings have decreased as a result of unpaid medical expenses they incurred while participating in Aliera's plans;

6. Remove the illegal dispute resolution procedures contained in Aliera's member materials; and

7. Pay the attorneys' fees, costs, and expenses incurred by Claimants as a result of Aliera's misconduct.

C. Potential Class Action Claim Under the Georgia Fair Business Practices Act

If, within thirty days, you do not provide the relief demanded above, Claimants will bring

a claim under the Georgia Fair Business Practices Act on behalf of themselves and the Class against The Aliera Companies, Inc. and Aliera Healthshare, Inc. seeking the relief described above.

Please direct all communications and responses regarding this notice to the undersigned by e-mail at stephen@sfclasslaw.com or by phone at 212-421-6942.

Sincerely,

/s/ Stephen J. Fearon, Jr.
Stephen J. Fearon, Jr.

SJF/cs