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Thrive Preventive Care
555 Sun Valley Dr. Ste F-2
Roswell, GA 30076

Re: Thrive Preventive Care Preventive Care Program

To whom it may concern:

Wellness benefit programs, from simple to complex, are offered as benefits embedded into already existing programs (e.g., group health coverage, indemnity policy riders, life insurance and disability insurance riders, etc.), and some offered as stand-alone programs, an employer wanting to implement a wellness program has important decisions to make. One type of wellness program receiving increased attention is the "combination program" where multiple benefits, multiple providers, and multiple delivery methods are combined together to form an elite wellness program.

A combination program is defined by how it assembles the different parts (e.g., types of benefits, benefits subject to the Employee Retirement Income Security Act of 1974 ("ERISA"), benefits not subject to ERISA, benefits that may be taxable, benefits that may not be taxable, etc.) and underlying principles together in an order to accomplish a particular benefit result. Great care must be taken when reviewing such combination programs. Each combination program is unique, and each must be reviewed accordingly. There are many laws, regulations, applications of laws and regulations, regulatory statements, and enforcement efforts that leave room for differing opinions regarding the advisability of a particular combination program with respect to a particular employer. The unique combination program and principles made available through this combination program assembled by Thrive Preventive Care ; the Thrive Preventive Care Preventive Care Program is referred to herein as "the Program." This letter focuses on that Program.

Summary Statement
The Program about which Thrive Preventive Care has requested our legal opinion consists of various benefits made available together to form a very robust wellness plan, including a wellness education benefit, virtual primary care, virtual urgent care, virtual mental health care, discounted lab work, and a discounted prescription drug benefit. Disclaimer: This letter is not intended as a legal opinion from this firm to a purchaser or potential purchaser of the Program. Based upon our review of documentation provided, our discussions, and review of IRS statutory and regulatory guidance, the Program provides benefits of real value and provides access to other benefits of real value. **In this firm's opinion, the Program described below satisfies applicable IRS requirements.**

Documentation Reviewed. In preparing this opinion letter, the following documentation[1] was reviewed:

- Thrive Preventive Care Preventive Care Plan
- Thrive Preventive Care Cafeteria Plan
- Clients Services Agreement

In addition, the following information was reviewed:

- Internal Revenue Code of 1986 ("Code") Sections 105, 106, 125, and 213(d)
- Internal Revenue Service ("IRS") regulatory and sub-regulatory guidance, and informal IRS commentary[2] regarding Code sections and various applications of them

Assumptions. In addition, this opinion letter is based upon the following assumptions:

- The Program is, and will continue to be, properly documented and administered under the Code, ERISA, and the Affordable Care Act ("ACA").
- The cost of the Program for which the employee is responsible shall be paid by the employee on a pre-tax basis through a cafeteria plan under Section 125 of the Code.
- All benefits available through the cafeteria plan are "qualified benefits" for purposes of Section 125 of the Code.
- The employee's ability to waive participation in the Program satisfies the choice requirements under Section 125 of the Code.
- Collectively, the benefits operate as a participatory wellness plan.[3]
- To receive any benefits under the Program, the individual (e.g., employee, spouse, child(ren)) must be coverage under an ACA-compliant employer-sponsored group health plan.[4]
- The salary reduction contributions contributed through the cafeteria plan are treated as plan assets subject to the exclusive purpose rule to the extent the qualified benefits available through the cafeteria plan are subject to ERISA.
- The Program is a group health plan that is a covered entity for purposes of HIPAA Privacy and Security and, therefore, must be operated as such including use of business associate agreements.

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[1] This letter is based upon the listed documentation as of May 7, 2025. Should circumstances change following the issuance of this letter, those changes may impact the statement, conclusions, and/or representations made in this letter.

[2] Including non-binding remarks at the ECFC Conference in Washington, D.C, earlier this year and Chief Counsel Advice ("CCA") memoranda regarding double-dip arrangements.

[3] A participatory wellness programs is not subject to the requirements under HIPAA including nondiscrimination based on health status factor, alternative means of satisfying, notice requirements, and limitations on maximum benefits.

[4] Coverage under the Program includes medical care under Section 213 of the Code. Unless exempted, the coverage is minimum essential coverage under the ACA and must satisfy the ACA mandates. By design, the coverage does not meet the ACA mandates on a stand-alone basis (e.g., first dollar coverage for preventive care, no annual or lifetime maximums). As a result, the wellness portion of the Program must be "integrated with" coverage that meets the ACA mandates. The employer-sponsored group health coverage meets the ACA mandates. The Program needs to be integrated with that coverage. That means to be eligible for coverage under the Program, the employee and any spouse or child receiving benefits through the employee under the Program must also be covered under an employer's group health coverage. That coverage could be through an employer sponsoring the Program or another employer such as the spouse's employer group health coverage.

Based upon the documentation reviewed and the assumptions stated above, the Program complies with the IRS requirements as those requirements are currently being applied. This opinion letter reflects the legal opinion of this law firm based upon the above listed documents and assumptions, applicable law as of the date of the letter, and our experience working with participatory wellness plans, employer-sponsored benefit coverages, and cafeteria plans. If any of this information is outdated, not accurate, or incomplete, it may impact the opinion expressed herein. In addition, should the law or the application of it change, it may impact the opinion expressed herein.

Analysis

The Law. The Program involves benefits triggering requirements under the Affordable Care Act ("ACA"), the Employee Retirement Income Security Act of 1974 ("ERISA"), and the Internal Revenue Code of 1986, as amended, ("Code"). Application of these laws is summarized below.

The Program. The Program consists of a robust and an extensive self-insured wellness plan including many wellness benefits (e.g., programs, services, resources) provided through multiple vendors acting alone and together to benefit the Program participants, a cafeteria plan, and an internal ordering of how benefits are paid and provided through the Program.[5]

In simple terms, the employee that chooses to participate (the "Participant"), pays the cost of the Program (the "premium equivalent") on a pre-tax basis through the cafeteria plan. That payment of the cost of the Program provides the Participant with access to an extensive list of programs, services, and resources intended to reach a diverse spectrum of Participants' needs. At the individual level, a Participant has needs at the start of participation. Those needs change as the Participant progresses within the Program or experiences changes in personal circumstances (e.g., knee replacement, pregnancy, back problems, stress, etc.). At the collective level, different Participants have different challenges (e.g., medical, physical, mental, psychological, age, family) and different interests (e.g., exercise, nutrition, meditation, cooking, etc.). The Program has diverse services and resources to address diverse needs. In addition, throughout the Program participation experience, assistance, monitoring, and coaching is available to maximize the wellness potential for Participants. In return for participating, Participants are rewarded in multiple ways including financially through the receipt of wellness benefit payments.

The Wellness Benefits Portion of the Program

ERISA. The wellness benefits portion of the Program is an employer-sponsored group health plan subject to ERISA because the wellness benefits include benefits that provide or pay for "medical care" as defined under Section 213(d) of the Code. ERISA imposes many requirements on a plan including a written plan document, a summary plan description ("SPD"), qualified child medical support orders ("QMCSOs"), Form 5500 annual filing, claims and appeals procedures, identification of a named fiduciary, operation in accordance with plan

[5] Because (1) the Program qualifies as group health plan that is not excepted from having to provide the mandated preventive benefits under the ACA, and (2) the Program does not (and because of its design cannot) satisfy those ACA requirements on a stand-alone basis, the Program is integrated with a traditional employer-sponsored group health plan that does provide the mandated preventive benefits under the ACA. The Program can integrate (i.e., be considered together with) such an employer-sponsored group health plan with respect to the sponsoring employer of the Program or another employer. In other words, to be a Participant in the Program, the employee must be covered under an employer-sponsored group health plan that provides the mandated benefits under the ACA.

document, and protective treatment of plan assets. *The plan asset issue is discussed in more detail below*. The Program includes a written document that serves as the written plan document and SPD under ERISA for the wellness benefits portion of the Program.

The Code. In addition to requiring a separate written plan document (already addressed and met because of ERISA), Section 105(h) of the Code requires the wellness benefits portion of the Program to be nondiscriminatory with respect to both (1) eligibility to participate, and (2) benefits provided. The plan document for the wellness benefits portion of the Program reflects the application of the Section 105(h) nondiscrimination requirements.[6]

COBRA. The wellness benefits portion of the Program is considered a group health plan. Under ERISA and the Code, a group health plan is subject to federal continuation of coverage requirements (often referred to as "COBRA") provided the employer meets the "20-employee in the prior calendar year" threshold. The plan document for the wellness benefits portion of the Program reflects the application of COBRA for employers meeting the size threshold.

ACA Compliance – Integration Required. As noted above, the wellness benefits portion of the Program is considered a group health plan. Unless exempted, the group health plan is minimum essential coverage under the ACA and must satisfy the ACA mandates. By design, the wellness benefits portion of the Program does not meet the ACA mandates on a stand-alone basis (e.g., first dollar coverage for preventive care, no annual or lifetime maximums). Consequently, the wellness benefit portion of the Program needs to be integrated with employer-sponsored group health coverage that meets the ACA mandates. The employer that sponsors the Program must also offer an ACA-compliant group health coverage. This requirement applies regardless of the employer's size.[7]

To be eligible to participate in the Program, an employee must be covered under an employer-sponsored ACA compliant group health coverage. This can be the coverage offered by the employer that sponsor's the Program or, by plan design, an ACA-compliant group health coverage offered by another employer (e.g., employer of a spouse).[8] The written plan document for the wellness benefits portion of the Program reflects the ACA integration requirement.

The Cafeteria Plan

In addition to the wellness benefits portion of the Program, the Program also includes a cafeteria plan within the meaning of Section 125 of the Code. The Participant pays its share of the cost of participating in the wellness benefit portion of the Program (e.g., "premium equivalent") with pre-tax dollars through salary reduction under the cafeteria plan sponsored by the employer.[9] Section 125 of the Code requires the plan to be established and

[6] Section 105(h) requires the self-insured plan to be nondiscriminatory with respect to eligibility and benefits.

[7] Employers that are not "applicable large employers" potentially subject to penalties for failing to offer affordable health care, must nevertheless offer ACA-compliant group health coverage in order to have a plan with which the Program can integrate.

[8] The ACA compliant coverage must be employer sponsored group coverage. Individual coverage, Medicare, Medicaid, etc. are not employer sponsored group coverage.

[9] Proposed Regulations Section 1.125-1(b)(1). "Section 125 is the exclusive means by which an employer can offer employees an election between taxable and nontaxable benefits without the election itself resulting in inclusion in gross income by the employees."; Preamble "The new proposed regulations provide that unless a plan satisfies the requirements of section 125 and the regulations, the plan is not a cafeteria plan."

operated according to Section 125 of the Code and the regulations issued under that section. Failure to establish and operate a plan in accordance with Section 125 of the Code and the regulations issued under that section places the entire plan for all at risk.[10] This is not a situation where only the person or persons improperly benefitting are penalized. Following the requirements under Section 125 of the Code and the regulations are a "qualification" requirement.[11]

Cafeteria Plan -- Choice. In general, a cafeteria plan provides the Participant with the choice between certain non-taxable benefits and certain taxable benefits. Often, the available choice for the Participant is to (1) not receive benefits (i.e., waive coverage) and take taxable compensation because there is no salary reduction, or (2) receive benefits and pay for them pre-tax. If the employee chooses to participate in the wellness portion of the Program, the cost of that coverage must be paid by salary reduction through the cafeteria plan portion of the Program. The written plan document for the cafeteria plan portion of the Program reflects that the "choice" exists at the wellness benefits portion of the Program. It operates on a negative election basis. An eligible employee is automatically enrolled in the Program and then has the opportunity to waive participation.

Cafeteria Plan – Plan Year & Elections. A cafeteria plan operates on twelve month "plan year." A number of cafeteria plan requirements are tied to the plan year. As noted above, the "choice" required under a cafeteria plan is tied to coverage under the wellness benefits portion of the Program. Once an election is made (i.e., once the employee chooses to participate in the wellness benefits portion of the Program by not waiving coverage), that choice is generally irrevocable under the cafeteria plan.[12] The plan document for the cafeteria plan portion of the Program reflects the plan year, irrevocable elections, and exceptions to the irrevocable election rule.

Code Nondiscrimination Testing – Cafeteria Plan Portion of the Program. The cafeteria plan portion of the Program is subject to nondiscrimination requirements under Section 125 of the Code. They are different from the nondiscrimination requirements that apply to the wellness benefits portion of the Program. These nondiscrimination requirements are in addition to the nondiscrimination requirements of the "components," the benefits offered through the cafeteria plan. In other words, there are nondiscrimination requirements that apply ***in addition to*** the nondiscrimination requirements applicable to the wellness benefits portion of the Program under Section 105(h) of the Code. The plan document for the cafeteria plan portion of the Program reflects the application of the Section 125 nondiscrimination requirements.

ERISA Plan Assets. A key area of compliance involves ERISA and the Code; the identification and treatment of plan assets. Under ERISA, employee contributions are always plan assets, even when withheld from pay on a pre-tax basis through a cafeteria plan. In general, ERISA requires plan assets be held "in trust" which requires segregation, investment, and annual reporting. Complying with this requirement involves increased administration and increased cost. The Department of Labor ("DOL"), responsible for ERISA enforcement, issued Technical Release 92-01 that provides a limited nonenforcement exception to the trust requirement when

[10] Preamble "The new proposed regulations provide that unless a plan satisfies the requirements of Section 125 and the regulations, the plan is not a cafeteria plan."; Proposed Regulations Section 1.125-1(b)(1). If a plan does not follow the Section 125 requirements, the choice between cash (e.g., salary reduction) and a nontaxable benefit (e.g., group health coverage) triggers taxable income to the employee even if the employee chooses the nontaxable benefit.

[11] Preamble "The new proposed regulations provide that unless a plan satisfies the requirements of Section 125 and the regulations, the plan is not a cafeteria plan."

[12] The regulations provide recognized exceptions to the irrevocable election rule. Most are permissive and, therefore, must be reflected in the cafeteria plan document to be available.

certain requirements are met. Under Technical Release 92-01, a trust is not required when (1) the plan is primarily funded through a cafeteria plan, (2) the amounts withheld from pay remain commingled with employer general assets until used to pay benefits, and (3) there is no intermediate stopping point for the funds on their way to pay benefits.[13] The plan document for the cafeteria plan portion of the Program reflects that no trust is required, and that benefits are paid from the employer's general assets.

ERISA also requires that plan assets be used for the sole and exclusive purpose of providing benefits under the plan and paying reasonable administrative expenses. Even though the salary reductions are left commingled with the employer's general assets until they are paid in benefits under the plan, the employer needs to be able to account for the use of those dollars. If for any reason there are dollars remaining, they are forfeited because they are plan assets must be used to provide benefits and pay expenses. They cannot revert to the employer and they cannot be returned to the employee that forfeited them.

Benefits under the Program

Section 105 of the Code addresses the tax consequences of benefits received through the wellness benefits portion of the Program. Benefits received through the wellness benefits portion of the Program may be taxable or non-taxable to the Participant. In general, to be non-taxable to the Participant, the benefit received must be for Section 213(d) "medical care." Section 213(d) defines "medical care" in part to include expenses "for the **diagnosis**, **cure**, **mitigation**, **treatment**, or **prevention** of disease, or for the purpose of affecting any structure or function of the body." A number of additional special rules add or subtract to the general rule. A significant additional rule relates to expenses for general health and wellbeing. Although health related, general health and wellbeing expenses are not Section 213(d) "medical care."[14] Most of the activities made available through the wellness benefits portion of the Program have CPT codes indicating the activity is medical or diagnostic in nature.

With respect to the benefits available through the wellness benefits portion of the Program, there are two categories. The first category is the benefit payment for participating in a basic activity each month. In this case, the basic activity is reviewing an article or other reference piece sent to the Participant electronically. The Participant needs to open and review the materials. The materials address topics of general concern and relate to the various other wellness benefits available through the wellness benefits portion of the Program. For example, an article sent electronically may address obesity and the impacts it has on quality of life now and in retirement. By participating in this monthly event, the Participant receives the benefit payment. The occurrence of the monthly event "triggers" the Participant's entitlement to a benefit payment. The amount of the payment bears no relationship to the value of the activity itself. For ease of administration and to keep costs down, the payment under the wellness benefits portion of the Program is added to a Participant's

[13] Technically, the last requirement would require a trust when funds are gathered by a third-party administrator ("TPA") and then forwarded to vendors of services. However, it is common industry practice for a TPA to gather the funds from employers and hold them for a "mere moment in time" to combine and send to vendors. From an operational standpoint, if the TPA must take possession, it should be for no more than a mere moment in time for purposes of gathering and forwarding to vendors. This should be reflected in the services agreement with the TPA.

[14] A criticism of including indemnity insurance policies is that promoters have assumed that any benefit paid through such an insurance policy is nontaxable. That thought process ignores the requirement that the benefits paid through any benefit program must be evaluated on their own regarding whether they result in taxable compensation. If the expense is an expense for "medical care" that is not provided elsewhere, it is not taxable. However, if the expense is "health related" or "for general health and well-being," the expense is taxable; it is not "medical care" within the meaning of Section 213(d) of the Code.

paycheck through the payroll process rather than by cutting separate checks to each Participant at the same time as each paycheck is issued.[15] The second category of benefits available through the wellness benefits portion of the Program is the access to the extensive menu of programs, services, and resource materials available to Participants. Although voluntary, for Participants that are interested in addressing a diagnosed medical condition, changing habits, living a healthier lifestyle, or just suggestions on losing or maintaining weight, there are many options to encourage widespread additional participation. The written plan document for the wellness benefits portion of the Program reflects the two categories of wellness benefits.

Treatment of the Benefit Payment

The treatment of the benefit payment under the wellness benefits portion of the Program occurs as follows:

1. As noted above, the Program consists of two types of wellness activities, activities done once at the start of the month and other wellness activities. Once an individual experiences the monthly activity (the "trigger event"), the individual earns a benefit payment. The amount of the benefit payment is unrelated to the value of the trigger event. It is simply a benefit payment that is awarded once a particular trigger event occurs.

2. The benefit payment is not immediately taxable when made. The determination of whether any portion of the benefit payment is taxable income occurs following the end of the tax year. The unreimbursed[16] Section 213(d) medical care expenses for the tax year "offset" the taxability of the benefit payments received during that same tax year. The individual has taxable income to the extent the sum of unreimbursed Section 213(d) medical care expenses for the tax year is less than the total benefit payments received under the Program for the same tax year. The individual has no taxable income to the extent the sum of unreimbursed Section 213(d) medical expense for the tax year equals or exceeds the total benefit payments received under the Program for the same tax year.

3. The Program's "systems" track the individual's participation in the wellness activities available through the Program over the course of the tax year. As noted above, most of the activities through the Program have CPT codes that indicate the activity is medical or diagnostic in nature. The systems also track the value of the activities with such CPT codes.

4. In addition, the Program's "systems" allow the Participant to upload unreimbursed Section 213(d) medical expenses (including key information regarding the expenses) that have been incurred during the tax year outside of the Program (e.g., orthodontia, eyeglasses, amounts paid due to a deductible under an employer's group health plan, etc.).

5. After the end of the tax year, the individual can print a list of expenses incurred during the tax year and identify which are Section 213(d) medical care expenses that have not been reimbursed elsewhere or claimed as a tax deduction. The individual compares that list to the total benefit payments for the same tax year. Taxable income only occurs to the extent the unreimbursed Section

[15] This is relatively easy and cost effective because the salary reduction amounts through the cafeteria plan portion of the Program remain in the employer's general assets to take advantage of DOL Tech. Rel. 92-01.

[16] "Unreimbursed" refers to not having been submitted for reimbursement or payment from another source. Other sources include a health spending account, health reimbursement account ("HRA"), other insurance, etc. The Participant also cannot claim the expense as a tax deduction on its tax returns.

213(d) medical expenses are less than the total benefit payments under the Program for the same tax year.

This tax treatment is analogous to the tax treatment described in IRS Rev. Rul. 69-154, Situation 3.[17] Applying this approach to the wellness benefits portion of the Program means in many cases, there will be no tax consequence to the Participant.

Legal Services Protection

To provide added comfort regarding the Program as described above, Legal Services Protection is provided consisting of $500,000 of legal support services for the employer, and $10,000 of legal support services for each Participant. This protection is provided because an employer has chosen to implement the Thrive Preventive Care Preventive Care Program described in this opinion letter.

Closing

With respect to the benefits (e.g., programs, services, resources, etc.) provided and available through the Program, the emphasis is on the expansive wellness portion of the Program. With respect to the documentation and operations supporting the Program, the emphasis is on compliance with the major areas: the ACA, ERISA, and the Code. These areas of emphasis are further supported by the Legal Services Protection.

Very truly yours,

Darcy L. Hitesman

DLH:tbm

[17] Rev. Rul. 69-154 (https://www.irs.gov/pub/irs-drop/rr-69-154.pdf) describes the tax consequences when employer paid coverage received due to a trigger event is more than the medical expenses (i.e., "excess indemnification"). As is often the case, to illustrate the concept, examples are included. Situation 3 describes a situation in which the employee had an employer paid policy and a personal policy. The trigger event occurred resulting in the employee receiving more than actual medical expenses. However, the situation made it clear that the personal policy was not included in the excess indemnification calculation because the employee paid that on its own. Only the employer paid policy was considered for purposes of whether there was excess indemnification that had to be included as taxable income. That situation illustrates what happens when there is only one employer paid indemnity policy. The amount paid because of the trigger is compared to the amount paid by the individual for medical care. The excess indemnification that was not offset by medical care was all that was taxable to the employee. As with Situation 3, the Program has an event that triggered a payment of an amount unrelated to the cost of the trigger event, and only when the amount paid that is greater than the medical cost of the trigger event, is the excess taxable. Following the approach set out in Rev. Rul. 69-154 and further illustrated by Situation 3.