Group fixed-indemnity plans pose legal, tax issues

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Aug. 27, 2024

In this article

Concerns that fixed-indemnity plans may too easily be mistaken for comprehensive medical coverage or may improperly treat some benefit payments as tax-free has led to a final rule from the departments of Labor, Treasury, and Health and Human Services. The rule requires fixed-indemnity plans to supply a new consumer notice beginning in 2025 but omits more sweeping proposals that would have required many employers to redesign their fixed-indemnity coverage. Treasury proposals to clarify the tax treatment of employer-provided accident and health plans — particularly the tax treatment of fixed-indemnity plans — also were left out of the final rule. This GRIST provides background information about group fixed-indemnity plans, details about the new consumer notice, an overview of proposals left out of the final rule, and a summary of IRS guidance identifying a variety of fixed-indemnity designs (often paired with a wellness program) as improper “double dipping” schemes. This article also summarizes provisions in the rule addressing individual fixed-indemnity plans and short-term limited duration insurance (STLDI).

Background on group fixed-indemnity plans

Many employers offer their employees coverage under a group fixed-indemnity plan that pays fixed benefits on the occurrence of a hospitalization or other similar event. A group fixed-indemnity plan typically does not satisfy certain group health plan mandates, such as the Affordable Care Act (ACA)’s prohibition on annual or lifetime dollar limits on essential health benefits (EHBs) and requirement for first-dollar coverage of specified preventive services. Group health plans that fail to satisfy those mandates risk substantial penalties, but fixed-indemnity plans can eliminate that risk by satisfying “excepted

benefit" standards. Group health plans qualifying as excepted benefits are exempt from many federal mandates, including most requirements under the ACA, portability requirements under the Health Insurance Portability and Accountability Act (HIPAA), and the Mental Health Parity and Addiction Equity Act (MHPAEA). However, some federal laws, such as ERISA, HIPAA's privacy and security requirements, and the continuation coverage requirements of the 1985 Consolidated Omnibus Budget Reconciliation Act (COBRA), apply to group health plans regardless of their excepted-benefit status.

The final rule adds a notice requirement to the excepted-benefit standards for group fixed-indemnity plans. The rule relates only to excepted-benefit status and doesn't clarify whether a group fixed-indemnity plan is a group health plan or simply an income replacement program. *See the additional discussion below on the voluntary benefit exception from ERISA for certain fixed-indemnity programs.*

Excepted-benefit standards for group fixed-indemnity insurance

Prior to the final rule, group fixed-indemnity insurance satisfying the following conditions qualified as an excepted benefit:

- Is issued as a separate policy
- Is not coordinated with exclusions from other group health plan benefits provided by the same employer
- Pays benefits regardless of whether other group health plan coverage offered by the same employer pays for the same event
- Pays a fixed dollar amount per day (or other period) of hospitalization or illness, regardless of the amount of expenses incurred

The final rule adds a notice requirement but otherwise leaves the standards above unchanged.

Potential penalties

Employer-sponsored fixed-indemnity plans or policies that are subject to group health plan mandates and do not meet excepted-benefit requirements must either meet the full panoply of group health plan standards or risk incurring fairly steep penalties of $100 per day per affected member. Failure to provide the ACA's required summary of benefits and coverage could trigger additional penalties (of up to $1,000 per failure, adjusted in 2024 to $1,406).

New consumer notice for group fixed-indemnity excepted-benefit plans

Starting in 2025, group fixed-indemnity excepted-benefit plans and issuers must display a new consumer notice on any marketing, application and enrollment materials. This notice is designed to help consumers

distinguish fixed-indemnity excepted-benefit coverage, which lacks the consumer protections of federal laws like ACA and HIPAA, from comprehensive medical coverage that is subject to those laws.

Who provides the notice. Any issuer or plan providing ERISA-covered group hospital indemnity or other fixed-indemnity insurance, or similar group insurance sponsored by a church or a state or local government, must display the notice. The notice obligation applies to the plan and its insurer, but either the plan or the insurer may satisfy the notice requirement for both parties. Plan sponsors should coordinate with their insurer to make sure that the notice is displayed as the rule requires.

What content is in the notice. The final rule includes the notice, which must be used without modification or customization.

Where the notice must be displayed. The notice must be displayed in all marketing, application, enrollment and reenrollment materials, provided to participants at or before enrollment in group fixed-indemnity insurance. The departments clarify that:

- Marketing materials include any document or website page that advertises the benefits or offers an opportunity to enroll or reenroll in the coverage.
- The notice does not have to be in the insurance policy, certificate or contract for group fixed-indemnity plans, because the plan sponsor rather than participants typically receive these documents.

The departments do not provide a comprehensive list of documents that must display the notice, so plan sponsors will need to review all plan communications and materials, including those on websites, to determine where to display the notice. The notice may need to appear in multiple locations (e.g., in a plan's enrollment guide, on the enrollment website, and on the application for coverage).

Summary plan description (SPD). The departments do not specifically address whether the notice must be included in the SPD that must be distributed to participants in any ERISA-covered group fixed-indemnity plan. SPDs generally must be distributed within 90 days *after* an employee initially becomes a participant, but the fixed-indemnity notice must accompany materials provided *at or before* enrollment. As a result, SPDs seemingly do not need to include the notice unless the employer chooses to distribute the SPD at or before enrollment. However, even employers distributing the SPD after enrollment may decide to include the notice to ensure participants and beneficiaries are aware of the limits of fixed-indemnity coverage.

How to display the notice. The notice must be prominently displayed on the first page of the paper or electronic materials (including on a website) in at least 14-point font. In the preamble to the rule, the departments state that they will consider a notice "prominently displayed" if it is easily noticeable to a typical consumer in the context of the page (either paper or electronic). For example, the font color should contrast with the document's background, the notice should not be obscured by other written or graphic content, and the viewer shouldn't have to click a link to view the notice.

How to deliver the notice. The final rule identifies the categories of documents that must include the notice but does not specify how to deliver it. Separate notice to a participant's spouse or dependents is not required.

When notice requirement takes effect. The notice requirements apply to new and existing coverage, including renewals, for plan years beginning on or after Jan. 1, 2025. Because the notice must be provided to participants at or before enrollment or reenrollment, the notice apparently must be distributed *before* the 2025 plan year begins. For many plans, this timing means including the notice with enrollment materials distributed in 2024.

> *Example:* XYZ Inc. sponsors a fixed-indemnity excepted-benefit plan with a plan year beginning Jan. 1. Every year, XYZ Inc. distributes an enrollment guide to employees in September before the annual open enrollment window begins in October. The enrollment guide distributed to employees in September 2024 should display the model notice.

No change to other group fixed-indemnity excepted-benefit standards

The departments did not finalize other significant proposed changes to the excepted-benefit standards for group fixed-indemnity plans, citing the need to study issues raised in comment letters. However, the departments remain concerned about certain fixed-indemnity designs and marketing practices and intend to revisit these issues in future rules.

Key fixed-indemnity proposals not finalized

Proposed standard for "fixed" benefits. The departments declined to finalize a new standard for providing benefits in a "fixed" amount. The proposed rule would have required the dollar amount paid on hospitalization or illness to remain fixed regardless of the services or items received, actual or estimated amount of expenses incurred, severity of the illness or injury, or other characteristics particular to an enrollee's course of treatment. The proposed rule also prohibited dollar amount variations on any other basis (such as a per-item or per-service basis).

Proposals on informal coordination with another group health plan. Current rules prohibit coordination between a group fixed-indemnity excepted-benefit plan and an exclusion under a group health plan with the same plan sponsor. The departments did not finalize a proposal to broadly interpret prohibited "coordination" to include *informal* coordination. Likewise, the final rule omits a proposed example that would have banned an employer from offering a preventive services plan (often called a minimum essential coverage or MEC-only plan) along with an excepted-benefit fixed-indemnity plan to the same group of employees.

Continued concerns with some fixed-indemnity programs

The departments remain worried that the marketing and design of some fixed-indemnity programs might cause individuals to confuse the coverage with a comprehensive medical plan. In the preamble to the final rule, the departments express concerns about the following fixed-indemnity designs:

- **Fixed-indemnity insurance with detailed fee schedules that, in effect, provide benefits for specific items and services, such as wellness exams or prescription drugs.** Such programs do not satisfy existing fixed-indemnity excepted-benefit standards, which require paying benefits on a per-period basis. The departments warn that merely affixing "per day" to specific items and services (i.e., paying a benefit of $50 per blood test *per day*) is not sufficient to satisfy excepted-benefit standards.
- **A benefit "package" pairing a non-excepted-benefit plan with minimal medical coverage (such as a preventive-services or MEC-only plan) with a fixed-indemnity policy that provides benefits for a broad range of items and services excluded by the medical plan.** The departments remain concerned that this design is a coordinated arrangement to circumvent federal consumer protections and worry that some employees — or employers — might mistake this combination of plans for comprehensive medical coverage.

The departments intend to return to these issues in future rulemaking.

Similar limited changes to individual fixed-indemnity excepted-benefit policies

The final rule makes similar changes to fixed-indemnity excepted-benefit policies sold in the individual market. Prior to the final rule, a fixed-indemnity policy sold in the individual market could qualify as excepted benefits exempt from many federal standards that otherwise apply to individual health insurance policies if it:

- Is issued as a separate insurance policy
- Is not coordinated with exclusions under any other health coverage
- Pays a fixed dollar amount per period of hospitalization or illness and/or per service of hospitalization or illness, regardless of the amount of expenses incurred
- Displays a notice in application materials

The final rule substantially boosts the existing notice requirement. For coverage periods beginning on or after Jan. 1, 2025, individual market fixed-indemnity excepted-benefit plans must display the same required notice on the same materials and in the same manner as group fixed-indemnity excepted-benefit plans. In addition, the first page of the insurance policy (or certificate or contract) also must prominently display the notice — unlike in the group market, enrollees in the individual insurance market typically receive the actual policy. The notice provisions apply both to new and existing coverage.

The agencies had also proposed but did not finalize a new individual insurance standard for benefits paid in a "fixed" amount:

- The proposed rule would have required that the coverage pay a fixed dollar amount per period — not per service — which would have aligned with the current standard for group fixed-indemnity excepted-benefit plans.
- Other proposed changes to the payment standard mirrored the group market proposals. The proposed rule would have required the dollar amount paid on hospitalization or illness to remain fixed regardless of the services or items received, actual or estimated amount of expenses incurred, severity of the illness or injury, or other characteristics particular to an enrollee's course of treatment. The proposed rule also would have prohibited dollar amount variations on any other basis (such as a per-item or per-service basis).
- The proposed rule also would have required paying benefits without regard to whether other health insurance coverage maintained by the same insurer would provide benefits for the same event.

None of the payment standard proposals were finalized, despite the departments' continued concerns about fixed-indemnity policies. Regulators intend to return to these proposals in future rulemaking.

Tax rule for accident and health plans postponed

The Treasury Department and IRS declined to finalize proposals clarifying the tax treatment of fixed-indemnity coverage (and any other employer-sponsored accident or health plan that pays benefits without regard to incurred medical expenses), citing the need to study issues raised in comment letters. However, the agencies continue to be concerned about how fixed-indemnity benefits are taxed and they intend to revisit this issue in future rules. In the meantime, IRS enforcement efforts will continue.

Proposed tax clarifications not finalized

Treasury and IRS did not finalize the following proposals, which would have amended the tax rules on when benefit payments from a fixed-indemnity or other accident or health plan with premiums paid on a pretax basis can be excluded from income under Internal Revenue Code Section 105(b).

Tax treatment of benefit payments from fixed-indemnity and similar coverage. Treasury and IRS proposed to clarify that if excepted-benefit fixed-indemnity coverage is paid for on a pretax basis, *all* benefit payments would be taxable income to the employee rather than excluded under Section 105(b) — even if the benefit payments are actually used to pay for medical expenses. Coverage is paid for on a pretax basis if either employees pay premiums pretax through a cafeteria plan or the employer pays the premiums without including (i.e., imputing) the value in employees' taxable income. The proposal also would also have applied to any other plan that — like excepted-benefit fixed-indemnity coverage — pays benefits regardless of the amount of Section 213(d) qualified medical expenses actually incurred.

Notably, the proposal would not have impacted fixed-indemnity or similar coverage purchased on an after-tax basis — either by the employee using after-tax dollars or by the employer reporting the value of

the coverage as imputed income to the employee. Benefit payments from such coverage are excluded from an employee's income under Code Section 104(a)(3).

Substantiation of medical expenses. Treasury and IRS proposed revising the Code 105(b) regulations to reiterate that *all* qualified medical expenses reimbursed from any employer-provided accident and health plan must be substantiated as a condition of exclusion from the participant's gross income. Without substantiation, benefit payments — even if used for medical expenses — would be taxable income to the employee.

Agency compliance efforts will continue

IRS intends to continue enforcement efforts to ensure that when fixed-indemnity coverage is paid for on a pretax basis, benefit payments unrelated to medical expenses are included in employees' income. IRS and Treasury describe in the preamble to the final rule their escalating concern about the tax practices of some fixed-indemnity plans under which the reimbursement of any tax-qualified medical expense is "doubtful."

In recent years, IRS also has publicly released four Office of Chief Counsel (OCC) advice memoranda, summarized in the chart below, addressing when fixed-indemnity payments (often paired with a rider that purports to be a wellness program) are taxable to the employee. These memoranda target a variety of schemes (often referred to as double-dipping schemes) in which an employee is neither taxed on the value of the fixed-indemnity coverage nor on the amounts paid as benefits. Because the benefit payments, according to IRS, do not reimburse the employee for medical care, the payments should be subject to income tax, as well as Federal Insurance Contributions Act (FICA) and Federal Unemployment Tax Act (FUTA) taxes. While this informal guidance lacks precedential value, the memoranda provide insight into IRS's thinking and illustrate the agency's ongoing concern about the taxation of fixed-indemnity payments.

IRS OCC memoranda	Description of benefit program	Are reimbursements tax-free?
IRS OCC memorandum 202323006 (May 9, 2023)	• Fully insured fixed-indemnity plan is funded by employee pretax contributions of $1,200 per month. • Employees receive a monthly benefit of $1,000 for completing certain health or wellness activities (which are often at no cost to the participant or covered by other health insurance), • Plan pays a benefit per day of hospitalization.	• The $1,000 monthly wellness indemnity benefit is taxable to the employee because it is paid regardless of whether the employee has any unreimbursed medical expenses.

IRS OCC memoranda	Description of benefit program	Are reimbursements tax-free?
IRS OCC memorandum 201719025 (April 24, 2017)	• Employees contribute $60 after tax to a self-funded fixed-indemnity plan that pays a fixed benefit of $1,425 for completing free wellness activities (such as attending a counseling session).* • The fixed-indemnity plan is sometimes paired with a wellness plan with high pretax premiums (for example, $1,500 per month). * *Although the memorandum doesn't discuss this point, the program would not satisfy the group fixed-indemnity excepted-benefit standards because it is self-funded.*	Fixed-indemnity payments are taxable for two reasons: • Arrangement fails to shift sufficient risk to have the effect of insurance, so payments are not excluded under Section 104(a)(3). • The large average benefit payments "markedly exceed" the after-tax employee contributions and thus are attributable to *employer* contributions.
IRS OCC memorandum 201703013 (Dec. 12, 2016)	• Fixed-indemnity plan pays $100 for each medical office visit and $200 per day of hospitalization, regardless of the amount of medical expenses. • Wellness program pays a fixed-indemnity cash payment for completing a health risk assessment, health screening and preventive care activities.	• If coverage is paid for on an after-tax basis, benefit payments are not taxable under Section 104(a)(3). • If coverage is paid for on a pretax basis, benefit payments are taxable.
IRS OCC memorandum 201622031 (April 14, 2016)	• Wellness program funded either by the employer or by pretax employee contributions provides some or all of these benefits: — Health screening and other health benefits — Nonhealth rewards like cash or gym membership fees — Reimbursement for some or all of the employee's pretax contributions	• Only the health screening and other medical care benefits are tax-free. • The nonhealth rewards and reimbursement of employee contributions are taxable income to the employee.

Advantages of paying for coverage post-tax

IRS reminds employers that many tax complexities can be avoided by paying for fixed-indemnity coverage on an after-tax basis. If employees pay the premiums with after-tax dollars, including after-tax payroll deductions, or if the value of employer-paid coverage is reported as income (i.e., imputed) to employees, all benefit payments will be tax-free under Section 104(a)(3). Employers avoid the

challenges of determining which benefits are taxable or tax-free under Section 105(b), as well as the administrative challenges of tracking and reporting taxable benefits as income.

Limited employer obligations for fixed-indemnity coverage that is an ERISA-exempt voluntary plan

Many employers offer their employees voluntary insured fixed-indemnity coverage. Under a regulatory safe harbor, voluntary insured plans generally are not subject to ERISA if employees bear the full cost of the plan, participation is voluntary, and the employer doesn't endorse or benefit financially from the plan. If a voluntary fixed-indemnity program satisfies the safe harbor, the employer should have fewer compliance obligations.

- Such a plan might still need to satisfy the excepted-benefit standards for fixed-indemnity plans, but the employer is not the plan's sponsor and would not be responsible for the plan's compliance.
- Because any employer action endorsing the voluntary fixed-indemnity plan jeopardizes the regulatory safe harbor, the employer presumably wouldn't be producing materials or maintaining a website that would require a fixed-indemnity excepted-benefit notice.
- Many employees pay for voluntary fixed-indemnity coverage on an after-tax basis to avoid the risk that an agency or a court might view pretax contributions through the employer's cafeteria plan as an employer endorsement, thus jeopardizing the regulatory safe harbor. Cash benefits from fixed-indemnity coverage purchased on an after-tax basis are excludable from income under Section 104(a)(3).

Employers should work with counsel to confirm that their fixed-indemnity program satisfies the voluntary plan safe harbor, determine the employer's compliance obligations and review whether any benefit payments are taxable income. This GRIST does not address the panoply of laws that apply if a fixed-indemnity plan doesn't satisfy the voluntary plan safe harbor and thus is covered by ERISA, or how those laws are affected by meeting the excepted-benefit standards. In those situations, employers should consult counsel about compliance requirements, including whether the program is subject to group health plan mandates like COBRA.

Major changes to STLDI

STLDI is a type of health insurance typically sold to fill in coverage gaps for individuals between jobs or in need of temporary coverage. Individual STLDI policies are exempt from many federal standards that apply to individual health insurance, such as the right to coverage regardless of health status, the ban on preexisting condition exclusions and the mandate to cover EHBs. The final rule returns to Obama-era standards limiting the duration of STLDI and revises the notice that must accompany such policies.

Duration of coverage shortened. The final rule limits the length of an STLDI policy issued on or after Sept. 1, 2024, to three months, with a maximum of one additional month — or four months total —

including renewals and extensions. This reverses a 2018 rule that allowed STLDI coverage of up to 12 months —or up to 36 months including renewals and extensions. The final rule also curbs the practice of stringing together (or "stacking") consecutive STLDI policies from the same insurer or a member of the insurer's controlled group. In that scenario, policies offered within 12 months of an initial STLDI policy are treated like a renewal or extension of that initial policy. However, the rule does not limit the stacking of STLDI policies by different issuers.

Notice. The final rule modifies the model notice insurers must provide to more clearly distinguish STLDI from comprehensive medical coverage and revise the contact information. The revised notice must be provided for STLDI policies sold or issued on or after Sept. 1, 2024, but existing policies must also provide the revised notice for any renewals or enrollments on or after Sept. 1, 2024. The notice must be displayed in at least 14-point font on the first page of the insurance policy, certificate, or contract (whether in paper or electronic form, including on a website) and in any marketing, application, and enrollment or reenrollment materials provided to individuals at or before the time they have the opportunity to enroll (or reenroll).

Limited impact on employer-sponsored coverage. Employer-sponsored group insurance policies are unlikely to mirror the STLDI coverage offered to individuals. While the federal definition of individual insurance coverage excludes STLDI, no similar exclusion from the definition of group health insurance exists, nor is STLDI a category of excepted benefits. As a result, any group STLDI coverage would have to meet all federal standards for group health plans.

An employer might have some employees who purchased inexpensive, individual STLDI coverage. Such STLDI coverage could expire sooner than expected because of the final rule — possibly in the middle of the employer's plan year. The departments clarify that individuals who lose eligibility for STLDI coverage because their policy ends may be eligible for a HIPAA special enrollment period to enroll in their employer's group health plan. The departments state that such individuals must have 60 days from date of losing STLDI coverage to enroll in their employer's plan. Regulators did not explain why the window to enroll is 60 days, rather than the 30-day window after a special enrollment event other than loss of coverage under Medicaid or a state children's health insurance program.

Next steps

Employers that sponsor a group fixed-indemnity excepted-benefit plan should:

- Prepare to satisfy the new notice requirement in the final rule.
  - Identify all marketing, application, enrollment and reenrollment materials, including any website that advertises or offers an opportunity to enroll or reenroll. The insurer may be responsible for many of these materials, but an employer might produce its own enrollment materials (paper or digital), so both the insurer and the employer could have notice obligations.

  - Confirm that the insurer will include the notice on any of the identified documents prepared starting with the 2025 plan year (including enrollment or renewal materials distributed before the 2025 plan year).
  - Include the notice on any documents that the employer prepares (for example, enrollment materials), starting with enrollment materials for the 2025 plan year (including enrollment or renewal materials distributed before the 2025 plan year).
- Monitor litigation that could modify the notice requirement. A recently filed lawsuit seeks to vacate the notice requirements for both group and individual fixed-indemnity insurance.
- Ensure that group fixed-indemnity coverage satisfies each of the other excepted-benefit standards.
  - Make sure that the indemnity coverage is not impermissibly coordinated with the medical plan.
  - Confirm that the indemnity coverage pays a fixed dollar amount per day or other time period and does not pay on a per service basis.
- Review all plan communications to ensure that they adequately inform participants about the limits of fixed-indemnity coverage and could not be construed as misleading.

Employers offering fixed-indemnity coverage and a plan with limited medical benefits (including a MEC-only or a preventive services plan) to the same employees should carefully review all benefit communications to eliminate any suggestion that the fixed-indemnity plan coordinates with exclusions in the limited medical benefit plan or that the two programs together provide comprehensive coverage. For example, avoid describing the programs together as forming a benefit package.

All employers offering fixed-indemnity plans should review how employees are currently taxed on benefit payments:

- If any coverage is paid for either by employees contributing pretax dollars through a cafeteria plan or by employers paying the premiums without imputing the value to the employees as taxable income, then:
  - Consult with counsel about which benefit payments should be included or excluded from employees' income under Section 105(b).
  - Review the administrative process for taxing employees on benefit payments that must be included as income. For example, confirm that the insurer will provide sufficient information to the employer about benefit payments, and consider how to report taxable benefit payments to former employees.
  - Consider the advantages, including administrative simplicity, of using after-tax payments to pay for coverage.

  - Compare current tax practices with IRS's OCC letters addressing the taxation of fixed-indemnity plans.

- Confirm that vendors are properly substantiating qualified medical expenses when required.

An employer sponsoring a group health plan subject to HIPAA's special enrollment rules should ensure that an employee who loses STLDI coverage can join the plan, if eligible, within 60 days of the loss of coverage, and determine whether any relevant plan documentation requires amendment.

Related resources

Non-Mercer resources

- Final regulations (Federal Register, April 3, 2024)
- Fact sheet (CMS, March 28, 2024)
- Press release (CMS, March 28, 2024)
- Office of Chief Counsel memorandum 202323006 (IRS, May 9, 2023)
- Office of Chief Counsel memorandum 201719025 (IRS, April 24, 2017)
- Office of Chief Counsel memorandum 201703013 (IRS, Dec. 12, 2016)
- Office of Chief Counsel memorandum 201622031 (IRS, April14, 2016)

Mercer Law & Policy resources

- Agencies propose overhaul of fixed-indemnity plan rules (July 18, 2023)

Note: Mercer is not engaged in the practice of law, accounting or medicine. Any commentary in this article does not constitute and is not a substitute for legal, tax or medical advice. Readers of this article should consult a legal, tax or medical expert for advice on those matters.

Appendix: Required notice for group and individual market fixed-indemnity excepted-benefit plans

**IMPORTANT: This is a fixed indemnity policy,
NOT health insurance**

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- **Visit HealthCare.gov** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.