WHAT COUNTS AS MEDICAL CARE UNDER §213(D)

CARE, NOT CODE

Section 213(d) defines medical care more broadly than the short list of doctor bills and prescriptions suggests, and it fences that breadth with a single test of purpose. A field guide to using the full scope of the statute, and stopping where it stops.

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EXECUTIVE SUMMARY

Most benefits professionals carry a narrow picture of what the tax code counts as medical care: the doctor's bill, the hospital stay, the prescription. That picture is not wrong, but it is incomplete, and the gap between the picture and the statute is where much of the confusion about fixed indemnity design comes from.

Section 213(d) defines medical care broadly. It reaches amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, and amounts paid for the purpose of affecting any structure or function of the body. That is wider than the short list suggests, and the breadth is the point.[1]

But breadth is not looseness. The same body of law that defines medical care broadly also fences it: an expense qualifies only when it is primarily for medical care, not when it is merely beneficial to general health. The scope is wide, the fence is real, and a defensible benefit design lives inside both.[2]

This paper sets out what Section 213(d) actually reaches, where its boundary runs, how that boundary operates as the trigger line for a fixed indemnity benefit, and what documentation supports a qualified expense. The reader who knows where the line is can use everything inside it with confidence, and can recognize the designs that have drifted across it.

HOW TO READ THIS

An important note before the analysis.

WHAT IT IS

A field guide to the §213(d) definition of medical care and the boundary that fences it, for testing any benefit trigger.

WHAT IT IS NOT

Not legal or tax advice, and not a recommendation of any product. It describes a federal statutory definition and the authorities that govern it.

1 **I.R.C. §213(d)(1)(A)**
Medical care: amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or to affect any structure or function of the body.

2 **Treas. Reg. §1.213-1(e)(1)(ii)**
Confined strictly to expenses primarily for the prevention or alleviation of a defect or illness; merely beneficial to general health is not medical care.

The Optiv Group has a commercial interest in the benefit structures discussed and publishes this paper; it is written to inform, not to recommend a product. State law is not addressed. Where a benefit is insured, the carrier is an A-rated, state-licensed insurance carrier and is not named.

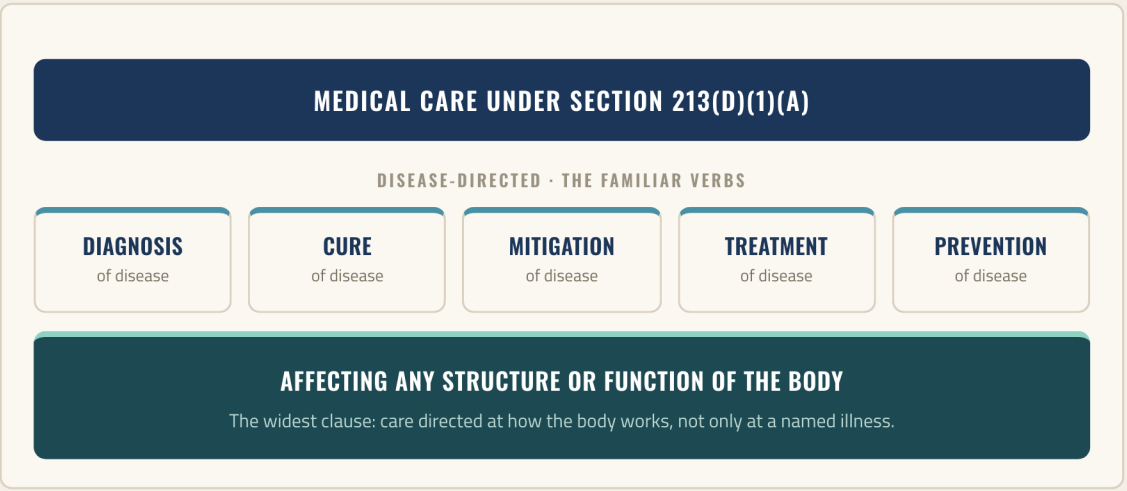
SECTION 1 · THE NARROW READING

THE QUESTION HIDING INSIDE "IS THIS COVERED"

Ask a room of benefits professionals what counts as a medical expense and the answers cluster around treatment: someone is sick, a provider treats them, the cost of that treatment is medical care. That is true, and it is the smallest part of the definition.

The statute is broader on its face. Section 213(d)(1)(A) defines medical care as amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body. Each part does work: diagnosis and prevention sit alongside cure and treatment, and the final clause reaches amounts paid to influence how the body works rather than only to treat a named illness.[3]

FIGURE 1 · THE DEFINITION, UNPACKED



I.R.C. §213(d)(1)(A).

This breadth is not a loophole and not an aggressive reading. It is the definition Congress wrote and the Treasury has applied for decades. A fixed indemnity benefit that pays on a documented medical event depends entirely on what counts as a medical event, and that is a Section 213(d) question. A narrow reading leaves real, qualifying events on the table.

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3 **I.R.C. §213(d)(1)(A)**
The disease-directed verbs and the structure-or-function clause; the latter reaches beyond a named illness to how the body works.

READ IT SLOWLY

Diagnosis and prevention are medical care just as treatment is. The narrow picture leaves most of the statute unused.

SECTION 2 · THE BREADTH

WHAT THE DEFINITION ACTUALLY REACHES

Take the statute's terms in turn. Medical care includes amounts paid for the diagnosis of disease, which covers the diagnostic visit, the laboratory work, and the diagnostic device, whether or not any disease is ultimately found. It includes prevention, mitigation, treatment, and cure, and amounts paid for the purpose of affecting any structure or function of the body.[4]

The implementing guidance fills in what this means in practice, and the list is longer than the short picture allows.

✓ INSIDE THE DEFINITION · MEDICAL CARE UNDER §213(D) AND PUB 502

- ✓ Fees of physicians, surgeons, dentists, and other practitioners
- ✓ Equipment, supplies, and diagnostic devices for medical purposes
- ✓ Premiums for insurance covering medical care
- ✓ Transportation primarily for and essential to medical care
- ✓ Lodging essential to care, within the stated nightly limit
- ✓ Qualified long-term care for a chronically ill individual
- ✓ Dental treatment; vision correction, eyeglasses, laser surgery
- ✓ Hearing aids, with batteries and maintenance
- ✓ Prescribed medicines and insulin
- ✓ Nursing services of a kind a nurse generally performs
- ✓ Inpatient hospital care, including its meals and lodging
- ✓ Psychiatric care and physical therapy
- ✓ A guide dog or service animal, with food and upkeep

All medical care under IRS Publication 502 (2024) and I.R.C. §213(d). The list is illustrative, not exhaustive.

None of these is exotic. Each is settled, published, and routinely applied: the fees of practitioners and the devices they use,[5] the transportation, insurance, and lodging that care requires,[6] the long-term care of the chronically ill,[7] and the dental, vision, hearing, nursing, and psychiatric care that fill an ordinary year. A professional who pictures only the doctor's bill is working with a fraction of the definition.

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4 **I.R.C. §213(d)(1)(A); Pub 502 (2024)**
Diagnosis includes the visit, lab work, and device, whether or not disease is found.

5 **IRS Publication 502 (2024)**
Fees of physicians, surgeons, dentists, and other practitioners; equipment, supplies, and diagnostic devices.

6 **I.R.C. §213(d)(1); Pub 502 (2024)**
Insurance premiums covering medical care; transportation and lodging primarily for and essential to care, within the stated limit.

7 **I.R.C. §213(d)(1)(C); §213(b), (d)(3)**
Qualified long-term care for a chronically ill individual; dental, vision, and hearing care; prescribed medicines and insulin.

SETTLED, NOT EXOTIC

Diagnosis, prevention, devices, transportation, dental, vision, nursing, long-term care: all of it is §213(d) medical care.

SECTION 3 · THE BOUNDARY

WHERE THE BOUNDARY RUNS

The same regulation that gives the definition its reach also gives it its limit, and the limit is a single governing idea. The deduction for medical care is confined strictly to expenses incurred primarily for the prevention or alleviation of a physical or mental defect or illness. An expense merely beneficial to general health is not medical care.[8]

That sentence is the fence. On one side, care primarily directed at a medical purpose; on the other, spending that improves general wellbeing but is not aimed at a defect or illness. Section 262 reinforces it from the other direction, denying any deduction for personal, living, or family expenses except where the Code expressly allows it.[9]

FIGURE 2 · INSIDE THE BOUNDARY, AND OUTSIDE IT

INSIDE · PRIMARILY FOR MEDICAL CARE	OUTSIDE · MERELY BENEFICIAL TO GENERAL HEALTH
■ Diagnostic visits, laboratory work, diagnostic devices	◆ Vitamins and supplements for general health
■ Equipment and supplies needed for medical care	◆ Health club and gym dues
■ Transportation primarily for and essential to care	◆ Cosmetic procedures directed at appearance
■ Lodging tied to medical care, within the stated limit	◆ A weight-loss program for general health or appearance
■ Qualified long-term care for a chronically ill individual	◆ Spending merely beneficial to general wellbeing
■ A supplement or program to treat a diagnosed disease	

The same category of spending can fall on either side. Purpose decides, not category. Treas. Reg. §1.213-1(e); I.R.C. §262; IRS Pub 502 (2024).

The boundary cases make the principle concrete. Vitamins for general health are not medical care; the same supplement to treat a physician-diagnosed condition can be. Health club dues are not; a weight-loss program is medical care only when it treats a specific diagnosed disease; cosmetic surgery is generally not, unless it corrects a deformity from a congenital abnormality, accident, or disfiguring disease.[10]

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8 **Treas. Reg. §1.213-1(e)(1)(ii)**
Confined strictly to expenses primarily for the prevention or alleviation of a defect or illness; merely beneficial to general health is not medical care.

9 **I.R.C. §262**
No deduction for personal, living, or family expenses except as expressly provided.

10 **IRS Publication 502 (2024)**
Vitamins, gym dues, weight-loss programs, and cosmetic surgery: in or out depending on whether the purpose is to treat a diagnosed condition.

THE FENCE

The scope is wide, the edge is real, and the edge is defined by purpose, not by category.

SECTION 3 · PURPOSE, NOT CATEGORY

THE SAME DOLLAR, TWO OUTCOMES

Notice what the boundary cases have in common. In each, the same category of spending lands inside or outside the definition depending on whether it is primarily for medical care or merely for general health. The dollar does not announce which side it is on. The purpose does.

FIGURE 3 · THE SAME DOLLAR, TWO OUTCOMES

A WEIGHT-LOSS PROGRAM

INSIDE §213(D) · MEDICAL CARE

- Prescribed to treat a physician-diagnosed disease: obesity, hypertension, heart disease
- Primarily for the alleviation of an illness
- Result: a qualifying medical expense

OUTSIDE §213(D) · PERSONAL EXPENSE

- Undertaken for general health or appearance
- Not aimed at a defect or illness
- Result: a personal, non-qualifying expense

The expense is identical. What it is primarily for determines whether it is medical care.

IRS Publication 502 (2024) (weight-loss program treatment); Treas. Reg. §1.213-1(e).

A weight-loss program prescribed to treat a physician-diagnosed disease is medical care; the identical program for general fitness is not.[11] The same line runs through meals at a hospital, a treatment at a health institute, dancing or swimming lessons, teeth whitening, and childcare for a healthy child: the category alone never decides.[12]

This is the boundary a defensible design respects and an aggressive one blurs. The breadth of Section 213(d) is real, and so is its edge, and the edge is defined by purpose, not by category. A reader who internalizes that test can place almost any expense.

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11 **IRS Publication 502 (2024)**
A weight-loss program is medical care only when it treats a specific disease diagnosed by a physician.

12 **IRS Publication 502 (2024)**
Hospital meals, health-institute treatment, lessons, teeth whitening, and childcare for a healthy child: each turns on purpose, not category.

PURPOSE DECIDES

The same dollar can be inside or outside the definition depending on what it is primarily for.

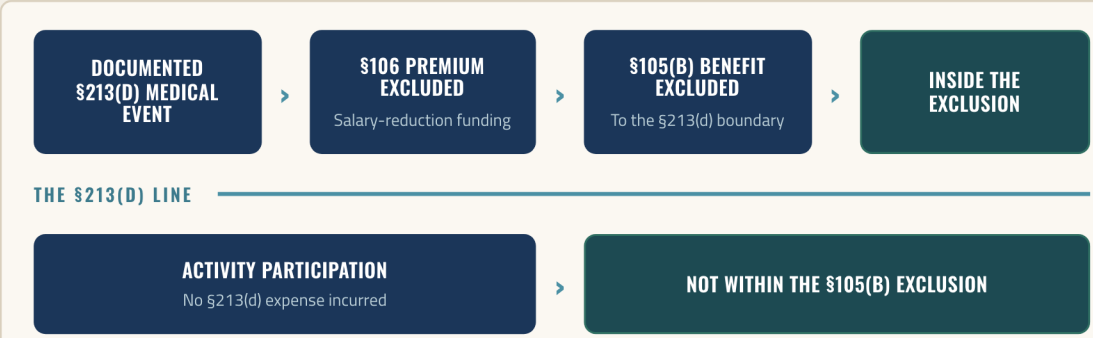
SECTION 4 · THE TRIGGER LINE

HOW THE BOUNDARY POWERS A FIXED INDEMNITY STRUCTURE

For a fixed indemnity benefit, the Section 213(d) boundary is not academic. It is the line the entire tax treatment runs through.

When the coverage is offered through a Section 125 cafeteria plan, the premium is funded by salary reduction treated as an employer contribution, excluded under Section 106.[13] The benefit the plan pays is excluded under Section 105(b), but only to the extent it reimburses the employee for medical care as Section 213(d) defines it. Any portion exceeding the employee's unreimbursed Section 213(d) expenses is includable in income, reconciled and reported by the employee under the longstanding excess-benefit rule.[14]

FIGURE 4 · THE §213(D) LINE AS THE INDEMNITY TRIGGER



A benefit paid on a documented medical event is inside the exclusion; a benefit paid on activity participation is not. I.R.C. §§106, 105(b), 213(d); Rev. Rul. 69-154; IRS CCA 202323006 (non-precedential).

So a benefit paid because a documented Section 213(d) event occurred sits inside the exclusion; a benefit paid because an employee did something that carried no Section 213(d) expense does not. In non-precedential guidance the Service addressed an arrangement that paid on participation in an activity rather than a substantiated medical event, and concluded the exclusion did not reach it. A design that conditions payment on a documented medical event is distinguishable on exactly that ground.[15]

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13 **I.R.C. §106; Treas. Reg. §1.125-1**
Salary-reduction amounts under a cafeteria plan are treated as employer contributions; employer-provided coverage is excluded from income.

14 **I.R.C. §105(b); §213(d); Rev. Rul. 69-154**
The benefit is excluded to the extent it reimburses §213(d) care; the excess over actual expense is includable and reconciled by the employee.

15 **IRS CCA 202323006 (May 9, 2023)**
Addressed an arrangement paying on activity participation rather than a substantiated §213(d) event; non-precedential and not binding.

THE SAME LINE

The line between qualifying care and general-health spending is the line between a defensible trigger and an aggressive one.

SECTION 5 · THE RECORD

WHAT DOCUMENTATION SUPPORTS A QUALIFIED EXPENSE

If the Section 213(d) event is the trigger, the documentation of that event is what holds the exclusion under examination. The record ties each benefit payment to a qualifying medical event: the provider's record of the service, the code that identifies it as Section 213(d) care, and a substantiation trail that matches the benefit to the qualifying expense.

A feature of the law here is easily misread. The regulations provide that amounts are excludable under Section 105(b) only when paid specifically to reimburse the employee for medical care, but that they may be so excludable even though paid without proof of the precise amount of the actual expense.[16] A fixed indemnity benefit can pay a set amount on a qualifying event without a dollar-for-dollar receipt for that exact event, which is part of what makes the structure workable. What the rule does not do is loosen the requirement that the payment correspond to genuine Section 213(d) care: Section 105(b) does not apply to amounts an employee would receive whether or not any medical expense was incurred.[17]

1. **The qualifying event.** The provider's record and the procedure or diagnostic code showing that a Section 213(d) service occurred. This is the evidence that the payment was for medical care and not for something else.

2. **The benefit record.** The amount the plan paid and the event it paid against, so the payment can be traced to the trigger. Operational, and held by the program's administration and the carrier.

3. **The employee-level reconciliation.** The running comparison of benefits received against unreimbursed qualifying expenses, which determines whether any excess is reportable. It belongs to the employee, who alone holds the full picture.

The law builds the reduction into the definition itself: medical care is reduced by any insurance or other reimbursement received for the same care, which is why the reconciliation cannot sit anywhere but with the person who has all the facts.[18]

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16 **Treas. Reg. §1.105-2**
Amounts are excludable only if paid specifically to reimburse medical care, even though paid without proof of the precise actual expense.

17 **Treas. Reg. §1.105-2**
§105(b) does not apply to amounts the employee would receive irrespective of whether expenses for medical care were incurred.

18 **IRS Pub 502 (2024); I.R.C. §213(d)**
Medical care is reduced by any insurance or other reimbursement received for the same care.

THE BRIDGE

Documentation is the bridge between the breadth on paper and the defensibility in fact.

SECTION 6 · BOTH HALVES AT ONCE

READING THE SCOPE WITHOUT OVERREADING IT

The two halves of this paper are meant to be held at once. Section 213(d) is broad, and the breadth is usable: diagnosis and prevention as well as treatment, the devices and transportation and lodging and long-term care that medical care requires. And the boundary is real: the expense must be primarily for medical care, with purpose rather than category deciding the question.

This is the design space Optiv Advantage occupies. It is a fixed indemnity benefit, funded through a Section 125 election, that pays on documented Section 213(d) medical events. It reaches across the genuine breadth of the definition, and it stops where the definition stops.[19]

It does not pay on general-health activity, and it does not dress a participation trigger up as a medical one, because that is the move that crosses the boundary and loses the exclusion. The benefit is described as what it is, a fixed indemnity benefit tied to qualified medical care, and never as free of tax, because the excess above qualifying expense is reportable and the design says so.

THE WORKING PRINCIPLE

Hold both the breadth and the boundary, and the scope of the statute becomes an asset the employer can use with confidence. Hold only the breadth, and a design drifts into the general-health space that draws scrutiny. The discipline is reading the whole definition, not half of it.

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19 **I.R.C. §§125, 106, 105(b), 213(d)**
A fixed indemnity benefit funded through a §125 election, paying on documented §213(d) events, with any excess reportable by the employee.

BOTH, NOT HALF

The strength of the approach is not a clever reading of the statute. It is using the statute as written, across its true scope, inside its true limit.

CONCLUSION

THE HONEST POSITION

Section 213(d) is broader than the short picture of doctor bills and prescriptions suggests, and the breadth is genuine and usable. It reaches diagnosis and prevention as well as treatment, the supplies and devices and transportation and lodging that care requires, and the long-term care of the chronically ill. That is settled law, and a benefit design is entitled to use all of it.

The breadth comes with a boundary that is equally settled. An expense is medical care only when it is primarily for the prevention or alleviation of a defect or illness, not when it is merely beneficial to general health. The boundary cases, vitamins and gym dues and weight-loss programs and cosmetic surgery, all turn on the same principle: purpose decides, not category. The same dollar can be inside or outside the definition depending on what it is primarily for.

For a fixed indemnity benefit, that boundary is the operative trigger line. A benefit paid on a documented Section 213(d) event is inside the Section 105(b) exclusion to the extent it reimburses qualifying care, with any excess reconciled by the employee. The documentation that ties each payment to a qualifying medical event is what holds the exclusion, and the rule that a benefit may pay without proof of the exact expense does not loosen the requirement that the payment be for genuine medical care.

Read the whole definition, use what is genuinely inside it, and stop where it stops.

That is what it means to build on care, not on code.

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SUPPORTING AUTHORITY

SOURCES AND DISCLOSURES

STATUTE AND REGULATION

I.R.C. §105(b) (exclusion for reimbursement of medical care); §106 (employer contributions to accident and health plans); §125 (cafeteria plans); §213(d) (definition of medical care); §262 (personal, living, and family expenses). Treas. Reg. §1.105-2 (amounts expended for medical care); §1.125-1 (cafeteria plans, general rules); §1.213-1(e) (the primarily-for-medical-care limitation).

IRS GUIDANCE AND RULINGS

Revenue Ruling 69-154, 1969-1 C.B. 46 (the excess-benefit rule for indemnification of medical care). IRS Chief Counsel Advice 202323006 (May 9, 2023), non-precedential, addressing an activity-participation fact pattern and not binding on the Service or the courts. IRS Publication 502 (2024), Medical and Dental Expenses, the includable and non-includable categories and the boundary exceptions used throughout this paper.

The Optiv Group has a commercial interest in the benefit structures described and publishes this paper; the analysis may not be independent. References reflect federal law as of the publication date and are subject to change, and this paper does not address the law of any state. Statutory facts cited here, such as the lodging per-night limit, are stated as published. The benefit structures described are offered through an A-rated, state-licensed insurance carrier that is not named. This paper is informational only and is not legal or tax advice; a reader weighing any benefit design should obtain advice from qualified counsel and a tax advisor on the reader's own facts. Contact: hello@optivhealth.us · optivhealth.us · (833) MY-OPTIV.