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Employee Benefits Alert

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Federal FAQs clarify pathways for employer coverage of fertility benefits

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The FAQs provide immediate, practical avenues for employers to expand fertility coverage under existing excepted-benefit frameworks.



What's the impact?

- Specified-disease policies for infertility can be offered today if insured and noncoordinated.
- Excepted benefit HRAs can reimburse out-of-pocket fertility expenses within indexed limits.
- EAPs may include fertility navigation supports without becoming significant medical coverage.
- With potential rulemaking on the horizon, sponsors should align near-term offerings with current rules and be ready to evaluate new limited excepted benefit options as they emerge.

Employers have new clarity on how to expand access to fertility treatment coverage while navigating Affordable Care Act (ACA), ERISA, and Internal Revenue Code requirements. In newly

issued Frequently Asked Questions (FAQs), the Departments of Labor, Health and Human Services, and Treasury (the Departments) outline the existing compliance frameworks that plan sponsors can use to offer fertility-related benefits as “excepted benefits,” including specified-disease policies, excepted benefit health reimbursement arrangements (HRAs), and certain employee assistance programs (EAPs). The guidance also previews potential rulemaking that could further broaden options, including self-funded approaches under the “limited excepted benefits” category.

The FAQs reflect a federal policy priority to protect access to in vitro fertilization (IVF), reduce out-of-pocket costs, and encourage adoption of a broader suite of fertility-related supports, including benefits that address root causes of infertility.

What’s in the fertility treatment coverage FAQs?

- / Employers may provide fertility benefits through fully insured specified-disease policies as “independent, noncoordinated excepted benefits” (e.g., infertility-only coverage or indemnity insurance providing a fixed-dollar amount for hospitalization or illness related to infertility).
- / Individuals enrolled in specified-disease fertility coverage remain eligible to contribute to HSAs if they are otherwise HSA-eligible.
- / Excepted benefit HRAs can reimburse out-of-pocket fertility costs if they comply with existing dollar limits and structural rules.
- / EAPs may include fertility coaching/navigator services so long as they do not provide significant medical care.

Independent, noncoordinated excepted benefits: Specified disease and fixed indemnity options

The FAQs confirm that an employer may offer a specified disease or illness policy that covers infertility-related benefits as an independent, noncoordinated excepted benefit, provided all statutory conditions are satisfied. Qualifying coverage must:

- / be provided under a separate policy, certificate, or contract of insurance;
- / involve no coordination between the excepted benefit and any exclusion under the plan sponsor’s other group health plans; and
- / pay benefits without regard to whether other group health plan coverage applies to the same event.

The guidance underscores several compliance nuances. First, participants need not be enrolled in the employer’s traditional group health plan to receive specified-disease infertility coverage.

Second, coverage in this category cannot be self-funded; it must be offered through a separate insurance policy. Third, certain hospital indemnity or other fixed-indemnity insurance paying a set dollar amount per period (e.g., \$100/day) of hospitalization or illness related to infertility may also qualify, if the above requirements are met.

Notably, the FAQs clarify that insurance for a specified disease or illness is among the types of permitted coverage that does not disqualify HSA eligibility, assuming the individual is otherwise covered by a qualifying high-deductible health plan and has no other disqualifying coverage.

Limited excepted benefits: Excepted benefit HRAs and EAPs

The FAQs reaffirm how existing “limited excepted benefit” vehicles can support fertility access.

EXCEPTED BENEFIT HRAS

Under final rules adopted in 2019, excepted benefit HRAs (and other account-based group health plans recognized as limited excepted benefits) are excepted if they satisfy structural conditions, including:

- / the HRA is not an integral part of the plan (i.e., the plan sponsor also makes other, non-excepted group health coverage available for the plan year);
- / the HRA’s annual newly available amount does not exceed the indexed cap (\$2,150 for plan years beginning in 2025);
- / prohibited premium reimbursements are excluded (with limited exceptions for excepted-benefit-only coverage); and
- / the HRA is uniformly available to similarly situated individuals without regard to health factors.

When these requirements are met, an excepted benefit HRA may reimburse employees’ out-of-pocket fertility-related expenses. Note that many major medical benefits provide at least some coverage for fertility services, so the excepted benefits HRA would be available to cover related cost-sharing or for services not covered by the plan (as long as the services are eligible medical expenses).

EAPS

EAPs remain excepted benefits when they do not provide significant benefits in the nature of medical care and adhere to the no coordination, no employee-premium/contribution, and no cost-sharing rules. The FAQs clarify that fertility coaching and navigator services alone do not render an EAP a provider of “significant” medical care. However, offering fertility treatments or other substantial medical services through an EAP would jeopardize excepted-benefit status.

Anticipated rulemaking: Broader limited excepted benefits and supplemental coverage

Looking ahead, the Departments signal intent to propose notice-and-comment rulemaking that could recognize additional fertility benefits as “other, similar limited benefits” within the limited excepted benefits category. This development could open the door to employer self-funding of certain fertility benefits when defined conditions are met. The Departments are also considering whether to modify standards for supplemental excepted benefits, including reevaluating the limitation-on-value safe harbor that has capped supplemental coverage at 15% of the value of primary coverage. Any such changes could enhance flexibility for plan sponsors looking to wrap fertility coverage around existing health plans.

Practical considerations for plan sponsors

Employers currently providing or considering providing infertility benefits should:

- / Coordinate with insurers to ensure separate-policy requirements and noncoordination criteria are satisfied for specified-disease coverage, where applicable.
- / Confirm that hospital indemnity/fixed-indemnity benefits are paid on a per-period basis regardless of expenses incurred, and that other independent, noncoordinated conditions are met.
- / Consider leveraging HRAs to reimburse a broad range of fertility-related out-of-pocket costs within annual dollar limits.
- / Think about enhancing EAPs with fertility education, coaching, and navigation tools.
- / Provide employees with clear disclosures and communications about eligibility, benefit scope, dollar limits, cost sharing (if any), and the relationship between excepted benefits and major medical coverage.
- / Maintain plan documents and administrative procedures reflecting excepted benefit structures, including separate policy arrangements, uniform availability criteria, reimbursement prohibitions, and EAP coordination safeguards.
- / Monitor forthcoming rulemaking that may broaden limited excepted benefit pathways for fertility coverage and consider how potential adjustments to supplemental-benefit value limitations could support wrap coverage or self-funding.
- / Work with ERISA counsel to ensure all plan documentation accurately reflects fertility programs and eligibility requirements.

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