reimburse medical expenses. Paragraph (e) of this section sets forth additional substantiation rules that may be used for medical expenses incurred at medical care providers and certain stores with the Drug Stores and Pharmacies merchant category code. Paragraph (f) in this section sets forth the requirements for an inventory information approval system which must be used to substantiate medical expenses incurred at merchants or service providers that are not medical care providers or certain stores with the Drug Stores and Pharmacies merchant category code and that may be used for medical expenses incurred at all merchants.

(2) *Debit cards used for dependent care assistance.* Paragraph (g) of this section sets forth additional rules for debit cards usable for reimbursing dependent care expenses.

(3) *Additional guidance.* The Commissioner may prescribe additional guidance of general applicability, published in the Internal Revenue Bulletin (see § 601.601(d)(2)(ii)(*b*) of this chapter), to provide additional rules for debit cards.

(d) *Mandatory rules for all debit cards usable to pay or reimburse medical expenses.* A health FSA paying or reimbursing section 213(d) medical expenses through a debit card must satisfy all of the following requirements—

(1) 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.

(2) 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.

(3) 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.

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

(5) 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);

(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).

(6) The employer substantiates claims based on payments to medical care providers and stores described in paragraphs (d)(5)(i) and (ii) of this section in accordance with either paragraph (e) or paragraph (f) of this section.

(7) 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. So, for example, if an employee has received an improper payment of $200 and subsequently submits a substantiated claim for $250 incurred during the same coverage period, a reimbursement for $50 is made; and

(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 improper payment as it would any other business indebtedness.

(e) *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).

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

(i) *Matching copayments—multiples of five or fewer.* If an employer's accident or health plan covering the employee (or the employee's spouse or dependents) has copayments 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 copayment for the specific service (for example, pharmacy benefit copayment, copayment 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.

(A) *Tiered copayments.* If a health plan has multiple copayments for the same benefit, (for example, tiered