

Debit Card Compliance

Managing your spending account debit card in today's regulatory environment



Plan Compliance: A Regulatory Necessity

In today's environment of fast-changing legislation and ever-increasing scrutiny on tax-qualified programs, precautions must be taken to ensure that your plan meets all regulatory criteria with proven processes and controls. Given the multitude of benefits that can be offered through a cafeteria plan, it is natural that most companies outsource their benefits administration; however, with outsourcing comes both decreased visibility into the inner workings of the benefit plans and a need for increased communication with your administrator.

The intent of this document is to outline SHPS' view on key spending account debit card functions and to describe how we ensure that your spending account plan debit card is fully compliant with all applicable IRS and Department of Treasury requirements, allowing you to be confident in your decision to entrust SHPS with your administrative needs.

Spending Account Debit Cards and Compliance: A Thorough Analysis

Over the last seven years, the IRS has issued several pieces of guidance regarding electronic payment cards ("debit cards") for health-related benefits. These regulations impacted how administrators were required to structure flexible spending accounts (FSAs), health reimbursement arrangements (HRAs), and limited FSA/HRA accounts (LFSAs/LHRAs) which offer debit cards.¹

The key to debit card compliance can be summed up in one word: **substantiation**. *The IRS requires that every debit card transaction be fully validated by an independent third party, proving that the card has been used for eligible medical expenses.* In order to make the process easier for participants, SHPS takes advantage of all the IRS-allowed validation processes, outlined and described below:

- IIAS Matching
- Co-pay Matching
- Recurring Expense Matching
- Carrier Claim Matching
- Manual (Participant) Substantiation



This document is provided to help our clients learn about SHPS' spending account card substantiation processes. This information is intended solely to provide SHPS' understanding of the rules and regulations that control its administrative services. This is not intended to be relied on by clients as legal advice or legal opinion. This information is not a substitute for consultation with legal counsel and is not an exhaustive listing of the statutes and regulations that apply to group health plans and other benefits offered by employers. SHPS strongly recommends that clients consult with their own legal advisors for legal advice or opinions on which they may rely.

¹ Please note that Health Savings Accounts (HSAs) are not subject to the same substantiation requirements that are discussed in this document.



Figure 1 below outlines the high-level approach to how SHPS uses allowed methods of substantiation in order to validate every card transaction.

Substantiation Process Flow

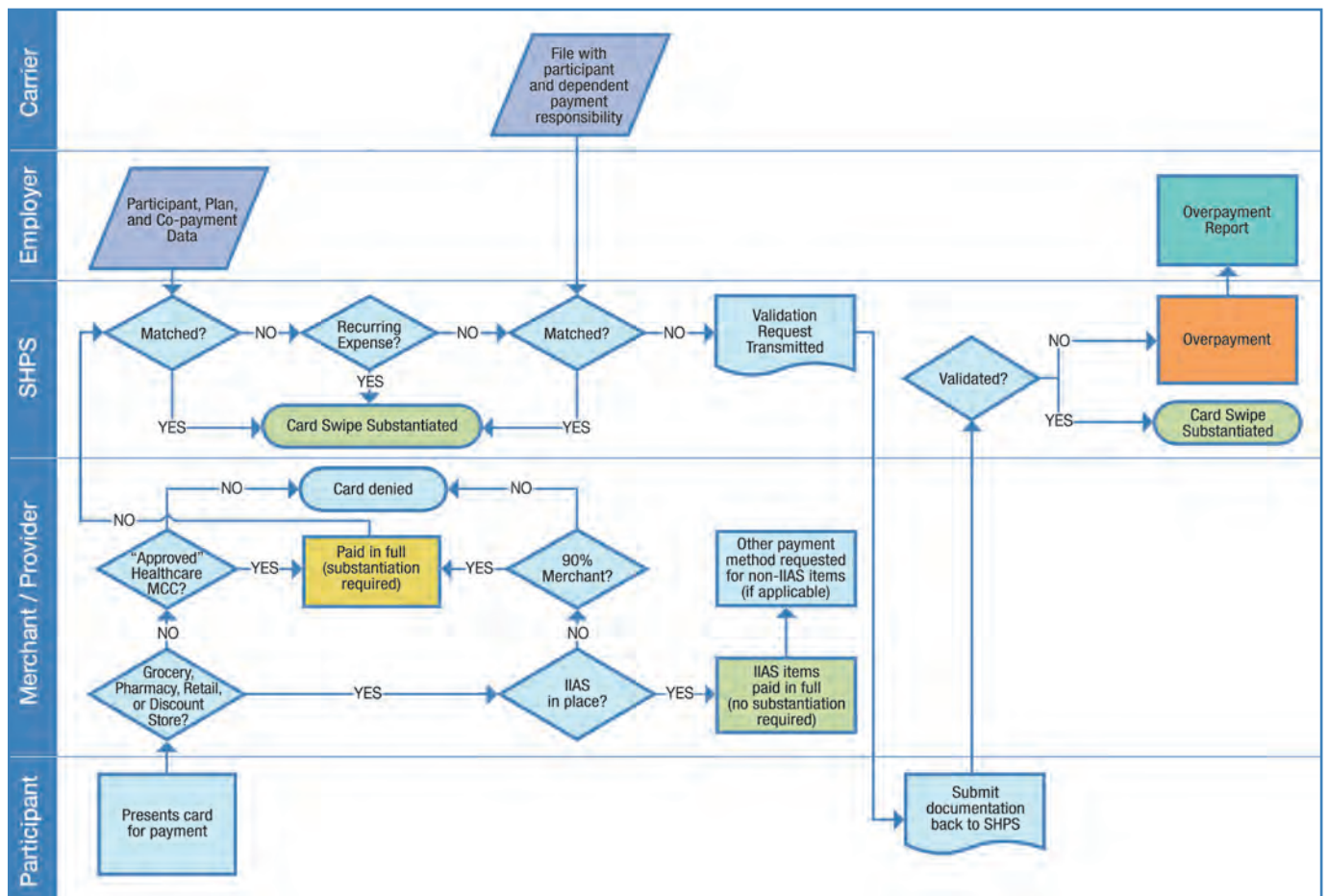


Figure 1

As outlined above, SHPS attempts all four methods of allowed automatic substantiation methods prior to requesting any participant action. These substantiation methods are described in detail on the following pages.

IIAS Matching

One of the most attractive features of spending account cards is the ability to streamline the initial substantiation process, thus potentially eliminating the need for an employee to submit receipts to SHPS. This initial substantiation functionality is made possible by retailers and merchants automatically recognizing eligible items at the time of purchase through an Inventory Information Approval System, or IIAS. The IRS requires that all merchants selling qualified medical goods and services (but who do not have a healthcare merchant category code (MCC)) have an IIAS in place to accept FSA/HRA cards (with one exception, discussed later in this section). Any MCC which is not considered a “healthcare” MCC is required to have an IIAS in place to accept spending account cards.

What is an MCC?

An MCC is a four-digit number assigned to a business by VISA when the business first starts accepting spending account cards as a form of payment. The MCC is used to classify the business by the type of goods or services it provides. For a complete listing of the MCCs that are eligible for use with the SHPS spending account card, please see [Appendix B](#).

The following is a list of merchants² who must adhere to IIAS and their associated MCC.

Description	Merchant Category Code
Grocery/Supermarkets	5411
Discount Stores	5310
Warehouse Clubs	5300
Online Pharmacies	5960, 5964, 5965, 5969
Drug Stores/Pharmacies	5912
Druggists/Druggist Proprietaries	5122

²The list is not intended to be exhaustive and may be subject to change.



IIAS

When the IRS originally adopted the IIAS concept, there were questions as to how retailers would standardize processes, including how to identify specific items eligible for reimbursement. In order to create industry-wide standards, a new professional group was formed called SIGIS, (the Specialty Interest Group for IIAS Standards). SIGIS is a non-profit organization whose sole purpose is developing standards that enable merchants and plan administrators to support IRS requirements for spending account card transactions. SIGIS members include retailers, card issuers, third-party plan administrators, merchant acquirers, processors, financial institutions, and other associated groups. SHPS has been a member of SIGIS since its inception.

IIAS Merchants and Eligible Items

All non-healthcare merchants must have an IIAS in place to accept cards and allow expenses to be automatically substantiated at the point-of-sale.

To see which retailers currently have an IIAS using the SIGIS-standard in place, you can visit their website by clicking [here](#), or go to **www.sig-is.org** and review the “IIAS Merchant List.” It is important to note that some retailers have developed proprietary compliance approaches for an IIAS (such as Walgreens); however, most merchants have voluntarily adopted the IIAS standard developed by SIGIS.

SIGIS maintains a list of eligible items, which is reviewed and monitored by a broad committee of industry experts, including representatives from SHPS. The list is restricted to “eligible medical expenses” as described in Section 213(d) of the Internal Revenue Code (including eligible non-prescription items such as insulin, medical equipment, and supplies). Although there is not currently a mechanism for formal IRS approval of this list, SIGIS and its members have met with IRS and Treasury representatives over the last several years to review and comment on the approach. To date, all comments have been favorable.



IIAS

How an IIAS Works

Upon checkout, the retailer scans each individual item into their system to obtain the specific stock-keeping unit (SKU) number, associated price, and whether the item is on the eligible healthcare item list. When the card is presented at checkout, the retailer's system identifies the sum of eligible expenses, which are then totaled and sent through the VISA network to SHPS' card processor, who then approves the payment for eligible medical care expenses up to the balance remaining in the participant's account.

The IIAS only approves card use for eligible expenses; when a card transaction is not approved for the full requested amount, the employee must then pay any remaining balance through another means. IIAS transactions are automatically considered fully substantiated and will be marked as such in SHPS' system. SHPS will mark each of these transactions in the database as substantiated and will not request that participants submit additional validation.

If the participant attempts to purchase both qualified and non-qualified items with their spending account card (for example, a prescription together with soda or chewing gum), an IIAS merchant will "parse" out the eligible expense(s) and approve the eligible item(s) (prescription) for payment through the spending account card, then request an alternative form of payment for the ineligible expense(s) (chewing gum). If the provider is registered as a 90% Merchant (discussed in the next section), the participant can use their spending account card for the full purchase, but will be required to substantiate their transaction at a later time.

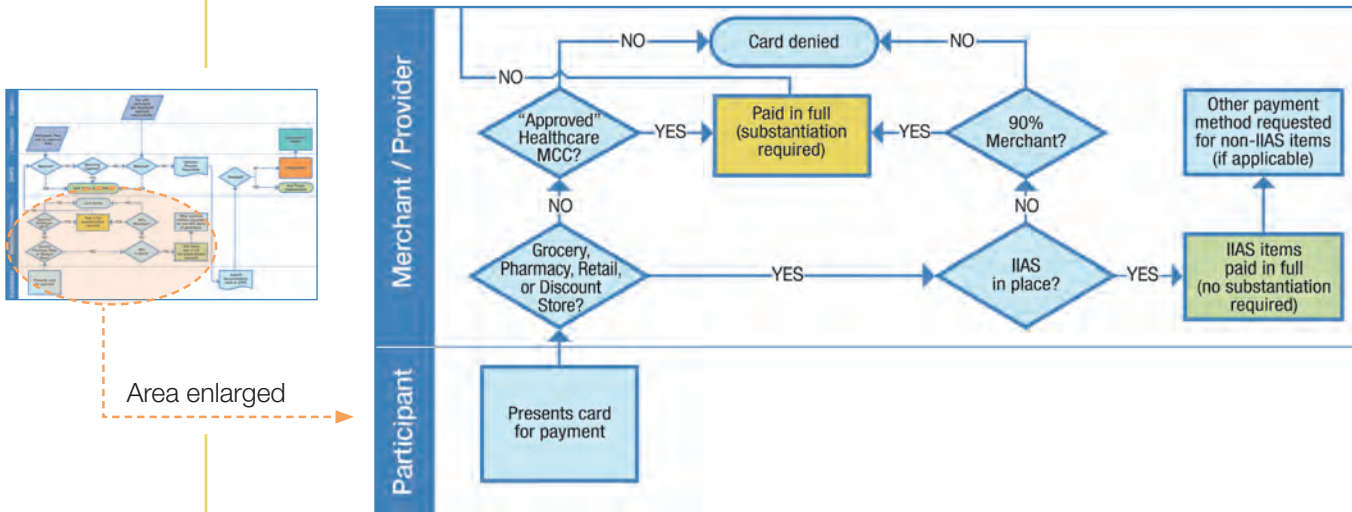


Figure 2

Example: An employee makes a purchase at an IIAS merchant and the total transaction is \$100. Of this total amount, \$40 is for prescription co-pays, \$40 is for other eligible healthcare expenses substantiated by the IIAS process, \$15 is for groceries, and \$5 is for a book. When the employee uses the spending account card, \$80 will be approved (pharmacy and healthcare expenses), and the employee will be asked to present another form of payment for the remaining \$20.

Over-the-Counter Medications

Under the Patient Protection and Affordable Care Act (PPACA), all over-the-counter (OTC) medications and drugs (except insulin) will require a prescription. IRS Revenue Notice 2010-59 states a “prescription” is defined as a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state in which the medical expense is incurred and that is issued by an individual who is legally authorized to issue a prescription in that state. Supporting documentation required to substantiate a prescription includes a customer receipt issued by a pharmacy which identifies the name of the purchaser (or the name of the person for whom the prescription applies), the date and amount of the purchase, and the Rx number.

Participants utilizing spending account debit cards may still purchase these items at the merchant’s point of sale, providing the following eligibility requirements are met:

- Prior to the purchase, the prescription for the OTC medicine or drug must be presented to the pharmacist;
- The OTC medicine or drug must be dispensed by the pharmacist in accordance with the applicable laws and regulations pertaining to the practice of pharmacy;
- An Rx number must be assigned;
- In accordance with IRS recordkeeping requirements, the pharmacy or vendor must retain a record of the Rx number, the name of the purchaser or the person to whom the prescription applies, the date and amount of the purchase; and
- All of these records must be available to the employer or its agent upon request.

The merchant’s point of sale will only accept the debit card when a drug has been processed through the IIAS system as a prescription and an Rx number has been generated.

90% Merchants

There is one exception to IRS rules which would allow non-healthcare merchants who do not have an IIAS to accept the spending account card. For any non-healthcare merchant who has a store location³ selling “eligible medical expenses” as described in Section 213(d) of the Internal Revenue Code (including eligible non-prescription items such as insulin, medical equipment, and supplies), and who has gross receipts equaling 90% or greater of their total store receipts from eligible items, can be considered “90% Merchants.”

The IRS established the 90% Rule as an exception to the IIAS requirement. Merchants who choose not to offer an IIAS and who meet the 90% requirement can register on a location-by-location basis with SIGIS and assert that they meet all IRS eligibility requirements. SHPS updates on an ongoing basis with our card processor partner all newly eligible 90% Merchants. A store’s 90% eligibility status is only good for one year; stores may lose their eligibility status if they do not renew their status annually. For an up-to-date list of approved 90% Rule Merchants, you can visit the SIGIS website by clicking [here](#), or go to www.sig-is.org and review the “90% Merchant List.”

Although SHPS’ spending account card will be accepted at 90% Merchants, the transaction will not be parsed out by approved and non-approved items, and the participant will need to substantiate the full value of the card transaction with SHPS following the purchase. For substantiation of OTC medicines and drugs, this would include submitting a customer receipt issued by the merchant which identifies the name of the purchaser (or the name of the person for whom the prescription applies), the date and amount of the purchase, and the Rx number.

IIAS and 90% Recap

In summary, all merchants that sell qualified medical goods and services but do not have a healthcare MCC (such as grocery stores, supermarkets, pharmacies, and discount, warehouse, convenience, and drug stores) will be treated as follows:

IIAS Implementation Method	Card Can be Used?	Transaction Automatically Substantiated?	Employee Substantiation Required?
IIAS Implemented	YES	Eligible items fully substantiated; ineligible items paid by other means	NO
IIAS NOT Implemented; Registered as 90% Merchant	YES	NO	YES
Neither IIAS nor 90%	NO	N/A	N/A

³90% eligibility is on a location-by-location basis. Each store must be validated separately.

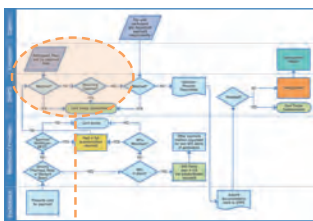
Co-pay Matching

When a spending account card is first implemented, SHPS will request that each employer or their TPA provide the following two files:

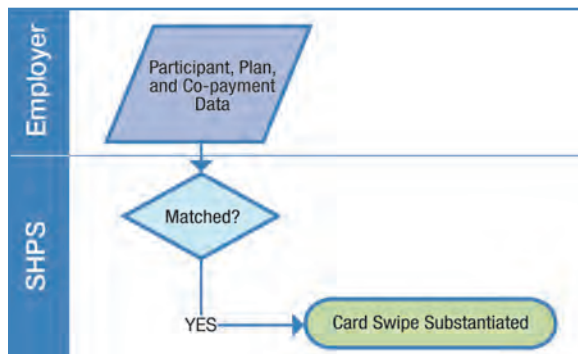
- Co-pay plan file (outlining each medical, dental, vision, and pharmacy plan co-payment values)
- Employee census file (outlining each participant's medical, dental, vision, and pharmacy enrollment)

If a card transaction cannot be validated at the point-of-sale, SHPS will attempt to validate the transaction on the back-end, matching the transaction against a previously-approved list of co-payment values. The card transaction will be substantiated if the transaction type (derived from the MCC) equals the co-payment type for the coverage elected by the employee, as derived by the employer file (i.e., medical MCC = medical co-payment) when any of following criteria is met:

- The card transaction equals a single co-pay value.
- The card transaction equals an exact match of multiple of a single co-pay value (up to five times the amount).
- The card transaction equals an exact match of any combination of co-pays or any multiple or combination up to five times the co-pay amount.



Area enlarged



Single Co-pay for a Specific Benefit

If the transaction equals a multiple of a co-pay value, no additional substantiation is required as long as the transaction amount does not exceed five times that co-payment value.

Example: Jane is enrolled in Plan A through her employer, which has a \$25 co-pay for medical-related expenses. Jane uses her card to pay for a \$125 visit at the doctor's office for services provided to her, her spouse, and her three children. This transaction would be automatically substantiated for Jane, as \$125 is a multiple of Jane's applicable medical co-payment and does not exceed five times the co-payment value.

Different Co-pays for a Specific Benefit

If the transaction equals a combination of co-pays for a particular benefit, no additional substantiation is required as long as the transaction amount does not exceed five times the maximum combination amount.

Example: Plan A requires a \$3 co-pay for generic drugs and \$15 co-pay for brand name drugs. Jane uses her card at a “90% Merchant” pharmacy to purchase three generic drugs and two brand name drugs for a total of \$39. Because she is using her card at a 90% Merchant, no validation will occur at the point of sale. Instead, SHPS will attempt to validate the transaction by co-pay amount. No additional substantiation is required because the \$39 is a multiple of a combination of the co-pays for the particular benefit and does not exceed five times the largest co-payment value.

Important!

- SHPS cannot allow co-pay matching under any health plan option provided by the employer randomly; it must equal a multiple of the specific co-pay applicable to the employee or the employee’s dependent.
- SHPS must receive certification from the employer regarding the co-pay applicable to participants in the plan (via a file or other means). Self-certification of co-pay amounts by participants is not sufficient.
- If the transaction amount exceeds the maximum transaction amount (five times the maximum co-pay for that type of benefit), or it is not a multiple of the co-pay or combination of co-pays for a benefit, additional substantiation is required for the entire transaction.

SHPS requests that employers transmit co-pay plan files to SHPS any time the information changes (typically annually prior to the beginning of the new plan year). Participant files are usually sent on a monthly basis reflecting additions and changes to ensure SHPS has the most recent data and to ensure transactions are matched against a valid date. The effective date ranges for the co-payment values are established by the employer.

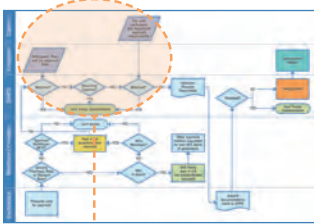


Recurring Expense Matching

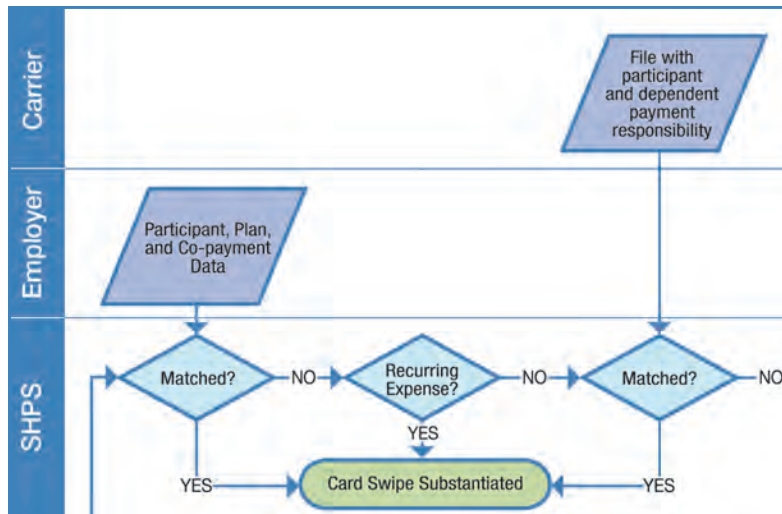
If the card transaction is still unsubstantiated after going through the co-pay matching process, SHPS will attempt to automatically substantiate recurring spending account card expenses that match a previously-approved expense when ALL of the following criteria have been met:

- The amount of the card transaction matches a previously approved claim;
- The provider name from the transaction exactly matches the previously approved claim;
- The type of transaction (i.e., medical, dental, vision) matches the previously approved claim; and
- The “matched” substantiated claim transpires within a recurring time frame.

This feature allows a participant to submit documentation for a recurring expense once during the plan year without needing to submit additional documentation for the same expense each time it occurs. As with carrier matching, a “hard stop” will occur at the end of the plan year to prevent substantiation of card transactions when the card is used for the current plan year to pay a previous plan year’s bill.



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Carrier Claim Matching

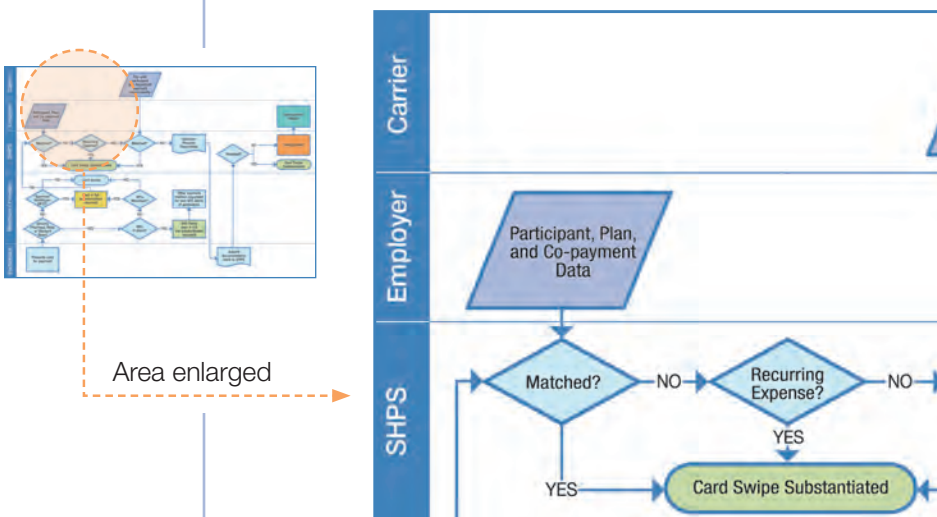
Should the card transaction still be unsubstantiated after all automated matching processes (IIAS, co-pay, and recurring expense matching), SHPS uses a substantiation file received from third parties (such as medical carriers) that would verify the validity of the expense. The information from the third party must indicate the date of the §213(d) service and the employee's responsibility for payment for that service (such as coinsurance payments or amounts below the plan's deductible). If the data from the carrier matches a card transaction value, the transaction will be fully substantiated without the need for further substantiation by the participant.

SHPS has partnerships with more than 61 distinct medical, dental, vision, and pharmacy carriers, comprising more than 2,300 files received annually. With each new implementation, SHPS works with the employer to coordinate receipt of new files, ensuring that if enrolled individuals use their card, SHPS can attempt to match the purchase amount to the out-of-pocket expense amount determined by the insurance carrier.

A spending account card transaction will be deemed "substantiated" when the following criteria is met:

- The card transaction type (derived from the MCC) equals the claim type (derived by the carrier file);
- The card transaction amount equals the participant responsibility amount; and
- The card transaction date equals the claim date on the carrier file (+/- 90 days to allow for fluctuations in billing).

It is important to note that the dollar values must match exactly; however, there can be a discrepancy of up to plus or minus 90 days from the date of service of the card transaction and the date of service.⁴ With coinsurance plans, the provider may not always require that the participant make a payment up-front; instead, he or she will provide the service and send a bill once the claim is filed with the carrier. Based on past experience, 90 days allows for a full billing cycle to occur and ensure that an individual can use his or her card to pay the provider's bill.



⁴Please note that 90 days is SHPS' standard based upon past experience with claims data. Depending upon plan design requirements, this date range can be configurable by client.

Example 1: Julie is currently enrolled in both the healthcare FSA and Medical Plan A with her employer. Julie visited the doctor on 2/15 and the total bill was \$100. Under Medical Plan A, Julie is responsible for 25 percent of the cost of services.

Julie's doctor identifies Julie's payment responsibility up-front, and requests Julie's payment of \$25, which Julie pays with her FSA card. The doctor will file a claim with Medical Plan A to receive the remaining \$75. On the next file feed from Medical Plan A, SHPS receives information indicating that Julie incurred a healthcare-related expense in the amount of \$25 on 2/15, and SHPS automatically substantiates Julie's card transaction.

Example 2: The same situation as above, but the doctor does not know the amount Julie must pay up-front, and thus must file with the medical plan first and bill Julie after-the-fact. Julie receives her bill from the doctor on 4/20, indicating that she owes the doctor \$25.

Julie pays the bill with her spending account card, and the transaction is processed by the doctor on 4/30. SHPS is able to substantiate the transaction, as the date of the card transaction was within 90 days of the date of service.

NOTE: For plan-year based plans such as health FSAs or most HRAs, a split will occur at the end of the plan year to prevent substantiation of card transactions against incorrect plan participation data.⁵

Carrier Claim "Roll-Up"

When data is sent to SHPS from carriers, SHPS typically receives one line item per unique claim (even if multiple items occurred on the same date at the same provider); however, it is possible that the carrier may roll these claims into one larger amount. For this reason, SHPS will "roll-up" transactions which occur on the same day for the same service type to attempt to match carrier data.

Example: While John visited the doctor, his wife and child were also seen by two other doctors at the same time. The bill for each is as follows:

John: \$100 total bill, \$75 insurance-paid, \$25 due by patient

Wife: \$100 total bill, \$75 insurance-paid, \$25 due by patient

Child: \$100 total bill, \$75 insurance-paid, \$25 due by patient

The carrier may send either three transactions of \$25 to SHPS or one "rolled-up" transaction of \$75. If John paid only for himself with the spending account card (\$25), SHPS would be able to substantiate on John's behalf if the carrier sent either three lines of \$25 or one line of \$75. This way, SHPS is able to leverage the carrier file regardless of what methodology is used by the carrier.

⁵Some plans, such as "Evergreen" HRAs may allow prior year-data to "crossover" into the new year based upon plan design.

Manual (Participant) Substantiation

SHPS' goal is to electronically substantiate as many card transactions as possible through all of the mechanisms described previously. Unfortunately, there will still be transactions which will need to be validated by the participant. If all attempts to automatically substantiate a card transaction fail, a manual validation request is generated and sent to the participant. Upon receipt of the information from the participant, SHPS reviews the documentation like any other claim and processes it according to the regulations. In short, the IRS states the following regarding claim substantiation:⁶

- The expense must be substantiated by information from a third party;
- The third party cannot be the employee, the employee's spouse, or the employee's dependents;
- The third party must provide information describing the service or product;
- The third party must provide the date of service or date of sale; and
- The third party must provide the amount.

SHPS validates the card transaction up to the amount that can be substantiated, which may be all, a portion, or none of the claim transaction. If these unsubstantiated card values are left alone and not validated, they become "improper payments" from the plan, and action must be taken.



When is a Spending Account Card Claim an "Improper Payment?"

Many conversations have been held within the industry regarding what truly constitutes an "improper payment"; however, the IRS has yet to publish clear guidelines on what would constitute an improper payment. SHPS sends bi-monthly statements to participants in order to keep them apprised of SHPS' ability to substantiate the claim automatically on their behalf. In the absence of clear regulatory requirements, SHPS adheres to the following process regarding card substantiation requests transmitted to participants:

- If a claim has occurred within 30 days of the statement, it will display as activity on the statement.
- If a claim has yet to be substantiated after 60 days, it will be displayed on their statement as "potentially ineligible."
- If, after 120 days,⁷ the claim has still yet to be validated, the claim will be moved to "ineligible expense" and SHPS will initiate manual reimbursement.

It is important to note that the expense MAY be eligible, but is being noted as "ineligible" due to the fact that SHPS has yet to receive information validating the expense. Based upon each employer's plan design, there are several options at this stage, noted below:

- A request can be sent to the participant identifying the amount as "ineligible" and requesting repayment for the amount.
- The participant's paycheck can be garnished for the ineligible expense.
- The card can be turned off until the improper payment has been repaid.
- Future claims can be utilized to offset the amount (i.e., be reduced in reimbursement value).
- The employer can write off the value of the ineligible expense.

⁶For exact verbiage, please see Section 1.125-5 of the New Proposed Cafeteria Plan Rules, (<http://edocket.access.gpo.gov/2007/pdf/E7-14827.pdf>).

⁷Based upon past experience, SHPS has noted that, once 90 days has lapsed, the likelihood of matching a card transaction to a carrier claim is minimal, thus requiring input from a participant—this is what is driving the 120 day timeline.

Once the amount has been identified as “ineligible,” SHPS’ standard process is to request repayment or submission of an offsetting claim. SHPS can, upon request, turn off the spending account card. SHPS generates reports at the end of the plan year to outline any outstanding claims which have yet to be substantiated allowing employers to choose to withhold pay, or write off expenses should they choose.

In the newly proposed cafeteria plan regulations, the IRS articulated a specific order in remedying ineligible expenses; however, these regulations have yet to be formally adopted. In order to offer the most flexibility, SHPS can work with employers to adopt different elements based on an employer’s specific plan structure.

Spending Account Cards and Dependent Care

The newly proposed cafeteria plan regulations incorporate guidance provided in Notice 2006-69, which gave employers and third-party administrators (TPAs) approval to use spending account cards to pay for dependent care FSA expenses; however, the ruling clearly limited the utilization of the card to only those expenses which have been previously incurred. In short, like traditional paper claims, the card cannot be used to pay for day care expenses in advance of the services actually being rendered.

In order to meet this requirement, the IRS stated that an employer offering a dependent care FSA may adopt the following method to provide reimbursements for dependent care expenses through a spending account card:

- At the beginning of the plan year or upon enrollment in the dependent care FSA, the employee pays the initial out-of-pocket dependent care expenses to the provider and substantiates the expense by submitting appropriate documentation from the dependent care provider.
- After the employer or plan administrator receives approvable documentation (but not before the date the services are provided as indicated by the statement provided by the dependent care provider), the card’s value is increased in the amount equal to the lesser of
 1. the previously incurred (substantiated) expense; or
 2. the employee’s total salary reduction amount to-date.
- The card may be used to pay for subsequently incurred dependent care expenses.
- The amount available through the card may be increased in the amount of any additional dependent care expenses only after the additional expenses have been incurred.

In essence, the IRS outlined that employees using a card to pay a dependent care expense must first pay the expense out-of-pocket, submit the appropriate substantiation to the administrator, and once approved, the approved amount could be allocated to the card. The employee could then use the card to pay the next dependent care installment without providing additional substantiation, and would continue to be increased at the end of each previously identified time period by the lesser of the original expense or payroll deposits.

Future card transactions would only be substantiated IF AND ONLY IF (a) the dependent care provider matched a previously-substantiated claim, (b) the amount of the transaction was equal to or less than the previously substantiated claim, and (c) the time period matched a previously manually-substantiated claim. Any dependent care transactions that did not meet these criteria would require manual substantiation, eliminating the ability to subsequently increase the value on the card.



SHPS' Position

Most employers and third-party administrators have chosen not to adopt the dependent care card reimbursement model, as the compliance risks are increased and the potential for participant dissatisfaction exists.

SHPS also has decided not to offer the dependent care card due to the risks and concerns outlined below:

Risk—Dependent care expenses must have already been incurred at the time of the card transaction: If a dependent care provider requires payment before the dependent care services are provided, the expenses **cannot** be reimbursed at the time of payment through use of a card or through other means and still allow the plan to be compliant. If the funds are on the card, there is no effective way to monitor this.

Concern—Potential point of participant dissatisfaction: The card value can only be increased by the **lesser** of the payroll withdrawals to-date or the initially substantiated expense. The individual will still be required to submit previously unsubstantiated claims into the service center for review/approval in order to increase the card balance moving forward.



Appendix A: IRS Spending Account Card Regulation

SHPS' standard guidelines for card processing have been developed in order to ensure that plans will be in compliance with applicable regulatory mandates and guidance.

The below matrix outlines key card regulations alongside of the Proposed Cafeteria Regulations, elements required by these regulations, and what processes SHPS has put in place to assist with keeping our partners' plans compliant.

Key	Ruling	Proposed Cafeteria Regulations
	Ruling Details	SHPS' Processes

IRS Revenue Ruling 2003 (Card certification)

The employee must certify upon enrollment in the health FSA or HRA (and each year thereafter) that the card will be used for eligible medical care expenses of the employee and the employee's spouse and dependents.

The employee must certify that he/she has not been previously reimbursed for those expenses, and will not seek reimbursement under any other plan.

Before any employee participating in a health FSA receives the debit card, the employee agrees in writing that he or she will only use the card to pay for medical expenses (as defined in section 213(d)) of the employee or his or her spouse or dependents, that he or she will not use the debit card for any medical expense that has already been reimbursed, that he or she will not seek reimbursement under any other health plan for any expense paid for with a debit card, and that he or she will acquire and retain sufficient documentation (including invoices and receipts) for any expense paid with the debit card.

For any individuals where SHPS is the enrolling entity (through contracted enrollment and eligibility services), a validation can be implemented at the Plan's request for all individuals participating in a spending account card program stating that the card will be used only "for the expenses of myself, my spouse, and my dependents, as defined in section 213(d)). Any expense paid through the card has not been previously reimbursed, and that I will not seek reimbursement under any other plan."

The verbiage should also be considered for individuals enrolling through COBRA (should the system support their enrollment).

IRS Revenue Ruling 2003-43 (Card certification placement)

The certification is printed on the back of the card and the cardholder understands the certification is reaffirmed each time the card is used.

The debit card includes a statement providing that the agreements described in paragraph (d) (1) of this section are reaffirmed each time the employee uses the card.

On the back of SHPS' spending account card, the following is printed as a standard: "By using the Card, you agree to the Cardholder Agreement, which is sent with the Card. Each time you use the Card, you certify that (i) it will be used only for Qualified Purchases as described in the Cardholder Agreement, and (ii) you have not received and will not seek reimbursement for any expenses paid with the Card from any other benefit source."

IRS Revenue Ruling 2003-43 (Card termination)

The card must be turned off upon termination of employment.

The debit card is automatically cancelled when the employee ceases to participate in the health FSA.

When SHPS receives a termination date on an inbound feed, SHPS stores this date in the system. If today's date is past or equals the termination date passed on the file, SHPS will disable the card. For clients on our platform, any extension of the termination date (rendering today's date to be less than the termination date in the system) or removal of the termination date will re-activate the ability for the participant to use his/her card.

Please note that SHPS will not "pay and chase" any claims which have been paid due to a delay in SHPS' receipt of a termination date on the inbound feed.

IRS Revenue Ruling 2003 (43 Receipt retention)

The cardholder must acquire and retain sufficient documentation for any expense paid with the Card, including invoices or receipts.

Not specified

SHPS encourages individuals in all pre-enrollment and enrollment materials to be certain to retain receipts, regardless of whether or not they have been auto-adjudicated on their behalf.

IRS Revenue Ruling 2003–43 (MCC requirements)

The card can only be used at merchants and service providers that have merchant category codes related to healthcare, such as physicians, pharmacies, dentists, vision care offices, hospitals, and other medical care providers.

The employer limits use of the debit card to (i) Physicians, dentists, vision care offices, hospitals, other medical care providers (as identified by the merchant category code);

Each terminal where a card is swiped at the point of sale has a specific ID, which is tied to a class of codes used by Visa (SHPS' card sponsor). To ensure that the card is likely to be utilized for health-related expenses, SHPS limits the debit card to specific categories of merchants, classified through a Merchant Category Code (MCC), which can be customized on a client-by-client basis. The list of MCCs currently tied to SHPS' standard Health FSA and HRA cards is noted in Appendix C at the end of this document.

IRS Revenue Notice 2006–69 (IIAS)

The IRS will allow inventory control systems to automatically substantiate card transactions.

The information required to be retained may be provided at the time of the transaction, or after the transaction (e.g., upon an examination of the employer by Internal Revenue Service). Rev. Proc. 98-25, 1998-1 C.B. 689, which sets out requirements where a taxpayer's records are maintained within an automatic data processing system, also applies to the inventory information approval system.

(continued from MCC requirements above) . . .(ii) Stores with the merchant category code for Drugstores and Pharmacies if, on a location by location basis, 90 percent of the store's gross receipts during the prior taxable year consisted of items which qualify as expenses for medical care described in section 213(d); and (iii) Stores that have implemented the inventory information approval system under paragraph (f).

In an expansion from the 2003 Ruling, cards may be used at merchants who do not have a health care related MCC if the merchant utilizes the inventory information approval system (IIAS) described in this notice.

Under the IIAS substantiation method, the card processor provides a system for approving and rejecting card transactions using inventory control information (e.g., stock-keeping units (SKUs)). When an employee uses the card, the merchant's system collects information about the items purchased using inventory control information.

The system compares the inventory control information for the items purchased against a list of items, the purchase of which qualifies as expenses for medical care under §213(d) (including nonprescription medications).

The §213(d)-qualifying medical expenses are totaled and the merchant's system approves the use of the card only for the amount of the §213(d) medical expenses subject to coverage under the health FSA or HRA. If the transaction is only partially approved, the employee is required to tender additional amounts, resulting in a split-tender transaction.

There is an industry-wide notation of IIAS-eligible SKUs, which is managed by the Specialty Interest Group for IIAS Standards (SIGIS). All merchants utilizing IIAS adhere to this standard except for Walgreens, who manages their own IRS-compliant system. First Data, SHPS' card processor partner, captures the auto-approved transaction values and passes them to SHPS, allowing SHPS to mark these transactions as automatically substantiated, thus negating the need for submission of a receipt by the employee or further review.

IRS Revenue Notice 2007–02 (Drug store/pharmacy restriction)

After December 31, 2008, health FSA and HRA debit cards may not be used at stores with the Drug Stores and Pharmacies merchant category code unless (1) the store participates in the inventory information approval system as described in Notice 2006-69, or (2) on a store location by store location basis, 90 percent of the store's gross receipts during the prior taxable year consisted of items which qualify as expenses for medical care under § 213(d) (including nonprescription medications).

Substantiation of expenses incurred at medical care providers and certain other stores with Drug Stores and Pharmacies merchant category code—(1) In general. A health FSA paying or reimbursing section 213(d) medical expenses through a debit card is permitted to comply with the substantiation provisions of this paragraph (e), instead of complying with the provisions of paragraph (f), for medical expenses incurred at providers described in paragraph (e)(2) of this section. (2) Medical care providers and certain other stores with Drug Stores and Pharmacies merchant category code. Medical expenses may be substantiated using the methods described in paragraph (e)(3) of this section if incurred at physicians, pharmacies, dentists, vision care offices, hospitals, other medical care providers (as identified by the merchant category code) and at stores with the Drug Stores and Pharmacies merchant category code, if, on a store location-by-location basis, 90 percent of the store's gross receipts during the prior taxable year consisted of items which qualify as expenses for medical care described in section 213(d).

IMPORTANT NOTE: 90% Merchants are only turned on for card utilization—the amount will not be auto-substantiated.

IRS Revenue Ruling 2003–43 (Available amount)

The amount available through the debit card equals the amount elected by the employee for the health FSA for the cafeteria plan year, and is reduced by amounts paid or reimbursed for section 213(d) medical expenses incurred during the plan year.

The amount available through the debit card equals the amount elected by the employee for the health FSA for the cafeteria plan year, and is reduced by amounts paid or reimbursed for section 213(d) medical expenses incurred during the plan year.

SHPS works with First Data, the card processor, to ensure that the notional funds loaded to the card equal the total amount available to the participant, minus any other card transactions or manual claims.

IRS Revenue Ruling 2003–43 (Auto-adjudication)

Auto-Adjudication for card-swipes is permitted via (i) co-payment matching, (ii) recurring claims, and (iii) real-time verified claims.

(i) Claims substantiation for co-payment matches, certain recurring medical expenses and real-time substantiation. If all of the requirements in this paragraph (e)(3) are satisfied, co-payment matches, certain recurring medical expenses and medical expenses substantiated in real-time are substantiated without the need for submission of receipts or further review.

(ii) Certain recurring medical expenses. Automatic payment or reimbursement satisfies the substantiation rules in this paragraph (e) for payment of recurring expenses that match expenses previously approved as to amount, medical care provider and time period (for example, for an employee who refills a prescription drug on a regular basis at the same provider and in the same amount). The payment is substantiated without the need for submission of a receipt or further review.

(iii) Real-time substantiation. If a third party that is independent of the employee and the employee's spouse and dependents (for example, medical care provider, merchant, or pharmacy benefit manager) provides, at the time and point of sale, information to verify to the employer (including electronically by e-mail, the internet, intranet or telephone) that the charge is for a section 213(d) medical expense, the expense is substantiated without the need for further review.

In order to ensure that a payment has been made “properly”, it must go through a substantiation process, which is outlined later in this document.

IRS Revenue Notice 2006–69 (Co-pay matching)

Exact matches of multiples or combinations of the co-payments (but not more than the exact multiple of five times the maximum co-payment) will be allowed to substantiate a card transaction without the need for submission of a receipt or further review.

Matching co-payments—multiples of five or fewer. If an employer's accident or health plan covering the employee (or the employee's spouse or dependents) has co-payments in specific dollar amounts, and the dollar amount of the transaction at a medical care provider equals an exact multiple of not more than five times the dollar amount of the co-payment for the specific service (for example, pharmacy benefit co-payment, co-payment for a physician's office visit) under the accident or health plan covering the specific employee cardholder, then the charge is fully substantiated without the need for submission of a receipt or further review.

Tiered co-payments. If a health plan has multiple co-payments for the same benefit, (for example, tiered co-payments for a pharmacy benefit), exact matches of multiples or combinations of up to five co-payments are similarly fully substantiated without the need for submission of a receipt or further review.

Co-payment match must be exact multiple. If the dollar amount of the transaction is not an exact multiple of the co-payment (or an exact match of a multiple or combination of different co-payments for a benefit in the case of multiple co-payments), the transaction must be treated as conditional pending confirmation of the charge, even if the amount is less than five times the co-payment.

No match for multiple of six or more times co-payment. If the dollar amount of the transaction at a medical care provider equals a multiple of six or more times the dollar amount of the co-payment for the specific service, the transaction must be treated as conditional pending confirmation of the charge by the submission of additional third-party information. See paragraph (d) of this section. In the case of a plan with multiple co-payments for the same benefit, if the dollar amount of the transaction exceeds five times the maximum co-payment for the benefit, the transaction must also be treated as conditional pending confirmation of the charge by the submission of additional third-party information. In these cases, the employer must (C) require that additional third-party information, such as merchant or service provider receipts, be submitted for review and substantiation, and the third-party information must satisfy the requirements in paragraph (b)(3) of this section.

As described in Rev. Rul. 2003-43, the co-payment match substantiation method is only permissible at merchants or service-providers that have healthcare-related merchant category codes.

Consistent with this approach, SHPS matches a card transaction with a specific category of expense (medical, dental, vision), and attempts to match the card swipe against the co-payment values provided by the employer or their vendor for that specific individual.

SHPS uses multiples or combination of multiples not exceeding 5X the dollar value of the co-payment for that specific category of service.

SHPS will request two files to support this: the first is the co-payment file, outlining the tiers of co-payments by health expense type (medical, dental, and vision). This file is required annually unless there is a mid-year change in plan design. Additionally, SHPS requires a census file, which identifies which plan(s) each participant is tied to. This allows SHPS to accurately match applicable co-payment values to each individual in the plan. SHPS typically requests these files monthly.

Card transactions using this method are fully substantiated without the need for submission of a receipt by the employee or further review.

IRS Revenue Notice 2006–69 (Co-pay verification)

The co-payment schedule required under the accident or health plan must be independently verified by the employer (i.e., the co-payment amount must be substantiated by a third-party; statements or other representations by the employee are not sufficient).

Independent verification of co-payment required. The co-payment schedule required under the accident or health plan must be independently verified by the employer. Statements or other representations by the employee are not sufficient. Self-substantiation or self-certification of an employee's co-payment in connection with co-payment matching procedures through debit cards or otherwise does not constitute substantiation. If a plan's co-payment matching system relies on an employee to provide a co-payment amount without verification of the amount, claims have not been substantiated, and all amounts paid from the plan are included in gross income, including amounts paid for medical care whether or not substantiated. See paragraph (b) in this section.

SHPS requires that the employer provide all documentation; the employee/participant cannot provide data by which to substantiate.

IRS Revenue Ruling 2003–43 (Adjudication requirements)

All claims must be adjudicated.

Substantiation requirements for all other medical expenses paid or reimbursed through a health FSA debit card. All other charges to the debit card (other than substantiated co-payments, recurring medical expenses or real-time substantiation, or charges substantiated through the inventory information approval system described in paragraph (f) of this section) must be treated as conditional, pending substantiation of the charge through additional independent third-party information describing the goods or services, the date of the service or sale and the amount of the transaction. All such debit card payments must be substantiated, regardless of the amount of the payment.

Per regulation, SHPS requires 100 percent substantiation for all card transactions; SHPS will not “sample” claims to substantiate, as the IRS clearly states that this is not a permitted adjudication method.

IRS Revenue Ruling 2003–43 (Improper payments)

The following is noted regarding “improper payments” made via a spending account debit card:

- Turn off the debit card until the improper payment has been repaid;
- Demand repayment by the employee back to the Cafeteria Plan;
- Withhold the overpaid amount from the employee’s pay, subject to applicable law;
- Use a claims offset approach to apply future eligible claims to the overpaid amount;
- Treat the overpayment as any other business indebtedness.

The employer follows all of the following correction procedures for any improper payments using the debit card—(i) Until the amount of the improper payment is recovered, the debit card must be de-activated and the employee must request payments or reimbursements of medical expenses from the health FSA through other methods (for example, by submitting receipts or invoices from a merchant or service provider showing the employee incurred a section 213(d) medical expense); (ii) The employer demands that the employee repay the cafeteria plan an amount equal to the improper payment; (iii) If, after the demand for repayment of improper payment (as described in paragraph (d)(7)(ii) of this section), the employee fails to repay the amount of the improper charge, the employer withholds the amount of the improper charge from the employee’s pay or other compensation, to the full extent allowed by applicable law; (iv) If any portion of the improper payment remains outstanding after attempts to recover the amount (as described in paragraph (d)(7)(ii) and (iii) of this section), the employer applies a claims substitution or offset to resolve improper payments, such as a reimbursement for a later substantiated expense claim is reduced by the amount of the improper payment; (v) If, after applying all the procedures described in paragraph (d)(7)(ii) through (iv) of this section, the employee remains indebted to the employer for improper payments, the employer, consistent with its business practice, treats the proper payment as it would any other business in indebtedness.

In order to ensure that a payment has been made properly, it must go through a substantiation process, which is outlined earlier in this document.

SHPS transmits bi-monthly statements to participants in order to keep them abreast of SHPS’ ability to substantiate the claim automatically on their behalf.

Many conversations have been held within the industry regarding the intent of “improper payments”, which has yet to be fully defined. SHPS adheres to the following process regarding debit card substantiation requests:

- If a claim has occurred within 30 days of the statement, it will display as activity.
- If a claim has yet to be substantiated, it will be displayed on their statement “potentially ineligible” once it has aged 60 days.
- If, after 120 days, the claim has still yet to be validated, the claim will be moved to “ineligible expense”.

It is important to note that the expense MAY be eligible, but is being noted as “ineligible” due to the fact that we require 100 percent of all claims to be validated.

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Based upon each employer's plan design, there are several options at this stage, noted below:

- The debit card can be turned off until the improper payment has been repaid.
- A request can be sent to the participant identifying the amount as "ineligible" and requesting repayment for the amount.
- The participant's paycheck can be garnished for the ineligible expense.
- Future claims can be utilized to offset the amount (i.e., be reduced in reimbursement value).
- The Employer can write off the value of the ineligible expense.

Once the amount has been identified as "ineligible", SHPS' standard is to request repayment or submit an offsetting claim. SHPS can, upon request, turn off the debit card. SHPS generates reports at the end of the plan year to outline any outstanding claims which have yet to be substantiated to allow employers to choose to withhold pay or write off the expenses.

Please also note that the New Regulations have yet to be codified. There has been much discussion on this in industry conferences, and several comments by Alston & Bird as well as non-binding comments by the Department of the Treasury that, upon finalization of the Proposed Cafeteria Plan Rulings, the requirement for mandatory sequencing may be lifted due to the implications from an administrative and participant experience perspective.

IRS Revenue Notice 2006-69 (Carrier claim matching)

If the employer is provided with information from an independent third-party (such as an explanation of benefits (EOB) from an insurance company) indicating the date of the § 213(d) service and the employee's responsibility for payment for that service (i.e., coinsurance payments and amounts below the plan's deductible), the claim is fully substantiated without the need for submission of a receipt by the employee or further review.

Not specified

SHPS currently partners with over 56 medical, dental, pharmacy, and vision carriers to obtain data feeds for the purposes of substantiating card transactions. During implementation, SHPS assesses which carriers employer is working with and works to obtain the claim data for that Employer's participants.

In order to ensure the matching is accurate, SHPS utilizes four pieces of data: SSN, claim "type" (i.e., medical/dental/vision), date of service, and amount. All items must be exact, except for the date of service. SHPS has implemented a +/- 120 day protocol for the date, as many times a card is utilized as payment (after adjudication with the carrier), thus preventing an exact match with the date of service.

Card transactions using this method are fully substantiated without the need for submission of a receipt by the employee or further review.

This applies whether the card is used for payment or not.

IRS Revenue Notice 2006-69 (Self-certification)

"Self-substantiation" or "self-certification" of an expense by an employee-participant does not constitute the required substantiation.

Not specified

SHPS does not reimburse participants who submit information without a statement from an independent third party verifying the expenses.

Cafeteria Plan Regulations Section 1.125-6 (Period of coverage)

Claims must be incurred during a participant's "period of coverage."

Not specified

A claim paid with a debit card must be for expenses incurred on or after the later of the participant's effective date or the effective date of the plan. As such, SHPS will not submit a request to have a card generated for a participant until the latter of the effective date of the plan or the participant's effective date.

Upon the receipt of a "termination" date, SHPS will turn off the card, ensuring the participant does not have immediate access to those funds. Individuals will be required to submit "manual" reimbursement requests to SHPS for any remaining funds to ensure that the dates of service were within the participant's period of coverage.

New Proposed Cafeteria Plan Regulations (IIAS retention requirements)

Not specified

Employer's responsibility for ensuring inventory information approval system's compliance with § 1.105-2, § 1.125-1, § 1.125-6 and record keeping requirements. An employer that uses the inventory information approval system must ensure that the inventory information approval system complies with the requirements in §§ 1.105-2, 1.125-1, and § 1.125-6 for substantiating, paying or reimbursing section 213(d) medical expenses and with the record keeping requirements in section 6001.

Reiterates prior rulings.

The IIAS entity will be responsible for retaining the records in accordance with the guidelines outlined.

Patient Protection and Affordable Care Act Section 9003 (OTC medicine and drug reimbursement)

For purposes of Sections §§ 105 and 106 of the IRS regulations, reimbursement for expenses incurred for a medicine or a drug will be treated as a reimbursement for medical expenses only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription), or is insulin.

Section 9003 revises the definition of eligible Section § 213(d) medical expenses for employer-provided accident and health plans. This includes health flexible spending arrangements (health FSAs), health reimbursement arrangements (HRAs), and health savings accounts (HSAs).

Per regulation, SHPS will require that all OTC medicines and drugs requirement a prescription to be eligible for reimbursement.

IRS Revenue Notice 2010-59 (Definition of a "prescription")

New § 106(f), as added by PPACA, provides that, for purposes of §§ 106 and 105, beginning after December 31, 2010, expenses incurred for a medicine or a drug shall be treated as a reimbursement for medical expenses only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin. Therefore, expenses incurred for medicines or drugs may be paid or reimbursed by an employer-provided plan, including a health FSA or HRA, only if (1) the medicine or drug requires a prescription, (2) is available without a prescription (an over the counter medicine or drug) and the individual obtains a prescription, or (3) is insulin.

For purposes of §§ 106(f), 223(d)(2)(A) and 220(d)(2)(A) only, a "prescription" means a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state in which the medical expense is incurred and that is issued by an individual who is legally authorized to issue a prescription in that state.

On and after January 16, 2011, over the counter medicine or drug purchases at all providers and merchants (whether or not they have an IIAS system) must be substantiated before reimbursement may be made. Substantiation is accomplished by submitting the prescription (or a copy of the prescription or other documentation that a prescription has been issued) for the over the counter medicine or drug, and other information from an independent third party that satisfies the requirements under Prop.Treas. Reg. § 1.125-6(b)(3)(i). An example provided by the IRS that may satisfy this requirement includes a customer receipt issued by a pharmacy which identifies the name of the purchaser (or the name of the person for whom the prescription applies), the date and amount of the purchase and an Rx number satisfies the substantiation requirements for over the counter medicines or drugs.

Notice 2010-59 also provides that, except with respect to 90% merchants, health FSA and HRA debit cards may not be used to purchase over the counter medicines or drugs after January 15, 2011.

The rules in §§ 106(f), 223(d)(2)(A), and 220(d)(2)(A) do not apply to items that are not medicines or drugs, including equipment such as crutches, supplies such as bandages, and diagnostic devices such as blood sugar test kits. Such items may qualify as medical care if they otherwise meet the definition of medical care in Treas. Reg. § 1.213(d)(1), which includes expenses for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body. However, expenses for items that are merely beneficial to the general health of an individual, such as vitamins, are not expenses for medical care. Treas. Reg. § 1.213-1(e)(1)(ii). These expenses require additional medical substantiation from a healthcare provider to be considered eligible for reimbursement.

To ensure compliance with the regulation, beginning after December 31, 2010, SHPS will require a customer receipt issued by a pharmacy which identifies the name of the purchaser (or the name of the person for whom the prescription applies), the date and amount of the purchase and an Rx number, for purposes of substantiation of an OTC medication or drug expense. Expenses which may have dual purposes, such as vitamins, will also require the submission of a letter of medical necessity (LMN) from the healthcare provider. The LMN must show how the OTC medicine or drug will be used for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body; and that the OTC medicine or drug would not have been purchased by the participant "but for" the recommendation of the healthcare provider.

IRS Revenue Notice 2011-5 (OTC reimbursement using spending account debit cards)

Notice 2011-5 amends the guidance provided in Notice 2010-59 to state that effective January 15, 2011, health FSA and HRA debit cards may continue to be used to purchase OTC medicines or drugs at drug stores and pharmacies, at non-health care merchants that have pharmacies, and at mail order and web-based vendors that sell prescription drugs, if: (1) prior to purchase, (i) the prescription (as defined in Notice 2010-59) for the over the counter medicine or drug is presented (in any format) to the pharmacist; (ii) the over the counter medicine or drug is dispensed by the pharmacist in accordance with applicable law and regulations pertaining to the practice of pharmacy; and (iii) an Rx number is assigned; (2) the pharmacy or other vendor retains a record of the Rx number, the name of the purchaser (or the name of the person for whom the prescription applies), and the date and amount of the purchase in a manner that meets IRS recordkeeping requirements; (3) all of these records are available to the employer or its agent upon request; (4) the debit card system will not accept a charge for an over the counter medicine or drug unless an Rx number has been assigned; and (5) the requirements of the guidance referred to in paragraph I.02 of this notice are satisfied. If these requirements are met, the debit card transaction will be considered fully substantiated at the time and point-of-sale.

After January 15, 2011, health FSA and HRA debit cards may also continue to be used to purchase over-the-counter medicines or drugs from vendors (other than drug stores and pharmacies, non-health care merchants that have pharmacies, and mail order and web-based vendors that sell prescription drugs) having health care related Merchant Codes, as described in Rev. Rul. 2003-43, 2003-1 C.B. 935, if all requirements in the preceding paragraph are satisfied, other than the requirements in clause (1) and clause (4) of the preceding paragraph and the requirement in clause (2) of the preceding paragraph that a record of the Rx number be retained. If these requirements are satisfied, these debit card transactions will be considered fully substantiated at the time and point-of-sale. Health FSA and HRA debit cards may be used to purchase over-the-counter medicines and drugs at "90 percent pharmacies" but only as provided in Notice 2010-59. For all other providers and merchants, other than those described in this notice, health FSA and HRA debit cards may not be used to purchase over-the-counter medicines or drugs after January 15, 2011.

The IRS and Treasury intend to amend the regulations at § 1.125-6 to reflect the provisions of this notice.

Per regulation, OTC medicine and drug purchases auto-substantiated at the point of sale will be considered eligible medical expenses. For items purchased at 90% merchants, or items considered to be dual-purpose, manual substantiation is also required. This includes the submission of a customer receipt issued by a pharmacy which identifies the name of the purchaser (or the name of the person for whom the prescription applies), the date and amount of the purchase and an Rx number. For dual-purpose medicines and drugs, an LMN will also be required.

Appendix B–MCC Listing

IIAS Required	Product	MCC	Description
	Medical	4119	Ambulance
	Medical	5047	Medical, Dental, Ophthalmic, hospital equip. and supplies
Yes	Rx	5122	Drugs, Druggists, Sundries
Yes	Rx	5300	Warehouses, Wholesale Clubs
Yes	Rx	5310	Discount Stores
	Rx	5311	Department Stores
Yes	Rx	5411	Grocery Stores, Supermarkets
Yes	Rx	5499	Misc. Food Stores
Yes	Rx	5912	Drug stores and pharmacies
	Medical	5975	Hearing Aids
	Medical	5976	Orthopedic Goods
Yes	Rx	5960, 5964, 5965, 5969	Online Pharmacies
	Medical	7277	Counseling
	Medical	8011	Doctors
	Dental	8021	Dentist Orthodontist
	Medical	8031	Osteopaths
	Medical	8041	Chiropractors
	Vision	8042	Optometrists
	Vision	8043	Opticians
	Vision	8044	Optical Goods
	Medical	8049	Chiropodists
	Medical	8050	Nursing Home
	Medical	8062	Hospital
	Medical	8071	Medical and Dental Labs
	Medical	8099	Medical Service & Health
	Medical	8211	Elementary and Secondary Schools
	Medical	8220	Colleges & Universities
	Medical	8351	Child Care Services
	Medical	9399	Government services not elsewhere classified

Appendix C–Reference

Ruling	URL	Effective Date
IRS Revenue Ruling 2003 – 43	http://www.irs.gov/pub/irs-drop/rr-03-43.pdf	January 1, 2004
Internal Revenue Notice 2006–69	http://www.irs.gov/pub/irs-drop/n-06-69.pdf	January 1, 2007
Internal Revenue Notice 2007–2	http://www.irs.gov/pub/irs-drop/n-07-02.pdf	January 1, 2008 and January 1, 2009
Proposed Cafeteria Plan Regulations	http://edocket.access.gpo.gov/2007/pdf/E7-14827.pdf	TBD
US Code § 213	http://www.law.cornell.edu/uscode/26/usc_sec_26_00000213----000-.html	January 1, 1954
PPACA - Section 9003	http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3590enr.txt.pdf	January 1, 2011
Internal Revenue Notice 2010–59	http://www.irs.gov/pub/irs-drop/n-10-59.pdf	January 1, 2011
Internal Revenue Notice 2011–5	http://www.irs.gov/pub/irs-drop/n-11-05.pdf	January 16, 2011

