# INTRODUCING
## VITAL110

HEALTH COMPASS INC.

www.healthcompassinc.com

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# INTRODUCTION

Health Compass is the program owner of the Vital110 plan. This plan aims to provide businesses and individuals with preventative care health insurance. Health Compass exclusively partners with The Ark Group, a national insurance brokerage and third-party administrator based in Omaha, Nebraska, with over 80 years of industry experience.

Health Compass has leveraged state-of-the-art technology and built excellent healthcare services to deliver the game changing health plan: **Vital110**. Our compliance department licenses and trains all Health Compass agents. The Vital110 Plan is unique in that it provides continuous medical monitoring and an open claim process to ensure compliance with federal regulations and avoid problems associated with excess benefits concerning tax deductibility.

The **Vital110** program is explained in detail in the summary plan description and Participant Enrollment Guide provided to all Agents. Health Compass has developed a comprehensive training program for Agents and solicitors, including weekly continuing education and an in-person certification requirement. This certification aims to ensure compliance and provide a thorough understanding of the Vital110 program.

Health Compass Agents must have a Health and Life Insurance license and review and execute the Health Compass Agent Agreement, abiding by all policies and procedures. Once certified and licensed, Health Compass agents can introduce, educate, and effectively present to their clients and prospects. Health Compass provides all underwriting and sales implementation infrastructure to assist agents in closing and long-term customer service for all Vital110 clients.

The Vital110 plan is a revolutionary approach to healthcare management and insurance, offering a range of benefits to both employers and employees. Health Compass has taken a conservative approach to implementing the **Vital110** program, ensuring compliance with federal regulations and avoiding potential liabilities to clients and agencies in the long term. Health Compass's partnership with The Ark Group has allowed them to develop a comprehensive training program for agents and solicitors, ensuring they have a deep and thorough understanding of the Vital110 program. Health Compass will continue to release compliant materials as they become available and encourages Agents to take advantage of this exciting opportunity to implement this game-changing program.

# HISTORY & THE CURRENT INDUSTRY

The Affordable Care Act (ACA) introduced various health insurance models with unique benefits and drawbacks, including participatory wellness plans, fixed indemnity plans, and programs emphasizing continuous care and preventive health. While participatory wellness plans encourage active health management, they often result in excess benefits that may lead to unfavorable tax implications for beneficiaries, as these benefits can be taxable income. Similarly, fixed indemnity plans, which provide set payments for specific medical services, may not cover the full extent of healthcare costs, leading to inefficiency and potential financial strain on individuals. In contrast, programs that focus on open continuous claims and utilize continuous care monitoring applications, coupled with effective Current Procedural Terminology (CPT) code claim submissions, receive more favorable tax treatment. These programs are designed to ensure comprehensive coverage and facilitate ongoing care management, which can lead to more efficient healthcare delivery and better health outcomes. This thesis will evaluate these models in the context of their tax implications, efficiency, and alignment with the ACA's goals. It will critically assess the potential financial impacts on individuals and the healthcare system. It will explore how the tax treatment of excess benefits in wellness and indemnity plans compares with the more favorable provisions for continuous care models.

In evaluating the legal standing of a preventative-only Minimum Essential Coverage (MEC) health insurance program against current indemnification programs and self-funded insurance plans, the ACA's regulatory framework must be considered. The ACA advocates for insurance models prioritizing preventive care and continuous health management to enhance public health outcomes and reduce long-term healthcare costs.

By focusing on preventive services, a preventative-only MEC plan aligns with the ACA's minimum essential coverage criteria, thus holding legal validity. These plans aim to cover a range of preventive services without imposing copayments, co-insurance, or deductibles, meeting the ACA's mandate for essential health benefits.

Conversely, indemnification programs offer set payments for specific diseases or injuries and may not provide comprehensive coverage, potentially leading to significant out-of-pocket costs for beneficiaries. While these programs are legal, they may fall short of the ACA's comprehensive coverage standards and are less effective in promoting preventive care. Moreover, when premiums are paid for acute care services that are not utilized, this can lead to an "excess benefits" issue. Such excess benefits may result in unfavorable tax implications, potentially invalidating the tax deductibility of the premiums paid and creating financial liabilities for the plan sponsors.

# HISTORY AND THE CURRENT INDUSTRY

Although self-funded plans, wherein employers directly bear healthcare costs, are exempt from specific ACA mandates, they are still required to cover preventive care without cost-sharing. These plans can emphasize preventive care, thus supporting the ACA's focus on continuous and preventive health management.

However, allocating premiums toward unused acute care services can generate excess benefits in self-funded and indemnification plans. This scenario may lead to adverse tax consequences, undermining premiums' tax deductibility and introducing potential liabilities for plan sponsors. These complexities necessitate careful plan structuring to ensure compliance with ACA regulations and avoid financial and legal repercussions.

Therefore, while a preventative only MEC health insurance program is legally sound and supportive of the ACA's preventive care ethos, its comparative value must be measured against the broader coverage and potential financial implications of indemnification and self-funded plans. Health insurance models under the ACA should promote preventive care and provide comprehensive health services to avoid legal and financial pitfalls associated with excess benefits and maintain tax advantages.

When juxtaposed with indemnification and self-funded plans, a preventative only MEC program's legal and financial integrity hinges on its adherence to ACA guidelines and ability to circumvent the challenges of excess benefits and tax compliance, ensuring comprehensive and continuous healthcare coverage.

# UNDERSTANDING CURRENT WELLNESS PROGRAMS AND POTENTIAL PITFALLS


## FIXED INDEMNITY PLANS: PLAN DESIGN AND COMPLIANCE ISSUES

The issue of taxation of fixed indemnity plan premiums is complicated when such premiums are pre-taxed and treated similarly to disability insurance, resulting in taxable benefits. This challenge becomes even more complex when claims are based on the insured's adjusted gross income (A.G.I.), with healthcare deductions set at 7.5% of A.G.I. However, carriers, plans, or brokers can find it challenging to accurately determine each employee's A.G.I., leading to the need for 1099 forms for taxable claims.

The issuance of 1099s for indemnity claims is a recurrent issue in the insurance industry. Carriers often choose not to issue 1099s for these claims, which means the responsibility of reporting and paying taxes is transferred to the employee and their tax professional. This practice can be seen as an evasion of the carrier's legal obligations, creating a significant challenge in the compliance process.

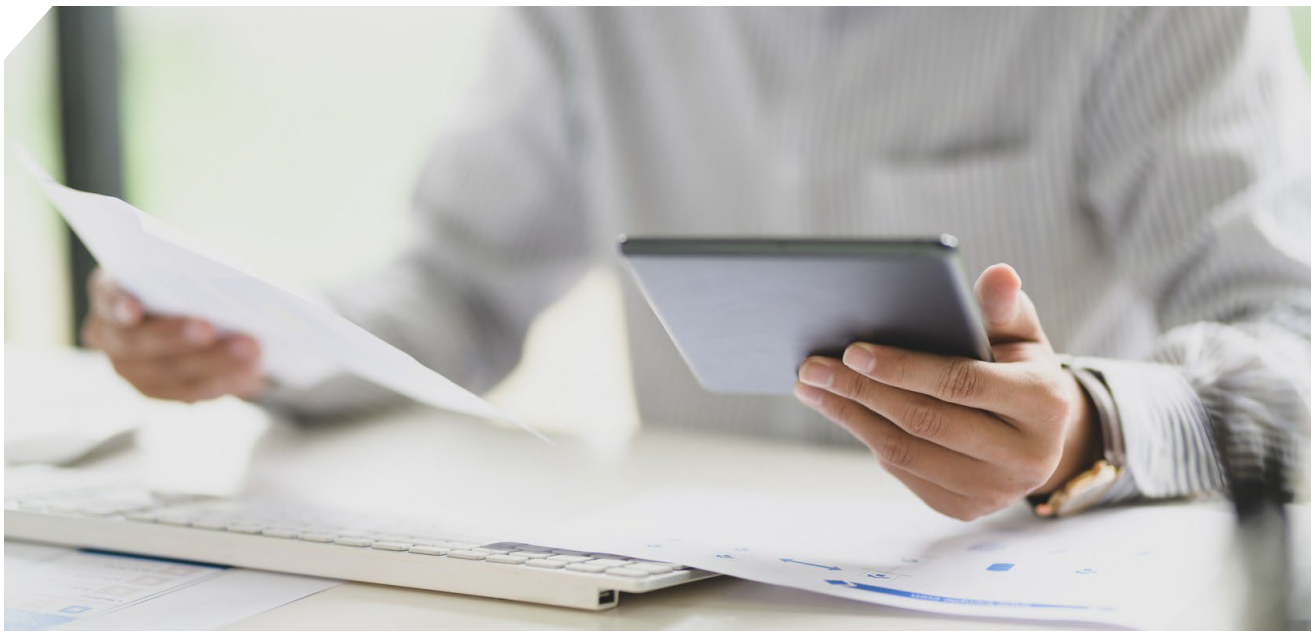
Carriers' reluctance to issue 1099s for indemnity claims can burden employees and their tax professionals, who may lack the knowledge and resources to report these payments accurately. Non-compliance with tax regulations can result in penalties and fines, which can be detrimental to both the carrier and the employee.

To address this issue, carriers could consider taking a more proactive role in educating employees and tax professionals about their responsibilities for reporting and paying taxes on indemnity payments. This might involve offering clear guidance on the reporting process and resources to help them navigate the tax code. By doing so, carriers can help ensure that all parties involved meet their obligations, mitigate the risk of non-compliance, and foster a more collaborative and compliant business environment.

The substantiation of claims in fixed indemnity plans is a complex issue, particularly the alignment of C.P.T. codes with the actual healthcare services rendered. Claim payment amounts do not consistently reflect the service's value, and the legitimacy of claim payments under these plans is problematic, especially for moderate to low healthcare utilizers.

Fixed indemnity plans require specified activities to be completed, usually every quarter. These activities are referred to in the insurance industry as benefit triggers. The issue with this plan design style is the timing of when the benefit trigger(s) is executed. These plan designs pay a monthly claim payment but only require that benefit triggers be completed once per quarter. A claim paid in a month where no benefit trigger(s) was executed cannot be considered legitimate. The absence of a triggering event, yet a claim is still being made, does not meet the definition of an insurance claim.

# UNDERSTANDING THE CURRENT WELLNESS PROGRAMS & POTENTIAL PITFALLS



As mentioned in the previous section, the actual value of the benefit triggers in these plan designs has been embellished. For example, paying a monthly claim of $800 or greater would require corresponding C.P.T. codes to substantiate the benefit paid. An acute care telemedicine visit, with primary health risk assessments and specific C.P.T. codes, does not reflect reimbursable amounts that correspond with those codes. The reimbursable amounts based on the appropriate C.P.T. codes are significantly lower than what would substantiate the claim payment made in these plan designs.

Fixed indemnity plans may lack the necessary legal documentation, such as Section 125 plan documents, Wrap Documents, and 5500 Form filings, which are essential for compliance, particularly for larger organizations.

Marketing these plans by highlighting FICA tax savings raises significant compliance and ethical concerns reminiscent of problematic practices in other insurance domains. The history of market conduct in the pension plan marketplace substantiates this.

Further compliance issues have stemmed from the marketing of these plans by non-insurance-licensed individuals or entities. This style plan falls under a state health insurance licensing requirement, and an agent must be licensed in the employer's domicile.

# SELF-FUNDED PLANS:

## DESIGN & COMPLIANCE ISSUES

The issue with a self-funded, participatory wellness plan design is that most entities who have created this plan do not seem to understand the concept of insurance or risk. Self-funding is not considered traditional insurance; it must meet the definition of insurance in its execution, which requires the actual transference of risk. These specific plan types do not meet the definition as there is no actual risk transference.

A risk is an event that will cause some financial loss where an insured has little to no control over the outcome. In these plan designs, a covered person voluntarily enrolls in a plan that doesn't define the risk. The potential financial loss communicated to the covered person is that should they fail to comply with required activities, they could be taxed on the premium they paid previously via pretax deduction. This does not meet the definition of insurance.

Self-funded plans are generally not required to provide 1099 for any claim payment, as they are typically considered reimbursement plans.

The legitimacy of claim payments under these plans is problematic, especially for moderate to low healthcare utilizers, just like the Fixed Indemnity style products. These plans require specified activities to be completed, usually every quarter. These activities are referred to in the insurance industry as benefit triggers. The issue with this plan design style is the timing of when the benefit trigger(s) is executed. These plan designs pay a monthly claim payment but only require that benefit triggers be completed once per quarter. A claim paid in a month where no benefit trigger(s) was executed cannot be considered legitimate. The absence of a triggering event, yet a claim is still being made, does not meet the definition of an insurance claim.

As mentioned in the previous section, the actual value of the benefit triggers in these plan designs has been embellished. For example, paying a monthly claim of $800 or greater would require corresponding C.P.T. codes to substantiate the benefit paid. An acute care telemedicine visit, with basic health risk assessments and specific C.P.T. codes, does not reflect reimbursable amounts that correspond with those codes. The reimbursable amounts based on the appropriate C.P.T. codes are significantly lower than what would substantiate the claim payment made in these plan designs.

# SELF-FUNDED PLANS: DESIGN & COMPLIANCE ISSUES


One of the most important yet least documented issues in this plan design is that once the purported claim has been paid, it would still be subject to excess benefit taxation. Excess benefits are the excess, if any, of the aggregate cost of the applicable coverage to the employee for the month over the applicable dollar limit for the month. In other words, the amount of the claim that exceeds the actual cost of care is subject to income tax.

Self-funded plans may lack the necessary legal documentation, such as Section 125 plan documents, Wrap Documents, and 5500 Form filings, which are essential for compliance, particularly for larger organizations.

Marketing these plans by highlighting FICA tax savings raises significant compliance and ethical concerns reminiscent of the problematic practices in other insurance domains, just like the fixed indemnity versions of what could be construed as similar plan designs but are fundamentally not the same whatsoever. Further compliance issues have stemmed from the marketing of these plans by non-insurance licensed individuals or entities. This style plan falls under a state health insurance licensing requirement, and an agent must be licensed in the domicile state of the employer.

# WHAT IS A MEC?

## MINIMUM ESSENTIAL COVERAGE (MEC) PROGRAM

Under the Affordable Care Act (A.C.A.), MEC is the type of health coverage an individual must have to meet the shared responsibility provision. The requirement for MEC is outlined in Section 5000A(f) of the Internal Revenue Code (I.R.C.).

Under the employer mandate (I.R.C. Section 4980H), employers must provide MEC to at least 95% of their full-time employees and dependents.

MEC plans must cover a set of health care services, which include preventive and wellness services.

Implementing an MEC program typically involves structuring the plan to comply with A.C.A. mandates while being cost-effective for employers. Some employers use MEC plans as a base layer of coverage, supplemented by additional insurance products to create a comprehensive benefits package.

An example of MEC implementation is a large retail chain that introduced an MEC plan to provide preventive care and wellness services to its part-time employees. This strategy allowed the company to comply with A.C.A. requirements while managing healthcare costs.

Another instance involves a public-sector employer implementing an MEC plan to ensure all employees have access to essential health services, emphasizing preventive care and chronic disease management. Thus, overall healthcare expenditures were reduced over time.

Legal challenges to MEC plans often revolve around compliance with A.C.A. mandates. In King v. Burwell (2015), the U.S. Supreme Court upheld provisions of the A.C.A. that allowed for subsidies in federal exchanges, indirectly affirming the importance of MEC in meeting the law's coverage requirements.

In Hobby Lobby Stores, Inc. v. Sebelius* (2014), the Supreme Court ruled that certain businesses could be exempt from providing these contraception insurance coverage under their MEC plans if doing so violated their owners' religious beliefs. This case showcases the tension between regulatory mandates and individual rights.

# PREVENTION ONLY:

## A MEC PLAN VARIANT

A preventive care-only Minimum Essential Coverage (MEC) plan is a type of health insurance plan that specifically covers preventive services as defined under the Affordable Care Act (ACA). While it provides less comprehensive coverage than a major medical health plan, it meets the ACA's requirements for having minimum essential coverage.

Here are the typical services covered under such a plan:

**Immunizations:**
Vaccines recommended by the Advisory Committee on Immunization Practices.

**Preventive Care Screenings:**
For adults, these can include screenings for blood pressure, cholesterol, colorectal cancer, and other conditions.

**Counseling Services:**
Counseling on topics such as quitting smoking, healthy eating, and substance abuse prevention.

**Wellness Visits:**
Annual physical exams and other routine health check-ups.

**Screenings for Children:**
Including pediatric screenings for vision, hearing, and developmental disorders, as well as immunizations and other preventive services recommended for children.

**Women's Health Services:**
Including mammograms, cervical cancer screening, prenatal care, and other women-specific preventive services.

# PREVENTION ONLY: A MEC PLAN VARIANT

Preventive care-only MEC plans are designed to fulfill the individual mandate of the ACA, which requires most Americans to have health insurance. They help prevent diseases and detect health issues early when they are easier to treat. However, it's important to note that these plans do not cover treatment if you become sick or injured; they only cover preventive services.

A plan to be considered MEC doesn't necessarily need to cover all the essential health benefits listed under the ACA. Still, it must cover at least preventive services without cost-sharing. Employers often offer these plans to provide employees with the minimum level of coverage required by law and to avoid penalties for failing to provide health insurance.

Self-funded preventative-only Minimum Essential Coverage (MEC) plans can be tax-deductible for employers because the premiums paid towards health insurance are considered a business expense. Here's how this works and the process for managing these deductions within an employer's payroll, along with the mechanism for the same payroll cycle Current Procedural Terminology (CPT) code assignment and reimbursement to the employee:

## Tax Deductibility:

When an employer funds a health insurance plan, including a preventative only MEC plan, the contributions made towards the plan are tax-deductible as a business expense. This reduces the employer's taxable income, resulting in tax savings.

## Payroll Process for Deductions:

Employers integrate the cost of the health plan into their payroll system. They must also keep track of each employee's contributions to the health plan, which are recorded as a business expense in the employer's financial records. The amount spent on health insurance, including self-funded MEC plans, is deducted from the employer's gross income when calculating taxable income.

## CPT Code Assignment and Reimbursement:

- Same Payroll Cycle CPT Code Assignment: Employers can assign CPT codes for the preventive services covered under the plan within the same payroll cycle. This assignment helps categorize and track healthcare services provided to employees.
- Assignment of Benefits and Reimbursement: The assignment of benefits is when the employee authorizes the insurer or plan administrator to reimburse the employer directly for the cost of the preventive services. When a healthcare provider renders a service to an employee, they submit a claim with the CPT code to the employer or plan administrator. Through the self-funded MEC plan, the employer reimburses the employee or pays the provider directly for the cost of the preventive service.

This process ensures that employees receive the preventive care benefits of the MEC plan while allowing employers to manage these benefits cost-effectively and maintain their tax-advantaged status. The detailed tracking and assignment of CPT codes facilitate the financial management of these benefits, ensuring accurate accounting and reimbursement for the services provided under the plan.

Given the complexity surrounding running a self-funded plan, the question becomes: "Can a third-party administrator provide for implementing this plan on behalf of the employer? Could the employer deduct the cost of the premium from such a plan to the payroll and then get a claim payment back, thus creating overall tax savings and not reducing the employee's net paycheck?

A Third-Party Administrator (TPA) can indeed facilitate the implementation of a self-funded preventative-only Minimum Essential Coverage (MEC) plan on behalf of the employer. The TPA's role includes coordinating with plan vendors and partners, processing pharmacy and medical claims, and ensuring the plan is managed correctly. Employers may contract with a TPA to gain greater control over plan design and benefit coverage options, access utilization data, and price transparency (OneDigital) (Association Health Plans).

Regarding the financial aspects of such plans, employers can deduct the cost of premiums for the health plan as a business expense, reducing their taxable income. Suppose the plan structure allows for reimbursements (for example, in a Health Reimbursement Arrangement or HRA). In that case, the employer can reimburse the employees for eligible healthcare expenses, which can be tax-advantaged for both parties. This arrangement doesn't reduce the employee's net paycheck and offers potential tax savings for the employer.

The specifics of how the deductions and reimbursements are handled in payroll would depend on the plan's structure and the agreement with the TPA. Generally, the TPA will manage the administrative tasks, including claims processing and reimbursements, according to the plan's rules and regulations, ensuring compliance with federal laws like ERISA (Employee Retirement Income Security Act) (Hnas).

To align with the law and benefit from tax advantages, the setup must comply with IRS and Department of Labor regulations governing self-funded health plans and related tax implications. Employers considering this approach should consult with legal and tax professionals to ensure the structure of their health plan and the operation of the TPA adhere to all applicable laws and regulations.

# ANALYSIS OF Vital110

## AS A SELF-FUNDED, PREVENTIVE CARE MINIMUM ESSENTIAL COVERAGE (MEC)


### 1. Introduction to Self-Funded MEC Plans under the ACA

Under the Affordable Care Act (ACA), a self-funded Minimum Essential Coverage (MEC) plan is an employer-provided health insurance plan that covers the minimum health services required by law. These plans must include preventive and wellness services, chronic disease management, and other essential health benefits. Employers choose self-funded MEC plans to manage costs while complying with ACA mandates.

### 2. Elements of a Self-Funded MEC Plan

A self-funded MEC plan must cover the ACA's essential health benefits, including preventive services, emergency services, hospitalization, maternity care, mental health services, prescription drugs, rehabilitative services, laboratory services, preventive and wellness services, and pediatric services. These plans are exempt from annual or lifetime coverage limits and cannot exclude pre-existing conditions.


### 3. Tax Deductibility and Payroll Processing

Employers can deduct premiums paid for self-funded MEC plans as business expenses, reducing taxable income. In payroll processing, employee contributions to the plan can be managed pre-tax, resulting in tax savings for employers and employees.

## 4. Preventative Care Only MEC Plan: Vital110

Vital110 is a self-funded MEC plan that focuses on preventative care. It fulfills ACA requirements by covering a range of preventive services without cost-sharing. This plan aims to detect health issues early and prevent diseases, aligning with the ACA's emphasis on preventive health care.

## 5. Role and Services of the Third-Party Administrator: The Ark Group

The Ark Group, the Third-Party Administrator (TPA), will manage Vital110. TPAs like the Ark Group handle the administrative aspects of health plans, including claim processing, compliance with healthcare laws, and coordination with healthcare providers and other vendors. The Ark Group will ensure Vital110 operates efficiently.


## 6. Financial Mechanics and Tax Advantages

Employers can deduct Vital110 contributions as business expenses, providing tax advantages. Additionally, through arrangements like Health Reimbursement Arrangements (HRAs), employers can reimburse employees for out-of-pocket medical expenses, further leveraging tax benefits and maintaining employees' net paycheck value.

## 7. Compliance and Legal Considerations

The Health Compass Vital110 Plan must comply with federal regulations such as ERISA. This compliance includes fiduciary responsibilities, plan documentation, and adherence to specific healthcare mandates. Health Compass expertise will ensure that Vital110 adheres to these legal and regulatory requirements, providing a seamless healthcare benefit to employees.

Implementing Vital110 as a self-funded, preventive care MEC plan through Health Compass allows the organization to provide essential health benefits to employees, manage costs, and comply with the ACA.

# VITAL110: FEATURES AND COMPLIANCE

## Not a Participatory Wellness Plan

Vital110 is a Group Health Plan with a MEC foundation featuring a comprehensive care management system. It is not classified as a Participatory Wellness Plan.

## A.C.A. Compliance and Integration

The healthcare plan complies with the Affordable Care Act (A.C.A.) regulations. It is specifically designed to integrate seamlessly with the existing major medical plans. The primary objective of this plan is to reduce the overall healthcare costs and claims by focusing on wellness and illness prevention. The plan is carefully crafted to provide comprehensive healthcare coverage, including preventive care, routine check-ups, and illness management. This plan aims to help individuals maintain good health, avoid serious illnesses, and reduce the need for expensive medical procedures by prioritizing preventive care. Overall, this healthcare plan is a cost-effective and efficient way to ensure good health and well-being for everyone.

Unlike traditional wellness plans, Vital110 offers a clear and substantiated return on investment, providing extensive care management services and remote patient monitoring.

## Lab Benefits and Cost Efficiency

Participants benefit from significant cost savings in lab work, with the plan absorbing these costs, thereby reducing expenses for the underlying health plan.

## Technology and Care Management

The plan utilizes advanced technology, such as smartphones and apps for remote monitoring and facial recognition, to ensure continuous and proactive healthcare management.

# VITAL 110:FEATURES AND COMPLIANCE

Participatory Wellness Plans and MEC programs represent significant components of the U.S. healthcare system, each with distinct regulatory challenges and compliance requirements. Fixed indemnity and self-funded plans must navigate complex legal frameworks to ensure their offerings are compliant and substantiated. MEC programs, mandated by the A.C.A., are crucial for meeting national health coverage standards, with legal precedents underscoring their importance and guiding their implementation. This memorandum elucidates the intricate legal and regulatory environment governing these healthcare models, providing a foundation for understanding their operational and legal intricacies.

# PLAN AND PAYROLL IMPLEMENTATION

## PAYCHECK EXAMPLE

### Step 1: Enrollment in the Vital110 M.E.C. Program

Employees enroll in the Vital110 M.E.C. program during the open enrollment period and use it as their primary or supplementary health plan. This program is self-funded and voluntary, aligning with M.E.C. requirements under the A.C.A.

### Step 2: Detailed Payroll Deduction and Credit Process

For an employee earning $50,000 annually, the monthly pre-tax income is approximately $4,166.67. If the M.E.C. program costs $800 monthly, this amount is deducted pre-tax from the payroll, reducing the taxable income.

### Step 3: Submitting Claims and Using the Smartphone Application

Participants submit claims for preventative healthcare expenses through a smartphone app provided by the T.P.A., Ark Group. This app supports an ongoing open claim process for efficient healthcare expense management.

### Step 4: Claim Processing and Immediate Reimbursement

Ark Group processes claims quickly, ensuring that the $800 used for the M.E.C. program is reimbursed to the employee within the same pay cycle, maintaining the net paycheck.

### Step 5: Tax Savings Calculation and A.C.A. Compliance

The pre-tax deduction of the M.E.C. program cost ($800) reduces the taxable income from $4,166.67 to $3,366.67 monthly. Over a year, this can significantly decrease the total taxable income, leading to tax savings. Assuming a 22% tax bracket, the monthly tax saving on the $800 would be approximately $176.

# PLAN AND PAYROLL IMPLEMENTATION

## Paycheck Example

- Gross Monthly Income: $4,166.67
- M.E.C. Program Deduction: $800
- Taxable Income After Deduction: $3,366.67
- Tax Savings (at 22% tax rate): $176.00.
- Net Income After Reimbursement: Same as gross income minus taxes on reduced taxable income

In this example, the employee benefits from reduced taxable income due to the pre-tax deduction for the M.E.C. program, and the Assignment of Benefit dollars being deposited back in the same pay cycle ensures that the employee's net paycheck remains unaffected by the initial deduction.

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HEALTH COMPASS INC.

# DISCLAIMER

This document is intended to serve as a preliminary guide and illustrative example of the payroll deduction and reimbursement process within the Vital110 Minimum Essential Coverage (M.E.C.) Group Medical Plan. It aims to highlight potential tax benefits and operational efficiencies associated with the program. Please note that this guide has been prepared in anticipation of a formal legal opinion from ERISA (Employee Retirement Income Security Act) counsel and is not a substitute for such an opinion.

The information provided herein is general and is not intended to address the specific circumstances of any particular individual or entity. It should not be relied upon as accounting, tax, legal, or other professional advice. This guide does not constitute a comprehensive or complete statement of the matters discussed or the law relating thereto and should not be used as a basis for any decision or action that may affect your finances or business.

We strongly recommend that clients not rely solely on this memorandum to make decisions about the Vital110 M.E.C. program. Instead, they should seek the advice of their own legal counsel and accounting professionals to ensure that their specific needs and legal requirements are adequately addressed.

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