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Via Electronic Mail

Matt Martinez
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RE: Memo on Champion Health's Insurance-Backed Fixed Engagement & Indemnity Platform

Dear Mr. Martinez:

Based on our conversations, it is understood that you and Champion Health, Inc. ("CHI") market a Healthcare Management and Engagement Platform ("Platform") that includes an employer-provided, self-funded Limited Benefit Health Insurance Policy ("Policy"). Specifically, the Platform provides for a self-funded arrangement ("SF") with an employer's Policy that functions as an indemnity health plan/policy available for employers and employees. Moreover, the Policy, operates like a fully-insured plan, and administered by a third-party administrator, provides certain benefits and payments for covered services, such as primary care visits, urgent care visits, pharmacy benefits for prevention and acute care, preventative care, telehealth, as well as direct primary care/concierge medicine, and such other 213(d)-based medical events, as well as health screenings, health risk assessments, risk resolution assessments, chronic medication fulfillment and other medically-based engagement activities under the Policy[1].

The Platform provides a plan in which employees can select benefit options and, if certain medical events take place, receive benefits from the Policy. As stated earlier, the Policy provides claim benefits / indemnity payments to employees, either

[1] For purposes of this Memorandum ("Memo"), the Policy and the specific provisions therein are not discussed in detail, unless otherwise indicated. For example, what constitutes as an indemnity benefit or health screening benefit are set forth in the Policy document. It is also assumed that the Policy meets all the required ERISA obligations, plan document requirements and such other mandated aspects for employers. This Memo also relies on CHI memorandum provided by Pierre Tax Group, LLC. Furthermore, it is assumed and based on the materials provided by CHI that the Policy is ACA compliant and is considered a MEC plan for those purposes.

directly or indirectly, upon the occurrence of certain specified medical events as provided for in the Policy. As such, the Policy does not make any claim benefit / indemnity payment to a participant in the Policy without the occurrence of a triggering medical event (as provided for under the Policy). If there is no triggering medical event for the Policy benefit, then no claim benefit / indemnity payment per the Policy is made to the employee.

Based on an analysis and discussion of the federal income tax issues set forth in the Internal Revenue Service's ("IRS") Internal Revenue Code ("IRC" or "Code") and the associated IRC regulations, it may be a reasonable and good-faith interpretation of the those rules that the Platform is set up to help employees curtail the cost of healthcare by providing certain benefits at a zero-cost, no copay basis and may comply with certain rules under Section 125 of the Code. The Platform is a legitimate compliant benefit offering available to employers and employees that is backed by the employer's Policy with specific fixed, medical-based, and indemnity-based medical activities and services.

Specifically, the following is set forth and/or provided for purposes of this Memo, based on my understanding, assumptions and reliance upon the materials provided by CHI[2]:

- The Policy supported by a SF employer, as offered by CHI, is an ERISA and ACA-compliant policy, as applicable.
- The Policy may be considered a limited medical benefit plan.
- The Policy may be paid for on a pre-tax basis via Section 125 or on a post-tax basis. If paid on a pre-tax basis, such premiums are reported on an employee's W-2, as required by the IRS for all healthcare premiums to be reported in Box 12 with Code DD.[3]
- Unless the IRS provides future guidance to the contrary, any health indemnity plan, limited medical benefit plan or group health plan (among others) may be paid for on pre-tax basis, with such payments sent to the designated third-party administrator, as applicable.

[2] This Memo is strictly based on the reliance of the materials provided by CHI, including the memo provided by Pierre Tax Group, LLC and the statements made therein. Furthermore, as it relates to the rules and regulations covering ERISA and ACA compliance, such analysis is outside of the scope of this Memo, including any analysis related to plan assets of an ERISA-governed plan or policy, as such analysis is strictly up to the employer client themselves, not CHI, given the variables surrounding an employer's plan assets. PLG assumes the information contained herein and, in the materials, provided as correct and should any information or rule of law or regulation dictate otherwise, this Memo shall be void and it is not PLG's responsibility to update this Memo as applicable. Again, this is purely a memorandum of understanding and shall not be used as a Circular 230 Opinion or relied upon by any other entity or employer outside of CHI, which includes any clients of CHI.

[3] See here: https://www.irs.gov/affordable-care-act/form-w-2-reporting-of-employer-sponsored-health-coverage

- Any premium amounts provided to the third-party administrator are considered plan assets.
- The Policy provides for medical-covered services with zero co-pays, such as primary care visits, urgent care visits, pharmacy benefits for prevention and acute care, preventative care, telehealth, as well as direct primary care/concierge medicine, and such other 213(d)-based medical events, which include applicable health screenings, health risk assessments, risk resolution assessments, chronic medication fulfillment and other medically-based engagement activities (as approved and provided for by the Policy)
- The Policy assumes an inherent transfer of risk, as required by the IRS, due to the zero-dollar outlay by the employee for the visits outlined above, as well as the pharmacy benefits and such other services provided under the Policy.[4]
- Just like any other limited medical / indemnity benefit, the Policy may pay the specified Policy benefit amounts pursuant to the qualified covered services directly to the individual/participant or through a third party (i.e., a third-party administrator or vis-à-vis an assignment of benefits or through the employer, themselves, if such payments pursuant to the Policy are for covered services under the Policy and there is applicable documentation for the triggering event).
- All claims under the Policy must be substantiated by the employee participant after a triggering event, as specified within the CHI Platform documents, for any claim to be paid under the Policy. No claim is paid or shall be payable to an employee participant without such corroborated evidence of such event.
- The CHI Platform and Policy documents set forth the variety of benefits and stipulations for purposes of any Policy benefits, rights, obligations and requirements for participants and beneficiaries.
- Given the assumed transfer of risk, it is not illegal for the Policy to pay any approved, documented covered benefits to the participant through an intermediary or third-party, such as the employer or another third-party, who then provides such benefit payment to the participant.[5]
- The covered benefits (i.e., Schedule of Benefits) under the Policy all require a medical CPT/NPI code, as normal with any limited medical / health indemnity plan. As such, no Policy benefits are paid without

[4] It is also assumed herein, and based on the materials provided, that the premiums set forth by the Policy were actuarially determined to cover the claim risk and meet certain medical loss ratio requirements, as and if applicable, in addition to any surplus risk exposure. The employer may take other risk loss measures, as applicable.

[5] See below for alternatives related to the Policy claim payments, as applicable.

proper documentation of a covered service happening, as set forth above.

- Pursuant to previous and current IRS guidance, claim payments made under the Policy may be reportable at the individual/participant level. Under prior rules and governance since 1969, the taxation of such payments is determined by the participant, as reported on their Form 1040. Whether the Policy benefits are excluded from taxation is based on an individual/family facts and circumstance, as well as the pre-tax and/or post-tax nature of the premiums. Notwithstanding, the Policy benefits should be eligible for exclusion from a participant's taxable income to the extent of the insured's aggregated unreimbursed expenses for medical care (or, if the Policy is paid on an after-tax basis, then the benefits received should be tax free under Section 104(a)(3)).[6]
- The tax treatment of the Policy benefit payments follows long-standing treatment by the IRS, which provide that the claim payments minus the aggregate out-of-pocket medical expenses determines taxation, as reported by the individual on Form 1040, as applicable.[7]

As it relates to the claim payments under the Policy, and how such payments are provided to the participant upon a qualifying covered event under the Policy, there are two alternatives for an employer should they not desire to use or act as a third-party administrator.

First, CHI, a third-party or otherwise, may provide a separate claim payment pursuant to the Policy to the employee. In other words, the participant would receive a separate claim/benefit pursuant to the Policy.

The second alternative would be to have an employer's payroll provider to facilitate the applicable claim/benefit payments pursuant to the Policy. In other words, instead of running payroll and facilitating the claim payments that are reported

[6] It is noted that some of the Policy's premium and/or the Platform is paid for on a combined pre-tax and post-tax premium basis. The amount of the post-tax premium does impact the strict non-taxable nature of any claim benefit / Policy benefit paid to a participant. However, the actuarial analysis or determination of the amount that is not taxable on a strict, straight-line approach is based on too many variables and factors for purposes of this Memo. That said, it is understood that any post-tax premium paid for a Policy does allow for the non-taxable receipt of claims provided under the Policy, as applicable. Further analysis of this issues and the pro-rata aspects is outside the scope of this Memo.

[7] As it relates to any analysis regarding a "wellness plan" or such aspects related to IRS Memorandums 201622031, 201703013 and 201719025, this Memo relies upon Pierre Tax Group, LLC analysis and is not considered in scope as it relates to certain aspects of the employer taxation of wages. Furthermore, please also note that such IRS memorandums may not be cited or used as precedent per the IRS as provided in plain terms under such memorandums with the phrase "This advice may not be used or cited as precedent." Given the strict advice by the IRS, this Memo does not take into consideration the use of such as precedent or cite to such memos as precedent. The IRS rules in which this Memo does take into consideration is Rev. Rul. 69-154, as applicable.

by the third-party administrator, the employer may engage a separate payroll provider to facilitate the payment.[8]

Given the specific points above, it is a reasonable and good-faith interpretation that based on existing guidance and laws considered, the Policy and/or the CHI Platform is a legal limited medical / fixed indemnity policy or program and that allows for the favorable treatment of claim benefit payments as provided above.[9]

As previously provided for, the information in this Memo provides a summary of the considered relevant guidance provided by the IRS. This Memo is not intended to be and should not be construed as a Circular 230 Opinion, nor should it be construed as legal or tax advice to any entity or individual, other than CHI, for whom this Memo was prepared. Specifically, no legal or tax opinion is expressed herein with respect to any federal tax or employment tax matters, or any other state or federal law matters as it relates to CHI clients or CHI. This Memo assumes compliance with other applicable federal and state law. Pope Legal Groupe (PLG) assumes no duty to update or supplement this Memo to reflect any facts or circumstances that may thereafter come to our attention or to reflect any changes in any law that may thereafter occur or become effective. This Memo is not a guarantee of result; rather, this Memo represents our good-faith legal interpretation and analysis of the existing law and based upon our review of existing law that we deem relevant to this Memo. Further, the Memo is conditioned upon the continuing accuracy and completeness of such facts and assumptions. Additional facts not presented to us, and therefore not stated herein, or the inaccuracy of the facts and assumptions, could change the conclusions reached in this letter.

I hope the information provided above is helpful as it relates to the Policy and the applicable laws discussed herein. If you have any questions or comments related to this Memorandum, please do not hesitate to contact me.

[8] It should be noted that a payroll provider or workers compensation provider would more than likely require that payroll be run through their system, and not just a one-off service. As such, employers may not desire this option or alternative.

[9] Please note that should the IRS provide future guidance or clarifications to the contrary, the Policy or platform may need to be modified or adjusted to conform to any future guidance. Furthermore, this Memo does not address or analyze any employer required taxes as such determination is based on varying factors not known to PLG and PLG does not opine or provide any analysis of the same related to the employer. However, it is commonly known that when employers provided for benefits through a Section 125 plan, any employer receives tax savings due to lower FICA amounts, as this has been long-standing application since Section 125 plans began and employers offered benefits on a pre-tax basis.