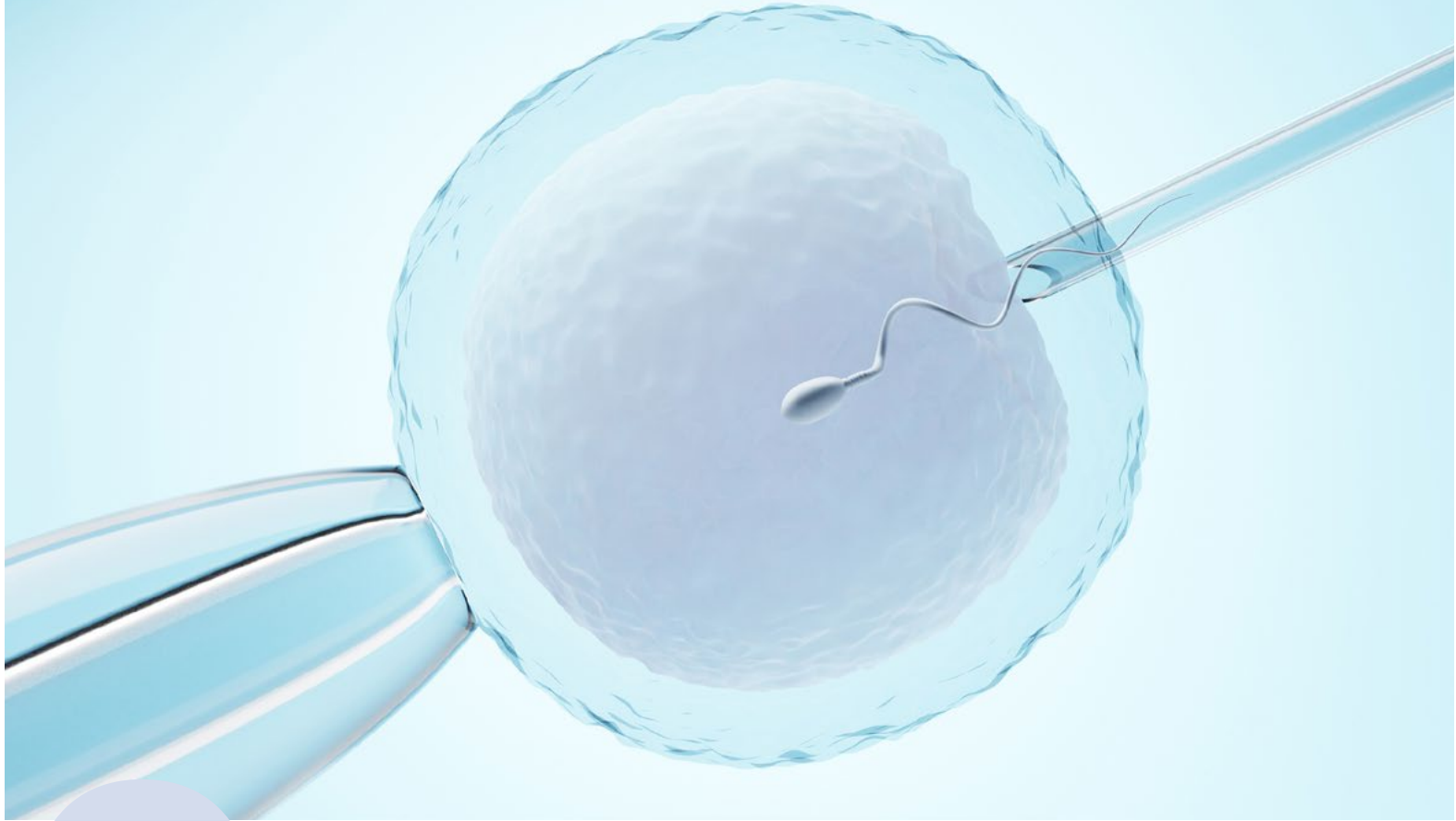


FERTILITY BENEFITS, EXCEPTED BENEFITS, AND FUTURE RULEMAKING -- FAQs



Written By Alston & Bird Health Benefits Practice

On October 16, 2025, the Departments of Labor, Health and Human Services (HHS), and the Treasury (collectively, “the Departments”) jointly released Part 72 of Frequently Asked Questions (FAQs) regarding the implementation of certain provisions of the Affordable Care Act (ACA). These FAQs clarify how stand-alone fertility benefits can be structured under existing law and are part of a broader policy initiative first announced in Executive Order (“EO”) 14216, “Expanding Access to In Vitro Fertilization.”

Among the EO’s recommendations was the issuance of regulations or guidance to allow employers to expand access to fertility coverage through excepted benefits. While these FAQs do not alter current law, the Departments have indicated their intent to propose new rulemaking in this area which will likely provide additional options for providing such benefits.

The guidance provides an overview of a complex area of law involving four categories of coverage collectively referred to as “excepted benefits.” Excepted benefits generally do not have to comply with certain federal laws that typically apply to employer group health plans—most notably, the ACA’s market reform requirements—provided certain conditions are met. Stand-alone fertility benefits can currently be offered through two of the four categories of excepted benefits without triggering ACA compliance requirements.

INDEPENDENT, NONCOORDINATED EXCEPTED BENEFITS – AN INSURED SOLUTION

Independent, noncoordinated excepted benefits include coverage for only a specified disease or illness and hospital indemnity or other fixed indemnity insurance. Employers often offer stand-alone voluntary insurance coverage for a specified disease, such as cancer; similarly, they could offer coverage for fertility benefits. To qualify as an independent, noncoordinated excepted benefit, the following conditions must be met:

- The benefit must be provided under a separate policy, certificate, or contract of insurance.
- There must be no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor.
- Benefits must be paid with respect to an event, regardless of whether benefits are provided under any group health plan maintained by the same plan sponsor.

If these conditions are satisfied, an employer could offer a specified disease or illness policy covering infertility as an excepted benefit, regardless of whether the employee is enrolled in the employer's traditional group medical plan. The benefit could be designed so that even part-time employees who are not eligible for the employer's traditional group medical plan could enroll in the excepted benefit fertility coverage.

It is important to note that fertility benefits offered through this exception cannot be self-funded by the employer. Independent, noncoordinated excepted benefits must be provided under a separate policy, certificate, or contract of insurance. Offering insured stand-alone coverage for fertility benefits may be costly, as individuals at higher risk for fertility challenges or with pre-existing conditions are more likely to purchase such coverage, increasing premium costs. However, if the adverse selection issues can be overcome, this coverage would be compatible with participation in a health savings account (HSA), since insurance for a specified disease or illness does not disqualify an individual from contributing to an HSA.



LIMITED EXCEPTED BENEFITS AND EBHRAS

Limited excepted benefits include, but are not limited to, certain types of health reimbursement arrangements (HRAs). Regulations specify that certain HRAs (and other account-based group health plans other than health flexible spending accounts) can qualify as limited excepted benefits if they meet specific conditions. These HRAs are known as excepted benefit HRAs, or “EBHRAs.”

Conditions for EBHRAs:

- The benefit must not be an integral part of the plan (other group health plan coverage must be available for the plan year).
- Benefits are limited in amount (for 2025, the limit is \$2,150).
- No reimbursement of certain health insurance premiums (except for coverage consisting solely of excepted benefits).
- Uniform availability to all similarly situated individuals, regardless of health factor.

For employers who prefer to self-fund fertility benefits—even for employees not enrolled in an employer’s major medical group health plan—an EBHRA may be an option that would not be subject to other group health plan mandates like the ACA. However, with an annual maximum of just \$2,150 in 2025, the cap is well below the cost of typical fertility treatments. By comparison, and not mentioned in these FAQs, an HRA integrated into the employer’s group health plan can provide unlimited, uncapped annual benefits. Although an integrated HRA would not be a stand-alone fertility benefit, it remains an option for employers wishing to self-fund a fertility benefit instead of offering it as a covered treatment or service under the major medical plan.

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Another drawback to an EBHRA (or even an integrated HRA) is that reimbursements for fertility expenses are limited to medical expenses as defined under Internal Revenue Code (“Code”) Section 213(d). Guidance and rulings in the area of fertility benefits have not kept pace with the lifestyles and expectations of would-be parents. For example, many women may expect coverage for egg storage, regardless of the length of storage, to be a 213(d) medical expense.

However, there is uncertainty as to whether the expense would qualify if it is for undefined future conception rather than temporary storage necessary for immediate conception. Expenses related to surrogates are also not Code Section 213(d) medical expense. Even fertility expenses for same-sex couples who may not meet a medical definition for “infertile” have not been formally addressed by the IRS in guidance applicable to all taxpayers. Clarification and expansion of 213(d) status to some of these expenses would be helpful for plan sponsors and plan participants alike.

EMPLOYEE ASSISTANCE PROGRAMS

Limited excepted benefits also include, but are not limited to, employee assistance programs (EAPs). The FAQs remind employers that coaching and navigator services for fertility options can be provided through an EAP, as long as the EAP does not provide significant benefits in the nature of medical care and meets other regulatory requirements. However, if the EAP offers significant medical care benefits, it would not qualify as a limited excepted benefit. Additionally, the EAP must not be coordinated with another group health plan, must not require employee premiums or contributions, and must not have cost sharing.

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POSSIBLE CHANGES FOR SUPPLEMENTAL EXCEPTED BENEFITS

The Departments are considering whether to modify the standards for supplemental health insurance coverage provided by a group health plan, including supplemental fertility coverage. Currently, one criterion is that the cost of coverage does not exceed 15 percent of the cost of primary coverage. The Departments are evaluating whether this limitation-on-value safe harbor should be increased, at least for fertility benefits, which often cost tens of thousands of dollars and are likely to be elected only by those at high risk or with pre-existing conditions, further driving up coverage costs.

Key Takeaways for Plan Sponsors, Employers, and TPAs

- **No Change to Current Law:** The FAQs clarify existing categories and conditions for excepted benefits. They do not change the law or create new obligations for plan sponsors, employers, or TPAs.
- **Fertility Benefits as Excepted Benefits:** Employers may offer fertility benefits as independent, noncoordinated excepted benefits or as limited excepted benefits, provided statutory and regulatory conditions are met.
- **Self-Funded Arrangements:** Currently, self-funded arrangements cannot qualify as independent, noncoordinated excepted benefits. The Departments intend to address this in future rulemaking.
- **Future Rulemaking and Guidance:** The Departments intend to propose new rules to expand the ways fertility benefits may be offered as excepted benefits. Clarification and expansion of the types of fertility services and treatment that qualify as a Code Section 213(d) medical expense would also be welcome.
- **Supplemental Coverage Standards:** The Departments are considering changes to the limitation-on-value safe harbor for supplemental coverage, which could impact how supplemental fertility benefits are structured. ■

Attorneys John Hickman, Ashley Gillihan, Amy Heppner, and Laurie Kirkwood provide the answers in this column. John is partner in charge of the Health Benefits Practice with Alston & Bird, LLP, an Atlanta, New York, Los Angeles, Charlotte, Dallas and Washington, D.C. law firm. Ashley is a partner in the practice, and Amy and Laurie are senior members in the Health Benefits Practice. Answers are provided as general guidance on the subjects covered in the question and are not provided as legal advice to the questioner's situation. Any legal issues should be reviewed by your legal counsel to apply the law to the particular facts of your situation. Readers are encouraged to send questions by E-MAIL to John at john.hickman@alston.com.