Addendum: for use with Indiana Life & Health online ExamFX courses and study guide version 23970en/24009en, per exam content outline updates effective 05/30/2019.

***Please note that Indiana is changing testing providers. Effective 5/30/2019, state insurance exams will be administered by Pearson Vue**. For additional information about exam requirements and complete exam content outlines, please review the Insurance Licensing Candidate Handbook at* www.pearsonvue.com/in/insurance

Please note the new exam format will be different. You will be taking a 2-part exam: General Knowledge and State Law. However, you will receive one overall score. New exam breakdowns are as follows:

Indiana Life Insurance Examination
95 Total Questions (80 scored, 15 pretest)
Time Limit: 2 hours; Passing Score: 70%

Chapter	Percentage of Exam
GENERAL KNOWLEDGE:	
Completing the Application, Underwriting, and Delivering the Policy	15%
Types of Life Policies	15%
Life Policy Provisions, Riders and Options	23%
Taxes, Retirement, and Other Insurance Concepts	10%
STATE LAW:	
Indiana Laws and Departmental Rules Common to All Lines	25%
Life Regulations	12%

Indiana Accident & Health Insurance Examination
95 Total Questions (80 scored, 15 pretest)
Time Limit: 2 hours; Passing Score: 70%

Chapter	Percentage of Exam
GENERAL KNOWLEDGE:	
Field Underwriting	11%
Types of Health Policies	18%
Health Policy Provisions, Clauses, and Riders	25%
Social Insurance	4%
Other Insurance Concepts	5%
STATE LAW:	
Indiana Laws and Departmental Rules Common to All Lines	25%
Health Regulations	12%

Indiana Life & Health Insurance Examination
150 Total Questions (135 scored, 15 pretest)
Time Limit: 3 hours; Passing Score: 70%

Chapter	Percentage of Exam
GENERAL KNOWLEDGE:	
Completing the Application, Underwriting, and Delivering the Policy	9%
Types of Life Policies	9%
Life Policy Riders, Provisions, Options, and Exclusions	13%
Taxes, Retirement, and Other Insurance Concepts	6%
Field Underwriting Procedures	7%
Types of Health Policies	10%
Health Policy Provisions, Clauses, and Riders	15%
Social Insurance	2%
Other Health Insurance Concepts	3%
STATE LAW:	
Indiana Laws and Departmental Rules Common to All Lines	15%
Life Regulations	6%
Health Regulations	5%

*The following are **content additions** to supplement your existing text:*

LIFE & HEALTH

Insurance Regulation

C. Producer and Company Regulation

1. Unfair Competition Law

Advertising covers a wide scope of communication, from publishing an ad in a newspaper or magazine, to broadcasting a commercial on television or the Internet. Advertisements cannot include any untrue, deceptive, or misleading statements that apply to the business of insurance or anyone who conducts it. The violation of this rule is called **false advertising.**

It is prohibited to advertise or circulate any materials that are untrue, deceptive, or misleading. False or deceptive advertising specifically includes **misrepresenting** any of the following:

- Terms, benefits, conditions, or advantages of any insurance policy;
- Any dividends to be received from the policy, or previously paid out;
- Financial condition of any person or the insurance company; or
- The true purpose of an assignment or loan against a policy.

Representing an insurance policy as a share of stock, or using names or titles that may misrepresent the true nature of a policy also will be considered false advertising. In addition, a person or an entity cannot use a name that deceptively suggests it is an insurer.

LIFE ONLY

Insurance Basics

Viatical Settlements

Viatical settlements allow someone living with a life-threatening condition to sell their existing life insurance policy and use the proceeds when they are most needed, before their death.

While viatical settlements are not policy options, they are **separate contracts** in which the insured sells the death benefit to a **third party** at a discounted rate. There are several important concepts you need to understand about viaticals:

- The insureds are referred to as **viators**;
- Viatical settlement **provider** means a person, other than a viator, that enters into a viatical settlement contract;
- Viatical **producers** represent the providers;
- Viatical **brokers** represent the insureds.

Viators usually receive **a percentage** of the policy's face value from the person who purchases the policy. The new owner continues to maintain premium payments and will eventually collect the entire death benefit.

Stranger-Originated Life Insurance (STOLI) and Investor-Originated Life Insurance (IOLI)

Stranger-originated life insurance (STOLI) is a life insurance arrangement in which a person with no relationship to the insured (a "stranger") purchases a life policy on the insured's life with the intent of selling the policy to an investor and profiting financially when the insured dies. In other words, STOLIs are financed and purchased solely with the intent of selling them for life settlements.

STOLIs **violate the principle of insurable interest**, which is in place to ensure that a person purchasing a life insurance policy is actually interested in the longevity rather than the death of the insured. Because of this, insurers take an aggressive legal stance against policies they suspect are involved in STOLI transactions.

Note that lawful life settlement contracts do not constitute STOLIs. Life settlement transactions result from existing life insurance policies; STOLIs are initiated for the purpose of obtaining a policy that would benefit a person who has no insurable interest in the life of the insured at the time of policy origination.

Investor-owned life insurance (IOLI) is another name for a STOLI, where a third-party **investor who has no insurable interest in the insured** initiates a transaction designed to transfer the policy ownership rights to someone with no insurable interest in the insured and who hopes to make a profit upon the death of the insured or annuitant.

USA PATRIOT Act and Anti-Money Laundering

The Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism Act, also known as the **USA PATRIOT Act** was enacted on October 26, 2001. The purpose of the Act is to address social, economic, and global initiatives to fight and prevent terrorist activities. The Act enabled the Financial Crime Enforcement Network (FinCEN) to require banks, broker-dealers, and other financial institutions to establish new **anti-money laundering (AML)** standards. With new rules in place, FinCEN incorporated the insurance industry into this group.

To secure the goals of the Act, FinCEN has implemented an AML Program that requires the monitoring of all financial transactions and reporting of any suspicious activity to the government, along with prohibiting correspondent accounts with foreign shell banks. A comprehensive customer identification and verification procedure is also to be set in place. The AML program consists of the following minimum requirements:

Assimilate policies, procedures and internal controls based on an in-house risk assessment, including:

- Instituting AML programs similar to banks and securities lenders; and
- File suspicious activity reports (SAR) with Federal authorities;
- Appointing a qualified compliance officer responsible for administering the AML program;
- Continual training for applicable employees, producers and other; and
- Allow for independent testing of the program on a regular basis.

Suspicious Activity Reports (SARs) Rules

Any company that is subject to the AML Program is also subject to SAR rules. SAR rules state that procedures and plans must be in place and designed to identify activity that one would deem suspicious of money laundering, terrorist financing and/or other illegal activities. Deposits, withdrawals, transfers or any other business deals involving $5,000 or more are required to be reported if the financial company or insurer “knows, suspects or has reason to suspect” that the transaction:

- Has no business or lawful purpose;
- Is designed to deliberately misstate other reporting constraints;
- Uses the financial institution or insurer to assist in criminal activity;
- Is obtained using fraudulent funds from illegal activities; or
- Is intended to mask funds from other illegal activities.

Some "red flags" to look for in suspicious activity:

- Customer uses fake ID or changes a transaction after learning that he or she must show ID;
- Two or more customers use similar IDs;
- Customer conducts transactions so that they fall just below amounts that require reporting or recordkeeping;
- Two or more customers seem to be working together to break one transaction into two or more (trying to evade the Bank Secrecy Act (BSA) requirements); or
- Customer uses two or more money service business (MSB) locations or cashiers on the same day to break one transaction into smaller transactions (trying to evade BSA requirements).

Relevant SAR reports must be filed with FinCEN within 30 days of initial discovery. Reporting takes place on FinCEN Form 108.

Life Insurance Policies

Return of Premium

Return of premium (ROP) life insurance is an increasing term insurance policy that pays an additional death benefit to the beneficiary equal to the amount of the premiums paid. The return of premium is paid if the death occurs within a specified period of time or if the insured outlives the policy term.

ROP policies are structured to consider the low risk factor of a term policy but at a significant increase in premium cost, sometimes as much as 25% to 50% more. Traditional term policies offer a low-cost, simple-death benefit for a specified term but have no investment component or cash value. When the term is over, the policy expires and the insured is without coverage. An ROP policy offers the pure protection of a term policy, but if the insured remains healthy and is still alive once the term limit expires, the insurance company guarantees a return of premium. However, since the amount returned equals the amount paid in, the returned premiums are not taxable.

Third-Party Ownership

Most insurance policies are written where the insured and owner of the policy is the same person. However, there are situations in which the contract may be owned by someone other than the insured. These types of contracts are known as third-party ownership. **Third-party owner** is a legal term used to identify an individual or entity that is not an insured under the contract, but that has a legally enforceable right under it. Most policies involving third-party ownership are written in business situations or for minors in which the parent owns the policy.

Tax Treatment of Insurance Premiums, Proceeds, Dividends

Generally speaking, the following taxation rules apply to life insurance policies:

- **Premiums** are not tax deductible;
- **Death benefit**:
    - Tax free if taken as a lump-sum distribution to a named beneficiary;
    - Principal is tax free; interest is taxable if paid in installments (other than lump sum).

Accelerated Benefits

When accelerated benefits are paid under a life insurance policy to a terminally ill insured, the benefits are received **tax free**. When accelerated benefits are paid to a chronically ill insured (for example, someone who has cancer, Alzheimer's disease or other severe illness), these benefits are tax free up to a certain limit. Any amount received in excess of this dollar limit must be included in the insured's gross income.

Life Insurance Policy Provisions, Options and Riders

A. Provisions

Consideration

Both parties to a contract must provide some value, or **consideration**, in order for the contract to be valid. The consideration provision states that the consideration (value) offered by the insured is the premium and statements made in the application. The consideration given by the insurer is the promise to pay in accordance with the terms of the contract. The consideration clause is not always a separate provision, but is often included in the entire contract provision. A separate provision concerning the payment of policy premiums is usually also found in the policy.

B. Riders

Other Insureds

There are riders that allow the policyowner to add additional insureds under the original policy, such as children's term or family term. There is also a nonfamily term rider that allows the policyowner to change the insured under the policy.

The **other insured rider** provides coverage for one or more family members other than the insured. The rider is usually level term insurance, attached to the base policy covering the insured. This is also known as a family rider. If the rider covers just the spouse of the insured, it can be specified as a **spouse term rider**, and allows the spouse to be added to coverage for a limited period of time and for a specified amount (it usually expires when the spouse reaches age 65).

The **children's term rider** allows children of the insured (natural, adopted or stepchildren) to be added to coverage for a limited period of time for a specified amount. This coverage is also term insurance and usually expires when the minor reaches a certain age (18 or 21). Most riders provide the minor with the option of converting to a permanent policy without evidence of insurability.

Children's term riders provide temporary life insurance coverage on all children of the family for one premium. The premium does not change on the inclusion of additional children; it is based on an average number of children.

The **family term rider** incorporates the spouse term rider along with the children's term rider in a single rider. When added to a whole life policy, the family term rider provides level term life insurance benefits covering the spouse and all of the children in the family.

Family Term = Spouse Term + Children's Term

Other riders are also available to insure somebody who is not a member of the insured's family – **nonfamily insureds**. The substitute insured or change of insured rider does not permit an additional insured, but instead allows for the change of insureds, subject to insurability. It is most commonly used with Key Person insurance when the key person or employee retires or terminates employment. The rider permits the policyowner, owner or employer, to change the insured to another key employee, subject to insurability.

This rider is often used by businesses that have a joint life policy that covers multiple key persons. Assume that the business has a joint life insurance policy covering key employees Jack and Jake. Jake retires and Jim is hired to replace him. Now the business would like a joint policy covering Jack and Jim, but Jack would no longer meet the underwriting requirements for a new policy because of changes in his health. If the policy covering Jack and Jake had a "Change of Insured Rider", the same policy could be maintained preserving Jack's insurability and Jim could be substituted for Jake as an insured, with only Jim needing to prove insurability.

Riders Affecting the Death Benefit Amounts

Term Riders

Term riders allow for an additional amount of temporary insurance to be provided on the insured, without the need to issue another policy. They are usually attached to a whole life policy to provide greater protection at a reduced cost.

Long-Term Care

Long-Term Care (LTC) coverage, which is often purchased as a separate policy, can also be marketed as a rider to a life insurance policy. These riders provide for the payment of part of the death benefit (called accelerated benefits) in order to take care of the insured's health care expenses, which are incurred in a nursing or convalescent home. As with the living needs rider, payment of LTC benefits will reduce the amount payable to the beneficiary upon the insured's death.

Group Life Insurance

Taxation of Group Life and Employer-Sponsored Plans

The **premiums** that an employer pays for life insurance on an employee, whereby the policy is for the employee's benefit, **are tax deductible to the employer** as a business expense. If the group life policy coverage is $50,000 or less, the employee does not have to report the premium paid by the employer as income (not taxable to the employee).

Any time a business is the named beneficiary of a life insurance policy, or has a beneficial interest in the policy, any premiums that the business pays for such insurance are not tax deductible. Therefore, when a business pays the premiums for any of the following arrangements, the premiums are not deductible:

- Key-employee (key-person) insurance;
- Stock redemption or entity purchase agreement;
- Split-dollar insurance.

The **cash value** of a business owned life insurance policy or an employer provided policy accumulates on a tax-deferred basis and is taxed in the same manner as an individually owned policy.

Policy loans are not taxable to a business. Unlike an individual taxpayer, a corporation may deduct interest on a life insurance policy loan for loans up to $50,000.

Policy death benefits paid under a business owned or an employer provided life insurance policy are received income tax free by the beneficiary (in the same manner as in individually owned policies).

If the general requirements for qualified plans are met, the following tax advantages apply:

- Employer contributions are tax deductible to the employer, and are not taxed as income to the employee;
- The earnings in the plan accumulate tax deferred;
- Lump-sum distributions to employees are eligible for favorable tax treatment.

HEALTH ONLY

Health Insurance Basics

Exclusions and Limitations

Exclusions specify for what the insurer will not pay. These are causes of loss that are specifically excluded from coverage. **Reductions** are a decrease in benefits because of certain specified conditions. The most common exclusions in health insurance policies are injury or loss that results from any of the following:

- War;
- Military duty;
- Self-inflicted injury;
- Dental expense;
- Cosmetic medical expenses;
- Eye refractions; or
- Care in government facilities.

In addition, most policies will temporarily suspend coverage while an insured resides in a foreign country or while serving in the military.

Mental and Emotional Disorders — Usually the lifetime benefit for major medical coverage limits the amount payable for mental or emotional disorders. The benefit is usually expressed as a separate lifetime benefit and there is frequently a limit on the number of outpatient visits per year. The benefit may also pay a maximum limit per visit. These limitations usually do not apply to inpatient treatment.

Substance abuse — As with mental and emotional disorders, outpatient treatment of substance abuse is usually limited to a maximum limit.

Copayments

A **copayment** provision is similar to the coinsurance feature in that the insured shares part of the cost for services with the insurer. Unlike coinsurance, a copayment has a **set dollar amount** that the insured will pay each time certain medical services are used.

Pre-Authorizations and Prior Approval Requirements

Some health insurance policies will require the pre-authorization or prior approval of certain medical procedures, tests, or hospital stays. The insured must obtain the insurer's approval before the procedure, test, or hospital stay to be sure the policy will cover the expenses.

Lifetime, Annual, or Per Cause Maximum Benefit Limits

The maximum benefit is the largest benefit amount a policy will pay. This may be expressed as a lifetime limit, an annual limit, or a per-cause limit.

- The **lifetime limit** specifies a benefit amount that is the most a policy will pay during the lifetime of the insured.
- An **annual limit** is the most a policy will pay each year that policy is in force.
- The **per-cause limit** is the most a policy will pay for expenses incurred from the same or related causes.

Owner's Rights

If an individual health insurance policy provides a death benefit, the policyowner will be able to designate a beneficiary and to change the beneficiary unless the beneficiary designation is irrevocable. The power to change the beneficiary is provided in the **change of beneficiary** provision. The policyowner also has the right to make any other change without the consent of the beneficiary(ies).

Dependent Children Benefits

Know that the Affordable Care Act mandates that every insurer that offers health insurance policies that provide coverage for dependent children of the insured must provide that coverage for the children **up to the age of 26**.

The law extends coverage for children of the insured to age 26 regardless of their marital status, residency, financial dependence on their parents, or eligibility to enroll in their employer's plan.

A policy providing coverage for a dependent child until a specified age may not terminate that coverage if the child is dependent upon the insured and is incapable of self-support because of physical or mental handicap. Proof of the dependency is required within 31 days of the child attaining the maximum age. Upon request, proof of dependency is required annually after a 2-year period following attainment of the maximum age.

Primary and Contingent Beneficiaries

Any death benefits available in a policy will be paid to a beneficiary. A **primary beneficiary** is the first person so designated. However, if the primary beneficiary should die before the benefits become payable, the benefits would go to a **contingent or secondary beneficiary**. If no beneficiary is designated, the benefits will be placed in the deceased's estate.

Multiple primary and contingent beneficiaries may be designated in a policy. If multiple primary beneficiaries are named, each individual will receive a proportionate percentages of the death benefit. If one of multiple primary beneficiaries dies, equivalent percentages are reestablished.

For example, if there are two primary beneficiaries named in a policy, each would receive 50% of the death benefit. If one of the two beneficiaries dies, the remaining beneficiary would receive 100%. If both primary beneficiaries die, the same situation would fall on the contingent beneficiary(ies).

If an individual health insurance policy provides a death benefit, it must also include a **change of beneficiary** provision. This provision gives the policyholder, unless he/she has made an irrevocable designation of a beneficiary, the right to change any primary and/or contingent beneficiary or make any other change without the consent of the beneficiary or beneficiaries.

Subrogation

Subrogation is the legal process by which an insurance company seeks recovery of the amount paid to the insured from a third party who may have caused the loss. Through subrogation, the **insured cannot collect twice**.

C. Major Health Insurance Providers

Point-Of-Service (POS) Plans

The **Point-Of-Service (POS)** plan is merely a combination of HMO and PPO plans.

With the Point-Of-Service plan the employees do not have to be locked into one plan or make a choice between the two plans. A different choice can be made every time a need arises for medical services.

Out-of-Network Provider Access

PPO plans, like HMOs, enter into contractual arrangements with health care providers who form a provider network. However, plan members do not have to use only in-network providers for their care.

Similarly, in a **POS plan** the individuals can visit an in-network provider at their discretion. If they decide to use an out-of-network physician, they may do so. However, the member copays, coinsurance and deductibles may be substantially higher.

In POS plans, participants usually have access to a provider network that is controlled by a primary care physician ("gatekeeping"). Plan members, however, have an option to seek care outside the network, but at reduced coverage levels. POS plans are also referred to as "open-ended HMOs."

PCP Referral (Gatekeeper PPO)

In a PPO, the insured does not have to select a primary care physician. The insured may choose medical providers not found on the preferred list and still retain coverage. The insured is allowed to receive care from any provider, but if the insured selects a

PPO provider, the insured will realize lower out-of-pocket costs. Conversely, if a non-network provider is used, the insured's out-of-pocket costs will be higher. In a PPO, all network providers are considered "preferred," and you can visit any of them, even specialists, without first seeing a primary care physician. Certain services may require plan pre-certification, an evaluation of the medical necessity of inpatient admissions and the number of days required to treat your condition.

Indemnity Plan Features

If a non-member physician is utilized under the Point-Of-Service plan, then the attending physician will be paid a fee for service, but the member patient will have to pay a higher coinsurance amount or percentage for the privilege.

Flexible Spending Accounts (FSAs)

A **Flexible Spending Account (FSA)** is a form of cafeteria plan benefit funded by salary reduction and employer contributions. The employees are allowed to deposit a certain amount of their paycheck into an account before paying income taxes. Then, during the year, the employee can be directly reimbursed from this account for eligible health care and dependent care expenses. FSA benefits are subject to annual maximum and "use-or-lose" rule. This plan does not provide a cumulative benefit beyond the plan year.

There are 2 types of Flexible Spending Accounts: a Health Care Account for out-of-pocket health care expenses, and a Dependent Care Account (subject to annual contribution limits) to help pay for dependent's care expenses which makes it possible for an employee and his or her spouse to continue to work.

An FSA is exempt from federal income taxes, Social Security (FICA) taxes and, in most cases, state income taxes, saving 1/3 or more in taxes. If the plan favors highly compensated employees, the benefits for the highly compensated employees are not exempt from federal income taxes.

Child and dependent care expenses must be for the care of one or more qualifying persons:

- A dependent who was under age 13 when the care was provided and who can be claimed as an exemption on the employee's Federal Income Tax return;
- A spouse who was physically or mentally not able to care for himself or herself; or
- A dependent who was physically or mentally not able to care for himself or herself and who can be claimed as an exemption (as long as the person is earning gross income less than an IRS-specified amount).

Persons who cannot dress, clean, or feed themselves because of physical or mental problems are considered not able to care for themselves. Also, persons who must have constant attention to prevent them from injuring themselves or others are considered not able to care for themselves.

The insured may change benefits during open enrollment. After that period, generally, no other changes can be made during the plan year. However, the insured might be

able to make a change under one of the following circumstances, referred to as qualified life event changes:

- Marital status;
- Number of dependents;
- One of dependents becomes eligible for or no longer satisfies the coverage requirements under the Medical Reimbursement plan for unmarried dependents due to attained age, student status, or any similar circumstances;
- The insured, the insured's spouse's or qualified dependent's employment status that affects eligibility under the plan (at least a 31-day break in employment status to qualify as a change in status);
- Change in dependent care provider; or
- Family medical leave.

The IRS limits the annual contribution for Dependent Care Accounts to a specified amount that gets adjusted annually for cost of living. This is a family limit, meaning that even if both parents have access to flexible care accounts, their combined contributions cannot exceed the amount.

High Deductible Health Plans (HDHPs)

High-deductible health plans (HDHPs) are often used in coordination with MSAs, HSAs, or HRAs. The high-deductible health plan features higher annual deductibles and out-of-pocket limits than traditional health plans, which means lower premiums. Except for preventive care, the annual deductible must be met before the plan will pay benefits. Preventive care services are usually first dollar coverage or paid after copayment. The HDHP credits a portion of the health plan premium into the coordinating MSA, HSA, or HRA on a monthly basis. The deductible of the HDHP may be paid with funds from the coordinating account plan.

Medical Expense Policies

E. Limited Health Policies

Cancer

Cancer policies cover only one illness: cancer, and pay a lump-sum cash benefit when the insured is first diagnosed with cancer. It is a supplemental policy intended to fill in the gap between the insured's traditional health coverage and the additional costs associated with being diagnosed with the illness. There are no restrictions on how the insured spends the funds, so the benefit can be used to pay for medical bills, experimental treatment, mortgage, personal living expenses, loss of income, etc.

Critical Illness or Specified Disease

A **critical illness** policy covers multiple illnesses, such as heart attack, stroke, renal failure, and pays a lump-sum benefit to the insured upon the diagnosis (and survival) of any of the illnesses covered by the policy. The policy usually specified a minimum number of days the insured must survive after the illness was first diagnosed.

Short-Term Medical

Short-term medical insurance plans are designed to provide temporary coverage for people in transition (those between jobs or early retirees), and are available for terms from one month up to 11 months, depending on the state. Unlike regular individual major medical plans, short-term health insurance policies are not regulated by the Affordable Care Act and their enrollment is not limited to the open enrollment period; they also do not meet the requirements of the federally mandated health insurance coverage.

Like traditional health plans, short-term plans may have medical provider networks, and impose premiums, deductibles, coinsurance and benefit maximums. They also cover physician services, surgery, outpatient and inpatient care.

Accident

Accident-only policies are limited policies that provide coverage for death, dismemberment, disability or hospital and medical care resulting from an accident. Because it is a limited medical expense policy, it will only pay for losses resulting from accidents and not sickness.

Health Regulations

Indiana Health Coverage Programs (IHCP)

The **Indiana Health Coverage Programs (IHCP)** are state-sponsored programs and services for Indiana residents who are aged, disabled, blind, pregnant, or meet other eligibility requirements. Healthcare benefits are administered through two delivery systems:

1. Fee-for-service delivery system; and
2. Managed care delivery system.

Most IHCP members receive services through the managed care delivery system. Under **managed care**, members are enrolled in a health plan with a managed care entity (MCE) that is responsible for the members' healthcare services. Each MCE maintains its own provider network, provider services unit, and member services unit for the health plans they offer. The MCE authorizes services, pays claims, and is responsible for subrogation activities. All providers wanting to offer services to members enrolled in managed care programs must first enroll with the IHCP and then contract one or more MCEs to deliver services to their members. Programs and benefit plans that operate under the managed care delivery system include the following:

- Health Indiana Plan (HIP);
- Hoosier Care Connect;
- Hoosier Healthwise; and
- Program for All-Inclusive Care to the Elderly (PACE).

The **fee-for-service** (FFS) delivery system reimburses providers on a per-service basis. Generally, members seek services from IHCP providers of their choice. The IHCP maintains centralized administrative oversite of the provider network and the associated provider and member services. Providers bill the appropriate IHCP claim-processing contractor for services rendered. Some of the programs and benefit plans that operate under this system are as follows:

- Traditional Medicaid;
- 590 Program;
- Family Planning Eligibility Program;
- Medicare Savings Programs; and
- Medicaid Rehabilitation Options Services.

The **Healthy Indiana Plan (HIP)** is a state sponsored plan designed to provide health coverage to low-income adults ages 19 to 64. As mentioned above, it is one of the managed care delivery systems under the IHCP. The plan pays for medical costs and, depending on the plan, could provide vision and dental coverage. HIP participants may not be eligible for Medicare or Medicaid.

In addition, the applicants must meet the following income level requirements:

- Individuals with an annual income up to $17,443;
- Couples with annual incomes up to $23,615; and
- Families of four with an annual income up to $35,960.

Eligible Indiana residents may enroll in HIP by mailing or by visiting the Division of Family Resources (DFR) office, or by filling out an application online through the Indiana Family & Social Services Administration website. Once a completed application is received by the state, it must be processed within **45 days**. The decision to approve or decline coverage will be sent to the applicant. If approved, the applicant is assigned to the health plan specified in the application. If a plan is not specified, a plan will be selected on the applicant's behalf.