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Employee Benefits Compliance

## Proposed Rule Permits Fertility Benefits on a Stand-Alone Basis

### Introduction

On May 10, 2026, the U.S. Departments of Labor, Health and Human Services, and the Treasury (the Departments) issued a [Notice of Proposed Rulemaking](#) (Proposed Rule) that would create a new option for employers to offer fertility and infertility-related benefits outside traditional group health plan coverage. Building on [Executive Order 14216](#) and [Frequently Asked Questions Part 72](#), which outlined pathways for providing fertility care through existing excepted benefit structures (see [Alert 2025-03](#)), the Proposed Rule would establish a new category of limited excepted benefits for fertility coverage. These benefits could be offered on a stand-alone basis if certain conditions are met.

### Background on Excepted Benefits

The Proposed Rule relies on the existing framework for excepted benefits, under which certain categories of coverage are exempt from many federal group health plan requirements under HIPAA, the Affordable Care Act (ACA), the No Surprises Act, and related market reform rules. One category, limited excepted benefits, includes narrow or supplemental coverage such as stand-alone dental and vision plans. Under the Proposed Rule, the Departments would exercise its authority to treat certain fertility-related benefits as a new type of limited excepted benefit.

### Overview of Proposed Rule

To qualify as an excepted fertility benefit under the Proposed Rule, coverage must meet four requirements:

1. **Covered Services.** Coverage must be limited to the diagnosis, mitigation, or treatment of infertility or infertility-related reproductive health conditions and must primarily be provided by medical professionals. Qualifying services may include:
  - Diagnostic services (e.g., bloodwork, imaging, hormone testing)
  - Mitigation services (e.g., lifestyle assessments, pre-conception care, surgical correction of infertility-related conditions)
  - Treatment services (e.g., ovulation induction, intrauterine insemination (IUI), assisted reproductive technologies, including IVF, counseling and care-navigation services)

- Treatment of underlying conditions contributing to infertility
2. **Dollar Limit.** Coverage must be capped at a \$120,000 lifetime limit per participant and eligible dependents combined. Beginning with plan years after December 31, 2027, this limit would be adjusted annually for medical inflation. The Departments are also seeking comment on whether an annual limit structure would be preferable to a lifetime cap.
  3. **Stand-Alone Requirement (Self-Insured Plans).** For self-insured fertility benefit arrangements, the fertility benefit must be offered separately from the major medical plan. Because such arrangements do not use a separate insurance policy structure, this requirement is met only if:
    - The employer also offers a traditional group health plan (not an HRA or similar account-based plan, e.g., not an ICHRA), and
    - Employees must be eligible for the traditional group health plan to receive fertility benefits, but are not required to enroll in it.

This framework is similar to the rules applicable to excepted benefit HRAs and health FSAs.

The Departments are also seeking comment on whether additional safeguards should apply, such as prohibiting employee contributions or cost-sharing (similar to employee assistance programs), or whether greater flexibility should be permitted (similar to limited-scope dental and vision plans).

4. **Participant Notice.** Employers and insurers must provide participants and dependents with a written notice describing the fertility benefit. The notice must include:
  - A summary of covered services and limits (including any lifetime dollar limit)
  - Instructions for identifying and using network providers, if applicable
  - Claims filing and submission procedures, including available electronic or paper submission methods and required documentation, as well as whether the fertility benefit uses the same claims procedures as the employer's group health plan

The notice is intended to function as a concise "executive summary" or "quick reference guide" and should avoid technical or complex medical terminology.

The notice must be provided no later than the date an individual is first eligible to enroll in the fertility benefit, annually thereafter, and upon request. It may be included with open enrollment materials or other plan communications. A single notice mailed to a participant's last known address generally satisfies the requirement for both participants and covered dependents, unless a dependent has a different last-known address, in which case a separate notice must be provided.

## Takeaway for Employer Plan Sponsors

If finalized, the Proposed Rule would allow employers to offer stand-alone fertility benefits as excepted benefits starting with plan years beginning on or after January 1, 2027. Employers with self-insured fertility arrangements would need to maintain a traditional group health plan, although employees would not be required to enroll in that plan to access fertility coverage. This flexibility may be particularly valuable for employees who obtain major medical coverage elsewhere, such as through a spouse's employer-sponsored plan. Employers currently offering fertility benefits through specialty vendors may want to evaluate whether their existing arrangements could be restructured to fit within the proposed excepted fertility benefit framework.

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