A.D.Banker&Company®
exam prep and continuing education

Health Insurance

Class Workbook

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Section 1 – General Insurance

I. Risks, Perils, and Hazards
II. Insurance Concepts
III. Legal Contracts
IV. Insurance Contract Definitions and Legal Interpretations

I. Risks, Perils, and Hazards

A. Risk – Uncertainty concerning a loss

Speculative Risk – A possibility of loss, no loss, or gain

Pure Risk – A possibility of loss or no loss

1. The type of risk in which only the chance of loss and no chance of gain exists, defines:

a) Active risk

b) Speculative risk

c) Passive risk

d) Pure risk

B. Peril – A **cause** of a potential loss

C. Hazard – **Increases** the chance of a loss occurring

3 Types of Hazards:

- _____ – A physical condition that increases the probability of loss
- _____ – Dishonest tendencies
- _____ – Indifference to loss, or failure to protect one's property from loss

II. Insurance Concepts

A. Insurance – The exchange of a **small certain** expense for a **large uncertain** loss

1. Transfers the risk
2. Protects against uncertainty
3. Shares the loss
4. Reduces anxiety

B. Law of Large Numbers – The **larger** the number of similar exposures, the **closer** the losses will equal the underlying probability of loss

2. When the number of similar units increases, the predictability of loss improves according to:

a) The Law of Predictability

b) The Law of Common Exposures

c) The Law of Assumption

d) The Law of Large Numbers

C. Insurable Interest

1. Insurable **interest** must exist in every enforceable contract
2. Potential for **financial hardship** in the event of loss
3. Must exist at the time of application

III. Legal Contracts

A. Elements of a Legal Contract – A valid contract requires **four** elements:

1. Competent Parties
2. Legal Purpose
3. Agreement
4. Consideration

B. Competent Parties

1. Parties must have **legal capacity** to enter into a contract
2. Restricted parties include:
   - ⦸ _____
   - ⦸ _____
   - ⦸ _____

C. Legal Purpose

1. May **not** be issued for illegal/immoral purpose
2. Every insured **must have** an insurable interest at the time of application

D. Agreement

1. The **agreement** is a 2 step process that involves an offer and acceptance
   - **Offer**
   - **Acceptance**
   -

E. Consideration – What two parties exchange in value to abide by the conditions of the contract

1. **Payment of premium** is Insured's consideration
2. Insurer's promise to **indemnify** in event of a loss
3. Mutual agreement is reached when the insurer delivers the policy upon initial premium payment

3. The value that each party gives the other in an insurance contract is said to be the:

a) Agreement

b) Offer and Acceptance

c) Legal Purpose

d) Consideration

IV. Insurance Contract Definitions and Legal Interpretations

1. **Conditional –** Both parties must perform certain duties and follow rules of conduct to make the contract enforceable
2. **Unilateral –** Only one party is legally bound to the contractual obligations after the premium is paid to the insurer
3. **Contract of Adhesion –** One party (insurer) prepares the contract and it is not negotiable
4. **Principal of Indemnity –** The insured is to be restored to their original financial position that they enjoyed prior to their loss
5. **Representation –** A statement made on the application that is believed to be true to one's knowledge
6. **Misrepresentation –** A false statement on the application that renders the contract void if material to acceptance of the risk
7. **Warranty –** A statement that is guaranteed to be true and coverage may hinge on the truthfulness of that statement
8. **Concealment –** When an applicant intentionally fails to make known a material fact
9. **Fraud –** The intentional misrepresentation, deceit, or concealment of material facts known by a person with the intention of causing injury to another

Match the term with the correct definition

1. Conditional	**a.** When an applicant intentionally fails to make known a material fact
2. Unilateral	**b.** A statement that is guaranteed to be true and coverage may hinge on the truthfulness of that statement
3. Contract of Adhesion	**c.** Both parties must perform certain duties and follow rules of conduct to make the contract enforceable
4. Principal of Indemnity	**d.** A false statement on the application that renders the contract void if material to acceptance of the risk
5. Representation	**e.** The intentional misrepresentation, deceit, or concealment of material facts known by a person with the intention of causing injury to another
6. Misrepresentation	**f.** One party (insurer) prepares the contract and it is not negotiable
7. Warranty	**g.** A statement made on the application that is believed to be true to one's knowledge
8. Concealment	**h.** Only one party is legally bound to the contractual obligations after the premium is paid to the insurer
9. Fraud	**i.** The insured is to be restored to their original financial position that they enjoyed prior to their loss

4. When an applicant intentionally fails to make known a material fact, this is known as:

a) Misrepresentation

b) Concealment

c) Fraud

d) Warranty

Section 2 – Health Basics

I. Definitions
II. Field Underwriting and Completing the Application
III. Health Insurance Underwriting
IV. Classification and Rating

I. Definitions

A. Accident and Health

B. Accidental Injury

C. Deductible

D. Coinsurance

E. Copayment

F. Morbidity Table

G. Pre-existing Conditions

H. Probationary Period

I. Sickness

Fill in the correct term for the following definitions:	
1.	Injury and sickness losses are covered
2.	Unforeseen and unintended act causing injury
3.	Cost sharing method stated as a %
4.	Initial amount payable before coverage applies
5.	Stated dollar amount paid by the insured per claim
6.	Probability of disability (injury or sickness)
7.	Prior medical condition
8.	Time before coverage begins for pre-existing condition
9.	Illness or disease causing a loss

K. Principal Types of Losses & Benefits

1. Disability Income
2. Medical Expense
3. Dental Expense
4. Long-Term Care
5. Accidental Death and Dismemberment

II. Field Underwriting and Completing the Application

A. Completing the application

1. A formal request for coverage
2. Producer's responsibilities
3. Required signatures
4. Changes in the Application
5. Incomplete application
6. Collect initial premium with the application
7. No initial premium collected

B. Disclosures

1. Notice of Information Practices – FCRA
2. Disclosure at Point of Sale – HIV testing

III. Health Insurance Underwriting

A. Underwriting – The process of evaluating a risk for the purpose of issuing insurance coverage

B. Individual Underwriting Factors

- ❑ Age
- ❑ Gender
- ❑ Smoking
- ❑ Occupation & hobbies
- ❑ Physical condition/ Health history
- ❑ Other insurance
- ❑ Plan applied for
- ❑ Geographical area of residence
- ❑ If more than 1 occupation use the most hazardous for rating

C. Sources of Underwriting

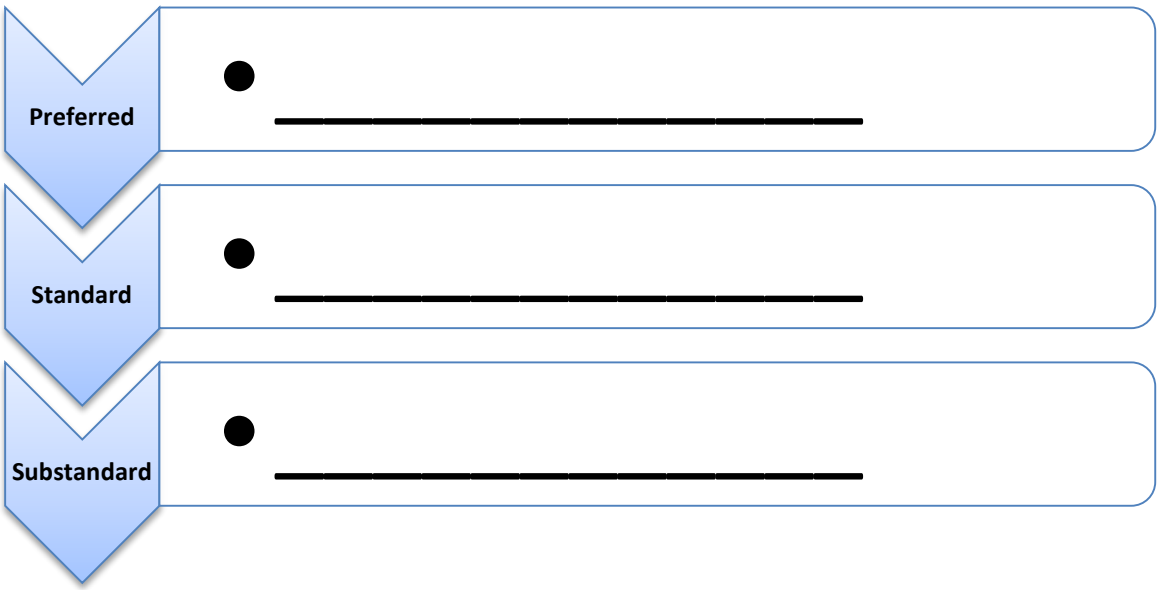
1. The Application
   - Part 1
   - Part 2
2. Medical information
3. Attending Physician Statement
4. Medical Information Bureau
5. Consumer Investigative or Inspection Report
6. Agent's report

IV. Classification and Rating

A. Premium determination

1. Assumptions and calculations
2. Premiums are based on:
    - Morbidity
    - Interest
    - Expenses

B. Classification – The insurer's underwriter will take one of the following actions upon receipt of application:



1. A rejected policy will not be issued

Section 3 – Medical Expense Plans and Concepts

I. Definitions
II. Classification of Healthcare Plans
III. Types of Service Providers
IV. Medical Expense Plans
V. Benefits and Provisions
VI. Optional benefits
VII. Limited Policies
VIII. Common Exclusions
IX. Dental Insurance

I. Definitions

A. Earned Premium

B. Unearned premium

C. Service Area

D. Subscriber

E. Insured

Definitions	
1.	Part of premium for protection already given
2.	Part of premium for protection not yet given
3.	Primary geographic area covered by HMO
4.	Person covered by service provider
5.	Person covered by indemnity provider

II. Classification of Healthcare Plans

A. Providers

1. **Indemnity Plan**
2. **Service Plan**
3. **Self-Funded Plan**

Classes of Providers	
1.	Reimburse insured for expenses based on specified dollar amount – issued by Commercial Insurers
2.	Pay directly to the provider of care – doctor or hospital
3.	Employers who fund their own claims

B. Payment and Benefit Structure

1. **Payment structure**
   - Blanket payment
   - Scheduled payment
   - Cash or Indemnity payment
   - Fee-for-Service
   - Prepaid
   - Usual, Customary and Reasonable (UCR)

III. Types of Service Providers

A. HMO

1. Managed care system
   - Primary Care Physician or Gatekeeper
2. Prepaid basis
3. Subscribers
4. Open and Closed panels
5. Service area
6. Emergency room
7. Copayment per office visit
8. Emphasize preventive medicine by…

- Physical exams and diagnostic procedures
- Reduce unnecessary hospital stays
- Reduce number of days per hospital stay

C. PPO

1. Providers are paid on a fee-for-service basis
2. Subscribers have more choices among doctors and hospitals
3. In network – similar to an HMO; Out of network – reduced benefits
4. Out of Network-reduced benefits are paid

D. Point of Service (POS)

1. Combines the features of an HMO and a medical expense plan
2. At the Point of Service, the subscriber chooses in network or out of network coverage
3. In network is an HMO and requires a small copayment
4. Out of network requires a deductible and coinsurance

1. In the situation described below, Monte is covered by a:

Monte has a health care plan whereby if he stays within the network, benefits are paid as an HMO. However, if he goes outside the network, benefits are paid from the medical expense portion of the plan subject to high deductibles and copayments

a) Preferred Provider Organization

b) Tri – Care Plan

c) Point of Service Plan

d) HMO

2. Sylvia is a participant in a Preferred Provider Organization and finds that if she opts to use a provider other than a preferred provider:

a) Her PPO will not pay at all

b) Her PPO will pay only if the circumstances for care were precipitated by an emergency.

c) Her PPO will pay a reduced amount with Sylvia paying the balance

d) Her PPO will cover any charges in full

IV. Medical Expense Plans

A. Basic Expense Plans – First dollar, no deductible

1. **Basic Hospital –** Hospital room and board (semi-private room) and miscellaneous hospital expenses up to a limit.
2. **Basic Surgical Expense** – Scheduled list of surgical procedures, covers surgeon's fees and anesthesiologist's fees
3. **Basic Medical Expense –** Nonsurgical outpatient physician services

B. Major Medical Policy

1. Lifetime Maximum
2. Annual deductible and Coinsurance apply
3. Protects against catastrophic losses

C. Major Medical Provisions

1. **Stop Loss –** Maximum dollar limit that the insured will pay, may include the deductible
2. **Family Deductible –** A maximum of 2 or 3 deductibles will satisfy the requirement for whole family per calendar year
3. **Common Accident –** More than one family member injured, only one deductible applies
4. **Deductible Carry-Over –** Expenses the last 3 months will be carried over to next year

D. Supplementary Major Medical

1. **Corridor Deductible –** Between basic and supplemental plan, insured pays

E. Comprehensive Major Medical – Integrated deductible

3. **Tom owns a policy that combines the best features of the traditional Basic Plans and Major Medical Insurance into a single policy to give him the most complete hospital coverage. Tom owns a:**

   a) Supplementary Major Medical Policy

   b) Combination Major Medical Policy

   c) Comprehensive Major Medical Policy

   d) Blanket Major Medical Policy

V. Benefits and Provisions

A. Newborn Infant Coverage – Includes necessary care and treatment of medically diagnosed congenital defects and birth abnormalities

B. Dependent Child Coverage – Coverage up to age 26

C. Mental Illness and Substance Abuse – Inpatient and outpatient, includes alcohol abuse and chemical dependency

D. Prescription drugs – May be provided within the plan itself or contracted through a third-party pharmacy benefit provider

E. Maternity Care – Prenatal and labor and delivery expenses and a minimum of two or four days in hospital post-partum

VI. Optional Benefits

A. Hearing

B. Vision

VII. Limited Policies

A. Accidental Death and Dismemberment

1. **Principal Amount (Sum)** – Full amount for death, double dismemberment or loss of eyesight if within 90 days of accident

2. **Capital Amount (Sum)** – 50% loss of 1 limb or sight in 1 eye – single dismemberment

B. Limited Accident

1. Specific benefit from specific causes

4. **Raymond owns an Accidental Death and Dismemberment Policy with a Principal amount of $50,000, and a Capital amount of $25,000. After owning the policy several months, Raymond dies as the result of coronary artery disease. Lynn, his beneficiary, can expect to receive what amount of benefit from the policy?**

   a) $0

   b) $25,000

   c) $50,000

   d) $75,000

C. Limited Sickness (Dread Disease)

1. Specific benefit for specific disease such as cancer (aka Specified Disease)

D. Hospital Income (Indemnity)

1. Pays directly to insured a set dollar amount per day, cash payment as stated in the policy

E. Blanket Insurance

1. Sold to groups with a common interest for a specific event

Limited Policies	
1.	Accident only, not disease Death 2 eyes or 2 limbs 1 eye or 1 limb: smaller amount
2.	From specific causes e.g. airlines travel
3.	Specific disease e.g. heart disease, cancer
4.	$/day to insured
5.	Sold to groups for specific events such as schools or sports teams

VII. Common Exclusions

A. Causes or conditions listed not covered

B. These are the most typical:

- Preexisting conditions
- Intentionally self-inflicted injuries
- War or act of war
- Elective cosmetic surgery
- Expenses payable under Workers' Comp
- Aviation
- Military service, overseas residence
- Care in a government facility

VII. Dental Insurance

A. The dental profession is very specialized and the following is a partial list of dental specialists:

- Endodontics – Services covering dental pulp care and root canals
- Orthodontics – Services for teeth alignment and other irregularities of the teeth
- Periodontics – Services for the treatment of gum problems and disease
- Prosthodontics – Services provide bridgework and dentures
- Restorative Care – Services to restore the functional use of natural teeth
- Oral Surgery – Surgical treatment of diseases, injuries and jaw defects

B. Types of Benefits

1. **Diagnostic/Preventive -** Routine diagnostic and preventive care services includes routine checkups,x-rays and cleaning
2. **Basic -** Fillings, periodontics and root canals are considered to be basic care
3. **Major** Major dental care includes any crowns, dentures or bridge work, and orthodontics

C. Exclusions

- Purely cosmetic services (unless necessitated by an accident)
- Replacement of prosthetic devices
- Duplicate dentures or prosthetic devices
- Oral hygiene instruction or training
- Occupational injuries covered by Workers' Compensation
- Services furnished by or on behalf of government agencies
- Certain services that began prior to the date of coverage

Section 4 – Disability Income

I. Disability Income
II. Definitions and Provisions
III. Disability Underwriting
IV. Disability Income Business Uses
V. Policy Riders
VI. Social Security Disability Income

I. Disability Income

A. Disability Income

1. Disability eliminates income, increases expenses

B. Loss of Time or Loss of Income Policy

1. Pays either a flat benefit or a percentage of earnings
2. Benefits paid monthly
3. Not designed to replace full income

C. Benefit Period

1. Period of time benefits are payable; renews per disability

D. Elimination Period (Waiting Period)

1. Period of time after disability occurs before benefits are payable, different for sickness than injury

II. Definitions and Provisions

A. Total Disability – Inability to perform **ALL DUTIES** of:

1. Own occupation, or

2. Any occupation which one is reasonably suited by education, training, or experience

B. Partial Disability – Inability to perform **ONE OR MORE** regular duties of one's occupation

1. An insured being "unable to perform all duties of any occupation for which he or she is reasonably qualified by education, training, or experience," is an example of:

a) Residual disability

b) Total disability

c) Recurrent disability

d) Permanent disability

C. Residual Disability – Benefits after the insured returns to work for less pay

D. Recurrent Disability – 2nd disability due to same cause, elimination period may be waived – usually 6 months

E. Presumptive Disability – Loss presumed to be total for loss of sight, hearing, speech or 2 limbs

2. Stephen returned to work after a period of total disability. Because he couldn't do his job as well as before, he couldn't earn as much. _____ benefits would help make up for his loss of income.

a) Residual Disability

b) Recurrent Disability

c) Presumptive Disability

d) Temporary Disability

Definitions and Provisions

1.	Covers on and off the job
2.	Covers off the job only
3.	1) Cannot perform duties in own occupation. 2) Cannot perform duties in any occupation for which reasonably suited
4.	50% of total benefit; Cannot perform at least 1 regular job duty
5.	Reduced benefit paid after return to work at reduced earnings
6.	Same cause of loss within 6 months; Elimination may not apply 2nd time
7.	Loss of sight, limbs, hearing, speech; No further exams required – lump sum

III. Disability Underwriting

A. Unique Aspects of Individual Disability Underwriting

1. Occupation
2. Hazardous hobbies
3. Age, Gender, and Health
4. Amount and length of benefit
5. Elimination period

B. Underwriting Group Plans

1. Usually offered only as non-occupational (Workers' Comp covers on the job)
2. Minimum number of employee participation required
3. No medical underwriting
4. Field underwriter guards against adverse selection and over-insurance

3. All of the following are false statements regarding group disability plans, EXCEPT:

a) There is individual medical underwriting.

b) There is no minimum number of participants required to formulate the plan.

c) The plans are typically written on a non-occupational basis.

d) There is no benefit allowance for those employed beyond age 65.

C. Short Term Disability

D. Long-Term Disability

IV. Disability Income Business Uses

A. Business Overhead Expense – Insures owner; pays rent, employee payroll, utilities

B. Key Employee Insurance – Insures key employee

4. **Ole Olson owns a Business Overhead Expense Policy whereby if he, the owner of the business, should become disabled, the policy will continue to meet expenses in his absence. The policy would cover all of the following, EXCEPT:**

   a) Ole's office rent

   b) Ole's employee payroll

   c) Ole's utility bills

   d) Ole's personal lost income

C. Buy-Sell Agreement – Insures partners; enables other partners to purchase the disabled partners share of business

Business protection	
1.	Owner becomes disabled: office rent, employee labor
2.	Pays replacement, training due to disability of employee; covers lost revenue
3.	Lump sum to buy out share of business if partner becomes disabled

V. Policy Riders

A. Cost of Living Rider – Automatically increases monthly benefits after the onset of a disability, as the Consumer Price Index increases

B. Guaranteed Purchase Option Rider (also known as **Guaranteed Insurability Rider**)

1. On certain dates, ages, occurrences, additional insurance may be purchased without proof of insurability

5. **The income from the Cost of Living Rider, when attached to a Disability Income Policy, starts:**

   a) Immediately upon claim

   b) After the insured has received benefits from the policy to which it is attached for 12 months

   c) After the insured has received benefits from the policy to which it is attached for 18 months

   d) After the insured has received benefits for at least two calendar quarters from the policy to which it is attached

C. **Waiver of Premium Rider** – Usually after 6 months of disability total disability and premiums are waived

D. **Impairment Rider** – Excludes a condition making insurability possible

E. **Return of Premium Rider** – Provides refund of premiums if favorable claims activity over specified time

F. **Non-Disability Injury Rider** – Pays medical expenses as a rider attached to an income policy

G. **Hospital Confinement Rider** – Waives elimination period if hospitalized

H. **Social Insurance Supplement (SIS) Rider** – Pays additional short-term benefits until Workers' Comp or Social Security begins

I. **Additional Monthly Benefit (AMB) Rider** – Short term benefit that pays additional income in addition to other policies

Riders

1. Non-disability injury	**a.** After onset of disability; increases monthly income to protect against inflation
2. Additional Monthly Benefit	**b.** Additional insurance without insurability at specified dates or events
3. Social Insurance Supplement	**c.** Starts after specified period and waives premiums
4. Hospital confinement	**d.** Excludes specified preexisting conditions
5. Waiver of premium	**e.** Based on favorable claims history
6. Cost of living	**f.** Pays medical expenses for injury not resulting in total disability
7. Impairment	**g.** Waives elimination during hospitalization
8. Return of premium	**h.** Pays until SS or workers comp payments begin
9. Guaranteed Insurability	**i.** Provides additional income for the first 6-12 months of disability

VI. Social Security Disability Insurance

A. Fully Insured - Contingent upon the employee having the proper insured status of fully insured **(20 of last 40 quarters)** and satisfy the waiting period

B. Contributions - Both employer and employee contribute to social security

C. Definition of Disability

1. Unable to engage in any kind of gainful employment
2. Lasted or expected to last **12 months** or result in early death

D. Waiting Period – 5 months, not retroactive

E. Disability Income Benefits

1. Benefits based on average indexed monthly earnings
2. Benefit is based on worker's PIA (Primary Insurance Amount)
3. Employee must be currently insured to collect

F. Coordination of Benefits

1. Workers' Compensation
2. Social Security Disability Income Limitation

6. All of the following statements about Social Security disability benefits are true, EXCEPT:

a) Benefits are based on the level of a worker's earnings up to the time of the disability

b) Benefits will continue only while the worker cannot work at all

c) Benefits are designed to replace the entire amount of a worker's earnings

d) Workers must be totally disabled for at least five months to be eligible for benefits

Section 5 – Senior Needs

I. Medicare Overview
II. Medicare Part A Hospital Insurance (Inpatient)
III. Medicare Part B Medical Insurance (Outpatient)
IV. Medicare PartC Medicare Advantage
V. Medicare Part D Prescription Drugs
VI. Medicare Supplement (Medigap)
VII. Medicaid
VIII. Long-Term Care

I. Medicare Overview

A. Eligibility

1. Age 65 or older
2. Social security disability income for 2 years
3. Kidney failure (End stage Renal Failure) for 18 months

1. All of the following are entitled to Medicare, EXCEPT:

a) Persons who are eligible for social security and are age 65

b) Persons with kidney failure for 18 months

c) Persons able to receive disability benefits for 24 months

d) Persons who qualify for public assistance programs

II. Medicare Part A Hospital Insurance (Inpatient)

A. No additional premium for those who qualify

B. Deductible/Copayments per benefit period

C. Benefit period begins first day of hospitalization

D. Benefit period ends after patient out of hospital or skilled nursing facility for 60 straight days

E. Hospitalization – Semiprivate room, miscellaneous hospital expenses, drugs while there

F. Skilled nursing – Must have been hospitalized for minimum 3 days prior, and admitted to facility within 30 days of discharge

G. Home health care – Medically necessary skilled care, nurses' visits, supplies

H. Hospice care – Full scope of pain relief and support to the terminally ill

I. Blood – Covered inpatient, except the first 3 pints annually

2. Part A of Medicare is known as:

a) Medical Insurance

b) Medicare + Choice

c) Outpatient Insurance

d) Hospital Insurance

III. Medicare Part B Medical Insurance (Outpatient)

A. Pay a monthly premium

B. Provides benefits for

1. **Medical Expense –** Physicians services, physical therapy, diagnostic tests, etc
2. **Laboratory Services –** Blood tests, biopsies, etc
3. **Home Health Care –** Medically necessary skilled care, supplies, etc
4. **Outpatient Hospital Treatment –** Reasonable and necessary services for treatment
5. **Blood –** Covered as outpatient after 3 pints annually

C. Prescription drugs are NOT covered

D. Medicare generally pays 80% of that scheduled amount

E. Annual deductible

F. Coinsurance required

G. Covers preventive care

H. Covers mental health on an outpatient basis

3. Part B of Medicare covers:

a) Skilled nursing over 100 days

b) Prescription drugs

c) Dental care

d) Outpatient surgery

IV. Medicare Part C Medicare Advantage

A. Medicare Advantage Plans (Part C) are health care options (like a HMO or PPO) that combine Part A and Part B coverage

B. These are programs that are approved by Medicare and run by private companies

C. Most include prescription drug coverage

D. Medicare services are covered through this one plan, and are not paid for under Original Medicare

V. Medicare Part D Prescription Drugs

A. Medicare Part D helps to cover the costs of prescription drugs

B. Offered by private insurance companies with a monthly premium

C. Individuals with Medicare Part A and/or Medicare Part B are eligible for Part D

D. Coverage stops once the plan's limit for prescription drugs has been reached

E. The insured is responsible for paying 100% of the drug costs until eligible for Catastrophic Coverage

F. This gap in coverage is known as the Coverage Gap or Doughnut Hole

VI. Medicare Supplement (Medigap)

A. Purpose

1. Supplement Medicare coverage
2. Pay some/all deductibles and coinsurance

B. Open Enrollment

1. 65 or older may purchase if applied within 6 months of enrolling in Part B
2. The Medigap open enrollment period lasts for 6 months beginning the month an individual turns age 65 and enrolls in Medicare Part B
3. If enrolled during this period, the insurer cannot use medical underwriting, refuse coverage, charge a higher premium, or impose a waiting period for preexisting conditions.

C. Guaranteed Issue

1. Insurer cannot deny issuance of effectiveness of policy that is offered and available to new enrollees
2. Cannot discriminate on pricing because of health status or impose exclusion due to pre-existing conditions
3. Pre-existing conditions may be excluded up to six months from policy effective date

D. Application questions

1. Designed to determine if applicant already has a policy in force
2. Whether this policy is intended to replace another policy

E. Standardized Plan (Core Benefits)

1. Requires all Medicare supplements to be standardized
2. MUST make Plan A (Core) available if they offer any plans
3. Plan A has the basic benefits found in all plans to which other benefits are added

F. Policy Requirements

1. Must contain 30 day free look in bold print on first page
2. Must contain outline of coverage containing benefits, deductibles, exclusions and premiums in bold print

G. Producers' Compensation

1. 1st year commission limited to 200% of renewal commissions

H. Minimum Benefit Standards

1. Must not exclude benefits for conditions that occurred more than 6 months prior to coverage
2. Must adjust benefits as Medicare adjusts
3. Must define skilled nursing facility same as Medicare
4. Hospice care may be received in a facility or in a person's own home (or home of another person)

4. Which statement is incorrect concerning a Medicare Supplement?

a) The policy must be guaranteed renewable

b) The policy must exclude pre-existing conditions

c) The policy must contain a 30 day free look

d) Coverage must adjust with the changes to Medicare

VII. Medicaid

A. A federal and state government administered program

B. Eligible individuals

C. Medicaid benefits

5. Which coverage is available premium free to persons at age 65?

a) Medicare Part A

b) Medicare Part B

c) Medicare supplement Insurance

d) Medicaid

VIII. Long-Term Care

A. Long-Term Care Insurance Overview

1. Provides benefits for persons with chronic disabilities not provided by Medicare
2. Designed for Seniors but any adult can be covered
4. Does not cover acute hospital care

B. Types of Contracts

1. Individual
2. Group
   - Renewable
   - Convertible
   - More economical than individual
3. Riders/endorsements to life contracts

C. Elimination Period/Benefit Period

1. Elimination period is the number of days the insured must receive care before a provider starts to pay benefits. Serves as a "time deductible"
2. Benefit period is time period that the insurer pays benefits per claim. The benefit period begins once the elimination period has been met.
3. The shorter the elimination period and longer the benefit period, the higher the premium

D. Benefit Triggers - ADLs

- **ADLs –** Bathing, eating, dressing, continence, toileting, and transferring. If incapable of any 2, benefits begin
- **Cognitive impairment –** Loss of memory or reasoning
- **Physician's Certification –** Stating that patient is in need of LTC

6. Activities of Daily Living (ADLs) include bathing, eating, dressing, toileting, transferring, and ambulating. Under a LTC policy the insured is considered to be functionally impaired if they cannot perform:

a) At least one of these functions

b) At least two of these functions

c) At least three of these functions

d) At least four of these functions

E. Level of Care

1. **Skilled Nursing**

- Provided in a licensed facility, operated according to the laws of the state, providing skilled nursing care under the direction of a licensed physician responsible for all patient care
- Continuous 24-hour nursing services by or under the supervision of an R.N.
- Provides specialized services such as feeding tubes, IV therapy and wound care
- Maintains a daily medical record for each patient

2. **Intermediate Care**

- Provided in a licensed facility, operated according to the laws of the state, providing daily but not 24 hour care under the supervision of a licensed medical professional
- Designed to help patients remain independent while assisting with daily needs; it is less than skilled care but more than room and board
- Maintains a daily medical record of each patient
- Assisted Living facilities generally provide intermediate care that is designed for senior citizens who need daily assistance but do not require care in a nursing homeLicensed facility under supervision of an RN or LPN

5. **Custodial (Nonskilled) Care**

- Nonmedical care to provide assistance with activities of daily living such as bathing, toileting, eating, dressing, transferring, and continence
- May be provided in a nursing home facility or in one's own home
- Providers are not required to undergo medical training

F. LTC Coverage – Care can be provided in an institutional setting (nursing home) or can be Community or Home based. Coverages provided by community or home care include:

1. **Home Health Care -** Noninstitutional care received in one's own home or the home of another
2. **Adult Day Care –** Custodial care in a day care setting
3. **Hospice Care –** Focus on pain control, comfort and counseling for the terminally ill patient and family
4. **Respite Care –** Temporary relief for caregivers needing a break
5. **Assisted Living** – A system of housing and limited care that is designed for senior citizens who need some assistance with daily activities but do not require care in a nursing home.

7. Which optional LTC coverage is designed to provide relief to the actual caregiver in a LTC situation?

a) Respite Care

b) Adult Day Care

c) Hospice Care

d) Home Health Care

LTC Coverages

1.	Noninstitutional care provided at home
2.	Custodial care in day care setting
3.	Pain control & counseling
4.	Temporary relief for main caregivers
5.	Housing and limited care

G. Optional Benefits and Riders

1. **Waiver of Premium**
2. **Nonforfeiture Options**
3. **Return of Premium**

Optional Benefits and Riders	
1.	Usually after 90 days of confinement
2.	Paid on lapse or surrender, reduced benefit after lapse, or full benefit paid for limited time after lapse
3.	Refund of all or partial premiums paid

H. Preexisting Conditions – Insurer cannot more restrictively define a preexisting condition than a condition for which advice or treatment was recommended or received within 6 months of the effective date of coverage

I. Minimum Benefit Standards

- 30-day free look
- Guaranteed Renewable
- Inflation protection
- Must not exclude benefits for Alzheimer's Disease

J. Long-Term Care Exclusions

- Nervous or mental disorders (except Alzheimer's disease)
- Intentionally self-inflicted injuries
- Injury while committing a felony
- War or act of war
- Services provided outside the US

K. Tax-qualified LTC Insurance

- Must meet benefits under NAIC requirements to qualify
- Non-reimbursed medical expenses deductible if exceed 7.5% adjustable gross income
- Benefits are tax free

8. Long-Term Care policies are sold to:

a) Provide medical care without hospitalization

b) Pay for extended hospital stays

c) Pay for surgery recuperating expenses

d) Share Medicare costs

Section 6 – Individual Policy Provisions

I. Mandatory Uniform Provisions
II. Optional Provisions
III. Other Provisions and Clauses
IV. Cost Containment
V. Policy Riders

I. Mandatory Uniform Provisions

A. These provisions **are required** to be in all Health policies with specific wording

B. Wording may be changed but only if is not less favorable to the insured

C. Mandatory provisions protect the **insured**

1. Which of the following statements regarding mandatory uniform provisions is correct?

a) Mandatory Uniform Provisions protect the interests of the insurer and Optional Uniform Provisions protect the interests of the insured.

b) Mandatory Uniform Provisions protect the interests of the insured and Optional Uniform Provisions protect the interest of the insurer.

c) Provision wording may not be changed no matter how favorable it may be to either the insured or insurer.

d) A provision may be added to restrict or modify a uniform provision.

D. Mandatory Uniform Provisions:

1. **Entire Contract**

   a. Policy, copy of the application and any riders

   b. Only applicant may make changes to application

2. **Time Limit on Certain Defenses (Incontestable)**

   a. No statement or misstatement may be contested after 2 years

   b. No time limit for fraud

2. The Time Limit on Certain Defenses (Incontestable) period is _____ years under individual health and disability contracts.

a) 2

b) 3

c) 5

d) 7

3. **Grace Period**

   a. Period after premium due date before policy lapses

   b. 7 days for weekly premium; 10 days for monthly premium, 31 days for all others

4. **Reinstatement**

   a. Allows insured to reinstate a policy by paying past due premiums

   b. Proof of insurability may be required

   c. Accidents covered immediately

   d. Sickness covered after 10 days

3. To reinstate a lapsed health policy, the insurer:

a) Cannot require a new application

b) Must respond to the application within 30 days

c) Must take into account the applicant's religion

d) Will require back due premiums be paid

5. **Notice of Claim** – **20 days** for the insured to report a loss

6. **Claim Forms** – **15 days** for the insurer to provide proper forms

7. **Proof of Loss** – **90 days** for insured to provide required proof, but not more than 1 year

8. **Time of Payment of Claims** – Immediately upon receipt of proof

9. **Payment of Claims** – Benefits paid to beneficiary or provider or insured

10. **Physical Exam and Autopsy** – Insurers right to examine insured where not prohibited by law

11. **Legal Action** – Insured must wait **60 days** but no later than **3 years** after proof of loss before legal action may be brought against the insurer

12. **Change of Beneficiary** – Unless revocable, the owner has the right to change the beneficiary

4. The Legal Actions provision preserves the insured's right to bring suit against their own insurer, but the insured must wait at least ____ days before pursuing this action after they have filed a proof of loss?

a) 30

b) 45

c) 60

d) 90

Mandatory Uniform Provisions

1.	Policy, riders, application are attached and in writing
2.	Usually after 2 yrs, cannot deny a claim for misstatements on app (fraud excepted)
3.	Death benefits to beneficiary Other benefits to provider or insured
4.	Can be required at insurer's expense to determine claim
5.	Consent not required unless irrevocable; effective on signature date
6.	Insured must wait **60 days** but no later than **3 years** after proof before legal action may be brought against the insurer
7.	Payment made immediately upon receipt of proof
8.	**20 days** for the insured to report or notify insurer of a loss
9.	**15 days** upon notification for the insurer to provide proper forms
10.	**90 days** for insured to provide required proof, but not more than 1 year
11.	Period after premium due date before policy lapses
12.	Allows insured to reinstate a policy by paying past due premiums

II. Optional Provisions

A. Provisions included at insurer's option

1. If used, they must conform to code

B. Optional provisions protect the *insurer*

C. Optional Provisions:

1. **Change of Occupation**
    a. Change to a more hazardous occupation, benefits are reduced
    b. Change to a less hazardous one, may apply for a rate reduction
2. **Misstatement of Age**
    a. Benefits will be adjusted to what premiums paid would have purchased at correct age
    b. If over limit, then premiums refunded
3. **Other Insurance with This Insurer**
    a. If more than one policy with same insurer, choose one
    b. Premiums for others returned
4. **Insurance with Other Insurers**
    a. If insured has same coverage with more than one insurer, each insurer's liability is limited to a proportion of the loss
5. **Relations of Earnings to Insurance**
    a. Loss of time benefits may not exceed monthly earnings, but not less than $200
6. **Unpaid Premiums**
    a. Allows insurer to deduct premiums from claims during grace period
7. **Conformity with State Statutes** – All provisions will conform to state law automatically
8. **Illegal Occupation/Act** – Claim denied if injured while committing an illegal act
9. **Intoxicants and Narcotics** – Claim denied if injury is caused by being intoxicated or under the influence
10. **Cancellation** – Insurer may cancel with written notice

5. All of the following are Optional Uniform Provisions contained in individual A&H policies, EXCEPT:

a) Conformity With State Statutes

b) Illegal Occupation/Act

c) Misstatement of Age

d) Reinstatement

Optional Provisions

1.	**To more hazardous:** benefits reduced **To less hazardous:** can apply for rate reduction
2.	Claim denied if injury occurred due to illegal activity
3.	Claim denied if injury occurred under influence
4.	Benefits adjusted to premiums paid at correct age
5.	**Same insurer:** choose policy, excess premiums returned **Other insurer:** coordinate benefits
6.	Benefits may not exceed monthly earnings
7.	Deduct unpaid premiums from claim benefit
8.	Automatic amendment of any provision in conflict
9.	Rights in which policy can be cancelled

III. Other Provisions and Clauses

A. Right to Examine (Free look) – Not less than 10 days (30 days for Senior plans)

B. Insuring Clause – Who is insured, by whom, for how much, how long, what peril

C. Consideration Clause – Payment and promise

6. The "Free Look" (Right to Rescission) clause of health insurance stipulates a minimum number of days the insured may review a policy and return it to the company for a full refund of premiums paid. What is the number of days?

a) 3

b) 5

c) 7

d) 10

D. Preexisting Conditions – Prior conditions which insured should have received medical advice or treatment

E. Probationary Period – Number of days at the start of the policy with no coverage for loss due to sickness

F. Elimination (Waiting) Period – Number of days after onset of illness or accident before benefits begin paying

G. Waiver of Premium – Premiums waived after stated period of time of disability

H. Occupational – On and off the job

I. Nonoccupational – Off the job only

7. Timothy owns an individual Accident and Health policy whereby in the event of an accident, he is required to prove only that the injury itself is unforeseen and unintended. Tim's policy is then based on which of the following?

a) Accidental Means

b) Accidental Bodily Injury

c) Both Accidental Means and Accidental Bodily Injury

d) Neither Accidental Means nor Accidental Bodily Injury

J. First Dollar Coverage – Provides that no out of pocket charges (deductibles or copayments) will be paid by the insured before benefits are payable by the plan

K. Coordination of benefits – A provision that determines the method of reimbursement when more than one insurer is responsible for the loss

L. Policy Renewal Provisions

_____1. Most favorable to insured, only owner can terminate, rates never increase

_____2. Insured may renew without proof of insurability, premiums not guaranteed, terms of contract may not be changed

_____3. Renew unless insurer gives notice to not renew

_____4. At insurer's option

_____5. Expressed period of coverage

_____6. Either party, any time

IV. Cost Containment

A. Mandatory Second Surgical Opinion – If in policy it requires insured to get second opinion

B. Non-Emergency Preauthorization – Scheduled procedure must be preauthorized or benefits may be reduced

C. Utilization Review – Length of hospital stay is monitored

D. Managed Health Care – Used to help contain costs with these characteristics…

- ❑ Controlled access to providers
- ❑ Comprehensive case management
- ❑ Preventive care
- ❑ Risk sharing

E. Emergency Services – Specifies what to do in an emergency

F. Out-of-area benefits and services – Description of what's available outside the service area

8. Managed Health Care attempts to contain health care costs by controlling the behavior of participants through all of the following, EXCEPT:

a) Unlimited access to providers

b) Comprehensive case management

c) Preventive care

d) Risk sharing

V. Policy Riders

A. Impairment Rider – A rider that specifically excludes a preexisting condition that would otherwise reject coverage for the insured

B. Guaranteed Insurability Rider – Guarantees issue of additional benefits without evidence of insurability

C. Multiple Indemnity Rider – Pays double or triple benefits if an insured dies within in specified time period due to an accident

Section 7 – Group health Insurance

I. Group Health Insurance
II. Types of Eligible Groups
III. Employer Group Insurance
IV. Group Health Underwriting
V. Loss of Coverage
VI. Federal Regulation

I. Group Health Insurance

A. Group Health Insurance Characteristics

1. In order for a group to be eligible it must be a Natural Group
2. Employer issued a Master Policy
3. Employees issued Certificates of Insurance

1. Group health plans usually cover:

a) Occupational injury or disease
b) Non-occupational injury or disease
c) Both occupational and non-occupational injury or disease
d) Neither occupational nor non-occupational injury or disease

II. Types of Eligible Groups

A. ERISA Requirements
B. Employer-Related Groups
1. METs
2. MEWAs
3. Unions
4. Associations

III. Employer Group Health

A. Eligibility
1. Full time employee – 30 hours
2. Employer determines benefits

3. No discrimination

B. Open Enrollment Period

1. Initial enrollment after probationary period
2. 3o days – no evidence of insurability required
3. Late enrollee – show insurability or wait for annual enrollment
4. Changes outside of enrollment - marriage or change in dependents

C. Dependent Coverage

1. Employee's spouse and children up to **age 26**
2. Disabled children who are not capable of self-support may continue to be covered beyond age 26

D. Nonduplucation and Coordination of Benefits

1. Determining primary and secondary coverage when an insured is covered by more than one group policy, and to help prevent nonduplication (overinsurance)
2. Primary coverage
3. Secondary Coverage
4. Dependent Coverage – birthday rule

IV. Group Health Underwriting

A. Employer Group Underwriting

1. Adverse Selection
2. Experience vs. Community Rating
3. Cost is determined primarily by type, size, average age, and gender

B. Plan Design Factors – New employees are eligible after a probationary period

1. _____ Plans require a minimum 75% participation of eligible employees
2. _____ Plans require 100% participation of eligible employees.

2. If employees of a company pay a part of their group health insurance premium, it is referred to as a:

a) Participating group policy
b) Contributory group policy
c) Non-participating group policy
d) Non-contributory group policy

VI. Loss of Coverage

1. **Coinsurance and Deductible Carryover**

2. **Reinstatement for Military Personnel**

3. **No Loss-No Gain**

4. **Events that Terminate Coverage**

5. **Extension of Benefits**

6. **Conversion Privilege**

3. Which of the following statements is true about group health insurance?

a) When an employee leaves a company they have the right to convert their group plan to an individual one

b) All employees (100% of the eligible employees) must be covered by the plan when it is contributory

c) At least 75% of the employees must participate if it is a non-contributory plan

d) Group policy premiums are typically more expensive than individual policies

VII. Federal Regulation

A. Consolidated Omnibus Budget Reconciliation Act (COBRA)

1. Employers with at least 20 employees must provide option to continue coverage to employees and dependents for up to 18 months in event of termination or no longer full-time employee

2. Coverage may be continued for up to 29 months if qualify for SS disability

3. Qualifying events to continue coverage for up to 36 months:

   - Death of employee
   - Divorce or legal separation
   - Dependent status lost
   - Medicare entitlement

4. **Under COBRA, coverage for dependents of the employee may continue up to 36 months for the following events, EXCEPT:**
   a) Termination of the employee
   b) Divorce or legal separation between employee and spouse
   c) Employee's entitlement to Medicare benefits
   d) Death of the employee

B. Health Insurance Portability and Accountability Act (HIPAA)

1. Designed to provide coverage for those with preexisting conditions
2. Those who have been insured at least 12 months must be covered immediately under new group plan
3. No more than a **63 day gap** in coverage for HIPAA rules to apply.
4. 12 month waiting period for preexisting conditions if requirement not met

5. **Under HIPAA, if an employee cannot meet the requirement of credited coverage, a pre-existing condition exclusion may be imposed up to:**
   a) 3 months
   b) 6 months
   c) 12 months
   d) 8 months

Section 8 –Health Concepts and Tax Considerations

I. Patient Protection and Affordable Care Act
II. Consumer Driven Health Plans
III. Federal Tax Considerations

I. Patient Protection and Affordable Care Act

A. Overview

1. Commonly referred to now as the Affordable Care Act (ACA), was signed into law on March 23, 2010.
2. Enacted with the goals of increasing the quality and affordability of health insurance, lowering the uninsured rate by expanding public and private insurance coverage, and reducing the costs of healthcare
3. The Act also established the Health Insurance Marketplace

B. Requirements

1. Individuals are responsible for obtaining "minimum essential coverage" for themselves and their dependents, or pay a penalty—a "shared responsibility payment."

C. Eligibility

1. Unless exempt, all Americans are required to obtain and maintain minimum essential coverage

D. Essential Benefits Package

1. Ambulatory patient services
2. Behavioral health treatment
3. Emergency services
4. Hospitalization
5. Laboratory services
6. Maternity
7. Mental health services
8. Newborn care
9. Pediatric services
10. Prescription drugs

11. Preventive care
12. Rehabilitation services
13. Substance use disorder services

E. Benefit Categories

1. Bronze
2. Silver
3. Gold
4. Platinum

II. Consumer Driven Health Plans

A. Three-tiered approach to funding the costs of medical services and treatment

1. Tier 1 – Pre-tax account
2. Tier 2 – The amount the insured chooses to pay out-of-pocket
3. Tier 3 – High Deductible Health Plan

B. High Deductible health Plan

1. Annual deductible must meet a minimum dollar amount
2. The maximum out-of-pocket may not exceed the maximum dollar amount as identified by the IRS
3. Limit contributions to health spending accounts

C. Health Savings Account

1. A trust created exclusively to pay qualified medical expenses
2. For high deductible plans
3. Not taxable as long as used for medical expenses

D. Health Reimbursement Arrangements (Accounts)

1. A type of plan that reimburses employees for qualified medical expenses
2. Employer-funded

E. Flexible Spending Accounts

1. Employer established plan
2. Permits employee to defer pre-tax earnings
3. Employee may withdraw funds from account to pay unreimbursed medical expenses
4. Use it or lose it by the end of the year

III. Federal Tax Considerations

A. Taxation of Individual Disability Income

1. The individual pays with after tax dollars, therefore the benefit is non-taxable

B. Taxation of Individual medical, dental, and long-term care insurance

1. Medical and dental premiums are after-tax dollars and benefits are non-taxable
2. Qualified long-term care premiums are after-tax unless the individual qualifies for a portion to be tax deductible
3. Benefits for both are non-taxable

C. Group Disability Insurance

1. The employer's premiums are pre-tax, therefore that percentage of benefit is taxable
2. The employee's premium are after tax dollars therefore that percentage of benefit is non-taxable

D. Group Medical, Dental, Long-Term Care insurance, and Accidental Death

1. Group insurance premiums paid by the employer are pre-tax; the premiums paid by the employee are after-tax. The benefits are non-taxable.

E. Business plans

1. Business Overhead Insurance premiums are pre-tax and the benefits are taxable
2. Key Person Insurance premiums are after-tax and the benefits are income tax free
3. Buy Sell Agreement (Disability Buyout) premiums are after-tax and the benefits are income tax free

Business & Group Policies	Premiums Deductible? ER	EE	Benefits Taxable?
Disability Income	**Yes**	**No**	_____
Medical	**Yes**	**No**	_____
Qualified LTC	**Yes**	**No**	_____
Accidental Death/Dismemberment	**Yes**	**No**	_____
Business Overhead Expense	**Yes**	**n/a**	_____
Disability Buy-Sell Agreement	**No**	**n/a**	_____

1. **Which statement is true regarding a group Accidental Death & Dismemberment Policy?**

   a) The benefits received are not taxable to the recipient upon claim

   b) The premiums paid by the employer are considered part of the employee's income

   c) The premiums paid by the employer are not deductible as a business expense to the employer

   d) Accidental Death and Dismemberment Insurance is not available on a group basis; only on an individual basis

2. Under which business related plan are benefits taxable as income to the owner?

a) Business Overhead Expense

b) Disability Buy-Sell Agreement

c) Both Business Overhead Expense and Disability Buy-Sell Agreement

d) Neither Business Overhead Expense nor Disability Buy-Sell Agreement

Personal Policies	Premiums Deductible?	Benefits Taxable?
Disability Income	_____	_____
Medical	_____	_____
LTC	_____	_____

Answers

Section 1

Question 1: d)

3 Types of Hazards:

1. Physical
2. Moral
3. Morale

Question 2: d)

Restricted Parties:

1. Minors
2. Mentally incompetent
3. Under influence drugs/alcohol

Question 3: d)

Insurance Contract Definitions and Legal Interpretations

1. c
2. h
3. f
4. i
5. g
6. d
7. b
8. a
9. e

Question 4: b)

Section 2

Definitions:

1. Accident and Health
2. Accidental Injury
3. Coinsurance
4. Deductible
5. Copayment
6. Morbidity Table
7. Pre-existing Condition
8. Probationary Period
9. Sickness

Classification:

1. Coverage at a lower rate
2. Coverage as quoted
3. Rated-up

Section 3

Definitions

1. Earned premium
2. Unearned premium
3. Service area
4. Subscriber
5. Insured

Classification of Healthcare Plans

1. Indemnity Plan
2. Service Plan
3. Self-Funded Plan

Question 1: c)

Question 2: c)

Question 3: c)

Question 4: a)

Limited Policies

1. Accidental Death and Dismemberment
2. Limited Accident
3. Limited Sickness
4. Hospital Income
5. Blanket Insurance

Answers

Section 4

Question 1: b)

Question 2: a)

Definitions and Provisions:

1. Occupational
2. Non-Occupational
3. Total disability
4. Partial disability
5. Residual disability
6. Recurrent disability
7. Presumptive disability

Question 3: c)

Question 4: d)

Business protection

1. Businessowners Overhead Expense
2. Key employee disability
3. Buy Sell Agreement

Question 5: b)

Disability Riders

1. f
2. i
3. h
4. g
5. c
6. a
7. d
8. e
9. b

Question 6: c)

Section 5

Question 1: d)

Question 2: d)

Question 3: d)

Question 4: b)

Question 5: a)

Question 6: b)

Question 7: a)

LTC Coverages:

1. Home care
2. Adult Dayl Care
3. Hospice
4. Respite
5. Assisted Living

Benefits and Riders :

1. Waiver of premium
2. Nonforfeiture
3. Return of premium

Question 8: a)

Section 6

Question 1: b)

Question 2: a)

Question 3: d)

Question 4: c)

Mandatory Uniform Provision

1. Entire Contract Clause
2. Time Limit on Certain Defenses
3. Payment of Claims
4. Physical Exam and Autopsy
5. Change of Beneficiary
6. Legal Action
7. Time of Payment of Claims
8. Notice of Claims
9. Claim Forms
10. Proof of Loss
11. Grace Period
12. Reinstatement

Question 5: d)

Answers

Optional Provisions:

1. Change of Occupation
2. Illegal Occupation/Act
3. Intoxicants and Narcotics
4. Misstatement of Age
5. Insurance with Other Insurers or Other Insurance with Insurer
6. Relation of Earnings to Insurance
7. Unpaid premiums
8. Conformity with State Statutes
9. Cancellation

Question 6: d)

Question 7: b)

Policy Renewal Provisions

1. Noncanceleable
2. Guaranteed renewable
3. Conditionally renewable
4. Optionally renewable
5. Nonrenewable period of time
6. Cancellable

Question 8: a)

Section 7

Question 1: b)

Group Health Insurance

1. Contributory
2. Noncontributory

Question 2: b)

Question 3: a)

Question 4: a)

Question 5: c)

Section 8

Federal Tax Consideration Group and Business Policies:

1. Yes/ partial
2. NoNo
3. No
4. Yes
5. No

Question 1: a)

Question 2: a)

Personal Policies

1. **Disability Income –** No No
2. **Medical and Dental –** No No
3. **Qualified Long-Term Care –** Yes No