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Via Electronic Mail

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RE: Memo on Champion Health's Fixed Engagement & Indemnity Platform with HSAs and Other Items

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.

Given this, it is desired to know if the CHI Platform is compatible with an employer's high-deductible health plan ("HDHP") where an employee/participant has a health savings account ("HSA"). Before diving into the rules related to HSAs, let's first understand the summary of the CHI Platform

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 provides a legitimate 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 Section 125-based 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]

CHI Platform, HDHP and HSAs

Given the summary above of the CHI Platform, let's now look further into the HSA rules provided by the IRS and the applicable governing bodies. With respect to HDHPs and HSAs, the Internal Revenue Service ("IRS") (and ACA to an extent) set rules related to their interplay together and how other plans, programs or incentives work, including how the HDHP plan works with different types of deductibles (embedded and non-embedded deductibles). The IRS set forth the general rules and

[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, unless otherwise noted below. 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.

the minimum deductible amounts for HDHPs and HSAs[8]. Important to note that with HSAs, they are dependent on the individual being enrolled in a qualified HDHP.[9] The qualified status of an HDHP does not depend on the HSA.[10] With HSAs, however, there are certain limits applied pursuant to Publication 969 and the regulations and notices thereunder. These limits are as follows:

Limits	2022
HDHP Minimum Deductible	Self-Only: $1,400 (increase of $0 from 2021) Family: $2,800 (increase of $0 from 2021)
HDHP Maximum Out-of-Pocket *Co-payments, deductibles, and other amounts except premiums*	Self-Only: $7,050 (increase of $50 from 2021) Family: $14,100 (increase of $100 from 2021)
HSA Contribution Limit *Employer and Employee Contributions*	Self-Only: $3,650 (increase of $50 from 2021) Family: $7,300 (increase of $100 from 2021)

An HSA allows participants to defer compensation on a pre-tax basis for the purpose of paying eligible medical expenses pursuant to section 223 of the Internal Revenue Code ("Code"). The HSA eligibility rules require that an individual (a) must be covered under an HDHP (as referenced above), and (b) must not be covered under a health plan that is not an HDHP, with respect to benefits covered under the HDHP[11]. I.R.C. §§223 (a) (requiring person to be an "eligible individual" to receive HSA tax benefits); 223(c)(1)(A) (defining "eligible individual").

Pursuant to Publication 969, any eligible individual can contribute to an HSA. For an employee's HSA, the employee, the employee's employer, or both may contribute to the employee's HSA in the same year. The amount an employee or a participant can contribute to the HSA depends on the type of HDHP coverage, the participant's age, the date the participant becomes an eligible individual, and the date the participant ceases to be an eligible individual. Generally, if an employee was an eligible individual the whole plan year (or considered one under the last-month rule), then the employee may defer or contribute the maximum amount for that year.

[8] https://www.irs.gov/publications/p969

[9] It's assumed for purposes of this Memo that any participant in an HSA with an employer is also a participant in a qualified HDHP.

[10] For example, the HDHP can be paired with a medical flexible spending account, health reimbursement account or such other limited-based arrangements.

[11] See I.R.C. §§223 (a) (requiring person to be an "eligible individual" to receive HSA tax benefits); 223(c)(1)(A) (defining "eligible individual").

Otherwise, the employee is subject to a pro-rata portion or may be subject to a 10% excise tax.

As set forth more fully in Publication 969, the IRS indicates that the definition of "health plan" for this purpose is not limited to the definition of "group health plan," but also includes other plans, policies and arrangements that pay for or reimburse medical expenses.

Existing IRS guidance makes clear that an individual covered under an HDHP may still be an "eligible individual" for HSA tax benefit purposes even if the individual is covered by one of the following:

1. Separate coverage consisting of so-called "permitted insurance," (I.R.C. §223(c)(1)(B)(i)), which generally is defined as insurance benefits for (i) workers' compensation, (ii) tort liabilities, (iii) property liabilities; (iv) a specific disease or illness; or (v) a fixed amount per service/period for hospitalization (i.e., hospital indemnity);

2. Separate coverage for certain "excepted benefits," which include the following:

(i) accidents;
(ii) disability;
(iii) dental care;
(iv) vision care; or
(v) long-term care[12];

3. "Preventative care" services that are otherwise covered under the HDHP (or under a separate plan) but the employee costs for which are not subject to the HDHP deductible (I.R.C. §233(c)(2)(C); IRS Notice 2004-23);

4. Coverage under an "employee assistance plan" ("EAP"), provided that the EAP does not (i) provide "significant benefits" in the nature of medical care; (ii) coordinate benefits with any other group health plan; (iii) require employee contributions or premiums to participate; or (iv) require any cost sharing (IRS Notice 2004-50, Q&A-10); or

5. A discount card program that entitles an individual to obtain discounts for health care services or products at managed care market rates and requires the individual to pay the costs of the health care (taking into account the discount) until the deductible of the HDHP is satisfied (Notice 2004-50, Q-9, as updated and amended, as applicable).

[12] See I.R.C. §223(c)(1)(B)(ii)

In addition to the items above, the employee/participant in an HDHP and who contributes to an HSA may also have "other coverage" in the sense that they contribute to a Health FSA or is part of an HRA. An employee can make contributions to an HSA while covered under an HDHP and one or more of the following arrangements.

1. Limited-purpose health FSA or HRA. These arrangements can pay or reimburse the qualified medical expense items, except long-term care. Also, these arrangements can pay or reimburse preventive care expenses because they can be paid without having to satisfy the deductible.

2. Suspended HRA. Before the beginning of an HRA coverage period, you can elect to suspend the HRA. The HRA doesn't pay or reimburse, at any time, the medical expenses incurred during the suspension period except preventive care. When the suspension period ends, you are no longer eligible to make contributions to an HSA.

3. Post-deductible health FSA or HRA. These arrangements don't pay or reimburse any medical expenses incurred before the minimum annual deductible amount is met. The deductible for these arrangements doesn't have to be the same as the deductible for the HDHP, but benefits may not be provided before the minimum annual deductible amount is met.

4. Retirement HRA. This arrangement pays or reimburses only those medical expenses incurred after retirement. After retirement you are no longer eligible to make contributions to an HSA.

With respect to embedded and non-embedded deductible and the impact on HDHPs and HSAs, it is important to understand the difference as it relates to family coverages under an HDHP with an HSA[13]. For a "non-embedded/aggregate" deductible, services under the HDHP plan are subject to the plan deductible, but before payment may be made, the entire family deductible must be satisfied (i.e., the $2,700 deductible must be met at a minimum). For "embedded" deductibles, services under the HDHP plan are subject to the plan deductible, but once the individual deductible is met, the member does not have to wait for the entire family deductible to be satisfied before benefits are payable. Again, with family coverage, an embedded deductible allows for coinsurance to apply for a specific individual if he/she meets the individual deductible, even if the family has not yet met the family deductible. In a non-embedded plan, the entire family deductible must be met by one individual or a combination of individuals before the plan begins to pay.

[13] Single coverage or employee-only coverage is not impacted by embedded or non-embedded; it is only family coverage.

Per the rules and regulations, in order for the HDHP to remain an HSA-qualified plan[14], it cannot provide benefits until the required IRS minimum deductible is met (other than preventative care and the coverages provided above). When the HDHP has an embedded deductible, that minimum deductible must be at least $2,800 (the statutory minimum deductible for family coverage) because for those enrolled in family coverage, the plan begins to reimburse services when any one individual meets the deductible.

Given the analysis of the legal rules above, it is clear that an employer may provide an HDHP along with an HSA for the HDHP participants, as well as any ancillary or hospital/indemnity-based policy. With the CHI Platform, it is a Policy that sits alongside an employer's HDHP or other major medical coverage. However, the Policy provided by CHI is an ancillary policy and considered the same as any other hospital indemnity policies, as there are no coordination of benefits and such payments under the Policy occur regardless of the cost of medical coverage, with such payments/coverage amounts based on a period-basis, not a service basis.

IRS Memorandums

There has been requested information to expand upon the IRS memorandums that related to certain "wellness plans" provided back in 2017. Specifically, how CHI and its Platform relate to the IRS Memorandums 201622031, 201703013 and 201719025 ("IRS Memos"). As indicated above, this Memo relies upon Pierre Tax Group, LLC analysis 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." What is applicable is that the IRS rules in which this Memo does take into consideration is Rev. Rul. 69-154, as applicable.

With the understanding above, the Platform, which includes the Policy, which provides for fixed, per period claim payment for certain events that qualify as medical care under the rules and regulations. Given the nature of the Policy, certain benefits under the Policy may be paid in consecutive months or, possibly, each month if certain triggering events happen. With this, there has been concern that certain platforms and/or plans have not been set up correctly. Specifically, the IRS has provided certain memorandums related to indemnity plans. The following outlines the understanding related to those certain memorandums from the IRS.

[14] It is important to note that for purposes of this Memo, having a non-compliant HSA does not make the HDHP non-compliant, but rather the HSA is non-compliant as it relates to those individuals with HSA accounts under the HDHP plan. This becomes an individual/employee issue, not an employer-based issue or legal aspect.

- The previous IRS memorandums [15] relate to self-funded wellness arrangements, not true health indemnity plans ("HIP"), such as the Policy.
- With an IRS allowed self-funded indemnity plans, a transfer of risk associated with a HIP, the Policy may be afforded the same treatment just like any other fully insured policy provided by another carrier (i.e., Aflac, etc.) as long as there is a transfer of risk or a risk of loss in the Policy.
- Specifically, the HIP has a risk of loss based on the several fortuitous occurrence(s) of a stated contingency, such as a hospital visit, ambulance ride, physician visit and/or such other covered service like a health screening benefit. Moreover, given the fact that these covered services are included in the actual Policy itself, such covered services have been approved and all conditions of risk and loss based on each occurrence of a fortuitous occurrence of a stated contingency has been approved. Additionally, as stated above, there is risk that the Policy pays out more than what the premium amount received is for a policy.
- The inherent transfer of risk is not removed if the Policy benefits pursuant to the qualified covered services are paid directly to the individual/participant or through a third party (i.e., a third-party administrator or vis-à-vis an assignment of benefits, as long as such payments pursuant to the Policy are for covered services under the Policy) and reported in a qualified, compliant manner.

Again, as noted above, the Policy does not pay out a claim unless a covered service occurs. Otherwise, no claim payment is made to the individual participant. Even further, the covered benefits (i.e., Schedule of Benefits) under a HIP all require certain medical CPT/NPI codes or procedures, as normal with any insured health indemnity plan or medical plan. As such, no Policy benefits could be paid without proper documentation of a covered service happening. This further exemplifies the risk-shifting nature of the Policy itself.

Given the fact that the Platform is based on an apparent risk transfer in the Policy, the Policy may be afforded the same tax treatments similar to other health insurance products.

In light of the information above, it's straightforward for employers and employees/participants to take advantage of a cafeteria plan so that employees can pay for qualified benefits on a tax-free basis through employee salary reduction. Employee salary reduction amounts may be used to pay for their share of the employer's major medical plan, dental, or vision coverage and also to pay premiums for supplemental insurance policies, such as specified disease, hospital, cancer or other fixed indemnity health policies on a pretax basis. This includes the Policy, that

[15] The IRS memorandums are found at here: April 2016 Memo (https://www.irs.gov/pub/irs-wd/201622031.pdf); December 2016 Memo (https://www.irs.gov/pub/irs-wd/201703013.pdf); April 2017 Memo (https://www.irs.gov/pub/irs-wd/201719025.pdf). The IRS memorandums do confirm the long-standing rules as it relates to the taxation of excess benefits, pursuant to Rev. Proc. 69-154.

is allowed to be paid for pre-tax. Tax benefits of such pretax arrangements are straightforward and distinguishable from the tax gimmicks marketed under other "wellness plans" that have been in the marketplace and addressed in the IRS memorandums mentioned above.

The tax treatment of benefits paid under the Policy, as well as any other fully insured indemnity plan for the past 50-plus years, is well established and depends on whether the premium was paid on an after-tax or pretax basis.

- If the premiums for the Policy are paid by the individual on an after-tax basis, then the benefits received are not subject to tax.

- If the premiums are paid on a pretax basis through employer contributions or employee pretax salary reduction through a cafeteria plan, then whether the benefits are taxable depends on the individual's unreimbursed medical expenses. If the amount paid under the policy does not exceed the individual's related unreimbursed medical expenses, then the amount received is not includible in the employee's income. However, if the amount received under the fixed indemnity policy is more than the individual's (including his/her spouse or family) aggregated and related unreimbursed medical expenses, then the "excess benefit," meaning the amount in excess of such unreimbursed medical expenses, is taxable to the participant and reported by the individual on their applicable Form 1040. This follows long-standing guidance.

IRS Revenue Ruling 69-154 sets forth the "excess benefit" rule and includes some detailed examples. Under Revenue Ruling 69-154, determining the amount, if any, of taxable benefits under a fixed indemnity health policy paid for with pretax dollars involves a variety of factors which are known only to the employee (*and not the employer or insurer, as applicable*). These factors include what other fixed indemnity policies the individual has, the total amount of medical expenses and the amount of reimbursed medical expenses. If the employee has more than one fixed indemnity policy, such as a policy paid with post-tax dollars, the calculation may be more involved, as the employee may need to allocate expenses between the various policies. The employee will make this determination with their tax advisor when filing their personal income taxes for the year in question. Again, the insurance carrier nor is an employer (if self-funded) is not a position to know what is taxable or not and such taxation is based only on factors that are known by the employee/policyholder (not the insurance carrier or employer).[16] In particular, the April 2017 memo by the IRS

[16] This has been the view of the IRS and confirmed by the likes of other major indemnity carriers, such as Aflac and their outside counsel, Alston & Bird, as set forth at https://www.aflac.com/docs/employers/advisories/art.irs_clears_the_air_again_fixed_indemnity.oc.pdf. Specifically, they provide that under the longstanding rule of Rev. Rul. 69-154, *"[t]he taxation of benefits under fixed indemnity health policies is governed by IRS Code section 105(b). In 1969, the IRS issued an important ruling under this code section, Revenue Ruling 69-154. This ruling concluded that*

reconfirms the continued validity of Rev. Rul. 69-154 and that "*if an indemnity health policy is paid for by the employer or by the employee with pretax salary reduction funds,* benefits are excludable up to the amount of unreimbursed medical expenses. Stated differently, only the excess amount paid above unreimbursed medical expenses is taxable. Further, since some portion of the benefits may be received tax-free, and *neither the employer nor the insurer can know what that portion is, only the employee/ policyholder will know what amounts to include in income (excess benefits) and should report such amounts on their personal Form 1040. It's up to the employee/policyholder to identify and report any amount of excess benefits, including income on their personal Form 1040*."[17]

The April 2017 memo also has a helpful example of a traditional fixed indemnity health plan that pays fixed amounts on the occurrence of health events, such as a medical office visit or a hospital stay where the premiums for the policy are paid on a pretax basis through a cafeteria plan. In their example, the plan pays $200 for a medical office visit. If the covered individual's unreimbursed medical cost as a result of the visit is $30, then $30 is excluded from the employee's income and the excess amount of $170 is taxable, subject to the employee's other associated unreimbursed medical expenses, and reported by the individual on their Form 1040.

It is also important to note that for the Policy or another HIP to provide a benefit, an expense does not have to be associated with such covered service. For example, assume an employee has an HIP that pays $5,000 for a hospital visit, alongside his/her major medical high-deductible health plan ("HDHP"), which pays 100% after meeting a $3,000 deductible amount. With this, if the employee has already met his/her deductible, and then has a hospital visit occur (or such other covered service, as applicable), the employee would pay nothing for the hospital visit. However, the employee would be entitled to the $5,000 indemnity claim payment. Remember, there is no coordination of care between the employee's HDHP and the HIP. The question of whether or not the $5,000 claim payment is taxable continues to follow the long-standing IRS guidance and is determined by the employee-participant, based on his/her aggregated, unreimbursed medical expenses, as reported on his/her Form 1040. This has always been the case with HIP and has not changed since the 1969 ruling by the IRS.[18]

when a fixed indemnity health policy is paid for on a pretax basis, benefits are taxable only to the extent that they exceed the individual's unreimbursed medical expenses (i.e., only "excess benefits" are taxable). Under Revenue Ruling 69-154, determining the amount, if any, of taxable benefits under a fixed indemnity health policy paid for with pretax dollars involves a variety of factors that are known only to the employee (and not the employer or insurer). These factors include any other fixed indemnity health policies the individual has, the total amount of medical expenses and the amount of reimbursed medical expenses. If the employee has more than one fixed indemnity health policy, such as a policy paid with after-tax dollars, the calculation may be more involved, as the employee may need to allocate expenses between their various policies. The employee will make this determination with their tax advisor when filing their personal income taxes for the year in question.

[17] *See* footnote above. Emphasis added.

[18] It should be noted that even if there is a fully-insured policy, the fact that claim payments are made under an insurance policy does not change the tax analysis of such claim payment for the policyholder.

Given the specific points above, it may be reasonable to interpret that the Policy and/or the CHI Platform is a legal limited medical / fixed indemnity policy or program that an employer may provide, and that due to Section 125, allows for potentially favorable treatment of claim benefit payments as provided above.[19]

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

Again, as stated previously, if premiums for fixed indemnity insurance are made pre-tax, then the excess benefits may be taxable. Without being repetitive, the tax treatment of claim payments to a policy holder is not changed if a claim payment is made from an insurance carrier. There are some plans that provide that due to a claim payment being made from an insurance carrier, the payment is tax-free. First, that can only be the case if the premium is paid for on an after-tax basis. Secondly, if paid on a pre-tax basis, the federal tax analysis remains the same as provided for since 1969 and any "excess benefit" is taxable. This has been confirmed by multiple sources, including the IRS and other providers in the marketplace. See here at https://www.hubinternational.com/products/employee-benefits/compliance-bulletins/2020/06/double-dip-tax/ ([t]he … IRS … say neither a decision by a state Department of Insurance to treat a fixed indemnity product as insurance … will change the federal tax analysis). Furthermore, HUB also provides an example that the IRS has clarified that indemnity payments under health policies should be excludable from income up to the amount of unreimbursed medical care expenses incurred. This means that cash proceeds paid to a participant (when premiums were funded pre-tax) are only to be received tax-free up to the amount of the otherwise unreimbursed medical expenses. In other words, if a cancer policy pays a lump sum $50,000 upon diagnosis - the participant would only be entitled to tax-free receipt of that portion of $50,000 to which he could substantiate actual medical expenses. And, upon diagnosis and receipt of payment, the person could literally have no expenses at all. As such, the $50,000 could be subject to taxation as reported by policyholder on his/her Form 1040.

[19] 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 or employer-related taxes with indemnity claim payments. 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.

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.