Compliance Alert

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Expanding Fertility Benefits: Proposed 2027 Rule Would Create New Excepted Benefit Category

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EXCEPTED FERTILITY BENEFITS — PROPOSED RULE FOR 2027

The Departments of the Treasury, Labor, and Health and Human Services (the Departments) announced a proposed rule (the Rule) on Mother's Day (May 10, 2026) that establishes fertility benefits as a new category of limited excepted benefits. The proposal seeks to implement Executive Order 14216, "Expanding Access to In Vitro Fertilization," which directed the Departments to ease regulatory burdens and expand access to fertility treatment, including in vitro fertilization (IVF).

Once finalized, the Rule will take effect for plan years beginning on or after January 1, 2027. The public comment period is open for 60 days following publication in the Federal Register on May 13, 2026.

Applies To:

- Employers sponsoring a traditional group medical plan who wish to offer standalone fertility benefits as a limited excepted benefit.
- Third-party administrators (TPAs) and carriers designing or administering fertility benefit arrangements.

Note, the Rule is not applicable to individual market coverage. HHS is considering separate guidance for individual market application. So, employers sponsoring an Individual Coverage Health Reimbursement Arrangement (ICHRA) cannot offer what the Rule is proposing.

Go Deeper:

If finalized, this Rule would create a major new type of excepted benefit for fertility benefits.

Currently, employers that want to cover fertility services such as IVF typically must do so through major medical coverage (which may not be available through the employer's insurance company) or with a bolt-on arrangement fully integrated with the medical coverage (which the Departments believe is the most common approach). In either setup, fertility benefits are subject to the full scope of group health plan rules, including ACA, MHPAEA, No Surprises Act, and more.

The Rule would allow employers to instead offer fertility benefits as a standalone, limited excepted benefit, reducing compliance complexity and potentially allowing employers to offer broader, more targeted fertility coverage than what is typical under a traditional group medical plan.

WHAT'S NEW

- Standalone fertility benefits, including IVF coverage, could qualify as a new limited excepted benefit beginning in 2027.
- Employers may offer fertility coverage outside the major medical plan while avoiding many ACA, MHPAEA, and No Surprises Act requirements.
- Fertility benefits would be subject to a proposed $120,000 lifetime cap per participant, indexed for inflation after 2027.
- Plans offering excepted fertility benefits must meet strict conditions, including separate plan design, participant notice requirements, and access regardless of enrollment in the employer's medical plan.

TAKEAWAY

If finalized, the proposed Rule would give employers a new, more flexible way to offer fertility benefits outside of traditional medical coverage, but only if the arrangement satisfies detailed compliance requirements and lifetime benefit limits.

What Are Excepted Fertility Benefits?

According to the Rule, "fertility benefits would be recognized as limited excepted benefits when coverage is limited to benefits substantially all of which are for the diagnosis, mitigation, or treatment of infertility or infertility-related reproductive health conditions and substantially all of which are provided by medical professionals authorized to practice under applicable law."

The benefit may cover a broad range of services, substantially all of which must be provided by medical professionals authorized to practice under applicable law. Such items and services are proposed to include:

- **Diagnostic Services:** Blood tests, hormone panels, semen analysis, laparoscopy, hysteroscopy, imaging, and genetic testing.
- **Medical Treatment:** Ovulation induction (oral or injectable medications), surgical procedures (e.g., removal of fibroids or endometriosis tissue), and intrauterine insemination (IUI).
- **Assisted Reproductive Technology (ART):** In vitro fertilization (IVF) and related procedures.
- Treatment of Underlying Conditions: Coverage for infertility-related reproductive health conditions such as polycystic ovary syndrome (PCOS), endometriosis, uterine fibroids, thyroid disorders, and other endocrinopathies that contribute to infertility.
- **Male-Factor Infertility:** Evaluation, medical management, and surgical approaches including robotic surgery.
- **Fertility Counseling and Education:** Provided that substantially all of the fertility benefits are still at the direction of a medical professional authorized to practice under applicable law.

The proposal explicitly excludes abortion and abortion-related services from the scope of excepted fertility benefits. And it does not appear to expand to allow coverage of services or expenses for someone other than the employee or beneficiary, such as a surrogate.

Conditions to Qualify as an Excepted Benefit

For fertility benefits to qualify as limited excepted benefits, all of the following conditions must be met:

- **Separate Offering:** Benefits must be provided under a separate policy, certificate, or contract of insurance, or must otherwise not be an integral part of the medical plan.
- **Traditional Plan Availability:** The plan sponsor must also offer a group health plan that is not limited to excepted benefits (and is not an HRA, individual coverage HRA (ICHRA), or other account-based plan) to the same participants offered the fertility benefit for the same plan year.
- **No Enrollment Mandate:** Participants are not required to enroll in the employer's traditional group health plan to be eligible for the fertility benefit. Employees who have coverage elsewhere (e.g., through a spouse's plan), or no coverage at all, may still enroll.
- **Scope Limitation:** Substantially all benefits must be for the diagnosis, mitigation, or treatment of infertility or infertility-related reproductive health conditions.
- **Medical Professional Requirement:** Substantially all services must be delivered by medical professionals authorized to practice under applicable law.
- **Lifetime Dollar Limit:** The maximum benefit payable to any participant (together with their beneficiaries) may not exceed $120,000 lifetime, indexed annually for medical inflation beginning with plan years after December 31, 2027.

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The $120,000 Lifetime Dollar Limit

One proposed condition is that the fertility benefit impose a lifetime dollar limit of no more than $120,000 per participant (inclusive of any beneficiary coverage), with indexing in future years. The Departments solicit comments about whether this is a narrow or broad range of items and services. A narrow scope benefit like long-term care, dental, vision, or EAP coverage does not need dollar limits. When eligible expenses reach beyond a narrow scope, a limit is typically required, such as that applied to health FSAs and EBHRAs.

The $120,000 lifetime cap reflects the reality that IVF costs typically range from $15,000 to $20,000 per cycle, with patients often requiring an average of 2.5 cycles. A $120,000 lifetime benefit is intended to allow meaningful coverage across multiple treatment attempts or for multiple children.

Once a participant exhausts the lifetime limit, no further excepted fertility benefits are allowed under this Rule. However, an employer may still choose to cover additional fertility services through its traditional group health plan, subject to applicable ACA and other requirements. And individuals could still receive fertility benefits through the excepted fertility benefit of another unrelated employer, such as through a spouse's separate, unrelated employer or the employee's future, unrelated employer.

The Departments are soliciting comments on the reasonableness of this approach, and whether they should instead consider an annual dollar limit approach which can carry over unused funds to future years.

Overlap with Medical Plan Permitted

Nothing prohibits this benefit from overlapping benefits provided under the participant's medical plans, and coordination of benefits rules will apply.

Required Notice

Plans and issuers offering excepted fertility benefits must provide a written notice to participants and beneficiaries. The notice must include:

- A description of the fertility benefit coverage.
- A summary of coverage limits and limitations, including the specific lifetime dollar limit.
- Information on identifying and accessing network providers, if applicable.
- Instructions on how to submit claims, including both electronic and paper options, required documentation, and claims procedures.
- A clear statement of whether the fertility benefit uses the same claims procedure as the sponsor's other group health plans.

The notice must be written in a manner that the average plan participant can understand (targeted at an 8th-grade reading level or below, with minimal technical jargon). The notice must be provided no later than the first date the participant is eligible to enroll, annually thereafter, and upon request. The notice may be bundled with other required enrollment materials and delivered electronically if otherwise permitted under plan disclosure rules. It must also be provided separately to beneficiaries with a known separate address.

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Regulatory Relief for Being an Excepted Benefit

As background, excepted benefits are a defined category of group health plans that are generally exempt from:

- The federal market requirements imposed under the Affordable Care Act (ACA);
- Consolidated Appropriations Act 2021 (CAA-21), which includes the No Surprises Act;
- Mental Health Parity and Addiction Equity Act (MHPAEA);
- Health Insurance Portability and Accountability Act (HIPAA) nondiscrimination and portability requirements;
- Newborns' and Mothers' Health Protection Act (NMHPA);
- Women's Health and Cancer Rights Act (WHCRA);
- Genetic Information Nondiscrimination Act (GINA);
- Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA);
- Michelle's Law; and
- Division J of the Consolidated Appropriations Act 2026 (CAA-26).

However, excepted benefits are not exempt from certain other group health plan rules. Rules that continue to apply include but are not limited to:

- ERISA (including plan document/SPD, 5500 filing, fiduciary obligations, plan asset rules, claim and appeal rules, and more);
- The Consolidated Omnibus Budget Reconciliation Act (COBRA);
- HIPAA Privacy & Security;
- Medicare Secondary Payer (MSP) Act;
- IRC Section 125 compliance when employees purchase the excepted benefit with pre-tax paycheck deductions;
- IRC Section 105(h) nondiscrimination rules when the excepted benefit is self-funded; and
- State laws that may apply, particularly to insurance contracts.

There are four statutory categories of excepted benefits:

- Benefits that are excepted in all circumstances (such as worker's comp);
- **Limited excepted benefits (which this Rule seeks to expand);**
- Independent, noncoordinated excepted benefits (such as indemnity policies); and
- Supplemental excepted benefits.

Limited excepted benefits are either provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a traditional medical plan. These include:

- Limited-scope dental and vision coverage;
- Benefits for long-term care, nursing home care, home health care, or community-based care that are offered separately;
- Certain health Flexible Spending Arrangements (health FSAs), subject to the Availability Condition and Maximum Benefit Condition;
- Employee Assistance Programs (EAPs), subject to four specific rules; and
- Starting in 2019, a newly approved type of Health Reimbursement Arrangement (HRA) called excepted benefit HRAs (EBHRAs) which must follow certain rules.

The Rule would add fertility benefits as a new type of limited excepted benefit with its own set of rules.

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Action Steps for Employers

- **Review the Proposed Rule:** Assess whether offering fertility benefits as a standalone excepted benefit aligns with your employee benefits strategy and workforce demographics.
- **Submit Comments:** The public comment period is open for 60 days after Federal Register publication. Comments may be submitted electronically at www.regulations.gov (Docket No. 1210-AC40). Employers, carriers, and advisors with views on the dollar limit structure, scope of covered services, or implementation timeline will want to engage.
- **Assess Existing Fertility Benefits:** Employers who currently offer fertility coverage through their major medical plan should consider whether supplementing that coverage with an excepted fertility benefit may provide meaningful benefits to employees and beneficiaries.
- **Coordinate with Carriers and TPAs:** Insurers and TPAs will need to develop compliant product offerings and claims administration procedures before the 2027 plan year.
- **Monitor for Final Rule:** Given the proposed January 1, 2027 applicability date, a Final Rule will need to be issued in advance of open enrollment season. Watch for the Final Rule and any sub-regulatory guidance from the Departments.

Consequences of Non-Compliance:

A fertility benefit arrangement that fails to satisfy the proposed conditions (including the $120,000 lifetime limit, the "substantially all" scope standard, the separate offering requirement, or the notice requirements) will not qualify as a limited excepted benefit. Instead, it would be treated as a group health plan subject to the full scope of HIPAA, ACA, No Surprises Act, and other requirements. This could expose the plan and plan sponsor to significant compliance obligations and potential penalties of $100 per person per day.

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