Brown & Brown

EMPLOYEE BENEFITS

Departments Release FAQs Related to Fertility Benefits

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On October 16, 2025, the Departments of Labor, Health and Human Services, and the Treasury (collectively, the Departments) released a set of FAQs[1] known as "FAQs about Affordable Care Act Implementation Part 72" addressing the ways in which fertility benefits would be considered an "excepted benefit" in accordance with regulations previously set forth by the Departments. This guidance was released in response to Executive Order 14216, dated February 18, 2025, which recommends policy protections related to fertility treatment and services, including in vitro fertilization (IVF), and also aims to "aggressively" reduce health plan costs associated with IVF treatment. Although fertility benefits offered under a major medical plan are allowed (and considered compliant) under regulations set forth by the Departments, some employer-sponsored group health plans do not include fertility benefits as a part of their major medical plans and offer such coverage through a stand-alone fertility benefits program. As a result, employers/plan sponsors seek to provide coverage of these fertility benefits through other means, including:

- Health reimbursement arrangements (HRAs) that are integrated with Affordable Care Act (ACA) compliant medical coverage, or
- Coverage of fertility benefits offered by third-party vendors through a stand-alone benefit program.

Previously, it was unclear whether fertility benefits offered under such stand-alone programs were compliant under federal regulations. However, these FAQs provide greater clarity as to how a fertility benefit can remain compliant under the regulations by qualifying as an excepted benefit. As a result, this new FAQ guidance is welcome news for many employer group health plan sponsors hoping to expand access to fertility benefits and reduce the cost of these services for their employees.

[1] *Generally, FAQs released by the Departments serve as sub-regulatory guidance from the Departments that answer questions from interested stakeholders to help them better understand the law and promote compliance.*

Background

Under current regulations issued by the Departments, excepted benefits (e.g., stand-alone dental/vision coverage, fixed indemnity plans, Medicare supplemental plans) are not subject to many of the regulations that govern their non-excepted benefit counterparts (e.g., medical coverage/minimum value coverage/minimum essential coverage). For instance, excepted benefits are not subject to certain ACA requirements, including:

- The prohibition on applying lifetime/annual dollar maximums to essential health benefits (EHBs) offered under a medical plan, and
- The requirement for plans to provide preventive care to plan participants without any cost sharing (i.e., preventive care must be covered and paid 100% by the plan).

The Departments previously issued regulations and guidance in connection with how certain benefit coverages may be considered excepted benefits. For a benefit plan to qualify as an excepted benefit, it must fall into one of four sub-categories that are prescribed under the federal rules. These four sub-categories are:

i. Non-health related benefits (e.g., automobile insurance, workers' compensation coverage, or accident/disability income insurance)
ii. Limited excepted benefits (e.g., stand-alone dental/vision coverage)
iii. Independent, non-coordinated excepted benefits (e.g., fixed/hospital indemnity plans and specified disease/illness plans)
iv. Supplemental excepted benefit plans (e.g., Medicare supplemental plans)

FAQs on Fertility Benefits Qualifying as Independent, Noncoordinated Excepted Benefits or Limited Excepted Benefits

For ease of understanding and for purposes of brevity, this article will focus on only two sub-categories of benefits that qualify as excepted benefits: 1) independent, noncoordinated excepted benefits; and 2) limited excepted benefits.

The new FAQ guidance confirms that fertility benefits can qualify as an excepted benefit through either of the above two sub-categories in certain circumstances. The following sections provide a detailed description of this guidance.

The Requirements for Fertility Benefits to Qualify as an Independent, Noncoordinated Excepted Benefit

For fertility benefits to be considered an independent, noncoordinated excepted benefit under the regulations, this FAQ guidance confirms the benefits must satisfy all three of the following requirements:

i. The benefits are provided for under a "separate policy certificate or contract of insurance," meaning it must be a fully insured plan;
ii. There is no coordination of benefits between the fertility benefits and the exclusion of such benefits from the other plans maintained by the same employer plan sponsor[2]; and
iii. The fertility benefits must be paid by the fertility benefits insurer regardless of whether such benefits are also provided by the group health plan maintained by the same employer plan sponsor.

Employees need not be enrolled in the major medical plan/traditional group health plan in order for the stand-alone fertility benefits to be considered an excepted benefit under the sub-category of an independent, noncoordinated excepted benefit. Further, at this time, the first requirement above means that fertility benefits cannot be provided on a stand-alone self-funded basis (i.e., fertility benefits cannot be offered as a stand-alone self-funded plan) if the employer is seeking to offer fertility benefits that qualify as an excepted benefit under the sub-category of an independent, noncoordinated excepted benefit. The FAQs state that the Departments intend to expand the list of excepted benefit sub-categories to include, in future rulemaking, stand-alone self-funded fertility benefits.

Also, notably, the FAQs include a footnote clarifying that hospital indemnity or other fixed indemnity insurance could qualify as an independent, noncoordinated excepted benefit if it pays a fixed dollar amount per period of hospitalization or illness related to infertility (for example, $100/day), regardless of expenses occurred. This is only true if it meets all of the other criteria for qualifying as a noncoordinated excepted benefit detailed earlier in this article.

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[2] The application of this condition is unclear. If the employer's group medical plan excludes all benefits for fertility and the employer wishes to provide fertility benefits through a stand-alone insurance policy, there could be a potential concern that the separate fertility insurance policy is coordinating with an exclusion of such benefits under the employer's medical plan. This issue should be further discussed with legal counsel.

The Requirements for Fertility Benefits to Qualify as a Limited Excepted Benefit

The FAQs also describe situations where fertility benefits can qualify as an excepted benefit under the category of limited excepted benefits. These methods may include payment for/reimbursement of fertility benefits through an excepted benefit HRA or an Employee Assistance Program (EAP), provided it meets the requirements set forth under the excepted benefits sub-category of limited excepted benefits. These situations are outlined in more detail below.

Excepted Benefit HRA

Another pathway for employees to be reimbursed for fertility-related expenses is through an "excepted benefit HRA," if the excepted benefit HRA meets the following requirements:

- It is not an integral part of the employer's group health plan, and the excepted benefit HRA is only offered to employees who are eligible for the employer's medical coverage.
- The reimbursement for fertility benefits (or any other qualified expenses that an excepted benefit HRA may reimburse) is limited to a certain amount. The inflation-adjusted limit is $2,200 for 2026.
- The excepted benefit HRA cannot reimburse certain health insurance premiums but can reimburse premiums for excepted benefit plans.
- The excepted benefit HRA must be provided to all "similarly situated" individuals, regardless of any health factor.

Employee Assistance Program (EAP)

Specific fertility benefits related to counseling or coaching/navigating services can be provided under an EAP that is considered an excepted benefit. As a general rule, for an EAP to be considered an excepted benefit, it cannot provide any "significant" benefits for medical care (along with other requirements set forth under the regulations). The FAQs underscore that "an EAP will not be considered to provide benefits that are significant in the nature of medical care solely because it offers benefits for coaching and navigator services to help individuals understand their fertility options."

An EAP that includes fertility benefits and does not provide "significant" medical care must satisfy the following additional requirements to qualify as an excepted benefit (under the sub-category of a limited excepted benefit):

- It must not be coordinated with other benefits under the employer's/plan sponsor's group health plan;
- Participants cannot be required to contribute towards the EAP as a condition for participation; and
- Participants cannot have any cost-sharing related to services received under the EAP.

Whether an EAP is considered an excepted benefit should be further discussed with legal counsel.

Excepted Benefits and HSA Eligibility

The Internal Revenue Service (IRS) allows individuals to contribute to a Health Savings Account (HSA) and receive first-dollar coverage (prior to satisfying their minimum applicable IRS deductible) under another non-HDHP plan in very limited circumstances[3]. The FAQs state that fertility benefits offered as an independent, noncoordinated excepted benefit policy will not jeopardize an employee's HSA eligibility. As a result, an employee may continue to contribute to an HSA even if they are receiving first-dollar coverage (prior to satisfying their minimum applicable IRS deductible) for fertility benefits under an independent, noncoordinated excepted benefit policy. However, coverage under an excepted benefit HRA typically will make an employee ineligible for HSA contributions.

Other Considerations for Employer Group Health Plan Sponsors Adopting Stand-Alone Fertility Benefit Programs

Employers/plan sponsors seeking to offer fertility benefits to their employees without subjecting those benefits to the numerous restrictions typically applied to major medical plans may find this FAQ guidance to be welcome news. However, for these fertility benefits to be offered as a stand-alone benefit outside of a plan sponsor's major medical coverage and preserve their status as an excepted benefit, employers/plan sponsors should proceed cautiously when implementing an independent, non-coordinated excepted benefit or a limited excepted benefit for fertility-related services and/or treatment. Although this new FAQ guidance confirms that fertility benefits may be offered as an excepted benefit (as outlined in this new FAQ's guidance), these benefits are still subject to many other group health plan rules, including ERISA[4] and COBRA[5].

The new FAQs can be accessed directly, here:

GO TO WEBSITE →

[3] *https://www.irs.gov/pub/irs-pdf/p969.pdf*

[4] *The Employee Retirement Income Security Act of 1974.*

[5] *The Consolidated Omnibus Budget Reconciliation Act.*

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