Test Alert!

Georgia
Life, Accident, and Health Insurance

License Exam Manual, 2nd Edition, Revised
Pearson Vue Exams Effective 10/1/08

9/19/08

L&H

The information included in this release, in addition to your other Kaplan Financial Education materials, is designed to assist you in preparing for concepts that your exam may include. We urge you to read it carefully and take time to review the sample questions and rationales.

Be sure to visit Kaplan Financial Education's Website at **www.kaplanfinancial.com** for the latest updates to this *Test Alert!*

KAPLAN FINANCIAL EDUCATION

Part I
Changes to Text

The following information contains changes to the content of the License Exam Manual since the date of its publication. Please refer to that text when reading this information.

On page 19, add the following content after paragraph "2.) Coverage and the receipt":

---

7. **Replacement** Replacement is the purchase of one life insurance policy to replace another. Because of the cash values that can build up in a policy and the favorable loan interest rates in older policies, replacement can be disadvantageous to consumers. However, there are good reasons to replace a policy, particularly if it does not meet the current needs of the consumer.

   When replacement of life insurance is involved, the producer must comply with all pertinent federal and state regulations. Each state has rules and regulations regarding replacement of life insurance products that are designed to protect the interests of the insuring public. Frequently, it is not in the best interests of the insured to replace existing life insurance with a new policy. There are many reasons for this.

   - New insurance requires the applicant to prove insurability.
   - Premiums may be higher for a new policy.
   - New policy provisions will have to be complied with, such as a new incontestable period.
   - The existing policy's provisions may be more liberal than a new policy's provisions.
   - Generally, a new policy will not have current cash values.

8. **Disclosures at point of sale** Under the Gramm-Leach-Bliley Financial Services Modernization Act of 1999 (also known as GLBA), an insurer must make two primary disclosures to customers: one at the time of the establishment of the customer relationship and the second before the insurer discloses protected information.

   a. **When customer relationship is established** The first disclosure is to be made at the time a consumer becomes a customer, usually by purchasing a policy. At this point, the insurer is required to give a clear and conspicuous disclosure to the new customer regarding its policies and procedures for customer privacy. The customer must, at least on an annual basis, receive an updated notice containing the same information.

© 2008 DF Institute, Inc.

b. **When protected information is to be shared** The second disclosure required by GLBA explains the customer's right to opt out of information sharing. Each customer must be given the right to opt out and must be told explicitly how he may exercise that right. The notice must identify the products and services to which the opt-out right applies. The only other requirement is that the opt-out agreement must be in writing and may be electronic if the customer agrees. If the customer does not take advantage of this option within a reasonable time, the company may share the information with others.

1.) **Blood tests for AIDS and HIV** Currently, state laws vary widely in regard to using certain tests to detect AIDS antibodies and using the results to make underwriting decisions. Blood tests for HIV before policy issuance are a common underwriting requirement. Typically, the proposed insured must sign a consent form before the blood test is performed. AIDS testing is almost always required whenever a large amount of insurance is applied for. Each insurance com¬pany sets thresholds for the ages and amounts of insurance for when medical underwriting (including blood tests for HIV) will be required.

2.) **Test results** Test results are confidential, and certain procedures must be followed to inform the applicant of positive results. A signed release form is required whenever test results will be disclosed to a party who is not otherwise entitled to the information.

On page 25, add the following content before "V. Contract Law," and re-letter subsequent sections accordingly:

V. **Do Not Call List** The National Do Not Call Registry is a list of phone numbers from consumers who have indicated their preference to limit the telemarketing calls they receive. The registry is managed and enforced by the Federal Trade Commission (FTC), as well as the Federal Communications Commission (FCC), and state officials.

The registry applies to any plan, program, or campaign to sell goods or services through interstate phone calls, including insurance. This includes telemarketers who solicit consumers on behalf of third parties. It also includes sellers who provide, offer to provide, or arrange to provide goods or services to consumers in exchange for payment.

Calls from or on behalf of political organizations, charities, and telephone surveyors are still permitted, as well as calls from companies that have the express written permission of the consumer. Calls are also permitted to consumers with whom the company has established a business relationship, as follows:

- A consumer can establish a business relationship with an insurer by requesting information from it or submitting an application

© 2008 DF Institute, Inc.

to it. In this case, the business can call for three months from the date of inquiry or application.

- A company with which a consumer has an established business relationship may call for up to 18 months after the consumer's last purchase, last delivery, or last payment, unless the consumer asks the company not to call again.
- Telemarketers and sellers are required to search the registry at least once every 31 days and drop from their call lists the phone numbers of consumers who have registered.
- A consumer who receives a telemarketing call despite being on the registry will be able to file a complaint with the FTC, either online or by calling a toll-free number. Violators could be fined up to $11,000 per incident.

On page 31, remove the references to "Modified" and "Family Income" from the list of Key Terms.

On page 44, remove paragraph "a. Family income policy or rider (FIP)." This topic is no longer subject to examination.

On page 45, remove paragraph "c. Family policy." This topic is no longer subject to examination.

On page 47, add the following content after paragraph "1. Fixed annuity" and before the flow chart of annuity types:

---

a. Equity-indexed annuities Equity-indexed annuities are generally considered to be fixed annuities because they offer a guaranteed minimum interest rate and a guarantee against loss of principal if held to term. (As with other fixed annuities, surrender charges may reduce principal if the policy is surrendered early.) However, with an equity-indexed annuity, interest crediting in excess of the minimum guaranteed rate is linked to the upward movement of a designated equity index, such as the Standard and Poor's 500. If the index moves upward, the interest rate is based on some portion of the increase. If the index moves downward, the equity-indexed annuity credits the guaranteed minimum rate.

For instance, suppose a person owns an equity-indexed annuity with a guaranteed minimum interest rate of 6% that is linked to the Standard and Poor's 500 Index. If the index goes up, the annuity interest rate will go up. If the index goes down, the lowest annuity interest rate will be 6%, the guaranteed minimum.

On page 50, remove question no. 10 from the Unit Quiz.

© 2008 DF Institute, Inc.

On page 54, add the following content after paragraph "A. Waiver of Premium," and re-letter subsequent paragraphs accordingly:

B. Waiver of Premiums with Disability Income Rider This rider specifies that in the event of disability, premiums will be waived retroactively to the beginning of the disability. The definition is usually permanent and total disability. However, a few companies have gone to a definition in terms of occupation, specifically:

- the insured is prevented by disability from engaging in his usual occupation; or
- the insured is prevented from engaging in any work for gain or profit.

If the insured meets the definition of permanent and total disability, he can invoke the benefits of this rider. The insurer will pay the insured a regular monthly income for as long as he remains totally and permanently disabled. The amount of the income is usually based on the face amount of the policy—for instance, $X per month per $1,000 of coverage.

Though they are often paired together, the waiver of premium and the disability income rider are two very different riders. The amount paid under the waiver of premium rider depends on the amount of the policy's premium. The amount paid under the disability income rider is based on the face amount of the policy.

On page 55, add the following content after paragraph "G. Accelerated (Living) Benefits":

H. Cost of Living Rider (Cost of Living Adjustment Rider) With the cost-of-living rider, the insured may increase the death benefit of the policy to match an increase in the cost-of-living index (usually the CPI-U, the Consumer Price Index-All-Urban). This is accomplished by either changing the face amount of an adjustable life policy (and increasing the premium accordingly) or attaching an increasing term rider to the base term or whole life policy and billing the policyholder for the additional coverage. (There is usually a cap on the increase.)

An increase in the death benefit will result in an increase in premium. Subsequent decreases in the index will not result in a decrease in the policy's death benefit. Note that when the CPI-U goes up, the insured is not required to increase the face value of the policy accordingly.

On page 73, remove "Buy-Sell Plans," "Key Employee," and "Split Dollar Plans" from the list of Key Terms, as these topics are no longer subject to examination.

© 2008 DF Institute, Inc.

On page 77, replace the first sentence of paragraph B(1)(c) with the following content:

c. Owners of IRAs must begin to receive payments from their accounts by April 1 of the year following the year in which they reach 70½ years of age.

On page 79, add the following sentence to paragraph 4, "Simplified employee pensions (SEPs)":

SEPs are sometimes used by small unincorporated businesses and self-employed individuals.

On pages 82-84, remove section "IV. Business Insurance," as this topic is no longer subject to examination.

On page 87, remove question no. 9 from the Unit Quiz.

On page 89, remove question no. 6 from the Discussion Questions.

On page 92, remove question no. 1 from the Life Insurance Practice Final Examination.

On page 93, remove question no. 18 from the Life Insurance Practice Final Examination.

On page 96, remove question no. 41 from the Life Insurance Practice Final Examination.

On page 98, remove the rationale for question no. 1 in the Answers to Life Insurance Practice Final Examination.

On page 99, remove the rationale for question no. 18 from the Answers to Life Insurance Practice Final Examination.

On page 100, remove the rationale for question no. 41 from the Answers to Life Insurance Practice Final Examination.

© 2008 DF Institute, Inc.

On page 112, insert the following content before "8. Multiple employer trust (MET)/multiple employer welfare association (MEWA)" and renumber subsequent paragraphs accordingly:

---

8. **Point of service (POS) plans** Point of service plans give the insured the choice of receiving in-network care or out-of-network care. With in-network coverage, the insured receives care through a particular network of doctors and hospitals participating in the plan, and all care is coordinated by the insured's primary care physician (PCP). This includes referrals to specialists and arrangements for hospitalization, which must all be approved by the PCP. In-network coverage is the highest level of coverage within the plan, which means the plan will pay more for medical services and the insured won't have to submit claim forms. Out-of-network coverage applies when the insured receives care from a provider who does not participate in the plan's network, and the care is not coordinated by the PCP. An insured receiving out-of-network care usually pays more of the cost than if it had been in-network care (emergencies excepted). Out-of-network care also means that the insured must submit claim forms in order to receive benefits.

9. **Flexible spending accounts (FSAs)** The flexible spending account (FSA) is a variation of the traditional cafeteria plan. The FSA is a cafeteria plan that is funded with employee money by means of a salary reduction. A salary reduction plan is a pretax plan; the employee agrees to a reduction in compensation, and this amount is used to cover certain medical expenses. This naturally results in a lower-cost plan from the employer's perspective, with an employer's expenses usually limited to administrative costs. FSAs typically are for moderate-sized to large employers. The salary reduction method results in the employees funding nontaxable benefits with nontaxed dollars. This also results in a reduced payroll and reduced payroll taxes for the employer.

10. **Health reimbursement accounts** Some employers provide employees with high-deductible medical expense plans and create a tax-favored savings account for each covered employee under which the employee can obtain reimbursement for certain medical expenses that are not covered under a high deductible plan. HRAs are the dominant form of consumer-directed health plans.

11. **High deductible health plans (HDHPs) and related health savings accounts (HSAs)** The Medicare Prescription Drug and Modernization Act of 2003 established a new way for consumers to pay for medical expenses: health care savings accounts (HSAs). An HSA is a tax-favored vehicle for accumulating funds to cover medical expenses. Individuals under age 65 are eligible to establish and contribute to HSAs if they have a qualified high-deductible health plan.

    a. **Health savings accounts** Employers may set up HSAs for their eligible employees and contribute to them, subject to the dollar limits discussed previously. Employer contributions are excluded from employees' taxable income. HSA distributions are tax free

© 2008 DF Institute, Inc.

if used to pay qualified medical expenses, which generally include the same kinds of medical expenses that are deductible as itemized deductions. Distributions for any other purposes are subject to income tax; a 10% penalty tax also applies unless the account beneficiary has died, become disabled, or is age 65 or older.

12. **Consumer-directed health plans** As described in the preceding sections, recent years have seen considerable interest in the concept of the consumer-directed health plan.

On pages 112-113, remove section "8. Multiple employer trust (MET)/multiple employer welfare association (MEWA)" as this topic is no longer subject to examination.

On page 118, add the following content to the end of the page:

I. **Limited Risk and Critical Illness Plans** A variety of special health insurance policies are available that provide limited coverage for specific diseases or illnesses. To ensure that the insured has sufficient notice that the coverage is limited, every policy that provides limited coverage must, by law, state plainly on the first page of the policy, "THIS IS A LIMITED POLICY."

1. Specified disease or dread disease insurance provides a variety of benefits for only certain diseases, usually cancer or heart disease.

J. **Worksite (Employer-Sponsored) Plans** Employers can provide accident and sickness insurance for their employees as a benefit of employment. Such coverage can include the following.

1. Disability income insurance can be issued on a group basis through an employer-sponsored plan, labor union, or association. Benefits paid are in accordance with the policy's provisions and, to a degree, the insured's loss of income.
2. Accidental death and dismemberment (AD&D) benefits may be included as riders on life insurance policies, as part of disability income insurance, as part of health insurance, or as a separate policy (a type of limited coverage).
3. Medical expense insurance, commonly referred to as hospitalization insurance, may be issued as a group insurance policy provided through an employer-sponsored program.
4. Dental expense benefits are generally sold as part of group health insurance coverage. Most insurers do not provide individual dental policies.

On page 120, remove question no. 12 from the Unit Quiz.

© 2008 DF Institute, Inc.

On page 121, remove question no. 9 from the Discussion Questions.

On page 129, add the following content after paragraph "11. Deductibles":

12. **Eligible expenses** Eligible expenses are defined in the health plan as being eligible for coverage. This could involve specified health services fees or customary and reasonable charges.

13. **Copayments** Copayments are an arrangement in which the insured pays a specified amount for various services and the health care provider pays the remainder. The insured usually must pay his share when the service is rendered. This is similar to coinsurance, except that coinsurance is usually a percentage of certain charges, while the copayment is a dollar amount.

14. **Pre-authorization and prior approval requirements** Pre-authorization and prior approval requirements are cost-containment measures that provide full payment of health benefits only when the hospitalization or medical treatment has been approved in advance.

15. **Usual, reasonable, and customary (URC) charges** Usual, reasonable, and customary charges are those that are approved for payment by the health insurer. Customary charges are those that are most often made by a provider for services rendered in a particular area.

16. **Lifetime, annual, or per cause maximum benefit limits** An accident or sickness policy may restrict benefits to payment of a specified amount for the insured's lifetime. It may also limit benefits on an annual basis or restrict the amount that will be paid for a single claim.

On p. 136, replace paragraph 3(c), "Medical Savings Accounts (MSAs)" with the following content:

c. **Medicare+Choice MSA** This was a pilot program that enables senior citizens to establish a special Medical Savings Account (MSA). As with regular MSAs, individuals with Medicare+Choice can apply their contributions to their MSAs for health care expenses; however, this kind of MSA must be used with a high-deductible (up to $6,000 per year) MSA health plan.

   1.) Annual contributions are limited to 75% of the individual's deductible under the required MSA health plan. For example, if the deductible was $5,000, contributions could not exceed $3,750.

   2.) All earnings on MSAs are excluded from taxable income for the current year.

   3.) Distributions to pay for qualified medical expenses are not included in the participant's income; however, distributions for purposes other than medical expenses must be included in taxable income.

© 2008 DF Institute, Inc.

4.) Medicare+Choice has largely been replaced with a Medicare option that provides for health savings accounts (HSAs).

d. **Health Savings Accounts (HSAs)** The Medicare Prescription Drug and Modernization Act of 2003 established a new way for consumers to pay for medical expenses: health care savings accounts (HSAs). An HSA is a tax-favored vehicle for accumulating funds to cover medical expenses.

1.) **Eligibility** Individuals under age 65 are eligible to establish and contribute to HSAs if they have a qualified high-deductible health plan. For an individual, a qualified high-deductible health plan is one with a minimum deductible of $1,100 for 2008 ($1,150 for 2009) and a cap of $5,600 for 2008 ($5,800 for 2009) on out-of-pocket expenses. For a family, a qualified health plan is one with a minimum deductible of $2,200 for 2008 ($2,300 for 2009) and a cap of $11,200 for 2008 ($11,600 for 2009) on out-of-pocket expenses. These figures are indexed annually for inflation.

2.) **Contribution Limits** Annual contributions of up to 100% of an individual's health plan deductible can be made to an HSA. For 2008, the maximum annual contribution is $2,900 for individual coverage and $5,800 for family coverage (indexed annually), provided the insured has a deductible at least that high. Individuals who are 55 to 65 years old can make an additional catch-up contribution. Individuals with HSAs who are age 55 and older may make additional annual contributions of $900 (as of 2008), increasing to a maximum addition calendar year contribution of $1,000 in 2009 and thereafter.

3.) **Tax Treatment** Earnings in HSAs grow tax free, and account beneficiaries can make tax-free withdrawals to cover current and future qualified health care costs.

a.) Qualified health care expenses include amounts paid for:

- doctors' fees;
- prescription and nonprescription medicines;
- necessary hospital services not paid for by insurance;
- retiree health insurance premiums;
- Medicare expenses (but not Medigap);
- qualified long-term care services; and
- COBRA coverage.

b.) Qualified medical expenses are those expenses incurred by the HSA owner, the spouse, and dependents. Nonqualified withdrawals are subject to income taxes and a 10% penalty. HSAs are fully portable, and assets can accumulate over the years. Upon death, HSA ownership may be transferred to a spouse tax free.

© 2008 DF Institute, Inc.

On p. 136, replace paragraph 4, "Part D—Prescription Drugs," with the following content:

---

4. **Part D (from the Medicare Prescription Drug, Improvement, and Modernization Act of 2003)** The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 is considered by many to be the most comprehensive change to the federal Medicare program since it was enacted in 1965. Its intent is to provide seniors and the disabled with a prescription drug benefit as well as more choices under Medicare.

   a. **Health savings accounts (HSAs)** Commonly known as Medicare Advantage, this option allows individual under 65 years to establish and contribute to an HSA if they have a qualified health plan. It provides a tax-favored way to accumulate funds to cover medical expenses.

      1.) A qualified health plan for an individual is defined as one with a minimum deductible of $1,100 for 2008 ($1,150 for 2009) and a cap of $5,600 for 2008 ($5,800 for 2009) on out-of-pocket expenses. For a family, the minimum deductible is $2,200 for 2008 ($2,300 for 2009) with a cap of $11,200 for 2008 ($11,600 for 2009). These amounts are indexed annually.

      2.) Annual contributions can be made up to 100% of an individual's health plan deductible. In 2008, the limit is $2,900 for self-only coverage and $5,800 for individuals with family coverage. These limits are indexed annually.

      3.) Catch-up contributions can be made by individuals age 55 to 65 in the amount of $900. This limit can be increased up to $1,000 in 2009 and thereafter.

      4.) HSA earnings grow tax-free. Tax-free withdrawals can be made to cover expenses such as retiree health insurance premiums, Medicare expenses, prescription drugs, long-term care services, and COBRA coverage.

      5.) Nonqualified withdrawals are subject to income tax as well as a 10% penalty. HAS assets can accumulate and are portable. At death, ownership may be transferred tax free to a spouse.

      6.) HSAs may be offered by employers through a cafeteria plan; employer contributions are made on a pretax basis are not taxable to the employee.

   b. **Medicare Part D—prescription drug plan (PDP)** Beginning in 2006, Medicare recipients can elect a prescription drug plan for an additional monthly premium. The provisions of this option include the following.

© 2008 DF Institute, Inc.

1.) For the standard benefits under the PDP plan, Medicare beneficiaries will pay a projected monthly premium of $35 and assume an annual deductible of $250. Beneficiaries will then pay 25% of the first $2,250 of prescription drug costs, and Medicare will pay the 75% balance. After this limit is reached, coverage stops completely until total drug costs exceed $5,100 (initial $2,250 plus another $2,850). After that, coverage starts again and beneficiaries contribute a copayment of $2 for generic drugs and $5 for brand name medications or 5% of total costs, whichever is higher. (Note that these dollar thresholds are scheduled to increase each year.)

2.) Benefits will be available through PDPs, which are private plans that will contract with Medicare, and through Medicare Advantage.

3.) A six-month enrollment period began on November 12, 2005. The law provides for federal subsidy payments to employers and unions that sponsor qualified retiree prescription drug plans.

4.) **Medicare supplement (Medigap) policies** Currently, three of the standardized Medicare supplement plans provide prescription drug coverage. Starting in 2006, the law prohibits the inclusion of prescription drug coverage in these policies. However, Medicare supplement policyholders who have the prescription drug coverage and do not enroll in Medicare Part D will be able to renew their policies.

   a.) Policyholders who enroll in Part D may keep their current Medigap policy without the prescription drug coverage and their premium will be adjusted, or they may change to another Medigap plan if they elect Part D during the initial enrollment period.

On p. 137, replace the last sentence of paragraph B(1), "Medicare Supplement (Medigap) Policies," with the following content:

(In 2006, Plans H, I, and J were discontinued and Plans K and L were introduced. More on this below.)

On p. 138, replace the first sentence of paragraph 4 with the following content:

As noted, two new Medigap benefit packages became available on January 1, 2006.

On p. 138, insert the following before paragraph 4(a):

© 2008 DF Institute, Inc.

a. Plan K includes coverage for the core benefits, 50% of the Medicare Part A deductible, and 50% of the skilled nursing facility coinsurance.

b. Plan L includes coverage for the core benefit, 50% of the Medicare Part A deductible, and 50% of the skilled nursing facility coinsurance.

On page 149, add the following content after “H. Managed Care”:

I. Workers' Compensation All state workers' compensation laws incorporate four categories of benefits:

- (loss of income) benefits;
- medical benefits;
- survivor (death) benefits; and
- rehabilitation benefits.

1. Benefits compensate for loss of income or earning capacity suffered by individuals injured in their occupation. Payments may be made on a weekly basis, a lump-sum basis, or some combination. On the other hand, an employee who suffers a permanent loss, such as amputation of a limb, will probably receive a flat lump-sum payment based on a predetermined schedule in the state's workers' compensation law.
2. Medical benefits compensate for the cost of medical treatment resulting from job-related injury. In most cases, workers' compensation will pay for the full cost of this treatment.
3. Survivor benefits attempt to compensate the widowed spouse or other survivor of an employee whose death results from a job-related injury. The amount of the benefit depends on the deceased's earnings, subject to fixed minimums and maximums and the number of surviving dependents. A fixed amount is also available for burial expenses. Benefits normally extend until the spouse remarries or until the children become adults.
4. Rehabilitation benefits are provided in every state because all states accept the provisions of the Federal Vocational Rehabilitation Act, which provides federal aid toward the costs incurred. Rehabilitation for gainful employment serves to reduce insurance losses while restoring the injured worker's dignity. Therefore, rehabilitation is considered worthy of federal help.

J. Subrogation Subrogation is the right of one who has taken over another's loss to also take over the person's right to pursue remedies against the offending third party. It is never used in life insurance and seldom used in the context of health insurance.

On page 190, remove paragraph “g. Multiple employer welfare arrangements” as this topic is no longer subject to examination.

© 2008 DF Institute, Inc.

Part II
Changes to Questions

There are no new questions at this time.

© 2008 DF Institute, Inc.

Part III
Changes to Answers or Rationales

There are no new answers or rationales at this time.

© 2008 DF Institute, Inc.

Part IV
Errata

On page 148, replace the last sentence of paragraph 2 with the following:

A self-employed individual may deduct premiums paid for medical insurance, limited to the net earnings from self-employment in the business for which the plan coverage was established.

© 2008 DF Institute, Inc.

To submit comments or suggestions, please send an email to **errata@kaplan.com**.

www.kaplanfinancial.com
1905 Palace Street, La Crosse, WI 54603
800-824-8742