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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF CALIFORNIA

CORLYN DUNCAN and BRUCE DUNCAN, individually and on behalf of all others similarly situated, Plaintiffs, v. THE ALIERA COMPANIES, INC., f/k/a ALIERA HEALTHCARE, INC., a Delaware corporation; TRINITY HEALTHSHARE, INC., a Delaware corporation; and ONESHARE HEALTH, LLC, formerly known as UNITY HEALTHSHARE, LLC and as KINGDOM HEALTHSHARE MINISTRIES, LLC, a Virginia limited liability corporation, Defendants.	Civil Case No. 2:20-cv-00867-TLN-KJN [*Assigned to the Hon. Troy L. Nunley*] **AMENDED CLASS ACTION COMPLAINT** Action Filed: April 28, 2020

AMENDED CLASS ACTION COMPLAINT

I. PARTIES

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

2. Defendant THE ALIERA COMPANIES, INC. ("Aliera") is a Delaware corporation headquartered in Atlanta, Georgia. It is incorporated as a for-profit business, without any express religious affiliation. It changed its name in 2019 from ALIERA HEALTHCARE, INC.

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

4. Defendant ONESHARE HEALTH, LLC ("OneShare") is a Virginia limited liability corporation. On information and belief, it is headquartered in Irving, Texas, and was previously headquartered in Atlanta, Georgia. OneShare was formerly known as KINGDOM HEALTHSHARE MINISTRIES, LLC, and before that as UNITY HEALTHSARE, LLC. Because the majority of the actions described in this Complaint occurred when OneShare was known as Unity Healthshare, LLC, it will be referred to as "Unity" in this Complaint. Unity is a subsidiary of Anabaptist Healthshare.

5. Aliera created, marketed, sold, and administered insurance plans for Unity and was solely responsible for the development of plan designs, pricing, marketing materials, vendor management, recruitment and maintenance of a sales force, and administration of claims on behalf of Unity.

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

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

II. JURISDICTION AND VENUE

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

9. Alternatively, jurisdiction of this Court arises pursuant to 28 U.S.C. § 1332(d)(2) and § 1367 because there is diversity of citizenship, the proposed Class that Plaintiffs seek to represent consists of hundreds, if not thousands of individuals and, based on information and belief, the amount in controversy related to the proposed class claims exceeds $5,000,000.00.

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

III. NATURE OF THE CARE

11. Defendants sold inherently unfair and deceptive health care plans to California residents, and failed to provide them with the coverage the purchasers believed they would receive. Defendants claimed the health care plans were not "insurance" in order to avoid both oversight by the state insurance commissioner and minimum requirements mandated by the Patient Protection and Affordable Care Act ("ACA"). At the same time, Defendants created the health care plans to look and feel like health insurance that would provide meaningful coverage for the purchasers' health care needs.

12. When Congress passed the ACA in 2010, it required all individuals to be covered by health insurance or pay a penalty. Congress allowed for a handful of exceptions to that requirement, set out in 26 U.S.C. § 5000A. One of those exceptions was for members of existing Health Care Sharing Ministries ("HCSMs"). In order to qualify as an HCSM under the ACA, an entity must meet rigid requirements, including: (1) it must be recognized as a 501(c)(3) tax exempt organization; (2) its members must "share a common set of ethical or religious beliefs and share medical expenses among members according to those beliefs;" and (3) it must have "been in existence at all times since December 31, 1999, and medical expenses of its members [must]

have been shared continuously and without interruption since at least December 31, 1999." 26 U.S.C. § 5000A(d)(2)(B)(ii). At no time has for-profit Aliera ever met the definition of an HCSM.

13. Aliera, in an attempt to exploit this exception, convinced Unity's parent to create defendant Unity as a sham HCSM. When Aliera's relationship with Unity's parent soured, it created Defendant Trinity as a sham HCSM to replace Unity.

14. Although Aliera and Unity represented Unity as a "recognized" HCSM, Unity did not meet the requirements of an HCSM under 26 U.S.C. § 5000A(d)(2)(B)(ii) because, for example, it was not in existence until 2016 and it had no members before then. Unity and Aliera falsely claimed that Unity had been "recognized" as an HCSM based on recognition of Unity's parent, Anabaptist Healthshare ("Anabaptist") as an HCSM, even though Anabaptist's recognition was based on service of a different religious community, and Anabaptist was not Unity's "predecessor." Similarly, although Aliera and Trinity represented that Trinity had been "recognized" as an HCSM, Trinity did not meet the requirements of 26 U.S.C. § 5000A(d)(2)(B)(ii) because it was not in existence continuously since 1999, and because it did not require its members to adhere to its stated ethical or religious beliefs. It was never, and could not have been, "recognized" as an HCSM because the federal agency that had at one time provided letters of recognition stopped doing so in 2016, before Trinity was created.

15. Aliera was authorized by Unity and then by Trinity to sell illegal health insurance plans to California residents, while representing those plans as from "recognized" HCSMs. Aliera sold, at the instance of Unity and Trinity, illegal health insurance plans to hundreds, if not thousands, of California residents. These plans did not comply with the minimum basic requirements for authorized health care plans under state or federal law, and have resulted in California residents (1) paying for an illegal contract, and (2) being denied coverage for medical care required by law to be provided. Defendants, and their principals, however, have realized exorbitant profits. On information and belief, Aliera takes over 83% of all payments made by individuals, while refusing to pay claims.

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

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

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

IV. CLASS ALLEGATIONS

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

> All California residents who purchased a plan from Aliera and either Unity Healthshare LLC or Trinity Healthshare, Inc. that purported to be a "health care sharing ministry" at any time since September 11, 2017 or the relevant statute of limitations.

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

21. ***Common Questions of Fact and Law:*** There are questions of law and fact that are common to all class members including: (1) whether the healthcare products that the Defendants created, marketed, sold, and administered to class members met the legal requirements of an HCSM under 26 U.S.C. § 5000A; (2) whether plans sold were "insurance" under California insurance law; (3) whether California insurance law and regulations forbid the creation, marketing, sale, and administration of health care products in the "business of insurance" without authorization or other legal exception; (4) whether Defendants failed to obtain proper authorization for the creation, marketing, sale, and administration of an insurance product in California; (5) whether class members are entitled to (a) rescission of the plan(s) and refunds of all premiums paid and/or (b) reformation of the plans to comply with the minimum insurance coverage requirements of California and federal law, and re-processing of all claims for expenses and costs incurred that would have been covered had the plan(s) properly complied with those laws; (6) whether Defendants' actions were unfair, deceptive, untrue or misleading, and likely to deceive consumers, in violation of California's Unfair Competition Law, False Advertising Law, and/or Unfair Insurance Practices Act; (7) whether Defendants owed a fiduciary duty to their members, and whether they breached that fiduciary duty; (8) whether Defendants have been unjustly enriched by collecting members' payments while failing to pay claims, and by paying themselves unreasonable fees and commissions; (9) whether a constructive trust should be imposed; and (10) whether class members are entitled to other relief resulting from Defendants' unfair and/or deceptive acts.

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

the class members because they have been subjected to the same practices as other class members and suffered similar injuries. The named Plaintiffs do not have interests antagonistic to those of other class members as to the issues in this lawsuit.

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

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

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

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

27. ***Amount in Controversy.*** Based upon the premium/contribution payments made by the named plaintiffs, the anticipated size of the proposed class, and defendants' statements that they are unable to pay all share requests/claims submitted, Plaintiffs anticipate that the amount in controversy is greater than $5,000,000.00. Specifically, Defendants have received more than $100 million in "premiums" and sign-up fees from its members nationwide, including those in California. Based on the population of California, far more that $5 million of these receipts would be expected to have been received from members of the putative class at issue in this case.

28. ***Class Counsel***. Named Plaintiffs have retained experienced and competent class counsel.

V. FACTUAL BACKGROUND

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

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

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

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

32. Aliera realized that it could greatly increase the sales of its healthcare products if it could take advantage of the federal statute that exempted taxpayers who purchased HCSMs from the ACA's individual mandate.

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

34. In 2016, Timothy Moses convinced Anabaptist to permit Aliera to market its own DCPMH plan "side by side" with Anabaptist's sharing program using Anabaptist's HCSM designation. Anabaptist created Unity, a wholly-owned subsidiary, for that purpose. Under the proposal, Aliera would market both its own plan and the Unity HCSM together as a healthcare product it claimed would be exempt from the ACA's mandates.

35. Aliera entered into a contract with Unity on or about February 1, 2017. Under that contract, Aliera would offer its own health products to the public that did not meet coverage requirements under the ACA and did not independently qualify for the HCSM exemption under 26 U.S.C. § 5000A. In return, Aliera's customers would join Unity, which claimed to be an HCSM, providing revenue to Unity and its parent Anabaptist.

36. Although Aliera marketed the plans to consumers throughout the country as HCSM plans through Unity, in reality, Unity was merely a shell with an HCSM designation. Unity

delegated all authority and responsibility to Aliera to create, design, market, and administer products sold under the Unity name. All those who purchased the Aliera/Unity products became members of both Aliera and Unity. Aliera, a for-profit entity that was never an HCSM, could push its own DCPMH plans, while also designing, marketing, selling, administering, and controlling the Unity HCSM plans. For example:

(a) All member payments were paid directly to Aliera.

(b) The purported "sharing" component of the HCSM was delegated to Aliera.

(c) Aliera handled all member claims for health care coverage.

(d) Aliera served as the program administrator for the Unity HCSM plans.

(e) Members interfaced only with Aliera, not Unity.

(f) Aliera personnel made the final decision whether a claim would be paid.

(g) Aliera controlled the Unity member list.

(h) Aliera developed all plans and programs for the HCSM component of the Aliera products.

(i) Aliera controlled the Unity website.

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

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

39. The healthcare plans marketed under Unity's name that Aliera designed, marketed, administered and controlled, and sold to California residents were sham HCSM products that did not exempt them from California insurance regulation or the ACA.

B. After Aliera's Relationship with Unity Soured, It Created Trinity, a Sham HCSM, Converted the Unity Products to Trinity Products, and Continued to Sell to California Consumers through Trinity

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

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

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

"continuously and without interruptions since at least December 31, 1999," and it had no predecessor entity.

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

44. While prospective agents must take a training assessment before selling the Trinity plans, the questions asked in the assessment do not address any religious or ethical motivation. Defendants' advertisements for prospective agents, and the training materials for agents do not mention a religious or ethical component for purchasers of these plans. In a training video posted on YouTube on November 1, 2018, an Aliera trainer explains that the "statement of faith"

> basically is saying that you believe in a higher power. It doesn't necessarily have to be a Christian God, or a Buddhist God, or a Jewish God. It doesn't … matter as long as we all believe that there is a higher power and we're all living our life that the best way that we possibly can. We're maintaining a healthy lifestyle. We're trying to avoid those types of foods, behaviors, habits – things that, you know, cause us illness that are in our control.
>
> As long as we're doing those types of things, we're all like-minded individuals. So if you feel that way, and you are a like-minded individual, that's all we're trying to find out. And, if you are, you're gonna say, "Yes," you believe in the five same statement of beliefs that we all do.

45. Agents in California have represented Trinity as being the most flexible in terms of belief statement and as having the "most relaxed statement of beliefs and qualifications" of purported HCSMs. *Appendix B,* at 24. It represents that it "welcomes members of all faiths." *Appendix C,* at 11.

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

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

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

49. Many of the plans Aliera had sold through the Unity brand, including those sold to the Plaintiffs, were then transferred to the Trinity brand, and pending claims were transferred to Trinity who assumed responsibility for "sharing" them. Throughout the time Aliera sold either

Unity or Trinity plans purporting to be HCSMs to California residents, Aliera maintained control of the sales of the plans, the member lists, the claims, and the claims administration, and commingled the funds of the members in an account or accounts it controlled.

C. The Products Aliera Creates, Markets, Sells, and Administers Are Health Insurance

50. Plaintiffs and members of the class have been, are, or will be enrolled in healthcare insurance products created, marketed, sold, and administered by Defendant Aliera either through Unity and/or through Trinity, that Defendants claimed were HCSM plans.

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

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

(b) The plans require a member to pay a deductible, which Defendants call a "Member Shared Responsibility Amount," or "MSRA." *Id.,* at 4. The higher a member's MSRA, the lower the member's "contribution."

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

(d) The plans require pre-authorization for certain non-emergency surgeries, procedures or tests, as well as for certain types of cancer treatments. *See, e.g., Appendix D,* at 30; *E,* at 18.

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

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

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

(h) The plans provide for "maximum out of pocket" expenses. *Id.*

52. The plans provide coverage for medical expenses. Among other things, the plans claim to provide coverage for preventive care, primary care, urgent care, labs and diagnostics, x-rays, prescription benefits, specialty care, surgery, and emergency room services. *Appendix D,* at 33-35; *E,* at 25-30.

53. The plans have established preferred provider networks ("PPOs").

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

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

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

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

58. Members' "contributions" (i.e. premiums) are not refundable. Although the member "contributions" are called "voluntary," if members fail to make the premium payment, they are not entitled to coverage for medical expenses. *Appendix D,* at 16; *E,* at 13.

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

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

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

61. None of the Defendants has a certificate of authority as required by Cal. Insurance Code § 700 to issue insurance within this state and they are not authorized insurers under California law. Each of Defendants have issued illegal and unauthorized insurance products to Plaintiffs and other members of the class.

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

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

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

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

(d) The plans impose lifetime caps.

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

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

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

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

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

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

65. Defendants have never maintained the 80% medical loss ratio of medical expenses paid to premiums received required by the ACA. 42 U.S.C. § 300gg-18.

66. Defendants' plans purport to require multiple levels of appeal in violation of 42 U.S.C. § 300gg-19(a)(2)(b) and 45 C.F.R. §147.136(b)(3)(G).

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

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

68. Multiple other states have taken similar action against Aliera and Trinity. *Appendix G*. Those states include:

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

(b) ***Washington.*** The Insurance Commissioner entered cease and desist orders against Aliera and Trinity on May 3, 2019, finding Aliera acted as an unlicensed healthcare service contractor and Trinity was not an HCSM. Trinity entered into a consent order on December 30, 2019, agreeing not to enroll any new Washington residents, and to pay a $150,000 fine. On March 31, 2020, the Insurance Commissioner found that Defendant Unity, now known as OneShare Health, LLC, was not a legitimate HCSM and was acting as an unauthorized insurer in the state of Washington. It issued a cease and desist order prohibiting it from continuing to solicit or sell insurance in Washington. *Appendix N.* On May 5, 2020, a Washington Administrative Law Judge denied a motion to stay the order, citing sufficient prima facie evidence that OneShare was unlawfully transacting in insurance and did not qualify as an HCSM. *Appendix O.*

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

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

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

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

F. Plaintiffs Were Sold Sham Products by Defendants That Did Not Provide the Benefits Promised

69. Plaintiffs Corlyn and Bruce Duncan enrolled in an AlieraCare Comprehensive Gold plan on or about November 28, 2017, while Aliera was selling Unity plans. Before they enrolled, the plan was represented to them by their insurance agent to be like a BlueCross insurance plan, but cheaper. Their membership effective date was January 1, 2018, and they received what they believed was an insurance card showing they had hospital, in-patient, out-patient, emergency room, specialty visit, preventive, and X-ray and imaging, with certain co-pays and a $1,000 MSRA. *Appendix H.*

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

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

72. In 2019, the Duncans were advised that their plan through Aliera/Unity was being transferred to Aliera/Trinity, with the same benefits and the same monthly contribution amount as the Aliera/Unity plan. *Appendix I.* Aliera, for itself and as agent for Trinity, represented that "all Medical history and historical claims" would "continue to track" after the Duncans' plans were transferred to Aliera/Trinity. *Id.* The Duncans filled out a new enrollment form. That enrollment form did not disclose that they would be obligated to arbitrate any disputes. *Appendix J.*

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

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

75. The Duncans paid $1,287.56 per month for their AlieraCare Comprehensive Gold plan while Aliera partnered with Unity, and $1,612.91 per month for their AlieraCare Comprehensive Gold plan while it partnered with Trinity. They also paid $125 in application fees.

76. The AlieraCare Comprehensive Gold plan sold to the Duncans was insurance under California law. However, the plan failed to comply with California and federal law in its provisions of benefits.

77. On March 16, 2018, Ms. Duncan required surgery. Before the surgery, she contacted Aliera for approval, and Aliera approved both the surgery and the facility where the surgery was performed.

78. Nevertheless, Aliera, as agent for Unity and/or Trinity, has paid only a fraction of the cost of the surgery, leaving her with a hospital bill of over $70,000. *Appendix L*.

79. The Duncans made repeated attempts to appeal Aliera's decision, but each time they called, they were either left on hold, and/or given inconsistent answers about whether, how much, and which charges would be covered. After authorizing the surgery, and despite written verification from the surgeon to the contrary, Aliera then insisted the surgery was for a "pre-existing condition" and refused to pay it. *See Appendix L, M.* The Duncans have submitted additional information in support of their appeal, but neither Aliera/Unity nor Aliera/Trinity has paid.

80. They have suffered damages by paying for the Unity plan and for the Trinity plan, which are both illegal insurance products, and by being denied health care coverage for their needed medical expenses. The Duncans continue to be pursued for their hospital debt, which has adversely affected their credit.

VI. CLAIMS FOR RELIEF

A. First Claim: Illegal Contract Against All Defendants

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

82. Defendants marketed, issued, delivered and administered unauthorized and illegal health insurance plans in violation of California law to Plaintiffs and all members of the Class, based on the following issues, among others:

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

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

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

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

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

(f) The plans failed to comply with legal requirements for a reasonable grievance and appeals process.

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

B. Second Claim: Violation of California's Unfair Competition Law Against All Defendants

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

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

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

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

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

(c) Defendants have advertised and represented that Unity and Trinity are each a "Health Care Sharing Ministry recognized pursuant to 26 U.S.C. § 5000A(d)(2)(B)." This is false. *See* ¶¶ 40-45, above. Defendants Aliera and Trinity have falsely represented, either directly or through sales agents in California, that Trinity is an "administrator for one of the HCSMs that has been around since before 1999," and that "Trinity has been helping people cover health care costs for years." *Appendix B.* These misrepresentations deceived consumers into believing that their healthcare plans were faith-based and would be administered in an ethical manner for the benefit of members, rather than for the benefit of for-profit Aliera.

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

(e) Defendants misrepresent that members' monthly contributions are put into a cost-sharing account with either Unity or Trinity, which "acts as an independent and neutral clearing house, dispersing [sic] monthly contributions as described in the membership instructions and guidelines." *Appendix D,* at 14; *E,* at 11. Defendants misrepresent that either Unity or Trinity, because it is a nonprofit with "nothing to gain or lose financially by determining if a need is eligible or not" is the entity to whom members delegated coverage decision authority. *Appendix D.,* at 21; *E,* at 15. In fact, contributions are not placed into a cost-sharing account with either Unity or Trinity, but are paid directly to for-profit Aliera which maintains complete control over payments for medical expenses and maintained exclusive access to and control over the Unity or Trinity membership list.

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

(g) Defendants Aliera and Trinity claim they have a "growing nationwide PPO network of more than 1,000,000 healthcare professionals and more than 6,000 facilities," *Appendix D,* at 13; *E,* at 9. Defendants provided lists of professionals and facilities, but then denied claims on the basis that those professionals and facilities were not in-network, or that the providers were charging too much.

(h) Defendants systematically engage in unfair claims handling practices by arbitrarily denying claims. Even though Defendants represent that the coverage provisions are not legally binding upon them and that they are not legally obligated to pay claims, they then insist members are legally obligated to follow the multilevel Dispute Resolution Procedure outlined in the Member Guides. *Appendix D*, at 31-32; *E*, at 19-20. This burdensome Procedure is not disclosed to consumers in the marketing materials before they commit to enrolling in the plans, and ultimately requires binding arbitration, in violation of California law. Defendants deceptively use the multilevel Procedure to subject members to Kafkaesque delays and false and inconsistent promises, to delay payment of legitimate claims, and to shield Defendants from legal action.

87. Members of the public are and have been deceived by these unfair and unlawful practices.

88. Aliera acted on its own behalf and as an express and apparent agent for Unity and Trinity, when it created, marketed, sold, and administered virtually identical plans under both the Unity and Trinity brands, and committed the above unfair and deceptive acts while acting for both entities.

89. Plaintiffs and the class have been injured as a direct result of Defendants' conduct. They suffered economic injury by paying for unregulated insurance products that are illegal under California law. The products provide less coverage than permitted under law, thereby rendering the policies less valuable than products that do comply with the law. Plaintiff and the class have been denied care, or limited in care, due to illegal caps, exclusions and limitations. Plaintiff and the class have foregone coverage under the ACA, including subsidized benefit packages that would provide legal, comprehensive, and secure health insurance coverage. Defendants' polices were overpriced for the coverage they purported to provide given that over 80% of the contributions were paid in fees and commissions, rather than to benefits, causing Plaintiff and the class to overpay for the illegal and unregulated policies. They purchased the products with the

reasonable belief that their medical bills would be paid, but Defendants have devised excuses not to pay those claims, or to unreasonably delay in payment of the claims.

C. Third Claim: Violation of California's False Advertising Law

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

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

92. These untrue and/or misleading statements include:

(a) Advertising and representing Unity and Trinity each as a "Health Care Sharing Ministry recognized pursuant to 26 U.S.C. § 5000A(d)(2)(B)."

(b) Consistently and repeatedly misrepresenting that AlieraCare/Trinity and AlieraCare/Unity and their related products are "not insurance."

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

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

(e) Misrepresenting that Trinity and Unity, because are nonprofits with "nothing to gain or lose financially by determining if a need is eligible or not" are the entities to whom members delegated coverage decision authority.

(f) Misrepresenting that Defendants provided coverage for medical expenses.

(g) Misrepresenting that there are over 1,000,000 providers and 6,000 facilities within Defendants' PPO, and then denying claims from those providers and facilities listed as within the PPO.

93. Members of the public are and have been deceived by these unfair and unlawful practices.

94. Plaintiffs and the class have been injured as a direct result of Defendants' conduct by paying for sham insurance products that did not provide either the benefits offered or that should have been offered under a legitimate healthcare plan. They have been further injured when, as a direct result of Defendants' conduct, they lost the opportunity to enroll in legitimate health plans either during open enrollment or special enrollment periods.

D. Fourth Claim: Breach of Fiduciary Duty – Aliera and Trinity

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

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

97. Defendants Aliera and Trinity further represent their trustworthiness by claiming Trinity is a "faith based" or religious organization.

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

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

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

101. Defendant Aliera has admitted in court filings and testimony in connection with the Georgia Case that it has a fiduciary duty to the members.

102. Defendants Aliera and Trinity have breached their fiduciary duty. Trinity has delegated sole control of members' funds, and all coverage decisions, to for-profit Aliera, which has commingled members' funds with other funds. Coverage decisions are made solely by the for-profit Aliera, and in order to secure its profits, not to provide coverage for members' medical needs. Plaintiffs and the class members have been arbitrarily denied claims for medical expenses in order to enrich Defendants.

103. On information and belief, approximately 84% of the member contributions are paid to Aliera in fees and administrative expenses, and not to cover the medical needs of the members.

104. Plaintiffs and the member class have been injured by Defendants' breaches of fiduciary duty. The funds that should have been used to pay their claims (including the claims of Unity enrollees who were induced to switch to Trinity based upon the representation that Trinity would be responsible for all past claims) have instead been used to enrich Defendants. The excess payments should be disgorged, and held in constructive trust for the benefit of the Plaintiffs and the class to pay their claims or reimburse their premiums.

E. Fifth Claim: Breach of Fiduciary Duty – Aliera and Unity

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

106. Defendant Unity, through its exclusive agent Aliera, represented that members voluntarily submit monthly contributions or gifts into an escrow account, and that Unity "acts as a neutral clearing house between members." *Appendix E,* p.3. While disclaiming that there is any legally binding agreement to reimburse members for medical needs, Aliera and Unity claim Unity will serve as "a clearing house" distributing monthly contributions as described in the membership instructions and guidelines. *Id*., p. 15.

107. Aliera and Unity further represented their trustworthiness by claiming Unity is "faith based," and is based on a "tradition of mutual aid, neighborly assistance and burden sharing." *Id*., pp. 2-3, 11.

108. Aliera and Unity represented that "since Unity HealthShare has nothing to gain or lose financially by determining if a need is eligible or not, the contributor designates Unity HealthShare as the final authority for the interpretation of these guidelines." *Id*., p. 15.

109. Aliera and Unity represented that monthly contributions are "voluntarily given" to Unity to hold as an escrow agent and to disburse "in accordance with the membership instructions." *Id*., p. 15.

110. Unity, and its exclusive agent Aliera, have complete control over the financial "contributions" members pay, and complete control over the coverage decisions. *Id.* p. 15.

111. Based on these representations and their control over members' "contributions," Aliera and Unity have a fiduciary duty to the members.

112. Defendant Aliera has also admitted in court filings in connection with the Georgia Litigation that it has a fiduciary duty to the members.

113. Defendants have breached their fiduciary duty. Unity delegated sole control over members' funds, and all coverage decisions, to for-profit Aliera, which has commingled members' funds with other funds. Coverage decisions were made solely by for-profit Aliera and in order to secure its profits, not to provide coverage for members' medical needs. Plaintiffs and the class members have been arbitrarily denied claims for medical expenses, and have been denied pre-authorization of needed medical care, in order to enrich Defendants.

114. The majority of the member contributions were paid to Aliera in undisclosed fees, and not to cover the medical needs of the members.

115. Plaintiffs and the class members have been injured by Aliera's and Unity's breaches of fiduciary duty. The funds that should have been used to pay their claims have instead

been used to enrich those Defendants. The profits should be disgorged and held in constructive trust for the benefit of the Plaintiffs and the class to pay their claims.

F. Unjust Enrichment Against Aliera

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

117. Plaintiffs and the class paid substantial monthly contributions. On information and belief, approximately 84% of the monthly contributions were siphoned off as fees and expenses, largely to benefit Aliera.

118. Plaintiffs and the class made their payments with the understanding that the funds would be shared among the members of Trinity or Unity to pay medical claims. They were never advised that a majority of their payments would actually go to Aliera's fees, administrative expenses, and commissions.

119. Aliera has retained the members' contributions while arbitrarily denying medical claims, and has been unjustly enriched at the expense of Plaintiffs and the class.

120. Plaintiffs and the class are entitled to restitution of the amount Defendants unjustly retained.

VII. PRAYER FOR RELIEF

WHEREFORE, Plaintiffs request that this Court:

(a) Certify that this action may proceed as a class action as defined in ¶ 19 above;

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

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

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

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

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

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

(h) Order disgorgement and restitution of all contributions Aliera unjustly retained;

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

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

DATED: June 26, 2020.

s/ Nina Wasow

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APPENDIX A

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

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

ORDER ENTERING INTERLOCUTORY INJUNCTION AND APPOINTING RECEIVER

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

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

I. FINDINGS OF FACT[1]

Background

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Parties' Business Relationship

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

AHS/Unity Terminates the Agreement

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Change from Unity HSCM to Trinity HCSM

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

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

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

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

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

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

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

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

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

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

The Court's TRO

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

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

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

II. CONCLUSIONS OF LAW

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Likelihood of Success on the Merits

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

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

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

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

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

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

Id. at 228-29 (citations omitted).

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

[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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APPENDIX B

Health SHARING Most States

800-320-6269 Our services are FREE to you ALIERA Healthcare Agent

Health share comparison (health-care-sharing-ministry-comparison-review.htm) - Trinity HealthShare health ministry sharing plans

TRINITY HEALTHSHARE PLAN REVIEW, RATES, AND ENROLLMENT

OUR HELP IS FREE TO YOU!

UPDATE: AlieraCare plans are now fully converted to Trinity HealthShare through Ensurian. The plan designs, networks, and options are similar. Trinity HealthShare was the underlying health care company and this change streamlines the offering.

ENSURIAN SM

At some point, push comes to shove.

We have been navigating the health insurance market since 1995.

We have found ourselves searching for options since 2014.

Rates have more than doubled since then.

Tripled for some people.

It's unsustainable and the law basically forced all the health plans into the same expensive box (if you don't get a tax credit).

(How-to-Quote-Aliera-care-health-sharing-rates.htm)

ENROLL ONLINE IN 10 MINUTES

(How-to-Apply-for-Aliera-Care-health-sharing-plans.htm)

We finally feel like we have an option to show people which we can get behind.

Trinity HealthShare health plans.

We'll go through the entire explanation of what Trinity HealthShare plans are but you can jump to any section here:

- Are Trinity HealthShare plans an Alternative to Obamacare
- Guide to Trinity HealthShare plans
- Trinity HealthShare plan Pricing - Get Ready to Smile (or frown less)
- Our Role with Trinity HealthShare plans

> We can generally get the 1st of the following month.

You can quote and enroll:

(How-to-Quote-Aliera-care-health-sharing-rates.htm)

Learn about their popular catastrophic health sharing plan called CarePlus Advantage here (AlieraCare-CarePlus-Advantage-catastrophic-health-sharing-plan-review-quote-comparison.htm).

Lots to cover. Lots to save!

Let's get started!

What Is HealthShare Sharing?

Quick synopsis.

In the ACA law (Obamacare), there was a small piece that gave certain non-profit companies, Health Care Sharing Ministries, the ability to offer plans to people that are not ACA compliant.

- These were generally religiously affiliated or based on a set of beliefs.
- The entities had to be in existence before 1999.
- Only six companies met the requirements.
- They had to be non-profit

Trinity HealthShare, Inc is an administrator for one of them.

> The entity they partnered with, Trinity Healthshare has actually been helping people cover health care costs for years.

Before with AlieraCare, Trinity HealthShare handled the big ticket items (hospital, etc) while AlieraCare handled the first dollar benefits (preventative, office consult, etc).

Now, it's all under one umbrella which makes it much cleaner.

Trinity HealthShare has been in business since 2011.

The net net to you...Health care sharing ministry plans like Trinity HealthShare plans allow you to essentially buy plans similar to the old benefits!

The plans before the ACA law.

In California, actually back to 1999 in some respects.

You can see the difference between Covered Ca and health care sharing ministry here (health-sharing-versus-Covered-California.htm).

> One note...Health care sharing ministry plans are NOT insurance.

When we say the "old plans" the new health care sharing ministry plans work similarly to them but are not insurance.

There are some very important differences to understand.

> Make sure to read "What Trinity HealthShare plans are NOT" below. Must Read!

We'll cover the pros and cons of these health care sharing ministry plans versus insurance (obamacare-health-insurance-versus-health-sharing-comparison.htm) later.

We have articles diving deep into Health care sharing ministry plans but here are the reasons it's important to you:

- The cost can be significantly lower than non-subsidized ACA health plans
- You avoid the tax penalty by accepting the relaxed Statement of Beliefs
- You can enroll any time of the year...no open enrollment
- The plans are guaranteed issue with waiting periods for pre-existing conditions.

Those are the real big bullet points (we'll cover more detail below) but the real reason Trinity HealthShare is taking over the market...

> The cost can be an affordable option compared to the unsubsidized Bronze ACA plans

You can quickly jump to the Trinity HealthShare plans quote here:

(How-to-Quote-Aliera-care-health-sharing-rates.htm)

Health care sharing ministry plans aren't for everyone.

Make sure to check out the section below on who health care sharing ministry plans works best for.

So...that's health care sharing ministry plans with broad strokes.

What about Trinity HealthShare plans specifically?

What Is Trinity HealthShare, Inc?

(How-to-Quote-Aliera-care-health-sharing-rates.htm)

Trinity HealthShare is one of the six companies that were accredited as Health Sharing entities under the ACA law.

> They are by far our favorite of the six for many reasons (see next section for why Trinity HealthShare plans are the best)

> In terms of doctors, Trinity HealthShare plans use the PHCS PPO network.

This is one of the largest PPO nationwide networks with almost 1M providers included.

This is a big deal.

Your health plan is only as good as the doctors it allows you to see.

We're seeing lots of issues with that on the ACA health plans as they continue to narrow their networks.

The PHCS (provider search here (https://www.trinityhealthshare.org/network/)) is a great asset for Trinity HealthShare plans.

You can access the Trinity HealthShare plans, rates, and provider search via the quote tool here:

(How-to-Quote-Aliera-care-health-sharing-rates.htm)

What Trinity HealthShare Plans Are NOT

We really want people to understand their options.

In doing so, we have to explain the downsides as well as the upsides of the Trinity HealthShare plans (or health care sharing ministry plans in general) plans.

> If an agent or company doesn't make this next bit clear, run don't walk.

We like Trinity HealthShare plans for SOME clients (see below for who Trinity HealthShare plans works for) but they have to understand the differences.

Trinity HealthShare Plan General Understanding

I understand that Trinity HealthShare, Inc (which administers for a health sharing ministry) is NOT insurance nor does it provide insurance coverage. It is not intended to be a replacement of comprehensive health coverage found through the Federal or State exchange.

Trinity HealthShare, is a health care sharing ministry. Eligible needs are shared by the members according to the membership guidelines. This membership is not a legal binding agreement and does not guarantee or promise that your eligible needs will be shared by the membership. It makes no assumption of risks. If sharing is not possible, you will remain financially liable for unpaid medical bills.

The financial assistance members receive come from other member's monthly contributions that are placed in an escrow account, not from Trinity HealthShare.

Trinity HealthShare does NOT fall under the oversight of the Department of Insurance (DOI).

There is no DOI protection or backstop in case the company goes bankrupt, expenses are not paid, or payment is denied.

Individuals who choose to enroll in a health care sharing ministry plan receive a waiver from the individual tax penalty..

I understand that:

1. There is a 24-month pre-existing condition exclusion for hospitalization in which the membership does not share on any hospital needs for any condition you've been treated for, received medical advice for, taken prescriptions for or had any surgery for

in the past 24 months prior to joining the membership.

2. This plan covers hospital expenses incurred by you and eligible members when you have an emergency room visit or has extended into a hospital stay for conditions not related to prior pre-existing conditions.
3. If the ER is used for a non-emergency situation then the expenses may not be covered.
4. All members are required to activate their accounts prior to using the membership.

Trinity HealthShare does not cover Mental Health benefits except on specific plans.

Trinity HealthShare is not required to cover the Essential Health Benefits under the ACA law.

By law, Trinity HealthShare does undergo an audit annually by an independent accounting firm to ensure financial stability. 20% of monthly membership dues are is held in reserves for paying eligible expenses.

Link to Brochure here (http://www.alierahealth.com/index.cfm?id=272962).

Member's guide available upon request at help@calhealth.net (mailto:help@calhealth.net)

There are many pros to Trinity HealthShare plans..primarily the cost.

For some people without a tax credit or who can't enroll during the year, it may be the only option they can afford.

> We're not doing our job though unless we help people understand the differences between it and ACA health plans.

Keep in mind that we are ultimately covering till we get to the next Open Enrollment or a Special Enrollment trigger.

12 months max.

All we can say is this...if you're comparing health care sharing ministries, we strongly recommend going with the safest among them.

In our calculation, it's Trinity HealthShare

We have had ZERO major issues and we're one of the bigger enrollers.

How Long Has Trinity Healthcare And Trinity Healthshare Been In Business?

For many people seeking healthcare offerings, Trinity Healthshare may be new.

This is less and less so with each rate increase on the Obamacare market.

Trinity Healthshare has been in existence for over 60 years.

They handle the bigger ticket items such as hospital, surgery, ER, etc.

Why Trinity HealthShare Is The Best Health Care Sharing Option

The benefits of Trinity HealthShare:

- Most flexible in terms of belief statement and who can be covered
- Guaranteed issue regardless of health conditions (with waiting periods built in)
- Works most similarly to traditional insurance with payment to the provider
- Uses the PCHS Multiplan PPO network with almost 1M providers nationwide (huge deal)
- Most sophisticated members services and online tools
- Broadest plan options and backend protection for big bills.
- Robust Preventative and First dollar benefits
- Keeps 20% of monthly dues for eligible expense payment reserve - Very

Important!

Trinity HealthShare has a relaxed eligibility requirement compared to other options. There are no secular or non-religious health care sharing (Secular-non-religious-health-sharing-plan.htm) plans by design, but Trinity HealthShare is definitely the most pragmatic.

Comparison for Health Sharing Companies (2018)
Reference only - Please see Member's Guide for Detailed Information

Health Sharing Plans are NOT Health Insurance
Learn more HERE

General	Trinity (Aliera Healthcare., Inc is administrator)	Liberty	Medi-Share	Samaritan	Altruia	Health Care Min
BBB	A+	B-	A+	NA	B	NA
When Founded	1922 Unity/1999 Aliera	1998	1993	1994	1997	1981
Enrollment (estimate)	1M+ members	1M+ members	1M+ members	500K+	300K+	250K+
Member Growth	Very Fast	Fast	Average	Average	Slower	Slower
Tax Penalty?	ACA Exempt	ACA Exempt	ACA Exempt	ACA Exempt	ACA Exempt	ACA Exempt
Eligibility						
Statement	Most Flexible	Most Flexible	Less Flexible	Less Flexible	Less Flexible	Less Flexible
Religious	Open	Open	Christian	Christian	Christian	Christian
Health	Does not Decline	Lifestyle/Health Qualifiers	Lifestyle/Health Qualifiers	Does not Decline	Does Not Decline	Life style Qualifiers
Pre-X	Waiting Periods	Waiting Periods/Decline	Waiting Periods	Waiting Periods	Waiting Periods	Waiting Periods
Waiting Periods	24 months enroll/lifetime for certain conditions	12 months from Enroll/Additional Limits	36 months from treatment	12 Month treatment-5 years	24 months eff date	1 year from treatment
Rates						
Range	$142-$490/person	$149-$244	$135-$470	$200-$495	$112-$470	$45-$150
Increases	Annual; birthday	Annual; birthday	Annual; birthday	Annual; birthday	Annual; birthday	Annual; birthday
Family Type	Single/Single+1/Family	Single/Single+1/Family	Single/Single+1/Family	1 Person/2 Per/3 Per	Member/+1/Family	per person
At Age Change	Yes	Yes	Yes	Yes	Yes	Yes
Age of Older Adult	Yes	Yes	Yes	Yes	Yes	Yes
Expected Stability	High	Low	Middle	High	Middle	Low
Plans						
Annual Max	$1M	No	No	$236K-$250K	$50K-1M	$125K/incident
Per Incident Max	$150-500K; $500K buy up	$125K-$1M	No	Misc	No	$125K
Share Range	$7500-$10K	$500-$1500	$3-$4K	$300-$1500	$3K-$5K	$500-$5000
Preventative	Yes	Yes	No	No	No	No
Maternity	Limited	Yes	Limited	Yes/Limits	Limited	Yes
Networks						
Reimburse Providers	Yes	No	Yes	No	Yes	Yes
Type of Network	PPO	None	PPO	No	PPO	PPO
Size of Network	Large	N/A	Large	N/A	Large	Large
Negotiated Rates	Yes	No	Yes	No	Yes	Yes
Eligible Expenses						
Reserves	**YES!!**	No	No	No	No	No
Pre-Auth	Yes	Yes	Yes	No	Yes	No
How Paid	Direct to Provider	Reimburse	Direct to Provider	Reimburse/Complicated	Reimburse	Reimburse
Review Process	Internal/4 Levels	Internal/4 Levels	Internal/2 Levels	Internal/Arbitration	Internal/Arbitration	No
Overall Ranking	1	4	2	5	3	6

Detail is summary level only. Each health care sharing plan has specific rules and qualifications. Make sure to see full member's guide before purchasing.

We have a comprehensive guide to comparing the main health care sharing ministries (health-care-sharing-ministry-comparison-review.htm).

Look. We're very conservative in terms of options to address health care needs.

We've seen lots of options come and go on the health market that agents loved because they were great for agents.

We ran from those because there were serious issues for the members if they had really large bills.

What's the point of a plan if it doesn't protect from the big bill.

> We really had to feel confident about Trinity HealthShare plans to recommend them to our clients...some of which we have had since 1995!

There's a lot of trust there and Trinity HealthShare meets our lofty requirements for certain clients.

Make sure to read the "Who are Trinity HealthShare plans good for" section as it's not for everyone.

Trinity HealthShare goes the farthest in protecting people from the big bills that are all too common in today's health care world.

> We've studied all the health care sharing ministries and Trinity HealthShare stands out as the best in our view.

As licensed health agents and appointed Trinity HealthShare plan agents, we're happy to walk through your situation to see if it's a good fit.

There's zero cost for our assistance.

With Trinity HealthShare plans or ACA health plans.

Trinity HealthShare plans are another option that's going to fit very well for a segment of the population.

Understanding Trinity HealthShare Plan Terms

As part of their exemption from the ACA requirements (especially the penalty!), health care sharing ministries have to use different terminology from traditional insurance.

Congress loves it rules!

> Keep in mind that Trinity HealthShare plans are NOT health insurance.

Here are the big ones and their corresponding term in health insurance:

- MSRA (Member Shared Responsibility Amount) - works like health plan deductible
- Consult Fee - works like health plan copay

One note...with Trinity HealthShare plans, the MSRA is also the same as the traditional insurance max out of pocket.

It's all one number which is a clean way to do it.

There isn't a percentage share between the two.

One less thing we would have to rename!

You'll see on the brochure the statement "This is NOT Insurance"

This is true.

See above for what Trinity HealthShare plans are not.

Very helpful and important to understand the difference before making any decision.

So what are they if not insurance?

A pool of people that all share eligible medical expenses together.

Just an FYI but that's similar to how insurance works albeit with government DOI oversight.

Make sure to see the Trinity HealthShare plan acknowledgement above to understand how this differs to you.

We'll cover the few items that are important to understand in the "Who are Trinity HealthShare Plan for" section but we feel really good about Trinity HealthShare's plan options (especially the Premium plan) for protection.

Trinity HealthShare Doctors

This is one of the items that really sets Trinity HealthShare plans apart from the other health sharing companies.

They have access to the PCHS PPO network of providers nationwide!

This is huge!

Run your Trinity HealthShare plan provider search here (http://www.alierahealthcare.com/members/network/).

> Keep in mind that the individual/family ACA networks available now are about 1/3rd the size of the group networks (through employer) or the old grandfathered networks.

This has been the biggest issue since 2014.

By far.

The networks seem to be only shrinking with every year.

More of the ACA plans are moving to EPO's and HMO's as well.

Having a PPO available through Trinity HealthShare is a huge deal.

> Some of the other health care sharing ministries ONLY reimbursement members rather than paying providers

Also, since it's a PPO network, we get the negotiated PPO rates in-network for eligible expenses.

That's generally a savings of 30-60% on average even before we meet our Member Share of Responsibility Amount (MSRA - similar to Deductible).

> This is a big difference from some of the other health sharing plans. If you don't have a network card to show a hospital, that's not great. It's the first thing they ask for!

We've seen discounts even higher for labs and hospital care.

It's a big deal and we get it with the large PCHS PPO network nationwide.

Why Are Trinity HealthShare Plans So Popular Now

It's a two parter.

> First, if you're not eligible for a tax credit, you've seen the price double to triple since 2014.

Even on the high deductible Bronze plan.

At renewal, people are throwing in the towel.

It's either an option like Trinity HealthShare plans or no health plan.

> The pricing for Trinity HealthShare plans can be an affordable option.

On the flip side, you don't want to get hit with the tax penalty of 2.5% of income (California is re-instating in 2020)

You also don't want to get hit with a major health insurance bill.

> 60% of bankruptcies are due to unforeseen health issues.

For healthy people with no tax credit, Trinity HealthShare plans may be the only option.

You have to able to afford the monthly cost.

A large percentage of our ACA members lapse coverage due to an inability to pay the monthly premium.

Even people with tax credits!

That explains why health care sharing plans are doing so well.

The second part deals specifically with Trinity HealthShare

Trinity HealthShare is by far our favorite of the health care sharing ministries.

We've talked about why Trinity HealthShare plans is the best but it comes down to this.

- Benefits are most similar
- Network is real PPO nationwide network

- They don't decline people (they have waiting periods for pre-x)
- They have first dollar expenses (office visits, preventative, etc)

Most importantly...

They have the most relaxed statement of beliefs and qualifications.

They are open to more people than the others!

That alone makes them the choice for many people!

By default!

You can quote them here (QUOTE_INDIVIDUAL_FAMILY.htm) to look rates, plans, even the online application.

Who Do Trinity HealthShare Plans Work Best For?

This is important.

Trinity HealthShare plans are not for everyone.

Let's first say who it probably isn't a good fit for.

Trinity HealthShare plans (and health care sharing ministry plans in general) probably are not be good for:

- People eligible for a tax credit through Obamacare based on income
- People with existing conditions; especially more serious
- People already pregnant (10 month waiting period for maternity)
- People with extensive and/or expensive medications

Basically, most of this comes down to two points.

Cost

If you can get cheaper coverage on the ACA marketplace (due to tax credit), that's the way to go.

Most of you do not have that option and therefore, you're investigating Trinity HealthShare plans here.

Secondly, Existing Health

Remember when we said Trinity HealthShare plans were like the health plans we had before the ACA law?

Even back to 1999?

Trinity HealthShare doesn't decline people based on health but there will be waiting periods for pre-x conditions.

This means that the carrier will not pay out for expenses related pre-existing conditions for a period of time depending on the plan.

> **There are also waiting periods for specific services until you've been on the plan for a while.**

Maternity for example might have a 10 month waiting period.

You can see the plan benefits here or the Trinity HealthShare plan brochure here (http://www.alierahealth.com/index.cfm?id=272962).

Another big point...Trinity HealthShare does not cover mental health benefits except on certain plans.

We need to understand this and it's in our Acknowledgement above.

This is to protect our clients and make sure they understand their options.

> Net net...if you expect more serious health issues or have more serious pre-existing conditions, Trinity HealthShare plans might not be the right fit.

We can help you compare Trinity HealthShare plans and the ACA plans (quote here (QUOTE_INDIVIDUAL_FAMILY.htm)) for your situation.

There's no cost for our assistance as Certified Covered Ca agents and licensed Trinity HealthShare plan specialist.

Call 800-320-6269 or email us (mailto:help@calhealth.net).

So...Who Are Trinity HealthShare Plans Good For?

Trinity HealthShare plans works best for these people who:

- Do not qualify for a tax credit based on income
- Are in good health
- Do not have serious pre-existing conditions
- Cannot afford the standard ACA plans
- Are unable to enroll in the ACA plans (missed open enrollment, do not qualify for SEP, etc)
- Unable to afford ACA health plans
- Just want catastrophic plan to address the big bill
- Do not have mental health needs

That last one is important.

The health care sharing plans do not cover mental healthcare except for specific plans.

This would include psychotropic medications for mental health.

> One note...keep in mind that we can switch to ACA plans that address some of these holes at Open Enrollment of each year or if you have a SEP (major life change such as losing eligible health, marriage, birth, or move that affects options).

This really gives us a 12 month window worse case after which we can switch to an ACA plan if need be.

We have a full comparison of the Trinity HealthShare health sharing plans including InterimCare, CarePlus, Standard Plan, and Comprehensive plans here (compare-and-contrast-alieracare-health-sharing-plan-benefits.htm).

When Can You Enroll In Trinity HealthShare Plans?

This is the great news.

Any time of the year!

That's right.

There's no open enrollment with Trinity HealthShare plans.

This is a huge issue with ACA plans where you can only enroll:

- During Open Enrollment - typically Nov 1st - Jan 31st (shorter in some States)
- With Special Enrollment Trigger - usually marriage, loss of coverage, birth, move

Many people call outside of either period and they're stuck.

We've had short term coverage in 3 month blocks but that's not great.

> Trinity HealthShare is a much better fit for people who missed open enrollment.

Trinity HealthShare plans are also guaranteed issue.

They don't decline based on health.

Instead, they do it the old way where waiting periods for pre-existing conditions and certain new ones (maternity after 10 months etc) are imposed.

This is still better than Short term which also has pre-x conditions and can decline based on health.

If you can't enroll in ACA plans due to missing open enrollment, quote Trinity HealthShare plans here:

How To Quote Trinity HealthShare Plans

How to quote Trinity HealthShare health plans:

- Click here to access rates (How-to-Quote-Aliera-care-health-sharing-rates.htm)
- View rates based on age of oldest spouse
- View 3 different plan options with 3 different deductible per option

That's it!

It's Free. Online. And Fast.

How To Enroll In Trinity HealthShare Plans

Even easier.

How to Apply for Trinity HealthShare plans:

- Click here to online enroll page (How-to-Apply-for-Aliera-Care-health-sharing-plans.htm)
- Select "Enroll" for Trinity HealthShare Plans - Value, Plus, Premium from listed options (most popular plan by far)
- Enter basic information including date of birth and zip code
- Complete online application and billing option

That's it!

Everything is online and secure.

Hard copy of the application is also available at the link here:

(How-to-Apply-for-Aliera-Care-health-sharing-plans.htm)

Please let us know if you have any questions on the application.

We're here to help at 800-320-6269 or by email (mailto:help@calhealth.net).

If you don't have more serious pre-existing conditions (basically expect larger health care expenses)

AND

You can't (or don't want to afford) "Obamacare"...

Trinity HealthShare is our go-to option for people who can't enroll in Obamacare plans (alternative-to-obamacare-health-insurance.htm) now.

Keep in mind that we're very conservative with our clients.

> We have been helping people for almost 30 years now as INDEPENDENT, licensed agents.

We're also Certified Covered California agents.

Our interest is our client's.

We have clients that have been with us since 1995.

We break it down this way.

Health care sharing plans allow us to go back in time.

To plan design similar to what we had before Obamacare.

The rates reflect that. They need to understand the trade-offs (see What Trinity HealthShare plans are NOT)

> For a segment of the population, these plans are perfect (no tax credit, good health, just want catastrophic plan, can't afford ACA plans, etc)

Secondly, of the health care sharing ministries (there are 6), Trinity Healthshare (which Trinity HealthShare administers for) is the most reasonable, similar to health insurance, and sophisticated.

They also don't decline people or have very strict requirements on eligibility like the other health care sharing ministries.

Furthermore, we don't like the fact that the others exclude more people for other reasons than health.

That doesn't feel very American to us.

That's why we like Trinity HealthShare plans as an option where it makes sense.

Get more detail on Obamacare health coverage versus Health Sharing (obamacare-health-insurance-versus-health-sharing-comparison.htm).

We're happy to help you compare the two.

Our assistance is 100% free to you. The rates available through us is identical for either Trinity HealthShare or Obamacare.

You can get more information on why Trinity HealthShare plans are our favorite health care sharing option. (what-is-best-health-sharing-ministry-plan.htm)

Call 800-325-6269 or email us (mailto:help@calhealth.net).

Guide To Trinity HealthShare Health Sharing Plan Benefits

You can always get the full benefit summary via the quote below or access the brochure here (http://www.alierahealth.com/index.cfm?id=272962).

We're also here to help with any questions.

But let's give you a quick synopsis.

Make sure to check out the "health care sharing terminology" above so that you understand the different way to say things (versus insurance).

Trinity HealthShare Everyday plans are the most popular of Trinity HealthShare's options that aren't ACA compliant.

Basically, you have a choice of 9 options.

3 different MSRA (similar to deductible):

- $5000
- $7500
- $10000

Combined with 3 different plan types:

- Value

- Plus
- Premium

The MSRA is pretty straight forward.

This is the amount you're responsible (although you'll get PPO discounted rate in-network which usually knocks things down 30-60%)

The MSRA is your responsibility.

There is no percentage paid after that amount before you meet a cap.

It's all one number for covered events in a calendar year.

The three plan types

This is where the plans change a bit.

The brochure here is a great place to start:

BROCHURE (http://www.alierahealth.com/index.cfm?id=272962)

We really like the premium.

It's closest to what people expect in their plans.

The main thing we look for the is the per incident max payout which jumps to $500K on the premium.

This is huge to us and makes us feel a lot better about what we're recommending for our clients.

All three options have a lifetime max of $1M.

> Keep in mind that we can always change to ACA plans at year end worst case but $1M is what we had before the ACA.

Take a look at the benefit benefits via the quote or the brochure.

We're here to help with any other questions!

Trinity HealthShare Plan Pricing Versus Obamacare

If you are not eligible for a tax credit and you're in good health, this is the reason most people are moving to Trinity HealthShare

The rates can be affordable compared to full ACA plans.

That's only growing wider as the ACA plans go up each year at double digit rates.

It will speed us as healthy people move to plans like Trinity HealthShare

Here's a real example with 2018 rates:

- Age 60 and 60, 90603 zip code
- Trinity HealthShare - $7500 MSRA Premium plan - $634.80
- Blue Shield PPO ACA Bronze 60 - $1560.54

That number is probably going up quite a bit at open enrollment!

You can run your own quote here for Trinity HealthShare plans (How-to-Quote-Aliera-care-health-sharing-rates.htm) and here for Obamacare (QUOTE_INDIVIDUAL_FAMILY.htm).

Compare the Bronze rates to Trinity HealthShare's Premium plan with the $7500 deductible.

That's a good benchmark.

> Keep in mind that Trinity HealthShare plans are not insurance.

How To Find Trinity HealthShare Plan Agent

Good news...we're it!

> We are licensed and appointed agents with Trinity HealthShare

The rates are identical through us!

Absolutely 100% the same.

We can help you with the entire process:

- Plan Comparison and Selection
- Plan Quoting and Enrollment
- Membership Changes and Questions
- Throughout the year.
- Throughout the years.
- We've had 1000's of clients since 1995 and we're busier than ever.
- Roughly 1/3rd of our clients are referrals even with a crazy web presence.

How can we help you?

Trinity HealthShare Health Share Plan Review

We've covered a lot.

Here's the net take away:

> If you do not receive a tax credit and you're in good health and you can't afford Obamacare or being uninsured?

Trinity HealthShare health share plans have to be in the mix.

We do not jump quickly or lightly into new healthcare options.

We're conservative.

> Look to see if any other agent or website fully explains the trade-offs of health sharing plans the way we did.

Make an informed decision!

That's our goal.

It took us some time to really get behind this option after researching and studying it.

We have clients that call us every day and say"...

> "I can't afford this (Obamacare plan) anymore"

We're getting those calls too often these days.

Trinity HealthShare health share plans are our go-to option for those people and more.

We're happy to run a quote for you to see how it compares for your situation.

Important Links:

Trinity HealthShare Health Share Plan Brochure (http://www.alierahealth.com/index.cfm?id=272962)
Trinity HealthShare Health Share Plan Quote (How-to-Quote-Aliera-care-health-sharing-rates.htm)
Trinity HealthShare Health Share Plan Enroll (How-to-Apply-for-Aliera-Care-health-sharing-plans.htm)

> You can run your 2020 Trinity HealthShare health share plan quote here (How-to-Quote-Aliera-care-health-sharing-rates.htm) to view rates and plans

Again, there is absolutely no cost to you for our services. **Call 800-320-6269 Today!**

(Aliera-care-health-sharing-plan-review-rates-plans.htm)

(Aliera-care-health-sharing-plan-review-rates-plans.htm)

(Aliera-care-health-sharing-plan-review-rates-plans.htm)

and more

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Agency Reviews for All Plans

from ***SC***
"My sincere thanks for making a miracle happen- 2014 health coverage !! Many thanks for your expertise and advice yesterday !!"

from ***SD***
"Thanks again for your help - I had absolutely no idea how to get this done when I got up this morning. You've made it remarkably easier than I expected. I hope you're not stuck at the office all night..."

from ***KV***
"Anyway, I hope you got some time off this past week! Thank you again for your help and efforts on my behalf! I was very lucky to find you."

from ***EK***
"I thank you very much for the time that you have invested in handling everything

from ***SR***
"I truly appreciate the quick response and will think of you in the future if I need to make any changes to my insurance plans."

from ***VH***
"You are awesome... takes a huge worry off my back, thank you for your kind. thanks for your time and kindness. !!"

from ***SA***
"Wow, I can't thank you guys enough for your help...I couldn't imagine trying to tackle this on my own!"

from ***LM***
"You are my new best friend. A HUGE thank you again.

About Calhealth.Net

20+ years of experience in the California health market has taught us one thing...Competent and experienced guidance is INVALUABLE

We can quickly (very important) size up your health coverage needs and clearly explain the options available to you. Our focus is finding the most coverage at the best cost to you.

We are licensed Covered Ca agents with in-depth knowledge of their plans, process, and health sharing plans.

Our Request A 10 Minute Health Plan Check-Up

We'll quickly see if health sharing plans like Trinity HealthShare might be a good fit for you.

800-320-6269

Services are FREE to You

Calhealth.net is a Goodacre Insurance Services Website (health sharing plans are NOT insurance)

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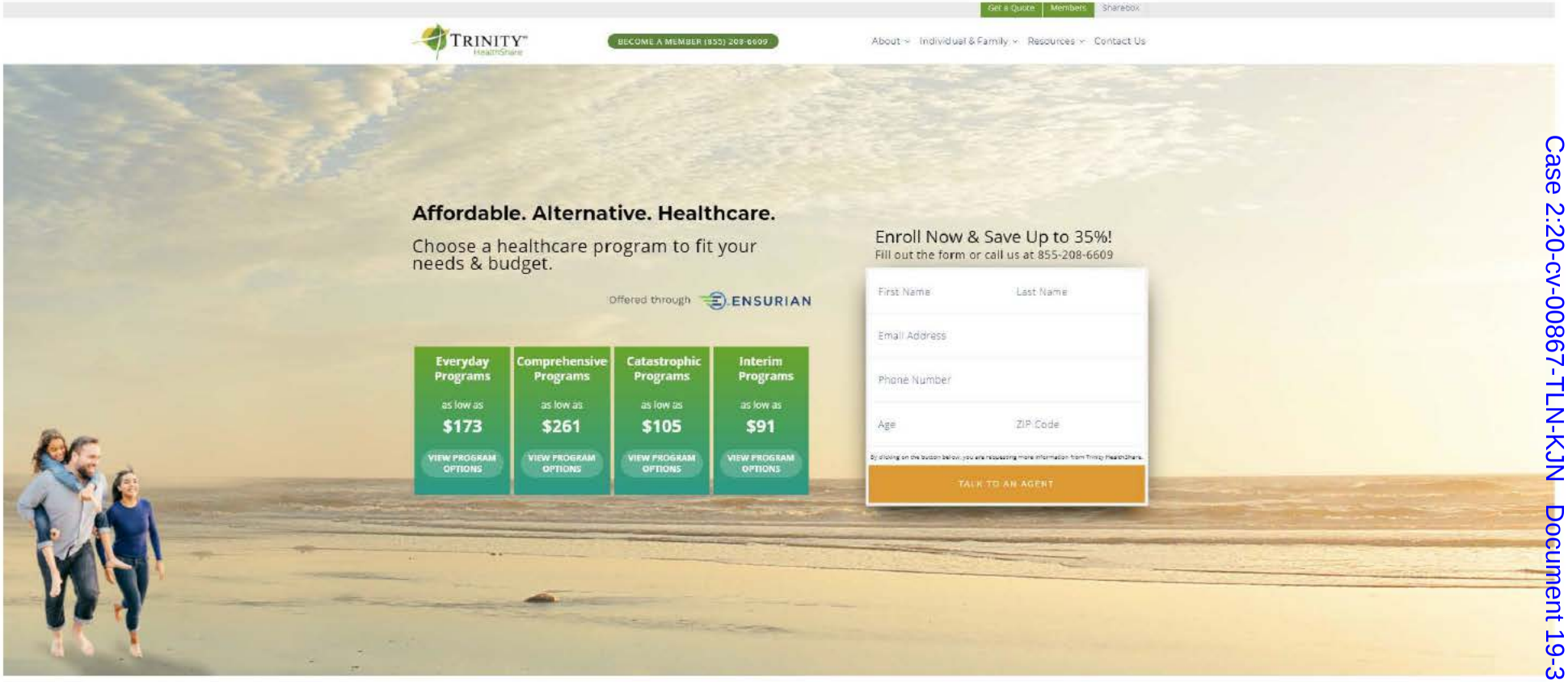
(https://www.facebook.com/pages/Calhealth/420824174626770) (https://plus.google.com/108076901415669235314/posts) (https://twitter.com/calhealthnet) (https://www.youtube.com/user/CalhealthVideo)

APPENDIX C



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

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

Solutions that work for *you* CONTACT US TODAY

Medical Cost Sharing: A Viable Alternative to Traditional Healthcare

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

Trinity HealthShare and traditional insurance are not the same

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

Traditional Health Insurance

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

Trinity HealthShare – HCSM

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

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

Traditional Health Insurance

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

Trinity HealthShare – HCSM

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

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

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

Learn about how healthcare sharing programs work.

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

1

Member Contribution

You send your contribution to Trinity

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

2

Activate

Activate Your Membership

Activate your membership through our partners website here.

3

Visit Network Doctor

Call the concierge line for appointments

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

4

Doctor Submits Bill

Your doctor sends the bill to Trinity

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

5

We Share Bill

Everyone shares in the cost

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

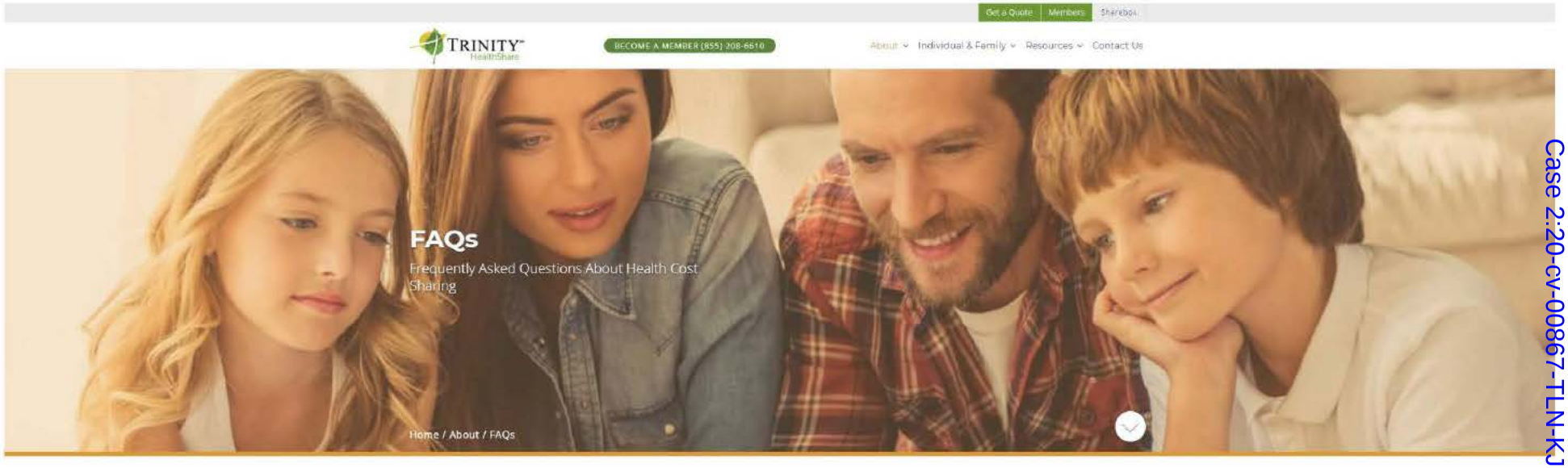
6

Payments To Doctors

Doctors and Hospitals are Paid

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

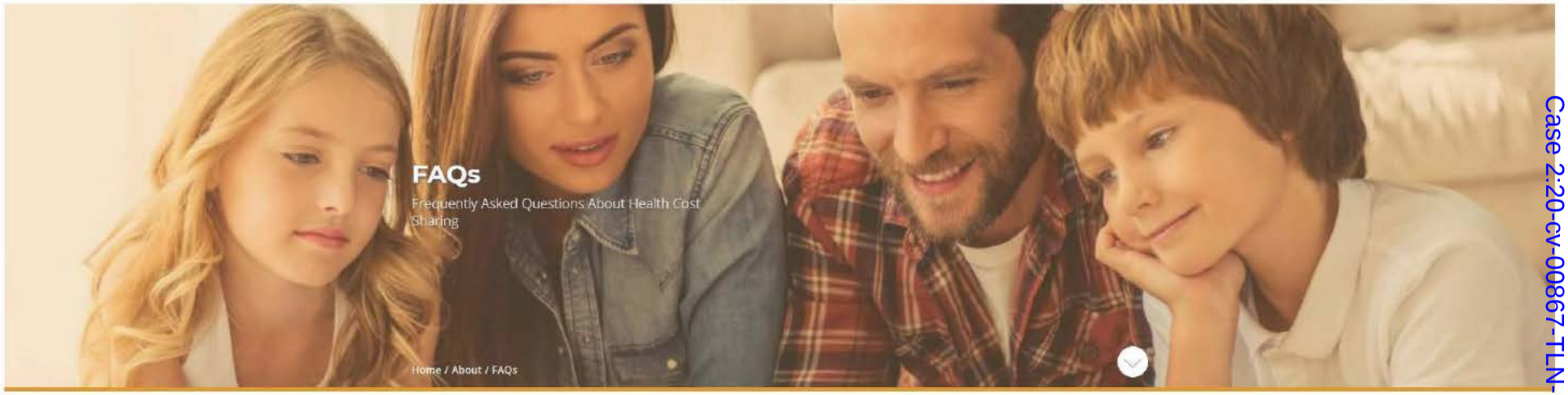
Affordable quality healthcare sharing programs can be found for those who embrace a healthy lifestyle. No longer does quality have to be sacrificed because of cost. With Trinity HealthShare, there is a viable alternative to traditional healthcare.



FAQs

▾ What medical needs are eligible for sharing?

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



FAQs

▸ What medical needs are eligible for sharing?

▾ Are maternity benefits included?

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

FAQs

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

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

FAQs

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

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

FAQs

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

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

FAQs

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

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

FAQs

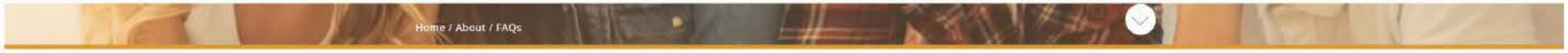
- What medical needs are eligible for sharing?
- Are maternity benefits included?
- How do I become a member?
- How much will Trinity HealthShare cost?
- Do contributions fluctuate each month?
- Are there religious restrictions for membership in Trinity HealthShare?
- What about pre-existing conditions?

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

FAQs

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

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



FAQs

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

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

FAQs

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

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

FAQs

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

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

FAQs

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

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

FAQs

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

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

FAQs

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- Are maternity benefits included?
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- How much will Trinity HealthShare cost?
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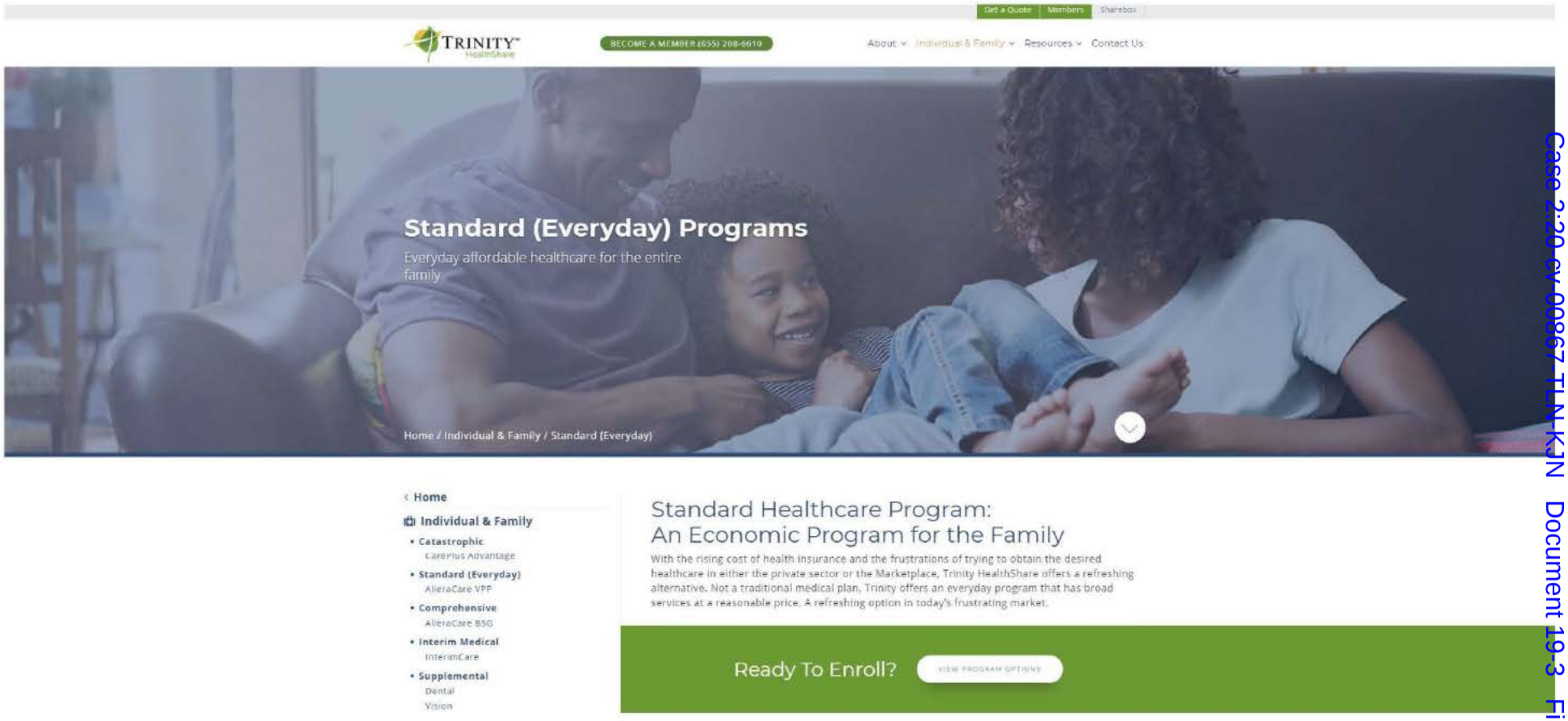
- How does my doctor or hospital get paid?
- What happens if I have a discrepancy with a non-eligible medical need?
- Can I be a member of Trinity HealthShare and also have medical insurance?
- Is Trinity HealthShare insurance?

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



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Standard Healthcare Program: An Economic Program for the Family

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

Ready To Enroll? VIEW PROGRAM OPTIONS

- **Interim Medical**
  - InterimCare
- **Supplemental**
  - Dental
  - Vision
- **Healthcare Cost Sharing**
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- **Basic Care**
  - PrimaCare

This is a Healthcare Sharing Ministry (HCSM) Product

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Ready To Enroll?

VIEW PROGRAM OPTIONS

Trinity's standard healthcare program

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

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

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

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

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

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

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

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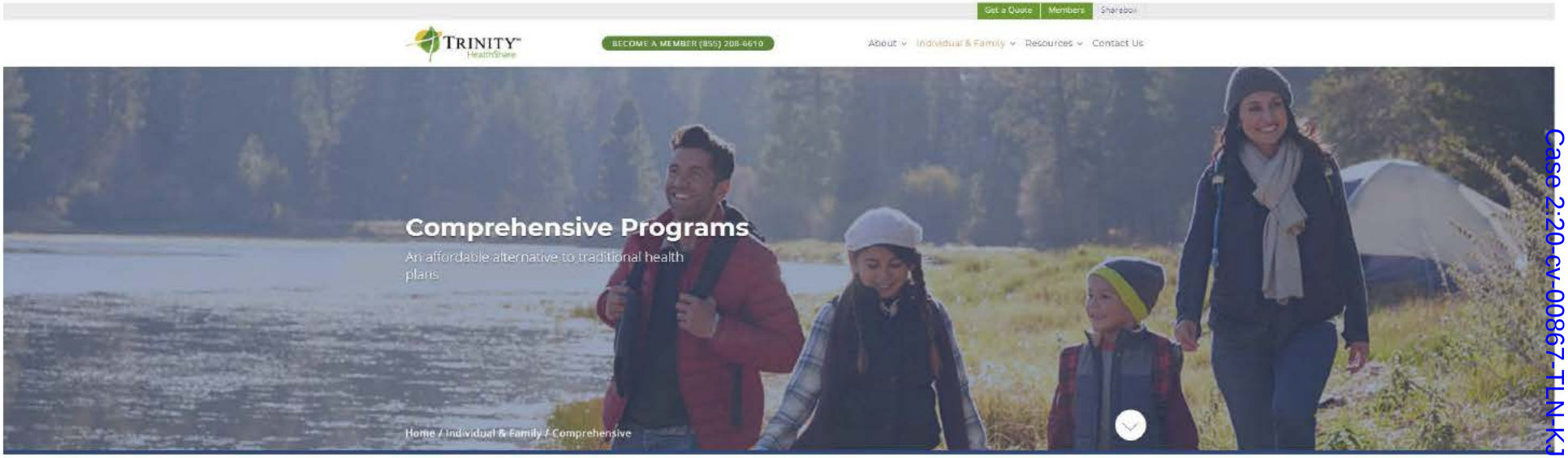
The standard healthcare plan's ideal candidate

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

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



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- Healthcare Cost Sharing

Comprehensive Healthcare: An Alternative to Major Medical

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

Ready To Enroll? VIEW PROGRAM OPTIONS

Vision

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What is a Trinity comprehensive program?

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

Services included in a Trinity comprehensive program:

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

The ideal candidate for a comprehensive medical program

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

Consider a Trinity comprehensive healthcare program if you:

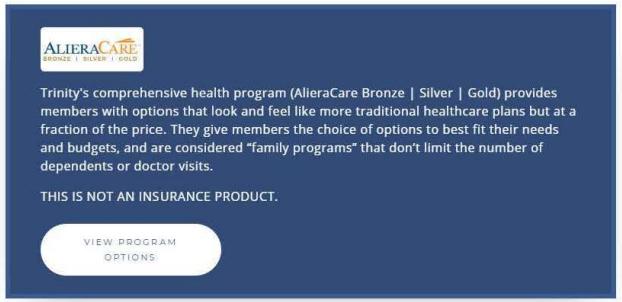
- Can't afford a traditional medical plan through Healthcare.gov or your employer
- Are not eligible for government subsidies
- Want a more comprehensive solution—similar to the traditional options you may be accustomed to seeing
- Missed open enrollment

How Trinity's comprehensive healthcare program works

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

Trinity HealthShare's membership requirements

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



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

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

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

Dental
Vision
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How It Works
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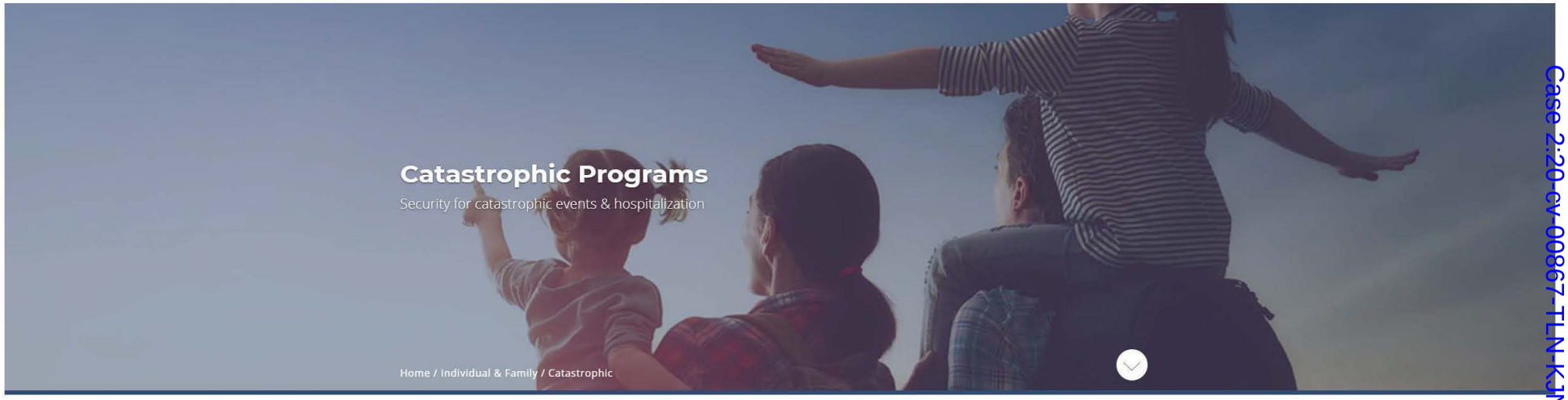
PrimaCare
Catastrophic
Trinity's catastrophic healthcare plan, CarePlus Advantage, is best suited for individuals and families who are primarily healthy and looking to provide security to their family knowing they are eligible for cost sharing for catastrophic hospitalization events or needs, plus emergency room cost sharing.
THIS IS NOT AN INSURANCE PRODUCT
VIEW PROGRAM OPTIONS
Standard (Everyday)
Trinity's standard healthcare plan, Trinity Value | Plus | Premium, is recommended for individuals and families who are primarily healthy and whose main concern is preventive services and basic medical needs, as well as cost sharing for a catastrophic care event.
THESE ARE NOT INSURANCE PRODUCTS
VIEW PROGRAM OPTIONS
Comprehensive
Trinity's comprehensive health plan, Trinity Bronze | Silver | Gold, is designed for those who want comprehensive healthcare closer to traditional medical plans, but are seeking affordable alternatives to major medical. From the doctor's office to the operating table, access comprehensive medical services when you need them most.
THESE ARE NOT INSURANCE PRODUCTS
VIEW PROGRAM OPTIONS

OPTIONS
Interim Medical
Trinity's interim medical health plan, InterimCare, is a great option for those in-between medical plans. Our interim plans are affordable, and are designed to cost share you and your family's healthcare expenses during a transition. InterimCare offers low cost care when you know you have infrequent medical needs, but still need peace of mind.
THESE ARE NOT INSURANCE PRODUCTS
VIEW PROGRAM OPTIONS
Supplemental
Life is full of unpredictable events, and unfortunately they often come when you least expect—and can least afford—it. Supplemental health plans help with out-of-pocket expenses associated with eye exams, teeth cleanings, ER visits, or prescription drugs.
THESE ARE NOT INSURANCE PRODUCTS
VIEW PLAN OPTIONS
Basic Care
Our basic care plans are a healthcare solution centered around the importance of primary care. Regardless of a person's age there is a critical need for regular preventive care, making a basic healthcare plan a necessity at minimum.
THESE ARE NOT INSURANCE PRODUCTS
VIEW PLAN OPTIONS



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Catastrophic Healthcare Program: Is It for Me?

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

Ready To Enroll? VIEW PROGRAM OPTIONS

- Healthcare Cost Sharing
  - How It Works
  - FAQs
- Basic Care
  - PrimaCare

This is a Healthcare Sharing Ministry (HCSM) Product

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Catastrophic healthcare cost sharing can give you peace of mind

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

The ideal candidate for a catastrophic medical program

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

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

The difference between catastrophic healthcare programs and major medical

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

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

How Trinity's catastrophic healthcare program works

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

How Trinity's catastrophic healthcare program works

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

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

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

APPENDIX D

2018-2019 MEMBER GUIDE

Gold Plan

ALIERACARE™

BRONZE | SILVER | GOLD

INDIVIDUAL & FAMILY

ALIERA™ HEALTHCARE

AlieraCare Plans are NOT Insurance.

CONTENTS

WELCOME

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

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

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

Member Portal

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

Contact Information

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

Phone: 844-834-3456

Fax: 404-937-6557

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

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

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

Disclaimer

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

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

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

PLAN SERVICES & MEMBERSHIP

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

Preventive Care

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

Episodic Primary Care

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

Chronic Maintenance

With an AlieraCare Bronze, Silver, or Gold plan, members are eligible to receive chronic care management from their primary care physician for conditions such as diabetes, asthma, blood pressure, cardiac conditions, etc.

Labs & Diagnostics

Labs at in-network facilities are included.

Telemedicine

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

Prescription Drug Program

The AlieraCare Bronze, Silver, or Gold prescription savings program delivers significant discounts for a variety of drugs (depending on prescription), saving members an average of 55% on prescription drug purchases. After $1,500 of prescription drug expenditures through Rx Valet, members are eligible for a percentage of reimbursement for preferred and mail order drugs. Maximum reimbursement of $4,000 per plan year. See Appendix for details.

Urgent Care

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

PLAN SERVICES & MEMBERSHIP AT A GLANCE

Membership

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

Specialty Care

For most everyday medical conditions, your PCP is your one-stop medical shop. However, there are cases when it's time to see a specialist who's had additional education and been board certified for that specialty. For situations like these, the AlieraCare 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.

Hospitalization

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

Surgery

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

Emergency Room

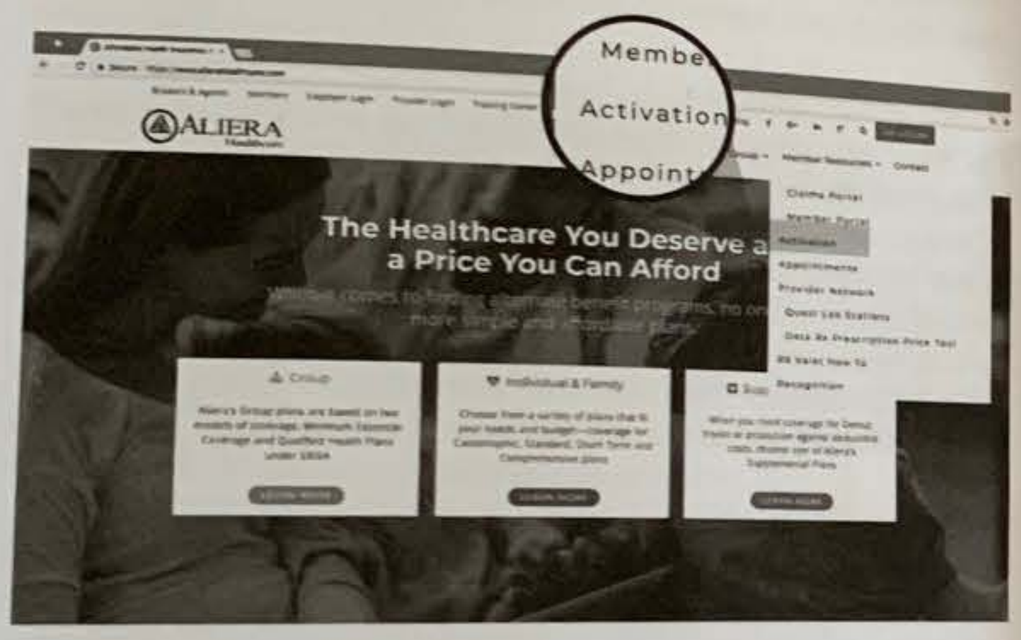
An emergency is defined as treatment that must be rendered to the patient immediately for the alleviation of the sudden onset of an unforeseen illness or injury that, if not treated, would lead to further disability or death. Examples of an emergency include, but are not limited to, severe pain, choking,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

TRINITY HealthShare

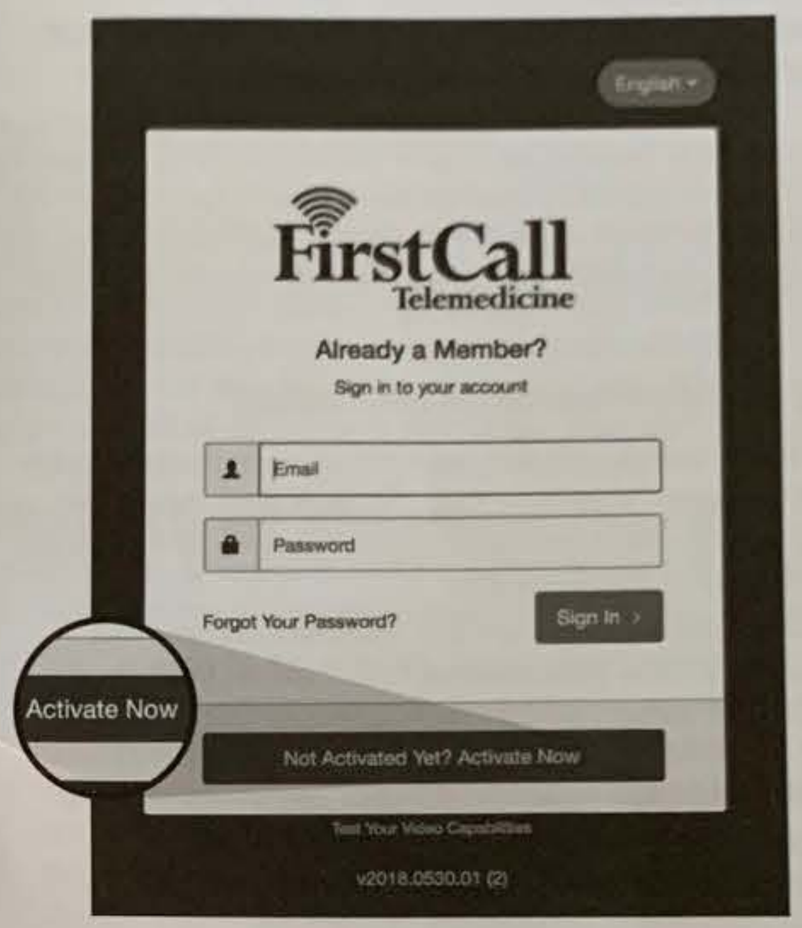
What does it mean?

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

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



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



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

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

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

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

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

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

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

Home Delivery Prescription Information:

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

Phone: 855-240-9368
NPI: 1174830475

Fax: 888-415-7906
NCPDP: 4229971

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

How to Use Your Membership

The Telemedicine Program

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

Offerings of the Telemedicine Program

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

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

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

PREVENTIVE CARE

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

How to Use Preventive Care Services

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

Labs and Diagnostics

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

URGENT CARE

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

- AlieraCare Bronze, Silver, and Gold plans have unlimited Urgent Care visits.
- See Appendix for your specific plan details.
- X-rays are included, and subject to $25 per read fee at Urgent Care.

How to Use the Urgent Care Service

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

If Urgent Care Services are Unavailable

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

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

Primary Care For Sick Care

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

- AlieraCare Bronze, Silver, and Gold plans have unlimited Primary Care visits.
- Annual Physicals are available immediately.
- For convenience, some clinics are open evenings and weekends.

How to Use Primary Care Service for Sick Care

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

Specialty Care

AlieraCare members are required to obtain referrals to visit a specialist, except for women in need of gynecological care for routine medical needs. Specialty visits have a consult fee at the time of service.

Hospitalization

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

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

PPO Network

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

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

Find a Network Healthcare Professional

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

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

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

PART II

How Your Healthcare Cost-Sharing Ministry (HCSM) Works

Membership Overview

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

Guidelines Purpose and Use

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

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

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

Individuals Helping Individuals

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

MEMBERSHIP QUALIFICATIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Monthly Contributions

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

Important Information About Plan Changes:

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

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

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

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

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

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

Early Voluntary Termination

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

MEMBERSHIP QUALIFICATIONS

Statement of Beliefs

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

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

DEFINITION OF TERMS

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

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

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

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

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

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

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

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

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

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

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

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

DEFINITION OF TERMS

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

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

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

Membership. All members of Trinity HealthShare.

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

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

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

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

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

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

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

CONTRIBUTORS' INSTRUCTIONS AND CONDITIONS

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

PART III

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

Eligible Medical Expenses*

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

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

1. **Allergy Office Visits and Testing**
2. **Anesthesiologist Services**
3. **Ambulance.** Emergency land or air ambulance transportation to the nearest medical facility capable of providing the medically necessary care to avoid seriously jeopardizing the sharing member's life or health. Air transportation is limited to $10,000.
4. **B12 Injections.** Eligible at a PCP or Specialist only.
5. **Birthing Center.** Eligible after MSRA.
6. **Cancer.** Cancer sharing eligibility is available immediately for new occurrences of cancer. Any pre-existing or recurring cancer condition is not eligible for sharing. Cancer sharing will not be available for individuals who have cancer at the time of or five (5) years prior to application. If cancer existed outside of the 5-year time frame of a pre-existing look-back, the following must be met in the five (5) years prior to application, to be eligible for future, non-recurring cancer incidents. 1. The condition had not been treated nor was future treatment prescribed/planned; 2. The condition had not produced harmful symptoms (only benign symptoms); 3. The condition had not deteriorated. Cancer is limited to a maximum per term of $500,000 when applicable.
7. **Chemotherapy.** Subject to cancer limitations.
8. **Radiation Therapy.** Subject to cancer limitations.

9. **Chronic Maintenance.** Chronic maintenance is eligible when a member has chosen a plan with chronic maintenance specifically included and a listing of the maximum number of allowable visits. See 'Appendix A' attached hereto.
10. **Cardiac Rehabilitation.** Eligible after MSRA.
11. **Diagnostic Lab & Pathology.** Eligible after MSRA.
12. **Diagnostic Lab & Radiology.** Eligible after MSRA.
13. **Emergency Room.** Emergency room services for stabilization or initiation of treatment of a medical emergency condition provided on an outpatient basis at a hospital, clinic, or Urgent Care facility, including when hospital admission occurs within twenty-three (23) hours of emergency room treatment.
14. **Eye Care.** Limited to medical necessity and accident only. Excludes cosmetic, frames, lenses, contacts, extensive eye exams and subject to pre-existing limitations.
15. **Home Health Care.** Eligible after MSRA.
16. **Home Infusion Services.** Eligible after MSRA.
17. **Hospice Services.** Eligible after MSRA.
18. **Hospitalization.** Hospital charges for inpatient or outpatient hospital treatment or surgery for a medically diagnosed condition.
19. **Maternity.** AlieraCare Bronze, Silver, and Gold plans have full maternity offerings. Medical expenses for maternity ending in a delivery by emergency cesarean section that are medically necessary, are eligible for sharing up to $8,000, subject to the applicable Member Shared Responsibility Amount. Medical expenses for a newborn arising from complications at the time of delivery, including, but not limited to, premature birth, are treated as a separate incident and limited to $50,000 of eligible sharing, subject to the Member Shared Responsibility Amount.
20. **Mental Health.** Plan holders are eligible for $2,500 (max) for Psychotherapy office visits and $1,000 (max) at out-patient facilities. Excludes in-patient and residential settings.
21. **Occupational Therapy.** Up to six (6) visits per membership year for occupational therapy
22. **Organ Transplant Limit.** Eligible needs requiring organ transplant may be shared up to a maximum of $150,000 per member. This includes all costs in conjunction with the actual transplant procedure. Needs requiring multiple organ transplants will be considered on a case-by-case basis.

23. **Physical Therapy.** Up to six (6) visits per membership year for physical therapy by a licensed physical therapist.
24. **Podiatry Services.** Eligible after MSRA.
25. **Preadmission Testing.** Eligible after MSRA.
26. **Prescription Drugs.** The AlieraCare plan includes a service by RX Valet, which includes discounts for prescription drugs. See Appendix for details.
27. **Preventive.** Most programs from either Trinity or Aliera provide everyone with the necessities of the 64 preventive care services as outlined by the United States Preventive Task force. (Excludes CarePlus Advantage.) Preventive care includes the PCP office visit and does not require a co-expense or consult fee.
28. **Primary Care.** Depending on your plan choice, primary care is at the core of preventing medical issues from escalating into a more catastrophic need. See Appendix for the specific plan details.
29. **Pulmonary Rehab**
30. **Retail Walk in Clinics.** Subject to specialty consult fee based on plan chosen. See Appendix for details.
31. **Routine Hearing Exams.** At Primary Care (PCP) only.
32. **Routine Nursing Care of Newborn Infant.** Eligible after MSRA.
33. **Skilled Nursing Facility.** Eligible after MSRA.
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.
35. **Smoking Cessation.** Members who have acknowledged they smoke and made an additional contribution are provided the opportunity to obtain free smoking cessation medication and counseling through the eligible preventive services.
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.

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

37. **Speech Therapy.** Up to six (6) visits per membership year. Only applicable after a stroke.
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.
39. **Telemedicine.** Telemedicine is included in all AlieraCare programs offered by Trinity HealthShare and Aliera Healthcare as your first line of defense. Your membership provides you and your family 24/7/365 access to a U.S. Board certified medical doctor.
40. **Urgent Care.** If your plan provides cost-sharing for Urgent Care, you will have the added benefit of enjoying the ability to choose an Urgent Care facility in lieu of an emergency room. See the Appendix for any urgent care options and any limitations to plan.
41. **X-rays.** X-rays listed on your plan details in the Appendix are for imaging services at PCP or Urgent Care facilities only and require a $25 read fee per view at time of service. Your MSRA will apply to all other x-rays. MRI, CT Scans and other diagnostics must be paid with your MSRA before cost-sharing is provided.

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

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

1. **Lifetime Limits.** $1,000,000: the maximum amount shared for eligible needs over the course of an individual member's lifetime.
2. **Per Incident.** The occurrence of one particular sickness, illness, or accident.
3. **Cancer Limits when applicable.** Cancer is limited to a maximum per term of $500,000 when applicable
4. **Member Shared Responsibility Amounts (MSRA).** Eligible needs are limited to the amounts in excess of the MSRA, which are applied per individual member per the plan year. MSRA(s). The eligible amount that does not qualify for sharing based on the membership type chosen by the member.
5. **Non-Affiliated Practitioner.** Services rendered by a non-affiliated practitioner will not be eligible for sharing nor will any amount be applied to your MRSA unless specified differently in the plan details contained herein.

Cost-Sharing for Pre-Existing Conditions

Bronze Program cost-sharing parameters for pre-existing conditions. The following restrictions are only applicable to a pre-existing condition 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 condition 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.

Silver Program cost-sharing parameters for pre-existing conditions. The following restrictions are only applicable to a pre-existing condition and do not affect normal sharing for other non-pre-existing related incidents, events, etc.

1. During the first two years of continuous membership, sharing is available up to $10,000 of total medical expenses incurred for pre-existing conditions per year, after a separate MSRA equal to two times your plan MSRA.
2. Upon inception of the 25th month of continuous

membership and thereafter, the condition 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.

Gold Program cost-sharing parameters for pre-existing conditions. The following restrictions are only applicable to a pre-existing condition and do not affect normal sharing for other non-pre-existing related incidents, events, etc.

1. During the first two years of continuous membership, sharing is available up to $20,000 of total medical expenses incurred for a pre-existing condition per year, after a separate MSRA equal to two times your plan MSRA.
2. Upon the inception of the 25th month of continuous membership and thereafter, the condition 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.

Other Resources. Offerings 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 that those sources do not pay, the member is authorized to submit the excess medical expenses for sharing, and the MSRA will be waived, up to the maximum MSRA as defined in the member's plan. The MSRA will only be waived if a third party source pays on the member's behalf. Sharing of monthly contributions for a need that is later paid, or found to payable by another source will automatically allow Trinity HealthShare full rights to recover the amounts that were shared with the member.

MEDICAL EXPENSES NOT GENERALLY SHARED BY HCSM

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

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

1. Abortion Services
2. Acupuncture Services
3. Aqua Therapy
4. Biofeedback
5. Birth Control (Male) Elective Sterilization
6. Birth Control (Male) Reversal of Sterilization
7. Cataract Contacts or Glasses
8. Chemical Face Peels
9. Chiropractic Services
10. Christian Science Practitioner
11. Cochlear Devices
12. Cosmetic Surgery
13. Custodial Care Services
14. Dental Services
15. Dermabrasion Services
16. Diabetic Insulin, Supplies, and Syringes
17. Doula
18. Durable Medical Equipment
19. Education Services
20. Exercise Equipment
21. Experimental Drugs
22. Experimental Procedures
23. Extreme sports: Sports that voluntarily put an individual in a life-threatening situation. Sports such as but not limited to "free climb" rock climbing, parachuting, fighting, martial arts, racing, cliff diving, powerboat racing, air racing, motorcycle racing, extreme skiing, wingsuit, and similar.
24. Gender Dysphoria Office Visit – PCP
25. Gender Dysphoria Office Visit – Specialist
26. Gender Dysphoria
27. Genetic Testing
28. Group Therapy Services
29. Hemodialysis

MEDICAL EXPENSES NOT GENERALLY SHARED BY HCSM

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

PRE-AUTHORIZATION REQUIRED

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

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

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

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

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

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

DISPUTE RESOLUTION AND APPEAL

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

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

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

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

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

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

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

DISPUTE RESOLUTION AND APPEAL

D. **Final Appeal.** If the aggrieved sharing member disagrees with the conclusion of his/her fellow sharing members, then the aggrieved party may ask that the dispute be submitted to a medical expense auditor, who shall have the matter reviewed by a panel consisting of personnel who were not involved in the original determination and who shall render their opinion in writing within thirty (30) days, unless additional medical documentation is required to make an accurate decision.

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

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

APPENDIX A: PLAN DETAILS BRONZE LEVEL

PPO Network	PPO Multiplan PHCS	
Eligible Medical Cost-Sharing	**Network**	**Non-Network**
Eligible prior to meeting Member Shared Responsibility Amount (MSRA)		
Wellness & Preventive Care	100%	50% after MSRA
Telemedicine	Unlimited	Unlimited
Primary Care	$50 Consult Fee	50% after MSRA
Specialty Care	$125 Consult Fee	50% after MSRA
Urgent Care	$100 Consult Fee	50% after MSRA
Emergency Room Services[1] Emergency room services including hospital facility and physician charges.	$500 Consult Fee	$500 Consult Fee
Eligible after meeting Member Shared Responsibility Amount (MSRA)[2,3,4]		
MSRA Per member 1 (1–2 members)	$1,000, $2,500, $5,000, $10,000	50% towards MSRA
MSRA Family maximum (3+ members)	$3,000, $7,500, $15,000, $30,000	50% towards MSRA
Out-of-Pocket Maximum Per member 1 (1–2 members)	$3,000, $7,500, $15,000, $30,000	$6,000, $15,000, $30,000, $60,000
Out-of-Pocket Maximum – Family maximum (3+ members)	$9,000, $22,500, $45,000, $90,000	$18,000, $45,000, $90,000, $180,000
Co-expense (Plan Pays)	60% after MSRA	50% after MSRA
Hospitalization In-Patient	60% after MSRA	50% after MSRA
Hospitalization Out-Patient	60% after MSRA	50% after MSRA
Imaging Eligible charges for CT, PET scans, MRIs, and the charges for related supplies.	60% after MSRA	50% after MSRA
Laboratory Out-Patient and Professional Services Sharing eligible for professional components of labs, including office, out-patient, and in-patient charges.	60% after MSRA	50% after MSRA
X-rays and Diagnostic Imaging Sharing eligible for the professional components of labs, including the office, out-patient, and in-patient charges.	60% after MSRA	50% after MSRA
Generic Prescription Drugs	No Cost-Sharing	Not eligible
Preferred Brand Drugs	50% Cost-Sharing*	Not eligible
Non-Preferred Brand Drugs	No Cost-Sharing	Not eligible
Mail-Order	75% Cost-Sharing*	Not eligible

See Legal Appendix on page 36

APPENDIX A: PLAN DETAILS
SILVER LEVEL

	PPO Network	PPO Multiplan PHCS
Eligible Medical Cost-Sharing	**Network**	**Non-Network**
Eligible prior to meeting Member Shared Responsibility Amount (MSRA)		
Wellness & Preventive Care	100%	60% after MSRA
Telemedicine	Unlimited	Unlimited
Primary Care	$35 Consult Fee	60% after MSRA
Specialty Care	$75 Consult Fee	60% after MSRA
Urgent Care	$75 Consult Fee	60% after MSRA
Emergency Room Services[1] Emergency room services including hospital facility and physician charges.	$300 Consult Fee	$500 Consult Fee
Eligible after meeting Member Shared Responsibility Amount (MSRA)[2,3,4]		
MSRA Per member 1 (1–2 members)	$1,000, $2,500, $5,000, $10,000	60% towards MSRA
MSRA Family maximum (3+ members)	$3,000, $7,500, $15,000, $30,000	60% towards MSRA
Out-of-Pocket Maximum Per member 1 (1–2 members)	$3,000, $7,500, $15,000, $30,000	$6,000, $15,000, $30,000, $60,000
Out-of-Pocket Maximum – Family maximum (3+ members)	$9,000, $22,500, $45,000, $90,000	$18,000, $45,000, $90,000, $180,000
Co-expense (Plan Pays)	70% after MSRA	60% after MSRA
Hospitalization In-Patient	70% after MSRA	60% after MSRA
Hospitalization Out-Patient	70% after MSRA	60% after MSRA
Imaging Eligible charges for CT, PET scans, MRIs, and the charges for related supplies.	70% after MSRA	60% after MSRA
Laboratory Out-Patient and Professional Services Sharing eligible for professional components of labs, including office, out-patient, and in-patient charges.	70% after MSRA	60% after MSRA
X-rays and Diagnostic Imaging Sharing eligible for the professional components of labs, including the office, out-patient, and in-patient charges.	70% after MSRA	60% after MSRA
Generic Prescription Drugs	No Cost-Sharing	Not eligible
Preferred Brand Drugs	50% Cost-Sharing*	Not eligible
Non-Preferred Brand Drugs	No Cost-Sharing	Not eligible
Mail-Order	75% Cost-Sharing*	Not eligible

See Legal Appendix on page 37

APPENDIX A: PLAN DETAILS
GOLD LEVEL

	PPO Network	PPO Multiplan PHCS
Eligible Medical Cost-Sharing	**Network**	**Non-Network**
Eligible prior to meeting Member Shared Responsibility Amount (MSRA)		
Wellness & Preventive Care	100%	70% after MSRA
Telemedicine	Unlimited	Unlimited
Primary Care	$20 Consult Fee	70% after MSRA
Specialty Care	$75 Consult Fee	70% after MSRA
Urgent Care	$75 Consult Fee	70% after MSRA
Emergency Room Services[1] Emergency room services including hospital facility and physician charges.	$150 Consult Fee	$300 Consult Fee
Eligible after meeting Member Shared Responsibility Amount (MSRA)[2,3,4]		
MSRA Per member 1 (1–2 members)	$1,000, $2,500, $5,000, $10,000	70% towards MSRA
MSRA Family maximum (3+ members)	$3,000, $7,500, $15,000, $30,000	70% towards MSRA
Out-of-Pocket Maximum Per member 1 (1–2 members)	$3,000, $7,500, $15,000, $30,000	$6,000, $15,000, $30,000, $60,000
Out-of-Pocket Maximum – Family maximum (3+ members)	$9,000, $22,500, $45,000, $90,000	$18,000, $45,000, $90,000, $180,000
Co-expense (Plan Pays)	80% after MSRA	70% after MSRA
Hospitalization In-Patient	80% after MSRA	70% after MSRA
Hospitalization Out-Patient	80% after MSRA	70% after MSRA
Imaging Eligible charges for CT, PET scans, MRIs, and the charges for related supplies.	80% after MSRA	70% after MSRA
Laboratory Out-Patient and Professional Services Sharing eligible for professional components of labs, including office, out-patient, and in-patient charges.	80% after MSRA	70% after MSRA
X-rays and Diagnostic Imaging Sharing eligible for the professional components of labs, including the office, out-patient, and in-patient charges.	80% after MSRA	70% after MSRA
Generic Prescription Drugs	No Cost-Sharing	Not eligible
Preferred Brand Drugs	50% Cost-Sharing*	Not eligible
Non-Preferred Brand Drugs	No Cost-Sharing	Not eligible
Mail-Order	75% Cost-Sharing*	Not eligible

See Legal Appendix on page 38

APPENDIX A: PLAN DETAILS
BRONZE

Lifetime Maximum Sharing: $1,000,000

Bronze Program cost-sharing parameters for pre-existing conditions. Hospitalization, In-Patient and Out-Patient Surgery, Specialty Care, and Emergency Room services for pre-existing conditions have a 24 month waiting period. All other healthcare services for pre-existing conditions are eligible upon effective date.

a. Pre-existing Condition: 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.

b. Upon the 25th month of continuous membership and thereafter, the condition will no longer be subject to the pre-existing condition sharing limitations.

c. Appeals may be considered for earlier sharing in surgical interventions when it is in the best interest of both the members and the membership to do so.

Cancer sharing is available immediately. Cancer sharing is only available for non-recurrent cancer diagnosis.

1. ER visits are subject to review, and are meant only for life threatening situations.

2. All members seeking cost-sharing must use the prescription services Rx Valet included with your plan. Prescription drugs are eligible for cost-sharing by the percentage shown once a separate MSRA of $1,500 for all prescriptions is met. Members are required to pay prescription cost out-of-pocket before submitting receipts to Trinity HealthShare mailing address, Attn. Trinity Rx Claims, for review and cost-sharing. Maximum reimbursement of $4,000 per plan year.

3. Members under the age of 20 can qualify as dependents. Members ages 20–26 can qualify as a dependent if proven to be a full-time student. Trinity HealthShare plans follow medical eligibility review protocols described in the plan but are not a promise to pay. Sharing is available for all eligible medical needs.

Administrative and Conditional Fees: $125 one-time application fee per enrollment

Products NOT available in: AK, HI, MD, ME, PR, WA, WY; subject to change w/o prior notice.

APPENDIX A: PLAN DETAILS
SILVER

Lifetime Maximum Sharing: $1,000,000

Silver Program cost-sharing parameters for pre-existing conditions. Hospitalization, In-Patient and Out-Patient Surgery, Specialty Care, and Emergency Room services for pre-existing conditions have limitations during the first 24 months of membership.

a. During the first two years (24 months) of continuous membership, sharing is available up to $10,000 of total medical expenses incurred for pre-existing conditions per year, after a separate MSRA equal to two times your plan MSRA.

b. Upon inception of the 25th month of continuous membership and thereafter, the condition may no longer be subject to the pre-existing condition sharing limitations.

c. 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 sharing is available immediately. Cancer sharing is only available for non-recurrent cancer diagnosis.

1. ER visits are subject to review, and are meant only for life threatening situations.

2. All members seeking cost-sharing must use the prescription services Rx Valet included with your plan. Prescription drugs are eligible for cost-sharing by the percentage shown once a separate MSRA of $1,500 for all prescriptions is met. Members are required to pay prescription cost
out-of-pocket before submitting receipts to Trinity HealthShare mailing address, Attn. Trinity Rx Claims, for review and cost-sharing. Maximum reimbursement of $4,000 per plan year.

3. Members under the age of 20 can qualify as dependents. Members ages 20–26 can qualify as a dependent if proven to be a full-time student. Trinity HealthShare plans follow medical eligibility review protocols described in the plan but are not a promise to pay. Sharing is available for all eligible medical needs.

Administrative and Conditional Fees: $125 one-time application fee per enrollment

Products NOT available in: AK, HI, MD, ME, PR, WA, WY; subject to change w/o prior notice.

APPENDIX A: PLAN DETAILS GOLD

Lifetime Maximum Sharing: $1,000,000

Gold Program cost-sharing parameters for pre-existing conditions. Hospitalization, Hospitalization, In-Patient and Out-Patient Surgery, Specialty Care, and Emergency Room services for pre-existing conditions have limitations during the first 24 months of membership.

a. During the first two years (24 months) of continuous membership, sharing is available up to $20,000 of total medical expenses incurred for pre-existing conditions per year, after a separate MSRA equal to two times your plan MSRA.

b. Upon inception of the 25th month of continuous membership and thereafter, the condition may no longer be subject to the pre-existing condition sharing limitations.

c. 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 sharing is available immediately. Cancer sharing is only available for non-recurrent cancer diagnosis.

1. ER visits are subject to review, and are meant only for life threatening situations.
2. All members seeking cost-sharing must use the prescription services Rx Valet included with your plan. Prescription drugs are eligible for cost-sharing by the percentage shown once a separate MSRA of $1,500 for all prescriptions is met. Members are required to pay prescription cost out-of-pocket before submitting receipts to Trinity HealthShare mailing address, Attn. Trinity Rx Claims, for review and cost-sharing. Maximum reimbursement of $4,000 per plan year.
3. Members under the age of 20 can qualify as dependents. Members ages 20–26 can qualify as a dependent if proven to be a full-time student. Trinity HealthShare plans follow medical eligibility review protocols described in the plan but are not a promise to pay. Sharing is available for all eligible medical needs.

Administrative and Conditional Fees: $125 one-time application fee per enrollment

Products NOT available in: AK, HI, MD, ME, PR, WA, WY; subject to change w/o prior notice.

APPENDIX B: TERMS, CONDITIONS, & SPECIAL CONSIDERATIONS

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

APPENDIX B: TERMS, CONDITIONS, & SPECIAL CONSIDERATIONS

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

Disclosures

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

Abbreviations

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

APPENDIX C: LEGAL NOTICES

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

General Legal Notice

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

State Specific Notices

Alabama Code Title 22-6A-2

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

Arizona Statute 20-122

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

Arkansas Code 23-60-104.2

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.

Maryland Article 48, Section 1-202(4)

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

Mississippi Title 83-77-1

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

Missouri Section 376.1750

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

Nebraska Revised Statute Chapter 44-311

IMPORTANT NOTICE. This organization is not an insurance 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.

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

Virginia Code 38.2-6300-6301

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

ALIERACARE™

BRONZE | SILVER | GOLD

TRINITY HealthShare

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

APPENDIX E

ALIERA Healthcare

UNITY™ HEALTHSHARE

BRONZE | SILVER | GOLD

MEMBER QUICK GUIDE & SHARING NEEDS

COMPREHENSIVE

UNITY™ HEALTHSHARE

Plans Presented By

ALIERA™ Healthcare

5901 Peachtree Dunwoody Road, Suite B-200
Atlanta, GA 30328
Toll-free 844-834-3456
www.AlieraHealthcare.com

Sharing is Caring

MEMBER QUICK GUIDE

CONTENTS

MEMBER QUICK GUIDE

WELCOME!

Welcome to our community of benefits. Unity HealthShare, a healthcare sharing ministry, is presented, marketed and managed exclusively by Aliera Healthcare, Inc. We are committed to providing you and your family with unparalleled service and care at an affordable cost, and we pledge to keep our focus on what's most important – your overall health and wellness.

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

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

Member Portal

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

Contact Information

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

Phone: 844-834-3456
eFax: 1-404-937-6557 (+1 required on eFax)
Email: memberservices@alierahealthcare.com
memberservices@unityhealthshare.com
Online: www.alierahealthcare.com
Mail: 5901 Peachtree Dunwoody Road
Suite B-200
Atlanta Georgia 30328

Disclaimer

Unity HealthShare[SM] is a faith-based medical need sharing membership. Medical needs are only shared by the members according to the membership guidelines. Our members agree to the Statement of Beliefs and voluntarily

submit monthly contributions into an escrow account with Unity HealthShare[SM] acting as a neutral clearing house between members. Organizations like ours have been operating successfully for over fifty years. We are including the following caveat for all to consider:

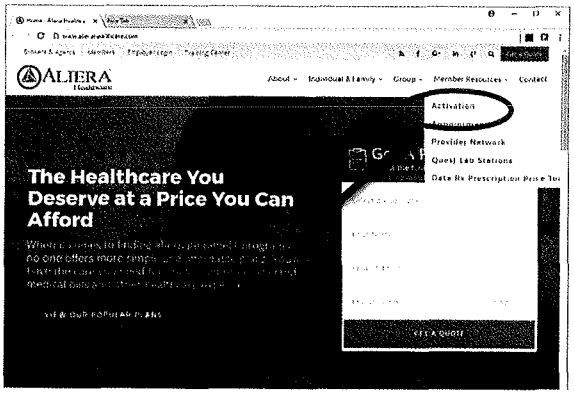
This publication or membership is not issued by an insurance company, nor is it offered through an insurance company. This publication or the membership does not guarantee or promise that your eligible medical needs will be shared by the membership. This publication or the membership should never be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

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

GETTING STARTED

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

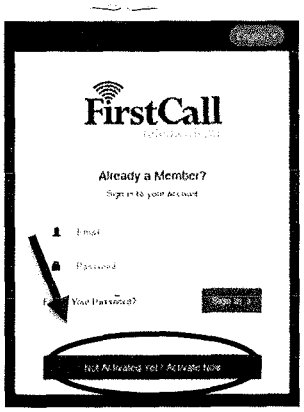
1. **Activate Your Membership**
   Visit www.alierahealthcare.com to securely enter your information. Click the Activate tab on the navigation bar or under the Member Services area and follow the instructions. If you require assistance, contact a Member Care Specialist toll-free at (844) 834-3456 or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



2. **Set Up Your Telemedicine Account**
   Follow the steps below to set up your telemedicine account. If you have not activated your Membership

Card, or if your Membership fees are not paid up to date, you are not eligible to set up your telemedicine account.

- Set up your account (Primary Member)
  Visit www.firstcalltelemed.com, Click "Set up account." Follow the online instructions and provide the required information, including your medical history.



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

3. **Review Your Benefits**
   This guide contains the information you need to understand each benefit available with your Plan. Keep your Member Card with you at all times; the contact number for your telemedicine provider is printed on your card. You must always contact your telemedicine provider before seeking medical attention.

PART I

How to Use Your Membership

THE TELEMEDICINE PROGRAM

More than 80% of primary medical conditions can be resolved by your telemedicine provider. Unity Members are required to contact their telemedicine provider first for quick, convenient medical assistance. The contact information for your telemedicine provider is found on your member card from the telemedicine provider.

Benefits of the Telemedicine Program

- At home, at work, or while traveling in the US, speak to a telemedicine doctor from anywhere, anytime, on the go!
- 24/7 access to a doctor via face-to-face internet consultation or by phone is available for you and dependents on your Plan.
- Speak with the next available doctor or schedule an appointment for a more convenient time.
- Telemedicine doctors typically respond within 15 to 30 minutes of your call.
- Save time and money by avoiding expensive emergency room visits, waiting for an appointment, or driving to a local facility.
- Telemedicine consultations are free for you and dependents on your Plan.
- Telemedicine providers can treat conditions such as:

- ► Cold and flu symptoms
- ► Bronchitis
- ► Allergies
- ► Poison ivy
- ► Pink eye
- ► Urinary tract infections
- ► Respiratory infections
- ► Sinus problems
- ► Ear infections; and more!

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

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

CONCIERGE SERVICE & CARE COORDINATION

Our care coordination service is designed to help members navigate the healthcare system effectively and efficiently. Aliera's Concierge Service smoothly coordinates your medical care. Members are encouraged to contact Aliera's Concierge Service for scheduling appointments for all services.

How to Use the Concierge Service

1. Always call your telemedicine provider first when you have a medical issue. The contact information for your telemedicine provider is found on your membership card from the telemedicine provider.
2. If the telemedicine provider is unable to resolve your medical issue and recommends further treatment, the Member may contact Aliera's Concierge Service at (844) 834-3456 for

coordination of your care and scheduling of appointments with doctors and urgent care facilities. Members are not required to use the concierge but it is available for your convenience.

3. Be sure to have your Membership number available when contacting Aliera's Concierge Service. Membership numbers are located on the front of your member card.
4. When you arrive for your appointment at the provider's location, please present your Membership Card and one photo ID. The front desk admin will check your eligibility status. If you have not activated your Membership Card, or if Membership fees are not current, your Plan will not cover the costs of the provider.
5. If your PCP makes a referral to a specialist or another provider, contact Aliera's Concierge Service at (844) 834-3456 to schedule and coordinate your visit. Emergency room, hospitalization, and specialty services are described under Part II (HCSM) and Part III (Eligible Needs and Limitations) of this document.

PREVENTIVE CARE

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

How to Use Preventive Care Services

1. Download the Preventive Healthcare Guidebook from the link found in your Welcome email or visit us online at www.AlieraHealthcare.com. or www.unityhealthshare.com
2. Members do not need to call their telemedicine provider to schedule preventive care. However, all preventive care appointments must be scheduled through Aliera's Concierge Service at (844) 834-3456.
3. Aliera cannot guarantee that a provider will accept an Aliera/Unity Plan if the Member fails to contact our Concierge Service first. Please allow 7–10 days for preventive care appointments.
4. Immunization, imaging, and radiological services are provided at select network centers in each state. Call Aliera's Concierge Service to schedule an appointment. Please allow up to three weeks for an appointment.
5. Upon arrival at a PCP, please present your Membership Card and one photo ID. The front desk admin will check your eligibility status. If you have not activated your Membership Card, or if Membership fees are not current, your Plan will not cover the costs of the provider.
6. Preventive health services must be appropriate for the covered person and follow the guidelines below:
   a) In general – those of the U.S. Preventive Services Task Force that have an A or B rating.
   b) For immunizations – those of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
   c) For preventive care and screenings for children and adolescents – those of the Health Resources and Services Administration.
   d) For preventive care and screenings for women – those of the Health Resources and Services Administration that are not included in section (A) of the U.S. Preventive Services Task Force schedule.

LABS AND DIAGNOSTICS

Aliera and Unity Members have access to lab work in the convenience of their provider's office or at any of the 2,000+ Quest lab network locations nationwide.

- Convenience: Aliera and Unity partner with **Quest Diagnostics** nationwide; you can be tested in a doctor's office or at any of the 2,000+ testing centers across the US.
- Expertise: With more than 40,000 employees, including nearly 900 MDs, PhDs, and other specialists, Quest assures the highest quality medical services.
- Services: Quest offers more than 3,000 tests, from basic to the most complex, including many you can't get elsewhere.
- Innovation: Quest introduced more than 100 tests – many of which were the first available on the market to help detect numerous diseases.

How to Access MyQuest

MyQuest allows you to schedule appointments 24/7 for testing, access your test results, and track your health conditions using your computer or smartphone.

1. To set up your MyQuest account, visit www.myquest.questdiagnostics.com. Click "Sign Up," then "Register Now."
2. Follow the online instructions and provide your information to complete the patient registration.
3. After setting up your MyQuest account, you can get Advanced Access, which allows you to see your test results as far back as 2010, including graphic representations of how your health is trending over time.
4. If you have not activated your Membership Card, or if Membership fees are not current, your Plan will not cover the costs of the services provided by Quest.
5. Visit www.Alierahealthcare.com to locate your nearest Quest facility. Click the Network tab and select "Lab Test Locations" from the drop-down menu.

URGENT CARE

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

How to Use the Urgent Care Service

1. Call 911 if your emergency is life threatening; otherwise, contact your telemedicine provider first via telephone or a scheduled face-to-face internet conference. Your provider will determine if your medical condition can be resolved without visiting a local urgent care facility.
2. If your medical issue cannot be resolved after your free consultation with a telemedicine doctor, call Aliera's Concierge Service at (844) 834-3456. A coordinator will call the urgent care facility ahead of your arrival to manage a smooth check-in.

3. After 6 p.m., contact an after-hours Member Care Specialist at (844) 834-3456. If you are unable to connect with the Concierge Service, please go to the nearest in-network urgent care facility. To locate a facility, visit www.AlieraHealthcare.com, click "Network" to find the nearest urgent care facility.
4. Upon arrival at an urgent care facility, present your Membership Card and one photo ID. The front desk admin will check your eligibility status. If you have not activated your Membership Card, or if Membership fees are not current, your Plan will not cover the costs of the provider.

If Urgent Care Services are Unavailable

If an urgent care facility in the network is unavailable to a Member requiring immediate urgent care, please adhere to the following procedure:

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

PRIMARY CARE FOR SICK CARE

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

- ► Consult fee based on plan. See appendix for plan details.
- ► For convenience, some clinics are open evenings and weekends.

How to Use Primary Care Service for Sick Care

1. Contact your telemedicine provider to speak with a US board-certified doctor via telephone or a scheduled face-to-face internet conference.
2. The telemedicine doctor may be able to resolve your medical issue and prescribe medication if needed. More than 80% of primary medical conditions can be resolved by your telemedicine provider.
3. If your medical issue cannot be resolved after your free consultation with the telemedicine doctor, you can call Aliera's Concierge Service at (844) 834-3456 to schedule an appointment with your local provider if you wish. You may make your own appointment.

4. Upon arrival at a clinic, present your Membership Card and one photo ID. The front desk admin will check your eligibility status before you can see a provider. If you have not activated your Membership Card, or if Membership fees are not current, your Plan will not cover the costs of the provider.

PRIMARY CARE FOR SICK CARE AND CHRONIC MAINTENANCE

Unity Bronze, Silver, Gold Plan Members are eligible to visit an in-network physician for an annual physical exam, chronic maintenance, and preventive services.

- ► For convenience, some clinics are open evenings and weekends.

How to Use Primary Care Service for Sick and Chronic Care

1. Contact your telemedicine provider to speak with a US board-certified doctor via telephone or a scheduled face-to-face internet conference.
2. The telemedicine doctor may be able to resolve your medical issue and prescribe medication if needed. More than 80% of primary medical conditions can be resolved by your telemedicine provider.
3. If your medical issue cannot be resolved after your free consultation with the telemedicine doctor, you can call Aliera's Concierge Service at (844) 834-3456 to schedule an appointment with your local provider if you wish. You may make your own appointment.
4. Upon arrival at a clinic, present your Membership Card and one photo ID. The front desk admin will check your eligibility status before you can see a provider. If you have not activated your Membership Card, or if Membership fees are not current, your Plan will not cover the costs of the provider.

SPECIALTY CARE

Unity HealthShare members are required to obtain referrals to visit a specialist, **except** for women in need of gynecological care for routine medical needs.

HOSPITALIZATION

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

1. Members are required to pre-authorize all hospitalization services and visits unless it is an obvious medical emergency. Please see pre-authorization section for instructions
2. You are responsible for your MSRA first before cost sharing is available to reimburse the providers and hospital facilities.
3. Emergency Room is subject to fixed consult fee. See appendix for plan details.

PPO NETWORK

With a growing nationwide PPO network of more than 1,000,000 healthcare professionals and more than 6,000 facilities, Multiplan

PHCS network offers Plan Members a range of quality choices to help them stay healthy.

- Search for providers by distance, cost efficiency, and specialty.
- While some Plans do not cover specialty services, Aliera's Concierge Service, in unison with Unity HealthShare, will help you find doctors in 22 different medical specialties who meet certain cost and quality measures. See specific Plan details for your Plan's Specialty Services coverage.

Find a Network Healthcare Professional

- Visit www.Multiplan.com and search for a provider by zip code, city, county, state, or other search criteria.
- Click search for a Doctor or Facility in the top right corner.
- Click the following logo:

- Continue to search.

Call Aliera Healthcare at (844) 834-3456 or Unity Healthshare at (800)-847-9794. Select the Provider Coordination Department and a care coordinator will help you navigate the healthcare process effectively and efficiently.

PART II

How Your Healthcare Cost Sharing Ministry (HCSM) Works

MEMBERSHIP OVERVIEW

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

Guidelines Purpose and Use

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

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

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

Individuals Helping Individuals

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

MEMBERSHIP QUALIFICATIONS

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

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

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

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

retroactive membership limitation or a retroactive denial to his/her effective date of membership.

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

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

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

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

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

Financial Participation. Monthly contributions are requested to be received by the 1st or 15th of each month depending on the member's effective date. If the monthly contribution is not received within 5 days of the due date, an administrative fee will be assessed to track, receive, and post the monthly contribution. If the monthly contribution is not received by the end of the month, a membership 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 reapply for membership under the terms outlined to them in writing by Unity HealthShare[SM]. Any member who submits a monthly contribution in such a manner as to have a membership become inactive three times will not be able to reapply for membership.

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

Administrative Costs. The fees for the first two months of membership are applied as an adiministrative fee. Beginning the third month of membership and each month following, a fee of $25 is assigned to administrative costs from each contribution amount regardless of family size. A single, couple, or family membership all contribute $25 from their monthly contribution for administration. In addition, the annual membership dues are also utilized by Unity HealthShare[SM] to defray administrative costs.

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

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

Other Criteria. Children under the age of 18 may not qualify for membership. Non-U.S. citizens may qualify for membership as determined by Unity HealthShare[SM] on a case-by-case basis.

MONTHLY CONTRIBUTIONS

Monthly contributions are voluntary contributions or gifts that are non-refundable. As a non-insurance membership, neither Unity HealthShare[SM] nor the membership are liable for any part of an individual's medical need. All contributors are responsible for their own medical needs. Although monthly contributions are voluntary contributions or gifts, there are administrative costs associated with monitoring the receipt and disbursement of such contributions or gifts. Therefore, declined credit cards, returned ACH payments, or any contribution received after the 1st or 15th of each month will incur an administrative fee.

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

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

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

a) has paid a monthly contribution and then cancels within 30 days of receiving medical attention, except within the last 90 days of the membership term.

b) receives care within the first 60 days of the plan and cancels his membership within 30 days of receiving medical care.

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

EARLY VOLUNTARY TERMINATION

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

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.

DEFINITIONS OF TERMS

Terms used throughout the Member Quick 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 Unity HealthShare[SM] works. Affiliated providers are those that participate in the PHCS network. A list of providers can be found at http://www.multiplan.com.

Application Date. The date Unity HealthShare[SM] receives a complete membership application.

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

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

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

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

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

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

Head of Household. Contributor participating by himself for herself; or the husband or father that participates in the membership; or the wife or mother if the husband does not participate in the membership.

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

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

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

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

Membership. All members of Unity HealthShare[SM].

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

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

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

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

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

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

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

CONTRIBUTORS' INSTRUCTIONS AND CONDITIONS

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

Medical Expenses not generally shared by HCSM

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

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

1. Any medical care outside of a hospital, except in the case of a needed surgery due to an accident. Members may be able to use out-patient facilities based upon the nature of the medical need and at the sole discretion of Unity HealthShare[SM]. In addition, some plans of Unity

HealthShare℠ include primary, urgent ,and specialty care. See the Appendix for your specific coverage.

2. Treatment or referrals received or obtained from any family member including, but not limited to, father, mother, aunt, uncle, grandparent, sibling, cousin, dependent, or any in-laws.
3. Pre-existing Conditions. Pre-existing conditions may vary based on plan option. Please see Appendix for specific plan details.
4. Illness or injuries caused by member negligence or for which the member has acted negligently in obtaining treatment. This could be documented by, but is not limited to, review of medical records or treatment plans by a licensed medical physician.
5. Procedures or treatments that are not recognized and approved by the American Medical Association (AMA) or that are illegal. Includes procedures not approved by the AMA for a given application, procedures still in clinical trials, procedures that are classified as experimental, or unproven interventions and therapies.
6. Lifestyles or activities engaged in after the application date that conflicts with the Statement of Beliefs (on the membership application).
7. Transportation (e.g., ambulance, etc.) for conditions that are not life-threatening, unless failure to immediately transport the member will seriously jeopardize the member's life; the additional expense for transportation to a facility that is not the nearest facility capable of providing medically necessary care; or charges in excess of $10,000 for transportation by air.
8. Congenital birth defects.
9. Elective cosmetic surgery.
10. Breast implants (placement, replacement, or removal) and complications related to breast implants, including abnormal mammograms, unless related to an otherwise eligible need.
11. Elective abortion of a viable fetus/embryo, unless medically necessary to protect the life of the mother.
12. Infertility testing or treatment, as well as any birth control measures to prevent conception (i.e., the pill, IUDs, shots, etc.)
13. Sterilization or reversals (vasectomy and tubal ligation).
14. Hysterectomy without first obtaining two independent opinions (neither physician may be a partner or other affiliate of the other). Both doctors must examine the patient prior to surgery and both must find that a hysterectomy is medically necessary. The member is responsible to ensure that both physicians submit medical necessity to Unity HealthShare℠ prior to surgery. Failure to follow these procedures will result in a finding of ineligibility for sharing by the membership.
15. Weight control and management including nutritional counseling for weight loss, weight gain, or health maintenance.
16. Hospital stays exceeding 60 days per medical need or additional charges for a private hospital room if a semi-private hospital room is available.
17. Any exams, physicals, or tests for which there are no specific medical symptoms, diagnosis in advance, or risk assessment testing.
18. Adult immunizations, HPV immunizations, and flu shots unless covered under an Aliera Healthcare part of the plan.
19. Chelation.
20. Physical therapy or occupational therapy that is not pre-authorized. Pre-authorized treatments are limited to a combined 6 visits in any calendar year.
21. Charges for emergency room visits and/or surgical removal for foreign objects placed in nose or ears by a child over five (5) years of age. Removal of foreign objects that can be done in an office setting will be reviewed under regular MSRAs or the Office Visit consult fee options.

22. Purchase or rental of durable or reusable equipment or devices (e.g. oxygen, orthotics, hearing aids, prosthetics, and external braces), including associated supplies, diagnostic testing, or office visits.
23. Needs for active members submitted 9 months after the date of treatment. Needs for inactive members submitted 6 months after the date of treatment.
24. Dental services and procedures, including periodontics, orthodontics, temporomandibular joint disorder (TMJ), or orthognathic surgery. Includes hospital charges for dental work done under general anesthesiology. Dental work required during surgery from an accident shall be eligible for cost sharing when the dental work is required after an accident and while the member is still admitted to a hospital.
25. Optometry, vision services, glasses, contacts, supplies, vision therapy, refraction services, or office visits.
26. Psychiatric or psychological counseling, testing, treatment, medication, and hospitalization.
27. Mental or psychiatric health, learning disability, developmental delay, autism, behavior disorders, eating disorders, neuropsychological testing, alcohol/substance abuse counseling, attention deficit disorder, or hyperactivity.
28. Speech therapy (except for a deficit arising from stroke/trauma).
29. Circumcisions.
30. Self/inflicted or intentional injuries.
31. Acts of war.
32. Exposure to nuclear fuel, explosives, or waste.
33. Occupational injury resulting from an injury incurred while performing any activity for profit.
34. Consumption of a prescription drug not prescribed for the member or prescription drug prescribed for the member and taken in excess that causes an adverse reaction; illicit drug use by a member.
35. Illness or injury caused by the illegal activities of the member or the member's family, including misdemeanors and felonies, regardless of whether or not charges are filed.
36. Treatment, care, or services that is not medically necessary.
37. Emergency room services, unless treatment at an emergency room is the only legitimate option because of the severity of the condition and lack of availability of treatment at an alternative facility.
38. Sexually transmitted diseases.
39. Diseases, including HIV/AIDS, due to tattoos, body piercing, or life-style choices.
40. Allergy testing or immunotherapy treatment.
41. Second surgeries are eligible for sharing based on member's treatment plan and are subject to third party case management approval. Second surgeries on a previously eligible surgical need are not eligible unless the member has followed through with the treatment plan laid out for him or her by their physician or complications occur within 15 days of eligible surgery.
42. Genetic testing and counseling.
43. Handling charges, conveyance fees, stat fees, shipping/handling fees, administration fees, missed appointment fees, telephone/email consultations, or additional charges for services supplied in an after-hours setting.
44. Drug testing unless required by membership.
45. Sexual dysfunction services.
46. Unity Bronze, Silver, and Gold plans have immediate eligibility for cancer. Any pre-existing or recurring cancer condition is not eligible for sharing. Cancer sharing will not be available for individuals who have cancer at the time of or within five (5) years prior to application. If cancer existed outside of the 5-year time frame, the following must be met in the five (5) years prior to application, to be eligible for future, non-recurring cancer incidents. 1. The condition had not been treated nor was future treatment

prescribed/planned; 2. The condition had not produced harmful symptoms (only benign symptoms); 3. The condition had not deteriorated.

47. Adenoid removal surgery eligible for sharing only at 50% if member has had a prior surgery to remove tonsils and the adenoids were not removed at the same time.
48. Injuries related to personal aircraft includes hang gliders, parasails, ultra-lights, hot air balloons, sky/diving, and any other aircraft not operated by a commercially licensed public carrier.
49. Extreme sports: Sports that voluntarily put an individual in a life-threatening situation. Sports such as but not limited to "free climb" rock climbing, parachuting, fighting, martial arts, racing, cliff diving, powerboat racing, air racing, motorcycle racing, extreme skiing, wingsuit, etc.

PRE-AUTHORIZATION REQUIRED

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

Hospitalizations. Non-emergency prior to admission; emergency visits notification to Unity HealthShare[SM] within 48 hours.

- MRI studies/CT scans/Ultrasounds
- Sleep studies must be completed in one session
- Physical or occupational therapy
- Speech therapy under limited circumstances only
- Cardiac testing, procedures, and treatments
- In-patient cancer testing, procedures, and treatments
- Infusion therapy within facility
- Nuclide studies
- EMG/EEG
- Ophthalmic procedures

- **ER visits, emergency surgery, procedure, or test:** Non-emergency use of the emergency room is not eligible for sharing. Unity HealthShare must be notified of all ER visits within 48 hours. Medical records will be reviewed for all ER visits to determine eligibility. An emergency is defined as treatment that must be rendered to the patient immediately for the alleviation of the sudden onset of an unforeseen illness or injury that, if not treated, would lead to further disability or death. Examples of an emergency include, but are not limited to, severe pain, choking, major bleeding, heart attack, or a sudden, unexplained loss of consciousness.

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

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

Early detection provides the best chance for successful treatment and in the most cost effective manner. Effective January 1, 2017, the membership will require that all members aged 40 and older receive appropriate screening tests every other year – mammogram or

thermography and pap smear with pelvic exams for women and PSA testing for men. Failure to obtain biannual mammograms and gynecological tests listed above for women or PSA tests for men will render future needs for breast, cervical, endometrial, ovarian, or prostate cancer ineligible for sharing.

DISPUTE RESOLUTION AND APPEAL

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

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

A. **1st Level Appeal**. Most differences of opinion can be resolved simply by calling Unity HealthShare[SM] who will try to resolve the matter within ten (10) working days in writing.

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 Unity HealthShare[SM] officials: the needs processing manager, the assistant director, and the executive director. The appeal must be in writing, stating the elements of the dispute and the relevant facts. Importantly, the appeal should address all of the following:

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

   Within thirty (30) days, the Internal Resolution Committee will render a written decision.

C. **3rd Level Appeal.** Should the matter remain unresolved, then the aggrieved party may ask that the dispute be submitted to three sharing members in good standing and randomly chosen by Unity HealthShare[SM], who shall agree to review the matter and shall constitute an External Resolution Committee. Within thirty (30) days the External Resolution Committee shall render their opinion in writing.

D. **Final Appeal.** If the aggrieved sharing member disagrees with the conclusion of his/her fellow sharing members, then the aggrieved party may ask that the dispute be submitted to a medical expense auditor, who shall have the matter reviewed by a panel consisting of personnel who were not involved in the original determination and who shall render their opinion in writing within thirty (30) days.

E. **Mediation and Arbitration.** If the aggrieved sharing member disagrees with the conclusion of the Final Appeal Panel, then the matter shall be settled by mediation and, if necessary, legally binding arbitration in accordance with the Rules of Procedure for Christian Conciliation of the Institute for Christian Conciliation, a division of Peacemaker Ministries. Judgment upon an arbitration decision may be entered in any court otherwise having jurisdiction. Sharing members agree and

understand that these methods shall be the sole remedy for any controversy or claim arising out of the Sharing Guidelines and expressly waive their right to file a lawsuit in any civil court against one another for such disputes, except to enforce an arbitration decision. Any such arbitration shall be held in Fredericksburg, Virginia, subject to the laws of the Commonwealth of Virginia. Unity HealthShare[SM] shall pay the fees of the arbitrator in full and all other expenses of the arbitration; provided, however, that each party shall pay for and bear the cost of its own transportation, accommodations, experts, evidence, and legal counsel, and provided further that the aggrieved sharing member shall reimburse the full cost of arbitration should the arbitrator determine in favor of Unity HealthShare[SM] and not the aggrieved sharing member. The aggrieved sharing member agrees to be legally bound by the arbitrator's decision. The Rules of Procedure for Christian Conciliation of the Institute for Christian Conciliation, a division of Peacemaker Ministries, will be the sole and exclusive procedure for resolving any dispute between individual members and Unity HealthShare[SM] when disputes cannot be otherwise settled.

PART III

Your Summary of Cost Sharing, Eligible Needs, & Limits

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

MEDICAL EXPENSES COVERED*

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

1. **Telemedicine.** Telemedicine is included in most programs offered by Unity HealthShare[SM] and Aliera Healthcare as your first line of defense. Your membership provides you and your family 24/7/365 access to a U.S. Board certified medical doctor.
2. **Preventive.** Most programs from either Unity Healthshare[SM] or Aliera provide everyone with the necessities of the 63 preventive care services as outlined by the United States Preventive Task force. (Excludes CarePlus Advantage.) Preventive coverage includes the PCP office visit and does not require a co-expense or consult fee.
3. **Labs & Diagnostics.** Your labs and diagnostics are covered when visiting a PCP or urgent care facility in network when your plan includes Primary and urgent care. For labs at hospitals or other facilities your MSRA will apply and you will be required to pay a co-expense of $25.
4. **Urgent Care.** If your plan provides cost sharing is for urgent care you will have the added benefit of enjoying the ability to choose an urgent care facility in lieu of an emergency room. See the Appendix for any urgent care coverage and any limitations to plan.
5. **Primary Care.** Depending on your plan choice, primary care is at the core of preventing medical issues from escalating into a more catastrophic need. See Appendix for the specific plan details.
6. **Specialty Care.** Specialty care is included in most plans, but has limits defined by your specific plan design. Refer to the Appendix for specific details of MSRA and co-expense requirements.
7. **X-Rays.** X-rays listed on your plan details in the Appendix are for imaging services at PCP or urgent care facilities only. Your MSRA will apply to all other hospital, pre or post surgical x-rays. MRI, CT Scans and other diagnostics must be paid with your MSRA before cost sharing is provided.
8. **Emergency Room.** Emergency room services for stabilization or initiation of treatment of a medical emergency condition provided on an outpatient basis at a hospital, clinic, or urgent care facility, including when hospital admission occurs within twenty-three (23) hours of emergency room treatment.
9. **Hospitalization.** Hospital charges for inpatient or outpatient hospital treatment or surgery for a medically diagnosed condition.
10. **Surgical Benefits. Please verify eligibility by calling Members Services before receiving any non-emergency surgical services.**
11. **Prescription Drugs.** Medication prescribed forty-five (45) days before and after each related Medical Expense Incident. In addition, your Unity Metal plans provide cost sharing for medications. See appendix

12. **Physical Therapy.** Up to six (6) visits per membership year for physical therapy by a licensed physical therapist.
13. **Ambulance.** Emergency land or air ambulance transportation to the nearest medical facility capable of providing the medically necessary care to avoid seriously jeopardizing the sharing member's life or health.
14. **Naturopathic and/or Alternative Treatments.** Does not included chiropractic services
15. **Prosthetics and their replacement, if medically necessary.**
16. **Medical Costs incurred outside the United States.** Charges for the care and treatment of a medically diagnosed condition when treatment outside the United States is financially beneficial or when traveling or residing outside the United States. Eligibility of such charges are subject to all other provisions of the Guidelines. Medical billing is requested to be submitted in English and converted to U.S. currency. Sharing will be considered on an out of network basis.
17. **Smoking Cessation.** Members with preventive coverage who have acknowledged they smoke and made an additional contribution are provided the opportunity to obtain free smoking cessation medication and counseling.
18. **Competitive Sports.** Plan holders who participate in organized and/or sanctioned competitive sports are eligible for $5,000 (max) of sharing per incident at an emergency room, subject to the member-shared responsibility amount.
19. **Maternity.** Maternity sharing, including prenatal, is eligible for sharing in Unity plans. Medical expenses for maternity ending in a delivery by emergency cesarean section that is medically necessary because of complications that arise at the time of delivery have limited sharing up to $8,000 (whether for a single or multiple birth pregnancy) subject to the applicable Member Shared Responsibility Amount. Medical expenses for a newborn arising from complications at the time of delivery, including, but not limited to, premature birth, are treated as a separate incident and limited to $50,000 of eligible expense, subject to the Member Shared Responsibility Amount.

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

LIMITS OF SHARING (MAXIMUM PAYABLE)

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

1. **Lifetime Limits.** $1,000,000: the maximum amount shared for eligible needs over the course of an individual member's lifetime.
2. **Annual Limits.** The maximum amount shared for eligible needs per member per 12 month term.
3. **Per Term.** The limit for each term of a sharing plan.
4. **Per Incident.** The occurrence of one particular sickness, illness, or accident.
5. **Cancer Limits when applicable.** Cancer is limited to a maximum per term of $500,000
6. **Member Shared Responsibility Amounts (MSRA).** Eligible needs are limited to the amounts in excess of the MSRA, which are applied per individual member per the calendar year.
7. **MSRA(s).** The eligible amount that does not qualify for sharing based on the membership type chosen by the member.
8. **Non-Affiliated Practitioner.** Services rendered by a non-affiliated practitioner will not be eligible for sharing nor will

any amount be applied to your MRSA unless specified differently in the plan details contained herein..

9. **Organ Transplant Limit.** Eligible needs requiring organ transplant may be shared up to a maximum of $150,000 per member not to exceed the maximum sharing limit of a membership type. This includes all costs in conjunction with the actual transplant procedure. Needs requiring multiple organ transplants will be considered on a case-by-case basis.
10. **Cost Sharing for Pre-Existing Conditions:**

- **Bronze Program cost sharing parameters for pre-existing conditions.** The following restrictions are only applicable to the pre-existing condition and do not effect normal sharing for other non pre-existing related incidents, events, etc.
  a. 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.
  b. Upon inception of the 25th month of continuous membership and thereafter, the condition may no longer be subject to the pre-existing condition sharing limitations.
  c. 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.

- **Silver Program cost sharing parameters for pre-existing conditions.** The following restrictions are only applicable to the pre-existing condition and do not effect normal sharing for other non pre-existing related incidents, events, etc.
  a. During the first two years of continuous membership, sharing is available up to $10,000 of total medical expenses incurred for pre-existing conditions per year, after a separate MSRA equal to two times your plan MSRA.
  b. Upon inception of the 25th month of continuous membership and thereafter, the condition may no longer be subject to the pre-existing condition sharing limitations.
  c. 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.

- **Gold Program cost sharing parameters for pre-existing conditions.** The following restrictions are only applicable to the pre-existing condition and do not effect normal sharing for other non pre-existing related incidents, events, etc.
  a. During the first two years of continuous membership, sharing is available up to $20,000 of total medical expenses incurred for a pre-existing condition per year, after a separate MSRA equal to two time your plan MSRA.
  b. Upon the inception fo the 25th month of continuous membership and thereafter, the condition may no longer be subject to the pre-existing condition sharing limitations.
  c. 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.

11. **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 (see item 8). Allowed charges will not exceed the Usual, Customary, and Reasonable charges for the area.

12. **Prescription Drug MSRA and Claims**. Prescription drugs are eligible by the percentage shown once a separate MSRA of $1500 for all medications is met. Members are required to pay drug cost first and then submit receipts to Unity HealthShare mailing address, Attn. Unity Rx Claims, for review and reimbursement. Additionally, all members seeking reimbursement must use the prescription services program Rx Valet, included with your plan, at the time of purchase.

Other Resources. Needs do not qualify for sharing to the extent that they are payable by an institutional source such as insurance, Medicare/Medicaid, VA, Tricare, private grants, or by a liable third party (primary, auto, home insurance, educational, etc.). If the member does not cooperate fully, the need will not be eligible for sharing. This limitation includes needs payable by Medicaid. If the member is 65 years of age or older and is eligible for Medicare, this limitation also includes needs that are payable by Medicare A or B. The MRSA's are waived up to the maximum MRSA's per membership type only if a liable third party or institutional source pays on the member's behalf. Sharing of monthly contributions for a need that is later paid or found to be payable by an institutional source or a liable third party will automatically allow Unity HealthShare℠ full rights to recover from the member the amounts shared on their behalf.

See Appendix A for Additional Sharing Limits by Plan

APPENDIX A: PLAN DETAILS

UNITY HEALTHSHARE **Unity HealthShare ► Bronze**

PPO Network ►	**Multiplan PHCS**	
Eligible Medical Cost Sharing	**Network**	**Non-Network**
Wellness and Preventive [Aliera]	100%	50% after MSRA
Telemedicine [Aliera]	Included	Included
MSRA – Individual/Family	Indiv: $1,000-$10,000 Family: $3,000-$30,000	50% towards MSRA
Out-of-Pocket Maximum – Individual/Family	Indiv: $3,000-$30,000 Family: $9,000-$90,000	Indiv: $6,000-$60,000 Family:$18,000-$180,000
Co-expense	60% after MSRA	50% after MSRA
Hospitalization In-Patient	60% after MSRA	50% after MSRA
Hospitalization Out-Patient	60% after MSRA	50% after MSRA
Emergency Room Services - Emergency room services including hospital facility and physician charges. Surgery, PT, or DME required during emergency room visit will be eligible under emergency room sharing.	$500 consult fee	$500 consult fee
Urgent Care [Aliera]	$100 consult fee	50% after MSRA
Primary Care Visits [Aliera]	$50 consult fee	50% after MSRA

Specialist Visits	$125 consult fee	50% after MSRA
Imaging – Eligible charges for CT, PET scans, MRIs, and the charges for related supplies.	60% after MSRA	50% after MSRA
Laboratory Outpatient and Professional Services – Sharing eligible for professional components of labs, including office, out-patient, and in-patient charges.	60% after MSRA	50% after MSRA
X-rays and Diagnostic Imaging – Sharing eligible for the professional components of labs, including the office, out-patient, and in-patient charges.	60% after MSRA	50% after MSRA
Generic Prescription Drugs	No cost sharing	Not eligible
Preferred Brand Drugs	50% cost sharing*	Not eligible
Non-Preferred Brand Drugs	No cost sharing	Not eligible
Mail-Order	75% cost sharing*	Not eligible

* Prescription drugs are covered by the percentage shown once a separate MSRA of $1500 for all medications is met. Members are required to pay drug cost first and then submit receipts to Unity HealthShare mailing address, Attn. Unity Rx Claims, for review and reimbursement. Additionally, all members seeking reimbursement must use the prescription services Rx Valet included with your plan.

UNITY HEALTHSHARE Unity HealthShare ► Silver

PPO Network ►	**Multiplan PHCS**	
Eligible Medical Cost Sharing	**Network**	**Non-Network**
Wellness and Preventive [Aliera]	100%	60% after MSRA
Telemedicine [Aliera]	Included	Included
MSRA – Individual/Family	Indiv: $1,000-$10,000 Family: $3,000-$30,000	50% towards MSRA
Out-of-Pocket Maximum – Individual/Family	Indiv: $3,000-$30,000 Family: $9,000-$90,000	Indiv: $6,000-$60,000 Family:$18,000-$180,000
Co-expense	70% after MSRA	50% after MSRA
Hospitalization In-Patient	70% after MSRA	50% after MSRA
Hospitalization Out-Patient	70% after MSRA	50% after MSRA
Emergency Room Services - Emergency room services including hospital facility and physician charges. Surgery, PT, or DME required during emergency room visits, will be eligible under emergency room sharing.	$300 consult fee	$500 consult fee
Urgent Care [Aliera]	$75 consult fee	60% after MSRA
Primary Care Visits [Aliera]	$35 consult fee	60% after MSRA

Specialist Visits	$75 consult fee	60% after MSRA
Imaging – Eligible charges for CT, PET scans, MRIs, and the charges for related supplies.	70% after MSRA	60% after MSRA
Laboratory Outpatient and Professional Services – Sharing eligible for professional components of labs, including office, out-patient, and in-patient charges.	70% after MSRA	60% after MSRA
X-rays and Diagnostic Imaging – Sharing eligible for the professional components of labs, including the office, out-patient, and in-patient charges.	70% after MSRA	60% after MSRA
Generic Prescription Drugs	No cost sharing	Not eligible
Preferred Brand Drugs	50% cost sharing*	Not eligible
Non-Preferred Brand Drugs	No cost sharing	Not eligible
Mail-Order	75% cost sharing*	Not eligible

* Prescription drugs are covered by the percentage shown once a separate MSRA of $1500 for all medications is met. Members are required to pay drug cost first and then submit receipts to Unity HealthShare mailing address, Attn. Unity Rx Claims, for review and reimbursement. Additionally, all members seeking reimbursement must use the prescription services Rx Valet included with your plan.

UNITY HEALTHSHARE Unity HealthShare ▶ Gold

PPO Network ▶	**Multiplan PHCS**	
Eligible Medical Cost Sharing	**Network**	**Non-Network**
Wellness and Preventive [Aliera]	100%	70% after MSRA
Telemedicine [Aliera]	Included	Included
MSRA – Individual/Family	Indiv: $1,000-$10,000 Family: $3,000-$30,000	50% towards MSRA
Out-of-Pocket Maximum – Individual/Family	Indiv: $3,000-$30,000 Family: $9,000-$90,000	Indiv: $6,000-$60,000 Family:$18,000-$180,000
Co-expense	80% after MSRA	70% after MSRA
Hospitalization In-Patient	80% after MSRA	70% after MSRA
Hospitalization Out-Patient	80% after MSRA	70% after MSRA
Emergency Room Services - Emergency room services including hospital facility and physician charges. Surgery, PT, or DME required during emergency room visits, will be eligible under emergency room sharing.	$150 consult fee	$300 consult fee
Urgent Care [Aliera]	$75 consult fee	70% after MSRA
Primary Care Visits [Aliera]	$20 consult fee	70% after MSRA

Specialist Visits	$75 consult fee	70% after MSRA
Imaging – Eligible charges for CT, PET scans, MRIs, and the charges for related supplies.	80% after MSRA	70% after MSRA
Laboratory Outpatient and Professional Services – Sharing eligible for professional components of labs, including office, outpatient, and inpatient charges.	80% after MSRA	70% after MSRA
X-rays and Diagnostic Imaging – Sharing eligible for the professional components of labs, including the office, outpatient, and inpatient charges.	80% after MSRA	70% after MSRA
Generic Prescription Drugs	No cost sharing	Not eligible
Preferred Brand Drugs	50% cost sharing*	Not eligible
Non-Preferred Brand Drugs	No cost sharing	Not eligible
Mail-Order	75% cost sharing*	Not eligible

* Prescription drugs are covered by the percentage shown once a separate MSRA of $1500 for all medications is met. Members are required to pay drug cost first and then submit receipts to Unity HealthShare mailing address, Attn. Unity Rx Claims, for review and reimbursement. Additionally, all members seeking reimbursement must use the prescription services Rx Valet included with your plan.

APPENDIX B: TERMS, CONDITIONS, & SPECIAL CONSIDERATIONS

1. The Welcome Kit you received electronically includes this Quick Guide, your Membership Card(s), a Welcome Letter, and important information to activate your membership.
2. Keep your Membership Card with you at all times to present to a provider to confirm eligibility.
3. The ACA is subject to change at any time; Aliera reserves the right to adhere to those changes without notice to the Member.
4. Activate your Plan Membership by following the instructions in this Quick Guide.
5. Set up your Aliera telemedicine account by following the instructions in the Welcome kit.
6. Telemedicine operates subject to state regulations and may not be available in certain states.
7. Because more than 80% of primary medical conditions can be resolved by your telemedicine provider, Members must always call the telemedicine provider first to receive medical attention.
8. Telemedicine phone consultations are available 24/7/365, with face-to-face internet consultations available between the hours of 7 a.m. and 9 p.m., Monday – Friday.
9. Telemedicine does not guarantee that a prescription will be written.
10. Telemedicine does not prescribe DEA-controlled substances, non-therapeutic drugs, and certain other drugs which may be harmful because of their potential for abuse. Telemedicine doctors reserve the right to deny care for potential misuse of services.
11. Durable Medical Equipment (DME) – crutches, etc. – is not included in your Plan. Members will be charged for DME at time of service.
12. Aliera cannot guarantee that a provider will accept an Aliera Plan if the Member fails to contact the Aliera Concierge Service first.
13. Member Care Specialists are available to assist you, Monday through Friday, 9 a.m. to 6 p.m. ET at (844) 834-3456. If you call after hours, follow the prompts.
14. Plans may vary from state to state. Providers may be added or removed from Aliera's network at any time without notice.
15. If you become sick while traveling within the U.S., contact your telemedicine provider first. If directed by the telemedicine doctor to seek further treatment, visit www.UnityHealthshare.com and click on "Network" to search by city, state, or zip code for a list of the nearest in-network providers.
16. Not all geographical areas are serviced by Aliera Healthcare. Should a Member visit an emergency room because urgent care facilities are unavailable in the Member's area, Aliera offers a one-time, once-a-year, $105 credit (ex gratia) to the Member to help offset the costs incurred.
17. If an urgent care facility is used for a primary care visit for sick care, an additional fee of $40 will be payable at time of service.
18. Aliera telemedicine partners do not replace the Primary Care Provider.
19. Primary Care is defined as "episodic primary care" or "sick care." Members are responsible for paying a consult fee at the time of service; no consult fee is due for preventive service.
20. Most Aliera/Unity network facilities are able to accommodate both urgent care and primary care needs.
21. Not all PPO providers accept an Aliera/Unity Plan. While Aliera offers one of the largest PPO networks in the country, some providers may not participate.

DISCLOSURES

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

ABBREVIATIONS

ACA	Affordable Care Act (Obamacare)
CMS	Center for Medicare and Medicaid Services
DEA	Drug Enforcement Administration
DME	Durable Medical Equipment
DPCMH	Direct Primary Care Medical Home Plans

APPENDIX C: LEGAL NOTICES

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

GENERAL LEGAL NOTICE

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

STATE SPECIFIC NOTICES

Alabama Code Title 22-6A-2
Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Arizona Statute 20-122
Notice: the organization facilitating the sharing of medical expenses is not an insurance company and the ministry's guidelines and plan of operation are not an insurance policy. Whether anyone chooses to assist you with your medical bills will be completely voluntary because participants are not compelled by law to contribute toward your medical bills. Therefore, participation in the ministry or a subscription to any of its documents should not be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this ministry continues to operate, you are always personally responsible for the payment of your own medical bills.

Arkansas Code 23-60-104.2
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
Unity HealthShare℠ is not an insurance company, and membership is not offered through an insurance company. Unity 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.

Maryland Article 48, Section 1-202(4)
Notice: This publication is not issued by an insurance company nor is it offered through an insurance company. It does not guarantee or promise that your medical bills will be published or assigned to others for payment. No other subscriber will be compelled to contribute toward the cost of your medical bills. Therefore, this publication should never be considered a substitute for an insurance policy. This activity is not regulated by the State Insurance Administration, and your liabilities are not covered by the Life and Health Guaranty Fund. Whether or not you receive any payments for medical expenses and whether or not this entity continues to operate, you are always liable for any unpaid bills.

Mississippi Title 83-77-1
Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment of medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Missouri Section 376.1750
Notice: This publication is not an insurance company nor is it offered through an insurance company. Whether anyone chooses to assist you with your medical bills will be totally voluntary, as no other subscriber or member will be compelled to contribute toward your medical bills. As such, this publication should never be considered to be insurance. Whether you receive any payments for medical expenses and whether or not this publication continues to operate, you are always personally responsible for the payment of your own medical bills.

Nebraska Revised Statute Chapter 44-311
IMPORTANT NOTICE. This organization is not an insurance 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. This is Healthcare Cost Sharing.

Please Note: Unity HealthShare℠ Bronze, Silver, and Gold Plans cannot be sold in the following states: Alaska, Hawaii, Maine, Maryland, Puerto Rico, Washington, and Wyoming. Limitations subject to change without prior notice.

NOTES:

APPENDIX F

CALIFORNIA DEPARTMENT OF INSURANCE
LEGAL DIVISION
Teresa R. Campbell, SBN 162105
Assistant Chief Counsel
1901 Harrison Street, 4th Floor
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Facsimile: 510-238-7830

Attorneys for
CALIFORNIA DEPARTMENT OF INSURANCE

BEFORE THE INSURANCE COMMISSIONER

OF THE STATE OF CALIFORNIA

In the Matter of: ALIERA HEALTHCARE, INC., dba as Aliera Companies, Inc., and TRINITY HEALTHSHARES, INC. Respondents.	File No. LA201900234 **CEASE AND DESIST; and NOTICE OF RIGHT TO HEARING and MONETARY PENALTY** (Insurance Code § 12921.8)

TO ALIERA HEALTHCARE, INC., dba as Aliera Companies, Inc., and TRINITY HEALTHSHARES, INC.:

JURISDICTION AND PARTIES

1. The California Department of Insurance, (hereafter "Department"), brings this matter against ALIERA HEALTHCARE, INC., dba as Aliera Companies, Inc., and TRINITY HEALTHSHARES, INC., before the Insurance Commissioner of the State of California, (hereafter "Insurance Commissioner").

2. ALIERA HEALTHCARE, INC. is a for-profit corporation organized under the laws of Delaware doing business in California (hereafter "Respondent Aliera").

3. Effective July 22, 2019, the name of Aliera Healthcare, Inc. changed to the Aliera

Companies, Inc. and become a holding company for multiple wholly-owned subsidiaries.

4. Respondent Aliera first incorporated on September 29, 2011.

5. Respondent Aliera does not hold a certificate of authority or other license authorizing it to transact insurance in the State of California.

6. TRINITY HEALTHSHARE INC. is a corporation organized under the laws of Delaware doing business in California (hereafter "Respondent Trinity").

7. Respondent Trinity first incorporated in Delaware on June 27, 2018.

8. Respondent Trinity does not hold a certificate of authority or other license authorizing it to transact insurance in the state of California.

9. On or about August 13, 2018, Respondent Aliera and Respondent Trinity entered into an Agreement wherein Respondent Aliera is named the administrator, exclusive marketer and program manager for Respondent Trinity.

10. Hereafter Respondent Aliera and Respondent Trinity shall be known collectively as "Respondents."

11. The Department has information and believes that Respondents have approximately 11,000 California residents as members.

FINDINGS & AUTHORITY

12. Insurance Code § 12921.8(a) authorizes the Insurance Commissioner to issue a Cease and Desist Order to a person who has acted in a capacity for which a license, registration, permit, or Certificate of Authority from the Insurance Commissioner was required but not possessed.

13. Insurance Code § 12921.8 does not require the Insurance Commissioner to hold a hearing prior to issuing a Cease and Desist Order.

14. California Insurance Code § 22 provides as follows: Insurance is a contract whereby one undertakes to indemnify another against loss, damage, or liability arising from a contingent or unknown event.

15. Insurance Code section 700 provides as follows:

> a) A person shall not transact any class of insurance business in this state without first being admitted for that class. Except for the State Compensation Insurance Fund as authorized by Sections 11770 and 11778 to 11780.5, inclusive, admission is secured by procuring a certificate of authority from the commissioner. The certificate shall not be granted until the applicant conforms to the requirements of this code and of the laws of this state prerequisite to its issue.
>
> b) The unlawful transaction of insurance business in this state in willful violation of the requirement for a certificate of authority is a public offense punishable by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code, or in a county jail not exceeding one year, or by fine not exceeding one hundred thousand dollars ($100,000), or by both that fine and imprisonment, and shall be enjoined by a court of competent jurisdiction on petition of the commissioner.

16. Insurance Code section 740 provides that "[n]otwithstanding any other provision of law, and except as provided herein, any person or other entity that provides coverage in this state for medical, surgical, chiropractic, physical therapy, speech pathology, audiology, professional mental health, dental, hospital, or optometric expenses, whether the coverage is by direct payment, reimbursement, or otherwise, shall be presumed to be subject to the jurisdiction of the department unless the person or other entity shows that while providing the services it is subject to the jurisdiction of another agency of this or another state or the federal government."

17. Insurance Code section 790.03 provides that the following are defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

> (a) Making, issuing, circulating, or causing to be made, issued or circulated, any estimate, illustration, circular, or statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon, or making any false or misleading statement as to the dividends or share of surplus previously paid on similar policies, or making any misleading representation or any misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates, or using any name or title of any policy or class of policies misrepresenting the true nature thereof, or making any misrepresentation to any policyholder insured in any company for the purpose of inducing or tending to induce the policyholder to lapse, forfeit, or surrender his or her insurance.

> (a) Making or disseminating or causing to be made or disseminated before the public in this state, in any newspaper or other publication, or any advertising device, or by public outcry or proclamation, or in any other manner or means whatsoever, any statement containing any assertion, representation, or statement with respect to the business of insurance or with respect to any person in the conduct of his or her insurance business, which is untrue, deceptive, or misleading, and which is known, or which by the exercise of reasonable care should be known, to be untrue, deceptive, or misleading.

18. Insurance Code section 1631 provides that "[u]nless exempt by the provisions of this article, a person shall not solicit, negotiate, or effect contracts of insurance, or act in any of the capacities defined in Article 1 (commencing with Section 1621) unless the person holds a valid license from the commissioner authorizing the person to act in that capacity. The issuance of a certificate of authority to an insurer does not exempt an insurer from complying with this article."

19. Insurance Code section 10112.27 provides that all non-grandfathered individual and small group health insurance policies issued in California shall provide coverage for essential health benefits pursuant to the PPACA.[1] Additionally, section 10112.27(e) provides that "A health insurer, or its agent, producer, or representative, shall not issue, deliver, renew, offer, market, represent, or sell any product, policy, or discount arrangement as compliant with the essential health benefits requirement in federal law, unless it meets all of the requirements of this section. This subdivision shall be enforced in the same manner as Section 790.03, including through the means specified in Sections 790.035 and 790.05."

20. Health Care Sharing Ministries ("HCSM") are organizations in which members share a common set of religious or ethical beliefs and agree to make payments to, or share, the medical expenses of other members. Respondents represent that they are a HCSM.

21. Respondent Trinity collects fixed monthly payments from its members, payments which vary according to the level of coverage, and conducts underwriting to screen for pre-existing conditions. Additionally, Respondent Trinity has a schedule of covered and excluded services, a schedule of copayments and deductibles, a claims adjudication process, and annual and lifetime limits.

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[1] Patient Protection and Affordable Care Act 42 U.S.C. § 18022(a) (2010)

22. In exchange for the fixed monthly payments, Respondents undertake to indemnify its members for loss, damage, or liability arising from a costs incurred in connection with health events.

23. Respondent Aliera markets Respondent Trinity products as alternatives to traditional health insurance to California consumers. Those products have many of the attributes of traditional health insurance products subject to Department jurisdiction, regulation, and authority.

24. Respondents' advertisements, solicitations, and other materials are deceptive and have the capacity and tendency to mislead or deceive consumers to believe they are purchasing traditional health coverage rather than a HCSM membership with no guarantee that claims will be paid and products that do not comply with the Affordable Care Act. Respondents make, issue, and circulate misleading advertisements and other materials to California consumers, in violation of Insurance Code section 790.03(a) and (b).

25. Respondents provide misleading training to sales agents concerning the nature of its products, violation of Insurance Code section 790.03(a) and (b).

26. Respondents sell products that do not cover preexisting conditions, abortion and/or contraception, or comply with the Mental Health Parity Act[2], in violation of Insurance Code section 10112.27 and the PPACA.

27. Respondents do not meet the definition of HCSMs under the Internal Revenue Code, and therefore, individuals that receive benefits through Respondents do not meet the California state individual health insurance mandate.

28. Respondents are not currently licensed or authorized by the Insurance Commissioner to act in any capacity regarding the transaction of insurance in California, and during relevant periods herein, did not hold any license, Certificate of Authority, or permit, issued by the Insurance Commissioner, to act in any capacity regarding the transaction of insurance in California.

[2] Insurance Code § 10144.5

29. The facts alleged in paragraphs 20-28 show Respondents have undertaken to indemnify California consumers against loss, damage, or liability by providing products, advertisements, and other materials to California consumers which contain information that is misleading or have misrepresented the benefits of the products offered, in violation of Insurance Code section 790.03(a) and (b).

30. The facts alleged in paragraphs 20-28 show Respondents are acting in a capacity for which a license, registration, or certificate of authority from the commissioner is required but not possessed, in violation of Insurance Code sections 1631 and 700.

31. The facts alleged in paragraphs 20-28 show Respondents did issue, deliver, renew, offer, market, represent, or sell any product, policy, or discount arrangement that are not compliant with the PPACA, in violation of Insurance Code section 10112.27.

ORDER TO CEASE AND DESIST

1. NOW THEREFORE, RESPONDENTS ARE HEREBY ORDERED to immediately CEASE AND DESIST from providing products and or benefits to California consumers which are misleading or misrepresent the benefits of such products.

2. RESPONDENTS ARE FURTHER ORDERED to immediately cease and desist from the following:

a. Transacting insurance in the State of California in any capacity, including as an insurer, insurance agent, broker, or solicitor.

b. Advertising or acting as an insurer, insurance agent, broker, or solicitor in the State of California.

c. Advertising or acting as an insurer, insurance agent, broker, or solicitor exempt from regulation in the State of California.

d. Advertising, or participating in advertising, by newspaper, telephone book or listing, mail, handout, business card, or by any other written or printed presentation, or by telephone, radio, television, Internet, public outcry or proclamation, or in any other manner or

means whatsoever, whether personally or through others, that implies that they are licensed, permitted, or authorized, or are engaged in the business of soliciting, negotiating, executing, delivering, or furnishing insurance in the State of California in any manner.

e. Receiving any money, commission, fee, rebate, payment, remuneration, or any other valuable consideration whatsoever, in connection with any insurance transactions.

NOTICE OF FINE and GROUNDS FOR MONETARY PENALTY AND POTENTIAL LIABILITY PURSUANT TO CIC §§790 *et seq*

PLEASE TAKE NOTICE that the Insurance Commissioner may, pursuant to Insurance Code § 12921.8(a)(3)(B), impose a fine of up to five thousand dollars ($5,000) for each day this Order is violated.

Additionally, the facts alleged above constitute grounds, under Insurance Code § 790.05, for the Insurance Commissioner to order Respondents to cease and desist from engaging in such unfair acts or practices and to pay a civil penalty not to exceed five thousand dollars ($5,000) for each act, or if the act or practice was willful, a civil penalty not to exceed ten thousand dollars ($10,000) for each act as set forth under Section 790.035 of the California Insurance Code

NOTICE OF RIGHT TO HEARING

Insurance Code § 12921.8(c), provides in part, as follows:

> "A person to whom a cease and desist order…has been issued, may, within seven days after service of the order…request a hearing by filing a request for the hearing with the commissioner."

If you desire a hearing in this matter, your written request for a hearing must be received within seven days after you are served with this Order. The seven day period begins on the day after you are served with this Order, and if the seventh day falls on a weekend or holiday, the

deadline is extended to the next business day. Your written request for a hearing must be directed to:

Teresa R. Campbell
Assistant Chief Counsel
California Department of Insurance,
1901 Harrison Street, 4th Floor
Oakland, California 94612

IN WITNESS THEREOF this 8th day of March, 2020.

RICARDO LARA
Insurance Commissioner

By: _____
TERESA R. CAMPBELL
Assistant Chief Counsel

APPENDIX G

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

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

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

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

I.
INTRODUCTION

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

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

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

II.
DISCOVERY CONTROL PLAN

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

III.
PARTIES

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

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

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

IV.
JURISDICTION AND VENUE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Ex. O (emphasis added).

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

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

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

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

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

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

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

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

Ex. O (emphasis added).

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

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

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

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

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

Ex. O (emphasis added).

50. The "sharing arrangement" offered by Aliera is insurance. Members each contribute present consideration to the sharing reserve to protect against future risk.

51. Aliera's membership documents establish a defined structure for claims to be paid from the sharing reserve. The membership documents further establish a mechanism to pay claims if the sharing reserve is depleted. Statements in Aliera's membership documents to the effect that the members have no guarantee of payment appear to be disclaimers asserted in an effort to avoid state insurance regulation.

52. To be eligible for a claim payment out of the sharing reserve, a member must pay fixed monthly membership fees into the sharing reserve. Aliera's guidelines state, "This membership is issued in consideration of the Member's application and the Member's payment of a monthly fee as provided under these Plans." If a member does not pay the monthly membership fee, the membership becomes "inactive," and the member is no longer eligible for claim payments out of the sharing reserve. It is a *quid pro quo*. In reality, members are paying their monthly membership fees in exchange for the right to insurance coverage for medical services.

ii. Aliera's contracts with third-party providers demonstrate that Aliera has taken on risk from its members in exchange for monthly payments.

53. At TDI's request, Aliera has provided copies of several contracts that Aliera has currently or did have with certain third-party providers. These contracts include (1) Multi-Service Provider Agreement between CityDoc Urgent Care

Center 4, PLLC, and Aliera (then doing business as HealthPass USA), dated December 10, 2015; (2) Teladoc Services Agreement, dated June 12, 2015; and (3) Laboratory Services Agreement between Aliera and Quest Diagnostics, Inc., dated October 1, 2015. These contracts provide additional documentary evidence that Aliera has taken on risk from its members, because in these contracts, Aliera uses "per member per month" payments to limit the risk it has taken on.

54. The Urgent Care agreement contains the following provisions:

"pay to Provider a portion of the membership fee in accordance with Exhibit A for members that are assigned to Provider for delivery of medical services contained herein and as currently performed at the provider's facility." Contract at p. __ (copy has been provided by counsel and stamped "confidential"; copy will not be filed with this amended petition but will be provided to the Court at a hearing upon request). "As a provider in the Organizers programs, Provider agrees to . . . provide medically necessary care in a timely manner," and agrees that it "shall perform all services currently performed by the practice to all members at no additional cost in accordance with Exhibit A schedule of services and payment parameters . . ."

55. The Urgent Care Agreement also provides: "Provider agrees to accept the Per Member Per Month (PMPM) payment rates set forth in Exhibit A as the total amount to be received by the Provider monthly for all covered services.

Organizer, its parent of affiliate shall pay only the amount due to Provider for monthly per member per month services rendered to Member, based the provisions of the applicable plan and Provider agrees to look to Organizer or its parent or affiliates only for said per member per month fee of such covered services except for any amounts required to be paid by Member pursuant to the Organizers appropriate plan." Urgent Care Agreement at p. __.

56 The termination of coverage provisions are similarly explicit: "2. Termination of Coverage of Members. Coverage for each Member may be terminated by Member or Organizer. When a Member whose coverage has terminated receives services from Provider, Provider agrees to bill Member directly. Organizer shall not be liable to Provider for any bills incurred by a Member whose coverage has been terminated. Provider shall verify eligibility through available electronics means or by calling the eligibility phone number provided by the organizer."

57. With respect to the Teladoc Agreement, the terms are similarly explicit: "8. Payment Terms. Teledoc shall invoice the RESELLER a PEPM fee on the 5th day of each month for the Program services to be provided in that month. . . . The RESELLER specifically acknowledges that it is responsible for paying all applicable PEPM fees and the other fees identified herein to Teladoc regardless of whether it has collected such fees from the Clients."

58. "9. Service Fees. Teladoc agrees to provide the services of the Program in exchange for the fees described in Attachment 2, which shall be paid by the RESELLER to Teladoc and adjusted quarterly based up the aggregate number of Covered lives in the Resellers book of business."

59. In the Quest Diagnostics Agreement, under "Duties of Company and Compensation," the agreement provides that "(a) Laboratory agrees to accept a per member per month fee from Company for lab services outlined in Exhibit B. With respect to such services, Laboratory agrees to accept the rates set forth in Exhibit B of this Agreement as full compensation for such services. Laboratory agrees to comply with pricing schedules for any additional service or direct cash payment from any HP USA member in accordance with Exhibit C contained herein for any HP USA member. Company will provide enrollment eligibility electronically in a mutually agreed upon format on a monthly basis."

60. Health maintenance organizations (HMOs) operate in much the same way. Members pay a fixed premium and the HMO provides specific health care services to their members either directly or by contracting with providers. Notably, capitation agreements with providers are an important tool that HMOs use to control costs. Because HMOs spread risk and essentially function in the same way as traditional health insurers, many courts have recognized that HMOs provide insurance. *See, e.g., Corp. Health Ins., Inc. v. Texas Dep't of Ins.*, 215 F.3d 526,

538 (5th Cir. 2000) (recognizing that an HMO provides insurance); *see also Kentucky Ass'n of Health Plans, Inc. v. Nichols*, 227 F.3d 352, 364-365 (6th Cir. 2000); *Washington Physicians Serv. Ass'n v. Gregoire*, 147 F.3d 1039, 1046 (9th Cir. 1998) ("HMOs function the same way as a traditional health insurer: The policyholder pays a fee for a promise of medical services in the event that he should need them. It follows that HMOs (and HCSCs) are in the business of insurance."); *Anderson v. Humana, Inc.*, 24 F.3d 889, 892 (7th Cir. 1994) ("Because HMOs spread risk—both across patients and over time for any given person—they are insurance vehicles under Illinois law."); *Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of Rhode Island*, 883 F.2d 1101, 1107 (1st Cir. 1989).

C. Aliera does not qualify for the faith-based "safe harbor" established by Tex. Ins. Code 1681.

61. A health care sharing ministry (HCSM) is a not-for-profit health care cost-sharing arrangement among persons of similar and sincerely held beliefs. Insurance Code Chapter 1681 establishes the requirements of a HCSM. Under Section 1681.001, a "faith-based, nonprofit organization that is tax-exempt under the Internal Revenue Code of 1986 qualifies for treatment as a health care sharing ministry under this chapter if it: (1) limits its participants to individuals of a similar faith; (2) acts as a facilitator among participants [for the payment of medical bills].

. .; (3) provides for the payment of medical bills of a participant through contributions from one participant to another; (4) provides amounts that participants may contribute with no assumption of risk or promise to pay by the health care sharing ministry to the participants; (5) provides a written monthly statement to all participants . . .; (6) discloses administrative fees and costs to participants; and (7) provides that any card issued to a participant for the purpose of presentation to a health care provider clearly indicates that the participant is part of a health care sharing ministry that is not engaging in the business of insurance."

62. Aliera does not allege that it is a faith-based, nonprofit organization. It is a for-profit corporation. Aliera contends that it only contractually administers the Trinity HCSM, and previously only contractually administered Unity's HCSM. Trinity and Unity are both nonprofit organizations that are tax-exempt under the Internal Revenue Code of 1986. However, Trinity, and Unity before it, are being used by Aliera in an attempt to disguise Aliera's profit-making venture as a HCSM and avoid insurance regulation.

63. Aliera has asserted in court documents filed in its home state of Georgia that at the time of Aliera's agreement with Unity Healthshare, the parties understood that "all products developed by Aliera, regardless of whether such products included an HCSM component, would remain the property of Aliera, not Unity or [Anabaptist]." Aliera's First Amended Complaint, *Aliera Healthcare, Inc.*

v. Anabaptist Healthshare, et al., Civil Action File No. 2018-CV-308981 (Superior Court of Fulton County, Georgia Dec. 3, 2018).

64. In court documents, Aliera further noted that under the Unity Agreement, Eldon Hochstetler and Tyler Hochstetler, director of Anabaptist and Unity, respectively, would each individually "receive $2.50 per enrolled member in Unity Healthshare, per month, for as long as Unity Healthshare exists, regardless of how many members enroll in Unity Healthshare." Aliera described this as a "*profit-sharing arrangement* with [Aliera]." (emphasis added). In less than two years under the Unity Agreement, Eldon Hochstetler and Tyler Hochstetler were each individually paid approximately $700,000. Aliera's First Amended Complaint, *Aliera Healthcare, Inc. v. Anabaptist Healthshare, et al.*, Civil Action File No. 2018-CV-308981 (Superior Court of Fulton County, Georgia Dec. 3, 2018).

65. Similarly, under the Trinity Agreement, Aliera is responsible for almost all aspects of the HCSM, including "plan design (defining the schedule of medical services eligible for sharing), and plan pricing." The Trinity Agreement also entitles Aliera to a large portion of member payments. Aliera retains contributions and/or management fees range from 20 cents per membership dollar to 71 cents per membership dollar. Agent sales commissions range from 10 cents per membership dollar to 40 cents per membership dollar. Because of these and other Aliera profit

centers, member sharing reserve amounts top out at 35 cents per membership dollar, but typically are around 8 to 15 cents per membership dollar.

66. Aliera, together with Trinity, and previously with Unity, is and always has been a profit-making venture. According to an affidavit filed by Aliera's comptroller, James Butler, Aliera earned more than $180,000,000 in revenue in 2018. Exhibit C at p. 315 (Butler testimony).

67. In the regulatory context, courts are permitted to disregard principles of corporate separateness when necessary to prevent corporations from "circumventing statutes and frustrating legislative intent by using a legislatively authorized corporate form to avoid a statute's reach and allow harms the Legislature set out to prevent." *Cadena*, 518 S.W.3d at 333. This principle is especially relevant here where Aliera's own documents demonstrate that it is using corporate fictions to control and operate a purported non-profit health sharing ministry, even stating in writing that Aliera "is authorized to make payments from each and all banking accounts opened ***in Trinity's name*** in connection with this Agreement." Aliera/Trinity Agreement at p. __ (emphasis added) [Exhibit J].

68. Aliera does not act as a facilitator among participants for the payment of medical bills, does not provide for the payment of medical bills by contributions from one participant to another, assumes risk and promises to pay.

69. Under Aliera's business model, members are required to pay a fixed amount to Aliera so that Aliera can pay covered claims directly to providers. Contributions are not made from one participant to another.

70. Membership contributions to the sharing reserve are not voluntary. To become and stay a member of one of Aliera's plans, a member must contribute a specified amount each month, a portion of which goes to the sharing reserve. If a member does not pay the total monthly fee within 5 days of the due date, the member is assessed a late fee. If the member does not pay the total monthly fee by the end of the month, the membership becomes inactive, and the member's covered medical expenses are not eligible for payment out of the sharing reserve. Additionally, if the sharing reserve is depleted in any given month, Aliera can initiate what is essentially an assessment of members to pay the outstanding needs.

72. Aliera's ability to assess members and raise monthly fees in response to the depletion of the sharing reserve also means that members are assuming risk. To maintain membership and health coverage, the member must pay the assessment or increased monthly fees.

D. Regulatory agencies in the state of Washington and Maryland have issued cease and desist orders to Aliera Healthcare based on these and similar allegations.

73. The State of Washington issued a cease and desist order against Aliera on May 13, 2019. In summarizing the findings of the investigation of the

Washington Insurance Commissioner, the order states that Aliera "provided misleading training to prospective agents about the nature of its HCSM products . . . provided misleading advertisements to the public and prospective HCSM customers about the nature of its HCSM products, [and] held itself out as health care service contractor without being registered." *See* Exhibit M. The Order notes "Aliera's repeated use of insurance terminology in its agent training and marketing materials," which "has the capacity to deceive both prospective agents and prospective consumers into believing they are purchasing a non-traditional *insurance* plan." Order at p. 3 (emphasis in original). The Order further finds that "Aliera solicits and sells plans to Washington consumers that are built on an extensive network of preferred providers and include other healthcare 'essentials' that may mislead consumers into thinking they are purchasing healthcare insurance." Order at p. 4.

74. Similarly, the Maryland Insurance Commissioner issued an order dated April 30, 2018, mandating that Aliera cease selling its plans in Maryland and pay a civil fine of $7,500.00. The order was based on conclusions of law that Aliera was engaged in the business of insurance in Maryland, and did not qualify for the health care sharing ministry exception granted under Maryland law. Aliera consented to the terms of this order.

75. Since filing its original complaint in this matter on June 13, 2019, state officials have received numerous inquiries from other regulatory agencies. Additional factual information arising out of these communications will be provided to the Court as it becomes available.

VII.
ALLEGATIONS OF IRREPARABLE HARM

76. The factual allegations set out above are incorporated as if fully repeated in support of the State's allegations of irreparable harm.

77. In addition, the State of Texas offers the following verified, sworn assertions regarding irreparable harm.

78. As described above, the defendant Aliera, as well as those acting in concert or participation with it, is selling unauthorized insurance products to the people of this State, which is recognized as an inherently harmful activity by our Legislature, our courts, and our executive agencies.

79. In addition, the Texas Department of Insurance has collected evidence of significant customer complaints as part of its investigation of Aliera. As of May 10, 2019, the Better Business Bureau had 95 complaints on file for Aliera, with about 10% of those from Texas. As of June 10, 2019, the online review platform Yelp had collected 69 one-star reviews for Aliera - again, about 10% from Texas - warning people that Aliera was a scam, and would not pay claims.

See Exhibit N. A recent article in the Houston Chronicle highlights one couple in Dallas who purchased an Aliera plan but had a claim for an expensive surgery denied. The article notes that "the similarities between traditional health insurance plans and the products Aliera promotes can be striking." Exhibit O.

80. Over the last few weeks, an investigator with the Texas Department of Insurance has attempted to reach some of the individuals who filed these complaints, and succeeded in making contact with eight of them. Each of the individuals contacted indicated that they believed the product Aliera offered was insurance, and were surprised when their claims were not paid.

81. In addition, this investigator submitted an online form expressing interest in Aliera's products, and was contacted by an insurance agent who was willing to take an application over the telephone, but would not provide written materials unless the investigator provided her credit card number for payment. Acknowledgement that the product was "not insurance" only came after the investigator specifically inquired about this issue.

82. The disclaimers provided in Aliera Healthcare's written materials are similarly alarming. As stated in the Member Guide, the first two monthly payments of any membership are completely taken for administrative costs. In addition, the Texas disclaimer provided on page 50 of the 2019 Member Guide states that of every dollar of share contributions, Aliera can only commit that 28

cents will go toward the "sharing fund" that would be used to pay claims. While the State does not currently have detailed financial evidence to offer at this time, it is difficult to see how any business model with this ratio of payment could survive unless it is sustained by a constant influx of new members.

83. Even with state-required disclaimers, the language of the 2019 Member Guide considered as a whole, increases the chances that consumers are being misled into believing that Aliera products are insurance and that by signing up with Aliera, these consumers are entering into an enforceable agreement for Aliera to pay claims in exchange for member fees.

84. Most recently, since the original petition in this case was filed on June 13, 2019, state regulators have learned that Aliera is once again attempting to evade responsibility for its unauthorized business by changing its corporate name and possibly engaging in other restructuring activities. In order to protect the public, this Court is empowered to enjoin not only the named defendant, Aliera Healthcare, but also any individual or entity acting in active concert or participation with it.

VIII.
CAUSES OF ACTION

Count I: Injunctive relief against Aliera for the unauthorized business of insurance.

85. The factual allegations set out above are incorporated as if fully repeated in support of this cause of action.

86. Aliera is directly or indirectly engaging in the business of insurance as defined in Tex. Ins. Code § 101.051.

87. Aliera has no authorization to engage in the business of insurance in Texas.

88. Aliera is violating Tex. Ins. Code § 101.102 because it is directly or indirectly doing an act or acts that constitute the business of insurance under Chapter 101 of the Texas Insurance Code without authorization.

89. Aliera is proposing to make and is making insurance contracts in Texas as an insurer. Aliera is actively promoting and selling insurance products in Texas and currently has more than 17,000 members in Texas. Aliera's membership certificates, applications, and guidelines, as provided on the website and also to customers directly, establish a contract of insurance, and Aliera is "a corporation, association, partnership, or individual engaged as a principal in the business of insurance." Tex. Ins. Code §101.002(1)(A).

90. Aliera takes and receives applications for its own insurance products and for Trinity's insurance products, including over the phone and through its agents. At least one TDI investigator has communicated with an agent attempting

to sell Aliera products and has been asked to provide credit card information in order to sign up with the plan after an application taken over the phone.

91. Aliera collects and receives consideration for its insurance products through Aliera's membership fees. Aliera's membership guide also states that it may assess its members for deficiencies in the sharing reserve.

92. Aliera issues and delivers insurance contracts to residents of Texas. More than 17,000 Texas residents have insurance contracts with Aliera. The insurance contract consists of membership certificate, application, and guidelines.

93. Aliera directly and indirectly sells insurance products to Texas residents both directly and through licensed Texas insurance agencies. Aliera offers commission of up to 40%, which is significantly higher than commission paid for the sale of authorized insurance products. Through its member guide and website, Aliera disseminates information relating to insurance coverage and rates and it receives and approves member applications. Aliera also sets the rates for the insurance products and delivers the insurance contracts. Further, Aliera adjusts claims directly and through contracted entities.

94. Aliera has capitated contracts with providers in Texas to pay the costs of its members healthcare expenses. Aliera also reimbursed providers and members in Texas directly for medical expenses under Aliera's sharing arrangement.

95. Aliera has deliberately designed its corporate structure and healthcare products to avoid insurance regulation. Aliera has attempted to structure its business to appear on its surface to fit within a legitimate exemption from insurance regulation. By avoiding insurance regulation up to this point, it has been able to offer healthcare plans to Texas that are significantly cheaper than plans offered by authorized insurance carriers, but without any of the statutory protections to Aliera's customers.

96. On application for injunctive relief and a finding that a person or entity, including an insurer, is violating or threatening to violate Chapter 101, the district court shall grant the injunctive relief and issue an injunction without bond. *See* Tex. Ins. Code § 101.105.

Count II: Civil penalties against Aliera Healthcare for the unauthorized business of insurance.

97. The allegations set out above are incorporated as if fully repeated in support of this cause of action.

98. A person or entity, including an insurer, that violates Chapter 101 is subject to a civil penalty of not more than $10,000 for each act of violation and for each day of violation. *See* Tex. Ins. Code § 101.105.

99. The State of Texas brings suit for the recovery of civil penalties against Aliera in the amount of $10,000 for each of Aliera's acts of violation and for each day of violation of Texas Insurance Code Chapter 101.

IX.
REQUEST FOR TEMPORARY RESTRAINING ORDER AND TEMPORARY INJUNCTION

100. The State of Texas asks that this Court enter a temporary restraining order prohibiting the defendant Aliera Healthcare from signing up any new Texas customers until the merits of this suit can be resolved. Further, the State asks that this Court further provide in its temporary orders that all money in the possession of Aliera, from Texas customers, and any money received from Texas customers during the pendency of this case be put into an escrow account with disbursements allowed only to pay claims from Texas customers pursuant to the terms and conditions of Aliera's Management and Administrative Agreement with Trinity Healthshare, Inc. or other contract governing disbursement from the Share Box Member Reserve. Further, the State asks this Court to provide in its temporary orders that Aliera must maintain an accounting of disbursements from the escrow account, which will be made available to TDI, the Texas Office of the Attorney General, or the Court, for inspection and copying, upon request.

101. Temporary injunctive relief is warranted when the plaintiff has (1) asserted a cause of action against the defendant, (2) is likely to succeed on the

merits of its cause of action, and (3) will suffer probable imminent, and irreparable injury if the injunction is not granted for which there is no adequate remedy at law. *Taylor Housing Auth. v. Shorts*, 549 S.W.3d 865, 877 (Tex. App. – Austin, 2018) citing *Butnaru v. Ford Motor Co.*, 84 S.W.3d 198, 204 (Tex. 2002); *Tex. Civ. Prac. & Rem. Code § 65.011*.

102. The State of Texas is likely to succeed on the merits. This petition presents substantial evidence that Aliera Healthcare is engaging in the unauthorized business of insurance in this state without a license. The bulk of these allegations come from statements made by Aliera Healthcare itself, through its website, its marketing materials, its Member Guide, and its executives submitting sworn testimony in the Georgia state litigation. Two other states have already issued cease and desist orders to Aliera based on these and similar allegations.

103. With respect to irreparable harm, the Texas Insurance Code is clear that "[i]t is the policy of this state to protect residents against acts by a person or insurer who is not authorized to do business in this state." Tex. Ins. Code § 101.001. In addition, "[i]t is a state concern" that residents holding policies from unauthorized insurers "face often insurmountable obstacles in asserting legal rights under the policies in foreign forums under unfamiliar laws and rules of practice." Tex. Ins. Code § 101.001(a). Courts in this State have often recognized the

seriousness of a charge of unauthorized insurance. See, e.g., *Strayhorn; Mid-American Indem. Ins. Co. v. King*, 22 S.W.3d 321, 326-327 (Tex. 1995) ("Both this Court and the United States Supreme Court have consistently recognized the right of the states to regulate the insurance industry in its operations affecting the public welfare.") (internal quotation marks omitted); *Southwest Professional Indem. Corp. v. Texas Dept. of Ins.*, 914 S.W.2d 256, 263 (Tex. App. – Austin 1996) ("The government . . . has a great interest in protecting citizens from the unauthorized practice of insurance.").

In *Republic Western Ins. v. State of Texas*, 985 S.W.2d 698, 706 (Tex. App. - Austin 1999), a temporary restraining order was upheld without specific findings on irreparable harm and no adequate remedy at law because the language of the statute was mandatory, providing that "an injunction shall issue if the court determines that a violation of that article has occurred." This specific provision has been repealed, but Tex. Ins. Code § 101.105 contains similar mandatory language. Tex. Ins. Code § 101.105 ("On application for injunctive relief and a finding that the person or entity . . . is violating or threatening to violate this chapter . . . the district court shall grant the injunctive relief and issue an injunction without bond.").

Even if findings as to irreparable harm are necessary, the allegations stated above demonstrate that Aliera Healthcare has failed to resolve numerous, serious

complaints regarding communications with customers and payment of claims. Also, this Court is entitled to take judicial notice that Aliera continued to employ Timothy Moses well after he admitted to taking non-profit funds without authorization.

104. Because the State has shown a likelihood of success on the merits, and multiple avenues for irreparable harm, Aliera Healthcare should be enjoined immediately from continuing to sell its health care products in Texas during the pendency of this case. Provisions in the Order should also be made for the treatment of funds collected from the over 17,000 members of Aliera Healthcare living in Texas. Aliera currently claims that it is entitled to retain over 70% of these funds for "administrative costs." During the pendency of this case, however, funds collected from Texas members should be segregated and placed in escrow with this Court, to be disbursed only with a proper accounting, reviewable upon request by TDI, the Office of the Attorney General or this Court.

106. Accordingly, the State of Texas brings suit for a temporary restraining order and temporary injunction against Aliera Healthcare, Inc. to remain in effect during the pendency of this case to be made into a permanent injunction to prevent Aliera Healthcare from engaging in the business of insurance in violation of Texas law after final trial.

Respectfully submitted.

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Attorney General of Texas

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First Assistant Attorney General

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Counsel for the State of Texas

CERTIFICATE OF SERVICE

I certify that a true and correct copy of the foregoing was sent to counsel of record electronically via eFileTexas.gov on July 11, 2019, as indicated below:

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Of Counsel for Aliera Healthcare, Inc.

/s/ H. Melissa Mather
H. Melissa Mather

VERIFICATION

STATE OF TEXAS §
§
TRAVIS COUNTY §

My name is Jamie Walker. I am Deputy Commissioner for Financial Regulation for the Texas Department of Insurance and I am legally competent to make this affidavit. The factual allegations in the first amended petition, paragraphs 8-29, 35-60, 62-78, and 82-84 are either within my personal knowledge or reported to me, from personal knowledge, by other TDI employees, or based on a review of available information existing and available at the time of the filing of this first amended petition.

Jamie Walker
Deputy Commissioner for Financial Regulation

This verification was acknowledged and executed before me, the undersigned authority, on July 11, 2019, by Jamie Walker, a person known to me, and she swore or affirmed that the facts stated above are true and correct and within her personal knowledge except where otherwise stated.

TOMMY TRAN
Notary Public-State of Texas
Notary ID #13135673-5
Commission Exp. NOV. 15, 2021
Notary without Bond

Notary Public in the State of Texas

VERIFICATION

STATE OF TEXAS §
§
TRAVIS COUNTY §

My name is Andy Buhl. I am an Investigator for the Texas Department of Insurance and I am legally competent to make this affidavit. The factual allegations in the first amended petition describing consumer complaints are within my personal knowledge or based on a review of available information available at the time of the filing of this first amended petition.

Andy Buhl
Investigator

This verification was acknowledged and executed before me, the undersigned authority, on July 11th, 2019, by Andy Buhl, a person known to me, and she swore or affirmed that the facts stated above are true and correct and within her personal knowledge except where otherwise stated.

MARY RUIZ
NOTARY PUBLIC
ID# 13079242-7
State of Texas
Comm. Exp. 08-23-2020
WITHOUT BOND

Notary Public in the State of Texas

CAUSE NO. D-1-GN-19-003388

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

ORDER GRANTING PLAINTIFF'S APPLICATION FOR TEMPORARY RESTRAINING ORDER

This Court, having considered Plaintiff's Application for Temporary Restraining Order and all other pleadings and arguments of counsel, has determined that the application should be, and is, GRANTED. The Court finds that there is evidence of irreparable injury, loss, and/or damage if the Court does not issue a temporary restraining order.

IT IS THEREFORE ORDERED that Defendant, Aliera Healthcare, Inc., its successors, affiliates, agents, and assigns, is prohibited from accepting any new customers in the State of Texas until such time that this case is resolved.

~~IT IS FURTHER ORDERED that Defendant, Aliera Healthcare, Inc., its successors, affiliates, agents, and assigns, must put all money currently in its possession from Texas customers into an escrow account.~~

~~IT IS FURTHER ORDERED that Defendant, Aliera Healthcare, Inc., its successors, affiliates, agents, and assigns, must put any money received from Texas customers at any time during the pendency of this case into the escrow account.~~

~~IT IS FURTHER ORDERED that~~ Defendant, Aliera Healthcare, Inc., its successors, affiliates, agents, and assigns, ~~may only disburse money from~~ the escrow account to pay Texas ~~customer~~ claims pursuant to the terms and conditions of its Management and ~~Administrative~~ ~~Agreement with Trinity HealthShare, Inc. or other contract governing disbursement from the~~

~~Share Box Member Reserve.~~

~~IT IS FURTHER ORDERED that that Defendant, Aliera Healthcare, Inc., its successors, affiliates, agents, and assigns, will maintain an accounting of disbursements from the escrow account available to the Texas Department of Insurance, the Texas Office of Attorney General, or the Court, for inspection and copying upon request.~~

E.S.

IT IS FURTHER ORDERED that a hearing on Plaintiff's application for Temporary Injunction is set for July 29, 2019 at 9:00A. The purpose of this hearing is to determine whether this temporary restraining order should be made a ~~permanent~~ temporary injunction pending a full trial on the merits.

This Order expires on July 26, 2019.

Signed this 12th day of July 2019.

Honorable
District Judge for the ____ Judicial District Court

CAUSE NO. D-1-GN-19-003388

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

RULE 11 AGREEMENT

Pursuant to Rule 11 of the Texas Rules of Civil Procedure, the parties in this case agree to be bound by the following terms during the pendency of this litigation to the same extent as if these terms were entered by the Court. The parties agree and acknowledge that this Rule 11 Agreement will be filed and made a part of the record in this case.

1. Aliera Healthcare, Inc., named as the defendant in this case, and now doing business as the Aliera Companies, on behalf of itself and its successors, affiliates, agents, and assigns, agrees that it will not accept or write any new business in the State of Texas until such time as this case is resolved.

2. Aliera Healthcare, Inc., now doing business as the Aliera Companies, on behalf of itself and its successors, affiliates, agents, and assigns, further agrees that it will refrain from transferring, expending, or disbursing any funds outside the ordinary course of business without approval from the Court until such time that this case is resolved.

3. The parties agree that all currently scheduled or noticed depositions are suspended until further agreement by the parties. No other depositions will be noticed or scheduled until the expiration of the Temporary Restraining Order in this case.

4. The parties agree to negotiate in good faith to address the issues raised in this matter. A settlement conference is tentatively scheduled for July 26, 2019.

5. Aliera Healthcare, Inc. agrees that, prior to July 26, 2019, it will send an accounting of money collected from Texas residents and paid on behalf of Texas residents to counsel for the State of Texas.

SIGNED AND AGREED:

Alexander J. Gonzales
State Bar No. 08118563
Duane Morris LLP
Counsel for Aliera Healthcare, Inc.

Melissa Mather

H. Melissa Mather
State Bar No. 24010216
Assistant Attorney General
Office of the Texas Attorney General
Counsel for the State of Texas

with permission

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

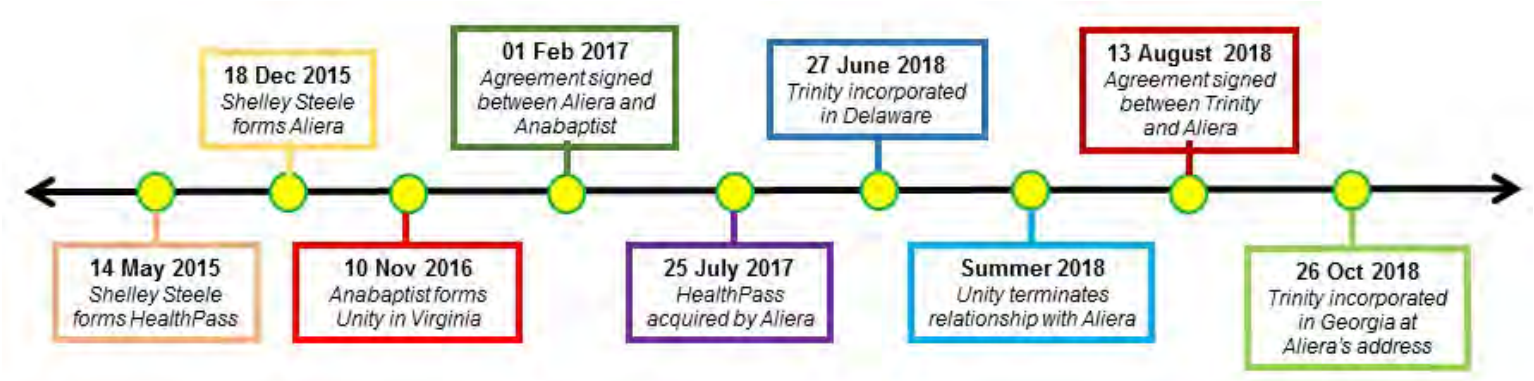
INV Robbins conducted a licensing check on Aliera through the National Association of Insurance Commissioners ("NAIC"), which disclosed Aliera has active producer's licenses in 36 states. It does not have a license in Washington (Exhibit 2). Trinity is not licensed with the NAIC or the OIC, because it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

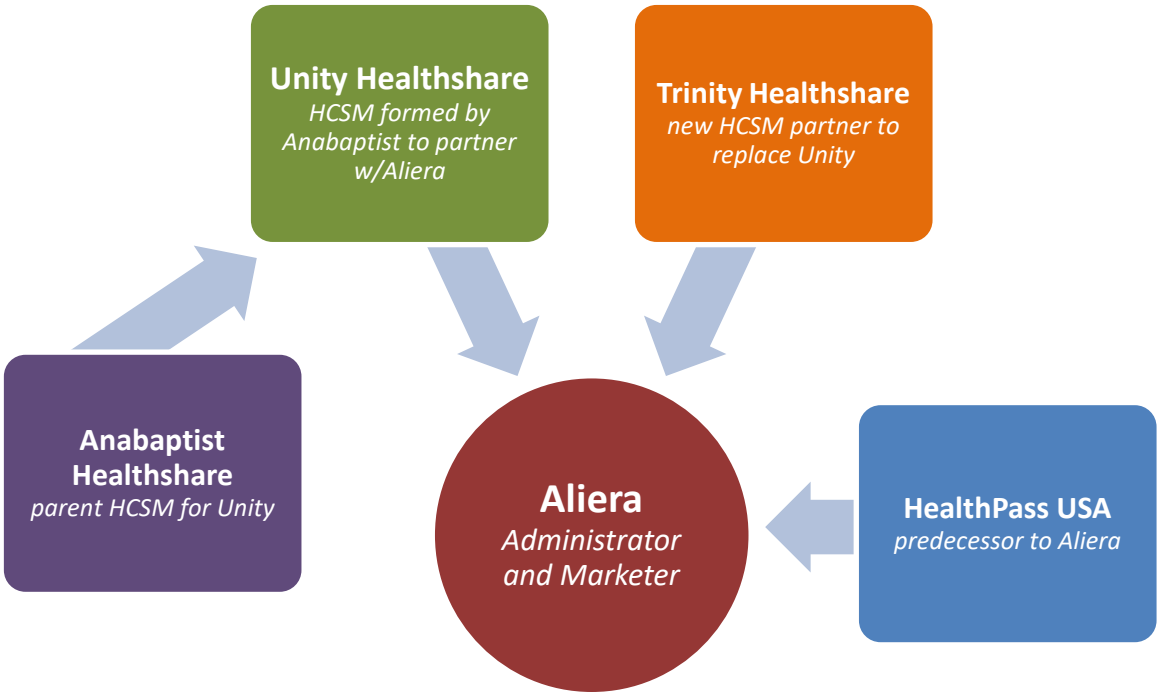
3. NOTIFICATION OF INVESTIGATION

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.

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).

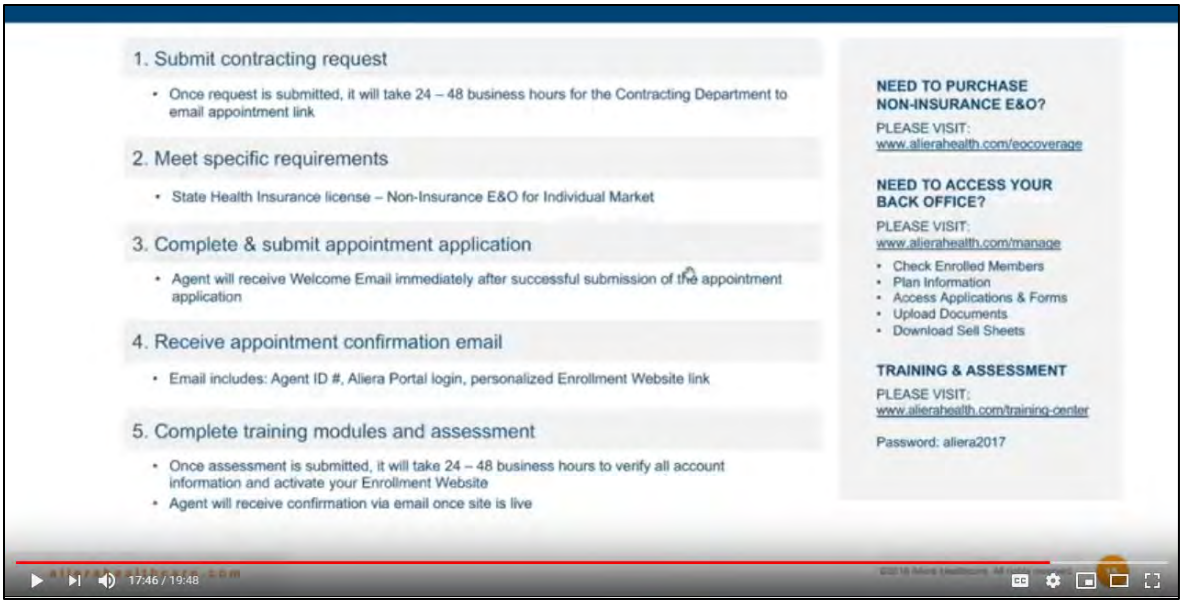
The narrator discussed various group coverage options, then transitioned to the "individual alternative market," which he described as "our bread and butter" which accounted for over 70% of Aliera's sales. Each of the branded plans in this category (below) are actually HCSM plans which Aliera markets 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/OjI5Ff1l2Ck.
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

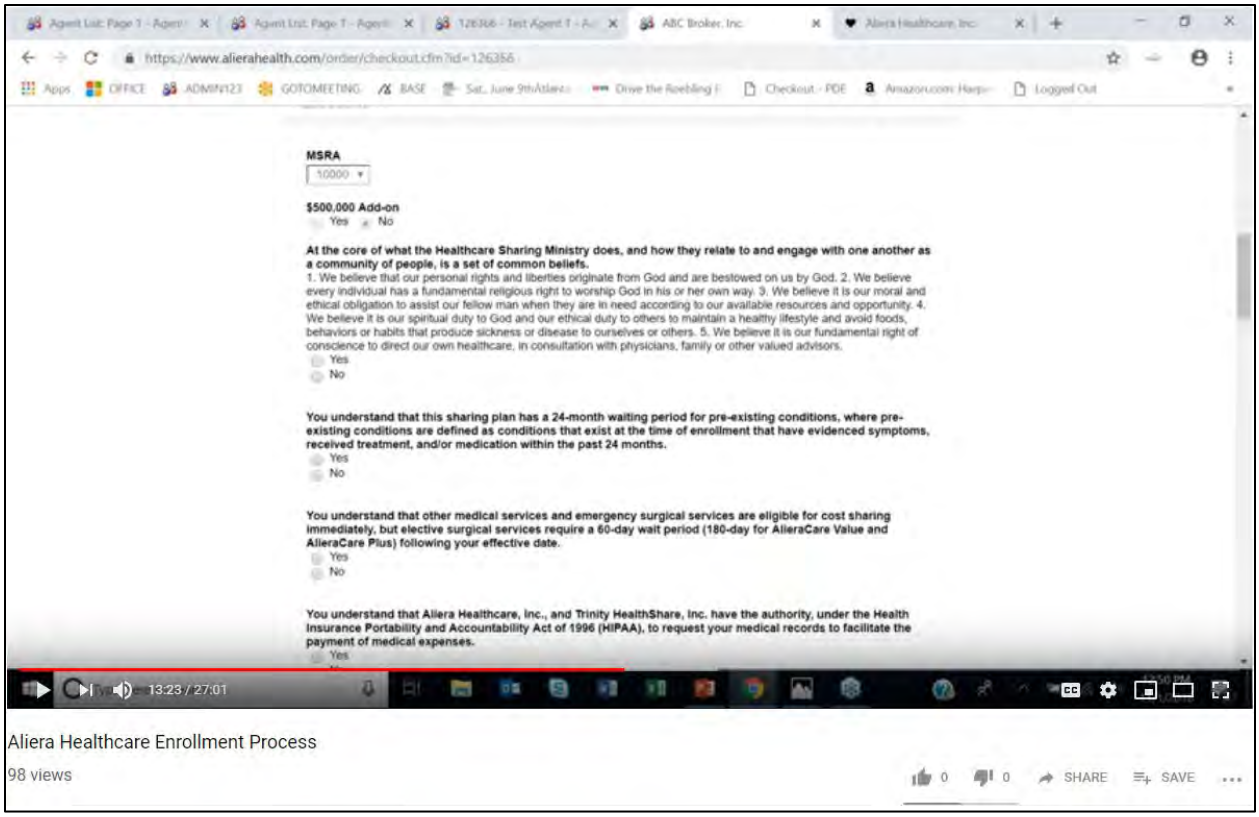
On 11/01/18, an unidentified Aliera trainer conducted a seminar for new or prospective agents about the "back office" functions of Aliera's agent portal. AHCP posted this video on YouTube the same day, with the title "Aliera Healthcare Enrollment Process."[11] INV Robbins obtained both mp3 and mp4 copies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

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”

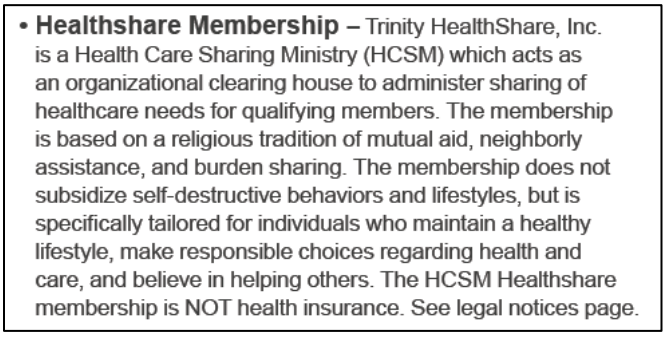
On 10/01/18, Aliera published a video of an appearance its Executive Vice President, Chase Moses (“Moses”), made on a Lifetime morning television program called *The Balancing Act.*[13] INV Robbins obtained mp3 and mp4 copies of the video (Exhibits 4z and 4aa). Moses explains, “Aliera has thrived in 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.

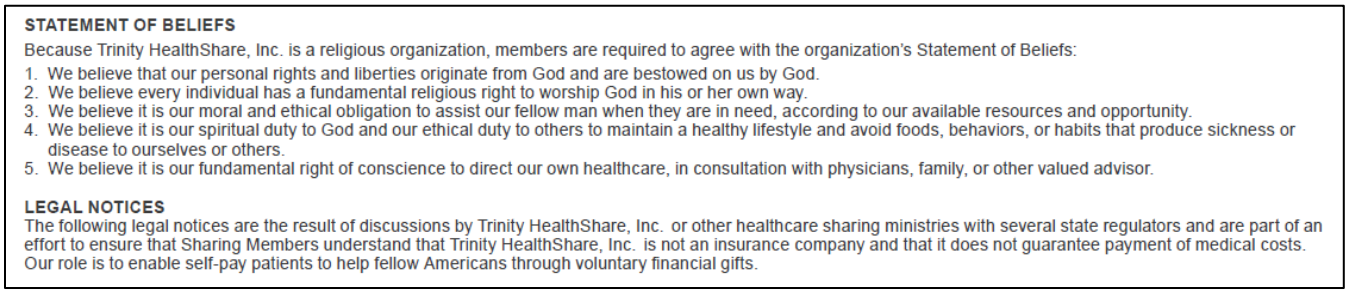
3. Literature:

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

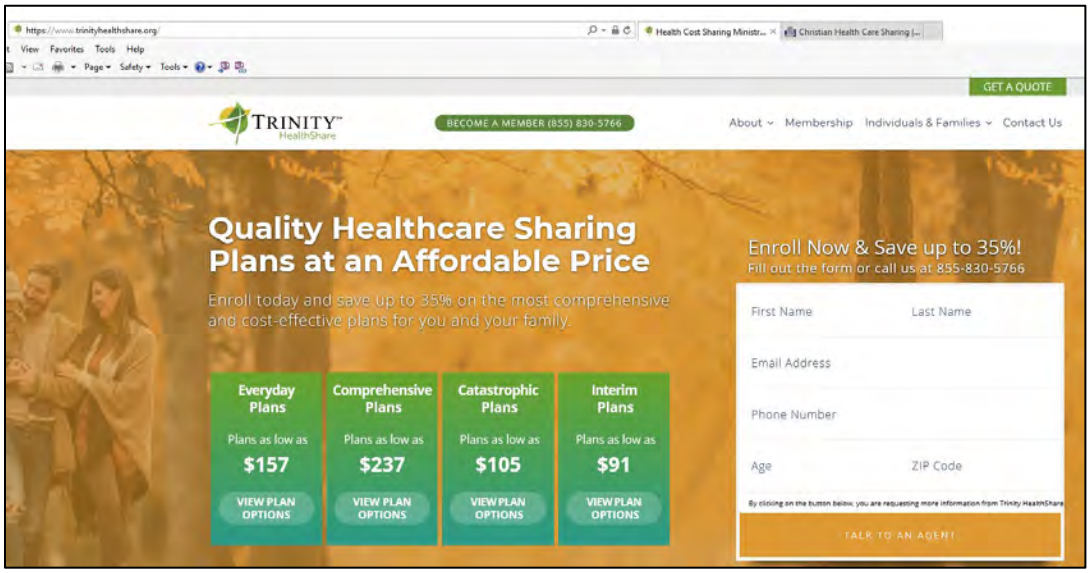
20. Emphasis mine. For further information on the "alone" and "only" statement bolded above, and the distinction between the historic Protestant and Roman Catholic understandings of salvation, see any public source discussion of the context of the "five solas" of the Protestant Reformation – even Wikipedia.

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.

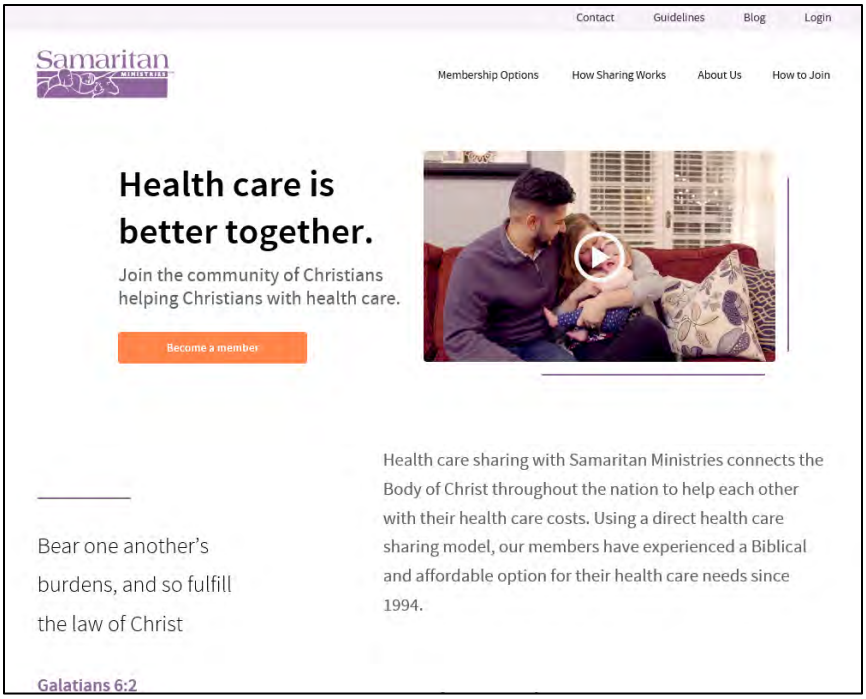
iii. **Website:**

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.**

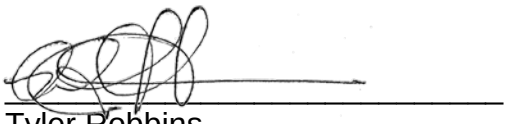
The allegation is substantiated because (1) Trinity's representations about its religious convictions are contradictory, (2) it has not been operating as a 501(c)(3) legal entity and sharing member medical needs continuously since December 31, 1999, and (3) evidence indicates Trinity was formed in 2018 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
Exhibit 5g	(11.16.2018) Aliera's Agreement with Trinity
Exhibit 5h	(02.19.2019) Aliera's Second Response to OIC
Exhibit 6a	(06.17.2015) HealthPass USA Articles and Certificate of Organization in Georgia
Exhibit 6b	(2016) HealthPass USA 2016 Annual Registrations in Georgia
Exhibit 6c	(03.30.2017) HealthPass USA 2017 Annual Registration
Exhibit 7a	(11.05.2018) Request to Delaware for Aliera (5045109)
Exhibit 7b	(01.10.2019) Aliera #2 Documents from Delaware
Exhibit 7c	(09.29.2011) Aliera's (#2) Home Registration with Delaware Secretary of State

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
Exhibit 8d	(12.07.2018) First Response from Trinity
Exhibit 8e	(03.11.2019) Second Response from Trinity
Exhibit 8f	(01.24.2019) Trinity's Website Home Page
Exhibit 8g	(2018) Trinity Health Care Sharing explained
Exhibit 8h	(2018) Trinity Healthshare FAQs
Exhibit 9a	(11.15.2018) Unity's Incorporation in Virginia
Exhibit 9b	(08.08.2018) Unity's Registered Agent Address Change
Exhibit 9c	(08.14.2018) Unity's Principal Address Change
Exhibit 9d	(08.22.2018) Unity's Principal Address Change
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
Exhibit 9h	(05.18.2018) Anabaptist HealthShare's Form 990 for 2016
Exhibit 9i	(11.16.2018) Aliera's Agreement with Unity
Exhibit 9j	(05.25.2018) 1539832 acknowledgment
Exhibit 9k	(06.05.2018) 1546395 acknowledgment
Exhibit 9l	(06.05.2018) 1549758 acknowledgment
Exhibit 9m	(06.05.2018) 1560917 acknowledgment

STATE OF WASHINGTON
OFFICE OF THE INSURANCE COMMISSIONER

In the Matter of **ALIERA HEALTHCARE INC.,** Unauthorized Entity. Respondent.	Order No. 19-0251 ORDER TO CEASE AND DESIST

Pursuant to RCW 48.02.080 RCW 48.15.023, RCW 48.17.063, RCW 48.30.010, RCW 48.44.016, and RCW 48.155.130(1) the Insurance Commissioner of the state of Washington ("Insurance Commissioner") orders the above-named Respondent, and its officers, directors, trustees, employees, agents, and affiliates to immediately cease and desist from:

A. Engaging in or transacting the unauthorized business of insurance or acting as an unregistered health care service contractor or as an unlicensed discount plan organization in the state of Washington;

B. Seeking, pursuing and obtaining any insurance or discount plan business in the state of Washington;

C. Soliciting Washington residents to purchase any insurance or discount plan to be issued by an unauthorized insurer or unlicensed discount plan organization;

D. Soliciting Washington residents to induce them to purchase any insurance contract or discount plan.

BASIS:

1. Aliera Healthcare Inc. ("Aliera") is a nonresident corporation domiciled in Delaware and incorporated on December 18, 2015. Aliera does not hold a certificate of authority and is not licensed to sell, solicit, or negotiate insurance in the state of Washington. Aliera is also

not registered as a health care service contractor or licensed as a discount plan organization in the state of Washington.

2. Trinity HealthShare, Inc. ("Trinity") is a nonresident corporation domiciled in Delaware. Trinity represents itself as a health care sharing ministry ("HCSM") as defined by 26 USC §5000A and incorporated by reference under RCW 48.43.009. Trinity does not hold a certificate of authority in Washington. Trinity HealthShare, Inc. is the subject of a separate but related Cease and Desist Order. See Order No. 19-0152.

3. To qualify as a health care sharing ministry under the Internal Revenue Service (IRS) and Washington law, a HCSM must be a 501(c)(3) organization whose members share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs. A HCSM must also have been in operation and continuously sharing member health care costs since at least December 31, 1999.

4. Aliera is the administrator, marketer, and program manager for Trinity and is solely responsible for the development of HCSM plan designs, pricing, marketing materials, vendor management, and recruitment and maintenance of a national sales force on behalf of Trinity.

5. By the terms of their Management and Administration Agreement ("the Agreement"), Aliera has the right, at its sole discretion, to develop and market "the schedule of medical services eligible for sharing under the HCSM" with other purportedly "non-insurance" health care products developed and managed by Aliera. Such products include telemedicine, discount prescription drugs, and concierge services to locate in-network providers. In order to purchase any of Aliera's HCSM-inclusive plans, individuals must acknowledge Trinity's statement of faith and lifestyle requirements, as deemed necessary by Trinity and agreed upon by Aliera.

6. Following receipt of a complaint, the Insurance Commissioner investigated to determine whether Aliera is accurately representing its products to Washington consumers as a HCSM in compliance with state and federal law. The complaint alleged that Aliera is soliciting and recruiting agents to sell misleading products to Washington consumers by using marketing materials that may lead the average consumer to believe they are purchasing healthcare insurance rather than a HCSM membership.

7. The investigation determined that Aliera 1) failed to represent Trinity's actual statement of faith, as defined by Trinity's own bylaws, 2) provided misleading training to

prospective agents about the nature of its HCSM products, 3) provided misleading advertisements to the public and prospective HCSM customers about the nature of its HCSM products, 4) held itself out as health care service contractor without being registered, and 5) is doing business as an unlicensed discount plan organization.

8. Trinity has communicated to state and federal regulatory authorities that it holds to a Protestant expression of the Christian faith. Trinity's own bylaws obligate its members to affirm this expression of faith. However, as marketed by Aliera, Trinity offers an alternative solution to health insurance and offers membership to individuals of "all faiths." In training materials to prospective agents, Aliera describes Trinity's statement of faith as simply a belief in a higher power, whether a Christian, Buddhist, or Jewish God. This statement of faith, as presented to the public, is materially different from and inconsistent with the statement of faith that Trinity has represented to regulatory authorities. Aliera also has the contractual right to "agree upon" Trinity's required statement of beliefs.

9. Aliera's web-based advertisement to recruit prospective agents to sell its HCSM products touts the opportunity to sell "the next generation Healthcare products" and suggests Aliera can offer employers "a healthcare plan that saves money." The advertisement does not include any reference to a required affirmation of a common set of ethical or religious beliefs. Likewise, Aliera's prospective agent training portal provides required training videos that explain Aliera's HCSM plan offerings with no reference to consumers' required affirmation of a common set of ethical or religious beliefs.

10. A video seminar for prospective agents refers to Aliera's "individual alternative market" as the company's "bread and butter." The narrator/trainer states that Aliera's comprehensive HCSM plans not only "mirrors traditional insurance, but truly provide comprehensive healthcare for an individual." The narrator/trainer also describes one of Aliera's HCSM plans (InterimCare) as "our short-term medical plan." Aliera's repeated use of insurance terminology in its agent training and marketing materials has the capacity to deceive both prospective agents and prospective consumers into believing they are purchasing a non-traditional *insurance* plan.

11. In another video seminar for prospective Aliera agents, a trainer represents Trinity's statement of faith in the following manner:

> *Just to give you a general overall synopsis of what it's saying ... It basically is saying that you believe in a higher power. It doesn't necessarily have to be a Christian God, or a Buddhist God, or a Jewish God. It doesn't ... it doesn't matter as long as we all believe that there is a higher power and we're all living our life that the best way that we possibly can. We're maintaining a healthy lifestyle. We're trying to avoid those types of foods, behaviors, habits - things that, you know, cause us illness that are in our control. As long as we're doing those types of things, we're all like-minded individuals. So if you feel that way, and you are a like-minded individual, that's all we're trying to find out. And, if you are, you're gonna say, "Yes," you believe in the five same statement of beliefs that we all do.*

12. Aliera solicits and sells plans to Washington consumers that are built on an extensive network of preferred providers and include other healthcare "essentials" that may mislead consumers into thinking they are purchasing healthcare insurance. Aliera's HCSM plans include telemedicine, prescription drug discounts, and access to in-network labs and diagnostics.

13. RCW 48.30.040 states no person shall knowingly make, publish, or disseminate any false, deceptive or misleading representation or advertising in the conduct of the business of insurance, or relative to the business of insurance or relative to any person engaged therein.

14. RCW 48.15.020(2)(a) provides that a person may not, in this state, represent an unauthorized insurer except as provided in this chapter.

15. RCW 48.17.060(1) provides that a person shall not sell, solicit, or negotiate insurance in this state for any line or lines of insurance unless the person is licensed for that line of authority in accordance with this chapter.

16. RCW 48.02.080(3) states if the Insurance Commissioner has cause to believe that any person is violating or is about to violate any provision of this code or any regulation or order of the Insurance Commissioner, he or she may: (a) issue a cease and desist order.

17. WAC 284-50-050(1) states the format and content of an advertisement to which these rules apply shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Whether an advertisement has a capacity or tendency to mislead or deceive shall be determined by the insurance commissioner from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence, within the segment of the public to which it is directed.

18. WAC 284-50-050(2) states advertisements shall be truthful and not misleading in fact or in implication. Words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology, shall not be used.

19. WAC 284-50-060(1) states no advertisement shall omit information or use words, phrases, statements, references, or illustrations if the omission of such information or use of such words, phrases, statements, references, or illustrations has the capacity, tendency, or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered, or premium payable. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale or an offer is made to refund the premium if the purchaser is not satisfied, does not remedy misleading statements.

20. RCW 48.44.015(1) provides that a person may not in this state, by mail or otherwise, act as or hold himself or herself out to be a health care service contractor, as defined in RCW 48.44.010 without first being registered with the commissioner.

21. RCW 48.155.020(1) provides that, before conducting discount plan business to which this chapter applies, a person must obtain a license from the commissioner to operate as a discount plan organization.

22. The Respondent's actions described herein violate Insurance Code provisions that include RCW 48.15.020 (representation of an unauthorized insurer prohibited), RCW 48.17.060 (license required), RCW 48.30.040 (false information and advertising), RCW 48.44.015(1) (registration by health care service contractors required), and RCW 48.155.020(1) (discount plan organization license required).

IT IS FURTHER ORDERED that nothing herein shall prevent the Respondent from fulfilling the terms of contracts formed prior to the effective date of this Order pursuant to RCW 48.15.020(2)(b).

Any violation of the terms of this Order by the Respondent and its officers, directors, trustees, employees, agents, and affiliates or the Respondent's failure to fulfill or perform its contracts subject to this Order will render the violator(s) subject to the full penalties authorized by RCW 48.02.080, 48.15.023, and other applicable sections of the Insurance Code of the state of Washington.

The Respondent has the right to demand a hearing in accordance with RCW 48.04.010, WAC 284-02-070, and WAC 10-08-110.

This Order shall remain in effect subject to the further order of the Insurance Commissioner.

THIS ORDER IS EFFECTIVE IMMEDIATELY AND IS ENTERED at Tumwater, Washington, this 13th day of May, 2019.

Mike Kreidler

MIKE KREIDLER
Insurance Commissioner

By and through his designee

Kimberly Tocco

KIMBERLY TOCCO
Insurance Enforcement Specialist
Legal Affairs Division

CERTIFICATE OF MAILING

The undersigned certifies under the penalty of perjury under the laws of the state of Washington that I am now and at all times herein mentioned, a citizen of the United States, a resident of the state of Washington, over the age of eighteen years, not a party to or interested in the above-entitled action, and competent to be a witness herein.

On the date given below I caused to be served the foregoing Order to Cease and Desist on the following individual(s) in the manner listed below:

By depositing in the U.S. mail via state Consolidated Mail Service with proper postage affixed to:

Aliera Healthcare Inc.
The Corporation Trust Company
Corporation Trust Center
1209 Orange St
Wilmington, DE 19801

By email and by depositing in the U.S. mail via state Consolidated Mail Service with proper postage affixed to:

Dwight Francis
Sheppard, Mullin, Richter & Hampton LLP
2200 Ross Ave, Ste. 2400
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Aliera Healthcare Inc.
5901 Peachtree Dunwoody Rd Ste B-200
Atlanta, GA 30328
tmoses@aliera.com

Reba Leonard
Vice President, Compliance and Regulatory Affairs
15301 Dallas Parkway, Suite 920
Addison, TX 75001
rleonard@alierahealthcare.com

Dated this 13th day of May, 2019, in Tumwater, Washington.

Christine Tribe

CHRISTINE TRIBE
Paralegal
Legal Affairs Division

STATE OF WASHINGTON
OFFICE OF THE INSURANCE COMMISSIONER

In the Matter of	
TRINITY HEALTHSHARE, INC.	Order No. 19-0252
Unauthorized Entity.	ORDER TO CEASE AND DESIST
Respondent.	

Pursuant to RCW 48.02.080, RCW 48.15.020, and RCW 48.15.023, the Insurance Commissioner of the state of Washington ("Insurance Commissioner") orders the above-named Respondent, and its officers, directors, trustees, employees, agents, and affiliates to immediately cease and desist from:

A. Engaging in or transacting the unauthorized business of insurance in the state of Washington;

B. Seeking, pursuing and obtaining any insurance business in the state of Washington;

C. Soliciting Washington residents to sell any insurance issued or to be issued by an unauthorized insurer;

D. Soliciting Washington residents to purchase any insurance contract.

BASIS:

1. Trinity HealthShare, Inc. ("Trinity") is a nonresident corporation domiciled in Delaware. Trinity represents itself as a health care sharing ministry ("HCSM") as defined by 26 USC §5000A and incorporated by reference under RCW 48.43.009. Trinity does not hold a certificate of authority in the state of Washington.

2. To qualify as a health care sharing ministry under the Internal Revenue Service (IRS) and Washington law, a HCSM must be a 501(c)(3) organization whose members share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs. A HCSM must also have been in operation and continuously sharing member health care costs since at least December 31, 1999.

3. Washington adopts the IRS definition of HCSM under RCW 48.43.009. HCSMs that comply with the required federal provisions are not considered Washington health carriers or insurers and are exempt from regulation under Washington's insurance code.

4. Following receipt of a complaint, the Insurance Commissioner investigated to determine whether Trinity is accurately representing itself to Washington consumers as a HCSM in compliance with state and federal law. The complaint alleged that Trinity's corporate partner, Aliera Healthcare, Inc. ("Aliera"), is soliciting and recruiting agents to sell misleading products to Washington consumers because the co-branded marketing materials use language that may lead the average consumer to believe they are purchasing healthcare insurance rather than a HCSM membership.

5. The investigation determined that Trinity does not meet the legal definition of a HCSM and is therefore acting as an unauthorized insurer in the state of Washington.

6. Trinity first incorporated in the state of Delaware on June 27, 2018. Approximately six weeks later, Trinity entered into a Management and Administration Agreement ("the Agreement") with Aliera. The Agreement was effective August 13, 2018, and stated Trinity's intent to partner with Aliera to include Trinity's HCSM program as a component of Aliera's new and existing healthcare products. Trinity also grants its corporate affiliate Aliera the exclusive right to develop, market, and sell its HCSM plans to individuals who agree to Trinity's statement of faith and lifestyle requirements.

7. Trinity has been in existence less than one (1) year. Further, at the time of the Agreement with Aliera, Trinity had zero members in its HCSM and there was no predecessor organization in which Trinity's members were sharing medical costs. Trinity, with zero members, further provided that any future enrolled members would become "customers" of Aliera, who would maintain ownership over the "membership roster." Trinity has not "been in operation and continuously sharing member health care costs since at least December 31, 1999" as required to qualify for exemption from state insurance regulation.

8. Trinity espouses contradictory versions of the required "common set of ethical or religious beliefs" that vary based on the intended audience. If Trinity's members do not share common beliefs – regardless of the content of such beliefs – and share medical burdens in accordance with those common beliefs, Trinity cannot represent itself as a HCSM.

9. Trinity has communicated to state and federal regulatory authorities that it holds to a Protestant expression of the Christian faith. Trinity's own bylaws obligate its members to affirm this expression of faith. However, according to its website, Trinity offers an alternative solution to health insurance and offers membership to individuals of "all faiths." In training materials to prospective agents, Trinity's statement of faith becomes simply a belief in a higher power, whether a Christian, Buddhist, or Jewish God. This statement of faith, as presented to the public, is materially different from and inconsistent with the statement of faith that Trinity has claimed to regulatory authorities, demonstrating that Trinity and its ministers do not share "a common set of ethical or religious beliefs" as required to qualify for exemption from state insurance regulation.

10. Finally, Trinity also grants Aliera the contractual right to "agree upon" the required statement of beliefs. Conditioning its common set of ethical or religious beliefs on the consent of its for-profit corporate partner is contradictory to Trinity's own statements about its religious traditions.

11. RCW 48.05.030(1) states no person shall act as an insurer and no insurer shall transact insurance in this state other than as authorized by a certificate of authority issued to it by the Insurance Commissioner and then in force; except, as to such transactions as are expressly otherwise provided for in this code.

12. RCW 48.30.040 states no person shall knowingly make, publish, or disseminate any false, deceptive or misleading representation or advertising in the conduct of the business of insurance, or relative to the business of insurance or relative to any person engaged therein.

13. RCW 48.02.080(3) states if the Insurance Commissioner has cause to believe that any person is violating or is about to violate any provision of this code or any regulation or order of the Insurance Commissioner, he or she may: (a) issue a cease and desist order.

14. RCW 48.15.023(5)(a) states if the Insurance Commissioner has cause to believe that any person has violated the provisions of RCW 48.15.020(1), the Insurance Commissioner may: (i) issue and enforce a cease and desist order in accordance with the provisions of RCW 48.02.080.

15. RCW 48.44.015(1) provides that a person may not in this state, by mail or otherwise, act as or hold himself or herself out to be a health care service contractor, as defined in RCW 48.44.010 without first being registered with the Insurance Commissioner.

16. The Respondent's actions described herein violate Insurance Code provisions that include RCW 48.05.030 (certificate of authority required), RCW 48.14.020 (failure to timely pay premium tax), RCW 48.15.020 (solicitation by unauthorized insurer prohibited), and RCW 48.30.040 (unfair practices and frauds).

IT IS FURTHER ORDERED that nothing herein shall prevent the Respondent from fulfilling the terms of contracts formed prior to the effective date of this Order pursuant to RCW 48.15.020(2)(b).

Any violation of the terms of this Order by the Respondent and its officers, directors, trustees, employees, agents, and affiliates or the Respondent's failure to fulfill or perform its contracts subject to this Order will render the violator(s) subject to the full penalties authorized by RCW 48.02.080, 48.15.023, and other applicable sections of the Insurance Code of the state of Washington.

The Respondent has the right to demand a hearing in accordance with RCW 48.04.010, WAC 284-02-070, and WAC 10-08-110.

This Order shall remain in effect subject to the further order of the Insurance Commissioner.

THIS ORDER IS EFFECTIVE IMMEDIATELY AND IS ENTERED at Tumwater, Washington, this 13TH day of MAY, 2019.

Mike Kreidler

MIKE KREIDLER
Insurance Commissioner

By and through his designee

Kimberly Tocco

KIMBERLY TOCCO
Insurance Enforcement Specialist
Legal Affairs Division

CERTIFICATE OF MAILING

The undersigned certifies under the penalty of perjury under the laws of the state of Washington that I am now and at all times herein mentioned, a citizen of the United States, a resident of the state of Washington, over the age of eighteen years, not a party to or interested in the above-entitled action, and competent to be a witness herein.

On the date given below I caused to be served the foregoing Order to Cease and Desist on the following individual(s) in the manner listed below:

By depositing in the U.S. mail via state Consolidated Mail Service with proper postage affixed to:

Trinity Healthshare
5901 Peachtree Dunwoody Rd., Ste 160
Atlanta, GA 30328

By email and by depositing in the U.S. mail via state Consolidated Mail Service with proper postage affixed to:

J. Joseph Guilkey
BakerHostetler
200 Civic Center Drive, Ste. 1200
Colombus, OH 43215
jguilkey@bakerlaw.com

Dated this 13th day of May, 2019, in Tumwater, Washington.

Christine Tribe
CHRISTINE TRIBE
Paralegal
Legal Affairs Division

001392427 12/23/2019 150,000.00

STATE OF WASHINGTON
OFFICE OF THE INSURANCE COMMISSIONER

In the Matter of

TRINITY HEALTHSHARE, INC.,

Respondent.

Order No. 19-0375

CONSENT ORDER LEVYING A FINE

This Consent Order Levying a Fine ("Order") is entered into by the Insurance Commissioner of the state of Washington ("Insurance Commissioner"), acting pursuant to the authority set forth in RCW 48.02.060 and RCW 48.15.023, and Trinity Healthshare, Inc. This Order is a public record and will be disseminated pursuant to Title 48 RCW and the Insurance Commissioner's policies and procedures.

BASIS:

1. Trinity Healthshare, Inc. ("Trinity" or "the Company") is a nonresident corporation domiciled in Delaware. Trinity represents itself as a health care sharing ministry ("HCSM") as defined by RCW 48.43.009. Trinity does not hold a certificate of authority to transact insurance in the state of Washington.

2. On May 13, 2019, the Insurance Commissioner ordered Trinity to cease and desist from the unauthorized business of insurance in the state of Washington under Order to Cease and Desist No. 19-0252 (the "Order"). Trinity fully complied with the Order and immediately stopped enrolling new Washington residents in its HCSM Sharing Program. Consistent with the Order, Trinity continued to facilitate sharing among state of Washington members who enrolled in Trinity Sharing Programs prior to May 13, 2019.

3. Under RCW 48.43.009, qualified HCSMs are not considered Washington health carriers or insurers and are exempt from regulation under the Washington insurance code.

4. The Insurance Commissioner opened this investigation following a complaint from an insurer related to the potential misrepresentation of certain "health share" products as insurance

and the recruitment of prospective brokers to sell these products to Washington consumers. The complaint alleged that Aliera Healthcare, Inc. ("Aliera"), which provides management and administrative services to Trinity, was soliciting and recruiting agents to sell misleading products to Washington consumers by using co-branded marketing communications containing language that may lead the average consumer to believe they are purchasing healthcare insurance rather than a HCSM membership.

5. Aliera is the subject of a separate but related enforcement action. *See* Consent Order Levying A Fine No. 19-0376.

6. Following receipt of the complaint, the Insurance Commissioner investigated to determine whether Trinity is accurately representing itself to Washington consumers as a HCSM in compliance with state law.

7. As a result of this investigation, the Insurance Commissioner has cause to believe that Trinity does not qualify as a HCSM under Washington law and is acting as an unauthorized insurer in the state of Washington.

8. To meet the definition of a health care sharing ministry under Washington law, a HCSM must be a 501(c)(3) organization exempt from taxation under section 501(a), whose members share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs. A HCSM, or a predecessor of which, must also have been in existence at all times since December 31, 1999 and continuously sharing member medical expenses without interruption since at least December 31, 1999.

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

10. Effective August 13, 2018, Trinity entered into a Management and Administration Agreement ("the Agreement") with Aliera. The Agreement stated Trinity's intent to include Trinity's HCSM program as a component of Aliera's new and existing healthcare products. Trinity had no members in its HCSM program at this time.

11. As a result of the investigation, the Insurance Commissioner has cause to believe that Trinity cannot qualify for an exemption from Washington state insurance regulation as a HCSM because neither Trinity, nor a predecessor of Trinity, have been in existence at all times and continuously sharing member health care costs since at least December 31, 1999.

12. In response to the Insurance Commissioner's investigation, Trinity stated its position that it meets the definition of a HCSM under RCW 48.43.009 and is therefore not a health

carrier as defined in RCW 48.43.005 or insurer as defined in RCW 48.01.050, and is exempt from regulation under the Washington insurance code. Trinity also stated its position that its operations do not constitute insurance under Washington law because Trinity does not promise to pay members anything or undertake any obligation to pay members.

13. As of June 15, 2019, 3,058 Washington consumers were actively enrolled in Trinity plans.

14. RCW 48.01.030 states the business of insurance is one affected by the public interest, requiring that all persons be actuated by good faith, abstain from deception, and practice honesty and equity in all insurance matters. Upon the insurer, the insured, their providers, and their representatives rests the duty of preserving inviolate the integrity of insurance.

15. RCW 48.01.040 states that "insurance" is a contract whereby one undertakes to indemnify another or pay a specified amount upon determinable contingencies.

16. RCW 48.01.050 states in relevant part that "insurer" as used in this code includes every person engaged in the business of making contracts of insurance.

17. RCW 48.43.009 states that health care sharing ministries are not health carriers as defined in RCW 48.43.005 or insurers as defined in RCW 48.01.050. For purposes of this section, "health care sharing ministry" has the same meaning as in 26 U.S.C. Sec. 5000A.

18. 26 U.S.C. Sec. 5000A states the term "health care sharing ministry" means an organization—(I) which is described in section 501(c)(3) and is exempt from taxation under section 501(a), (II) members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the State in which a member resides or is employed, (III) members of which retain membership even after they develop a medical condition, (IV) which (or a predecessor of which) has been in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously and without interruption since at least December 31, 1999, and (V) which conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.

19. RCW 48.05.030(1) states that no person shall act as an insurer and no insurer shall transact insurance in this state other than as authorized by a certificate of authority issued to it by

the Insurance Commissioner and then in force; except, as to such transactions as are expressly otherwise provided for in this code.

20. RCW 48.15.020(1) states that an insurer that is not authorized by the Insurance Commissioner may not solicit or transact insurance business in this state.

21. RCW 48.15.023(2) states that for the purpose of this section, an act is committed in this state if it is committed, in whole or in part, in the state of Washington, or affects persons or property within the state and relates to or involves an insurance contract.

22. RCW 48.15.023(3) states that any person who knowingly violates RCW 48.15.020(1) is guilty of a class B felony punishable under chapter 9A.20 RCW.

23. RCW 48.15.023(4) states that any criminal penalty imposed under this section is in addition to, and not in lieu of, any other civil or administrative penalty or sanction otherwise authorized under state law.

24. RCW 48.15.023(5)(a) states if the Insurance Commissioner has cause to believe that any person has violated the provisions of RCW 48.15.020(1), the Insurance Commissioner may:

(i) Issue and enforce a cease and desist order in accordance with the provisions of RCW 48.02.080; and/or

(ii) Assess a civil penalty of not more than twenty-five thousand dollars for each violation, after providing notice and an opportunity for a hearing in accordance with chapters 34.05 and 48.04 RCW.

25. As a result of this investigation, the Insurance Commissioner has cause to believe that Trinity does not meet the requirements for an exemption from insurance regulation under RCW 48.43.009 and is acting as an unauthorized insurer in the state of Washington. In view of the complex issues raised and the probability that long-term litigation or administrative proceedings would be required to resolve these disputes, Trinity desires to resolve this matter by entering into this Order and does not contest that as a result of this investigation the Insurance Commissioner has cause to believe Trinity does not meet the requirements for an exemption from insurance regulation under RCW 48.43.009 and is acting as an unauthorized insurer in the state of Washington.

26. As a result of this investigation the Insurance Commissioner has cause to believe that Trinity's activities in Washington violated RCW 48.05.030(1) and RCW 48.15.020(1), justifying imposition of a fine under RCW 48.15.023(5)(a)(ii). In view of the complex issues raised

and the probability that long-term litigation or administrative proceedings would be required to resolve these disputes, Trinity desires to resolve this matter by entering into this Order and does not contest that as a result of this investigation the Insurance Commissioner has cause to believe that Trinity's activities in Washington violated RCW 48.05.030(1) and RCW 48.15.020(1).

CONSENT TO ORDER:

The Insurance Commissioner of the state of Washington and Trinity agree the best interest of the public will be served by entering into this Order. NOW, THEREFORE, Trinity consents to the following in consideration of its desire to resolve this matter without further administrative or judicial proceedings. The Insurance Commissioner consents to settle this matter in consideration of Trinity's payment of a fine, and upon such terms and conditions as are set forth below:

1. Trinity acknowledges its duty to comply fully with the applicable laws of the state of Washington.

2. Trinity consents to the entry of this Order, waives any and all hearing or other procedural rights, and further administrative or judicial challenges to this Order.

3. By agreement of the parties, the Insurance Commissioner will impose a fine of One Hundred Fifty Thousand Dollars ($150,000.00) to be paid by **December 27, 2019**.

4. By agreement of the parties, Trinity will not solicit state of Washington residents to enroll in its HCSM Sharing Programs. Additionally, within ten (10) days of the entry of this Order, Trinity will notify all state of Washington residents who were enrolled in Trinity HCSM Sharing Programs prior to May 13, 2019, that Trinity will no longer be offering its Sharing Programs in the state of Washington. Trinity may continue to facilitate sharing among current state of Washington Trinity members for one (1) year after the entry of this Order such that members have sufficient time to find alternative options.

5. Trinity understands and agrees that any further findings that Trinity has failed to comply with the statutes and/or regulations that are the subject of this Order constitute grounds for further penalties, which may be imposed in direct response to further violations.

6. This Order and the violations set forth herein constitute admissible evidence that may be considered in any future action by the Washington Insurance Commissioner involving Trinity.

7. This Order is based solely on the application of the Washington State insurance code to the specific facts of the Insurance Commissioner's investigation in this case. Trinity and the Washington Insurance Commissioner are the only parties to this Order. Therefore, this Order, and any provision, findings, or conclusions contained herein, do not, and is not intended to, determine any factual or legal issue in any other jurisdiction, or have any preclusive or collateral estoppel effects in any lawsuit or action by any person or party other than the Washington State Insurance Commissioner.

EXECUTED this 20th day of December, 2019.

TRINITY HEALTHSHARE, INC.

By: William H. Thead III

Printed Name: William H. Thead III

Printed Corporate Title: Chairman

AGREED ORDER:

Pursuant to the foregoing factual Basis and Consent to Order, the Insurance Commissioner of the state of Washington hereby Orders as follows:

1. Trinity shall pay a fine in the amount of One Hundred Fifty Thousand Dollars ($150,000.00), receipt of which is hereby acknowledged by the Insurance Commissioner.

2. Trinity will not solicit state of Washington residents to enroll in its HCSM Sharing Programs. Additionally, within ten (10) days of the entry of this Order, Trinity will notify all state of Washington residents who were enrolled in Trinity HCSM Sharing Programs prior to May 13, 2019, that Trinity will no longer be offering its Sharing Programs in the state of Washington. Trinity may continue to facilitate sharing among current state of Washington Trinity members for one (1) year after the entry of this Order such that members have sufficient time to find alternative options.

3. This Order is based solely on the application of the Washington State insurance code to the specific facts of the Insurance Commissioner's investigation in this case. Trinity and the Washington Insurance Commissioner are the only parties to this Order. Therefore, this Order, and any provision, findings, or conclusions contained herein, do not, and is not intended to, determine any factual or legal issue in any other jurisdiction, or have any preclusive or collateral estoppel effects in any lawsuit or action by any person or party other than the Washington State Insurance Commissioner.

ENTERED at Tumwater, Washington, this 30TH day of DECEMBER 2019.

Mike Kreidler

MIKE KREIDLER
Insurance Commissioner

By and through his designee

Kimberly Tocco

KIMBERLY TOCCO
Insurance Enforcement Specialist
Legal Affairs Division

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.

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[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

BEFORE THE DIVISION OF INSURANCE, STATE OF COLORADO

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

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

In the Matter of TRINITY HEALTHSHARE, INC.

Respondent.

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

PARTIES AND JURISDICTION

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

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

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

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

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

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

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

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

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

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

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

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

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

---

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

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

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

FINDINGS OF FACT

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

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

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

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

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

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

CONCLUSIONS OF LAW

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

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

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

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

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

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

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

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

ORDER

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

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

OTHER MATTERS

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

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

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

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

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

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

Dated this 12 day of August, 2019.

KATE HARRIS
CHIEF DEPUTY COMMISSIONER
LIFE & HEALTH POLICY

BEFORE THE DIVISION OF INSURANCE, STATE OF COLORADO

Case File No. 268068
DOI Order No. 0-20-005

FINAL AGENCY ORDER

In the Matter of TRINITY HEALTHSHARE, INC.

Respondent.

This matter comes before Michael Conway, Commissioner of Insurance for the State of Colorado ("Commissioner"), pursuant to §§ 10-3-901 through 10-3-910, C.R.S., whereby the Commissioner is authorized to issue a Final Agency Order. After reviewing the Stipulation and grounds therein, and being fully advised in the premises, the Commissioner makes the following Findings and enters the Orders as hereinafter set forth:

FINDINGS

1. On August 12, 2019, the Commissioner, pursuant to §§ 10-3-901 through 10-3-910, C.R.S., issued an *Ex Parte* Emergency Cease and Desist Order against Trinity ("Order").

2. Trinity denies any wrongdoing or engaging in any activities that violate any Colorado insurance laws. By entering into the Stipulation, Trinity knowingly and voluntarily waived the right to: a hearing in this matter, the right to be represented at such hearing by counsel chosen and retained by Trinity; the right to present a defense, oral and documentary evidence and cross-examine witnesses at such hearing; the right to seek judicial review of the Stipulation and this Final Agency Order.

ORDER

Based upon the foregoing and the terms of the Stipulation between the Division and Trinity, it is hereby ORDERED as follows:

1. Trinity will no longer accept voluntary contributions from Colorado residents after January 31, 2020, and will not process sharing requests from Colorado members for any service rendered after January 31, 2020. Trinity may, however, continue to process sharing requests from Colorado members for services rendered to them prior to January 31, 2020.

2. The cease and desist order by the Commissioner in Paragraph twenty-nine (29) of the Order remains in effect. Notwithstanding the above, upon entry of the Commissioner's Final Agency Order approving this Stipulation Trinity shall be released of its obligation to maintain any and all existing contracts plans, policies or memberships with Colorado consumers effective January 31, 2020.

3. Trinity will withdraw its request for hearing relating to the Order.

4. Subject to Division approval, Trinity will provide a notice to all current Trinity Colorado members explaining the following:

    a. Trinity will no longer do business with Colorado residents as of January 31, 2020;
    b. ACA-compliant insurance is available through Connect for Health Colorado during the open enrollment period; and
    c. The Division has opened a special enrollment period extending the open enrollment deadline 60 days, which will extend the open enrollment deadline for Trinity members from January 16, 2020 to March 16, 2020.

5. Trinity shall exercise its best efforts to have Aliera itself or through its third-party administrator perform an audit of all sharing request denials (partial and whole) for adherence with the applicable member sharing agreement ("Audit"). The Audit shall relate to all Trinity's Colorado members from Trinity's inception until present. Trinity shall direct Aliera to prepare a spreadsheet for the Division including the following information for all audited denials:

    i. Member Name;
    ii. Date of Service;
    iii. Provider name;
    iv. Provider Network Status;
    v. Total Charge;
    vi. Allowed Amount (per network repricing);
    vii. Denied Amount;
    viii. Amount Applied to MSRA;
    ix. Total Payment made by Aliera;
    x. Total Member Responsibility;
    xi. Original Basis for Denial; and
    xii. Comments/Notes explaining the results of the audit and whether Aliera upheld its original denial or reversed following the audit.

6. Trinity will follow up with the Division's Lead Analyst regarding his inquiry relating to a specific Colorado Consumer.

7. The Stipulation is incorporated by reference, and all of its conditions, terms, and agreements are specifically made part of this Order as though fully set forth herein.

DONE AND ORDERED this 13th day of January, 2020.

Michael E. Conway
Insurance Commissioner

CERTIFICATE OF SERVICE

This is to certify that I have duly served the within **FINAL AGENCY ORDER** upon all parties herein by depositing copies of same in the United States mail, first class postage prepaid, at Denver, Colorado, this 13th day of January 2020 addressed as follows:

LEWIS ROCA ROTHGERBER CHRISTIE LLP

Kris J. Kostolansky, Esq. (Bar No. 13764)
Hilary D. Wells, Esq. (Bar No. 33952)
1200 17th Street, Suite 3000
Denver, Colorado 80202
kkosto@lrrc.com
hwells@lrrc.com

Counsel for Trinity Healthshare. Inc.

(Via Electronic Mail)

Karl D. Kaesemeyer (Bar No. 38993)
First Assistant Attorney General
Peter Frigo (Bar No. 38621)
Senior Assistant Attorney General
Evan Spencer (Bar No. 47651)
Assistant Attorney General
Business and Licensing Section
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Counsel for the Division of Insurance

/s/
For the Division of Insurance

BEFORE THE DIVISION OF INSURANCE, STATE OF COLORADO

Case File No. 268068
DOI Order No. 0-20-005

STIPULATION FOR ENTRY OF FINAL AGENCY ORDER

In the Matter of TRINITY HEALTHSHARE, INC.

Respondent.

The Colorado Division of Insurance ("Division") and Trinity Healthshare Inc. ("Trinity") hereby enter into this Stipulation for Entry of Final Agency Order ("Stipulation") to resolve the matters at issue in Division file number 268068 and do hereby stipulate and agree as follows:

1. On August 12, 2019, Michael Conway, Commissioner of Insurance for the State of Colorado ("Commissioner"), pursuant to §§ 10-3-901 through 10-3-910, C.R.S., issued an *Ex Parte* Emergency Cease and Desist Order against Trinity, Order Number 0-20-005 ("Order").

2. Trinity denies the allegations in the August 12, 2019 Order against Trinity and any wrongdoing or violation of Colorado insurance laws. However, in order to avoid the uncertainty of litigation and resolve the matters at issue, the Division and Trinity agree to the following:

    a. Trinity will no longer accept voluntary contributions from Colorado residents after January 31, 2020, and will not process sharing requests from Colorado members for any service rendered after January 31, 2020. Trinity may, however, continue to process sharing requests from Colorado members for services rendered to them prior to January 31, 2020.

    b. Trinity agrees that the cease and desist order by the Commissioner in Paragraph twenty-nine (29) of the Order remains in effect. Notwithstanding the above, upon entry of the Commissioner's Final Agency Order approving this Stipulation, Trinity shall be released of its obligation to maintain any and all existing contracts plans, policies or memberships with Colorado consumers effective January 31, 2020.

    c. Trinity agrees to withdraw its request for hearing relating to the Order.

    d. Subject to Division approval, Trinity will provide a notice to all current Trinity Colorado members explaining the following:
        i. Trinity will no longer do business with Colorado residents as of January 31, 2020;
        ii. ACA-compliant insurance is available through Connect for Health Colorado during the open enrollment period; and

iii. The Division has opened a special enrollment period extending the open enrollment deadline 60 days, which will extend the open enrollment deadline for Trinity members from January 16, 2020 to March 16, 2020.

e. Trinity shall exercise its best efforts to have Aliera itself or through its third-party administrator perform an audit of all sharing request denials (partial and whole) for adherence with the applicable member sharing agreement ("Audit"). The Audit shall relate to all Trinity's Colorado members from Trinity's inception until present. Trinity shall direct Aliera to prepare a spreadsheet for the Division including the following information for all audited denials:

i. Member Name;
ii. Date of Service;
iii. Provider name;
iv. Provider Network Status;
v. Total Charge;
vi. Allowed Amount (per network repricing);
vii. Denied Amount;
viii. Amount Applied to MSRA;
ix. Total Payment made by Aliera;
x. Total Member Responsibility;
xi. Original Basis for Denial; and
xii. Comments/Notes explaining the results of the audit and whether Aliera upheld its original denial or reversed following the audit.

f. Trinity will follow-up with the Division's Lead Analyst regarding his inquiry relating to a specific Colorado Consumer.

3. By entering into this Stipulation, Trinity knowingly and voluntarily waives its rights pursuant to §§ 10-3-904.6(1)-(4); and 24-4-104, 105, and 106, C.R.S., including, but not limited to the right to a hearing in this matter; the right to be represented at such hearing by counsel chosen and retained by it; the right to present a defense; to present oral and documentary evidence; to cross-examine witnesses at such hearing; and the right to seek judicial review of this Stipulation and the Final Agency Order approving this Stipulation.

4. By execution of this Stipulation and the Final Agency Order approving the Stipulation, the Division and Trinity intend to and do resolve Trinity's request for a hearing relating to the Order.

5. The Stipulation is subject to approval by the Commissioner or his designee, and shall become binding upon the parties hereto upon such approval.

6. Should the Commissioner not approve this Stipulation, each party shall retain all of its rights, claims and defenses.

7. In the event the Division takes action relating to alleged violations of this Stipulation or Final Agency Order approving this Stipulation, the Commissioner shall retain all authority provided to him under 10-3-904.6(5), C.R.S., including, but not limited to, the right to determine whether the Stipulation or Final Agency Order have been violated; the right to conduct a hearing to make such determination; and the right to impose civil penalties and restitution in accordance with 10-3-904.6(5)(a), (b), and (c), C.R.S.

8. Upon the Commissioner's entry of the Final Agency Order approving this Stipulation, this Stipulation and the Final Agency Order shall be a public record in the custody of the Division under the Colorado Public Records Act, as required by §§ 24-72-200.1, et seq., C.R.S.

9. This Stipulation and the Final Agency Order approving this Stipulation shall be reported to the National Association of Insurance Commissioners pursuant to § 10-2-803(2), C.R.S.

10. This Stipulation and Final Agency Order embody the entire agreement between the Division and Trinity, and there are no agreements, understandings, representations or warranties which are not expressly set forth herein.

11. A facsimile or other copy of this Stipulation and Final Agency Order approving this Stipulation shall be treated as an original.

12. There are four (4) pages to this Stipulation, including all signature pages.

FOR THE COLORADO DIVISION OF INSURANCE

Kate Harris
Chief Deputy Commissioner
Life & Health Policy

1/2/20
Date

FOR TRINITY HEALTHSHARE INC.

William H. Thead, III
Chairman and CEO of Trinity Healthshare, Inc.

12-23-19
Date

APPROVED AS TO FORM

PHILIP J. WEISER
Attorney General

Karl D. Kaesemeyer (Bar No. 38993)
First Assistant Attorney General
Peter Frigo (Bar No. 38621)
Senior Assistant Attorney General
Evan Spencer (Bar No. 47651)
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Counsel for the Division of Insurance

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BAKER AND HOSTETLER LLP

/s/ Laurin Quiat

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Counsel for Trinity Healthshare, Inc.

STATE OF COLORADO **DEPARTMENT OF REGULATORY AGENCIES** **DIVISION OF INSURANCE** 1560 Broadway, Suite 850, Denver, CO 80202	
Before the Division of Insurance,	**▲ AGENCY USE ONLY▲**
IN THE MATTER OF ALIERA HEALTHCARE, INC. (n/k/a THE ALIERA COMPANIES, INC.)	**Final Agency Order Number:** Division File No.: 268068 DOI Order No. O-20-035

FINAL AGENCY ORDER

THIS MATTER comes before Michael E. Conway, Commissioner of Insurance for the State of Colorado ("Commissioner"), upon the Stipulation for Entry of Final Agency Order ("Stipulation") between the Colorado Division of Insurance ("Division") and Aliera Healthcare, Inc. ("Respondent"). After reviewing the Stipulation, the Commissioner makes the following findings and enters the following order:

FINDINGS

1. The Commissioner has jurisdiction over Respondent and the subject matter herein pursuant to the provisions of the Colorado Producer Licensing Model Act, §§ 10-2-101 through 10-2-1101, C.R.S. (the "PLMA").

2. By entering into the Stipulation, Respondent has waived its right to a hearing in this matter pursuant to §§ 10-2-801, 10-3-904.6, and 24-4-104, 105, and 106, C.R.S.; the right to be represented at such hearing by counsel chosen and retained by it; the right to present a defense, to present oral and documentary evidence, to cross-examine witnesses at such hearing, and the right to seek judicial review of this Final Agency Order.

3. The Commissioner accepts the terms of the Stipulation.

4. Respondent admits the facts recited in Section II of the Stipulation.

ORDER

Based upon the foregoing and the terms of the Stipulation between the Division and Respondent, it is hereby ORDERED as follows:

1. Aliera and its subsidiaries, affiliates, and assigns will not provide any services or contract with any unauthorized insurers or unauthorized insurance products, including but not limited to, Health Care Sharing Ministries ("HCSM") or programs representing themselves as HCSMs, unless and until HCSMs are permitted to be marketed in Colorado either by statute, or through an administrative or judicial determination that HCSMs are not an insurance product subject to regulation by the Commissioner.

2. Notwithstanding the above, Aliera shall continue to administer and act as program manager for any and all Colorado consumers currently enrolled in Trinity Healthshare, Inc. ("Trinity") programs until the Commissioner releases such obligation.

3. Aliera agrees to comply with all Colorado insurance laws and regulations.

4. The Division agrees to withdraw the Cease and Desist Order upon the execution of the Final Agency Order approving this Stipulation.

5. In the event the Division takes action relating to alleged violations of this Stipulation or Final Agency Order approving this Stipulation, the Commissioner shall retain all authority provided to him under 10-3-904.6(5), C.R.S., including, but not limited to, the right to determine whether the Stipulation or Final Agency order have been violated; the right to conduct a hearing to make such determination; and the right to impose civil penalties and restitution in accordance with 10-3-904.6(5)(a), (b), and (c), C.R.S.

6. In the event the Division commences an action against Respondent for an alleged violation of this Final Agency Order, the Final Agency Order, Stipulation, and the factual basis of this proceeding shall be admissible in any such action.

7. The Stipulation is incorporated by reference, and all of its conditions, terms, and agreements are specifically made a part of this Order as though fully set forth herein.

DONE AND ORDERED this 13th day of January, 2020.

MICHAEL E. CONWAY
COMMISSIONER OF INSURANCE

CERTIFICATE OF SERVICE

This is to certify that I have duly served the within **FINAL AGENCY ORDER** upon all parties herein by depositing copies of same in the United States mail, first class postage prepaid, at Denver, Colorado, this 13th day of January, 2020, addressed as follows:

Alissa H. Gardenswartz, #36126
Brownstein Hyatt Farber Schreck, LLP
410 Seventeenth Street
Suite 2200
Denver, CO 80202
Attorney for Aliera Healthcare, Inc.

(Via e-mail)

Evan Spencer
Assistant Attorney General
Peter W. Frigo
Senior Assistant Attorney General
Colorado Department of Law
Evan.spencer@coag.gov
Peter.frigo@coag.gov
Attorneys for the Division of Insurance

For the Division of Insurance

STATE OF COLORADO **DEPARTMENT OF REGULATORY AGENCIES** **DIVISION OF INSURANCE** 1560 Broadway, Suite 850, Denver, CO 80202	
Before the Division of Insurance,	**▲ AGENCY USE ONLY▲**
IN THE MATTER OF ALIERA HEALTHCARE, INC. (n/k/a THE ALIERA COMPANIES, INC.)	**Final Agency Order Number:** Division File No.: 268068 DOI Order No. 0-20-006

STIPULATION FOR ENTRY OF FINAL AGENCY ORDER

The Colorado Division of Insurance ("Division"), and Aliera Healthcare, Inc., hereby enter into this Stipulation for Entry of Final Agency Order ("Stipulation") to resolve the matters at issue in *Ex Parte* Emergency Cease and Desist Order number 0-20-006 ("Cease and Desist Order"), and hereby stipulate and agree as follows:

I. JURISDICTION AND PARTIES

1. Pursuant to § 10-1-108(7), C.R.S., the Commissioner of Insurance ("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. 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.

3. 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.

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

5. 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.

6. 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.

7. 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.

8. 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.

9. 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.

10. Aliera Healthcare, Inc. (n/k/a The Aliera Companies, Inc.) ("Aliera") is a foreign, for-profit corporation, organized under the laws of Delaware and doing business in Colorado.[2]

11. Aliera first incorporated in the State of Delaware on September 29, 2011.

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

[2] Aliera Healthcare, Inc. has secured a name change to The Aliera Companies, Inc in both Delaware and Colorado Secretary of State records. The statement of change of entity name was filed with the Colorado Secretary of State on September 20, 2019. Aliera has not updated its licensing record with the Division to incorporate this name change.

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

13. The Commissioner has jurisdiction over Aliera and the subject matter of the Cease and Desist Order pursuant to §§ 10-3-901 through 10-3-910, C.R.S.

II. PROCEDURAL HISTORY AND FACTUAL FINDINGS

14. The Cease and Desist Order relates to Aliera's relationship with Trinity Healthshare, Inc. ("Trinity"), a foreign corporation organized under the laws of Delaware.

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

16. Trinity does not hold a certificate of authority in the State of Colorado.

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

18. Under the Agreement, Aliera is the administrator, marketer, and program manager for Trinity.

19. As program manager for Trinity, Aliera 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.

20. Under the Agreement, Aliera has the exclusive right to design, market, and sell the Trinity HCSM.

21. Aliera markets Trinity's HCSM products as alternatives to traditional health insurance.

22. Aliera 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.

23. On August 12, 2019, the Commissioner issued the Cease and Desist Order against Aliera based on his finding that Trinity was operating as an unlicensed insurance company. The Cease and Desist Order ordered Aliera 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.

III. RESOLUTION

24. In order to avoid the time, cost, and uncertainty of litigation, and for the consideration recited below, the sufficiency of which is acknowledged by the parties, Aliera and the Division agree to settle this matter pursuant to the following terms:

a. Aliera admits the facts recited in Section II above;

b. Aliera agrees not to challenge the Cease and Desist Order;

c. Aliera and its subsidiaries, affiliates, and assigns agree not to provide any services or contract with any unauthorized insurers or unauthorized insurance products, including but not limited to, HCSMs or programs representing themselves as HCSMs, unless and until HCSMs are permitted to be marketed in Colorado either by statute, or through an administrative or judicial determination that HCSMs are not an insurance product subject to regulation by the Commissioner. Notwithstanding the above, Aliera shall continue to administer and act at program manager for any and all Colorado consumers currently enrolled Trinity programs until the Commissioner of Insurance releases such obligation.; and

d. Aliera agrees to comply with all Colorado insurance laws and regulations;

e. The Division agrees to withdraw the Cease and Desist Order upon the execution of the Final Agency Order approving this Stipulation.

25. By entering into this Stipulation, Aliera knowingly and voluntarily waives its rights pursuant to §§ 10-3-904.6(1)-(4); and 24-4-104, 105, and 106, C.R.S., including, but not limited to the right to a hearing in this matter; the right to be represented at such hearing by counsel chosen and retained by it; the right to present a defense; to present oral and documentary evidence; to cross-examine witnesses at such hearing; and the right to seek judicial review of this Stipulation and the Final Agency Order approving this Stipulation.

26. The Division and Aliera agree that this Stipulation is a full and final settlement of the matters at issue in *Ex Parte* Emergency Cease and Desist Order number 0-20-006.

27. Neither this Stipulation nor the Final Agency Order approving this Stipulation shall be deemed in any manner to prevent the Division from commencing any other agency action relating to any other conduct of Aliera not settled herein, and without regard to whether such conduct occurred prior to the date of this Stipulation or the Final Agency Order approving this Stipulation.

28. Aliera understands and acknowledges that the Division may take such lawful steps as may be required or appropriate to investigate and determine whether Aliera is in compliance with this Stipulation and the Final Agency Order approving this Stipulation, and may take any action it deems appropriate to enforce compliance with the terms of the Stipulation and Final Agency Order.

29. In the event the Division takes action relating to alleged violations of this Stipulation or Final Agency Order approving this Stipulation, the Commissioner shall retain all authority provided to him under 10-3-904.6(5), C.R.S., including, but not limited to, the right to determine whether the Stipulation or Final Agency order have been violated; the right to conduct a hearing to make such determination; and the right to impose civil penalties and restitution in accordance with 10-3-904.6(5)(a), (b), and (c), C.R.S.

30. In the event the Division takes action relating to alleged violations of this Stipulation or Final Agency Order approving this Stipulation, the Stipulation and Final Agency Order shall be admissible in full in that proceeding for any purpose.

31. This Stipulation is entered into by Aliera freely and voluntarily, after having had the opportunity to consult with counsel of its choice, and with full understanding and acceptance of the legal consequences of this Stipulation and the Final Agency Order approving this Stipulation. Aliera affirms that it has read this Stipulation and fully understand its nature, meaning, content, and consequences.

32. Aliera understands that this Stipulation and the Final Agency Order approving this Stipulation shall be reported to the National Association of Insurance Commissioners pursuant to § 10-2-803(2), C.R.S.

33. Aliera agrees that upon execution of this Stipulation, no subsequent action or assertion shall be maintained or pursued in any manner asserting the invalidity of this Stipulation or the Final Agency Order approving this Stipulation and its provisions.

34. Invalidation of any provision of this Stipulation or the Final Agency Order approving this Stipulation by a court of competent jurisdiction will in no way affect any other provisions, which shall remain in full force and effect.

35. Upon the Commissioner's entry of the Final Agency Order approving this Stipulation, this Stipulation and the Final Agency Order shall be a public record in the custody of the Division under the Colorado Public Records Act, as required by §§ 24-72-200.1, *et seq.*, C.R.S.

36. This Stipulation is subject to approval by the Commissioner or his designee, and shall become binding upon the parties hereto upon such approval.

37. Should the Commissioner not approve this Stipulation, each party shall retain all of its rights, claims and defenses.

38. This Stipulation embodies the entire agreement between the Division and Aliera, and there are no agreements, understandings, representations or warranties, which are not expressly set forth herein.

39. A facsimile or other copy of this Stipulation and Final Agency Order approving this Stipulation shall be treated as an original.

40. There are seven (7) pages to this Stipulation, including all signature pages.

CHASE MOSES
ON BEHALF OF ALIERA HEALTHCARE, INC

12/05/19
DATE

Subscribed and sworn to before me in the County of Fulton, State of Georgia, this 5th day of December 2019, by Chase Moses on behalf of Aliera Healthcare, Inc.

NOTARY PUBLIC

My Commission expires: February 8th, 2021

Fulton County, [illegible]
I certify this to be a complete,
copy of the original document. Certi
5th day of December
Notary P
DEBORAH DIANA MCCAGE
My commission expires February 8, 2021

FOR THE COLORADO DIVISION OF INSURANCE

Kate Harris
Chief Deputy Commissioner
Life & Health Policy

12/10/19
Date

APPROVED AS TO FORM

BROWNSTEIN HYATT FARBER SCHRECK, LLP

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Attorneys for the Division of Insurance

STATE OF NEW HAMPSHIRE
INSURANCE DEPARTMENT

In re: Aliera Healthcare, Inc. (dba The Aliera Companies, Inc.)
& Trinity Healthshare Inc.

Docket No.: INS No. 19-027-EP

CEASE AND DESIST ORDER

The Commissioner of the New Hampshire Insurance Department ("NHID"), pursuant to his authority under RSA 400-A:3, orders the Respondents Aliera Healthcare, Inc. and Trinity Healthshare Inc. to immediately Cease and Desist from engaging in the unlicensed business of insurance; administering health insurance plans without being certified as a third party administrator; falsely holding out products as exempt from insurance regulation in New Hampshire; and misleading New Hampshire consumers by offering, marketing and administering health coverage that does not meet state and federal requirements.

In support this Order to Cease & Desist, the NHID states as follows:

Factual Allegations

1. Respondent Aliera Healthcare, Inc. ("Aliera") is a foreign, for-profit corporation organized under the laws of Delaware with a business address of 5901-B Atlanta, Peachtree Dunwoody Rd. #200, Atlanta, GA 30328.

2. Aliera is a non-resident business entity insurance producer (NPN # 18501490) that is licensed to sell Life, Accident and Health insurance products. Aliera holds no appointments in New Hampshire.

3. Aliera is not licensed as an insurance company and, other than its insurance producer license, holds no licenses, certificates, or other approvals to engage in the business of insurance in New Hampshire.

4. Aliera does not hold a certificate of authority to act as a Third Party Administrator ("TPA") in New Hampshire.

5. Aliera markets and administers health plans in New Hampshire on behalf of Respondent Trinity Healthshare ("Trinity"). Prior to August 10, 2018 Aliera marketed and administered health plans on behalf of Unity Health Share ("Unity.") This relationship ended when Unity terminated its agreement with Aliera on August 10, 2018.

6. Trinity was created in Delaware on June 27, 2018 by Aliera and its principals.

7. Trinity holds no licenses, certificates, or other approvals to engage in the business of insurance in New Hampshire.

8. Trinity claims to be Health Care Sharing Ministry ("HCSM") that is exempt from insurance regulation in New Hampshire under RSA 126-V. Like a health insurance company, Trinity collects fixed monthly payments from its members, payments that vary according to the level of coverage and conducts medical underwriting to screen for pre-existing conditions. There is also a schedule of covered and excluded services, a schedule of copayments and deductibles, a claim adjudication process, use of provider networks and annual or lifetime limits.

9. August 13, 2018 Aliera and Trinity entered into a Marketing and Administration Agreement. Under this agreement Aliera is the program manager for Trinity's health care sharing ministry plans, responsible for the development of plan designs, pricing, marketing, vendor management, recruitment and maintenance of the a national sales force and accounting and management of sales commissions on behalf of the ministry.

10. Aliera has the exclusive right to design market and sell HCSM plans to its existing members and prospective members.

11. Per the agreement, Aliera also maintains ownership of the "Membership Roster" of all Trinity enrollees.

12. Aliera markets Trinity HCSM products as alternatives to traditional health insurance to New Hampshire consumers and utilizes licensed resident insurance producers to sell Trinity's products within the state.

13. Aliera has made false and misleading claims to New Hampshire consumers concerning the Aliera and Trinity products it markets and administers.

14. Aliera and Trinity are currently the subject of administrative actions in Texas, Washington and Colorado.

Applicable New Hampshire Laws

15. Per NH RSA 405:1, no foreign insurance company shall engage in the insurance business in New Hampshire unless it has first obtained a license to do so.

16. The following acts, when done on behalf of an unlicensed insurer, are deemed to constitute the transaction or doing of insurance business in this state:

a. The making of or proposing to make an insurance contract;
b. The taking or receiving of any application for insurance;
c. The receiving or collection of any premium, commission, membership fees, assessments, dues or other consideration for any insurance;
d. The issuance or delivery of contracts or certificates of insurance to residents of this state;
e. Directly or indirectly acting as an agent for or otherwise representing or aiding another person or insurer in the solicitation, negotiation, procurement, or effectuation of insurance or renewals thereof, or in the dissemination of information as to coverage or rates, or forwarding of applications, or delivery of policies or contracts, or inspection of risks, a fixing of rates or investigation or adjustment of claims or losses or in the transaction of matters subsequent to effectuation of the contract and arising out of it, or in any other manner representing or assisting a person or insurer in the transaction of insurance with respect to subjects of insurance resident, located or to be performed in this state; or
f. Doing any kind of insurance business specifically recognized as constituting the doing of an insurance business within the meaning of the insurance statutes. RSA 406-B:2.

17. New Hampshire law exempts health care sharing organizations from insurance regulation if they meet the requirements of RSA 126-V:1.

18. To qualify for the exemption from insurance regulation under RSA 126-V:1, II, a health care sharing organization must meet all of the following criteria:

a. Be a nonprofit organization that is tax-exempt pursuant to section 501(c)(3) of the Internal Revenue Code;
b. Have been in existence continuously and have facilitated the sharing of medical expenses of participants without interruption since December 31, 1999, including predecessor organizations;
c. Be faith-based and limit its participants to individuals who share a common set of ethical or religious beliefs; and
d. Share medical expenses among its participants in accordance with those beliefs.

19. Qualifying organizations are subject to other requirements, including providing a notice to consumers warning that the organizations do not offer insurance and are not regulated by the NHID. RSA 126-V:1, III(g). Providing the notice to consumers is not sufficient to qualify an organization for the exemption if the requirements of RSA 126-V:1, II are not also met.

20. Under Title XXXVII, as well as applicable federal requirements, health insurance coverage in New Hampshire is subject to numerous requirements including prior form and rate approval, coverage requirements for specified services, and limitations on medical underwriting and preexisting condition exclusions.

21. Under New Hampshire's Managed Care Law, RSA Chapter 420-J, network-based health insurance is subject to numerous requirements designed to protect members, including grievances and appeals procedures, network adequacy requirements, and the obligation to protect members from balance billing by providers.

22. Under New Hampshire law, "administrator" or "third party administrator" or "TPA" is defined as "a person who directly or indirectly underwrites, collects charges or premiums from, or adjusts or settles claims on residents of this state, in connection with life, annuity, or health coverage or workers' compensation insurance . . ." RSA 402-H:1, I. "Underwrites or Underwriting" is further defined, though not limited to, accepting employer or individual applications in accordance with the written rules of the insurer or self-funded plan for the overall planning and coordinating of a benefits program. RSA 402-H:1, XIII.

23. New Hampshire law provides that "[n]o person shall act as, or offer to act as, or hold himself or herself out to be an administrator in this state without a valid certificate of authority as an administrator issued by the commissioner." RSA 402-H:11.

Legal Allegations/Violations

24. Trinity cannot meet the exemption requirements of RSA 126-V:1, II, specifically in that it has not been in existence continuously and have facilitated the sharing of medical expenses of participants without interruption since December 31, 1999. Trinity had no members as of August 13, 2018 when it signed the Management and Administrative Agreement with Aliera.

25. Trinity also fails to establish that it is faith based and limits its membership to individuals who share a common set of ethical or religious beliefs. Trinity's bylaws indicate that the organization adheres to a Christian expression of faith; however, its applications and policy documents only ask participants to believe in nonsectarian religious views. This statement of faith is inconsistent with the religious views purportedly held by Trinity.

26. Further, Aliera also offers Trinity HCSM plans, not only to individuals, but also to employer groups. This is inconsistent with RSA 126-V:1 II, which limits participation in HCSM to individuals.

27. As Trinity does not meet the required elements to designate it as a HCSM under RSA 126-V, it is operating as an unlicensed insurance company in violation of RSA 406-B:3 and RSA 405:1.

28. Based on the conduct described herein, Aliera, through its arrangement with Trinity, is engaging in the "insurance business," as defined by RSA 406-B:2, by acting as an

unlicensed insurance company in New Hampshire without the proper license or authorization in violation of RSA 406-B:3 and RSA 405:1.

29. Alternatively, Aliera, by directly or indirectly underwriting, collecting charges or premiums from, and adjusting and settling claims on behalf New Hampshire residents in connection with Trinity, is operating as a unlicensed Third Party Administrator for a health insurance company within the meaning of RSA 402-H.

30. Aliera does not qualify for any exemption from the requirement to be certified as a TPA in New Hampshire under RSA 402-H. Aliera marketing and administration activities with respect to Trinity health plans go beyond the sale of these plans as a producer, and Aliera is not authorized to transact insurance in New Hampshire, nor is Aliera a subsidiary or affiliated corporation of a licensed insurer.

31. Aliera is operating as an unlicensed TPA in violation of RSA 402-H.

32. Based upon the information and allegations recited above, the New Hampshire Commissioner of Insurance hereby ORDERS that Trinity and Aliera immediately CEASE AND DESIST from writing any new coverage or renewing any coverage for New Hampshire insurance consumers.

33. Pursuant to RSA 400-A:17, the Respondents may request a hearing regarding this Order by filing a written application for hearing with the Commissioner within 30 (thirty) days of the date the Respondents either knew or should have known of the issuance of this Order.

SO ORDERED

NEW HAMPSHIRE
INSURANCE DEPARTMENT

Date: 10/30/19

John Elias, Commissioner

CERTIFICATION OF SERVICE

I certify that the a copy of the foregoing Cease and Desist Order has been served upon the above-captioned Respondents by United States first class mail, postage prepaid. Said Order was mailed to the Aliera Healthcare Inc. 5901 Peachtree Dunwoody Rd. Ste B-200, Atlanta GA, 30328 and Trinity Healthshare Inc. 5901 Peachtree Dunwoody Rd. Ste C-160, Atlanta, GA 30328

Date: 10/30/2019

M. B
Mary C. Bleier, Esq.

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.

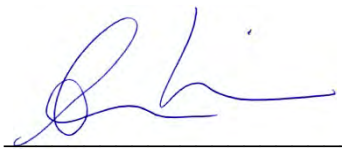
Pursuant to General Statutes § 38a-17, IT IS THEREFORE ORDERED by the Insurance Commissioner:

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

MARYLAND INSURANCE COMMISSIONER 200 ST. PAUL PLACE, SUITE 2700 BALTIMORE, MARYLAND 21202	*	
v.	*	
ALIERA HEALTHCARE, INC. License No. 3000134860 5901 Peachtree Dunwoody Road Building B, Suite 200 Atlanta, GA 30328	*	CASE NO.: MIA-2017-10-001
	*	INVESTIGATION NO. MCLH-159-2016-I

* * * * * * * * * * * * *

CONSENT ORDER

The Maryland Insurance Commissioner ("Commissioner") enters into this Consent Order ("Consent Order") with the consent of Aliera Healthcare, Inc. ("Respondent"), pursuant to Md. Ann. Code, Insurance ("Insurance Article") §§ 2-108, 2-204, and any other applicable sections. As the basis for this action, the Maryland Insurance Administration ("Administration") states:

I. Explanatory Statement

1. Respondent is a corporation with a principal place of business and mailing address of 5901 Peachtree Dunwoody Road, Building B, Suite 200, Atlanta, GA 30328.

2. Respondent is licensed by the Commissioner to operate in Maryland as a business entity insurance producer.

3. Between November 29, 2016 and September 8, 2017, the Administration conducted an investigation of Respondent's activities. Prior to and throughout the course of this investigation, Respondent met with the Commissioner and his staff seeking guidance pertaining to compliance with Maryland law as a voluntary noncontractual religious publication arrangement as described in §1-202(a)(4) of the Insurance Article. The Respondent cooperated with this investigation in all respects.

4. On October 2, 2017, the Commissioner issued an Order ("the Initial Order") detailing the findings of the investigation and holding the Respondent in violation of certain sections of the Insurance Article.

5. Respondent requested a hearing to contest the Initial Order.

6. The parties agree to this Consent Order into order to avoid litigation and to fully and finally resolve all issues stated in this Order.

II. Provisions of Law

The Commissioner considers that following provisions of law relevant to this matter. Pursuant to §2-204(b)(2), the failure to designate a particular provision of the article in this Order does not deprive the Commissioner of the right to rely on that provision in enforcing this Order.

1. **Section 1-101(s)** provides, in relevant part, as follows:

> (s) Except as expressly provided otherwise in this article, "insurance" means a contract to indemnify or to pay or provide a specified or determinable amount or benefit on the occurrence of a determinable contingency.

2. **Section 1-101 (p)** provides, in relevant part, as follows:

> (p)(1) "Health insurance" means insurance of human beings against:
> (i) bodily injury, disablement, or death by accident or accidental means, or the expenses of bodily injury, disablement, or death by accident or accidental mans;
> (ii) disablement or expenses resulting from sickness or childbirth; and
> (iii) expenses incurred in prevention of sickness or dental care.

3. **Section 1-202(a)(4)** provides, in relevant part, as follows:

> (a) This article does not apply to:
> ...
> (4) a voluntary noncontractual religious publication arrangement that:
>
> > ...
> > (ii) publishes a newsletter whose subscribers are limited to members of the same denomination or religion;
> > (iii) acts as an organizational clearinghouse for information between subscribers who have medical costs and subscribers who choose to assist with those costs;
> > (iv) matches subscribers with a willingness to pay and subscribers with present medical costs;

(v) coordinates payments directly from one subscriber to another;
(vi) suggests amounts to give that are voluntary among the subscribers, with no assumption of risk or promise to pay either among the subscriber or between the subscribers and the organization;
(vii) does not use a compensated insurance producer, representative or other person to solicit or enroll subscribers.
...
(x) does not use funds paid by subscribers for medical costs to cover administrative costs[.]

III. Conclusions of Law

After conducting the investigation described above and in light of the relevant Maryland and federal law, including without limitation the provisions cited above, the Administration hereby reaches the following conclusions of law.

1. This plan does not meet the requirements of §1-202(a)(4) of the Insurance Article.

2. The Unity plan and its operator, Aliera, are not excluded from the application of the Insurance Article by § 1-202.

3. The Insurance Commissioner has jurisdiction over the subject matter of this Order.

4. In consideration of the statutory law of the State, the Commissioner enters this Order to enforce the Insurance Article.

ORDER

WHEREFORE, for the reasons set forth above, it is this 30th day of April, 2018, **ORDERED** by the Commissioner and consented to by Respondent that:

A. Effective immediately and as of the date of this Order, Respondent shall stop selling, soliciting, offering, renewing, or effecting any new memberships in the state of Maryland in the Unity Healthshare Ministry plan, and shall further cease and refrain from selling, soliciting, offering, renewing or effecting policies or memberships in any other health care ministry, plan or program that is not compliant with §1-202 of the Insurance Article.

B. Respondent shall provide written notice no later than June 1, 2018, of the terms of this Consent Order to all present Maryland-resident members of the Unity Healthshare Ministry plan. This notice shall indicate that the Unity plan will not be operational in Maryland after December 31, 2018. This notice shall further indicate the necessity for current members to explore other healthcare coverage options for the period beginning January 1, 2019.

C. This notice to Maryland-resident members shall further indicate that any member may terminate his or her membership in the Unity Healthshare Ministry plan by providing one (1) month's notice to Respondent of his or her intention to so terminate the membership.

D. With respect to members that do not choose to terminate their membership, Respondent is permitted to continue to operate the Unity Healthshare Ministry plan and to collect Monthly Share Amount payments for the remainder of all memberships that are in force as of the date of this Consent Order until December 31, 2018, inclusive. Respondent shall manage cost sharing requests and payments under the terms of the currently in-force membership guidelines.

E. Effective January 1, 2019, Respondent is to permanently cease the sale, solicitation or operation in Maryland of the Unity Healthshare Ministry plan and any other plan that is not excluded from the application of the Insurance Article by §1-202, and thereby constitutes health insurance under the terms of §1-101(p), and that is operated without a valid certificate of authority.

F. Respondent is directed to provide a written affirmation of its compliance with the terms of this Consent Order no later than February 1, 2019. This affirmation shall include a statement to the effect that Respondent has complied with this Order, a statement to the effect that the Unity Healthshare Ministry is no longer operational in Maryland, and a statement to the effect that all Maryland-resident previous members of the plan have been apprised of the terms of this Order. This affirmation shall be sent to Erica Bailey, Associate Commissioner, Compliance &

Enforcement Unit, 200 St. Paul Place, Suite 2700, Baltimore, MD 21202, and shall identify the case by Identification # MCLH-159-2016-I.

G. Contemporaneously with the execution of this Consent Order, Respondent shall pay an administrative penalty to the State of Maryland for the violations stated herein in the amount of seven thousand five hundred dollars ($7,500.00). Administrative penalties shall be made payable to the Maryland Insurance Administration and shall identify the case by Identification # MCLH-159-2016-I. Unpaid penalties will be referred to the Central Collection Unit for collections.

H. The parties acknowledge that this Consent Order contains the entire agreement between the parties relating to the administrative actions addressed herein and that this Consent Order resolves all matters relating to the factual assertions and agreements contained herein. This Consent Order supersedes the Initial Order. All time frames set forth in this Consent Order may be amended or modified only by subsequent written agreement of the parties. The Administration will impose no sanction upon Respondent beyond the terms of this Consent Order for the conduct and time period described in the Initial Order.

I. Respondent has had the opportunity to have this Consent Order reviewed by legal counsel of their choosing, and are aware of the benefits gained and obligations incurred by the execution of the Consent Order. Respondent waives any and all rights to any administrative hearing of this Consent Order to which they would otherwise be entitled under the Insurance Article with respect to any of the determinations made or actions ordered by this Consent Order for the conduct and time period described herein.

J. For the purposes of the Administration and for any subsequent administrative or civil proceedings concerning Respondent, whether related or unrelated to the foregoing paragraphs, and with regard to requests for information about the Respondent made under the Maryland

Public Information Act, or properly made by governmental agencies, this Order will be kept and maintained in the regular course of business by the Administration. For the purposes of the business of the Administration, the records and publications of the Administration will reflect this Consent Order.

K. Nothing herein shall be deemed a waiver of the Commissioner's right to proceed in an administrative action or civil action to enforce the terms of this Consent Order. Failure to fully comply with the terms of this Consent Order may subject Respondent to further legal or administrative action.

L. This Order shall be effect upon signing by the Commissioner or his designee, and is a Final Order of the Commissioner under § 2-204 of the Insurance Article.

ALFRED W. REDMER, JR.
INSURANCE COMMISSIONER

By: signature on file with original
Erica Bailey, Associate Commissioner
Compliance & Enforcement Unit

RESPONDENT'S CONSENT

Respondent Aliera Healthcare, Inc. hereby CONSENTS to the representations made in, and to the terms of, this Consent Order. On behalf of Respondent, the undersigned hereby affirms that he or she has taken all necessary steps to obtain the authority to bind Respondent to the obligations stated herein and does, in fact, have the authority to bind Respondent to the obligations stated herein.

Date Printed Name of Signatory signature on file with original Signature

LARRY HOGAN
Governor

BOYD K. RUTHERFORD
Lt. Governor

AL REDMER, JR.
Commissioner

JAY COON
Deputy Commissioner

MARYLAND
INSURANCE ADMINISTRATION

200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202
Direct Dial: 410-468-2009 Fax: 410-468-2020
Email: melanie.gross@maryland.gov
1-800-492-6116 TTY: 1-800-735-2258
www.insurance.maryland.gov

February 27, 2020

CERTIFIED MAIL
RETURN RECEIPT REQUESTED
REGULAR MAIL

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

Alexander J. Gonzales, P.C.
Duane Morris, LLP, Las Cimas IV
900 S. Capital of Texas Highway, Suite 300
Austin, TX 78746-5435

Re: *Maryland Insurance Administration v.* Aliera Healthcare, Inc.
Case No.: MIA-2020-02-025

Dear Parties:

The Maryland Insurance Commissioner has entered an Order taking disciplinary action against your company. A copy of the Order is attached and is self-explanatory. This Order is subject to your right to request a hearing as set forth on the last page of the Order.

Please include the above case number on all future correspondence to the administration. **Payment of administrative penalties must also reference the above case number or include a copy of this letter when making payment.**

If you have any questions regarding this Order, you may contact the Associate Commissioner of Compliance & Enforcement at 410-468-2113.

Sincerely,

Melanie Gross
Executive Assistant to the Deputy Commissioner

Enclosure
cc: Al Redmer, Jr., Commissioner
Jay Coon, Deputy Commissioner
Erica J. Bailey, Associate Commissioner
Philip Pierson, Assistant Attorney General
Craig Ey, Director of Communications
Denise Owens, Management Associate

BEFORE THE MARYLAND INSURANCE COMMISSIONER

MARYLAND INSURANCE ADMINISTRATION **200 ST. PAUL PLACE, SUITE 2700** **BALTIMORE, MARYLAND 21202**	*	
V.	*	**CASE NO.: MIA-2020-** 02-025
ALIERA HEALTHCARE, INC. **License No. 3000134860** **990 Hammond Drive, Ste. 700** **Atlanta, GA 30328**	*	**INVESTIGATION NO. MCLH-25-2019-I**

* * * * * * * * * * * * * * *

ORDER

This Order is entered by the Maryland Insurance Administration ("the Administration") against Aliera Healthcare, Inc. ("Aliera" or "Respondent"). The purpose of the Order is to enforce Md. Code Ann., Insurance §§ 4-101, 4-203, 4-205 and 10-126. As the basis for this action, the Maryland Insurance Administration ("Administration") states:

I. Facts

1. Respondent is a corporation with a principal place of business in Georgia. Respondent's mailing address is alternately listed as:

(a) 5901 Peachtree Dunwoody Road, Building B, Suite 200, Atlanta, GA 30328;

(b) P.O. Box 28220, Atlanta, GA 30358; and

(c) 990 Hammond Drive, Ste. 700, Atlanta, GA 30328.

2. Throughout the period of the investigation described below, Respondent has been licensed by the Commissioner to operate in Maryland as a business entity insurance producer.

3. On November 29, 2016, the Commissioner began an investigation into the activities of the Respondent. This investigation continued into 2017.

4. On October 2, 2017, the Commissioner issued an Order ("the Initial Order") detailing the findings of the investigation and holding the Respondent in violation of §§ 4-101, 4-203 and 4-205 of the Insurance Article.

5. The Respondent requested a hearing to contest the Initial Order.

6. On April 30, 2018, the parties executed a Consent Order ("the Consent Order"), which found that the "health sharing ministry" operated and sold by Respondent was not a "voluntary noncontractual religious publication arrangement" and was not exempt from the application of the Insurance Article.

7. The Consent Order further stated that "Respondent is directed to provide a written affirmation of its compliance with the terms of this Consent Order no later than February 1, 2019."

8. The Consent Order further stated that "[e]ffective January 1, 2019, Respondent is to permanently cease the sale, solicitation or operation in Maryland of the Unity Healthshare Ministry plan and any other plan that is not excluded from the application of the Insurance Article by § 1-202, and thereby constitutes health insurance under the terms of § 1-101 (p), and that is operated without a valid certificate of authority."

9. Respondent failed to provide the written affirmation required by the Consent Order by February 1, 2019.

10. On June 7, 2019, counsel for the Administration contacted counsel for Respondent to inquire as to Respondent's failure to submit this required written affirmation.

11. On June 13, 2019, Respondent admitted that it had failed to file the written affirmation as it had agreed to do in the Consent Order.

12. Also on June 13, 2019, Respondent belatedly filed the required written affirmation.

13. This belatedly-filed written affirmation stated that "Aliera has not sold, solicited or been in operation in the State of Maryland under the Unity Healthshare Ministry plan or any other plan that is not excluded from the application of the Insurance Article by § 1-202 since January 1, 2019."

14. On or about March 28, 2019, in conjunction with follow-up investigations into Aliera's conduct, an Administration investigator entered her name, email address, and ZIP code into the online portal of Aliera's website.

15. Shortly after entering this information, this investigator was contacted, via email, by a sales representative from Aliera. The email and its attachments solicited the purchase of a membership in a program designated as "Aliera's PrimaCare program in conjuction [sic] with Trinity HealthShare, Inc."

16. The sales documents attached to the email touted the benefits offered by the PrimaCare program, included a schedule of premium rates charged, provided a list of medical services covered, and urged the recipient to sign up for a membership in the Program.

17. The sales documents further described Trinity HealthShare, Inc. as "a religious organization" and a "health care sharing ministry." The documents further stated that "Our role is to enable self-pay patients to help fellow Americans through voluntary financial gifts."

18. The documents further contained a reference to "Maryland Article 48, Section 1-202(4)."

19. The sales documents contained the logos of Aliera healthcare and Trinity Healthshare. The email to the Administration's investigator was sent from the email address "ssummers@alierahealthcare.com" and contained the Aliera Healthcare logo.

II. Violations

20. The Administration considers the following provisions of the Insurance Article relevant to this matter:

Section 1-101(s) provides, in relevant part, as follows:

(j) "Certificate of authority" means a certificate issued by the Commissioner to engage in the insurance business.

...

(s) Except as expressly provided otherwise in this article, "insurance" means a contract to indemnify or to pay or provide a specified or determinable amount or benefit on the occurrence of a determinable contingency.

...

(p)(1) "Health insurance" means insurance of human beings against:

(i) bodily injury, disablement, or death by accident or accidental means, or the expenses of bodily injury, disablement, or death by accident or accidental means;
(ii) disablement or expenses resulting from sickness or childbirth; and
(iii) expenses incurred in prevention of sickness or dental care.

...

(t)(1) "Insurance business" includes the transaction of:

(i) all matters pertaining to an insurance contract, either before or after it takes effect; and
(ii) all matters arising from an insurance contract or a claim under it.

...

(u)(1) "Insurance producer" means a person that, for compensation, sells, solicits, or negotiates insurance contracts, including contracts for nonprofit health service plans, dental plan organizations, and health maintenance organizations, or the renewal or continuance of these insurance contracts for:

(i) persons issuing the insurance contracts; or
(ii) insureds or prospective insureds other than the insurance producer.

...

(ll) "Solicit" means to attempt to sell insurance or to ask or urge a person to apply for a particular kind of insurance from a particular insurer.

Section 1-201 provides, in relevant part, as follows:

A person that engages in or transacts insurance business in the State, or performs an act relative to a subject of insurance resident, located, or to be performed in the State, shall comply with each applicable provision of this article.

Section 1-202(a)(4) provides, in relevant part, as follows:

(a) This article does not apply to:

...

(4) a voluntary noncontractual religious publication arrangement that:

...

(ii) publishes a newsletter whose subscribers are limited to members of the same denomination or religion;
(iii) acts as an organizational clearinghouse for information between subscribers who have medical costs and subscribers who choose to assist with those costs;

(iv) matches subscribers with a willingness to pay and subscribers with present medical costs;
(v) coordinates payments directly from one subscriber to another;
(vi) suggests amounts to give that are voluntary among the subscribers, with no assumption of risk or promise to pay either among the subscribers or between the subscribers and the organization;
(vii) does not use a compensated insurance producer, representative, or other person to solicit or enroll subscribers;
...
(x) does not use funds paid by subscribers for medical costs to cover administrative costs[.]

Section 4-101(a) provides, in relevant part, as follows:

(a)(1) Except as otherwise provided in this article, a person may not act as an insurer and an insurer may not engage in the insurance business in the State unless the person has a certificate of authority issued by the Commissioner.

Section 4-203(b) provides, in relevant part, as follows:

(b) With respect to a subject of insurance resident, located, or to be performed in the State, a person may not in the State directly or indirectly act as an insurance producer for, or otherwise represent or help on behalf of another, an unauthorized insurer to:
(1) solicit, negotiate, or effect insurance or an annuity contract;
(2) inspect risks;
(3) fix rates;
(4) investigate or adjust losses;
(5) collect premiums; or
(6) transact insurance business in any other manner.

Section 4-205(b) and (c) provide, in relevant part, as follows:

(b) An insurer or other person may not, directly or indirectly, do any of the acts of an insurance business set forth in subsection (c) of this section, except as provided by and in accordance with the specific authorization of statute.
(c) Any of the following acts in the State, effected by mail or otherwise, is considered to be doing an insurance business in the State:
(1) making or proposing to make, as an insurer, an insurance contract;
...
(6) except as provided in subsection (d) of this section, with respect to a subject of insurance resident, located, or to be performed in the State, directly or indirectly acting as an insurance producer for, or otherwise representing or helping on behalf of another, an insurer or other person to:
(i) solicit, negotiate, procure, or effect insurance or the renewal of insurance;
(ii) disseminate information about coverage or rates;
(iii) forward an application;

> ...
> (ix) in any other manner represent or help an insurer or other person to transact insurance business;
> (7) doing any kind of insurance business specifically recognized as doing an insurance business under statutes relating to insurance;
> (8) doing or proposing to do any insurance business that is substantially equivalent to any act listed in this subsection in a manner designed to evade the statutes relating to insurance.

Section 4-212 provides as follows:

> An unauthorized insurer or person that violates this subtitle is subject to a civil penalty of not less than $100 but not exceeding $50,000 for each violation.

Section 10-126(a) provides, in relevant part as follows:

> (a) The Commissioner may deny a license to an applicant under §§ 2-210 through 2-214 of this article, or suspend, revoke, or refuse to renew or reinstate a license after notice and opportunity for hearing under §§ 2-210 through 2-214 of this article if the applicant or holder of the license:
> (1) has willfully violated this article or another law of the State that relates to insurance;
> ...
> (13) has otherwise shown a lack of trustworthiness or competence to act as an insurance producer.

21. By failing to comply with the Consent Order to which it agreed in 2018, which required the submission of a written affirmation of compliance no later than February 1, 2019, Respondent violated § 10-126(a)(13).

22. By soliciting the sale of memberships in the PrimaCare program in the state of Maryland, despite that program's lack of eligibility for § 1-202(a)(4) or any other exemption from the Insurance Article, Respondent violated §§ 4-203, 4-205(b), and 10-126(a)(1) and (13).

23. By submitting a written affirmation in June, 2019, which stated "Aliera has not sold, solicited or been in operation in the State of Maryland under the Unity Healthshare Ministry plan or any other plan that is not excluded from the application of the Insurance Article by § 1-202 since

January 1, 2019," despite having solicited the sale of PrimaCare memberships in the state of Maryland in 2019, Respondent violated § 10-126(a)(13).

III. Sanctions

24. By the facts and violations stated above, Respondent's license to act as an insurance producer in the State of Maryland is subject to suspension or revocation, and/or the imposition of an administrative penalty, and/or a requirement to pay restitution.

25. In view of the gravity of the violations and considering that insurance producers are in a position of trust and responsibility, revocation and an administrative penalty are the appropriate disciplinary actions in this case. The Respondent's failure to comply with the terms of the 2018 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.

26. Administrative penalties shall be made payable to the Maryland Insurance Administration and shall identify the case by number or name. Unpaid penalties will be referred to the Central Collection Unit for collections. Payment of the administrative penalty shall be sent to the attention of: Erica J. Bailey, Associate Commissioner, Compliance and Enforcement, Maryland Insurance Administration, 200 St. Paul Place, Suite 2700, Baltimore, MD 21202.

27. This Order does not preclude any potential or pending action by the Insurance Fraud Division of the Administration or prosecution by any other person, entity or governmental authority, regarding any conduct by Respondent including the conduct that is the subject of this Order.

28. This is a reportable administrative proceeding. As such, it is a public record. The Administration construes this as an adverse administrative action. As a result, the Respondent may

be required to disclose this Order on any license application, and may be required to report this action to any state in which Respondent currently holds an insurance license.

WHEREFORE, for the reasons set forth above, and subject to Respondent's right to request a hearing, it is this 27th day of February, 2020, ORDERED that:

A. The insurance producer license of Respondent Aliera HealthCare, Inc. is REVOKED.

B. Respondent shall pay an administrative penalty of $11,000 (Eleven Thousand Dollars).

C. If any Maryland residents were sold a membership in any Healthshare program sold or operated by Respondent after January 1, 2019, Respondent shall provide to the Administration, within 30 days of the date of this Order, a list of all such Maryland residents. The list shall include the names of the Maryland residents and the date enrolled.

D. If any Maryland residents were sold a membership any Healthshare plan or program sold or operated by Respondent after January 1, 2019, Respondent shall provide written notice to all such Maryland-resident members indicating that Healthshare plan will no longer be operational. This notice shall include the return of all monies received from such Maryland-resident members that paid a contribution to any of the Healthshare plans on or after January 1, 2019.

ALFRED W. REDMER, JR.
INSURANCE COMMISSIONER

By: _____
Erica J. Bailey
Associate Commissioner
Compliance & Enforcement

Date: 2/27/2020

RIGHT TO REQUEST A HEARING

Pursuant to § 2-210 of the Insurance Article and Code of Maryland Regulations ("COMAR") 31.02.01.03, an aggrieved person may request a hearing on this Order. This request must be in writing and received by the Commissioner within thirty (30) days of the date of the letter accompanying this Order. However, pursuant to § 2-212 of the Article, the Order shall be stayed pending a hearing only if a demand for hearing is received by the Commissioner within ten (10) days after the Order is served. The request shall include the following information:

(1) the action or non-action of the Commissioner causing the person requesting the hearing to be aggrieved;
(2) the facts related to the incident or incidents about which the person requests the Commissioner to act or not act; and
(3) the ultimate relief requested.

The failure to request a hearing timely or to appear at a scheduled hearing will result in a waiver of your rights to contest this Order and the Order shall be final on its effective date. Please note that if a hearing is requested on this initial Order, the Commissioner may affirm, modify, or nullify an action taken or impose any penalty or remedy authorized by the Insurance Article against Respondent in a Final Order after hearing.

The written request for hearing must be addressed to the Maryland Insurance Administration, 200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202, Attn: Melanie Gross, Executive Assistant to the Deputy Commissioner.

APPENDIX H

UNITY HEALTHSHARE - Welcome - ID [redacted]

From: info@alierahealth.com

To: [redacted]

Date: Tuesday, November 28, 2017, 1:58 PM PST

UNITY HEALTHSHARE

Welcome to your family of healthcare cost sharing. We look forward to serving your healthcare needs. Please read this welcome letter as it contains:

- your member portal login information
- temporary ID card
- other valuable information

As a new member, what are your next steps?

1. **Before your plan is effective, become familiar with the benefits of your membership.**
   - Your Unity Bronze, Silver, Gold Quick Guide contains everything you need to know regarding your healthcare plan. For your product Quick Guide, please click here.
   - The Quick Guide booklet is included in your membership kit which will arrive at your mailing address within 14 business days ***after your plan's effective date.***
   - Your temporary card is included below. Please print it and use it until you receive your permanent card in your membership kit.

2. **On or after your effective date**
   - ***Begin by completing your registration with FirstCall Telemedicine.*** Access FirstCall by visiting www.FirstCallTelemed.com to register your account or call 1-866-920-DOCS (1-866-920-3627) for assistance. Click here for instructions. Until you complete the account set-up, your status will be listed as "Pending" in their system and you will be unable to use their services. **FirstCall Telemedicine login information is not provided, please complete registration to obtain login information.**
   - ***Activate your card and verify your membership.*** Click here and follow the instructions.
   - ***Access your member login*** for ability to manage your information and get answers to benefit, provider, and claims questions. Go to www.alierahealthcare.com and select "Members" in the top menu bar on the left and then select "Login" and click on "New Member Registration" to access your login information.
   - ***Access your Member Plan Portal*** to view and update your personal or payment information. Go to www.alierahealthcare.com and select "Member Resources" in the navigation menu, and then select "Plan Portal." Enter your username and password information:

     Username: [redacted]
     Password: [redacted]

     Keep your login information in a safe place for future reference.

3. **Using your benefits**
   - Until you receive your permanent ID card, use the temporary card. Your membership is active and you can immediately begin to take advantage of your benefits.
   - If you have a medical emergency, call 911.
   - For individual plans, you may contact your provider to schedule an appointment, or you may call Unity's Concierge line at 877-649-7466 for assistance. You can also request an appointment at http://www.alierahealthcare.com/appointments/

At the core of our Healthcare Sharing Ministry is our Statement of Beliefs. If you do not or did not agree with the Statement of Beliefs below, please let us know and we will be happy to answer any of your questions or help you understand what it is like to be a member of Unity HealthShare.

Below is a review of the *Statement of Beliefs* you have agreed to:

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 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.

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

Member Care

Our friendly and highly experienced staff is ready to help you with all your questions and concerns about your membership. Whether you have a question regarding your services, need assistance, or have a special request contact a Member Services Representative at (844) 834-3456, Monday through Friday from 9:00 AM until 5:00 PM, Eastern Time, or by email at memberservices@alierahealthcare.com.

Order Information

Please review the information below to ensure all details are correct. If you need to make any changes please call Member Care.

Product: Unity Healthshare - Gold - Individual plus 1 Dependent
Order Date: November 28, 2017
Effective Date: December 15, 2017
Amount Paid: $1,412.56 - November 28, 2017 - Credit Card - SALE - Approved - Payment 1 - Completed - - -
3885177046 - 185185 - Products: Unity Healthshare - Gold (17186)

*The entry on your bank or credit card statement for your healthcare payments is "HEALTHPASS".

Member Information

ID:[redacted]
Name: corlyn duncan
Address:[redacted]
City: benicia
State: CA
Zip Code: 94510
Day Phone:[redacted]
Email:[redacted]

bruce duncan - Spouse - M -[redacted]/1962

Your Temporary ID Card

Until you receive your permanent Member Card in the mail, please print and use the temporary card shown below.

UNITY HEALTHSHARE	PHCS	Effective Date: 12/15/2017 Plan ID: UnityGold MSRA*: 1000
Primary: corlyn duncan Primary ID:[redacted] Dependents: bruce duncan	Hospital: YES In-Patient: YES Out-Patient: YES	ER: Verify Eligibility Specialty: Verify Eligibility
	Rx Valet 855-798-2538 | www.MyRxValet.com	

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

***MSRA** = Member Shared Responsibility Amount

Verify eligibility for payment: 800-UHS-9794 (800-847-9794)

UNITY HEALTHSHARE

Quest Diagnostics FirstCall Telemedicine

MyQuest.QuestDiagnostics.com

Mail claims forms to:
Aliera Healthcare Unity
P.O. Box 16818
Lubbock, TX 79490-6818
or EDI # : ALH01 | 1-800-252-3684

Member Services: 800-847-9794
Telemedicine: 866-920-3627
Pharmacy: 855-798-2538
Eligibility: 800-847-9794

PROVIDER should verify eligibility before providing treatment or service.

Unity HealthShare Plans*

PCP Visit: Bronze: $50 Silver: $35 Gold: $20 Urgent Care Visit: Bronze: $100 Silver: $75 Gold: $75	Emergency Room: Bronze: $500 Silver: $300 Gold: $150 Specialty Visit: Bronze: $125 Silver: $75 Gold: $75	Preventive: $0 X-Ray and Imaging: Bronze: 60% after MSRA Silver: 70% after MSRA Gold: 80% after MSRA	**Visit multiplan.com or call 800-922-4362 for your PHCS provider.**

MSRA = Member Shared Responsibility Amount | * Consult fees shown are in-network rates.

www.alierahealthcare.com | www.unityhealthshare.com

APPENDIX I

Find messages, documents, photos or people

← Back | Archive | Move | Delete | Spam | ...

Inbox 14
Unread
Starred
Drafts 1
Sent
Archive
Spam
Trash
^ Less

Views Show

Folders Hide
+ New Folder
1 Yacht s...
2015 Eur...
Aliera He...
Alliant Cr...
> Aztec Fin...
Bank Of ...
Bath Tub N... 1
Bayliner ...
BBB
Ben Rifki...
Build.com 2
C-pay
Cancun ...
Captain's Li... 1
Cardinal ... 118
CPA
Craigslist
Custome...
Dean Ha...
Deleted ...
delux.com -... 2
Design I... 431
Drafts
Duncan T...
EnerBank In... 2
Eric Swa...
Exotic Tr...
Insurance I... 2

Aliera Healthcare Member Update: Get Your Next Month Free

Yahoo/Inbox

5/13/19
Approved

planupdate@alierahealthcare.com
To: [redacted]

May 3 at 4:20 PM

ALIERA™ HEALTHCARE

Dear Corlyn,

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

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

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

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

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

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

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

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

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

DocuSign

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

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

Aliera Healthcare
Toll Free 844-326-2980

APPENDIX J

Member Information

Name: Corlyn Duncan
Address: [redacted]t, Benicia, CA 94510[redacted]
Phone: [redacted]
Email: [redacted]
Date of Birth: [redacted]-1959
Gender: F

Dependent Information

Name	Relationship	Date of Birth	Gender	SSN
bruce duncan	Spouse	[redacted]-1962	M	[redacted]

Product Information

Trinity HealthShare Gold

$564.52 per Month for Individual plus 1 Dependent

$25.00 one-time Application Fee

Questions

MSRA

1000

At the core of what the Healthcare Sharing Ministry does, and how they relate to and engage with one another as a community of people, is a set of common beliefs.

Yes

You understand that this sharing plan has a 24-month waiting period for pre-existing conditions, where pre-existing conditions are defined as conditions that exist at the time of enrollment that have evidenced symptoms, received treatment, and/or medication within the past 24 months.

No

You understand that other medical services and emergency surgical services are eligible for cost sharing immediately, but elective surgical services require a 60-day wait period (180-day for AlieraCare Value and Plus) following your effective date.

You understand that Aliera Companies, and Trinity HealthShare, Inc. have the authority, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to request your medical records to facilitate the payment of medical expenses.

No

Check any of these health conditions you have:

[redacted]

Please list any other concerns you may have:

No

Do you use tobacco in any form?

No

Do you have or ever had Cancer?

No

If you had Cancer, how long ago?

Never

Do you play in any competitive sports?

No

Do you drink alcohol?

No

AlieraCare Gold

Trinity HealthShare's AlieraCare Bronze | Silver | Gold program is a comprehensive family program that don't limit the number of dependents or doctor visits.

$1,048.39 per Month for Individual plus 1 Dependent

$100.00 one-time Application Fee

Questions

Do you play in any competitive sports?

No

Do you drink alcohol?

No

If you drink Alcohol, what is your weekly intake?

1-3 weekly

Is anyone applying pregnant?

No

If applicable, does anyone else in your family applying have any of the above conditions, diseases, and/or ever have or had cancer?

Spouse

If applicable, please fill out any dependent medical information.

bruce duncan spouse [redacted]

Terms and Conditions for AlieraCare Gold

Aliera Healthcare Plan Disclosures

This is not a contract. This is a voluntary program offered by Aliera Healthcare, in relationship with a HealthCare Sharing Ministry (HCSM) program offered within certain plans. Your membership is with Aliera and cannot be transferred to anyone else. Only you and your enrolled dependents are eligible under the membership.

All Aliera members utilizing any Health Care Sharing Ministry services are required to declare their acknowledgment of the Statement of Beliefs and make an attestation that they are of like mind with the ministry 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

THE MINISTRY IS NOT AN INSURANCE COMPANY AND THE MINISTRY DOES NOT OFFER ANY INSURANCE PRODUCTS OR POLICIES. THE MINISTRY DOES NOT ASSUME ANY RISK FOR YOUR MEDICAL EXPENSES, AND THE MINISTRY MAKES NO PROMISE TO PAY. HEALTH CARE SHARING MINISTRIES ARE NOT GOVERNED BY INSURANCE LAWS.

THE HEALTH CARE SHARING MINISTRY OFFERS VOLUNTARY PARTICIPATION IN ITS HEALTH CARE SHARING MINISTRY. MINISTRY SERVICES ARE ADMINISTERED BY ALIERA HEALTHCARE, INC.

This is not Insurance

A Health Care Sharing Ministry ("HCSM") is a group of individuals that share a common set of ethical or religious beliefs and share their medical expenses in accordance with those beliefs without regard to the state in which a member resides or is employed.

Services are based on a religious tradition of mutual aid, neighborly assistance, and burden sharing. The ministry does not subsidize self-destructive behaviors and lifestyles but is specifically tailored for individuals who maintain a healthy lifestyle, make responsible choices regarding health and care, and believe in helping others. A Health Care Sharing Ministry program is **NOT** health insurance.

Tax Exemption

YOU SHOULD CONSULT WITH A TAX PROFESSIONAL FOR DETAILS REGARDING YOUR EXEMPTION.

Health Care Sharing Disclosures

Promise to Pay

The ministry does not make a promise to pay or any guarantee of payment of your medical expenses. You will be responsible for the payment of your medical bills. The ministry does not assume your risk. The ministry does not guarantee that your medical expenses will be shared by other members participating in an Aliera Plan that utilize health care sharing services.

Voluntary

Participation in the ministry HCSM is voluntary. Enrollment as an Aliera member and participant of the ministry HCSM is voluntary and the sharing of monetary contributions are also voluntary. Enrollment in the ministry sharing plan is not a contract. You are free to cancel your participation at any time. The ministry requests a Monthly Share Amount, to be collected each month you are enrolled, to facilitate the payment of sharing requests published on behalf of other participants.

Guidelines

The ministry manages its sharing contributions by establishing guidelines that define eligible sharing ("Guidelines"). The Guidelines are not a contract of insurance. They do not constitute an agreement, a promise to pay, or an obligation to share. The Guidelines are intended to ensure that every participant has paid their own medical expenses, as they are financially able, before requesting others to share with you to assist in paying remaining medical expenses. The Guidelines specify what type of expenses are eligible for sharing requests, so all participants of the ministry HCSM can expect a reasonable and equitable level of sharing requests to be published monthly.

The ministry is authorized to exclude sharing for pre-existing conditions. You are required to fully disclose pre-existing conditions as part of your participation in the HCSM. The ministry reserves the right to exclude sharing eligibility for any pre-existing conditions, whether disclosed at the time of your enrollment or discovered after the effective date of the membership.

AlieraCare Value, Plus, Premium

- Pre-existing conditions have a 24-month waiting period.
- Cancer diagnoses after enrollment have a 12-month continuous membership requirement before sharing is eligible. This means that if you are diagnosed with cancer after you become a member, you are not eligible to request cost sharing of your expenses until you have been an Aliera member for 12 consecutive months.
- There is a maximum limit of $1 million on this Plan.

AlieraCare Bronze, Silver, Gold

- Pre-existing conditions:
  - Bronze: 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.
  - Silver: During the first two years (24 months) of continuous membership, sharing is available up to $10,000 of total medical expenses incurred for pre-existing conditions per year, after a separate MSRA equal to two times your plan MSRA.
  - Gold: During the first two years (24 months) of continuous membership, sharing is available up to $20,000 of total medical expenses incurred for pre-existing conditions per year, after a separate MSRA equal to two times your plan MSRA.
- Cancer sharing eligibility is available immediately for new occurrences of cancer. Any pre-existing or recurring cancer condition is not eligible for sharing. Cancer sharing will not be available for individuals who have cancer at the time of or five (5) years prior to application.
- There is a maximum limit of $1 million on this Plan.

CarePlus

- Cost sharing does not apply (not eligible) to any illness or accident for which a person has been diagnosed, received medical treatment, been examined, taken medication, or had symptoms within the 24-month period prior to the application date.
- Events covered during the first year of membership become pre-existing condition for the second year, resetting after 24 months.

InterimCare

- Pre-existing conditions have a 24-month waiting period.
- Cancer coverage is provided immediately if a pre-existing cancer condition did not exist within 5 years prior to or at the time of application.
- Charges resulting directly from a pre-existing condition are excluded from cost sharing.
- The pre-existing condition exclusions for Interim Care plans will apply for all members, including those under the age of 19.
- There is a maximum limit of $1 million on this Plan.

Dates of Service

The ministry reserves the right to make updates to its Guidelines at any time. The Guidelines in effect at the time of service will supersede all previous versions of the Guidelines. Members will be notified in advance of updates.

Membership Dues and Fees

- An administrative fee of $25.00 is assigned to administrative costs from each Monthly Share Amount regardless of family size, as provided in the Guidelines. Collection of this fee will begin in the third membership month and will be collected monthly for each following month.

Assigned Need

The ministry will assign a non-refundable 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 and other general overhead costs to successfully carry out the duties of administering these services.

Membership Guidelines Details

Each Aliera member is responsible for reviewing the HCSM Guidelines provided at the time of enrollment, and to abide by the terms of the Guidelines. It is your responsibility to understand which of your medical expenses are eligible for cost sharing, and which medical expenses are NOT eligible for cost sharing. Members are also provided with a toll-free number to contact Member Services with any questions they have. It is recommended that members call Member Services with any questions regarding eligibility prior to seeking medical services.

Authorizations

- I authorize Aliera Healthcare, Inc. ("Aliera"), on behalf of the ministry, to collect the Monthly Share Amount as a recurring monthly transaction.
- I authorize my first Monthly Share Amount to be processed immediately upon completion of my enrollment.
- I understand that the enrollment fee will be refunded automatically if all individuals on my enrollment form fail to attest to the ministry Statement of Beliefs or if I withdraw my enrollment prior to my membership effective date.
- I understand that the enrollment fee will not be refunded if, in the course of enrolling, I fail to respond to written or verbal inquiries from the ministry or Aliera (as the ministry's administrator) for more than sixty days.
- I understand that the ministry offers voluntary participation in the health care sharing ministry, and I understand that Aliera owns and administers memberships on behalf of the ministry.
- I understand both Aliera and the HCSM have the authorization to contact providers to request the release of medical records on behalf of the member.

Acknowledgment

- I affirm that the name and personal information provided on this form are true and correct.
- I affirm that I understand and accept the disclosures presented above.

Refunds

You are entitled to a full refund, including the one-time enrollment fee, if you cancel your membership within 10 days of the effective date of the membership. You must cancel within 10 days of your effective date to be eligible for a full refund.

If you are canceling your membership after the first 30 days of your membership, you may be eligible for a refund of the most recently paid membership period, but only if you cancel within 10 days of your scheduled billing date. 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.

Terms and Conditions for Unity Healthshare - Gold

HCSM Terms & Conditions

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.

Cost Sharing Understanding

- Unity HealthShare, a registered DBA, is a faith-based medical need sharing membership. Medical needs are only shared in by members per the membership guidelines. This application or membership is not issued by an insurance company, nor is it offered through an insurance company. This membership does not guarantee or promise that the eligible medical needs will be shared by the membership. This membership should never be considered as a substitute for an insurance policy.
- I understand that the membership is not insurance but is a voluntary medical needs sharing ministry, and that there are no representations, promises, or guarantees that my medical needs will be shared on my behalf. I also understand that sharing for medical needs does not come from an insurance company, but from the membership per the guidelines and membership Escrow Instructions. I also understand that any medical condition that is inquired about but not disclosed on this application, whether meeting the definition of a pre-existing condition or not, and then discovered after my membership is effective will be treated as if it had been disclosed at the time of application by applying the governing standards set forth in the Membership Eligibility Manual retroactively to my effective date of membership.
- I understand that the guidelines in effect on the date of medical services supersede any spoken or verbal communication and all previous versions of the guidelines. I also understand that with notice to the general membership the guidelines may change at any time based on the preferences of the membership, and decisions, recommendations and approval of the Board of Trustees.
- I understand that the guidelines are not a contract and do not constitute a promise or obligation to share, but instead are for UHS' reference in following the Membership Escrow Instructions. I also understand that the guidelines are part of and incorporated into this UHS Application as if appended to it.
- I understand that each child must be a dependent to participate on their parent's membership. I also understand that eligibility for the membership for anyone, a dependent or otherwise, is based on the guidelines and that continued submission of monthly contributions does not extend an ineligible participant's membership.
- I understand that the application fee will be refunded automatically if all individuals on my application are declined for membership or if I withdraw my application prior to my membership effective date. I also understand that the application fee will not be refunded if, in

UHS for more than sixty days. I also understand that the $25 donation portion of the application fee to UHS Ministries is non-refundable.

- I understand that monthly contribution amounts are based on operating and medical needs and the total number of members and that monthly contributions are figured on a periodic basis as needed and are subject to change at any time. I also understand that the submission of my monthly contributions is voluntary and that I am not obligated in any way to send any money.

Payment Method

Type: ACH Bank Draft
Name: corlyn duncan
Routing: [redacted]
Account [redacted]

Electronic Signature

By electronically acknowledging this authorization, I acknowledge that I have read and agree to the terms and conditions set forth in this agreement.

Date: August 20, 2019 at 6:51:35 PM
IP Address: 108.247.121.92
System: Mozilla/5.0 (Windows NT 10.0; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/75.0.3770.142 Safari/537.36

Please continue your signature.

Clear Signature

Type Your Name

APPENDIX K


ERACARE
SILVER | GOLD
PHCS
Specific Services. Call to Confirm
Effective Date: 1/ /20 1
Plan ID: TrinityGold
MSRA*: 1000
Corilyn Duncan
ry ID: [redacted]
endents:Bruce Duncan
Hospital: YES
In-Patient: YES
Out-Patient: YES
ER: $150 Consult
Specialty: $75
RX VALET
855-798-2538
Fax Fill: 888-415-7906
www.MyRxValet.com
Additional Pharmacy Services
Group: 2504
BIN #: 006053
PCN: SS
ID # [redacted]
rticipant and any listed dependents are Members of a Health Care Sharing Ministry recognized pursuant to 26
§ 5000A(d)(2)(B) that does not engage in the business of insurance. Members make monthly contributions that
sed to voluntarily pay each other's medical expenses based on a shared set of ethical or religious beliefs
RA = Member Shared Responsibility Amount
Verify eligibility for payment: 844-457-7726

ALIERACARE
BRONZE | SILVER | GOLD

FirstCall
Telemedicine

Mail claims forms to:
Aliera Healthcare
P.O. Box 16818
Lubbock, TX 79490-6818
or EDI #: ALH01 | 1-800-252-3684

Member Services: 844-834-3456
Telemedicine: 866-920-3627
Pharmacy: 855-799-2538
Eligibility: 801-847-9794

Providers should verify eligibility before treatment or service

AlieraCare BSG Plan Summaries*

PCP Visit:
Bronze: $50
Silver: $35
Gold: $20

Urgent Care Visit:
Bronze: $100
Silver: $75
Gold: $75

Emergency Room:
Bronze: $500
Silver: $300
Gold: $150

Specialty visit:
Bronze: $125
Silver: $75
Gold: $75

Preventive: $0

X-Ray and Imaging:
Bronze: 60% after MSRA
Silver: 70% after MSRA
Gold: 80% after MSRA

Provider Network Info

Visit multiplan.com or call 800-922-4362 for your PHCS provider.

See PHCS Network Logo on front of card to pick corresponding network.

MSRA = Member Shared Responsibility Amount. *Consult fees shown are in-network rates.

www.alierahealthcare.com

APPENDIX L

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

TRINITY

AR_1

Explanation of Benefits

Forwarding Service Requested

THIS IS NOT A BILL

Member Information

Name: CORLYN DUNCAN
EOB Date: 04/26/2019
ID No: [redacted]
Group ID: AHUNC
Group Name: ALIERA HEALTHCARE

Contact Us

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

**********MIXED AADC 945
PB-DSM-407-ENV 778 10
CORLYN DUNCAN
[redacted]
BENICIA CA 94510[redacted]

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

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

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

Patient: CORLYN DUNCAN
Claim #: AHL540330

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

The Reduction Amount reflects a previously paid payment of $4069.36

Patient: CORLYN DUNCAN
Claim #: AHL586909

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

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

APPENDIX M

ALIERA

05/22/2019

Aliera Healthcare
5901 Peachtree Dunwoody Rd.
Building B. Suite 200
Atlanta, GA 30328

Re: Corlyn Duncan
DOB: [redacted]1959
Member ID: [redacted]

Corlyn Duncan
[redacted]
Benicia, CA 94510

To Whom This May Concern,

Aliera Healthcare, LLC is in receipt of your appeal regarding our determination of eligibility for your sharing request in the amount of $5,229.00 for the date of service 03/16/2018.

Following a review of the medical services provided, Aliera has determined that your appeal is denied for the following reason:

- ☐ Not a life-threatening emergency.
- ☐ The services are not eligible for sharing under the Aliera Master Guidelines.
- ☒ Member has reached the maxed amount allotted for a preexisting condition.
- ☐ The services were provided by an out of network provider or facility and are not eligible for sharing under the Aliera Master Guidelines.
- ☐ Medical condition is self-inflicted in contradiction to elements of a healthy and spiritual lifestyle as enumerated in the Aliera Master Guidelines as follows:

This was not pre existing

1. Refrain from tobacco use in any form.
2. Follow spiritual teachings on the use or abuse of alcohol.
3. Avoid abuse of prescription drugs, which means consuming prescription medications in a manner not intended by the prescriber that would likely result in bodily harm or dependency.
4. Abstain from the use of illegal drugs including, without limitation, any hallucinogenic substance, barbiturates, amphetamines, cocaine, heroin or other opiates, marijuana, illegal intravenous drugs, or narcotics.
5. Exercise regularly and eat healthy foods that do not harm the body.

If you are in possession of documentation that refutes our findings, we will gladly take that information into account. Please mail copies of supporting documentation to:

Aliera Healthcare, LLC
5901 Peachtree Dunwoody Rd. Suite C 160
Atlanta, GA 30328

If you have immediate questions regarding this appeal decision, please phone us at (404) 618 0602.

You are also welcome to email your documentation to our Administrator, Aliera Healthcare, Inc at Claimsaccess@alierahealthcare.com, or you can fax them to (404) 420 5750. Please clearly indicate that you are submitting documents for consideration of your appeal request.

If you have no additional documentation to submit, and the medical expense is creating a true financial hardship, please contact us at (800) 847-9794 to request a hardship request form. If Aliera determines that you have a true financial hardship, your request will be considered for sharing.

Additional information about the Aliera health care sharing ministry plans can be found at www.Alierahealthcare.com

Sincerely,

Aliera Healthcare – *Claims Dept.*

APPENDIX N

STATE OF WASHINGTON
OFFICE OF THE INSURANCE COMMISSIONER

In the Matter of

ONESHARE HEALTH, LLC,

Unauthorized Entity/
Respondent.

Order No. 20-0250

ORDER TO CEASE AND DESIST

Pursuant to RCW 48.02.080 and RCW 48.15.023, the Insurance Commissioner of the state of Washington ("Insurance Commissioner") orders the above-named Respondent, and its officers, directors, trustees, employees, agents, and affiliates to immediately cease and desist from:

A. Acting as an insurer in the state of Washington;

B. Engaging in or transacting the unauthorized business of insurance in the state of Washington;

C. Seeking, pursuing, and obtaining any insurance business in the state of Washington;

D. Soliciting Washington residents to purchase any insurance to be issued by an unauthorized insurer; and

E. Soliciting Washington residents to induce them to purchase any insurance contract.

BASIS:

1. The parent of OneShare Health, LLC, Anabaptist Healthshare, Inc., incorporated on May 26, 2015 in Virginia; on August 31, 2018, it amended its name to Kingdom Healthshare International; and on March 12, 2019, it amended its name to OneShare International (hereinafter referred to as "the Organization"). On April 9, 2019, the Organization registered Anabaptist

Healthshare as a d.b.a. The Organization represents itself as a health care sharing ministry ("HCSM"), exempt from insurance regulation. It does not have members in Washington State.

2. On November 10, 2016, the Organization formed a wholly owned subsidiary, Unity Healthshare, LLC; on August 27, 2018, it amended its name to Kingdom Healthshare Ministries, LLC; and on March 11, 2019, it amended its name to OneShare Health, LLC ("OneShare"). OneShare is incorporated in Virginia and headquartered in Texas. OneShare represents itself as a HCSM, exempt from insurance regulation. It has members in Washington State and it does not hold a Certificate of Authority in this state.

3. There is pending litigation in Fulton County Superior Court (Georgia) between OneShare and Aliera Healthcare, Inc. ("Aliera"), regarding Aliera's marketing of OneShare's insurance products. Aliera is also the subject of an enforcement action by the Insurance Commissioner.

4. Following a referral from its producer licensing division, the Insurance Commissioner opened an inquiry to determine 1) if OneShare is a legitimate HCSM in compliance with state and federal law, and 2) if it is not a bona fide HCSM, whether it is acting as an unauthorized insurer in Washington State.

OneShare does not meet the legal definition of a health care sharing ministry.

5. To qualify as a health care sharing ministry under Internal Revenue Service (IRS) and Washington law, a HCSM must be a 501(c)(3) organization whose members share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs. In addition, the organization (or its predecessor) must also have been in operation and continuously sharing member health care costs since at least December 31, 1999.

6. OneShare has not been in operation and continuously sharing amongst members since 1999. To meet this requirement, OneShare relies entirely on a letter, dated July 14, 2015, from the Department of Health & Human Services ("DHHS"), approving the Organization as a HCSM. However, there are several problems with OneShare's reliance on this letter: (1) the Organization serves a different religious community than OneShare serves, (2) the letter from DHHS contains a disclaimer that it is not binding on state authorities, (3) the Organization has not been in operation since 1999, and (4) the Organization is not OneShare's "predecessor."

7. OneShare explained that the Organization and OneShare serve different communities. The Organization's membership focuses on members of the traditional Anabaptist church or those who work for Anabaptist ministries or employers. The Organization does not have and has never had any Washington members. On the other hand, OneShare members are not required to be practicing Anabaptists or among those who work for Anabaptist ministries. Instead, each member must attest to OneShare's Statement of Beliefs which is founded on Biblical principles. OneShare explained that creating OneShare allowed a larger community to take advantage of healthcare sharing services in accordance with their faith. This distinction in beliefs between the two sets of members runs contrary to the continuous sharing requirement for HCSMs.

8. OneShare denies that it is a separate legal entity from the Organization and points out that, for tax purposes, it is not treated as a separate legal entity. In support, it provided an IRS Announcement which states that an LLC, if wholly-owned by an organization exempt under section 501(c)(3) of the Internal Revenue Code, may be disregarded as a separate entity for federal tax purposes. However, members were signed up with OneShare as their insurer, not the Organization. Further, and most importantly, the Insurance Commissioner is not bound by the IRS's tax treatment of OneShare.

9. Additionally, in order to qualify as an HCSM, an entity must conduct an annual audit performed by an independent certified public accounting firm. OneShare failed to meet this requirement. OneShare provided the Insurance Commissioner with an audit of the Organization for year ending December 31, 2016. The audit report is dated September 20, 2019. On this basis alone, OneShare fails to qualify as an HCSM.

OneShare is acting as an unauthorized insurer in the state of Washington.

10. Because OneShare is not qualified as a HCSM, it is acting as an unauthorized insurer. OneShare asserts throughout its website and written materials that it is not insurance, does not guarantee payment of medical expenses, and does not enter into contracts with members. However, based on those same materials, the members pay a monthly fee and, in return, OneShare pays providers for covered services upon the members getting sick or injured. This qualifies as insurance.

11. At the time OneShare terminated its contract with Aliera on August 10, 2018, OneShare had approximately 2,900 Washington members. Since then, 1,470 Washington residents

have been OneShare members, with a current total of 1,091 Washington members. Members from Washington have paid OneShare a total of $1,239,328.15 to date.

12. Based on their website, OneShare continues to offer Washington consumers insurance.

13. RCW 48.01.040 states that "insurance" is a contract whereby one undertakes to indemnify another or pay a specified amount upon determinable contingencies.

14. RCW 48.01.050 states in relevant part that "insurer" as used in this code includes every person engaged in the business of making contracts of insurance.

15. RCW 48.43.009 provides that health care sharing ministries are not health carriers as defined in RCW 48.43.005 or insurers as defined in RCW 48.01.050. For purposes of this section, "health care sharing ministry" has the same meaning as in 26 U.S.C. Sec. 5000A.

16. 26 U.S.C. Sec. 5000A states the term "health care sharing ministry" means an organization—

> (I) which is described in section 501(c)(3) and is exempt from taxation under section 501(a),
> (II) members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the State in which a member resides or is employed,
> (III) members of which retain membership even after they develop a medical condition,
> (IV) which (or a predecessor of which) has been in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously and without interruption since at least December 31, 1999, and
> (V) which conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.

17. RCW 48.05.030(1) states no person shall act as an insurer and no insurer shall transact insurance in this state other than as authorized by a certificate of authority issued to it by the Insurance Commissioner and then in force; except, as to such transactions as are expressly otherwise provided for in this code.

18. RCW 48.15.020(1) states that an insurer that is not authorized by the Insurance Commissioner may not solicit or transact insurance business in this state.

19. RCW 48.15.023(5)(a)(i) states that if the Insurance Commissioner has cause to believe that any person has violated the provisions of RCW 48.15.020(1), the Insurance

Commissioner may issue and enforce a cease and desist order in accordance with the provisions of RCW 48.02.080.

20. RCW 48.02.080(3)(a) states if the Insurance Commissioner has cause to believe that any person is violating or is about to violate any provision of this code or any regulation or order of the Insurance Commissioner, he or she may issue a cease and desist order.

21. The Respondent's actions described herein violate Insurance Code provisions that include RCW 48.05.030(1) [Certificate of Authority required] and RCW 48.15.020(1) [solicitation by insurer not authorized prohibited].

IT IS FURTHER ORDERED that nothing herein shall prevent the Respondent from fulfilling the terms of contracts formed prior to the effective date of this Order pursuant to RCW 48.15.020(2)(b).

Any violation of the terms of this Order by the Respondent and its officers, directors, trustees, employees, agents, and affiliates or the Respondent's failure to fulfill or perform its contracts subject to this Order will render the violator(s) subject to the full penalties authorized by RCW 48.02.080, RCW 48.15.023, and other applicable sections of the Insurance Code of the state of Washington.

The Respondent has the right to demand a hearing in accordance with RCW 48.04.010, WAC 284-02-070, and WAC 10-08-110.

This Order shall remain in effect subject to the further order of the Insurance Commissioner.

THIS ORDER IS EFFECTIVE IMMEDIATELY AND IS ENTERED at Tumwater, Washington, this 31 day of March, 2020.

Mike Kreidler

MIKE KREIDLER
Insurance Commissioner

By and through his designee

Ellen Range

ELLEN RANGE
Insurance Enforcement Specialist
Legal Affairs Division

CERTIFICATE OF MAILING

The undersigned certifies under the penalty of perjury under the laws of the state of Washington that I am now and at all times herein mentioned, a citizen of the United States, a resident of the state of Washington, over the age of eighteen years, not a party to or interested in the above-entitled action, and competent to be a witness herein.

On the date given below I caused to be served the foregoing Order to Cease and Desist on the following individual(s) in the manner listed below:

By email and by depositing in the U.S. mail via state Consolidated Mail Service with proper postage affixed to:

Tyler Hochstetler
2452 S. Seminole Trail
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Dated this 31st day of March, 2020, in Tumwater, Washington.

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APPENDIX O

BEFORE THE STATE OF WASHINGTON
OFFICE OF THE INSURANCE COMMISSIONER

In the Matter of: **ONESHARE HEALTH, LLC,** Respondent	Docket No. 20-0250 **ORDER ON MOTION FOR DISCRETIONARY STAY**

I. Background

On March 31, 2020, the Office of the Insurance Commissioner ("OIC") issued Order to Cease and Desist ("Order") No. 20-0250 *In the Matter of OneShare Health, LLC*. The Order alleged that OneShare Health, LLC ("OneShare") was acting as an unauthorized insurer in Washington because it did not qualify as a health care sharing ministry. The Order, effective immediately, prohibited OneShare from enrolling new members, although it allowed OneShare to continue to serve members already enrolled. On April 13, 2020, OneShare filed a Demand for Hearing to contest the Order. On April 21, 2020, OneShare filed "Respondent's Motion to Stay Cease and Desist Order and Request for Briefing Schedule,"[1] with declarations and attachments, the main purpose of which was to request a stay of the Order pending the outcome of the hearing. After a briefing schedule was set, the OIC responded and filed "OIC's Response in Opposition to Appellant's Motion to Stay Cease and Desist" on April 28, 2020. OneShare then filed "Respondent's Reply in Support of Motion to Stay Cease and Desist Order" on May 1, 2020.

On May 4, 2020, both parties appeared at oral argument which was held via videoconferencing. Attorneys Robert McKenna and Jeffrey Coopersmith appeared on behalf of OneShare, and Insurance Enforcement Specialist Ellen Range appeared on behalf of OIC.[2]

II. Issues

Whether a discretionary stay of the Order to Cease and Desist No. 20-0250 should be granted?

[1] In order to avoid confusion, the term "respondent" will now be used with reference to OneShare Health, LLC, as a party to this proceeding.
[2] A number of other persons appeared, but did not participate in the hearing.

III. Decision

As there is sufficient prima facie evidence that OneShare is unlawfully transacting in insurance, and does not qualify as a health care sharing ministry, the potential danger to the public outweighs the potential harm in restricting OneShare's ability to do business in the state of Washington. The request for discretionary stay is denied.

IV. Analysis

Standard for Discretionary Stay

The analysis of this issue necessarily starts with deciding what standard applies in granting a discretionary stay. There is no specific statutory guidance provided. RCW 48.04.020(2) states that "where an automatic stay is not provided for, and if the commissioner after written request therefor fails to grant a stay, the person aggrieved thereby may apply to the superior court for Thurston county for a stay of the commissioner's action." An automatic stay is not provided for in either RCW 48.15.023(5)(a)(i) nor RCW 48.02.080, both of which discuss the Commissioner's authority to issue a cease and desist order.[3]

The parties are not in agreement about what standard should apply. OIC asks that the judicial standard described in RCW 48.04.140(2) be adopted, which provides in pertinent part that "[a] stay shall not be granted by the court in any case where the granting of a stay would tend to injure the public interest," and that here allowing OneShare to continue to act as an unauthorized insurer is a danger to the public. OneShare argues that the stay should be granted because it will suffer irreparable harm if it is not, and also argues that it has not only a substantial case on the merits, but a substantial likelihood of prevailing on the merits, and thus again a stay should be granted.

A stay is not a matter of right, but is an exercise of judicial discretion. *Virginian R. Co. v. United States*, 272 U.S. 658, 672 (1926). "Where a court is 'sufficiently convinced that a stay is necessary to avoid undue prejudice to a party's prosecution [or defense] of a matter,' a discretionary stay may be warranted." *In re Marriage of Herridge*, 169 Wn. App. 290, 302 (2012). "The party requesting a stay must make out a clear case of hardship or inequity in being required to go forward." *State v. Longo*, 185 Wn. App. 804, 812, 343 P.3d 378, 382 (2015).

Considering these standards, an equitable weighing of the interests at stake seems the most prudent approach. Thus, the harm OneShare alleges will occur if not granted a stay is weighed against the interests OIC asserts justify the Order.

[3] The Commissioner has lawfully delegated authority to hear and determine matters such as this to the Presiding Officer pursuant to WAC 284-02-070(2)(d)(i).

The asserted harm to the public by OIC is the unlawful and unregulated transacting of insurance. So, there must be some prima facie evidence and authority presented by OIC that OneShare is both 1) transacting insurance and 2) does not qualify as a health care sharing ministry under state and federal definitions (which are one and the same). Obviously, OneShare is not entitled to reprieve from any alleged harm if it is acting unlawfully. Similarly, the justification for the Order is lacking if OneShare is operating lawfully in the state of Washington.

Whether OneShare is transacting in insurance, and whether it qualifies as a health care sharing ministry, is addressed below.

Whether OneShare is Transacting Insurance

OIC is only entitled to regulate OneShare if OIC can show that OneShare is an unauthorized entity transacting insurance in the state of Washington. As OneShare argues its business falls outside of OIC's jurisdiction regardless of its status as a federally recognized health care sharing ministry, that issue is addressed first.

"Insurance" is defined in RCW 48.01.040 as "a contract whereby one undertakes to indemnify another or pay a specified amount upon determinable contingencies." RCW 48.01.050 defines insurer in pertinent part as including "every person engaged in the business of making contracts of insurance…" That same statute then goes on to note exceptions to the definition of insurer.

Washington courts have addressed the definition of insurance in limited contexts. In *In re Estate of Smiley*, 35 Wn.2d 863, 864 (1950), the court affirmed a finding that the proceeds of the policies at issue were not insurance policies, and thus were not exempt from taxation upon distribution of the proceeds; the nature of the transaction was akin to transferring property to another for safekeeping, with instructions for distribution upon death, which did not involve "any hazard or risk to anyone." *Id*. at 867. In another case, the Court held that self-insurance did not constitute insurance for the purposes of the state's insurance guaranty act. *Stamp v. Dep't of Labor & Indus.*, 122 Wn.2d 536 (1993). In examining whether a contract is one of insurance, the Court notes that "[n]o one can change the nature of insurance business by declaring in the contract that it is not insurance." *McCarty v. King Cty. Med. Serv. Corp.*, 26 Wn.2d 660, 684 (1946). Specifically, the nature of the contract, and "the examination of its contents," aside from the terms used or omitted, determine whether a contract is one of insurance. *Id*.

Our state courts have not addressed whether the structure of a health care sharing ministry constitutes insurance, but other jurisdictions have addressed this question. The Idaho Supreme Court found that a health care sharing ministry's plans did not constitute insurance, as they did not believe there was sufficient evidence that the entity assumed the risk of paying members' claims. *Altrua Healthshare, Inc. v. Deal*, 299 P.3d 197, 198 (2013). The court did note that "the structure of the membership plan and statements made in Altrua's brochure and guidelines are substantial and competent evidence supporting the

Hearing Officer's finding that Altrua's membership contract creates a reliance interest in its members that their claims will be paid," but went onto say that such reliance "is not sufficient on its own to make Altrua an indemnitor." *Id.* at 201-02. One member noted in concurrence that perhaps Altrua's program met the definition of insurance under a different prong, and that Altrua "designed its program to look like insurance and act like insurance but [intended] to exclude it from being insurance by virtue of its numerous disclaimers." *Altrua Healthshare, Inc. v. Deal*, 154 Idaho 390, 395-96, 299 P.3d 197, 202-03.

An Iowa court also addressed whether a religious sharing program constituted insurance; they determined that a Christian newsletter, through which medical costs were shared among its subscribers, did not constitute insurance. *Barberton Rescue Mission v. Ins. Div.*, 586 N.W.2d 352, 353 (Iowa 1998). However, the structure of the sharing program in that case was quite different than the facts here; members paid each other directly after being assigned to a claim. *Id.* at 353-54.

Finally, a Kentucky court also examined whether a health care sharing ministry's sharing program constituted insurance. In that case, the court found that the offered sharing programs pooled resources amongst the members in order to "pay the actual medical bills as claims for payment are submitted." *Commonwealth v. Reinhold*, 325 S.W.3d 272, 278 (Ky. 2010). Despite disclaimers on the program's material that specifically stated it was not insurance, the court found that it was, "in practice and function," insurance. *Id.*

OneShare offers health care coverage to Washington consumers that it calls "Health Care Sharing Programs for Individuals and Family." Leslie Pearsall Declaration, Exhibit 6, p. 1. OneShare tells consumers it is "committed to providing you the most comprehensive, affordable, flexible program to best fit your needs." Pearsall Declaration, Exhibit 6, p.2. Sharing services include an Individual Sharing Amount ("ISA"), which is what the consumer is responsible for before expenses will be covered, or "shared," and an out of pocket maximum. Pearsall Declaration, Exhibit 6, p. 3-5, 10; Exhibit 7, p. 8-10. The plans give examples of what a member's financial responsibility would be in certain situations, note the difference in cost and reimbursement for in-network and out of network, issue cards that are presented to providers who call to obtain preauthorization and then send the "medical need" directly to OneShare, who issues the member an Explanation of Sharing, and sends a check to the provider. Pearsall Declaration, Ex. 7, p. 8-12.

The informational brochure and membership guidelines published by OneShare do contain advisements and disclaimers that the programs are not insurance, that it does not offer insurance, that it does not promise to pay, and that the membership guidelines do not create a contract. But, as the cases above have noted, it is not necessarily the words that are or are not used, but the nature and function of the programs or contracts at issue that determine whether they constitute insurance. OneShare's description of its plans look like insurance. While it argues no risk is assumed, based on the information available at this time, it looks as though OneShare operates to enroll many members in order to pool resources to cover medical expenses, while advertising that things such as preventative care are covered. This *is* an assumption of some risk to pay. Indeed, OneShare argues that

it needs to continue to add members in order to ensure that currently enrolled members have the benefit of a pool big enough to cover their costs.

The plans appear to operate as insurance, and while OneShare represents to consumers the plans are not insurance, that does not serve to nullify the nature of the plans themselves.

Whether OneShare Meets the Definition of Health Care Sharing Ministry

Again, if OneShare qualifies as a health care sharing ministry under the state and federal definitions, it is exempt from OIC's jurisdiction and regulation. Per RCW 48.43.009:

> Health care sharing ministries are not health carriers as defined in RCW 48.43.005 or insurers as defined in RCW 48.01.050. For purposes of this section, "health care sharing ministry" has the same meaning as in 26 U.S.C. Sec. 5000A.

In turn, 26 U.S.C. § 5000A(d)(2)(B)(ii) provides:

> **(ii)** Health care sharing ministry. The term "health care sharing ministry" means an organization—
> **(I)** which is described in section 501(c)(3) [26 USCS § 501(c)(3)] and is exempt from taxation under section 501(a) [26 USCS § 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.

Annual Audits

OIC alleges that OneShare does not meet criteria (IV) and (V) above. Regarding the audits, OneShare has completed the audits through 2018, although certainly not on an "annual" basis. And it is true that OneShare still awaits completion of the 2019 audit, which is anticipated to be completed in July of 2020. Additionally, reading the statute to

mean that OneShare simply had to complete the audits eventually would seem contrary to the intent that the audits be available for public review. Such a reading of the statute does not interject a time requirement, it simply gives full meaning to the term "annual audit." "Statutes must be interpreted and construed so that all the language used is given effect, with no portion rendered meaningless or superfluous." *State v. J.P.*, 149 Wn.2d 444, 450 (2003). However, while OneShare has perhaps not met this requirement with strict adherence, any shortcomings in this area do not initially appear, in and of themselves, to be a sufficient basis to justify a cease and desist order. This would seem especially so at this point, as OneShare is now attempting to comply, and is hindered by litigation out of state that requires a schedule somewhat out of their control.

In this case, regarding OneShare's status as a health care sharing ministry, the real question is whether OneShare meets the criteria described in section (IV) above: is OneShare an organization "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?"

Existence Prior to 1999

OIC alleges that OneShare does not meet this criteria in two ways. First, it asserts neither OneShare itself, nor a "predecessor," has been in existence at all times since December 31, 1999. Second, OIC argues that the medical expenses of OneShare's members have not been "shared continuously and without interruption since at least December 31, 1999."

There is no dispute that OneShare Health, LLC, is an organization that has been in existence since 2016. Pearsall Declaration, Exhibit 2. The question is OneShare's parent company, Anabaptist Healthshare[4], is a "predecessor" of OneShare within the meaning of 26 U.S.C. § 5000A. The Center for Medicare and Medicaid Services determined Anabaptist Healthshare met the definition of health care sharing ministry under the federal statute. Declaration of Tyler Hochstetler, Exhibit B. OneShare argues that because Anabaptist Healthshare has met the definition of health care sharing ministry, including the existence requirement, such status extends to OneShare.

The term "predecessor" is not defined in 26 U.S.C. § 5000A. "In the absence of [a definition], statutory construction requires that we give undefined words their common and ordinary meaning. To ascertain this meaning, we may use a dictionary. In determining the meaning of a term in a statute, we must also consider the intent of the legislature. If statutory language is susceptible to more than one definition, we will adopt the definition that promotes the purpose of the statute." *Vance v. Dep't of Ret. Sys.*, 114 Wn. App. 572, 577 (2002). Statutes should be interpreted to avoid absurd or strained results. *Homeowners' Ass'n v. Hal Real Estate Invs.*, 108 Wn. App. 330, 340 (2001).

[4] Anabaptist Healthshare is a registered d/b/a of OneShare International, the sole owner of OneShare Health, LLC, and is used to avoid any confusion between the two companies.

OneShare makes two arguments regarding its existence prior to 1999. First, it argues the term "predecessor" includes OneShare's sole owner, Anabaptist Healthshare, and as Anabaptist Healthshare was found to qualify as a health care sharing ministry by tracing its lineage through a predecessor in existence prior to 1999, OneShare meets that qualification. Second, OneShare argues that because it is disregarded as a separate entity from Anabaptist Healthshare for tax purposes, that the finding that Anabaptist Healthshare met criteria for a health care sharing ministry must be imputed to OneShare, as it is not a legally distinct entity from Anabaptist Healthshare.

Regarding the definition of "predecessor," OneShare proposes the definition found in Black's Law dictionary: "predecessor" is "[s]omeone who precedes another, especially in an office or position." 11th Ed. 2019. OIC asks that the term be given the same meaning as Washington courts have attached when discussing corporations, using the terms "predecessor" and "successor" when one has acquired the assets of the other. *See Eagle Pac. Ins. Co. v. Christensen*, 135 Wn.2d 894 (1998); *Payne v. Saberhagen Holdings, Inc.*, 147 Wn. App. 17 (2008); *Leren v. Kaiser Gypsum Co.*, 9 Wn. App. 2d 55 (2019).

The apparent intent of the statute was to limit the application of the qualification for health care sharing ministries only to organizations that were in existence prior to 1999, or organizations that could show a predecessor existed prior to 1999. OneShare proposes the adoption of a broad definition of predecessor that is specific to persons, not companies and/or organizations, and which essentially eliminates any separation between a subsidiary company and its parent company. That interpretation is contrary to the intent of the statute as it would tend to create a broad exception, as all new subsidiaries would necessarily meet this requirement assuming the parent had. In contrast, OIC's reading of the term "predecessor" is consistent with the apparent intent of the statute, which is to provide a narrow exception, restricted by operation preceding a date in time, using a definition that is consistent with state and federal law that recognizes the distinction of a parent company from a subsidiary, and regards the two as separate legal entities.

Federal and state courts have also recognized a parent corporation as a separate entity from its subsidiary in the context of liability. *United States v. Bestfoods*, 524 U.S. 51, 61 (1998) ("It is a general principle of corporate law deeply 'ingrained in our economic and legal systems' that a parent corporation (so-called because of control through ownership of another corporation's stock) is not liable for the acts of its subsidiaries.") *Minton v. Ralston Purina Co.*, 146 Wn.2d 385, 399, 47 P.3d 556, 563 (2002) (Where there was no evidence of using the corporate structure to void a duty or to defraud shareholders, or specific intent to disregard the corporate structure, parent corporation was not liable due to its ownership of subsidiary.) Under Washington law, an LLC incorporated in Washington is a "separate legal entity." RCW 25.15.071(3). Interestingly, Virginia law (where OneShare is incorporated) provides that "[a] limited liability company's status for federal tax purposes shall not affect its status as a distinct entity organized and existing under this chapter." Va. Code Ann. § 13.1-1002.

Finally, one unpublished case has noted that an LLC's tax status as a disregarded entity does not have effect on other legal matters. *Londen Land Co., Ltd. Liab. Co. v. Title Res. Guar. Co.*, No. CIV-09-980-PHX-MHB, 2010 U.S. Dist. LEXIS 78387, at *8-9 (D. Ariz. Aug. 2, 2010).

Based on the above, it is not appropriate to impute Anabaptist Healthshare's status as a health care sharing ministry to OneShare. Rather, OneShare is a separate legal entity for purposes other than taxation, created well after 1999. A company's status as a "parent corporation" to another company does not make it that company's predecessor. Anabaptist Healthshare's ownership of OneShare. alone does not qualify it as OneShare's "predecessor."

Continuous sharing of medical expenses among members

The second way in which OIC alleges OneShare does not meet the definition of a health care sharing ministry is that OneShare's members have not been continuously, and without interruption, sharing medical expenses since prior to December 31, 1999.

For the reasons outlined above, Anabaptist Healthshare is not a "predecessor" of OneShare. As such, OneShare cannot establish that its members have been sharing medical expenses continuously and without interruption since prior to 1999. OneShare was formed well after 1999, and its membership is distinct from Anabaptist Healthshare. Although Anabaptist Healthshare was found to meet this requirement, because OneShare and Anabaptist Healthshare are legally separate entities, outside of OneShare's disregarded status for tax purposes, OneShare does not meet this requirement

Weighing the interests

OneShare alleges a harm in that it cannot enroll new members pursuant to the Order, which shrinks the pool of contributions that are available to current members, and threatens their ability to combat natural attrition, and possibly even their existence in Washington. But this harm is one they are only entitled to avoid if they are lawfully doing business and not subject to OIC regulation. Further, OneShare also does not allege any harm or prejudice in their *rights or ability to contest the Order* if the stay is not granted. There is nothing that prevents them from moving forward with this proceeding, regardless of a stay.

In contrast, without regulation from OIC, the state does not have the ability to ensure OneShare meets the statutory requirements adopted to protect consumers, such as coverage of pre-existing conditions, or capital and surplus requirements meant to establish the solvency of insurers and their ongoing ability to pay claims. In order to minimize the effects of the Order, the OIC has only prohibited OneShare from enrolling new members, while allowing them to continue to serve existing members, instead of ordering OneShare to cease and desist all operations. OIC has made a sufficient prima facie showing that OneShare is transacting insurance without a certificate of authority, and that it does not

meet the criteria to be a health care sharing ministry and thus is not exempt from OIC's jurisdiction. In summary, based on review of the evidence submitted by the parties to date, the public interest in preventing OneShare, as an apparently unauthorized insurer, from enrolling new members in Washington outweighs the harm OneShare may suffer while this proceeding is pending.

V. Order

Thus, IT IS ORDERED:

The request for a discretionary stay of Order to Cease and Desist No. 20-0250 is DENIED.

DATED: May 15, 2020

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Julia Eisentrout
Presiding Officer

CERTIFICATE OF SERVICE

The undersigned certifies under the penalty of perjury under the laws of the state of Washington that I am now and at all times herein mentioned, a citizen of the United States, a resident of the state of Washington, over the age of eighteen years, not a party to or interested in the above-entitled action, and competent to be a witness herein.

On the date given below I caused to be filed and served the foregoing Order on Motion for Discretionary Stay on the following people at their email addresses listed below:

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Dated this 15 day of May, 2020, in Tumwater, Washington.

Julia Eisentrout
Presiding Officer