Addendum: for use with Indiana Life and Health online ExamFX courses and study guide version 24593en/24594en, per exam content outline updates effective 2/28/2020.

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

LIFE

Taxes, Retirement, and Other Insurance Concepts

E. Retirement Plans

2. Individual Qualified Plans – IRA and Roth IRA – *revised as follows per required minimum distribution rule change*

A Traditional **Individual Retirement Account (IRA)** allows individuals with *earned income* to make tax deductible contributions regardless of age. Previously, individuals were allowed to contribute to the account until the age of 70 ½; however, the SECURE Act of 2019 removed the prior age limit for all contributions starting in tax year 2020. Plan participants are allowed to contribute up to a specified dollar limit each year, or 100% of their salary if less than the maximum allowable amount. Individuals who are **age 50 or older** are entitled to make additional catch-up contributions. A married couple could contribute a specified amount that is double the individual amount, even if only one person had earned income. Each spouse is required to maintain a separate account not exceeding the individual limit.

In traditional IRAs, the owner may **withdraw** the funds at any time. However, withdrawals prior to age 59 ½ are considered early withdrawals and are subject to a 10% additional tax. Starting at age 59 ½, the owner may withdraw assets without having to pay the 10% additional tax. However, the owner must start receiving distributions from the IRA at the age of 72 (the SECURE Act of 2019 raised the required minimum distribution age from 70 ½ to 72). Starting at age 72, the owner must receive at least a minimum annual amount, known as the **required minimum distribution (RMD)**.

The **Roth IRA** is a form of an individual retirement account funded with after-tax contributions. An individual can contribute 100% of earned income up to an IRS-specified maximum, as with traditional IRAs (the dollar amounts change every year). Roth contributions can continue regardless of the account owner's age, and in contrast with a traditional IRA, distributions do not have to begin at age 72 (previously 70½). Roth IRAs grow tax free as long as the account is open for at least 5 years.

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Life Regulations

B. Group Life

2. Policy Provisions

Insurable Interest on Employees

In life insurance, insurable interest must exist at the **time of application**. Employers who provide life insurance, health insurance, disability insurance, retirement benefits, or any other employee benefits have insurable interest in the life of the employee. Additionally, a trustee of a trust established by an employer, which also provides benefits and acts in a fiduciary capacity to the employee or employee's dependents, has an insurable interest in the life of the employee.

An employer may purchase insurance on an employee in whom the employer has an insurable interest, as long as the employee provides consent to be insured. An employee consents to be insured if the employee is provided written notice of the insurance coverage and does not object to the insurance coverage within **30 days** of receipt of the notice.

All proceeds of an insurance policy on an employee are exempt from the claims of the employee's creditors or dependents.

HEALTH

Types of Health Policies

A. Medical Expense Insurance

7. High Deductible Health Plans (HDHPs) and Related Health Savings Accounts (HSAs)

HSAs are linked to high deductible insurance. A person may obtain coverage under a qualified health insurance plan with established minimum deductibles ($1,400 for singles and $2,800 for families in 2020).

Each year eligible individuals (or their employers) are allowed to save up to certain limits, regardless of their plan's deductible (current contribution limits are $3,550 for singles and $7,100 for families). When opening an account, an individual must be under the age of Medicare eligibility. For taxpayers aged 55 and older, an additional contribution amount is allowed (up to $1,000).

An HSA holder who uses the money for a nonhealth expenditure pays tax on it, plus a 20% penalty. After age 65, a withdrawal used for a nonhealth purpose will be taxed, but not penalized.

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Social Insurance

A. Medicare – *revised as follows per Medicare rule change*

4. Part D

Those who sign up for the standard Prescription Drug Benefit plan will have a monthly premium and a deductible. The monthly premium varies by plan. After the deductible is paid, the plan would provide prescription drug costs coverage until a benefit limit is reached. Most Medicare drug plans have a coverage gap, also called a "donut hole." The coverage gap begins after the beneficiary and the drug plan have spent a certain amount for covered drugs ($4,020 in 2020). In the coverage gap, the beneficiary is responsible for **25%** of brand name prescription drug costs, and **25%** of the plan's cost for covered generic drugs. Note that as of 2020, the donut hole for generic drugs has closed.

Once the beneficiary has met the plan's out-of-pocket cost requirements for the year *($6,350 in 2020)*, **catastrophic coverage** begins automatically. Catastrophic coverage will cover 95% of prescription drug costs. The beneficiary pays the greater of the specified amount or 5%. The cost limit for generic drugs would be lower than for name brand drugs.

Health Regulations

A. Health Insurance Contracts

3. Underwriting Restrictions

AIDs/HIV

The Indiana Insurance Code strictly regulates the use of **AIDS (acquired immune deficiency syndrome)** and **HIV (human immunodeficiency virus)** information as underwriting criteria by insurance companies:

- During the application process, the insurer may require an applicant to submit medical tests to determine HIV infection, as long as:
  - The test is necessary to provide a fully informed underwriting determination;
  - An insurer obtains the applicant's written consent; and
  - No adverse underwriting decision is made upon positive test results, unless test protocols determined by the Commissioner are met.
- Adverse underwriting determinations may only be based on:
  - Two positive ELISA (enzyme-linked immunosorbent assay) tests;
  - One positive Western Blot test; or
  - Any other alternative screening or test approved by the Commissioner in compliance with the federal Food and Drug Administration.
- An insurer is responsible for any medical test expenses related to AIDs or HIV determination;
- Test results are confidential and may only be shared with the applicant, applicant's physician, the insurer's underwriting department, and applicable reinsurers

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- Test results may be reported to the MIB, as long as:
  - The insurer does not report the presence of HIV, but instead that the test results are abnormal; and
  - The insurer provides test results for multiple non-HIV related diseases or conditions.
- Limitations or exclusions in coverage cannot be based solely on positive HIV, AIDS, or other related condition test results.

During the underwriting process, an insurer may ask any **medically specific** questions that are necessary for making informed underwriting decisions. However, the following conditions apply:

- Questions **cannot be directed toward determining the applicant's sexual orientation**. For example, the applicant's marital status, living arrangements, occupation, beneficiary designation or zip code cannot be used to establish the applicant's sexual orientation.
- Questions regarding the applicant having HIV are allowed only if they are factual, objective and designed to establish the existence of the condition. However, no adverse underwriting decisions can be made based on the fact that the applicant has demonstrated concern about HIV by seeking testing or counseling from health care professionals.
- Questions relating to the applicant having, or being diagnosed with, a sexually transmitted disease are allowed.

Genetic Testing

The term "**genetic information**" means any information about genes, gene products, hereditary susceptibility to disease or inherited characteristics that may derive from the individual or family member.

To prevent genetic information discrimination in accident and health or sickness insurance coverage, insurers may not engage in any of the following practices:

Use an individual's or a family member's genetic information to deny or limit any coverage or establish eligibility, continuation, enrollment or premium payments;
Request or require collection or disclosure of an individual's or family member's genetic information; or
Disclose an individual's or family member's genetic information without the written consent of the person affected.

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C. Long-Term Care and Medicare Supplement Policies

2. Medicare Supplements

Policy Provisions

No Medicare supplement policy advertised, solicited, or issued for delivery in this state may:

- Contain limitations or exclusions more restrictive than those found in Medicare policies;
- Use waivers to exclude, limits or reduce coverage or benefits for specifically named pre-existing conditions;
- Contain benefits that duplicate those in a Medicare policy;
- Renew a policy with outpatient prescription drug benefits, unless:
    - The policy is adjusted to exclude outpatient prescription drug coverage after an individual's Medicare Part D plan takes effect; and
    - Premiums are adjusted to reflect the outpatient prescription drug exclusion.

Pre-existing Conditions

A Medicare supplement policy or certificate may not exclude or limit benefits for losses incurred more than **6 months** from the effective date of coverage because the loss involved a pre-existing condition.

The policy may not define a pre-existing condition more restrictively than *"a condition for which medical advice was given or treatment recommended by or received from a physician within 6 months before the effective date of coverage."*

Appropriateness of Recommended Purchase and Excessive Insurance – *additions to the existing text*

Insurers are prohibited from issuing a Medicare supplement policy to an individual who is already enrolled in Medicare Part C.

If a Medicare Supplement policy is issued to an individual who already has a policy in effect, the insured must either refund premiums or pay claims on the policy, whichever is greater. Insurers are required to report all excessive Medicare supplement policies, no later than March 2nd of each year. Reports must include each excessive policy's certificate number and date of issue.

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