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Agencies Open the Door to Offering Fertility Coverage as Limited Excepted Benefit

Compensation & Benefits on **May 12, 2026**

Building on FAQs Part 72 released last fall, on May 10, the Departments of Labor, Treasury, and Health and Human Services announced proposed regulations outlining a path for employers to offer fertility coverage as a limited excepted benefit.

What does this mean?

Employers could cover fertility-related expenses for employees without complying with the ACA mandates that typically apply to group health coverage, similar to the current rules for limited-scope dental or vision benefits. If finalized as proposed, the new structure would be available for plan years starting on or after January 1, 2027.

Does this impact plan sponsors and employers who currently offer fertility benefits?

Probably not at this point in time. This proposal seems intended to encourage employers not already offering fertility benefits to offer fertility coverage in the future. That said, depending on how the proposed rule is finalized, some employers currently offering fertility benefits as part of their major medical plan might be interested in restructuring their fertility coverage to qualify as a limited excepted benefit.

Okay, I'm still interested. What is a limited excepted benefit?

By way of brief background, ACA market reforms that apply to group health coverage (such as first-dollar coverage of preventive care and the prohibition on annual and lifetime limits on essential health benefits) do not apply to "excepted benefits," including limited excepted benefits. In the proposed rules, the agencies have added a new category of "limited excepted benefit" to cover qualifying fertility expenses incurred by employees.

Limited excepted benefits can be fully-insured or self-insured. Under the current rules, a limited excepted benefit must either: (1) be provided under a separate policy, certificate, or contract of insurance; or (2) otherwise "not be an integral part of the plan."

Must the limited excepted benefit for fertility be "integrated" with other group health coverage?

No. Unlike most health reimbursement arrangements (HRAs), which typically require integration with ACA-compliant coverage, there is no requirement that an individual be covered both by the limited excepted benefit for fertility and major medical group health coverage.

If the benefit is fully-insured, the employer is not required to also offer major medical coverage to the employee. If the benefit is self-insured, the employer would be required to offer major medical coverage to the employee in order for the benefit to qualify as a limited excepted benefit, but the employee could decline enrollment in major medical coverage and still enroll in the fertility benefit—no integration required.

What expenses would be covered by the limited excepted benefit for fertility?

Plan sponsors could offer coverage for diagnosis, mitigation, and treatment of infertility or infertility-related reproductive health conditions provided by medical professionals authorized under applicable law. The proposed rules contemplate coverage of a broad range of treatments, interventions, and prescription drugs. The proposed rules do not appear to condition coverage on the benefits qualifying as "medical care" under Internal Revenue Code Section 213(d), which suggests that plan sponsors might be able to provide coverage for taxable expenses assuming they are related to infertility treatment. (We discuss certain tax issues that can arise with fertility benefits here.) Additional guidance on taxability issues would be welcome.

Is there a cap on the fertility benefits that can be provided?

Yes, the proposed rules include a lifetime dollar limit of $120,000, indexed for medical inflation. However, plan sponsors would have flexibility to impose a lower dollar limit cap, structure the limit on a plan-year basis, and impose participant cost-sharing and premiums.

The proposed rules do not specify whether the lifetime limit resets when an individual is covered by multiple programs from different employers. For example, can an employee access up to $240,000 in limited excepted benefits if an employee changes jobs and both the former employer and current employer offer a limited excepted benefit structure for fertility coverage? What if an employee is covered both by their employer's plan and their spouse's employer plan? Detail about application of the lifetime limit in these situations would be helpful.

Can fertility coverage be provided pre-deductible for HSA-eligible individuals?

This is not addressed in the proposed rule, but probably not. By way of quick background, to be eligible to make or receive contributions to a health savings account ("HSA"), an individual must be covered by a high-deductible health plan (HDHP). Coverage for medical services before the minimum deductible is satisfied would make an HDHP participant ineligible to make or receive HSA contributions, with limited exceptions for permitted insurance, permitted coverage, and direct primary care service arrangements.

Under the current rules, it does not appear that fertility coverage would qualify as permitted insurance or permitted coverage, meaning that an individual wishing to maintain their HSA eligibility would need to satisfy their minimum deductible before the fertility benefit could pay for eligible expenses.

Would an employer be required to offer COBRA?

The proposed rule does not discuss the COBRA obligations that would apply to a limited excepted benefit for fertility. Under the same rules that apply to limited scope dental and vision benefits, however, employers otherwise subject to COBRA (generally, employers with 20+ employees) would be required to offer COBRA coverage for the fertility benefit on the same basis as for other group health plan benefits to which COBRA applies.

Would special notice requirements apply to the limited excepted benefit for fertility?

Yes. For the benefit to qualify as a limited excepted benefit, the plan sponsor would be required to provide (upon eligibility and annually) a separate "quick reference guide" to participants intended to function as an executive summary of the available fertility benefits. This notice requirement would be in addition to the SPD requirements that would apply to the fertility benefit.

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Takeaways for plan sponsors and employers: Our expectation is that most plan sponsors will want to sit tight for the time being. Given the wide scope of comments requested by the agencies in the proposed rulemaking, it is possible that the final regulations may differ significantly from the proposal, making it impractical for employers to take steps based on the proposal. Additionally, key details remain open in the proposed regulations, especially with respect to participant eligibility to make HSA contributions and benefits taxability. Stay tuned for updates.

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