Welcome

Insurance and risk professionals today need learning choices from many sources. As time and economic pressures bear down on everyone, The National Alliance continues to push forward with excellent online programs, carefully designed to fulfill your professional development needs.

In the pages that follow, be sure to read and understand the requirements for completing your course. If you have any questions, you may contact us via the link on the bottom navigation bar.

I hope you enjoy your journey into online learning. Thank you for choosing a National Alliance online course!

William T. Hold, Ph.D., CIC, CPCU, CLU
President
Please pause here.
In order to receive credit for this course you must fulfill several requirements.

Click on each heading on the left and read each requirement.

System Requirements
Recommended Operating System: Microsoft Windows XP or Higher
Recommended Browser: Internet Explorer 9 or higher

Warning: Some exercises may not work well with Firefox, Safari or Chrome browsers.

The course has not been optimized for tablet devices.

Please make sure you have the latest version of Adobe Flash Player, and the latest version of Adobe Reader installed on your computer.
Lessons and Topics

This course consists of several Lessons with several Topics in each. The pages include many relevant examples and graphics, with frequent knowledge check questions and exercises to test your understanding.

Taking the Self Quizzes:

Self quizzes are located at intervals throughout the topics. You may complete a self quiz as many times as you wish.

Once you restart a self quiz, the score resets to 0.

At the end of each quiz, click on the Assessment Results link on the score page, then right click to print out the results of your quiz.

50 Question Final Exam (Proctor Required)

A passing score on the Proctored Final Exam is required if your goal is to achieve the CISR Designation.

A passing score on the Proctored Final Exam is required if you would like to earn continuing education credits for a state issued insurance license.

A passing score on the Proctored Final Exam also earns designation update credit if you are a CISR or CSRM who has elected NOT to take the Review Test.

3 attempts are allowed for current CISR designation holders.
1 attempt is allowed for all other students.
**Review Test (No Proctor Required)**

The Review Test is available after you have completed all of the self quizzes.

The Review Test is a great study aid for the Final Exam.

For CISRs and CSRMs, use this test to earn designation update credit if you are not planning to take the final exam for state continuing education credits.

Unlimited attempts for all students.

**Selecting the Proctor**

No proctor is required for the Review Test. HOWEVER, the Final Exam requires a proctor. You are expected to select the proctor and make an appointment prior to the end date of your course timeframe.

Choose a disinterested third party as your proctor. Your state may have additional requirements. Click on the link below for state-specific proctor requirements.

[Proctor Instructions](#)

**Receiving Credit for the Final Exam**

Once you have received a score of 70 or above on the Final Exam, you must submit an affidavit of exam and CE Request Form in order receive credit for your successful completion. If you do not need CE credits, indicate this by checking the box at the bottom of the CE Request Form.

Print your affidavit of exam and CE request form prior to your exam. These documents can be found by using this link:

[Affidavit/CE Request Forms](#)

Do not submit an Affidavit/CE Request Form for any Review Test or for an unsuccessful attempt at the Final Exam.
Frequently Asked Questions and Student Instructions Document:

You may print the complete Student Instructions document for your course by navigating to this page in the online course introduction, or by navigating to:

http://www.scic.com/online_courses

Use the links on the left side of the web page for FAQs and additional information.

Course Introduction Page 4

Course Home Page

Use the home symbol on the bottom left navigation bar to access this page during your course. Links to self-quiz scores, help desk hours and other useful information are provided on this page.

Online Help Desk Hours:

cisronline@scic.com

To phone the Online Help Desk call:
800-633-2165 and select the online option.
Monday through Friday 8:30 am to 5 pm Central Standard Time

Instructions for navigating to your MyPage Account at www.scic.com:
View your MyPage on our website, www.TheNationalAlliance.com/MyPage. Use the same username and password for MyPage log on as you use for your online course.

Course Introduction p5

REQUIRED READING FOR FLORIDA RESIDENTS ONLY:

An entity that is required to be licensed or registered with the Florida Office of Insurance Regulation but is operating without the proper authorization is identified as an unauthorized insurer. All persons have the responsibility of conducting reasonable research to ensure they are not writing policies or placing business with an unauthorized insurer. Any person who, directly or indirectly, aid or represent an unauthorized insurer can lose their licenses or face other disciplinary sanctions. Please see section 626.901, Florida Statutes, to read the laws. Lack of careful screening can result in significant financial loss to Florida consumers due to unpaid claims and/or theft of premiums. Under Florida law, a person can be charged with a third-degree felony and also held liable for any unpaid claims and refund of premiums when representing an unauthorized insurer. It is the person’s responsibility to give fair and accurate information regarding the companies they represent.

Welcome to Life & Health Essentials p1 (LHE)

Welcome!

Life & Health Essentials

To understand what your customer needs to know about life insurance, just imagine your spouse and children's financial situation should you pass away prematurely. If you are single, have you set aside the funds for your funeral expenses, in addition to what you are planning to leave your loved ones? How about loans? Creditors will certainly apply to the estate of the deceased for repayment, and sometimes to the family.

Do you have customers who are employers? Life insurance can be a very affordable and worthwhile
employee benefit.

Medical insurance protects individuals against the financial consequences of illness, poor health and injury. Premiums and health care expenditures are increasing steadily, straining the resources of employers and individuals. In fact these costs have become a major expense category for most Americans.

"Safety net" issues are important to your customers, and the more you know, the more you can help them find affordable solutions. In this course, we will overview the range of life insurance and health insurance products available today.

Welcome to Life & Health Essentials p2 (LHE)

Course Study and Exam Preparation

Have you ever thought about how you learn? The study aids listed below will help you determine your progress and test your understanding of concepts and examples presented in the course.

Learning objectives are designed for managing your own learning. The learning objectives for the course are listed at the beginning of each topic. The learning objectives are indicated throughout the course pages as well.

At the end of the course, you will have the opportunity to read the learning objectives again, and see how confident you feel about each one.

Self quizzes are another learning management tool.

You are required to pass each self quiz with a score of 70 or above before moving forward in the course, and you can launch a self quiz as many times as needed.

To print the score page of your self quiz, click on Assessment Results, then right click on the page. The Assessment Results page makes an excellent study aid.

Glossary terms and definitions are critical to insurance and risk management professionals, and a key study aid for your online course.

To define a term, click on the Glossary link above. Definitions of newly introduced terms will also be included on the course pages.*

Knowledge Checks are application level questions. By attempting to apply the concepts of the course, you will better prepare yourself for the final exam. Make sure you attempt each knowledge check in the course.

And don't forget to email the Course Mentor with your questions about the curriculum. Our faculty
members are distinguished producers and risk managers who currently work in the insurance industry. The mentors are happy to explain and clarify the concepts in the course. They will return your email on or before the next business day.

Welcome to Life & Health Essentials p3 (LHE)

The Life & Benefits Essentials book, published by The National Alliance Research Academy, was used as a source for developing this course. Life & Benefits Essentials is practical and thorough, with nearly 200 pages. This guide allows readers to learn the basic characteristics, provisions, and riders found in most life, health, disability and long term care insurance policies. Annuities are also included. It clarifies the basic coverages, terminology, and concepts in language that is easy to understand. A Q&A CD study guide is included to enhance the learning process. The book may be ordered from The Academy bookstore at www.TheNationalAlliance.com.

Welcome to Life & Health Essentials p4 (LHE)

This course consists of eight lessons.

1. Overview of Life Insurance
2. Term Life
3. Permanent Life Insurance
4. Common Characteristics of Life Insurance
5. Medical Expense Policies
6. Policy characteristics
7. Federal Regulation & Consumer-Driven Plans
8. Medicare

Each lesson is further broken down into topics. In each topic, you will have content to read, graphical material to view, and self-quizzes to test your comprehension of important points. You may link to the final exam after completing all of self quizzes in the course with a score of 70 or above.
Lesson 1 – Overview of Life Insurance

Property and casualty insurance products protect insureds from the financial effects of losses from covered perils, in which the possibility of having a loss must be uncertain. Life insurance, on the other hand, pays benefits for a completely certain peril: death of the insured. Furthermore, the payment of the benefit goes not to the insured, but to another party, the designated beneficiary.

<table>
<thead>
<tr>
<th>Term Life Insurance</th>
<th>Permanent Life Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Insured</td>
</tr>
<tr>
<td></td>
<td>Owner</td>
</tr>
<tr>
<td></td>
<td>Payor</td>
</tr>
<tr>
<td></td>
<td>Beneficiaries</td>
</tr>
</tbody>
</table>

Overview of Life Insurance

If there were no people, there would be no cars, houses, boats, clothes, businesses or anything else. People are at the core of everything that is created, owned and operated. Most of us realize that it is wise to insure all of those items mentioned above. In fact we want them insured at "replacement cost".

People don't often think in the same way about insuring themselves. And, when they begin to do so, they usually need to learn which type of policy is going to be right for their situation.

We will start our study of life insurance products by looking at each of the parties to the life insurance contract.

Learning Objectives:

1. Know the parties involved in a life insurance contract.
2. Name two common owner/insured relationships for life insurance policies.
3. Define insurable interest.
4. Describe the work of actuaries and why life insurance companies use them.
5. Give an overview of the life insurance application process and underwriting issues.
6. Understand the proper beneficiary selection and terminology.
7. Describe why a survivorship clause would be needed for a life insurance contract.
8. Understand why people buy life insurance.
Lesson 1 Topic A - Parties Involved in a Life Insurance Contract

Learning Objective: Know the parties involved in a life insurance contract.

<table>
<thead>
<tr>
<th>Insurance Company</th>
<th>The insurance company evaluates the applicant, or risk, by underwriting the information provided and if the risk is insurable, makes an offer of insurance. Once the insured accepts the offer and meets all other requirements, such as payment of premium, the contract is in force.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insured</td>
<td>The insured is the person (or persons) whose life is insured.</td>
</tr>
<tr>
<td>Owner</td>
<td>The owner controls the life insurance policy.</td>
</tr>
<tr>
<td>Premium Payor</td>
<td>The payor is the person or entity that pays the premium on a life insurance policy.</td>
</tr>
<tr>
<td>Assignees</td>
<td>Sometimes the owner will assign a death benefit, or part of a death benefit, to a party other than a beneficiary. This is usually done as a requirement of a legal agreement.</td>
</tr>
<tr>
<td>Beneficiaries</td>
<td>The beneficiary is the individual or entity that receives any death benefit if the life insurance policy is in force when the insured dies.</td>
</tr>
</tbody>
</table>

Lesson 1 Topic A Parties Involved p2 (LHE)

Learning Objective: Know the parties involved in a life insurance contract.

The Insured

When the insured dies, the insurer will pay a death benefit, subject to policy conditions. It should be stated here that policy conditions generally favor the insured, and for a death claim not to be paid is highly unlikely.

- The insured must be insurable by meeting the life insurance company’s underwriting criteria for health, occupation, and high risk activities.
- The insured must answer the underwriting questions on the application and sign the application, or if the insured is a minor, a parent or guardian must answer the questions and sign the application for that insured.
- The insured gives the company permission to obtain underwriting information from third parties, such as an attending physician and MIB Group, Inc.
- The insured may be the owner and/or the payor of the life insurance policy, as well.
Lesson 1 Topic A Parties Involved p3 (LHE)

Learning Objective: Know the parties involved in a life insurance contract.

The Owner

- names the beneficiary,
- makes changes,
- borrows or withdraws cash values,
- selects options (such as dividend, non-forfeiture, and settlement options),
- and can even change the ownership of the policy.

Lesson 1 Topic A Parties Involved p4 (LHE)

Learning Objective: Name two common owner/insured relationships for life insurance policies.

- A parent can own a life insurance policy on their child.
- A husband and wife can own life insurance policies on each other.
- A business owner can own a life insurance policy on a partner.
- A business can own a life insurance policy on an employee.

The owner can be, and usually is the insured, but that is not always the case.

Lesson 1 Topic A Parties Involved p5 (LHE)

Learning Objective: Define insurable interest.

Insurable Interest

Note: With the exception of insurance on a minor child, an application will not be accepted and a policy will not be issued without the permission of the insured. For the sake of simplicity, throughout this topic on life insurance, unless otherwise noted, the insured and the owner are the same person.
For a life insurance policy to be considered for issue, there must be an insurable interest (valid and legal reason for the insurance) between the insured and the beneficiary.

The most obvious is a familial relationship (spouses) where there is a potential monetary loss to either in the form of lost income, or cost of replacement of lost family service such as home duties, child care, etc.

A business relationship is also a legitimate explanation of insurable interest as in the case of business partners. There is indeed a monetary component that exists between partners whether involving money invested or services rendered on behalf of the business.

Unlike property and casualty policies, where the insured must have an insurable interest at the time of loss, after a life insurance policy has been issued, the insurance company no longer requires an insurable interest between the owner, insured or beneficiary.

Lesson 1 Topic A Parties Involved p7 (LHE)

Learning Objective: Know the parties involved in a life insurance contract.

**The Premium Payor**

The same individual could be the payor, owner, and insured or a combination of these parties. A parent could be the owner of a life insurance policy on a child (the insured), and the child’s grandparent could be the premium payor.

Lesson 1 Topic A Parties Involved p8 (LHE)

**Learning Objective: Know the parties involved in a life insurance contract.**

**Assignees**

A bank wants to assure repayment in the event of death of the borrower. It requires an assignment of life insurance proceeds until the debt is repaid.

- The owner must notify the insurance company in writing of the assignment.
- The insurance company is not responsible for the legal accuracy of the assignment agreement.
- However, the insurance company must give the assignee notification of lapse of coverage.

If the assignment is an **absolute** assignment, the owner **gives up all policy rights** and the assignment is irrevocable. It is permanent.
If the assignment is a **collateral assignment**, the owner gives up some of the policy rights.

If the assignment is **temporary** (example would be until a loan is paid), then the full ownership rights revert back to the owner when the loan is paid off, or the obligation is met.

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**Lesson 1 Topic A Parties Involved p9 (LHE)**

**Learning Objective: Know the parties involved in a life insurance contract.**

**Beneficiaries**

The last party to the insurance contract is the beneficiary, and we will spend several pages on this in the next short section.

The primary beneficiary is the individual who receives the death benefit. A beneficiary designation can be revocable or irrevocable, meaning that the designation, if irrevocable, cannot be changed without the beneficiary's permission.

Contingent beneficiaries are needed in case the primary dies before the insured.

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**Lesson 1 Topic A Parties Involved p10 (LHE)**

**Learning Objective: Describe the work of actuaries and why life insurance companies use them.**

**Actuaries**

Insurance companies employ actuaries (statistical and probability professionals) to mathematically determine premiums that should allow them to pay administrative expenses, guaranteed cash values (if any), and projected death claims, all while earning a profit.

An actuary is a person, often holding a professional designation (e.g. ACAS, FCAS), who computes statistics relating to insurance, typically estimating loss reserves and developing premiums.

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**Lesson 1 Topic A Parties Involved p11 (LHE)**

**Learning Objective: Give an overview of the life insurance application process and underwriting issues.**
The Process

The law requires life insurance companies to apply standard underwriting guidelines to all applicants.

The process begins with:

- A completed and signed application and usually a deposit premium.
- Company underwriting guidelines will dictate all other requirements, based on other factors such as the insured’s age, sex, medical conditions and history, occupation, hobbies, and any other pertinent facts.

In addition, the company receives permission from the insured (parent or guardian if the insured is a minor) to use the Medical Information Bureau (MIB) as an additional source of information when underwriting applications.

Based on the information provided on the application, information received from the MIB, and other underwriting tools, such as physicals and additional interviews, the insurance company will decide if an offer of insurance is appropriate.

MIB Group, Inc.

The MIB is a clearing house of any past application information on all persons who have ever applied for life insurance.

The mission of the MIB is to prevent fraud and misrepresentation. In other words, the reports can tip-off insurance companies that an applicant is lying. If an individual is denied by Insurance Company A for life insurance because they have congestive heart failure then conveniently "forget" to mention that diagnosis when applying to Insurance Company B, the MIB report will expose the fraud to the other insurer. Information is kept for 7 years.

Lesson 1 Topic A Parties Involved p12 (LHE)

Learning Objective: Give an overview of the life insurance application process and underwriting issues.

Premium Charges

The company has a number of options for premium charges, depending on the characteristics of the prospective insured.

1. Discount Rate: The company may charge a rate lower than the standard rate if the insured has a lower risk of premature death, (e.g. a non-nicotine user).
2. **Standard Rate**: The manner in which premium is determined is called "Rate Class". It is based on the individual's health condition, occupation, hobbies and other factors specific to that person's situation and lifestyle.

4. **Decline Coverage**: The company may decline to offer the applicant a life insurance contract.

What are “non-medical” policies?

If an insured is deemed to be an impaired risk (e.g. due to health or occupation) the company may charge a premium in excess of standard rates. Some increased rates can be permanent such as for a health condition that will never go away, OR a temporary rating such as for a dangerous occupation or avocation that could change (stop) in the future. The company may decline to offer the applicant a life insurance policy.

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**Lesson 1 Topic A Parties Involved p13 (LHE)**

**Learning Objective**: Give an overview of the life insurance application process and underwriting issues.

**Increased Rate/Declines**

Policies can be offered for increased rates or declined due to the insured's occupation, health or life activities.

<table>
<thead>
<tr>
<th>Health:</th>
<th>Examples: Heart condition; nicotine use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupation:</td>
<td>Example: working in high rise construction</td>
</tr>
<tr>
<td>Life Activities, Avocations:</td>
<td>Example: skydiving</td>
</tr>
</tbody>
</table>

**Lesson 1 Topic A Parties Involved p14 (LHE)**

**Learning Objective**: Give an overview of the life insurance application process and underwriting issues.

**Backdating**

In a process called backdating, an insurer may allow the agent to make the effective date of a policy earlier than the application date, which would make the insured’s age at issue lower than it actually was in order to get a lower premium. State laws often limit this backdate period to six months.
The insured can “save age” since the application was 5 months away from their last birthday. This means that the applicant can ask for a 2/14 policy issue date, pay the last 5 months premium, and have the policy issued at the age they were before their last birth date, thereby saving premium going forward.

Lesson 1 Topic A Parties Involved p15 (LHE)

Learning Objective: Give an overview of the life insurance application process and underwriting issues.

Periodic Reviews

After a policy has been issued, it may be eligible for periodic reviews to determine if a lower risk of premature death exists, leading to a reduction in the premium. An example would be a contract that will convert from a tobacco user rate to a non-tobacco user rate if the insured has not used any form of tobacco for three years. Each company has developed its own standards and rules for re-underwriting after a policy has been issued.

The insured has an original application date of 7/22/1. At this time the insured’s rate is based on the fact that they are a smoker. The insured has a review on 7/22/13. They are no longer a smoker, so their rate is adjusted accordingly.
Lesson 1 Topic B – Beneficiaries

**Learning Objective:** Understand the proper beneficiary selection and terminology.

Proper beneficiary designation should be a priority for an owner/insured at the time of purchase and on a continuing basis if situations change, since the beneficiary is the person or organization who the insured wishes to receive the death proceeds. How one beneficiary or multiple beneficiaries is described and the sequence of priority in payment of proceeds will be addressed in the following pages. There is one point to stress; beneficiary assignment must be correct as to the wishes of the insured, at the death of the insured. If not, after that it is irreversible and too late.

**Primary Beneficiaries**

The owner selects the beneficiary and can change the beneficiary at any time before the insured dies – provided it is not an irrevocable beneficiary. The wording selected when naming beneficiaries should be done after careful consideration of the current situation.

Not naming a beneficiary, or the improper naming of a beneficiary can result in delayed payment of death proceeds, additional costs, and/or legal complications. Since no one can anticipate all aspects of future situations, it is imperative that the owner periodically review the beneficiary designations and make changes when needed.

**Primary vs. Contingent Beneficiaries**

Initial primary beneficiaries are named on the original application. Professionals recommend that the owner name not only a primary beneficiary but a contingent beneficiary, as well. The contingent beneficiary will only receive death benefits if the primary beneficiary dies before the insured.
Learning Objective: Understand the proper beneficiary selection and terminology.

Irrevocable Beneficiaries

An irrevocable beneficiary is a beneficiary that cannot be changed without his or her consent. This type of designation is uncommon. It may be used when a court order for child support requires that a life insurance policy be maintained in order to guarantee that the support payments will be made even if the parent should die.

Sample Wording – Beneficiary Designations

Rather than listing the beneficiaries as "all my children" it would be better to list as:

"All surviving children of the marriage (union)."

This keeps any illegitimate children from staking a claim to the death proceeds, and also, it doesn't allow money to go to a child's estate should that child pre-decede the insured. Rather, the money will be split by any and all remaining children.

"I direct that the entire proceeds go to my wife, Mary Ruth Jones, but if she should pre-decease me, then I direct that my proceeds go to my brother, Mark Michael Jones."

Minors as Beneficiaries

The insured should consider the consequences of naming a minor as a beneficiary.

- The life insurance company will not release the death benefits to a minor without a court order. This will create additional costs and administrative delays. Otherwise, the company will keep the proceeds in an interest-bearing account and pay them to the minor when he or she comes of legal age (generally age 18).
• It is advisable to name a trust or trusted adult if minor children are involved. That way, the money will be available for the minor’s use under the direction and supervision of the trustee or adult.

• It is also unadvisable to name “the estate of the insured” as beneficiary because this may allow creditors to gain access to the proceeds. In addition, the life insurance benefits could be subject to additional probate costs and administrative delays.

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**Lesson 1 Topic B Beneficiaries p7 (LHE)**

**Learning Objective:** Understand the proper beneficiary selection and terminology.

**Survivorship Clauses**

In an effort to clarify the beneficiary issues, the owner may wish to include a survivorship clause in the contract, which will spell out what happens if the insured and beneficiary die at the same time. A survivorship clause requires a beneficiary to outlive the insured by a specific time period for the insurer to consider that person a survivor and therefore eligible to receive any death benefits.

This clause prevents a death benefit from going to a beneficiary’s estate if that person does not survive the insured by the specified time period. The death proceeds would then go directly to the contingent beneficiary.

Some states have a survivorship requirement in the state’s probate statutes concerning life insurance proceeds.

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**Lesson 1 Topic B Beneficiaries p8 (LHE)**

**Learning Objective:** Describe why a survivorship clause would be needed for a life insurance contract.

**Example: Survivorship Clauses**

A policy shows the current spouse of the insured as the primary beneficiary and the insured’s child from a former marriage as the contingent beneficiary. The insured and spouse are in a common automobile accident. The insured is killed outright and the spouse survives the insured by two days.
Without Survivorship Clause

The death proceeds of the life insurance policy would legally pass to the spouse as the primary beneficiary that was alive when the insured died.

The death proceeds would then be part of the estate of the primary beneficiary (current spouse). The death proceeds would then be subject to claim by the heirs or family of the spouse, clearly not the wishes of the insured who wished for the proceeds to go to the child of the previous marriage.

With Survivorship Clause

With, for example, a 15 day survivorship clause, contingent beneficiary (the insured’s child) would directly receive the death proceeds since the primary beneficiary (insured’s spouse) did not outlive the insured by 15 days.

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Learning Objective: Describe why a survivorship clause would be needed for a life insurance contract.

Uniform Simultaneous Death Act

In some states, the Uniform Simultaneous Death Act mandates that if the insured and the beneficiary die in the same accident, and it cannot be determined who died first, it will be assumed that the beneficiary died first, and the death proceeds will then pass to the contingent beneficiary.

If the owner lists more than one primary beneficiary and/or contingent beneficiary, the policy must also designate the percentage of death benefits each is to receive.

Dollar amounts are not used since it is uncertain exactly how many dollars will be paid because of the variables. (e.g., withdrawal of cash values) that can affect the amount paid at death.
Please refer to Lesson 1 Topic B Beneficiaries p10-12 to complete the Knowledge Checks at this time.
Lesson 1 Topic C – Why People Buy Life Insurance

Lesson 1 Topic C Why People Buy p1 (LHE)

Learning Objective: Understand why people buy life insurance.

People buy Life Insurance because they either Have to, or they Want to. More sales are made because people want to buy it than that they have to buy it.

One agent had a novel way to remember this. He had written on his desk the letters FOWTL. They stand for Find Out What They Love.

Yes, most life sales happen because people love someone else, they love themselves, or they love something else (for example their college). They need to analyze who and what they love, and then determine if they would like to leave them money when they die.

There are two reasons why people buy life insurance:

- They have to buy it
- They want to buy it

Lesson 1 Topic C Why People Buy p2 (LHE)

Learning Objective: Understand why people buy life insurance.

"Have To Buy" Life Insurance: Required by a business arrangement

Individuals may have to buy insurance because a business arrangement or court order requires the coverage. It is not uncommon for lenders to require a life insurance policy when loaning money to an individual or a business. On a business loan, the lender may request life insurance on the owner and/or a key person.

In this way, the lender can be more assured of repayment in the event of the premature death of that key person.

- The lender does not have to be the owner of the life insurance policy, but it will likely require a collateral assignment of death benefits from the owner to secure the loan.
- At death of the owner or key person, the life insurance proceeds would pay off the loan, and any remaining proceeds would go to the primary beneficiary.
Note that the lender will require notification from the insurance company if the borrower does not keep the policy in force.

Certain types of business arrangements require a method of funding the plan or agreement prior to finalizing the plan or agreement. Life insurance may be the best funding vehicle for such business arrangements.

Buy-sell agreements, key person insurance, executive bonus, and deferred compensation agreements are examples of such agreements. The details of such agreements are best discussed in a more advanced course, such as a CIC Life and Health Institute.

Lesson 1 Topic C Why People Buy p3 (LHE)

Learning Objective: Understand why people buy life insurance.

"Have to Buy" Life Insurance continued: Required by Court Order

Divorce decrees may require the purchase of life insurance to guarantee future child support payments should a person responsible for support payments die before the child reaches a certain age.

This is a situation where an irrevocable beneficiary designation would be used, assigning the benefits to the support payment recipient until the court order expires.

Lesson 1 Topic C Why People Buy p4 (LHE)

Learning Objective: Understand why people buy life insurance.

"Want to Buy" Life Insurance

Probably the greatest majority of life insurance is sold because of someone’s conscious desire to leave funds for personal, business, or emotional reasons.

- A person may want to be sure family needs will be met, such as replacing income, paying off outstanding loans or a home mortgage, providing funds for a child’s education, and meeting a variety of other responsibilities that would not be met in the event of a premature death. The death of a wage earner in a family creates the obvious problem of terminated income and can devastate those left behind.
There is also the issue of final expenses, such as funeral costs, probate costs, current liabilities, and taxes, which can severely deplete a family’s resources.

Lesson 1 Topic C Why People Buy p5 (LHE)

Learning Objective: Understand why people buy life insurance.

They Want to Buy Life Insurance continued

In a business situation, though the business relationship is not requiring the coverage, partners may want to own life insurance on each other to provide readily available funds to buy out any heirs of the deceased partner and retire the partnership. Planning for such an untimely event by the use of other sources, such as savings or other assets, quite often does not create enough of an “estate” or sufficient liquid funds to accomplish the buyout.

Other reasons to buy life insurance could include a desire to leave funds to a charitable organization or to pay estate taxes. In any event, a life insurance policy can create immediate funds to mitigate the money problems while a family deals with the emotional loss. The face amount of the life insurance benefit is a function of the amount of cash desired to solve an anticipated financial deficiency.

Please refer to Lesson 1 Topic C Why People Buy p6 to complete the Knowledge Check at this time.

Refer to the end of Lesson 1 Topic C to complete Self Quiz 1.
Lesson 2 – Term Life Insurance

Term Insurance is an important part of the consumer "safety net". Why? Term is a product that typically doesn’t accrue cash value. Consequently, it is very affordable for younger insureds, who have a need to protect their families but cannot afford the premium for, say whole life or universal life (products that accrue cash value in addition to maintaining a death benefit).

Term Life Insurance:

- Guaranteed Renewable
- Guaranteed Convertible
- Level Term
- Renewable Level Term
- Decreasing Term

Lesson 2 Introduction p2 (LHE)

Additional Terms and Concepts:

Earlier we learned the terms that correspond to the parties in an insurance contract. Now we will look at the characteristics of the policy. Here are a few terms in this topic that you may wish to note before continuing:

**Cash Value (Surrender Value)** - Amount of cash due to an insured who surrenders a Cash Value Life Insurance policy.

**Attained Age** - Current age of an insured person.

**Renewable** - A life insurance policy is renewable if the insurer is willing to extend coverage for a new term. Guaranteed renewable refers to the ability of the insured to obtain a new coverage period without proving that he or she is an insurable risk (usually with a medical exam.)

**Convertible** - The ability of the insured to convert one type of policy to another type of policy.

**About Terms:** Other important terms will be defined on the topic pages. If you find any terms or concepts that need more explanation, go through the topic once more, and check the glossary. If you still need explanation, contact the course mentor.
Learning Objectives:

1. Know the characteristics of term life insurance.
2. Explain the difference between term life insurance policies and permanent life insurance policies, using the concepts of policy term, cash value accrual and premium cost.
3. Define the policy provisions known as guaranteed convertible and guaranteed renewable.
4. Understand the way that premium and/or death benefit increases or decreases for three variations of term insurance: level term, renewable level term and decreasing term.
Lesson 2 Topic A – Characteristics of Term Life Insurance

Learning Objective: Know the characteristics of term life insurance.

Term life insurance provides life insurance for a specific time period. While death is certain, term life insurance does not insure against this certainty since the insured’s death may occur after the term of the policy has expired.

From the insurance company’s perspective, term life insurance is actuarially designed to expire before the death of the insured. The death benefit is payable only if the policy is in force and the insured’s death occurs during the specified term or policy period.

- Conventional term life insurance has no cash value.

  Generally, there is no surrender value in a term life insurance policy. That means if the owner stops paying premiums, and the policy lapses or the policy is cancelled, the owner receives nothing of value.

- Also, in a traditional term life policy, all paid premiums are fully earned by the insurance company.


<table>
<thead>
<tr>
<th>Term Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Terms: 1, 10, 20, 30 yrs; to age 65 etc.</td>
</tr>
</tbody>
</table>

**Note:** Some term policies offer a “return of premium” option, which means the insurer will return premiums if the policy stays in force for a stated period of time. There is an additional premium charge for this option.

Please refer to Lesson 2 Topic A Characteristics p2 (LHE) to complete the Knowledge Check at this time.
Lesson 2 Topic B – Term Life vs. Permanent Life

Learning Objective: Explain the difference between term life insurance policies and permanent life insurance policies, using the concepts of policy term, cash value accrual and premium cost.

We've said that term life is actuarially designed to expire before the insured dies. Conversely, permanent insurance is designed to provide a benefit when the insured dies. For this reason, premiums are much higher for permanent life insurance. We'll study permanent insurance after the discussion of term insurance.

Permanent life insurance accrues cash value for the insured, term does not. Term life insurance can be used to insure a specific need for a specific amount of coverage and for a specific period of time. Examples of these needs are:

- Mortgage;
- Loans;
- Court order to guarantee future child support;
- Temporary funding for a business agreement.

Please refer to Lesson 2 Topic B Term Life vs. Permanent Life p2 (LHE) to complete the Knowledge Check at this time.

Premium Costs

Premium cost is lower for term, (as compared to permanent insurance) but it is important to point out that it is lower at younger ages. The term rates rise sharply as the insured’s age increases.

Young people and families often purchase term life insurance to meet the current needs when resources to pay premiums are limited.
Imagine the term policy renewing for a new period of time in the future. Perhaps the term was 10 years and the new term will also be 10 years. The renewal rate will be based on the age of the insured at the time of renewal, or the insured’s "attained age." As the attained age increases, so does the rate.

At some point, the renewal rate may be so high that it will become cost prohibitive, and in all likelihood the insured will elect not to renew or simply allow the policy to lapse.

Life insurance contracts are not standard contracts. However, the following types and terminology are common.

<table>
<thead>
<tr>
<th>Guaranteed Renewable</th>
<th>Provision that guarantees an insurance policy can continue in force, provided the policy premiums are paid on time.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guaranteed Convertible</td>
<td>Guarantees the policy is convertible into a different type of policy at any time.</td>
</tr>
<tr>
<td>Level Term</td>
<td>Insurance that pays out a level death benefit should the insured die during the term of the policy.</td>
</tr>
<tr>
<td>Renewable Level Term</td>
<td>A policy the insured can renew without presenting evidence of insurability, also known as guaranteed renewable.</td>
</tr>
<tr>
<td>Decreasing Term</td>
<td>Provides a death benefit that declines throughout the term of the contract, reaching zero at the end of the term.</td>
</tr>
</tbody>
</table>

Lesson 2 Topic C Policy Provisions p2 (LHE)

Learning Objective: Define the policy provisions known as guaranteed convertible and guaranteed renewable.

Guaranteed Renewable

| term policy issue date | policy period | policy renewal date |

Policy period

This policy provision allows the owner of a term life insurance policy to renew the policy for a new term period. Common choices include annual, five-year or 10-year terms. The insured does not have to provide evidence of insurability (no underwriting) for the new term.

Policy renewal date

However, the policy premium will increase at each renewal period and will be based on the attained age (actual age) of the insured at the renewal date. As mentioned, this increase in renewal premium eventually may become prohibitive, making renewing a policy impractical.
Renewable policies may establish a point in time where the guaranteed renewable provision stops. An example is a term policy that is renewable for additional five year terms until the insured reaches age 65. Once the insured reaches age 65, the company will not offer a renewal term.

Lesson 2 Topic C Policy Provisions p3 (LHE)

Learning Objective: Define the policy provisions known as guaranteed convertible and guaranteed renewable.

Guaranteed Convertible - Converting a Term Policy into a Permanent Policy

The guaranteed convertible provision guarantees the future insurability of an insured within the conversion period stated in the contract.

Conversion period

Example: 10-year or attainment of a specified age.

Permanent policy issue date

Before the end of the conversion period, the owner can exchange the existing term life insurance policy for a permanent life insurance policy offered by the company without the insured having to prove he or she is insurable.

Premiums for the new permanent policy will be based on the age of the insured at the time of conversion.

- Some policies will allow conversion of an amount equal to 100 percent of the death benefit of the term policy.
- Others may limit the conversion amount to a percentage of the term death benefit
- Some policies may have conversion credits. Subject to contract language, the insurance company may give credit for part of the paid term premiums if the owner converts the term policy to a permanent policy.

Please refer to Lesson 2 Topic C Policy Provisions p4 (LHE) to complete the Knowledge Check at this time.
Lesson 2 Topic D – Premium and Death Benefit

Lesson 2 Topic D Premium & Death Benefit p1 (LHE)

Learning Objective: Understand the way that premium and/or death benefit increases or decreases for three variations of term insurance: level term, renewable level term and decreasing term.

Three most common term policy designs have distinct characteristics that affect the premium structure as well as the death benefit. Each policy has its own benefits to the owner/insured so the decision on which is best can only be determined by the situational needs of that person.

Lesson 2 Topic D Premium & Death Benefit p2 (LHE)

Level Term

This term policy has a level death benefit for the entire term, and premiums remain level for entire term. When the term expires, to purchase another policy, the insured may have to qualify from a health and activity standpoint. The premium will be based on the age of the insured (attained age) at the time of application. Examples of fixed period level term are term to age 65, or 10, 20, or 30-year level term policies.

Visual of Fixed Term

Lesson 2 Topic D Premium & Death Benefit p3 (LHE)

Learning Objective: Understand the way that premium and/or death benefit increases or decreases for three variations of term insurance: level term, renewable level term and decreasing term.
The insured has the option to renew the policy for another period of time when the current term ends. This renewable option may be subject to contract provisions concerning the age of the insured and/or the amount of death benefit for each renewable period. Generally, the policy is renewed with the death benefit remaining the same. The premiums on renewal will be based on the attained age of the insured when the new term begins. Depending on the contract the policy may be renewed for several periods.

**Annual Renewable Term**

- Death Benefit Remains Level
- Annual Premiums Increase
- Time Line - company may not renew or premiums become prohibitive

**Visual of Annual Renewable Term**

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**Visual of Five-year Renewable Term**

- Death Benefit Remains Level
- Premiums Increase for Each Renewal Period
- Time Line - company may not renew or premiums become prohibitive

**Lesson 2 Topic D Premium & Death Benefit p4 (LHE)**

**Learning Objective:** Understand the way that premium and/or death benefit increases or decreases for three variations of term insurance: level term, renewable level term and decreasing term.

**Decreasing Term**

The death benefit from this type of term life insurance decreases during the policy period. With a uniform decreasing term contract, the death benefit decreases at a fixed rate throughout the term of the policy, generally resulting in a “straight line” decrease of the death benefit. With a mortgage decreasing term, following the pattern of the loan, the rate of decline is slow in the early years and accelerated in the late years of the policy term, resulting in a curved line decrease of the death benefit.
Visual of Uniform Decreasing

Premium is level
Death benefit decreases uniformly over term

Time Line - If insured is living at end of term there is no death benefit

Visual of Decreasing Mortgage

Premium is level
Death benefit decreases slowly in early years

Time Line - If insured is living at end of term there is no death benefit

Please refer to Lesson 2 Topic D Premium & Death Benefit p5 (LHE) to view a sample policy at this time.

Please refer to Lesson 2 Topic D Premium & Death Benefit p6 to complete the Knowledge Check at this time.

Refer to the end of Lesson 2 Topic D to complete Self Quiz 2.
Lesson 3 – Permanent Life Insurance

Lesson 3 Introduction p1 (LHE)

Permanent Life insurance products are designed to meet other needs in addition to the death benefit. Because these products accrue cash value, the owner of the policy can take a loan against the cash value, for example.

Permanent Life Insurance : Death Benefit + Cash Value

- Whole Life
- Universal Life
- Variable Life
- Equity Indexed Life

Lesson 3 Introduction p2 (LHE)

Additional Terms and Concepts

Here are a few terms in this lesson that you may wish to note before continuing:

**Benefit** - The amount of money specified in a life insurance contract to be paid to the beneficiary upon the death of the insured.

**Non-Forfeiture** - Provision that guarantees the insured cannot lose the equity of a whole life insurance policy.

About Terms: Other important terms will be defined on the topic pages. If you find any terms or concepts that need more explanation, go through the topic once more, and check the glossary. If you still need explanation, contact the course mentor.

Lesson 3 Introduction p3 (LHE)

Learning Objectives:

1. List four types of permanent life insurance.
2. Explain the difference between a living benefit and a death benefit under the terms of a permanent life insurance contract.
3. Explain the term "paid up policy".
4. Explain cash value in life insurance policies and describe the tax treatment of these amounts.
5. Explain loans against the cash value of a permanent life insurance policy as a living benefit.
6. Explain the term "non-forfeiture option".
7. Describe the major characteristics of whole life insurance.
8. Understand how cash value accumulates in a whole life insurance contract.
9. Describe the major characteristics of Universal Life Insurance.
10. Describe features of Universal Life Insurance that allow more flexibility to the insured in paying premium or accumulating cash value.
11. Define variable life insurance.
13. Describe the general features of three variations on permanent life insurance: joint life, survivorship life and graded benefit.
Lesson 3 Topic A – Permanent Life

Lesson 3 Topic A Permanent Life p1 (LHE)

Learning Objective: List four types of permanent life insurance.

After our study of permanent life insurance policies, we will look at the four different types of permanent life.

• Whole Life
• Universal Life
• Variable Life
• Equity Indexed Life

Lesson 3 Topic A Permanent Life p2 (LHE)

Learning Objective: Explain the difference between a living benefit and a death benefit under the terms of a permanent life insurance contract.

Permanent Life Insurance: Death Benefit

While term life insurance is actuarially designed to expire before the insured dies, permanent life insurance is designed to pay a death benefit.

Assuming the owner keeps the permanent life insurance policy in force, the policy can pay a benefit during the insured's lifetime (living benefit) or at the insured's death, whenever that may be.

Permanent Life Insurance: Life Benefit

Examples of benefits that can be paid during the insured's lifetime are:

• the use of cash values;
• other living benefits such as Accelerated Death Benefits and/or Long-Term Care Riders. (You will find more details about Accelerated Death Benefits and Long-Term Care Riders later in this chapter.)
Lesson 3 Topic A Permanent Life p3 (LHE)

Learning Objective: Explain the difference between a living benefit and a death benefit under the terms of a permanent life insurance contract.

Long Term Uses of Permanent Life Insurance

Like term insurance, permanent life insurance can provide for temporary needs. However, unlike term, permanent life can also provide for long-term or lifetime needs:

- funding certain business agreements through the use of the cash value;
- paying estate taxes;
- equalizing inheritance;
- supplementing retirement income.

Lesson 3 Topic A Permanent Life p4 (LHE)

Learning Objective: Explain the term "paid up policy".

Premiums

With underwriting considerations and benefit amounts being equal, the initial premiums for permanent insurance are higher than the premiums for term insurance. This is because permanent life insurance will always pay benefits. However, the premiums for most permanent insurance (such as whole life) are generally fixed and remain level for life.

In some cases the owner may pay premiums at an accelerated rate for a specific period of time, and the life insurance policy can become “paid-up”. A “paid-up” or “fully paid” life insurance policy means no additional premiums are payable in the future, and both living and death benefits are available.
Learning Objective: Explain cash value in life insurance policies and describe the tax treatment of these amounts.

Tax Treatment of Cash Values

In addition to providing a lifetime death benefit, permanent life insurance policies can generate cash values.

Current federal tax law allows the cash value feature of a permanent life insurance policy to receive favorable tax treatment. Growth accumulates on a tax-deferred basis, meaning no taxes are paid on the growth of the cash value while it is accruing inside the life insurance policy.

The owner can use the cash value of a permanent life insurance policy while the insured is living by taking a policy loan.

As long as the policy remains in force, there are no current income tax liabilities when the owner takes out a loan against a life insurance policy. If the policy lapses or is surrendered (cashed in), taxes are due on any money received in excess of the amount of premiums paid.

Lesson 3 Topic A Permanent Life p5 (LHE)

Learning Objective: Explain cash value in life insurance policies and describe the tax treatment of these amounts.

Tax Treatment of Cash Values

In addition to providing a lifetime death benefit, permanent life insurance policies can generate cash values.

Current federal tax law allows the cash value feature of a permanent life insurance policy to receive favorable tax treatment. Growth accumulates on a tax-deferred basis, meaning no taxes are paid on the growth of the cash value while it is accruing inside the life insurance policy.

The owner can use the cash value of a permanent life insurance policy while the insured is living by taking a policy loan.

As long as the policy remains in force, there are no current income tax liabilities when the owner takes out a loan against a life insurance policy. If the policy lapses or is surrendered (cashed in), taxes are due on any money received in excess of the amount of premiums paid.

Lesson 3 Topic A Permanent Life p6

Learning Objective: Explain loans against the cash value of a permanent life insurance policy as a living benefit.

Since the cash value actually belongs to the policy owner, why does the owner have to borrow his or her own money?

The answer is that when calculating premium rates, the life insurance company plans on having the use of the cash values to generate earnings. For that reason, the owner must compensate the company if cash value is withdrawn in the form of a policy loan.

Accessing the cash value through a loan is normally a quick and easy process. The owner notifies the company of how much cash value they would like to borrow and the company sends it to them. There is no approval process or loan committee approval needed.
The owner must borrow against the loan value, rather than simply withdraw it.

More About Loans Against the Cash Value

The life insurance contract will outline repayment schedules and interest rates when loans are made against the cash value of a policy. Generally there is no fixed time table for repayment, as long as the policy is in force.

If the insured dies with an unpaid loan balance, that amount will be deducted from the payable death benefit.

Example:

Death Benefit: $225,000
Unpaid Loan Amount: $74,100
Death Benefit Payable: $150,900

Regulation of the use and size of cash values falls under state and/or federal insurance and tax regulation.

Learning Objective: Explain the term "non-forfeiture option".

Non-Forfeiture Options

Because of the cash value feature, permanent policies have mandatory non-forfeiture (sometimes called surrender) options. Non-forfeiture options allow the owner to receive value should the owner decide to cancel the policy or should it lapse for non-payment of premium. For example, the insured can:

1. Receive the Guaranteed Cash Value (cash surrender)
2. Have Permanent Life Policy paid for, but at a reduced insurance amount (reduced paid up)
3. Have the same amount of insurance in force, although as a Term Policy, for an Extended Period of time (actuarially determined) by the company (extended term)

Non-Forfeiture options address receiving value at surrender of policy.
What Is Lapse Protection?

If a policy has a cash value feature, lapse protection may be included in the form of a premium loan provision. This provision instructs the company to pay missed premiums from available cash values if the policy is in danger of lapsing. The payment of these premiums is treated as a cash value loan. (Automatic Premium Loan – APL.)

Please refer to Lesson 3 Topic A Permanent Life p9-11 (LHE) to complete the Knowledge Checks at this time.

Lesson 3 Topic A Permanent Life p12 (LHE)

Learning Objective: List four types of permanent life insurance.

Types of Permanent Life Insurance

There are a variety of types of Permanent Life Insurance and we will explore each of these types in greater depth as we move forward in this course.

- Whole Life Insurance
- Universal Life Insurance
- Variable Life Insurance
- Equity Indexed Life Insurance
Lesson 3 Topic B – Permanent Life Insurance: Whole Life

Learning Objective: Describe the major characteristics of whole life insurance.

Whole life insurance (also called ordinary or straight life) provides a fixed death benefit (face amount) for fixed level-premium payments until the maturity date. Policies have a guaranteed death benefit and cash value. Mortality charges (the cost of the life insurance) and expense charges (company expenses for administration of the policy) do not change. While these guarantees are advantages of whole life insurance, some may consider the lack of flexibility and the rate of growth of the cash value to be disadvantages of whole life insurance.

Additional Terms and Concepts

Here are a few terms in this topic that you may wish to note before continuing:

**Face Value** - The amount of coverage provided by a life insurance policy.

**Maturity or Endowment** - The date at which the cash value equals the face value of a whole life or endowment policy and becomes payable to the policy owner.

**Mortality charges** - The cost of the insurance protection in a universal life insurance policy.

**Policy expense charges** - Administrative charges associated with an insurance policy.

**Mutual Life Insurance Companies** - Owned by policyholders, generally pay dividends.

**Stock Life Insurance Companies** - Owned by stockholders, generally do not pay dividends to policyholders.
About Terms: Other important terms will be defined on the topic pages. If you find any terms or concepts that need more explanation, go through the topic once more, and check the glossary. If you still need explanation, contact the course mentor.

Lesson 3 Topic B Permanent Life: Whole Life Insurance p3 (LHE)

Learning Objective: Describe the major characteristics of whole life insurance.

Endowment Life Insurance Contracts

Since most insureds will not live until the policy matures, it is generally felt that whole life is intended to provide a level amount of death benefit while being able to provide supplemental cash, if needed, through the use of policy loans. At some time before the maturity date, many whole life policies are surrendered to the life insurance company for a “surrender value.” Surrender value will be discussed later in this section.

A policy endows when the cash value is equal to the face amount. At that endowment or maturity date, the policy is “paid up,” and no future premium payments are due. These policies are sometimes known as endowment life insurance contracts.

While many whole life policies have a maturity date at the insured’s 100th birthday, endowment policies are designed to mature when the insured reaches a certain age (e.g., 65 or 20 years).

Whole Life Policies are the types of policies that pay "Non-Forfeiture Values" that we discussed in the introduction of this lesson.

Lesson 3 Topic B Permanent Life: Whole Life Insurance p4 (LHE)

Learning Objective: Describe the major characteristics of whole life insurance.

Premium Payment Schedules

Limited Payment
A limited payment whole life policy is designed for premiums to be paid during the income earning years of the insured.

Examples:

Premiums payable for 20 years or 30 years or whole life paid up at age 65 or age 70.

(Since the premium payment period is a shorter period of time, the premium payments will be higher than a traditional whole life plan.)

Single Payment

A single premium whole life policy is designed for the premium to be paid in a single, lump sum payment. Because it is paid up at inception, the policy usually guarantees that it will remain a paid up policy for the insured’s lifetime.

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Learning Objective: Understand how cash value accumulates in a whole life insurance contract.

Growth in Cash Value

During the early years of a whole life policy, the insurance company charges more than is actually needed to cover the statistical risk of death.

The insurance company looks to recover their initial expenses (new business commissions, medical exams, and other costs associated with underwriting and issuing the policy) during the early years.

For this reason the cash value may not start to grow for a couple of years. As the policy ages, and the company recovers initial expenses, the power of compounding interest and deferred taxation enables the cash value to grow at a faster rate.

---

Learning Objective: Understand how cash value accumulates in a whole life insurance contract.

Cash Value and Mortality Cost

The cash value is paid as part of a death benefit, so the insurance company charges for an amount of insurance on the life of the insured to cover the “amount at risk” (difference between the cash value and...
As the cash value grows, the amount of insurance needed to cover the “amount at risk” decreases allowing the cash value to grow at a faster rate.

Generally speaking, the annual growth of cash value in a whole life policy should equal or exceed the annual premium paid some time between the 10th and 20th year.

**Lesson 3 Topic B Permanent Life: Whole Life Insurance p7 (LHE)**

Learning Objective: Understand how cash value accumulates in a whole life insurance contract.

**Cash Value versus Amount at Risk**

1. Death Benefit is made up of Life Insurance and Cash Value.
2. In early years, there is little or no cash value. The insurance company must recover start up costs, so the insurance company uses premium to charge for 1-year term insurance equal to amount at risk.
3. As policy ages, cash value grows and less term insurance is needed each year.
4. When policy matures (endows) the cash value will equal the death benefit.
5. When a whole life policy endows, the premiums cease and the face amount is paid to the policy owner.
Lesson 3 Topic B Permanent Life: Whole Life Insurance p8 (LHE)

Learning Objective: Understand how cash value accumulates in a whole life insurance contract.

Guaranteed Cash Value

This is the amount guaranteed by the policy. After the insurance company has paid for the cost of insurance and expenses, the remainder of the premium grows as Guaranteed Cash Value on an actuarially calculated basis. It will continue to grow inside the policy tax-deferred. Non-participating policies that do not pay dividends will show a table of the guaranteed cash in any given year that the owner can refer to. Participating policies that could pay dividends will also show a table of the guaranteed cash value in the policy contract. However if and when a dividend is declared and if the owner chooses paid up additions, the cash value and the face amount will increase over the guaranteed amount thus providing more cash value as well as increased death benefit. Owners of participating whole life policies will typically receive an annual statement indicating current values based upon the dividend choice made by the owner.

Please refer to Lesson 3 Topic B Permanent Life: Whole Life Insurance p8 to view a sample policy.

Lesson 3 Topic B Permanent Life: Whole Life Insurance p9 (LHE)

Learning Objective: Understand how cash value accumulates in a whole life insurance contract.
Sample Whole Life Policy

Initial Death Benefit: $250,000
Gender: Male Age: 35 Nicotine: No

<table>
<thead>
<tr>
<th>End Of Year</th>
<th>Annual Contract Premium</th>
<th>Dividends</th>
<th>PUA Amount</th>
<th>PUA Cash Value</th>
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Tip: Many Whole Life Policies add dividends to the policy and these additional dividends can cause the policy to increase its basic Death Benefit. In our example, the death benefit in this schedule increases from the initial amount of $250,000. (PUA = Paid Up Additional Insurance)

Please refer to Lesson 3 Topic B Permanent Life: Whole Life Insurance p10-11 to complete the Knowledge Checks at this time.
Lesson 3 Topic C - Permanent Life: Universal Life Insurance

Learning Objective: Describe the major characteristics of Universal Life Insurance.

“Universal Life” insurance, the name coined in the 1970’s, is a type of permanent life insurance that separates or “unbundles” the mortality charges, expense charges, cash value and interest credit into a separate, identifiable statement that an insured can see.

Insurance companies designed this product as a response to the marketplace and consumers’ desire to have more transparency and control over the functionality of life insurance policies.

It also is no accident that high interest rates and high returns on investment during that time period contributed to consumer desire to attempt to get more “bang for the buck” in cash value accumulation.

When you think of Universal Life, think of the word **FLEXIBLE**.

Potential for Higher Investment Risk

The flexibility of all aspects of UL makes it desirable to fit many circumstances with a very important caveat. Overly aggressive assumptions, specifically regarding future interest or return on cash value, and necessary premium deposits over time, can cause problems in the long-term life span of a UL policy.

Unlike Whole Life insurance, which has fixed premiums and guarantees in the contract, UL flexibility allows decision making that brings with it a certain element of risk to the consumer’s ability to have adequate coverage in force at the most critical time, the death of the insured.
Lesson 3 Topic C Permanent Life: Universal Life Insurance continued

1. A premium is paid into the policy account.
2. The company purchases one month of term life insurance to cover the death benefit – this is the mortality charge. The term life insurance (death benefit) is maintained in the account.
3. The company deposits the remainder of the premium into a cash value (side fund) account that earns interest, based on the company declared interest rate.
4. The company deducts the cost of the administrative work involved in maintaining the contract, including the agent’s commissions. This is the expense cost.
5. Interest is credited to the cash value account.

Lesson 3 Topic C Permanent Life: Universal Life Insurance continued

Additional Terms and Concepts

**Limited Premium Payment** - Premium that is paid for an indicated number of years.

**Lump Sum Premium Payment** - Premium that is paid all at one time

**Minimum Premium** - Premium that is lower than the target premium.

**Guideline Premium** - The maximum premium that can be paid into universal life policies and still have the benefit qualify as life insurance under federal tax laws.

**Target Premium** - A suggested premium used in universal life policies.

**Guaranteed Minimum Interest Rate/Interest Sensitive Provision** - Provision in variable and some flexible-premium policies, which guarantees certain interest earnings plus an additional interest percentage should the current interest rate rise above a specified percentage.

**About Terms:** Other important terms will be defined on the topic pages. If you find any terms or concepts that need more explanation, go through the topic once more, and check the glossary. If you still need explanation, contact the course mentor.
Learning Objective: Describe features of Universal Life Insurance that allow more flexibility to the insured in paying premium or accumulating cash value.

Benefit Options of Universal Life Insurance

Generally, companies offer two benefit options with universal life insurance. They are:

- Option A/Level Death Benefit and
- Option B/Increasing Death Benefit

Refer to Lesson 3 Topic C Permanent Life: Universal Life Insurance p4 (LHE) for sample Universal Life Option policies.

Lesson 3 Topic C Permanent Life: Universal Life Insurance p5 (LHE)

Learning Objective: Describe features of Universal Life Insurance that allow more flexibility to the insured in paying premium or accumulating cash value.

Benefit Options of Universal Life Insurance Continued

Option A

With Option A (sometimes called Option 1), the cash value is included as part of the death benefit. Just like with whole life insurance, as the cash value increases the amount of life insurance needed to pay the difference decreases over time.

- The death benefit remains level for a long period of time, unless the insured requests a change.
- Unlike Whole Life Insurance, which endows when the cash value equals the death benefit, the universal policy does not “endow”.
- At a point in time, when the cash value of an Option A Universal Life Policy approaches the death benefit, the death benefit will continue to increase, maintaining a corridor of life insurance. This feature is required due to federal tax law that deals with life insurance and the maximum cash value accumulation allowed in the contract.
## Lesson 3 Topic C Permanent Life: Universal Life Insurance p6 (LHE)

**Learning Objective:** Describe features of Universal Life Insurance that allow more flexibility to the insured in paying premium or accumulating cash value.

### Benefit Options of Universal Life Insurance Continued

#### Option B

With Option B (sometimes called Option 2) the cash value is paid in addition to the death benefit.

- The amount of life insurance needed to pay the death benefit does not decrease.
- This option creates a greater death benefit over time which is sometimes referred to as an “inflation proof feature” for the insured and beneficiary. It also removes the issue of the federal tax law.

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**Lesson 3 Topic C Permanent Life: Universal Life Insurance p7 (LHE)**

### Annual Statement

Due to the flexible nature of a universal life insurance policy, the company provides an annual statement to the policy owner, identifying current cash values, as well as current and upcoming changes in interest rates, expenses and charges, and other relevant information.

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**Lesson 3 Topic C Permanent Life: Universal Life Insurance p8 (LHE)**

**Learning Objective:** Describe features of Universal Life Insurance that allow more flexibility to the insured in paying premium or accumulating cash value.

### Flexibility of UL Premiums
The death benefits may be increased or decreased, subject to company underwriting requirements. The premium payments are flexible and can even be skipped. However, this can result in ultimately lapsing the policy. Companies will establish three basic premiums with a Universal Policy.

**Minimum Premium**

**Minimum:** This amount is how much it will take to keep the policy in force to a specific age (established by the company). An easy way to remember this is to think of Term Insurance. A U.L. policy with minimum premium is similar to a term policy.

**Target Premium**

**Target:** Target really only has to do with a way for the company to establish how much the agent will earn in commissions.

**Maximum Premium**

**Maximum:** This amount is determined by the IRS, making sure that the policy is a Life Insurance and not solely a Tax Free Investment account.

If the policy’s cash value is depleted, with nothing left to pay the mortality and expense costs, the policy will lapse. This can happen if there isn’t enough premium going into the policy. Because this policy premium is flexible, often insured’s minimize their premium payments, and the danger of this can be a lapsed policy.

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*Lesson 3 Topic C Permanent Life: Universal Life Insurance p9 (LHE)*

**Learning Objective:** Describe features of Universal Life Insurance that allow more flexibility to the insured in paying premium or accumulating cash value.

**Other Features**

**Additional Lump Sum Deposits**

Additional lump sum deposits can be made into the cash account. Since this cash account grows on an income tax-deferred basis, the amount of money that can be deposited and maintained is defined by federal regulations.

The larger the amount of life insurance, the larger the cash value account can be.
Loans Against the Cash Value

The policy owner can borrow from the cash value (as in whole life insurance policies) or they can withdraw cash value. Withdrawing cash values lowers the size of the death benefit.

Before making a withdrawal the owner should check with a tax advisor or the insurance company to determine if there will be any tax considerations.

Guaranteed Minimum Cash Value

A guaranteed minimum interest rate is set in the contract. In contracts with interest-sensitive provisions, companies may pay a rate over their guaranteed minimum, driven by market rates, but keep in mind that current performance expectations may not be achieved in the future. Premiums should be based on guarantees and not estimated returns.

If premiums are calculated on estimated returns and estimated returns are not realized, in the future significant additional premiums may be needed to keep the policy in force.

Flexible Mortality and Expenses Charges

Mortality and expense costs are deducted from the cash account, but these, too, are not fixed. The maximum that can be charged for these costs will be disclosed in the contract.

Please refer to Lesson 3 Topic C Permanent Life: Universal Life Insurance p9 (LHE) for a sample scenario.

Please refer to Lesson 3 Topic C Permanent Life: Universal Life Insurance p10-11 (LHE) to complete the Knowledge Checks at this time.
Lesson 3 Topic D – Permanent Life Insurance: Variable Life

Learning Objective: Define variable life insurance.

In Variable Life Insurance, changes in the death benefit and cash value are related to the investment performance of the policy’s underlying assets. A premium is paid and a mortality charge is made to purchase life insurance to cover a specified guaranteed death benefit. Additional deductions are made for other expenses (including administrative costs for managing the investment accounts.

The remaining premium is allocated to one or more investment accounts offered by the insurance company. The policyholder selects the amount (by percentage) to allocate in any particular investment account, and the accounts are invested in various securities (e.g., stocks, bonds, mutual funds, money market funds, etc.) When you think of Variable Life think of the Stock Market.

More on Variable Life

The policy owner is normally allowed to switch investments from time to time per contract provisions. The cash value accumulated in the investment accounts will vary depending on the performance of the investment vehicle and, in theory, can fall to zero.

Generally there is a guaranteed minimum death benefit, but there is no guaranteed cash value.
Definition of Variable Life Insurance

A whole life contract with the assets supporting the policy benefits being held in an account, separate from the insurance company, that is invested in mutual funds or similar equity securities. Cash value accumulation over time will depend solely on the performance of the separate account funds.

Lesson 3 Topic D Permanent Life: Variable Life Insurance p3 (LHE)

Learning Objective: Define variable life insurance.

Variable Life Insurance continued

Since the policy owner chooses the investment vehicle, variable life insurance is considered a security. Insurers must sell these contracts using a prospectus (a document giving facts about the company and the policy), and the company must be registered with SEC as an investment company. In addition to a life insurance license, an agent who sells variable life policies must hold an advanced securities license.
Lesson 3 Topic E Permanent Life Insurance: Equity Indexed Life Insurance

Learning Objective: Briefly describe equity indexed life products.

Equity indexed life insurance policies are generally some form of whole life, universal, or variable life insurance with the cash value account tied to a stock index (the most common is the Standard and Poor’s 500 -- S&P 500).

Most offer a minimum guaranteed interest rate.

Indexed policies are complex products involving indexing schedules, participation rates, cap rates, vesting schedules, and other concepts. It may be difficult to compare one indexed policy to another indexed policy, even if they are based on the same index, due to the differences in indexing schedules.

These types of products are outside the scope of this course. An overview of how the indexing works is as follows:

The insurance company invests a portion of the cash value in government bonds and purchases call options on the selected index with the remainder. If the index goes up, the company sells the call options and credits the policy subject to a percentage rate and/or cap rate spelled out in the contract. If the index goes down, the company uses the growth from the bonds to cover the loss and pays a minimum interest.
Lesson 3 Topic F – Variations of Life Insurance Plans

Learning Objective: Describe the general features of three variations on permanent life insurance: joint life, survivorship life and graded benefit.

First-To-Die Plans (Joint Life) - Creates a provision allowing two separate people to be insured on the same policy. The death benefit is paid at the death of the first person. These types of variations may be useful for mortgages, large liens, etc. At the death of the first insured, some companies even allow the remaining person to continue a policy at the original rates.

Second-To-Die or Last-To-Die Plans (Survivorship Life) - These contracts insure two lives rather than one and will pay a benefit when the second or last insured dies. Generally speaking, second to die plans are written using permanent policies. These policies are most commonly used in estate planning situations where large sums of money will be needed to pay estate taxes when the surviving spouse dies, or to provide money for surviving children.

The underwriting is influenced by the insured who is least likely to die (youngest or healthiest) since death benefits are not paid until two people have passed away. For that reason it may be easier to purchase a second-to-die life insurance policy than purchasing two individual policies. Premiums are based on a joint life expectancy.

Graded Benefit Plans - These plans offer possible protection for an insured who may be unable to qualify for a traditional life insurance policy. The policy will only pay a return of premium with minimum interest if a death occurs within a specific period of time. The policy adds a percentage of a maximum death benefit at intervals specified in the contract. Medical underwriting may be minimal.

An example is a plan that would return premium plus 2% if the insured dies in the first year; then it pays 10% of the face amount if the death occurs in year two; 25% in year three, 50% in year four, 75% in year five, and 100% in year six and beyond.

Refer to the end of Lesson 3 Topic F to complete Self Quiz 3.
Lesson 4 – Common Characteristics of Life Insurance Policies

Lesson 4 Introduction p1 (LHE)

An interesting difference between life contracts and property and casualty contracts is that the application for insurance becomes part of the contract, along with the policy and any riders. In this section we will study the components of life insurance contracts.

- Application
- Premium
- Contract Provisions
- Exclusions
- Riders
- Surrender/Settlement

Lesson 4 Introduction p2 (LHE)

Learning Objectives:

1. List the types of premium payments.
2. Recognize the components of life insurance policies:
   - Application
   - Conditional Receipts and Temporary Insurance Agreements
   - Exclusions and Riders
   - Provisions regarding dividends, settlement and non-forfeiture and surrender options.
3. Describe life insurance applications, including standardization of forms and how the application is used.
4. Describe what a conditional receipt is used for and what restrictions may be placed on issuing a conditional receipt.
5. Recognize and briefly describe the following common contract provisions of life insurance policies:
   - Entire Contract Provision
   - Misstatement of Age and/or Sex Provision
   - Right to Examine Period
   - Grace Period for Premium Payment Provision
   - Incontestable Clause
   - Suicide Provision
   - Reinstatement Provisions
6. Recognize and briefly describe the following life insurance policy exclusions:
   - War Clause
   - Cause of Death Exclusions
   - Flat Extra

7. Recognize and briefly describe the following life insurance policy riders:
   - Waiver of Premium Rider
   - Accidental Death Rider
   - Guaranteed Insurability Rider
   - Living Benefit Riders
   - Payor Benefit Rider
   - Family Riders
   - Term Insurance Rider
   - Return of Premium Rider

8. Recognize the ways that the owners or beneficiaries of a life insurance policy can take payment for accrued cash value and death benefit.

9. Understand the basic tax considerations of life insurance.
Lesson 4 Topic A – Premium Payment

Lesson 4 Topic A Premium Payment p1 (LHE)

Additional Terms and Concepts

Here are a few terms in this topic that you may wish to note before continuing:

**Pre-Paid vs. Traditional Premium Payment** - Traditional premium payment refers to paying an annual premium in one payment, or by installment. Pre-paid refers to payment of more than one annual premium at a time.

"**Up-Charge**" - Refers to the increment added to an installment premium payment.

**About Terms:** Other important terms will be defined on the topic pages. If you find any terms or concepts that need more explanation, go through the topic once more, and check the glossary. If you still need explanation, contact the course mentor.

Lesson 4 Topic A Premium Payment p2 (LHE)

**Learning Objective:** List the types of premium payments.

**Premium Payment**

Just like with Property and Casualty, there are a variety of ways to pay the Life Insurance premiums. Individual companies will establish their own preferred payment methods, but we will share with you the most common methods.

Premiums can be paid by:

- Traditional Modes
- Pre-payment

Lesson 4 Topic A Premium Payment p3 (LHE)

**Learning Objective:** List the types of premium payments.

**Traditional Premium Payment Modes**
Most life insurance companies prefer payment of the annual premium. There is no “up charge” when this is done. This normally allows the company to quickly recover the high start up costs of issuing the policies (underwriting, commissions, and administrative costs).

If the payor wishes to pay in a mode other than the annual amount, the company charges an “up charge” based on the mode selected. The following examples illustrate how such “up charges” may apply when the annual premium is $1,000:

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<tr>
<td>One payment of $1,000</td>
<td>$1,040 in two installments of $520 each</td>
<td>$1,080 in four installments of $270 each</td>
<td>$1,188 in twelve installments of $99 each</td>
<td>$1,032 in twelve monthly drafts of $86 each</td>
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**Lesson 4 Topic A Premium Payment p4 (LHE)**

**Learning Objective:** List the types of premium payments.

**Pre-Payment of Premiums**

Some insurance companies may give discounts for prepaying a multiple of the annual premiums (e.g., three-year prepaid premium). Agents should check with the company and should also be sure to get a legal opinion from the carrier that such lump sum premium payment does not create a current tax liability under present tax laws.

**Please refer to Lesson 4 Topic A Premium Payment p5 (LHE) to complete the Knowledge Check at this time.**
Lesson 4 Topic B – Components of a Life Insurance Policy

Learning Objective: Recognize the components of a Life Insurance Policy.

Since a Life Insurance Policy is issued by an Insurance Company, it is a 'legal contract', subject to similar legal requirements and qualifications that you may be accustomed to working with in the Property and Casualty business.

However, unlike Property & Casualty, where we can inspect the property we are insuring, we can't really inspect the prospective insureds, as they must qualify medically, and we can't see what they 'look like on the inside'. Therefore, binding authority is handled differently with Life Insurance than in the Property & Casualty business.

Components of a life insurance policy continued.

The Application – The statement of information given when a person applies for life, health, or disability insurance. The insurance company underwriter uses this information as a basis in determining whether the applicant qualifies for acceptance under the company’s guidelines. Applications are attached to and made a part of most individual contracts.

Conditional Receipts or Temporary Insurance Agreements – A form normally required to be signed by the agent and given to the prospective owner at the time a new application is completed. The issuing of a receipt is subject to individual company rules. Most companies require that the agent collect an initial premium and most usually grant some level of limited coverage, under special conditions, before issuance of the policy. Without a valid conditional receipt and a deposit premium, no coverage is in force until the policy is issued, delivered, and accepted.

Life Insurance Contract Provisions – While life insurance contracts are not standard contracts, the following provisions are generally part of all life insurance policies: The Entire contract Provision, Misstatement of Age and/or Sex Provision, Right to Examine Period (Free Look), Grace Period for Premium Payment Provision, Incontestable Clause Provision, Suicide Provision and Reinstatement Provision.

Life Insurance Policy Exclusions – Though the policy has limitations due to the incontestable and suicide provisions, an unendorsed life insurance policy has no exclusions. However, the insurance company may have the right to invoke the policy’s “war clause” in time of war. Additionally, companies may endorse a life insurance policy to add “cause-of-death exclusions” at the time the policy is issued.
Life Insurance Policy Riders – A rider is an addition to the life insurance policy that offers additional benefits or changes in benefits not found in a standard contract.

Dividends Paid on Life Insurance Contract – A dividend is a return of part of the premium to the policy holder. Dividends are based on the company’s profits resulting from mortality experience, expense costs, and investment return. Not all life insurance policies pay dividends, and when they do, dividends are not guaranteed.

Non-forfeiture or Surrender Options – Provisions that the insured cannot lose the equity of a whole life insurance policy. A policyholder can select from three options under the provisions: cash surrender value, extended term insurance, and reduced paid-up insurance. If none is selected, a clause in the policy will stipulate the option that automatically goes into effect, usually extended term insurance.

Settlement Options – The choices available for the payment of death benefits. The owner can select a settlement option before the insured’s death and the beneficiary has no choice but to accept the option on death. If there is no option selected before the death of the insured, the beneficiary has the option to select the method of benefit payment.

Additional Terms and Concepts

Misrepresentation - Intentionally lying and/or concealing information on a life insurance application can be prosecuted as a crime in all states. In addition, policies obtained through fraud may be voided at death.

Mortality/Morbidity Tables - Table which shows, for each age, what the probability is that a person will become sick or injured (morbidity) or die (mortality) before his next birthday.

Extra Percentage Table - Mortality or morbidity tables showing the extra premium for certain impaired health conditions.

Insurance Rider - A special provision that the insurer attaches to a policy to expand or restrict policy benefits.

About Terms: Other important terms will be defined on the topic pages. If you find any terms or concepts that need more explanation, go through the topic once more, and check the glossary. If you still need explanation, contact the course mentor.
Learning Objective: Describe life insurance applications, including standardization of forms and how the application is used.

The application is:

**A major underwriting tool** – Life insurance companies rely on the information in the application in the underwriting process. Information is to be supplied by the insured, and the insured must sign the application. If the insured is a minor, however, a parent or guardian can provide the information, and that person will sign the application.

**A document that contains protected private information** – The application contains personal information that must be protected. However, the company may share certain parts of the application information with the Medical Information Bureau (MIB Group, Inc.).

When the insured (or their parent or guardian) signs the application they normally give the life insurance company permission to provide past application information to the MIB and to receive past application information from the MIB. The life insurance company may also be allowed to request personal information from other databases, such as driving and criminal records.

**A standardized form, subject to state regulation** – Companies must use applications that comply with state insurance codes. Insurance companies may also adopt additional underwriting guidelines that could include the acquisition of additional medical and/or other personal information in addition to that required on the initial application. These too, must comply with state insurance codes.

**Amendable, for a new offer** – A company may amend an application and offer a different policy than the one applied for. This occurs when the applicant does not qualify for life insurance as requested in the application. A new offer by the company normally requires the insured sign a statement acknowledging the amended offer and that information given in the original application, unless noted, has not changed.

An insurer that accepts an applicant who does not qualify for a standard policy will usually base the premium for the revised offer on extra percentage tables, which are mortality or morbidity tables showing the extra premium for certain impaired health conditions. Usually, this develops an additional premium based on a percentage of the standard premium, a form of substandard rating.

**A part of the life insurance contract** – The life insurance application actually becomes part of the contract, and a copy is attached to the policy when it is issued. Any mistake on an application must be corrected and initialed by the insured, or better yet, a new application completed in its entirety with no errors.
**Lesson 4 Topic B Components - Application, Conditional Receipts p5 (LHE)**

**Learning Objective:** Describe life insurance applications, including standardization of forms and how the application is used.

**Who Can Complete the Application**

Life insurance agents, as representatives of life insurance companies, may be involved in the application process. Some companies require the life insurance agent to collect the application information by questioning the insured (parent or guardian) and witnessing their signature on the application.

Some companies allow the agent to complete the application based on the applicant’s responses to questions, while others want the applicant to actually complete all of the sections of the application in their own handwriting.

If involved in the application process, the agent will also be required to sign the application and witness the insured’s signature.

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**Lesson 4 Topic B Components - Application, Conditional Receipts p6 (LHE)**

**Learning Objective:** Describe what a conditional receipt is used for and what restrictions may be placed on issuing a conditional receipt.

**Conditional Receipts or Temporary Insuring Agreements**

During the life insurance application process, a conditional receipt or temporary insuring agreement describes the agreement between the insurance company and the applicant and provide temporary life insurance coverage until the company has issued the policy.

**Agent’s Authority to issue Conditional Receipt is limited** — Here is where binding authority is different from property and casualty insurance!

If the agent accepts money, he/she must provide a conditional receipt or temporary insuring agreement for a limited amount of protection, due to the fact that the agent can’t determine if the prospect is healthy and meets the underwriting criteria.
Circumstances that may be restricted—Examples of situations that may prohibit giving conditional receipts or temporary insurance agreements are situations of known or admitted medical conditions, dangerous jobs and/or hobbies, the age of the insured, the amount of life insurance request, or other adverse underwriting conditions known to the agent and outlined in the company’s underwriting guidelines.

Temporary agreements “on approval” basis—Generally speaking, if an agent accepts premium payment to submit with the application, some type of conditional receipt or temporary insurance agreement will be issued. If the agent does not collect a premium payment to submit with the application, the application is submitted on a “for approval basis”, no conditional receipt or temporary insurance agreement is issued, and no coverage until policy issued, accepted and paid for.

Lesson 4 Topic B Components - Application, Conditional Receipts p7 (LHE)

Learning Objective: Describe life insurance applications, including standardization of forms and how the application is used.

Insurability—Most conditional receipt guidelines require that the insured must be insurable for the exact insurance applied for when the application is made and that other terms of the conditional receipt must be met before temporary insurance will be provided.

Underwriting Requirements—The insured may be required to complete underwriting requirements, such as:

- a medical exam performed by a paramedic or company approved physician,
- blood work or urine specimen,

after which the temporary insurance will take effect.

Otherwise, if the insured meets the company “non-medical” guidelines, then the temporary insurance can begin immediately.

Specified Time Limits and Maximum Amounts of Coverage—Most conditional receipts will be subject to specified time limits and maximum amounts of coverage. In other words, if all of the underwriting requirements are not completed and submitted to the company for consideration within, for example, 60 days, the temporary insurance expires, and premium deposit is refunded, and generally the underwriting process stops, until the applicant decides to comply and restarts the process.

In addition, the temporary insurance coverage amount is the requested face amount on the application but only up to a maximum allowed by that company, and if the requested face is more, the temporary insurance amount is the smaller of the two.
Note: Most temporary insurance agreements provide temporary insurance coverage until the company refunds the premium or issues the policy, just as conditional receipts do. Most temporary insurance agreements have beginning and termination dates, special limitations, and maximum amounts of coverage.

Since life insurance contracts are not standardized contracts, you should have the expectation that the provisions for conditional receipts or temporary insurance agreements will vary between life insurance companies.

Please refer to Lesson 4 Topic B – Components – Application, Conditional Receipts p8 (LHE) for examples of Conditional Receipt language and Temporary Insurance Agreement language.

Please refer to Lesson 4 Topic B – Components – Application, Conditional Receipts p9 (LHE) to complete the Knowledge Check at this time.

Learning Objective: Recognize and briefly describe the common contract provisions of life insurance policies.

Even though Life Insurance policies are not standardized contracts there are certain provisions found in all Life Insurance contracts.

**The Entire Contract Provision** – The entire contract clause states that the insurance policy, the policy owner’s application that is attached to the policy, and any individual applications of any insured person, constitute the entire insurance contract. This clause also stipulates that no agent has any authority to waive or amend any provisions of the insurance contract.

**Misstatement of Age and/or Sex Provision** – Misstatement of age or sex will generally not rescind the policy. Because the insured’s attained age of the policy was incorrect, and adjustment would be needed. The face amount of the policy could be adjusted if not enough premium had been paid. Conversely, a premium refund could be made to the payor, if too much premium had been paid to the policy.

**Right to Examine Period (Free look)** – The right to examine is inherent in a Life Insurance policy. Most state laws require a minimum of 10 days after the policy is delivered to the prospect, for the prospect to review the policy and decide whether or not they wish to keep it.

**Grace Period for Premium Payment Provision** – The grace period is designed to allow the policy to stay in force due to non-payment on due date by the insured. Grace periods are 30 or 31 days, depending on the state. This is required by law. If the insured dies during the grace period, the company will reduce the death benefits by the modal premium (“modal premium” amount is based on the mode of payment, monthly, annually etc.).

**Incontestable Clause** – Typically, the insurer has 2 years from the date of policy issuance to contest the accuracy of information about the insured. After that, a death claim is rarely denied.

However, recent case law allows for the possibility of an insurance company challenging payment of a claim in which there was willful and intentional fraud on the part of an applicant/insured that would have affected the company decision to issue a policy during the application process.

**Suicide Provision** – Most policies do not provide any coverage if the insured dies by suicide within a minimum time period (typically 1 or 2 years) from the date of issue. In the case of suicide of the insured occurring within the minimum time period, the death benefit would not be paid, but the premium is often refunded. If the insured dies by suicide after that minimal time period, the insurance company will treat the suicide like death from any other cause and pay the claim.
Reinstatement Provision – Reinstatement allows the policy owner to reacquire the policy after it has lapsed. This provision must meet certain state laws as well as the insurance company requirements.

Additional Terms and Concepts

Reinstatement – Reinstatement allows the policy owner to reacquire the policy after it has lapsed. This provision must meet certain state laws as well as the insurance company requirements.

Rescission - Canceling or making the coverage under a policy null and void.

Misstatement (vs. Misrepresentation) - Misstatement typically refers to unintentional or minor errors on the application. Misrepresentation typically refers to fraudulent information on the application.

Lapse - The termination of an insurance policy, usually due to non-payment of premium.

Contestable Clause - A provision in an insurance policy setting forth the conditions under which and the period of time during which the insurer may contest or void the policy. After that time has lapsed, normally two years, the insurer cannot challenge the validity of the contract based on misrepresentations made during the application process.

About Terms: Other important terms will be defined on the topic pages. If you find any terms or concepts that need more explanation, go through the topic once more, and check the glossary. If you still need explanation, contact the course mentor.

Entire Contract Clause – The entire contract clause states that the insurance policy, the policy owner’s application that is attached to the policy, and any individual applications of any insured person, constitute the entire insurance contract. This clause also stipulates that no agent has any authority to waive or amend any provision of the insurance contract.

The contract terms can be amended or waived only by an endorsement, requested by the owner and issued by the insurer. This provision prohibits either party from modifying the terms of the contract through other means, such as oral agreements.
Right to Examine – The right to examine is inherent in a Life Insurance policy. If the prospect received the policy and decides within the ‘right to examine’ time frame to return the policy to the issuing company, they will receive a full refund of the premium paid. This provision helps the buyer know that what they thought they were buying and what they receive, are the same. The right to examine clause is determined by state statute, often allowing 10 days, beginning the date the owner receives the policy.

Lesson 4 Topic C Components - Contract Provisions p4 (LHE)

Learning Objective: Recognize and briefly describe the common contract provisions of life insurance policies.

Misstatement of Age or Sex – Misstatement of age or sex will generally not rescind the policy. All that will happen is that either the premium will be adjusted to the correct amount for the amount of insurance requested, or face amount of the insurance will be adjusted based upon the premium being paid.

Generally speaking, misstatement of age and/or sex is not considered material misrepresentation in a life insurance contract. Some states have adopted statutes that allow a life insurance to void the contract for this misstatement only if the correct statement would have prevented the issuance of the policy, but this is not a common practice. For the most part, coverage will still be in force.

If the misstatement is discovered before the insured’s death – The policy is amended to reflect the correct information, and benefit or premium will be adjusted accordingly. This normally results in lowering of the death benefit or increasing of the premium since stating of a lower than actual age is the most common misstatement. If the death benefit amount is maintained, in addition to higher future premiums, the life insurance company would be entitled to earned back premium.

If the misstatement is discovered after the insured’s death – The company will adjust the death benefit to what it would have been had the correct information been given and based on the premium paid. Most of the time this adjustment means a reduction in death benefit, since the stating of a lower than actual age is the most common misstatement.

Lesson 4 Topic C Components - Contract Provisions p5 (LHE)

Learning Objective: Recognize and briefly describe the common contract provisions of life insurance policies.

Grace Period for Premium Payment – The grace period is a length of time after the normal due date of a life insurance premium that the policy remains in force if the premium has not been paid.
Required by States – All states require life insurance companies to provide a grace period of 30 or 31 days (depending on state law) on life insurance policies. Individual companies have extended the grace period for their policies during natural disasters, such as Hurricane Katrina. However, life insurance companies are not required to offer extensions, and how if extensions apply will vary from company to company.

Not Free Insurance – The grace period is not a period of free insurance. The company treats premiums received during the grace period as received on the due date and future premium due dates fall at their normal time. Interest is not charged on premiums that are received during the grace period.

If the insured dies during the grace period without any premium being remitted to the life insurance company, the death proceeds will be paid to the beneficiary, but the company will be allowed to deduct the owed premium from the death proceeds.

Policy Lapse – If the premium is not received before the end of the grace period, if it is a term policy, the policy lapses. If it is a type of whole life insurance it can be paid at the end of the grace period from any cash value, if a premium loan provision is not included in the contract.

Premium Loans Provision – This occurs only if there is a cash value available, and the contract includes the “automatic premium loan” wording. If the premium is not received or paid from a premium loan provision, the policy lapses and a non-forfeiture option is offered to the owner (non-forfeiture is discussed later in this chapter).

It should be noted here that Universal Life policies are not subject to this issue as the mortality costs for the insurance component are automatically deducted from the cash value fund as part of its design, and a lapse occurs only if no cash is available.

Lesson 4 Topic C Components - Contract Provisions p6 (LHE)

Learning Objective: Recognize and briefly describe the common contract provisions of life insurance policies.

Incontestable Clause – A majority of states require that a provision be included in life insurance policies that make the policy incontestable after a stated period of time, usually two years (depending on individual state statutes). In its simplest form, the incontestable clause provision states that after the policy has been in force for the required period of time, the insurance company cannot challenge the validity of the contract based on misrepresentations made during the application process.

The trigger for beginning the contestability period is the life insurance policy issuance date, not the date of the application.
A misrepresentation is generally viewed as a false representation of a fact that is made prior to policy issuance, which if the company had known the truth, it would not have issued the exact policy applied for. The intent of the fraud by the insured is not required for a misrepresentation to take place.

There is however recent case law that allows for the possibility of an insurance company challenging payment of a claim in which there was willful and intentional fraud on the part of an applicant/insured that would have affected the company decision to issue a policy when applied for.

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**Lesson 4 Topic C Components - Contract Provisions p7 (LHE)**

**Learning Objective:** Recognize and briefly describe the common contract provisions of life insurance policies.

**Suicide Provision**—Virtually all life insurance policies include some type of suicide provision. This provision states the life insurance company does not have to pay a death benefit if the insured commits suicide within a certain time period following the issue date of the life insurance policy. While most states limit the time for a suicide provision to two years, a few allow one year.

If death occurs by suicide within the specified time period and the company successfully denies the claim, most states’ laws require the insurer to return paid premium, and in some cases, interest on the returned premium.

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**Lesson 4 Topic C Components - Contract Provisions p8 (LHE)**

**Learning Objective:** Recognize and briefly describe the common contract provisions of life insurance policies.

**Reinstatement Provision**—Some life insurance policies contain a provision that allows for a reinstatement of the policy within a certain time period after it lapses for non-payment of premium. Depending on the company and/or the length of time the policy is out-of-force, reinstatement may be subject to new underwriting and the insured being insurable.

The company may require payment of all past due premiums, and some companies may require interest to be paid on the past due premiums as well as repayment of outstanding loans. Reinstatement normally triggers a new incontestability period and suicide period.

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**Please refer to Lesson 4 Topic C – Components – Contract Provisions p9 (LHE) to complete the Knowledge Check at this time.**
Lesson 4 Topic D – Components of a Life Insurance Policy: Exclusions, Riders

Lesson 4 Topic D Components - Exclusions, Riders p1 (LHE)

Here are a few terms in this topic that you may wish to note before continuing:

**Proof of insurability** - For life insurance, this means medical exams and other underwriting requirements set by the insurer.

**Exclusions vs. Limitations** - Exclusionary language is designed to preclude coverage under certain circumstances. Limiting language restricts coverage, and may not exclude it entirely. An exclusion may be a part of the contract or attached to the contract by endorsement.

**About Terms**: Other important terms will be defined on the topic pages. If you find any terms or concepts that need more explanation, go through the topic once more, and check the glossary. If you still need explanation, contact the course mentor.

Lesson 4 Topic D Components - Exclusions, Riders p2 (LHE)

**Learning Objective**: Recognize and briefly describe the life insurance policy exclusions.

Though the policy has limitations due to the incontestable and suicide provisions, an unendorsed life insurance policy has no exclusions.

**War Clause** – However, the insurance company may have a right to invoke a policy’s “war clause” in time of war. This clause states that in wartime no death benefit, other than return of premium and interest, will be paid if the insured is killed as a direct result of “war-like action”. A “war clause” cannot be added to an existing contract. Such a clause applies to new applications and is generally removed after the war ends.

**Cause of Death Exclusions** – Additionally, companies may endorse a life insurance policy to add “cause-of-death exclusions” at the time the policy is issued. Such exclusions are usually reserved for hazardous jobs or sports-related activities like underwater salvage or skydiving. The insured is required to sign an acknowledgement of the endorsement adding the “cause-of-death exclusion”.

**Flat Extra** – Alternatively, an insurer may choose to insure the job or activity and charge an extra premium in addition to the regular premium to cover any extra hazard or special risk. This is commonly referred to as a Flat Extra.
Learning Objective: Recognize and briefly describe the life insurance policy riders.

A rider is an addition to the life insurance policy that offers additional benefits or changes in benefits not found in the standard contract, similar to an endorsement in P&C. The following are the most common riders offered by life insurance companies:

- Waiver of Premium Rider
- Accidental Death Rider
- Guaranteed Insurability Rider
- Living Benefit Riders
- Payor Benefit Rider
- Family Riders
- Term Insurance Rider
- Return of Premium Rider

Not all companies offer all of these riders, and the language of any specific rider can vary between companies. Though companies may include some riders for no charge, most of these riders will produce additional premium charges.

Waiver of Premium Rider – This rider states that if the insured becomes disabled, as defined in the policy (most policies require total disability), the company will waive the payment of premiums. Generally speaking, the insured must be disabled, as defined, for a period of time (usually six continuous months) called a waiting period. Once the insured has been disabled for the required period of time, most companies will refund the premium paid during the waiting period. The premium will be waived and the policy remains in force until the insured is no longer considered disabled as determined by a physician’s examination, or permanently if so deemed.

This rider may have limitations or exclusions if the disability is self-inflicted or begins after the insured reaches a certain age.

When this rider is attached to a universal life insurance policy, only the mortality and expense charges may be waived, not the target or actual premium paid. It is necessary to understand exactly what portion of contribution will be waived, based on individual company procedures.

Accidental Death Rider – This rider provides for the payment of a multiple (two times, or double indemnity, is an example) of the face amount in the event of the insured’s death resulting from accidental bodily injury.
Normally, accidental death must be caused directly by the accident and be independent of all other causes, and the death must occur within a certain time period (normally from 90 to 180 days) following the occurrence of the accident.

**Lesson 4 Topic D Components - Exclusions, Riders p5 (LHE)**

**Learning Objective:** Recognize and briefly describe the life insurance policy riders.

**Guaranteed Insurability Rider**

The guaranteed insurability rider gives the insured options to purchase additional life insurance from the company at specific future intervals without having to prove insurability. If an insured becomes uninsurable after the original policy is issued, this rider could permit the purchase of significant amounts of additional life insurance. These intervals are generally based on the insured’s age near the policy anniversary dates, or on life events such as marriage, purchasing a home or having a child near the policy anniversary dates.

**Example:**

The insured reaches age **25, 28, 31, 34, 37, and 40**. Normally companies do not offer options beyond the insured’s age 40.

When the insured reaches each of these ages, the company will offer additional life insurance. Acceptance of the additional coverage can be accomplished by signing the request and paying the premiums when due. The insured may decline the additional life insurance option. If the insured declines a regularly scheduled option when it is due, the option will no longer be available, but the insured will still have the remaining future options.

**Lesson 4 Topic D Components - Exclusions, Riders p6 (LHE)**

**Learning Objective:** Recognize and briefly describe the life insurance policy riders.

**Improving Coverage after a “Life Event”**
1. The insured marries at 26. She can use the age 28 option because of this “life event”, and purchase additional life insurance at age 26. The next regular option would then occur at age 31.

2. If the insured buys a house at age 27. The age 28 option has already been used so the age 31 option is the alternative for that “life event”. The next regular option would then occur at age 34.

3. The insured has a child at age 28 and the next regular option will still be at age 34. In our example, the maximum number of options an insured could take would be six.

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**Lesson 4 Topic D Components - Exclusions, Riders p7 (LHE)**

<table>
<thead>
<tr>
<th>Issue Age</th>
<th>Maximum Each Option Date - Lesser of Face Amount of Base Policy or:</th>
<th>Option Ages</th>
</tr>
</thead>
<tbody>
<tr>
<td>00-24</td>
<td>$30,000</td>
<td>25, 28, 31, 34, 37, &amp; 40</td>
</tr>
<tr>
<td>25-27</td>
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</tr>
<tr>
<td>34-36</td>
<td>$50,000</td>
<td>37, &amp; 40</td>
</tr>
</tbody>
</table>

**Maximum Each Option Date** – The type of life insurance issued will be the same or equivalent type the insured has in place.

**Issue Age** – The premium will be based on the insured’s attained (actual) age at the time an option is taken. The amount of insurance available for purchase at any one option period will be stated in the rider.

*If the insured exercises this option to purchase additional insurance coverage, the insurer generally issues a separate life insurance policy, triggering a suicide provision clause for the new policy.*

*A guaranteed issue policy may not allow additional riders without proof of insurability.*

Please refer to Lesson 4 Topic D – Components – Exclusions, Riders p8 (LHE) to complete the Knowledge Check at this time.

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**Lesson 4 Topic D Components - Exclusions, Riders p9 (LHE)**

**Learning Objective:** Recognize and briefly describe the life insurance policy riders.
Rider Options

If the insured is 21 when the original policy is issued, and he takes advantage of each opportunity to buy additional insurance each time, how much will he have by age 40 when all the options expire?

This rider offers the potential of purchasing a total of $230,000 of life insurance (the original face amount of $50,000 plus six $30,000 policies), even if a disability caused permanent uninsurability.

$30,000 X 6 =$180,000 + $50,000 face value of the policy = $230,000.

Lesson 4 Topic D Components - Exclusions, Riders p10 (LHE)

Learning Objective: Recognize and briefly describe the life insurance policy riders.

Living Benefit Rider – These riders allow benefits to be paid on all life insurance policy while the insured is still living. A specific set of circumstances must occur before a benefit is paid.

When is the Rider used?

Examples might include the insured being:

- Diagnosed with an irreversible medical condition or illness for which death is likely to occur within a specific time period (generally one year);
- Diagnosed with a chronic medical condition that would greatly reduce the insured’s expected life span unless a medical procedure such as a major organ transplant or installing a heart pacemaker is performed;

Accelerates Payment of Death Payment – If a term insurance policy includes a living benefit rider, the insured generally has to qualify for the benefit while at least two years remain on the term. Up to 50% of the death benefit may be paid to the insured/owner subject to the contract provisions.

Contract Language Varies by Company – The language for these riders varies greatly between policies. Not all life insurance policies will provide living benefits for all the examples cited, and some policies may not contain any living benefit rider. If a policy was issued without a living benefit, the owner may be able to ask the company to add one to the existing policy. If the company agrees to add a living benefit rider, a copy of the form should be attached to the policy.

Lesson 4 Topic D Components - Exclusions, Riders p11 (LHE)

Learning Objective: Recognize and briefly describe the life insurance policy riders.
Characteristics of Living Benefit Riders

**Premium or Administrative Charge** – Some companies charge a premium for living benefit riders, and some do not. Some companies may charge an administrative fee (for example, $150) to process a claim for a living benefit.

**Parties to the Contract: Owner is not the Insured** – If the insured is not the owner of the insurance policy, the company will normally require the written permission of the owner before paying a living benefit. Also, written permission will be required from an irrevocable beneficiary or collateral assignee before a living benefit will be paid.

**Benefit Amount: Amount of Life Insurance** – Normally, the rider indicates that the amount an insured may collect under a living benefit rider is limited to a specific dollar amount ($300,000 as an example) or a percentage of the face amount (80 percent), whichever is less.

**Tax Treatment of the Benefit Payment** – Recent tax law adjustments treat any ‘accelerated benefit’ to be the same as a ‘death benefit’, therefore, it remains un-taxable. Also, if the insured receives an accelerated benefit and then recovers their health, the money advanced is treated as though it were part of the death benefit, it remains un-taxed as long as the policy remains in force. At death, the death benefit of the policy is reduced by the amount accelerated.

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*Lesson 4 Topic D Components - Exclusions, Riders p13 (LHE)*

**Learning Objective:** Recognize and briefly describe the life insurance policy riders.

Living Benefit Riders can also be called Accelerated Benefit Riders. The following is a sample form:

**Sample Accelerated Benefit Rider Statement**

A. **Acceleration Conditions** – The accelerated benefit rider allows you, while the policy is in force and not within two years of expiry, to elect an acceleration of the death benefit under the policy and any term insurance rider that is less than two years prior to expiry. The benefit is available if the insured has an irreversible medical condition that can be expected to result in the insured’s death within twelve months.

B. **Accelerating Options** – One benefit for each insured may be paid under the accelerated benefit rider. An accelerated benefit will be paid to the owner in a single sum unless we agree otherwise. You may accelerate all or part of the eligible death benefit, subject to a $2,500 minimum benefit and a $500,000 maximum benefit on all policies issues by us. We reserve the right to limit this maximum amount if the policy is reinsured. The face amount of the policy or rider that will remain after a partial acceleration must be at least the minimum face amount required for the policy or rider. The amount accelerated will be discounted for twelve months’ interest and will be reduced by
any outstanding policy loan, if not otherwise paid, multiplies by the percentage of the eligible amount which is accelerated.

C. Premium for Accelerated Benefit Rider – There is no premium charge for the accelerated benefit rider.

D. Administrative Expense Charge – An administrative fee of up to $150 may be required with a request for the accelerated benefit.

E. Other Acceleration Conditions –
   1. No benefit is available if an insured’s irreversible medical condition results from a self-inflicted injury and such injury occurs within a two-year period following the policy date. If such injury occurs beyond such period, the amount that may be requested with respect to such insured may not include any part of the death benefit that was first effective within such two-year period prior to such injury.
   2. The payment of the accelerated benefit must first be approved in writing by an irrevocable beneficiary and any collateral assignee.

Lesson 4 Topic D Components - Exclusions, Riders p13 (LHE)

Learning Objective: Recognize and briefly describe the life insurance policy riders.

Additional Riders

Payor Benefit Rider – The rider may be added to a life insurance policy insuring the life of a juvenile. If the payor (the one paying the premium) dies or becomes totally disabled prior to the juvenile’s reaching a specified age (generally between age 18 and 25), subsequent premiums that are due are automatically waived until the insured reaches said age.

Family Riders – These riders allow the purchase of term insurance for the spouse and/or children of the insured. Generally, insureds may purchase them in units of coverage (example: 1 unit equals $5,000 coverage for spouse and $1,000 for each child). Many allow for the future conversion to some type of permanent life insurance without evidence of insurability under specific conditions.

Term Insurance Rider – This rider provides an additional amount of temporary coverage, which may be attached to an existing permanent policy for a specified period of time. Normally, the insurance company offers this option when the policy is originally issued.

Return of Premium Rider – When this rider is attached to term life insurance products, the policy owner is returned the premium paid if the insured outlives the term. One of the biggest disadvantages of term insurance is that it is designed to expire before the insured dies. With this rider, if the policy is kept in force for a specified time period, the life insurance company will return some or all of the premium paid. One thing that can be considered a negative is that this rider can increase the standard premium by 25% to 50% for the entire length of the policy term.
Please refer to Lesson 4 Topic D – Components – Exclusions, Riders p14 (LHE) to complete the Knowledge Check at this time.
Lesson 4 Topic E – Dividend Payments to the Policy Owner

Learning Objective: Recognize the ways that the owners or beneficiaries of a life insurance policy can take payment for accrued cash value and death benefit.

A dividend is a return of part of the premium to the policyholder. Dividends are based on the company’s profits resulting from mortality experience, expense costs, and investment return. Not all life insurance policies pay dividends, and when they do, dividends are not guaranteed.

- Mutual life insurance companies (those owned by the policyholders) generally pay dividends
- Stock life insurance companies (those owned by stockholders) generally do not pay dividends to policy owners.

Additional Terms and Concepts

Here are a few terms in this topic that you may wish to note before continuing:

**Participating Policy** - A policy providing for the payment of dividends is known as participating. Because the company only pays dividends if the board of directors authorized such payments, dividends are not guaranteed.

**Non-participating Policy** - In a non-participating policy, the premiums, cash surrender values, and death benefits are determined at policy issue and cannot be altered after the policy is issued. The company assumes all risk of future performance. Non-participating policies do not pay dividends.

**Automatic Surrender or Non-Forfeiture Option** - Typically insurers give owners a number of policy surrender options and have an automatic option in place should the owner fail to choose any of the given options.

**About Terms**: Other important terms will be defined on the topic pages. If you find any terms or concepts that need more explanation, go through the topic once more, and check the glossary. If you still need explanation, contact the course mentor.
Lesson 4 Topic E Components - Dividend, Non-Forfeiture, Settlement p3 (LHE)

Learning Objective: Recognize the ways that the owners or beneficiaries of a life insurance policy can take payment for accrued cash value and death benefit.

Dividend Options

If a participating policy pays a dividend, the policy owner normally has several choices on how to receive the dividend.

1. **Pay Directly to the Owner** – The dividend payment can go directly to the policy owner. Since dividends are considered overpayment of premium, cash payments are not normally subject to income tax.
2. **Pay Down the Premium** – The policy owner can use the dividend to reduce the current premium on the life insurance policy. With this choice, the gross premium minus the dividend becomes the net premium due at each payment date.
3. **Hold in an Interest Bearing Account** – The policy owner can allow the life insurance company to deposit the dividend into an interest bearing account. The dividend is not taxable, and interest that the account earns is taxable in the year credited.
4. **Purchase Paid Up Insurance** – The policy owner can use the dividend to purchase a small amount of paid-up life insurance on the insured. No future premium is ever due on this paid-up life insurance. Over a period of time, these paid-up additions can add significant dollars to a death claim.
5. **Buy Term Insurance** – The policy owner can use the dividend to purchase an amount of one-year term insurance on the insured. The death benefit on this term insurance will be larger than the paid-up benefit, but since it is term insurance the insured must die before the term expires, or no death benefit will be paid.

Lesson 4 Topic E Components - Dividend, Non-Forfeiture, Settlement p4 (LHE)

Learning Objective: Recognize the ways that the owners or beneficiaries of a life insurance policy can take payment for accrued cash value and death benefit.

**Three Main Non-Forfeiture or Surrender Options**

This feature allows the policy owner to receive the cash value of a life insurance policy when surrendering the policy, or if the policy lapses for non-payment of premium. The company generally offers the policy owner the following three choices. If the policy owner fails to select a choice, the policy will trigger an automatic non-forfeiture option.

1. The owner can surrender the life insurance policy and receive a check from the company for the cash value. Any amount in excess of the premiums paid would be taxable.
2. The owner can use the cash value to purchase a single-premium, paid-up life insurance of the same type as the original policy. This paid-up policy will be for a reduced amount of insurance.

3. The owner can use the cash value to purchase extended term insurance for the face amount of the policy, with premium based on the insured’s attained age. This extended term insurance is often the automatic option that is triggered if the owner fails to notify the company. The reason is that term insurance is designed to expire before the insured dies.

Learning Objective: Recognize the ways that the owners or beneficiaries of a life insurance policy can take payment for accrued cash value and death benefit.

Table of Non-Forfeiture Values

Life insurance policies with cash values will have a table of non-forfeiture values included in the contract language. This table will give the policy owner an idea of what the guaranteed non-forfeiture values would be at the end of each policy year. The actual values could be different if the cash value grew due to dividends applied.

Please refer to Lesson 4 Topic E Components -Dividend, Non-Forfeiture, Settlement p5 (LHE) to view a sample non-forfeiture table.

Learning Objective: Recognize the ways that the owners or beneficiaries of a life insurance policy can take payment for accrued cash value and death benefit.

Settlement Options

If the life insurance policy is in force when the insured dies, a death benefit will be paid to the beneficiary. Simply stated, settlement options are the manner in which the death benefit can be paid to the beneficiary.

- The policy owner can select the settlement option to be paid, if they do so before the insured dies.
- If the policy owner has not selected a settlement option before the insured dies, the beneficiary will get to select the settlement option.
Lesson 4 Topic E Components -Dividend, Non-Forfeiture, Settlement p7 (LHE)

Learning Objective: Recognize the ways that the owners or beneficiaries of a life insurance policy can take payment for accrued cash value and death benefit.

Common Settlement Options

Keep in mind that the beneficiary receives the basic death benefit tax-free but any other choice of settlement options could have some tax consequences. The most common settlement options are:

**Cash** – The beneficiary receives the death benefit in a lump sum. Normally the life insurance company opens a checking account with the balance equal to the death benefit. A checkbook is then presented to the beneficiary. The beneficiary can write a check for the entire amount or draft money as needed. Any remaining balance normally earns a modest interest rate.

**Interest Income** – The death benefit is left with the insurance company, and the interest it earns is paid to the beneficiary. This option is normally used for a short period of time, giving the beneficiary time to make a decision on a permanent settlement option.

**Fixed Period or Fixed Time** – The insurance company pays periodic installments to the beneficiary for a specific period of time. An example would be quarterly payments for the next 10 years. The amount paid is determined by the death benefit and the interest it earns during the time period. The interest is taxable to the beneficiary.

**Fixed Amount or Installments** – The insurance company pays the beneficiary equal installments until all proceeds (death benefit and earned interest) are paid out. An example would be that the beneficiary will receive $1,000 a month. This option focuses on the installment amount rather than an amount of time.

**Life Income or Annuity** – The death benefit is used to purchase an annuity and equal installments will be paid during the lifetime of the beneficiary. The pay-out may include a guaranteed payment period. A life insurance contract that provides income on a monthly basis, as opposed to a policy that pays proceeds in a lump sum, can be called an income policy or it may be set up as an annuity.

| Tip: | The beneficiary also has a commutation right, or the right to receive in a single lump-sum the remaining payments under an installment option selected for the settlement of life insurance proceeds. |

Please refer to Lesson 4 Topic E Components -Dividend, Non-Forfeiture, Settlement p8 (LHE) to complete the Knowledge Check at this time.
Lesson 4 Topic F – Basic Tax Considerations of Life Insurance

Additional Terms and Concepts

- **Tax deferred** - The annual growth in the value of an investment is not subject to income tax until withdrawals or distributions from that investment are made.

- **Viatical** - A general term referring to transactions in the viatical settlement marketplace. A viatical settlement is the proceeds from the sale of a life insurance policy to a third party by a terminally ill individual.

- **Incidents of ownership (of a life insurance contract)** - Various rights a policy owner may exercise under the policy contract. Some of the incidents would be rights to (1) cashing in the policy, (2) receive a loan on the cash value of the policy, and (3) change the beneficiary.

About Terms: Other important terms will be defined on the topic pages. If you find any terms or concepts that need more explanation, go through the topic once more, and check the glossary. If you still need explanation, contact the course mentor.

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**Lesson 4 Topic F Tax Considerations p2 (LHE)**

**Learning Objective:** Understand the basic tax considerations of life insurance.

**Basic Tax Considerations of Life Insurance**

Life insurance premiums are not normally deductible for federal and/or state income tax purposes. Generally, the death proceeds paid by the insurance company to the beneficiary upon the death of the insured are not included as taxable income for federal and state income tax purposes.

If the insured is also the owner or has any incidence of ownership, such as naming beneficiaries, accessing cash value, assigning benefits, and/or surrendering the policy, the death proceeds may be included in the insured’s estate and be subject to federal and state estate and/or inheritance tax.
Lesson 4 Topic F Tax Considerations p3 (LHE)

Learning Objective: Understand the basic tax considerations of life insurance.

Annual Increases in Cash Value are Tax Deferred

The cash value growth of a life insurance policy is on a tax-deferred basis. Annual increases in the cash surrender value of a life insurance policy are not normally taxed until the policy is surrendered, sold, or it fails to meet tax code definitions of a life insurance contract.

If the owner receives cash values in excess of the premiums paid, for example, if the owner surrenders the policy, tax is due on the excess at the time it is received. Life insurance policies that are funded too rapidly (generally in one large payment) may result in adverse tax consequences.

Exchanged Policies Subject to Special Tax Rules

Special tax rules apply when a life insurance policy is exchanged or replaced with another life insurance contract or annuity contract. The Internal Revenue Code Section 1035 deals with the taxation of exchanging or replacing life insurance policies. It is imperative that these rules be followed to avoid adverse tax consequences.

Viatical Settlements Exempt from Federal Tax

In 1995, legislation was passed that specifically exempts viatical settlements from federal income tax for the policy owner/seller. The purchaser may have an income tax liability as this is similar to other investments. In a viatical settlement, the owner of a life insurance policy sells the policy to another individual/entity.

Please refer to Lesson 4 Topic F Tax Considerations p4 (LHE) to complete the Knowledge Check at this time.

Refer to the end of Lesson 4 Topic F to complete Self Quiz 4.
Lesson 5 – Overview of Medical Expense Policies

Lesson 5 Introduction p1 (LHE)

Before the 1930's most health costs were covered by the individual who was sick and needed care. The prepaid hospital plan that later became the basis for Blue Cross was developed at Baylor University, Dallas, Texas in 1929.

By the late 40's market conditions began to favor the emergence of the employer based system that still dominates today. Insurance companies, seeing the success of Blue Cross began offering their own plans.

Between 1940 and 1955, the percentage of the US population covered by a health insurance plan rose from 10% to 70%.

Source: BlueCross Blue Shield Assoc.; History of BCBSA; bcbs.com/about/history/

Lesson 5 Introduction p2 (LHE)

Health Insurance Introduction continued

Group Plans vs. Individual Plans

Health insurance provides financial protection against the monetary consequences of medical expenses caused by poor health and/or accidents. Thought by many individuals to be their most important insurance protection, health insurance can also be one of the largest personal expenditures for Americans today.

Today, most people who have health insurance and are not covered by a government plan such as Medicare obtain their coverage through employer-sponsored group plans.

The remainder who have coverage most likely have purchased individual health policies covering themselves and possibly family.

Lesson 5 Introduction p3 (LHE)

Here are a few terms in this topic that you may wish to note before continuing:

**Preventative Care** - Medical care that focuses on disease prevention and health maintenance

**Primary Care** - Basic or general health care usually provided by general practitioners, family practitioners, internists and pediatricians.
Major Medical Care - Care for serious or expensive medical costs or hospitalization

About Terms: Other important terms will be defined on the topic pages. If you find any terms or concepts that need more explanation, go through the topic once more, and check the glossary. If you still need explanation, contact the course mentor.

Lesson 5 Learning Objectives

After completing this lesson, you will be able to:

1. List and briefly describe types of medical expense policies available in today's markets.
2. Give an overview and description of group medical plans.
3. Name and describe some of the ancillary, voluntary products that an individual may choose if offered by their employer.
4. Understand the role that federal legislation plays in health care coverage.
5. Explain the purpose of the Federal Regulation known as COBRA, and describe the benefit periods available and the premium payment required.
6. Describe the Family Medical Leave Act (FMLA) requirements for employees and employers.
7. Identify major changes brought by health insurance reform and list the minimum essential benefits.
8. List and briefly describe the health care delivery systems used by health benefit providers.
Lesson 5 Topic A - Types of Health Insurance

Lesson 5 Topic A Types p1 (LHE)

Learning Objective: List and briefly describe types of medical expense policies available in today’s markets.

Early forms of health insurance coverage (1940’s) could be characterized as “basic,” in that benefits were specific and often limited.

**The Hospital Expense** benefit would only pay the daily room and board charge, general nursing care, and other routine services, often with little or no deductible. In addition there could be a limit on the number of days of coverage per confinement, such as 30 days.

**Surgical Expense** benefit, paying for surgical procedures, which were subject to a schedule of charges indicating the maximum payable for each.

Naturally, other ancillary charges associated with any illness often were not covered in these “basic” plans. The most obvious would be a simple visit to a doctor’s office. These coverage limitations and expenses over the maximums became the responsibility of the patient, or out-of-pocket expenses.

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Lesson 5 Topic A Types p2 (LHE)

Health Care Plans

**Learning Objective:** List and briefly describe types of medical expense policies available in today’s markets.

**Categories of Health Care Plans include:**

- Comprehensive Major Medical
- Short Term Medical Plans
- Specific or Critical Illness Policy

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Lesson 5 Topic A Types p3 (LHE)

**Comprehensive Major Medical**

**Learning Objective:** List and briefly describe types of medical expense policies available in today’s markets.
Major Medical type coverage, first developed in the 1950's, became necessary as insurers realized that basic plans were woefully inadequate for providing realistic coverage for any serious accident or prolonged illness.

Today most health insurance policies are comprehensive, meaning that they provide benefits for most medical expenses in one policy.

Although all policies contain certain exclusions, most Comprehensive Major Medical policies provide benefits for:

- inpatient care,
- surgical expenses,
- both inpatient and outpatient physician expenses, and
- prescription medications.

Short Term Medical Plans

Learning Objective: List and briefly describe types of medical expense policies available in today's markets.

Short term policies are written for specific periods, usually one to six months and can sometimes be renewed for one additional equal period of time. While most short term policies do not cover routine care or pre-existing conditions, they would cover emergency services, hospitalization, diagnostic tests and follow-up visit charges related to a specific illness or injury suffered during the policy period. With premiums that can be lower than $100 a month for qualifying insureds, short-term health insurance plans can be much less expensive than other medical plans, such as COBRA continuing coverage.

This becomes an attractive alternative for some people who lose their job based insurance. However, failure to elect and exhaust COBRA continuation coverage can cost the individual several consumer rights, such as coverage for pre-existing medical conditions and the opportunity to purchase a permanent individual health insurance policy at a later date. Others who might elect to purchase this coverage might be a graduate in a temporary situation between parental coverage and a new job.

Other limitations of short-term medical insurance:

- Might include a high deductible that applies per injury or per illness, which results in an insured paying most routine medical costs as out-of-pocket expenses.
- An obvious limitation is the end of the policy period, which may precede the end of the medical expenses for a certain condition or illness.
This policy is designed as a temporary solution that protects an insured from the expenses of a costly injury or illness. Again, it is up to the insured or insurance advisor to review the coverage to understand the nature of out-of-pocket expenses.

**Note:** This type of policy will likely disappear given the P.P.A.C.A.

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*Lesson 5 Topic A Types p4 (LHE)*

**Specific or Critical Illness Policy**

*Learning Objective:* List and briefly describe types of medical expense policies available in today’s markets.

Specific illness policies pay for the expenses associated with a specific illness listed on the policy. Unlike most medical insurance, critical illness insurance pays an upfront, lump-sum benefit when an insured receives a diagnosis of a critical illness or condition listed on the policy. Covered illnesses might be cancer, heart disease, stroke, Alzheimer’s, kidney failure, etc. Because this payment is not tied to doctor or hospital bills, insureds may use the coverage to get alternative or extraordinary treatment, pay travel expenses to that treatment location, even to take a vacation, which most traditional policies will not pay.

This coverage started overseas but its use has grown in the US in the last 10 years. Because it is a relatively new and unregulated coverage, insureds and advisors need to determine what types of critical illnesses are covered, and under what circumstances.

For instance, some policies exclude certain types of cancer, or cover only internal cancer, or a policy may not cover a wide range of critical illnesses, including Alzheimer’s disease, loss of limbs, sight or hearing, Parkinson’s disease, or third degree burns.

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*Please refer to Lesson 5 Topic A Types p5 (LHE) to complete the Knowledge Check at this time.*
Lesson 5 Topic B - Ancillary Health Products

Learning Objective: Name and describe some of the ancillary, voluntary products that an individual may choose if offered by their employer.

Travel Insurance

Travel insurance is typically sold to people traveling from the United States to foreign countries, and variations exist that cover citizens of other countries while visiting and traveling in the U.S.

- Designed to cover expenses resulting from accidents
- May provide limited benefits for illnesses
- May provide limited coverage for transferring an ill or injured insured back to their home country (repatriation expenses)

Accidental Death and Dismemberment Insurance

This coverage can be written as a separate policy or added as a rider to a life insurance policy.

AD&D is often provided as an additional benefit for a member of an association or perhaps a trade group. Employers include it as part of group life insurance or as a stand-alone elective benefit.

AD&D will provide a defined benefit for death due to an accident;

or

Partial benefit for loss of limbs, loss of sight, or permanent paralysis.

Dental Plans

Dental plans come with varying levels of benefits. They can be part of an employee group benefit package, or they can be written on a stand-alone policy. Typical plans include:
• Payment of 100% of basic service charges
• Deductible with internal dollar limitations on more complicated procedures
• Coverage without deductible for basic services (such as teeth cleaning) one visit every six months or once per year

Plans may require a coinsurance payment for major services such as root canals and crowns, and most plans have a calendar-year maximum benefit.

Vision Plans

Vision plans also come with varying levels of benefits:

• Basic plans - discounts on contacts, eyeglasses, and frames
• Better plans - coverage for eye examinations, and full coverage for eyeglasses and contact lenses

Please refer to Lesson 5 Topic B Ancillary Health p3 (LHE) to complete the Knowledge Check at this time.
Learning Objective: Understand the role that federal legislation plays in health care coverage.

Federal Regulations since the 1970's have impacted the health insurance sector of the U.S. economy.

As health care costs have risen, insurance companies have reduced or eliminated coverage for certain types of care. Over time, complaints from consumers caused the Federal Government to review the industry's practices and enact numerous laws.

In 2010, the Patient Protection and Affordable Care Act (PPACA) brought major reforms to the individual health insurance market and significant changes to group insurance plans. The impact of PPACA is still unfolding.

Federal Regulations continued

Learning Objective: Understand the role that federal legislation plays in health care coverage.


ERISA sets minimum standards to make sure employers establish and maintain employee benefit plans in a fair and financially sound manner.

COBRA - Consolidated Omnibus Budget Reconciliation Act (COBRA)

Covering groups of 20 or more employees, COBRA allows for the continuation of the employee and dependent health, dental and vision coverage after employment ends.

FMLA - Family Medical Leave Act of 1993

Allows an employee to take up to 12 weeks of unpaid leave for specific situations, such as the birth of a child.

NMHPA - Newborns' and Mothers' Health Protection Act of 1996

This act provides health coverage for a hospital stay following a normal delivery.

MHPA - Mental Health Parity Act of 1996
This act requires employers to provide coverage for the diagnosis and treatment of mental illness under the same terms and conditions applied to other medical conditions.

**HIPAA - Health Insurance Portability and Accountability Act of 1996**

HIPAA legislation was passed to protect workers and their families from losing coverage or limiting benefits, and primarily to make it easier for anyone to change jobs, even with a significant health condition.

**SCHIP - State Children’s Health Insurance Program of 1997**

The State Children's Health Insurance Program (SCHIP) established low-cost health insurance designed for families who earn too much money to qualify for Medicaid, yet cannot afford to buy regular private insurance for their children.

**WHCRA - Women's Health and Cancer Rights Act of 1998**

This act sets requirements of a group health plan that provides coverage for medical and surgical benefits for a mastectomy.

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**Lesson 5 Topic C Federal Regulations p3 (LHE)**


Learning Objective: Understand the role that federal legislation plays in health care coverage.

Employers have an obligation to provide the promised benefits and satisfy ERISA’s requirements for managing and administering employee benefit plans.

- The provisions of ERISA cover most private sector employee benefit plans if the group has 15 or more employees.
- ERISA covers employee benefit plans that are voluntarily established and maintained by an employer.
- Typically, ERISA does not apply to plans that are established or maintained by government organizations or churches for their employees.
- ERISA also does not apply to plans maintained solely to comply with workers compensation, unemployment, or disability laws.

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**Lesson 5 Topic C Federal Regulations p4 (LHE)**

**Consolidated Omnibus Budget Reconciliation Act (COBRA)**
Learning Objective: Explain the purpose of the Federal Regulation known as COBRA, and describe the benefit periods available and the premium payment required.

COBRA applies to health, dental and vision benefits; it does not apply to group life or disability income coverage. COBRA covers group plans of 20 or more enrollees.

An employee or covered dependent has at least 60 days from the date of a status change to advise if he wants to continue his health benefits. The discharged employee or covered dependent must pay the entire premium directly or through the employer and the employer may charge a fee of 2%.

Employees

Employees may elect an 18-month continuation of coverage if employment is terminated, or if a reduction of hours (to part-time status) causes a loss of coverage.

Dependents Separated from Coverage

Employee's dependents may elect a 36 month continuation of coverage if death, divorce or legal separation causes loss of coverage from the covered employee.

Social Security Disability Recipients

Employees may choose a 29-month continuation of coverage if Social Security disability applies to the employee.

Medicare Recipients

Coverage under COBRA automatically ends when the employee is eligible for Medicare.

Please refer to Lesson 5 Topic C Federal Regulations p5 (LHE) to complete the Knowledge Check at this time.

Lesson 5 Topic C Federal Regulations p6 (LHE)

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Learning Objective: Describe the purpose of HIPAA.

HIPAA legislation was passed to protect workers and their families from losing coverage or limiting benefits, and primarily to make it possible for anyone to change jobs, even with a significant health condition.
The new health insurance company must accept individuals with pre-existing conditions under certain rules:

- The new insurer may impose a pre-existing condition limitation if an individual receives medical care, treatment, consultation, or prescription drugs during the six-month period immediately preceding that individual’s new effective date of coverage. Pre-existing conditions treated earlier than the 6 month period could be covered.
- The waiting period for coverage that is imposed under a pre-existing condition limitation can be no longer than 12 months, and waiting periods for coverage cannot apply to pregnancy, newborn children, or newly adopted children.

However, HIPAA rules dictate that the preexisting condition limitation must be reduced by the amount of time the employee was covered on the previous plan. The law goes on to say that the employee cannot have any breaks in health coverage exceeding 63 days within the last year.

**In other words, if the employee had creditable coverage for 12 months prior to the new employer, the pre-existing condition is covered.**

Passage of the PPACA virtually overrides most consumer provisions of HIPAA, therefore making it possible to obtain health coverage regardless of the HIPAA law. We will discuss the PPACA later in this course.

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**Lesson 5 Topic C Federal Regulations p7 (LHE)**

**Family Medical Leave Act of 1993 (FMLA)**

**Learning Objective:** Describe the Family Medical Leave Act (FMLA) requirements for employees and employers.

FMLA generally applies to employers of 50+ employees and allows an employee to take up to 12 weeks of unpaid leave for certain reasons. The law also allows for intermittent leave and reduced work schedule.

The employee may take 12 weeks of unpaid leave for:

- the birth of a child,
- his or her own serious health condition,
- caring for an immediate family member with a serious health condition (child, spouse, parent), or
- the placement of a child with the employee for adoption or foster care.

**The FMLA requires employers to:**

- Allow eligible employees to take up to 12 weeks of unpaid leave for the above circumstances.
- Provide continued health benefits during leave.
- Restore employees to the same position upon return from leave (or to a position with the same pay, benefits, and terms and conditions of employment).
- Notify employees of their rights and responsibilities under the Act.

Spouses working for the same employer are limited to a total of 12 weeks combined unpaid leave. An exception to this is when one spouse is caring for the other spouse who has a serious health condition.

Please refer to Lesson 5 Topic C Federal Regulations p8-9 (LHE) to complete the Knowledge Checks at this time.

Lesson 5 Topic C Federal Regulations p10 (LHE)

Mental Health Parity Act of 1996 (MHPA)

Learning Objective: Understand the role that federal legislation plays in health care coverage.

This act requires employers to provide coverage for the diagnosis and treatment of mental illness under the same terms and conditions applied to other medical conditions. A plan must provide equal lifetime and annual maximums for medical and mental health benefits.

The Act was updated in 2008 and this type of coverage is further elaborated on in the PPACA.

Lesson 5 Topic C Federal Regulations p11 (LHE)

Newborns’ and Mothers’ Health Protection Act of 1996 (NMHPA)

Learning Objective: Understand the role that federal legislation plays in health care coverage.

This act provides health coverage for a hospital stay following a normal delivery. Coverage may not be limited to less than 48 hours for both the mother and newborn child. This limit is extended to 96 hours following a cesarean section birth.

This Act applies to both group health insurance and individual policies. A plan cannot offer incentives to the health providers to encourage the mother and baby to leave the hospital earlier than the minimum time stated, however the provider may decide, after consulting with the mother, to discharge earlier.
Lesson 5 Topic C Federal Regulations p12 (LHE)

**Woman’s Health and Cancer Rights Act of 1998 (WHCRA)**

**Learning Objective:** Understand the role that federal legislation plays in health care coverage.

This act states that a group health plan that provides coverage for medical and surgical benefits for a mastectomy shall provide for a participant who elects breast reconstruction coverage for:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and physical complications during all stages of the mastectomy

This coverage may be subject to annual deductibles and coinsurance provisions.

Lesson 5 Topic C Federal Regulations p13 (LHE)

**State Children’s Health Insurance Program 1997 (SCHIP)**

**Learning Objective:** Understand the role that federal legislation plays in health care coverage.

The State Children’s Health Insurance Program (SCHIP) established low-cost health insurance designed for families who earn too much money to qualify for Medicaid, yet cannot afford to buy regular private insurance for their children.

Run by state governments, SCHIP coverage provides eligible children, as well as pregnant mothers, and some other eligible adults with coverage for a full range of health services including regular checkups, immunizations, prescription drugs, lab tests, X-rays, hospital visits, and more.
Lesson 5 Topic D - Health Insurance Reform

**Learning Objective:** Identify major changes brought by health insurance reform and list the minimum essential benefits

Recent passage of the Patient Protection and Affordable Care Act (PPACA or simply ACA) has eliminated some provisions in health insurance that heretofore were in place.

**Key changes include:**

- Individuals, other than those exempted by law, are required to purchase health insurance coverage.
- Eligible dependents can be covered to age 26.
- Larger employers face penalties if they do not make affordable health plans with minimum essential benefits available to their employees; (implementation has been delayed until 2015, 2016 for employers with 50 -99 employees).
- Most health insurance plans must meet "Minimum Essential Coverage" and affordability requirements.
- Individual and group health insurance policies are guaranteed issue effective 1/1/2014
- Pre-existing medical conditions are no longer limited or excluded in individual or group plans.
- Insurance "exchanges" established by the states or federal government's Department Health and Human Services (HHS).
- Lifetime maximum benefits can no longer be capped.

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**PPACA Key Provisions**

**Learning Objective:** Identify major changes brought by health insurance reform and list the minimum essential benefits

New Minimum benefit and affordability requirements for both individual and group policies is a major change.

"Essential Health Benefit" means that the plan contains coverage for:

- a. Outpatient care
- b. Emergency care
- c. Hospital care
- d. Maternity and newborn care
- e. Mental health and substance abuse care
f. Rehabilitative care and devices  
g. Laboratory services  
h. Prevention and wellness programs/Chronic Disease management  
i. Prescription drugs  
j. Pediatric services including dental and vision care

Lesson 5 Topic D Health Insurance Reform p3 (LHE)

PPACA Key Provisions

Learning Objective: Identify major changes brought by health insurance reform and list the minimum essential benefits

In 2014 as a result of PPACA all individual and group plans became guaranteed issue, meaning that a policy must be issued to an applicant regardless of pre-existing condition or current health status. Previous to this, individual policies were medically underwritten and group plans were only subject to state guaranteed issue regulations.

Guaranteed Renewable

With a guaranteed renewable policy, the renewal is guaranteed and class, such as age group or occupational category, sets the rate. The insurance company cannot cancel the policy, but the premiums can be increased on a class basis.

Guaranteed Rates

With guaranteed rates, the policy premium cannot be increased for the time period specified in the policy. After this time period, the insurer can increase the rates.

An underwriter will be concerned whenever offering anything with the word ‘guaranteed’ in it. When offering ‘guaranteed rates’, the underwriter wants to make sure that all information regarding the group is accurate and that the company is not taking on unknown risk, as they are determining a premium that may be difficult to adjust in the future and they want to make sure that they are charging the appropriate rate for the risk.
Learning Objective: Identify major changes brought by health insurance reform and list the minimum essential benefits

"Grandfathered" Plans

Health plans that were in existence on or after March 23, 2010 are exempt from PPACA if they do not make significant changes to benefits or affordability.

Some of the consumer protections included in the PPACA apply to grandfathered plans and some do not. The impact of the PPACA on these older plans is still in process.

Lesson 5 Topic D Health Insurance Reform p5 (LHE)

PPACA Key Provisions

Learning Objective: Identify major changes brought by health insurance reform and list the minimum essential benefits

Uniform Summary of Benefits Coverage

All health insurance providers must provide all consumers with a Summary of Benefits Coverage (SBC) at time of application, enrollment and annual re-enrollment. This document is a summary of benefits intended to provide the insured with improved easier to understand information about their health insurance plan.

Waiting periods for new employees.

The PPACA prohibits waiting period of more than 90 days for new employee enrollment in a group health plan

Medical Loss Ratio (MLR) Rebates

Insurers must spend premium dollars on medical care and quality improvement to a fixed percentage; 80% in the individual and small group markets and 85% in the large group market. If they do not, rebates are to be provided to enrollees. (MLR was actually effective 1-1-2011)

Flexible Spending Accounts

Limited to $2500 per year; a small carryover amount may be allowed; changes to reimbursable expenses for FSA accounts; more about FSAs later in this section.

New Employer Notice Requirements:

Employer are required to provide employees with written notice of the existence of health insurance exchanges (The Marketplace) and of their potential eligibility for federal assistance in premium subsidy.
Lesson 5 Topic E: Group Medical Plans

Learning Objective: Give an overview and description of group medical plans.

Employer - Employees

The most common group is employer – employees.

Each individual participant in a group insurance policy receives a certificate, setting forth the basic contract provisions of the group coverage. The master policy is available upon request.

Employer > Broker, CSR, Agent, Producer > Group Plan > Subscribers, Participants

Multiple Employer and Group Purchasing Arrangements

Other examples are labor unions, multiple-employer groups and association groups. In a multiple-employer group, or group-purchasing arrangement, two or more small employers purchase health insurance collectively, often through a common intermediary who acts on their collective behalf.

Such arrangements may go by different names, including:

- cooperatives,
- alliances
- or business groups on health.

Major Characteristics of Group Insurance

Learning Objective: Give an overview and description of group medical plans.

These groups differ from one another along a number of dimensions, including governance, functions and status under federal and state laws.
Some are set up or chartered by states, while others are entirely private enterprises.

Some centralize more of the purchasing functions, such as risk pooling, price negotiation, choice of health plans offered to employees, and various administrative tasks.

Depending on their functions, these groups may be subject to different state and/or federal rules.

At the highest level, group insurance arrangements need two factors in order to work correctly:

- flow of lives (younger participants consistently entering the group while older participants are leaving the group) and
- minimum participation requirements.

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Lesson 5 Topic E Group Medical Plans p4 (LHE)

Major Characteristics of Group Insurance continued

Learning Objective: Give an overview and description of group medical plans.

Example:

Imagine that employers wanting to participate in the XYZ Health Plan must meet the following minimum participation requirements:

- Employers must have at least 75% of its workers enrolled in the XYZ (excepts "eligible opt-outs")
- Employers who have adopted the XYZ Health Plan cannot offer another health plan alongside the XYZ Health Plan (no "dual choices")

Eligible "Opt-outs" are workers who are not enrolled in the XYZ Health Plan because they already have health coverage. Eligible Opt-outs include:

- A spouse’s group health plan
- A parent’s group health plan
- A former employer’s group health plan
- A military as a retiree
- A medicare supplement plan
- A government medical assistance program for low-income persons
- A foreign country plan
- Eligible employees must work no less than 20 hours per week or 1000 hours per year

Please refer to Lesson 5 Topic E Group Medical Plans p5 (LHE) to complete the Knowledge Check at this time.
Lesson 5 Topic F - Delivery Systems

Learning Objective: List and briefly describe the health care delivery systems used by health benefit providers.

There are two types of delivery systems for health insurance: Indemnity Plans and Managed Care Plans.

Indemnity plans are traditional or fee-for-service medical plans “indemnified”, defined as “to pay on behalf of” the insured, for covered medical expenses. The insured is allowed the choice of seeking treatment from any licensed medical professional and typically shares a pre-determined percentage of the cost of covered health services, such as 20%.

The health insurance industry did little to “manage” the type or amount of medical care provided, and research indicated that many medical practitioners were prescribing medical procedures and tests that were neither required nor necessary for a patient’s condition. This drives up overall health care costs.

Additional Terms and Concepts

Indemnity - Reimbursement. An undertaking whereby one agrees to indemnify another upon the occurrence of an anticipated loss. (Black Law Dictionary, Six Edition)

Fee For Service (FFS) Plan - Health coverage in which doctors and other providers receive a fee for each service such as an office visit, test, procedure, or other health care service. The plan will either pay the medical provider directly or reimburse the insured for covered services after the bill has been paid and a claim has been filed.

Capitation Basis - A health insurance premium payment method that pays a fixed amount per person.

About Terms: Other important terms will be defined on the topic pages. If you find any terms or concepts that need more explanation, go through the topic once more, and check the glossary. If you still need explanation contact the course mentor.
The Rise of Managed Care Plans

Learning Objective: List and briefly describe the health care delivery systems used by health benefit providers.

As medical care costs have increased, health care plans are shifting to self-funded plans, employees taking on more cost, and increased usage of managed care plans like preferred provider organizations (PPOs).

The industry developed this “managed care” approach as a means of controlling escalating medical costs while providing quality care, determining the necessary types of treatment, and monitoring treatment outcomes.

This approach creates a partnership with medical providers, which requires them to share some of the costs of medical treatment effectiveness. Managed care plans can also provide an opportunity for health care providers to emphasize the prevention of illness in addition to treating disease.

Lesson 5 Topic F Delivery Systems p4 (LHE)

Managed Care continued

Learning Objective: List and briefly describe the health care delivery systems used by health benefit providers.

Managed care companies hire physicians and nurses to collaborate with the insured’s physician and other medical providers in determining the appropriate medical treatment. The intended outcome is to provide the appropriate level of care while eliminating unnecessary care and expenses and controlling health insurance premiums.

The insurer may also have the option of using a professional review organization, which is a group of doctors that reviews services to determine if they are medically necessary.

We’ll look at the following types of managed care models:

- Health Maintenance Organization (HMO)
- Preferred Provider Organization (PPO)
- Exclusive Provider Organization (EPO)
- Physician-Hospital Organization (PHO)
- Point-of-Service Plans (POS)

Lesson 5 Topic F Delivery Systems p5 (LHE)
HMO Types

Learning Objective: List and briefly describe the health care delivery systems used by health benefit providers.

Health Maintenance Organizations

Health maintenance organizations, where insureds must choose a primary-care physician when they become insured, and see that physician prior to seeking any other treatment, were the first approach to managed care.

Created in the 1960s, HMOs were originally developed to provide comprehensive care to members of a specific organization or employees (and their dependents) of a specific large employer. The passage of the Federal Health Maintenance Act of 1973 opened HMOs to all employer groups, with the theory that managed care controls would alleviate rapidly increasing health care costs.

Staff-Model HMO (Closed-panel)
Group-Model HMO (Closed-panel)
Mixed-Model HMO
Network-Model HMO (Open-Panel)
Independent Practice Association (Open-Panel)

Staff Model HMO - Closed Panel

This model is the most restrictive type of HMO. Closed-panel means that subscribers can only see providers employed by the HMO or a contracted entity, and have very little choice of a physician.

- HMO usually owns its own treatment facilities
- HMO usually employs its own physicians and other medical professionals
- HMO employees have a stake in the profitability of the HMO

Group Model HMO - Closed Panel

In this model, the physicians and other medical providers are employees of another legal entity and contract with the HMO to supply medical services.

- HMO may contract one or several medical provider entities
- HMO may pay on a "capitation" basis, meaning they pay the same price per subscriber annually without respect to whether or not the subscribe uses the medical services

Network Model HMO - Open Panel

In the Network-Model, the HMO contracts with an independent group or groups of medical providers

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HMO contracts with an independent group or groups of medical providers to provide services to subscribers (the “HMO Network”)

- More physician choices, but subscriber still must see his or her primary care physician before seeing a specialist
- HMO often pays physicians on a uniform fee per person basis for HMO subscribers, and a fee-for-service basis for non HMO subscribers

Independent Practice Association - Open Panel

In Independent Practice Associations (IPA), independent physicians or small groups of physicians contract with the HMO to provide medical services to their subscribers

- The IPA acts as an intermediary between the HMO and contracted medical providers
- As with the Network-Model, the IPA physicians also treat non-HMO patients, for which they are paid on a fee-for-service basis

Mixed Model HMO

Mixed-Model HMOs have grown and become more mainstream in the healthcare industry, as Closed-Panel HMO’s wish expand into other geographic areas, or into other employer groups in an Open-Model approach.

This means that some subscribers to an HMO would receive services under the more restrictive Closed Panel model and others would receive services under an Open Panel Model.

Lesson 5 Topic F Delivery Systems p6 (LHE)

Learning Objective: List and briefly describe the health care delivery systems used by health benefit providers.

More Delivery Systems

Preferred Provider Organization (PPO)

As the name implies, a Preferred Provider Organization (PPO) has a network of contracted providers that are "preferred," and the insured will typically receive better benefits if treated by a "preferred provider." However, subscribers do not have to choose a primary-care physician, and can be treated by a provider who is not contracted by the PPO and still receive benefits, although the insured will usually pay a greater proportion of the cost of treatment than if they are treated by a contracted provider.

PPOs have become popular since the 1980’s due to greater provider choices than would be found with HMOs, and because the less flexible HMOs do not have significantly lower premiums than PPOs today.
Exclusive Provider Organization (EPO)

An Exclusive Provider Organization (EPO) is a network of individual medical care providers who have entered into written agreements with an insurer to provide health care services to subscribers. In an EPO, the medical care provider enters a mutually beneficial relationship with an insurer.

The insurer reimburses an insured subscriber only if the medical expenses come from the designated network of medical care providers. The established network of medical care providers in turn will provide subscribed patients medical services at significantly lower rates. In exchange for reduced rates of medical services, medical care providers get a steady stream of business.

As a member of an EPO, an insured must use the doctors and hospitals within the EPO network, and cannot go outside the network for care. If the insured goes to a hospital or doctor outside of the network for an emergency; the insured will pay medical bills partially or completely out of pocket.

Physician-Hospital Organization (PHO)

Physicians and hospitals may form alliances to help providers attain market share, improve bargaining power, and reduce administrative costs. These entities sell their services to managed care organizations or directly to employers.

Point-of-Service Plans (POS)

A Point-of-Service plan is a hybrid of an HMO and a PPO. Insureds may choose medical providers at the time medical care is needed, and typically have the choice of a more restrictive HMO network of providers, or a broader PPO network of providers. POS plans can require a "gatekeeper," a primary care physician like an HMO, or they can function like a PPO, allowing participants to choose any provider within the network.

Please refer to Lesson 5 Topic F Delivery Systems p7 (LHE) to complete the Knowledge Check at this time.
Lesson 5 Topic G - Self-Insured Health Plans

Learning Objective: List the four benefits an employer might realize if they choose to insure on a self-funded basis.

Some employers choose to self-insure employee health benefits. They establish funding for the plan based on a premium equivalent, or the cost per covered employee for the costs of claims paid, administration, and stop-loss premiums.

The employer gains several benefits from self-insuring:

- Avoidance of state-mandated benefits requirements and state premium taxes.
- Potentially reduced cost of plan administration.
- Plan costs based on the group’s own claims experience, not the experience of other groups.
- Potential investment earnings from claim reserves, which may be used to pay plan expenses.

Lesson 5 Topic G Self-Insured Health p2 (LHE)

Additional Terms and Concepts

**Third Party Administrator (TPA)** - An individual or firm hired by an employer to handle claims processing, pay providers, and manage other functions related to the operation of health insurance. The TPA is not the policy holder or the insurer.

**Stop Loss Coverage** - A form of reinsurance for self-insured employers that limits the amount the employers will have to pay for each person’s health care (individual limit) or for the total expenses of the employer (group limit).

About Terms: Other important terms will be defined on the topic pages. If you find any terms or concepts that need more explanation, go through the topic once more, and check the glossary. If you still need explanation, contact the course mentor.

Lesson 5 Topic G Self-Insured Health p3 (LHE)

Entities Involved with Self Insurance Plans

Learning Objective: List the four benefits an employer might realize if they choose to insure on a self-funded basis.
Self-insured companies may contract with insurers or third-party plan administrators to design the plan and handle the day-to-day management of the plan including:

- claims payment
- prescription drug cards
- establishing provider networks, and
- ensuring compliance with the Employee Retirement Income Security Act (ERISA) fiduciary obligations.

Self-insured companies may also purchase “stop loss” coverage through an insurer to pay for the costs of an extraordinary illness for an individual group member, or for a particularly bad year for the group.

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Lesson 5 Topic G Self-Insured Health p4 (LHE)

Types of Self Insurance Plans

Learning Objective: List the four benefits an employer might realize if they choose to insure on a self-funded basis.

In a Minimum Premium Plan, the premium paid to the insurer is small because the self-insured employer, which is the group policyholder, pays all of the claims, or most of the claims up to an agreed level. The insurance company fully administers the plan and would pay only claims above an agreed amount.

Along with Minimum Premium Plans, the other types of plans (Conventional Indemnity, PPO, EPO, HMO, POS, and PHOs) can be financed on a self-insured basis.

Considering that the government regulates the way employers deliver insured plans, but not self-insured plans, some employers choose to offer a combination of self-insured and fully insured plans to employees.

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Please refer to Lesson 5 Topic G Self-Insured Health p6 (LHE) to complete the Knowledge Check at this time.

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Please refer to the end of Lesson 5 Topic G to complete Self Quiz 5 at this time.
Lesson 6 - Common Policy Characteristics

Lesson 6 Introduction p1 (LHE)

Cost containment features are increasingly important in medical expense policies and health care delivery. However, insurers must design their products to contain costs while still meeting federal requirements and satisfying the needs of their customers.

- Payment Provisions
- Eligibility
- Cost Containment Features
- Exclusions
- Limits

Lesson 6 Introduction p2 (LHE)

Lesson 6 Learning Objectives

After completing this lesson, you will be able to:

1. Name the provisions that affect a benefit payment to an insured and that determine the dollar amount paid by the insurance provider versus the amount paid by the insurer.
2. Determine the amounts payable by the benefit provider and the insured given the specifics of a sample medical claim.
3. Understand eligibility requirements such as waiting periods, and minimum participation and contribution.
4. Know that managing eligibility requirements for health insurance can also mean excluding a class of insureds.
5. List and describe cost containment features being used to control rising health care costs.
6. List some of the typical exclusions that would be found in most medical expense insurance policies.
7. Recognize and briefly describe typical internal limits in a health insurance policy.
Lesson 6 Topic A - Payment Provisions

**Learning Objective:** Name the provisions that affect a benefit payment to an insured and that determine the dollar amount paid by the insurance provider versus the amount paid by the insurer.

In order to control plan utilization and costs, medical insurance plans typically require the insured to pay some portion of medical expenses, a practice sometimes known as cost sharing. The expenses the insured pays are usually the first expenses incurred, and the amount the insured must pay usually stops at some predetermined limit or amount.

Payment provisions include:

- Deductibles
- Copayments
- Coinsurance
- Out-of-Pocket Maximum or Stop-Loss Provision

**Payment Provisions continued**

**Learning Objective:** Determine the amounts payable by the benefit provider and the insured given the specifics of a sample medical claim.

**Deductibles**

Medical plans typically require that the insured pay the initial amount of medical expenses before the plan pays any benefits. If a plan has a $500 deductible, the insured must pay the first $500 of covered expenses.

While there are several different ways that deductibles are defined based in the company's policy design, two of the most common are calendar year (Jan 1 to Dec 31) and plan year (such as May 1 to April 30).

The amount the insured pays toward satisfaction of the deductible is cumulative throughout the year, meaning that the insured would only be required to satisfy the deductible once each year, whether the insured incurs expenses from one claim or from multiple claims throughout the year.

Most medical plans require that a new deductible be satisfied each new calendar or plan year, although some plans include a deductible carry-over for any expenses incurred during the last quarter of the previous year. This last feature clearly benefits insureds.
Copayments are an amount of money the insured must pay directly to the physician or facility at the time of each visit. Copayments could be as little as $20 or as much as $50, and are intended to limit usage and minimize "frivolous" visits and expenses.

Coinsurance

The coinsurance found in medical plans differs from the coinsurance in property and casualty in that the insured always pays a proportionate amount of specified expenses. After satisfying the calendar or plan year deductible, the insured will still pay a specified percentage of covered expenses until a predetermined limit is met. If the coinsurance provision is "80/20," the insurance carrier will pay 80 percent of covered expenses, and the insured will pay 20 percent.

Example: A PPO may have an "80/20 coinsurance provision" for in-network expenses, and a "60/40 coinsurance provision" for out-of-network expenses.

PPO plans typically require that the insured pay a greater proportion of expenses "out-of-network" providers than for "in-network" providers. This is designed to encourage insureds to use contracted, "preferred," providers, rather than non-contracted providers.

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**Lesson 6 Topic A Payment Provisions p3 (LHE)**

Payment Provisions continued

**Learning Objective:** Determine the amounts payable by the benefit provider and the insured given the specifics of a sample medical claim.

Out-of-Pocket Maximum or Stop Loss Provision

The Out-of-Pocket Maximum, or Stop-Loss Provision, defines the maximum dollar amount the insured must pay in "out-of-pocket" expenses during a specified period of time, usually the calendar year. With a true Stop-Loss Provision, the insured would pay the deductible and the coinsurance limit; then the medical plan would begin to pay 100 percent for all covered expenses.

80/20 plan with $500 deductible

| covered expenses | $5,500 | Insured pays | $1,500 | Insurer pays | $3,540 | 100% further expenses |
For example, if a plan has a $500 deductible and a coinsurance provision of 80 percent of the next $5,000 of covered expenses, the insured would pay the $500 deductible and then 20 percent of the next $5,000 (which is $1,000). Then the plan would pay 100 percent of any further covered losses.

Keep in mind that amounts in excess of the plan's scheduled allowances and other non-covered expenses do not count toward the out-of-pocket maximum. Some policies may also require the insured to pay the out-of-pocket maximum for each year, even on a continuing illness, and they may have more than one out-of-pocket maximum limit for different types of claims. Many policies also define a family out-of-pocket maximum.

The amount the insured pays toward satisfaction of the deductible is cumulative throughout the calendar or plan year, meaning that the insured would only be required to satisfy the deductible once each year, whether the insured incurs expenses from one claim or from multiple claims throughout the year.

Please refer to Lesson 6 Topic A Payment Provisions p4-5 (LHE) to complete the Knowledge Check at this time.
Lesson 6 Topic B - Policy Provisions

Learning Objective: Understand eligibility requirements such as waiting periods, and minimum participation and contribution.

Medical insurance Policy Provisions include certain limitations and exclusions to clarify policy language and to limit coverage for specified expenses. In this topic we will discuss:

- Contribution and participation requirements
- Usual, reasonable, and customary charges
- Cost containment features
- Typical Exclusions
- Typical Limitations

Lesson 6 Topic B Eligibility p2 (LHE)

Additional Terms and Concepts

Adverse selection - A situation of concern for a health insurance company in which people with poor health are more apt to apply for or continue insurance than those with average or better-than-average health.

Transfer treatment - A requirement from the Health Insurance Portability and Accountability Act that allows that when groups change insurance carriers, coverage will continue under the new policy for anyone already receiving payments under an old policy for treatment of an illness or injury.

Waiting periods - In health insurance coverage the waiting period typically refers to an amount of time that must pass before a new employee is eligible for health insurance benefits. The PPACA now limits to a maximum waiting period of 90 days.

About Terms: Other important terms will be defined on the topic pages. If you find any terms or concepts that need more explanation, go through the topic once more, and check the glossary. If you still need explanation, contact the course mentor.

Lesson 6 Topic B Eligibility p3 (LHE)

Contribution and Participation Requirements
Learning Objective: Understand eligibility requirements such as waiting periods, and minimum participation and contribution.

Employer Contributions

Group medical plans typically require that the employer pay a specified portion of the employee's premiums (employer contribution).

- Many insurers require a minimum contribution on the part of the employer of 50% of employee premiums, leaving 50% employee premium and 100% dependent premiums payable by the employee.
- In competitive employment markets, employers will often pay more.

Employee Participation

State and federal regulations help determine who within the employee group may or may not be eligible for coverage.

- A minimum participation requirement that 75 percent of the “eligible” employees must be covered by an employer-sponsored health insurance plan is common.
- Adverse selection impacts the participation rules. If an employer opted to only cover selected individuals, the insurer might have to assume risk for only those employees with known health problems.
- State and federal regulations, along with insurer requirements, determine minimum participation and other eligibility rules.

By requiring a minimum participation of “eligible” employees, the carrier is more likely to insure employees who are currently healthy, as well as employees who have known health conditions. This is also known as “spreading the risk” among both healthy and unhealthy employees.

“Eligible” employees are those employees who are eligible for coverage under the employer’s plan, as well as those who do not have other health insurance coverage.
Waiting Periods

An employee would usually not be eligible until a “waiting period” for new employees had been completed, is working a minimum numbers of hours per week (usually 25 or 30), and is not a member of an excluded group of employees. (PPACA now mandates a max of 90 days)

Lesson 6 Topic B Eligibility p5 (LHE)

Contribution and Participation requirements continued

Learning Objective: Know that managing eligibility requirements for health insurance can also mean excluding a class of insureds.

Although many state and federal regulations may preclude the employer from excluding specific classes or categories of employees, this strategy is not considered discriminatory by federal discrimination law.

Excluding from eligibility a class or category of employees who typically do not participate in the health plan due to premium cost or high attrition often can be a legitimate means of meeting a carrier’s participation requirement (e.g., seasonal workers, union vs. non-union).

An employer may have a 75% of all eligible employees participation requirement. However, they are a 'seasonal business' running a Ski Lodge. Since most of the employees only work from Nov. through March (4 months), they can be excused from the 75% requirement as stated in the definition section (noted previously) because they fail to meet the 1,000 hours per year requirement.

This understanding helps the employer provide coverage for those employees who consistently help their business grow, and also allows the insurance company to get a consistent feel for the risk.
Lesson 6 Topic C - Usual, Reasonable, and Customary Charges

Learning Objective: List and describe cost containment features being used to control rising health care costs.

Continually increasing medical costs have created many cost control methods, one of which is the practice of insurance carriers only paying the price for covered medical expenses that are considered “usual, reasonable and customary” (URC).

This practice uses survey information that identifies charges by geographic area, specific medical service Current Procedural Terminology (CPT) code, and medical cost trends.

Many carriers apply an “80th percentile” factor in determining the level of cost they consider to be URC, meaning they will use the level 80 percent of the providers in the surveyed area are currently charging for specific medical services.

A carrier may override this limitation if extenuating circumstances warrant an exception.

Lesson 6 Topic C Cost Containment p2 (LHE)

Cost Containment Features

Learning Objective: List and describe cost containment features being used to control rising health care costs.

- Pre-admission Certification
- Pre-admission Review
- Case Management
- Pre-admission Testing
- Second Surgical Opinion
- Non-Emergency Weekend Admission Restriction

Lesson 6 Topic C Cost Containment p3 (LHE)

Pre-Admission Certification and Pre-Admission Testing
The basic intent of cost containment is to provide appropriate and adequate medical care consistent with an individual’s health care needs, while avoiding unnecessary medical services and related expenses. Often perceived by insureds as unnecessarily restrictive, cost containment has helped to reduce the exponential increase in healthcare costs.

**Pre-Admission Certification**

Most insurers require health care provider authorization, or pre-admission certification, for hospital admission prior to a group member's hospitalization.

**Intended Cost Outcome**

Avoid unnecessary procedures and expenses; failure to obtain this for non-emergency treatment can reduce or eliminate the provider's obligation to pay for services rendered.

**Pre-Admission Testing**

Insurers require pre-admission testing, which is designed to encourage patients to obtain necessary diagnostic services on an outpatient basis prior to non-emergency hospital admission.

**Intended Cost Outcome**

Lower costs by reducing the length of a hospital stay

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**Lesson 6 Topic C Cost Containment p4 (LHE)**

**Learning Objective:** List and describe cost containment features being used to control rising health care costs.

**Pre-Admission Review**

Pre-admission review (PAR) requires an insured to notify the insurance carrier prior to an elective inpatient hospital admission, and generally within 48 hours after an emergency admission.

Failure to obtain the preadmission review, or failure to comply with a hospital discharge decision, will usually result in the insured paying a larger portion of the hospital and related expenses.

**Example:**
Instead of paying 20 percent of the expenses after a deductible, the insured may be required to pay 30 percent, with a higher out-of-pocket limit.

**Intended Cost Outcome**

Reduce the length of inpatient admission. By reviewing the necessity of an inpatient admission with the insured's physician, the PAR medical personnel collaboratively determine whether other treatment options exist, and if not, the appropriate length of inpatient care.

If the insurer approves an extended inpatient stay, continuous monitoring by PAR personnel assures that the insured will be released when inpatient care is no longer required.

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**Lesson 6 Topic C Cost Containment p5 (LHE)**

**Learning Objective:** List and describe cost containment features being used to control rising health care costs.

**Second Surgical Opinion**

Many plans require, or at least encourage, an insured to obtain a second opinion if their physician recommends surgery in order to confirm that the surgery is appropriate.

Most plans will pay 100 percent, for the second opinion and will even pay for a third opinion if the first two opinions are contradictory.

**Intended Cost Outcome**

Reduce unnecessary procedures. The insured usually is not required to abide by the surgical necessity determination, but the carrier may restrict benefits if the insured elects to have a surgery the insurer deems not appropriate or necessary.

**Non-Emergency Weekend Admission Restriction**

Many insurers impose limits on reimbursement to patients for non-emergency weekend hospital admissions.

**Intended Cost Outcome**

Avoid the extra expenses of emergency room treatment for routine procedures.
Learning Objective: List and describe cost containment features being used to control rising health care costs.

Case Management

When unusually high expenses are projected for a condition, a "Case Management" team will carefully review and monitor the entire treatment process. Treatment expenses for catastrophic illnesses, AIDS, cancer, transplants, and severe trauma can easily reach hundreds of thousands of dollars, and are difficult to monitor as to the appropriate long-term treatment and outcome.

By working with the medical personnel who are treating the patient, comprehensive case management teams can have a positive effect on cost containment, while facilitating the appropriate treatment for the individual.

Intended Cost Outcome

Control expenses for high-cost ongoing illnesses. The team may consider alternative treatment methods, even those that would not normally be approved for other conditions. "Out of the box" thinking may be required to ultimately keep the cost of appropriate care at reasonable levels.

Please refer to Lesson 6 Topic C Cost Containment p7 (LHE) to complete the Knowledge Check at this time.
Lesson 6 Topic D - Typical Exclusions

Learning Objective: List some of the typical exclusions that would be found in most medical expense insurance policies.

Although the list of exclusions may vary from one policy to another, health insurance policies contain exclusions that limit or eliminate the insurance carrier’s exposure to certain types of losses. Exclusions allow the carrier to avoid paying for losses that are catastrophic in nature, beyond the scope of the specific policy, or are uninsurable by the very nature of the loss.

Three Reasons for Medical Insurance Policy Exclusions are:

- Catastrophic Loss
- Beyond the scope of a specific policy
- Uninsurable risk

Occupational injury or Disease

These are excluded to the extent that benefits are provided by workers' compensation laws or similar benefits.

Services furnished by or on behalf of government agencies

These are excluded unless there is a requirement for the patient or the patient's medical expense plan to pay.

Care provided w/no charge

Care provided by family members or when no charge would be made for the care received in the absence of the insurance contract.

Cosmetic Surgery
These procedures are excluded except as required by the Women's Health and Cancer Rights Act, and unless such surgery is to correct a condition resulting from either an accidental injury or a birth defect (if the parent had dependent coverage when the child was born)

**Physical Examinations**

Excluded unless such examinations are necessary for the treatment of an injury or illness. (However, plans are increasingly providing preventive care that involves specific types of physical examinations.)

**Experimental Medicine**

For example; let’s suppose that you hear of a treatment plan with very good results being used in Switzerland. However, this level of care hasn't been approved in the United States. To go to Switzerland and take advantage of their treatment would be excluded under most all policies as 'experimental'.

**Medicare/Medicaid**

Expenses paid by or eligible for payment under Medicare or other federal, state, or local medical expense programs.

**Eye refraction**

Eye refraction, or the purchase and fitting of eyeglasses or hearing aids. Eye refraction or the purchase and fitting of eyeglasses are not included in major medical coverage. This benefit can be provided under a separate plan.

**Dental Care**

Dental care, except for (1) treatment required because of injury to natural teeth, and (2) hospital and surgical charges associated with hospital confinement for dental surgery. (This exclusion is usually not included if dental coverage is provided under the major medical contract.)

Note: There is an exception to this exclusion, under the PPACA, Pediatric Dental is a required coverage.

**Convalescent, custodial, or rest care**

Convalescent care can be any type of care that supports you or a loved one during times of recovery from a weakened state. This care helps people during the healing process.

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Please refer to Lesson 6 Topic D Exclusions p3 (LHE) to complete the Knowledge Check at this time.
Lesson 6 Topic E - Typical Limitations

*Learning Objective:* Recognize and briefly describe typical limits internal to a health insurance policy.

Health insurance plans also contain certain limitations that impose internal limits or “caps” on specific types of medical care. With a cap in place, the medical expense is covered, but will have a maximum benefit limit, after which there is no further coverage under the plan. Limitations *may* apply to the following types of medical expenses:

- Excess of Reasonable and Customary Charges
- Hospital Room and Board
- Extended care facilities, home health care benefits, and hospice care
- Dental care, vision and hearing care, and physical examinations
- Infertility treatment

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*Internal Limits*

**Learning Objective:** Recognize and briefly describe typical limits internal to a health insurance policy.

**Excess of Reasonable and Customary Charges**

In the absence of provider contracts specifically defining the allowable charges, a health insurance policy will not pay for expenses that exceed the reasonable and customary amount.

**Hospital Room and Board:**

Room and board charges are usually limited to the semi-private room charges or equivalent, unless other types of accommodations are medically necessary;

**Extended care facilities, home health care benefits, and hospice care:**

These benefits are typically limited to a dollar maximum or a maximum number of visits per calendar year or for the life of the policy;

**Dental care, vision and hearing care, and physical examinations:**

When coverage is provided for these types of expenses, the policy typically limits them to a dollar maximum per calendar year;
Infertility Treatment:

Benefits are typically limited to a dollar maximum, unless required by law to be covered as any other illness.

Please refer to the end of Lesson 6 Topic E to complete Self Quiz 6 at this time.
Lesson 7 - Consumer Driven Plans

Lesson 7 Introduction p1 (LHE)

We discussed previously how the history of health insurance in the United States has been a story of steadily climbing costs, and a story of how insurers and other stakeholders have responded to those rising costs.

In this section we'll cover the concept of a consumer driven plan. This term usually refers to health insurance reimbursement accounts designed to work with high deductible health plans.

Note: The high deductible health plans that underlay these types of reimbursement accounts are subject to PPACA.

Lesson 7 Introduction p2 (LHE)

Lesson 7 Learning Objectives

After completing this lesson, you will be able to:

1. List three types of consumer driven health plans.
2. Describe the benefits of Health Savings Accounts
3. List the four requirements an individual must meet to be eligible for a Health Savings Account (HSA).
4. Describe the rules regarding contributions into an HSA.
5. Describe Health Reimbursement Accounts (HRA)
6. Describe Flexible Spending Accounts (FSA).
7. Compare the differences of Health Reimbursement Accounts (HRA) and Flexible Spending Accounts (FSA).
8. List the four major benefits an employer might realize if they choose to insure on a self-funded basis.
Lesson 7 Topic A - Consumer-Driven Health Plans

Lesson 7 Topic A Consumer-Driven Health p1 (LHE)

Consumer-driven health plans originated in the late 1990s to encourage healthcare consumers (insureds and dependents) to shop more carefully for healthcare services.

In return for allowing insureds to establish a health-care financial reserve on a tax-favored basis, the federal government expected health care consumers to negotiate lower healthcare costs, placing pressure on the medical profession to keep costs low.

However, since consumers were inexperienced in negotiating healthcare costs, and did not fully understand the economics of the healthcare system, the results of this strategy had been disappointing. Current events and increased consumer involvement in health care related issues may be changing the situation.

We will study three types of consumer driven health plans:

- Health Savings Accounts (HSA)
- Health Reimbursement Accounts (HRA)
- Flexible Spending Accounts (FSA)

Lesson 7 Topic A Consumer-Driven Health p2 (LHE)

Additional Terms and Concepts

**Qualified medical expenses** - A type of expense that may be reimbursed by a health savings account, flexible spending account or health reimbursement account.

**Tax deferred growth** - Growth in the value of a plan, such as a Health Savings Account is not taxed each year.

**Tax exempt distributions** - A withdrawal from an account that the insured 'never' has to pay tax on, because it meets the criteria determined by the Federal Government as an 'eligible' expense.

**About Terms:** Other important terms will be defined on the topic pages. If you find any terms or concepts that need more explanation, go through the topic once more, and check the glossary. If you still need explanation contact the course mentor.

Lesson 7 Topic A Consumer-Driven Health p3 (LHE)
What is a High Deductible Health Plan (HDHP)?

Regardless of the early poor results, the concept of requiring the healthcare consumer to accept some of the risk of increasing medical costs was established and may yet prove to be successful. For Health Savings Accounts the insured must be covered by a High Deductible Health Plan.

A High Deductible Health Plan is a health plan that meets certain requirements. As an example, for the calendar year 2014 the HDHP must have a deductible of at least $1,250 per single person and $2,500 per family.

Maximum out of pocket expense for a single person is $6,350 and $12,700 for a family. The Federal Government indexes these numbers each year. (http://www.irs.gov)

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Lesson 7 Topic A Consumer-Driven Health p4 (LHE)

Health Savings Accounts (HSA)

Learning Objective: Describe the benefits of Health Savings Accounts

Tax-favored monetary contributions are made by or on behalf of eligible individuals (by employee or employer) to an account, and the contributed amounts and interest income can be distributed tax-free for eligible medical expenses. 2014 Max Annual Contribution - HSA

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<td>55+ can deposit additional $1,000/yr</td>
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Oh, man, that means that I am going to have to pay way more than I’m currently paying for my health insurance!

Lester works for a publishing company and this year his employer has announced that the firm is moving to a High Deductible Health plan with the option of contributing to a Health Savings Account.

Hmm, OK I’m listening, but I’m still worried about paying more out of my pocket. I like the idea.
At first the high deductible on the plan is alarming, but once he learns more, he’s interested. For instance, the premium on the HDHP is much lower than his old plan. He decides to open the HSA when his employer informs him that the company will match his contributions up to a certain point.

Large Deductible, but

- Lower Premiums
- No coinsurance
- Plenty of Qualified Expenses
- Ample maximum contributions
- Tax Exempt Savings

And the money that I put in each year that is unused continues to grow in interest and is available next year. I like the sound of that!

He decides to put a certain amount into his HSA each month. Contributions to his HSA decrease his annual tax liability, and the growth of the investment will also be tax exempt.

Whew, what a tough year! But you know what, when I compare what I paid this year (My High Deductible plus my share of the premiums) and compare it to what these medical bills would have cost me last year (My Previous Deductible, + Co-pays, + Coinsurance, + premium) I saved a lot of money this year.

And I didn't use up all that my employer and I have contributed, so I have money in my account for next year to handle my deductible already. I think I could get used to this!

Even if his family has a bad health year and has to pay out expenses up to the deductible amount, the tax, premium and coinsurance savings still make it a better deal than his old plan would have been under the same circumstances.

Lesson 7 Topic A Consumer-Driven Health p5 (LHE)

Health Savings Accounts - Eligible Individuals

Learning Objective: List the four requirements an individual must meet to be eligible for a Health Savings Account (HSA).

Money not used in an HSA is NOT subject to use it or lose it! It stays in the account and rolls over to be used in future years.

Eligible individuals are persons who:

1. Are covered by a High Deductible Health Plan (HDHP) on the first day of the month.
2. Are not covered by any other health plan that is not a HDHP.
3. Are not entitled to benefits under Medicare.
4. Cannot be claimed as a dependent on another person’s tax return.

Lesson 7 Topic A Consumer-Driven Health p6 (LHE)

HSA

Learning Objective: Describe the rules regarding contributions into an HSA.

Contributions

- Employer contributions are tax-deductible by the employer.
- The contributions are not subject to Social Security taxes.
- Employers who offer a high-deductible plan with HSAs must make comparable contributions for all employees with comparable coverage.

Insured (or account holder) Contributions

Contributions made by the insured are tax deductible. Contributions made by someone other than the insured are deductible by the account holder (except the employer.)

Once an individual is eligible for (and applies for) Part A Medicare OR opts to begin receiving Social Security Retirement benefits, which automatically enrolls them in Part A, no further contributions can be made to an HSA account.

Withdrawals

Qualified Expenses

To be excluded from Federal income tax, funds in an HSA must be used for qualified expenses (examples on page 8 of this section)

Non-Qualified Expenses

Prior to age 65, funds used for non-qualified expenses are subject to income tax and a 20 percent penalty. After 65, income tax only.

Distributions and Investment
• Any amounts not used by year end are not forfeited and they can continue to accumulate tax deferred.
• Distributions because of death or disability of the account holder are not subject to income tax.
• Upon death, HSA ownership may transfer to the spouse on a tax-free basis.

Portability

HSAs are portable: If an employee leaves the company, he or she can continue the plan.

Lesson 7 Topic A Consumer-Driven Health p7 (LHE)

Health Savings Accounts - Examples of Eligible Expenses

Learning Objective: Describe the rules regarding contributions into an HSA.

- Acupuncture
- Ambulance services
- Artificial limbs
- Chiropractic treatments
- Crutches
- Dental fees
- Doctor’s fees
- Drug addiction recovery
- Drugs (prescription)
- Eyeglasses and examination fees
- Health maintenance organization
- Hospital care
- Laboratory fees
- Nursing home care
- Psychiatric care
- Surgical fees
- Therapy treatments
- Wheelchair
- X-rays

See IRS publication 502 for a full list of eligible expenses.


Lesson 7 Topic A Consumer-Driven Health p8 (LHE)

Health Reimbursement Accounts (HRA)

Learning Objective: Describe Health Reimbursement Accounts (HRA).

An HRA is funded solely by contributions from an employer to be used for qualified medical expenses on behalf of current, former, or retired employees, including dependents. In addition to supplying the funds, the employer owns the account, maintains control of the funds, and determines the plan design to fit the
individual needs of their employees.

While there is no requirement for an accompanying health insurance plan as there is with an HSA, it would be advisable for the employer to have an HDHP in place to handle any potential catastrophic claim expenses.

If an employer moves from a traditional health insurance plan to an HDHP, the resultant decrease in premium should assist in offsetting the contributions made to the HRA. There is no IRS prescribed maximum contribution limit and the contributions are tax deductible to the employer and are not taxable for the employee.

An employer provides a Health Reimbursement Account for his employees. He provides a High Deductible Health Plan for his employees as well, to handle catastrophic illness, although with an HRA an associated HDHP is not required.

He likes the tax advantage he receives on the contribution amounts. Further, it represents a tax free benefit to his employees. He controls the amounts, whether or not contributions roll over and the range of qualified expenses.

He also likes the flexibility of HRAs. Although he knows what his maximum reimbursement cost will be annually, he only has to pay out what he incurs. In addition to an HRA, he can provide his employees with other health plan options, such as an FSA.

Lesson 7 Topic A Consumer-Driven Health p9 (LHE)

Flexible Spending Accounts (FSA)

Learning Objective: Describe Flexible Spending Accounts (FSA).

Health care Flexible Spending Accounts are employer-established benefit plans that reimburse employees for specified medical expenses as they are incurred. These accounts are allowed under section 125 of the Internal Revenue Code and are also referred to as "cafeteria plans" or "125 plans." The employee contributes funds to the account through a salary reduction agreement with their employer and is able to withdraw the funds set aside to pay for "eligible medical expenses," as well as dependent expenses such as child and senior daycare, as defined by the employer. Here's an example:

Jennifer is a single mom whose employer offers a Section 125 plan. A total of $1200 is deducted from 24 paychecks in the amount of $50 each to pay for this benefit. This amount is the maximum set by her employer, and it applies to all the employees at Jennifer's company.
Jennifer uses this account to reimburse herself for child care expenses, and with the cost of child care these days, she's not a bit worried that she must "use or lose" all of the $1200 she is able to set aside, before tax, from her wages.

The deduction that happens with each pay check, $50.00, reduces the amount of Jennifer's income that is subject to withholding for Federal and State taxes. So, she realizes the actual tax benefit of participating in this plan each month. From Jennifer's perspective, she gets a discount on her child care costs by participating in the plan.

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**Lesson 7 Topic A Consumer-Driven Health p10 (LHE)**

**Contributing to an FSA**

**Learning Objective:** Describe Flexible Spending Accounts (FSA).

Due to the PPACA, there is a statutory maximum contribution limit of $2,500 for healthcare.

Once the employee has set an amount of contribution during the open enrollment period that occurs once each year, the employee is not allowed to change the amount or drop out of the plan during the year unless he or she experiences a change of family or employment status. By law, the employee forfeits any unspent funds in the account at the end of the plan year.

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**Lesson 7 Topic A Consumer-Driven Health p11 (LHE)**

**Recap of Consumer-Driven Health Plans**

**Learning Objective:** Compare the differences of Health Reimbursement Accounts (HRA) and Flexible Spending Accounts (FSA).

**Eligibility:**

**HSA:**
- Requires an HDHP
- May not be covered by another plan
- May not be entitled to benefits under Medicare
- May not be claimed as a dependent

**HRA:**

Life & Health Essentials Course Print 04.07.2014
• No requirement for an HDHP
• Employer owns the account and controls the funds

FSA:

• No requirement for HDHP
• Employer establishes benefit plans to reimburse employees

Contributions

HSA:

• Contributions can come from either the Employer, Employee or both. However, they cannot exceed the stated maximum for that year.
• Contributions by employer are not taxable to employee
• Contributions are not subject to use it or lose it; un-used contributions roll over and gain on the account is tax-exempt

HRA:

• Employer makes the contributions
• No IRS prescribed maximum contribution limit
• Contributions are tax-deductible for employer

FSA:

• Employee makes contributions
• Employer sets the maximum annual contribution
• Contributions made through a salary reduction agreement with employer
• Any unused contributions left at the end of the year are forfeited. They are subject to use it or lose it unless the employer opts to amend the plan and allow for some carryover. Effective in 2014 the IRS rules now allow an individual to carry over up to $500 from one year to the next.

Withdrawals

HSA:

• Withdrawals used for qualified medical expenses are not subject to income tax.
• Prior to age 65 withdrawals for non-medical uses are possible but are subject to a 20% penalty plus income tax.
• After age 65, income tax only.

HRA:
Employees are reimbursed tax free for qualified medical expenses up to a maximum dollar amount for a coverage period. HRA’s only reimburse for those items agreed to by the employer which are not covered by the company’s selected standard insurance plan.

FSA:

Use it or lose it for qualified medical expenses except for recent IRS ruling cited above.

Please refer to Lesson 7 Topic A Consumer-Driven Health p12-14 (LHE) to complete the Knowledge Checks at this time.
Lesson 8 – Medicare

Medicare and Medicaid were enacted in 1965. Medicare provides hospital and medical expense insurance to seniors and is funded by a Federal employment tax. In this lesson we will overview the eligibility and coverages for seniors under Medicare.

**Note:** Medicaid is a health care program for the poor, that is managed by the individual states, and paid for with both state and federal funds. Medicaid will not be covered in this course.

Medicare Part A – Hospital Insurance  
Medicare Part B – Supplemental Medical Insurance  
Medicare Part C – Medicare Advantage Plans  
Medicare Part D – Prescription Drug Insurance  
Medicare Supplement Plans – Medigap plans for coinsurance, copayment and deductible costs.

Lesson 8 Learning Objectives

After completing this lesson, you will be able to:

1. Understand eligibility requirements for Medicare parts A, B, C, and D.
2. Describe the enrollment periods for the Medicare Program
3. Identify the core benefits provided in Medicare Part A.
4. Identify the core benefits provided in Medicare Parts B, C and D.
5. Understand the use of, qualifications necessary, and benefits of a Medicare Supplement Policy.
Lesson 8 Topic A - Medicare & Medigap Plans

Learning Objective: Understand eligibility requirements for Medicare parts A, B, C, and D.

After our study of Medicare, we will look at the four parts of Medicare plans, as well as Medigap plans.

- Medicare Part A
- Medicare Part B, C & D
- Medicare Supplement

Lesson 8 Topic A Medicare p2 (LHE)

Additional Terms and Concepts

Enrollee - An individual who is enrolled and eligible for coverage under a health insurance policy. This person can also be called a member, insured, or participant.

Formularies - Lists of drugs that are covered under a prescription drug plan.

Skilled Nursing Facility (SNF) - A facility, either free-standing or part of a hospital, with a professionally trained staff that provides medical treatment, continuous nursing, rehabilitation, and various other health and social services to patients who are not in an acute phase of illness, but who require skilled care on an inpatient basis in lieu of hospital in patient services.

Hospice - A program or facility that provides care to the terminally ill.

Custodial Care - In health or long-term care insurance, the care that is needed for personal needs such as eating, dressing and bathing, which can be provided by an individual with non-medical skills.

About Terms: Other important terms will be defined on the topic pages. If you find any terms or concepts that need more explanation, go through the topic once more, and check the glossary. If you still need explanation contact the course mentor.

Lesson 8 Topic A Medicare p3 (LHE)

Medicare

Learning Objective: Understand eligibility requirements for Medicare parts A, B, C, and D.
Medicare is a federal health insurance program that covers individuals who are eligible due to age (over 65). Those who are under 65 can qualify for benefits if they are receiving disability through Social Security Disability Insurance (SSDI), have permanent kidney failure known as End Stage Renal Disease (ESRD), or have Amyotrophic Lateral Sclerosis (ALS or more commonly known as Lou Gehrig’s Disease).


There are four coverage parts to Medicare Insurance:

- Part A: Hospital Insurance
- Part B: Supplemental Medical Insurance
- Part C: Medicare Advantage Plans
- Part D: Prescription Drug Insurance

Note: More detailed information than that contained in this lesson can be obtained from www.medicare.gov.

Lesson 8 Topic A Medicare p4 (LHE)

Eligibility for Medicare Part A - Retirement Age

Learning Objective: Understand eligibility requirements for Medicare parts A, B, C, and D.

Generally, an individual is eligible for Medicare if that person and/or a spouse worked at least 10 years in Medicare-covered employment and he or she is 65 years or older. An individual can get Part A at age 65 without having to pay premiums if:

- They receive Social Security benefits or railroad retirement benefits;
- They are eligible to get Social Security benefits or railroad retirement benefits, but have not yet filed for them;
- They or their spouse (including living, deceased, or divorced spouses) worked 40 quarters in a job where Medicare taxes were paid.

Tip: An individual who is 65 but does not meet any of these eligibility requirements may be able to purchase Medicare Part A (Hospital Insurance) by paying a premium.

Lesson 8 Topic A Medicare p5 (LHE)

Eligibility for Medicare Part A - Under Retirement Age
Learning Objective: Understand eligibility requirements for Medicare parts A, B, C, and D.

If an individual is under 65, they are eligible for Medicare Part A (Hospital Insurance) without having to pay premiums if:

- They receive Social Security disability benefits for 24 months;
- They receive a disability pension from the railroad retirement board and meet other conditions;
- They have ALS;
- They have ESRD and meet certain requirements.

Lesson 8 Topic A Medicare p6 (LHE)

Eligibility Requirements

Learning Objective: Understand eligibility requirements for Medicare parts A, B, C, and D.

Eligibility Part B

Anyone who is eligible for Part A (Hospital Insurance) can enroll in Medicare Part B (Medical Insurance). Part B is optional, and there is a minimum premium charge. A sliding scale increases premiums based on annual gross income.

An individual who is 65 but does not meet any of these eligibility requirements may be able to purchase Medicare Part B (Medical Insurance) by paying a premium if they are a United States citizen or a lawfully admitted noncitizen who has resided in the United States for at least five years.

Eligibility Part C

Anyone enrolled or eligible to enroll in both Medicare Part A and Part B can choose to join a Medicare Advantage plan (Part C). These plans combine benefits of Part A and B (and in some cases Part D) into coverage from private insurance companies approved by Medicare.

Eligibility Part D

Anyone entitled to Medicare Part A, Part B, or Part C coverage is eligible for Medicare Part D (Prescription Drug Insurance). If an individual has a Medicare Advantage plan that includes prescription drug coverage they will not need Medicare Part D coverage. There is an additional monthly premium for Medicare Part D.

Lesson 8 Topic A Medicare p7 (LHE)
Enrollment Periods

Learning Objective: Describe the enrollment periods for the Medicare Program.

Initial Enrollment Period

An individual who is receiving SS benefits prior to age 65 will automatically have the opportunity to enroll in Medicare Part A and the option to enroll in Part B. Each person will need to contact Social Security to sign up, and should do so three months in advance of the 65th birthday.

The initial enrollment period is the seven month period, beginning three months before the 65th birthday month and ending three months after the birthday month. When an individual enrolls before their birth month, coverage begins the first day of the birth month. When a person enrolls during their birth month, coverage begins the first day of the following month. For someone who enrolls the month after their 65th birthday month, coverage is delayed until the first day of the second month after enrollment, and if enrollment takes place more than one month (but less than three months) after their birthday month, coverage begins on the first day of the third month following enrollment.

General Enrollment Period

The General Enrollment Period is from January 1 to March 31 each year. Any individual who failed to enroll for Part B Coverage during their initial enrollment period may enroll during this time. However for these individuals, coverage will not start until July 1 and the monthly premium will include a late enrollment penalty.

Fall Open Enrollment Period

The Fall Open Enrollment Period is October 15 to December 7 and individuals have one opportunity to enroll in, discontinue, or switch a Medicare Advantage plan during this open enrollment period. New coverage will begin January 1 as long as request is received by December 7.

Special Enrollment Period

Special Enrollment Periods allow individuals to delay enrolling in Part B because they are covered by employer-sponsored health insurance. They have eight months to enroll from the time they (or their spouse) retire or lose their health insurance. Part B coverage starts the month after the election is made, and no late premium penalty is assessed.

Additional Special Enrollment Periods exist for Medicare Advantage and prescription Drug Plan enrollment and disenrollment under certain conditions. Examples include individual moving into or out of a nursing home, moving out of a service area, or other circumstances approved by Medicare.
Please refer to Lesson 8 Topic A Medicare p8 (LHE) to complete the Knowledge Check at this time.
Lesson 8 Topic B - Medicare Part A

Part A – Hospital Insurance benefits include:

- in-patient hospital care,
- limited skilled nursing facility care, limited home health care,
- hospice care, and blood.

Part A does not include custodial or long-term care. An individual is responsible for deductibles and specified co-payments for Part A benefits.

How is Medicare Part A Financed?

Most individuals pay for Medicare Part A through federal payroll taxes (FICA taxes) paid into Social Security. Individuals who have not paid qualifying FICA taxes because of insufficient time working (by themselves or by spouses), have the option of paying for Part A coverage themselves.

Lesson 8 Topic B Medicare Part A p2 (LHE)

Summary of Core Benefits

Learning Objective: Identify the core benefits provided in Medicare Part A.

Summary of Part A Core Benefits

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Patient Hospital Care</td>
<td>Semi-private room, meals, nursing care, and other approved hospital services and supplies.</td>
</tr>
<tr>
<td>Skilled Nursing Facility Care</td>
<td>Semi-private room, meals, skilled nursing and rehabilitative care, and other services and supplies. Part A pays for this care only after you have been in a hospital for three or more days. Your care in the facility must begin within 30 days after you leave a hospital.</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Part-time skilled nursing care; physical, occupational, and speech therapy; some home health aides; medical social services; medical equipment (wheelchairs, hospital beds, walkers, and oxygen); and other approved supplies and services.</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>Doctor and nursing services; drugs for pain symptom control, counseling services; and care in a hospice, hospital, nursing home, or home.</td>
</tr>
<tr>
<td>Blood</td>
<td>Blood received at a hospital or skilled nursing facility is covered from the 4th pint forward. Pints 1-3 are not covered.</td>
</tr>
</tbody>
</table>
Lesson 8 Topic B Medicare Part A p3 (LHE)

Medicare Part A Benefits: In Patient Hospital Care

Learning Objective: Identify the core benefits provided in Medicare Part A.

Subject to deductibles, co-payments, and coinsurance percentages, which are the responsibilities of the patient, Medicare Part A helps pay for in-patient hospital services for up to 90 days in each benefit period. (See [www.medicare.gov](http://www.medicare.gov) for current deductible and coinsurance amounts.)

A benefit period begins on the first day a person receives service as an inpatient in a hospital and ends after the person has been out of the hospital and has not received skilled care in any other facility for sixty days in a row.

Lesson 8 Topic B Medicare Part A p4 (LHE)

Lifetime Reserve Days

Learning Objective: Identify the core benefits provided in Medicare Part A.

When sixty days have passed without that person receiving any skilled care, a new benefit period will begin if the individual requires another in-patient hospital stay. A new benefit period also means that the new event will be subject to new deductibles, co-pays, and coinsurance.

Medicare Part A also allows 60 lifetime reserve days (LRDs) of coverage, which the patient may elect to use after the 90th day in the hospital. This is a non-renewable lifetime benefit that a patient may use for some assistance paying for days in the hospital past the basic 90-day benefit period. For example: an individual is hospitalized 102 days and uses 12 LRDs, they only have 48 LRDs remaining.
Lesson 8 Topic B Medicare Part A p5 (LHE)

In Patient Hospital Stays

Learning Objective: Identify the core benefits provided in Medicare Part A.

Medicare Part A pays for:

- Customary charges for bed and board in a semi-private room.
- Private room charges are authorized only when medically necessary or no other accommodations are available.
- Meals
- Nursing services
- Drugs furnished and administered by the hospital
- Operating room and anesthesia costs
- X-rays and lab tests
- Equipment use and appliances
- Blood transfusions (subject to the 3-pint deductible)
- Other expenses approved by Medicare

Medicare Part A does not pay for:

- Any physician or surgeon services except those provided by a resident or intern in an approved teaching facility
- Convenience items requested by the patient, such as telephone or television
- Supplies or appliances for use away from the hospital unless medically necessary, such as a pacemaker

Lesson 8 Topic B Medicare Part A p6 (LHE)

Skilled Nursing Facility Care

Learning Objective: Identify the core benefits provided in Medicare Part A.

For Medicare to provide coverage, a skilled nursing facility must meet the standards of the Medicare program. It can be a stand-alone facility or part of a hospital, but it cannot offer only custodial-type care. The facility must:

- Have at least one full time registered nurse,
- Provide 24 hour nursing service, and
- Require residents to be under the care of a physician.
Important: Custodial-type care is not covered by Medicare. Recall that this is the type of care given for a patient's personal needs, such as dressing and bathing, which can be provided by non-medical personnel.

Lesson 8 Topic B Medicare Part A p7 (LHE)

Skilled Nursing Facility Care

Learning Objective: Identify the core benefits provided in Medicare Part A.

Medicare Part A pays for:

Subject to deductible after first 20 days, Medicare will help pay for up to 100 days in a benefit period. Covered services are:

- Semi-private room and board
- Nursing services
- Drugs and supplies
- Meals
- Rehabilitation services, physical, occupational, and speech therapy
- Other services as required and approved by Medicare

Medicare Part A does not pay for:

Services not covered include:

- Physician services (Medicare Part B is needed)
- Custodial care, if that is the only necessary service
- Telephone, television, etc.
- Private nurse

Lesson 8 Topic B Medicare Part A p8 (LHE)

Home Health Care

Learning Objective: Identify the core benefits provided in Medicare Part A.

An individual who is discharged from a hospital or skilled nursing facility may need additional care that can be provided in the home. If the attending physician determines the care is necessary and prescribes a home health care plan, Medicare may provide some assistance. Medicare will pay for approved visits during a 60-day "episode of care," with the payment amount based on the individual's condition and care needs.
Home care “episode” needs physician certification: A physician must certify the necessity for home care, with periodic follow up.

Facility needs Medicare approval: Medicare provides standards for home health care agencies to meet if they intend to receive reimbursement for services rendered to a Medicare recipient. The home health care service provided must also be approved by Medicare.

Limited part-time skilled nursing home care: Medicare will only pay for limited part-time skilled nursing home care. Medicare defines part time or “intermittent” as skilled nursing care that is needed or given on fewer than 7 days each week or less than 8 hours each day over a period of 21 days (or less) with some exceptions in special circumstances.

Patient must be home-bound: The patient must be home-bound, meaning not able to leave home without assistance.

Lesson 8 Topic B Medicare Part A p9 (LHE)

Home Health Care

Learning Objective: Identify the core benefits provided in Medicare Part A.

Medicare Part A pays for:

- Part-time skilled nursing care
- Physical and speech therapy
- Assistance by a home health aide for services such as dressing changes, administering medications, personal care while the patient also requires skilled nursing care
- Medical supplies
- Durable medical equipment such as wheelchairs or hospital beds, but with a coinsurance payment of 20 percent from the patient, 80 percent from Medicare

Medicare Part A does not pay for:

- Full time (24 hour) home care
- Meal delivery service
- Services such as house cleaning, shopping, laundry, unless these are related to a skilled services plan of care
- Custodial care (dressing, bathing, using the bathroom) if this is the only care needed
Hospice Care

**Learning Objective:** Identify the core benefits provided in Medicare Part A.

Hospice care is available as long as the enrollee:

- Has a doctor and hospice care provider who certify that the person is terminally ill (life expectancy of less than 6 months),
- Elects to receive hospice services in place of any other care related to improving the condition,* and
- Agrees to waive any Medicare coverage for hospice care other than from the chosen provider,
- Receives care from a Medicare-approved provider

Tip: A person may elect to stop hospice care coverage and reinstate full Medicare benefits at any time. Hospice care coverage can be either inpatient or home care, and Medicare pays all expenses, except some limited coinsurance for outpatient drugs and inpatient respite care.

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**Lesson 8 Topic B Medicare Part A p11 (LHE)**

Hospice Care

**Learning Objective:** Identify the core benefits provided in Medicare Part A.

Medicare Part A will pay for the following hospice services for the terminal and related conditions:

- Nursing services
- Counseling
- Medical supplies
- Drugs
- Physical therapy
- In-home personal care
- Short-term respite care in an approved facility to allow caregivers in the home of the patient to take time to rest. (This is limited to no more than five consecutive days and includes five percent coinsurance, payable by the patient.)

**Medicare Part A will not pay for:**

- Treatments or prescription drugs intended to cure the terminal illness
- Care from a hospice provider not arranged by the hospice medical team
- Payments for room and board, other than respite care
• Inpatient care, ambulance transportation, care in an emergency room, unless the hospice care team arranges it, or it is not related to the terminal illness

Lesson 8 Topic B Medicare Part A p12 (LHE)

Blood

Learning Objective: Identify the core benefits provided in Medicare Part A.

The Medicare insured (enrollee) pays 100% of the cost of the first three pints of blood.

Medicare Part A pays 100% of the cost for additional units.

Please refer to Lesson 8 Topic B Medicare Part A p13 (LHE) to complete the Knowledge Check at this time.
Lesson 8 Topic C - Medicare Part B

Learning Objective: Identify the core benefits provided in Medicare Parts B, C and D.

Part B - Supplementary Medical Insurance (SMI), is optional to those who are eligible for Medicare. It helps cover medically necessary services like doctors’ services, outpatient care, and other medical services Part A does not cover.

- Anyone who is eligible for free Medicare hospital insurance (Part A) is also automatically eligible for Medicare Part B (supplemental medical insurance)
- Participants who do not decline the coverage pay a monthly premium.
- If a person who initially declines Part B enrolls in Part B more than 12 months after the initial enrollment period, Medicare will charge a permanent 10 percent increase in the premium for each full 12 month period the person could have enrolled and failed to enroll.

Part B Medicare Continued

Learning Objective: Identify the core benefits provided in Medicare Parts B, C and D.

Part B Medicare pays for:

- Doctors’ services whether in-hospital, office visits or house calls
- Outpatient hospital care
- Surgeons, anesthesiologists, radiologists, etc;
- Lab tests and x-rays
- Medical supplies and equipment;
- Ambulance services
- Some preventive care services
- Outpatient physical, speech, and occupational therapy
- Some home health care (not covered under part A)

Important Note:

Part B does not include custodial or long-term care.

Part B also covers some preventive services.
These include a one-time “Welcome to Medicare” physical exam, bone mass measurements, flu and pneumococcal shots, cardiovascular screenings, cancer screenings, diabetes screenings, and more.

**Medicare Part C – Medicare Advantage**

*Learning Objective: Identify the core benefits provided in Medicare Parts B, C and D.*

Part C is an alternative to Parts A and B. In 1997, Medicare Part C (originally called Medicare + Choice) became available to persons who are eligible for Part A and enrolled in Part B. Under Part C, private health insurance companies, approved by the Department of Health and Human Services, can contract with the federal government to issue policies that cover Medicare benefits.

These insurance companies are able to offer Medicare beneficiaries health coverage, through private fee-for-service plans, as well as through managed care plans (HMOs) and preferred provider organizations (PPOs).

**Medicare Advantage Continued**

In Medicare Part C, now known as “Medicare Advantage,” an individual who is entitled to Medicare Part A, enrolled in Part B, and resides in the plan’s service area may switch to a Medicare Advantage plan. The advantage is that these privately insured plans usually have extra benefits, more choices, and lower co-payments than in the original Medicare plan.

The way it works is that Medicare pays a set amount of money every month to the health plan for each insured individual. Additionally, the insured may pay a monthly premium for any extra benefits.

- Subsidized by Medicare, plans are offered by private insurers
- Additional benefits
- Lower co-pays
- Insured may pay additional premium
- Provides all of Part A (Hospital) and Part B (Medical) coverages
- Some Plans may also provide Part D (Prescription Drug) coverage

Individuals who are:

- entitled to Medicare Part A,
enrolled in Medicare Part B, and
residing in the plan’s service area
can move to Medicare Part C.

**Lesson 8 Topic C Medicare Parts B, C & D p5 (LHE)**

**Medicare Advantage Continued**

**Learning Objective:** Identify the core benefits provided in Medicare Parts B, C and D.

The following types of Plan C Medicare Advantage Plans are available in some areas to Medicare eligible individuals who meet certain conditions.

Health Maintenance Organization (HMO) Plans: Medicare HMOs provide comprehensive health care to members who have Medicare Parts A and B. They have been the most popular kinds of Medicare Advantage plans in some states. In most cases, an individual must see a primary care doctor to get a referral before seeing any other health care provider.

Preferred Provider Organization (PPO) Plans: PPOs have network doctors and hospitals, but an individual can also use out-of-network providers for covered services, usually for a higher cost.

In Medicare PPOs, the enrollee:

- Does not need to choose a primary care doctor
- Can get health care from any doctor or hospital
- Generally need a referral to see a specialist or any out-of-network provider
- Individuals wanting prescription drug coverage must purchase it for an additional cost

Private Fee-for-Service (PFFS) Plans: In a PFFS plan, an individual should make sure the doctors and other health care providers accept the plan's rules before receiving services.

The private insurance company that issues the policy (not Medicare) decides how much it will pay and what the insured individual pays for services received. Providers must agree to bill the plan, not Medicare, for services.
Learning Objective: Identify the core benefits provided in Medicare Parts B, C and D.

Medicare Medical Savings Account (MSA) Plans: Medical Savings Account (MSA) Plans include a high-deductible Medicare Advantage MSA Health Plan (which begins to pay covered costs only after an insured has met the annual deductible), and a Medical Savings Account, into which Medicare deposits money the enrollee may use to pay health care costs.

Medicare Special Needs Plan: Medicare Special Needs Plans pay for all Medicare Part A and Part B health care and services for eligible individuals who require:

- Special care for chronic illnesses
- Help with the management of multiple diseases
- Focused care management (e.g. people in nursing home settings, or who have certain chronic or disabling conditions)

Medicare Advantage Plans with Prescription Drug Coverage: Many Medicare Advantage Plans offer prescription drug coverage, although some do not.

If the plan includes prescription drug coverage as an option, paying the additional premium for the optional coverage is the only way for someone who is on that plan to get the coverage.

If a plan does not include prescription drug coverage, other options for getting coverage include:

- Switching to another Medicare Advantage Plan that offers prescription drug coverage
- Returning to the Original Medicare Plan and joining a stand-alone Medicare Prescription Drug Plan

Lesson 8 Topic C Medicare Parts B, C & D p7 (LHE)

Medicare Part D – Prescription Drug

Learning Objective: Identify the core benefits provided in Medicare Parts B, C and D.

Unlike Parts A and B, the Part D benefit is only available through private insurance companies. Medicare Part D is a federal program to subsidize the costs of prescription drugs for Medicare beneficiaries in the United States.

Individuals who are eligible for Medicare Parts A and B receive notification of the option to purchase a separate policy from an insurance company or other Medicare-approved private company to cover Part D.

Lesson 8 Topic C Medicare Parts B, C & D p8 (LHE)
Network Pharmacies and Formularies

Learning Objective: Identify the core benefits provided in Medicare Parts B, C and D.

Though the insurers may offer different approaches, the intended benefits of Plan D are simple, to help insureds pay less for prescriptions. Using the same concept offered by many other types of insurance plans, Plan D prescription drug insurers usually include a list of preferred “in-network” pharmacies where insureds may purchase covered drugs at lower out-of-pocket costs than at non-preferred “out-of-network” pharmacies.

A list of drugs covered by a Plan D insurer is called a “formulary.” Those drugs are further grouped into tiers, which break down the cost of those drugs, and the amounts paid by the insurer. Plan tiers often fall into the following categories:

- Tier 1 - Generic drugs.
- Tier 2 - Preferred brand-name drugs.
- Tier 3 - Non-preferred brand name drugs.

Additionally, for safety, as well as cost factors, plans may limit the quantity of drugs covered during a certain time period.

Lesson 8 Topic C Medicare Parts B, C & D p9 (LHE)

Application of Deductibles and Co-Payments

Learning Objective: Identify the core benefits provided in Medicare Parts B, C and D.

For the monthly premium payment to the insurer, Part D plans give each insured a plan member card (like a prescription drug card used in group insurance), which the member will use when purchasing prescriptions at a pharmacy. Though most costs will be lower than paying the regular price, the member will pay any applicable deductible (which may be a sizable amount), copayment, and coinsurance charges at the time of purchase. (See www.medicare.gov for current deductible and coinsurance amounts)

Because of the amounts members must pay with most plans, beneficiaries can become, for a time, responsible for all prescription costs. However, low-income Medicare beneficiaries may qualify for a low-income subsidy (LIS) to help pay costs associated with Part D plans.

Please refer to Lesson 8 Topic C Medicare Parts B, C & D p10 (LHE) to complete the Knowledge Check at this time.
Lesson 8 Topic D - Medicare Supplement (Medigap Plans)

Learning Objective: Understand the use of, qualifications necessary, and benefits of a Medicare Supplement Policy.

Medicare supplements are insurance plans, often called Medigap Plans, which help pay the coinsurance, copayment, and deductible costs of Medicare-covered services. Private insurance companies offer these plans to individuals enrolled in Medicare Parts A and B only.

10 Plans with standardized wording are available to insurers offering this type of coverage.

An Important Note about Medigap Eligibility

Anyone enrolled in a Medicare Advantage Plan (Part C), or diagnosed with endstage renal disease, is ineligible for a Medigap policy.

In addition to covering other costs not paid by Medicare, some Medigap plans did cover prescription drugs. After Plan D took effect in 2006, no carriers offer this to new insureds.

However, those who have already signed up for a Medigap plan with drug coverage can stay on the plan until they sign up for Part D instead.

Open Enrollment for Medigap Plans

Learning Objective: Understand the use of, qualifications necessary, and benefits of a Medicare Supplement Policy.

Currently, all Medigap policies are written as “guaranteed renewable,” meaning that an insured cannot lose coverage, except for non-payment of premium, material misrepresentation on the application, or the insurance company goes out of business.

- An individual who turns age 65 and enrolls in Medicare Part B has a six-month window to purchase a Medigap plan and not be subject to medical underwriting by the insurance company.
- An individual who waits to apply for a Medigap policy until after the initial open enrollment period of six months very likely will be subject to medical underwriting acceptability.
- Individuals may wait to apply for Medigap coverage in several situations and still be able to use the “open enrollment” option.
Example: For instance, an individual who continues to work past age 65 and is covered by an employer’s group health plan may not need to enroll in Medicare Part B.

Upon leaving that employer, or dropping out of the group plan, the individual can enroll in Part B, and the six-month open enrollment window for Medigap coverage will begin at that time.

Lesson 8 Topic D Medicare Supplement p3 (LHE)

Open Enrollment and Pre-Existing Condition Limitation

Learning Objective: Understand the use of, qualifications necessary, and benefits of a Medicare Supplement Policy.

Under certain circumstances, Medigap insurance companies can impose a waiting period of up to six months before covering a pre-existing condition.

The pre-existing condition waiting period can be shortened, waived, or eliminated if the individual has had at least six months of prior, continuous health coverage (called “creditable coverage”), before applying for a Medigap policy during the initial open enrollment period.

Lesson 8 Topic D Medicare Supplement p4 (LHE)

Explanation of Standardized Plans

Learning Objective: Understand the use of, qualifications necessary, and benefits of a Medicare Supplement Policy.

Medicare requires standardized Medigap plans, which private insurers offer as Plan A through Plan N, (no longer offering plans E, H, I and J.) Because Federal laws and state statutes require standard policy wording, basic benefits are identical from one carrier to the next for each of the 10 plans. However, comparison shopping is important because prices vary widely between companies for the different coverages, as well as for insureds of different ages. During this research, keep in mind that not all insurers offer all 10 Medigap Plans, and individual state statutes may dictate state specific Medicare Supplement requirements.

A Medigap policy must clearly state that the coverage is “Medicare Supplement Insurance.” Each of the A through N Medigap Plans has a different set of basic and extra benefits, demonstrated on the Medicare website as a chart that has checkmarks for covered benefits (much like a hotel chain might list amenities at its different locations).

For complete information about enrolling and the specifics about coverages see www.medicare.gov.
Medigap Plans

- 10 types (Plan A through Plan N - E, H, I, J no longer available)
- Each Plan has standard wording
- Not all insurers offer all 10
- Prices vary widely between companies

Please refer to Lesson 8 Topic D Medicare Supplement p5 (LHE) to complete the Knowledge Check at this time.

Please refer to the end of Lesson 8 Topic D to complete the Self Quiz at this time.
We suggest reviewing the Learning Objectives for this course to prepare for the final exam.

Lesson 1 Review

1. Know the parties involved in a life insurance contract.
2. Name two common owner/insured relationships for life insurance policies.
3. Define insurable interest.
4. Describe the work of actuaries and why life insurance companies use them.
5. Give an overview of the life insurance application process and underwriting issues.
6. Understand the proper beneficiary selection and terminology.
7. Describe why a survivorship clause would be needed for a life insurance contract.
8. Understand why people buy life insurance.

Lesson 2 Review

1. Know the characteristics of term life insurance.
2. Explain the difference between term life insurance policies and permanent life insurance policies, using the concepts of policy term, cash value accrual and premium cost.
3. Define the policy provisions known as guaranteed convertible and guaranteed renewable.
4. Understand the way that premium and/or death benefit increases or decreases for three variations of term insurance: level term, renewable level term and decreasing term.

Lesson 3 Review

1. List four types of permanent life insurance.
2. Explain the difference between a living benefit and a death benefit under the terms of a permanent life insurance contract.
3. Explain the term "paid up policy".
4. Explain cash value in life insurance policies and describe the tax treatment of these amounts.
5. Explain loans against the cash value of a permanent life insurance policy as a living benefit.
6. Explain the term "non-forfeiture option".
7. Describe the major characteristics of whole life insurance.
8. Understand how cash value accumulates in a whole life insurance contract.
9. Describe the major characteristics of Universal Life Insurance.
10. Describe features of Universal Life Insurance that allow more flexibility to the insured in paying premium or accumulating cash value.
11. Define variable life insurance.
13. Describe the general features of three variations on permanent life insurance: joint life, survivorship life and graded benefit.
Lesson 4 Review

1. List the types of premium payments.
2. Recognize the components of life insurance policies:
   - Application
   - Conditional Receipts and Temporary Insurance Agreements
   - Exclusions and Riders
   - Provisions regarding dividends, settlement and non-forfeiture and surrender options.
3. Describe life insurance applications, including standardization of forms and how the application is used.
4. Describe what a conditional receipt is used for and what restrictions may be placed on issuing a conditional receipt.
5. Recognize and briefly describe the following common contract provisions of life insurance policies:
   - Entire Contract Provision
   - Misstatement of Age and/or Sex Provision
   - Right to Examine Period
   - Grace Period for Premium Payment Provision
   - Incontestable Clause
   - Suicide Provision
   - Reinstatement Provisions
6. Recognize and briefly describe the following life insurance policy exclusions:
   - War Clause
   - Cause of Death Exclusions
   - Flat Extra
7. Recognize and briefly describe the following life insurance policy riders:
   - Waiver of Premium Rider
   - Accidental Death Rider
   - Guaranteed Insurability Rider
   - Living Benefit Riders
   - Payor Benefit Rider
   - Family Riders
   - Term Insurance Rider
   - Return of Premium Rider
8. Recognize the ways that the owners or beneficiaries of a life insurance policy can take payment for accrued cash value and death benefit.
9. Understand the basic tax considerations of life insurance.

Lesson 5 Review

1. List and briefly describe types of medical expense policies available in today’s markets.
2. Give an overview and description of group medical plans.
3. Name and describe some of the ancillary, voluntary products that an individual may choose if offered by their employer.
4. Understand the role that federal legislation plays in health care coverage.
5. Explain the purpose of the Federal Regulation known as COBRA, and describe the benefit periods available and the premium payment required.
6. Describe the Family Medical Leave Act (FMLA) requirements for employees and employers.
7. Identify major changes brought by health insurance reform and list the minimum essential benefits.
8. List and briefly describe the health care delivery systems used by health benefit providers.

**Lesson 6 Review**

1. Name the provisions that affect a benefit payment to an insured and that determine the dollar amount paid by the insurance provider versus the amount paid by the insurer.
2. Determine the amounts payable by the benefit provider and the insured given the specifics of a sample medical claim.
3. Understand eligibility requirements such as waiting periods, and minimum participation and contribution.
4. Know that managing eligibility requirements for health insurance can also mean excluding a class of insureds.
5. List and describe cost containment features being used to control rising health care costs.
6. List some of the typical exclusions that would be found in most medical expense insurance policies.
7. Recognize and briefly describe typical internal limits in a health insurance policy.

**Lesson 7 Review**

1. List three types of consumer driven health plans.
2. Describe the benefits of Health Savings Accounts.
3. List the four requirements an individual must meet to be eligible for a Health Savings Account (HSA).
4. Describe the rules regarding contributions into an HSA.
5. Describe Health Reimbursement Accounts (HRA).
6. Describe Flexible Spending Accounts (FSA).
7. Compare the differences of Health Reimbursement Accounts (HRA) and Flexible Spending Accounts (FSA).
8. List the four major benefits an employer might realize if they choose to insure on a self-funded basis.

**Lesson 8 Review**

1. Understand eligibility requirements for Medicare parts A, B, C, and D.
2. Describe the enrollment periods for the Medicare Program.
3. Identify the core benefits provided in Medicare Part A.
4. Identify the core benefits provided in Medicare Parts B, C and D.
5. Understand the use of, qualifications necessary, and benefits of a Medicare Supplement Policy.