

Test Alert!

New Hampshire Life, Accident, and Health Insurance

License Exam Manual

2nd Edition

2/22/06

L&H

The information included in this release, in addition to your other Kaplan Financial 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's Website at www.kaplanfinancial.com for the latest updates to this Test Alert!

As always, we strive to provide you with the most current test preparation information. If you have any questions about this or any other Kaplan Financial study material, please call AnswerPhone at 1-800-621-9621, ext. 3598, between the hours of 8 AM and 6 PM CT, Monday through Friday.

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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 260, insert the following content before “b. Minimum standards for accident and health policy provisions [Sec. 1901.04]”:

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- 10.) Preexisting condition defined [Reg. 1901.03(k)]** Preexisting conditions cannot be defined more restrictively than the existence of symptoms that would cause an ordinarily prudent person to seek diagnosis, care, or treatment within a two-year period preceding the effective date of coverage or a condition for which medical advice or treatment was recommended by a physician within a two-year period preceding the effective date of coverage.
- a.) Preexisting condition exclusion limitation [Reg. 1901.04(c)]** An insurer cannot exclude coverage due to a preexisting condition for more than 12 months after the policy’s issue date when the application does not ask the applicant to disclose prior illnesses, diseases, physical conditions, or medical care of the preexisting condition. It may not exclude coverage for a preexisting condition when the policy does not specifically exclude it.

On page 261, insert the following content before “c. Rules regarding policy provisions for individual accident and health policies”:

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- 7.) Minimum standards for benefits [Reg. 1901.06(a)(11)]** Benefits for accidental death and dismemberment must be paid if the loss occurs within 90 days of the accident, regardless of total disability. If disability income benefits are paid, they may not require the loss to begin within 30 days of the accident. If the insurer cancels or refuses to renew a policy after an accident, the insured is still entitled to benefits if the accident happened when the policy was still in force.
- 8.) Probationary periods [Sec. 1901.05(a)]** Individual accident and health insurance policies cannot contain a probationary or waiting period during which the policy provides no coverage. However, a policy may specify a probationary or waiting period of up to six months for the following diseases or conditions:
- Hernia disorder of reproductive organs
 - Varicose veins
 - Adenoids
 - Appendix and tonsils

This six-month exception does not apply when these diseases or conditions are treated on an emergency basis. Accident policies cannot contain probationary or waiting periods.

- 9.) Military suspense provision [Reg. 1901.05(c)(5)]** If a policy suspends coverage during the insured's military service, it must refund premiums on a pro rata basis upon written request of the policyholder.

On page 264, insert the following content after "5. Conversion [Sec. 415:18]":

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- a. Free-look period [Reg. 1901.06(a)(11)]** As in the case of any individual health insurance policy, a person who converts coverage from a group health insurance plan to an individual policy is entitled to a 30-day free-look period during which he may return the policy for any reason and have his premium refunded in full.

On page 268, insert the following content after paragraph f in "4. Required disclosure provisions":

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- 1.) Excessive insurance** Any sale of a Medicare supplement policy to an insured who already has a policy is prohibited. An insurer cannot issue a Medicare supplement policy to a person enrolled in Medicare Part C unless the effective date of coverage is after the termination date of the person's Part C coverage.

On page 269, insert the following content after "5. Requirements for replacement":

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- a. Waiver of waiting periods for preexisting conditions** If a Medicare supplement policy replaces another, the replacing insurer must waive any time periods that apply to preexisting conditions, waiting periods, elimination periods, and probationary periods in the new Medicare supplement policy to the extent that the insured satisfied such periods under the original policy. However, if a Medicare supplement policy replaces another that has been in effect for at least six months, the replacing policy cannot require the insured to satisfy any new periods that apply to preexisting conditions, waiting periods, elimination periods, and probationary periods.

On page 269, insert the following content after paragraph 7:

A Medicare Select policy must pay for covered services that are not available through participating (network) providers. It may not restrict payment for covered services provided by providers outside the network if the services are provided on an emergency basis, and the services are needed immediately, and the insured cannot reasonably obtain these services through a network provider.

On page 269, insert the following content before “D. Long-Term Care Required Provisions [Sec. 415-D]”:

- 8. Prohibited marketing practices [Reg. 1905.19]** In addition to the marketing practices that are prohibited when marketing any accident and health insurance policy, insurers marketing Medicare supplement insurance cannot engage in any of the following practices:

 - a. High-pressure tactics** Insurers cannot use any method that has the effect of or tends to induce the purchase of insurance through force, fright, threat, or undue pressure to buy or even consider an insurance purchase.
 - b. Cold-lead advertising** Insurers cannot use any marketing method that fails to clearly disclose that the purpose of the marketing method is to solicit insurance and that an insurance agent or insurance company will contact the prospect.
 - c. Language** Insurers cannot use the terms Medicare supplement, Medigap, Medicare wrap around, or such terms in a policy unless it complies with the above requirements.
- 9. Notice of change [Reg. 1905.16(b)]** As soon as practicable, but no later than 30 days before the annual effective date of any Medicare benefit change, an insurer must tell its insureds of any changes it has made to Medicare supplement insurance. This notice must:

 - describe the changes to the Medicare program;
 - state when the premium will be adjusted due to changes in Medicare; and
 - not contain or accompany any solicitation for the purchase of insurance.

On page 269, insert the following content after paragraph 2 in “D. Long-Term Care Required Provisions [Sec. 415-D:7]”:

- 3. Free look [Sec. 415-D:7]** Applicants for long-term care insurance are entitled to return the policy within 30 days after delivery and have the premium refunded if they are not satisfied with the policy for any reason.
- 4. Preexisting conditions [Sec. 415-D:5(III)]** A long-term care insurance policy cannot define a preexisting condition more restrictively than a condition for which medical advice or treatment was recommended by, or received from, a health care provider within six months before the effective date of coverage. No long-term care policy may exclude coverage for a loss or confinement that results from a preexisting condition unless the loss or confinement begins within six months after the effective date of coverage.

On page 269, insert the following content after “E. Group Coordination of Benefits [Chapter 1904]”:

1. **Coverage under two or more plans [Regs. 1904.05-.07]** When a person is covered by two or more policies, the primary plan will pay benefits as if the secondary plan did not exist. However, if the primary plan is a closed panel plan and the secondary plan is not, the secondary plan will pay benefits as if it were the primary plan when the insured uses a non-panel provider. Emergency services or authorized referrals that the primary plan pays for or provides are still covered by the primary plan.

If an insured is covered by more than one secondary plan, each plan takes into consideration the benefits of the primary plan and the benefits of any other plan that are determined before those of the secondary plan.

- a. **Order of benefit determination** Every plan determines its order of payment using the first of the following rules that applies:

- 1.) **Dependent or nondependent** The plan that covers the person other than as a dependent is the primary plan. The plan that covers the person as a dependent is the secondary plan.

- a.) If the person is a Medicare beneficiary, Medicare is secondary to the plan that covers the person as a dependent, but primary to the plan covering the person other than as a dependent.

- 2.) **Dependent child covered under more than one plan** Unless a court order requires otherwise, plans covering a dependent child pay benefits in the following order:

- a.) For dependent children whose parents are married or living together:
 - The plan of the parent whose birthday is earlier in the year is the primary plan.
 - If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
- b.) For dependent children whose parents are divorced or separated or not living together:
 - If a court orders that one parent is responsible for the child’s health care expenses, that parent’s plan is primary. If that parent does not have health coverage and the spouse does, the spouse’s plan is primary.
 - If a court orders that both parents are responsible or grants joint custody, the primary plan is determined as if the parents were married or living together.

- If no court order determines the primary plan, the benefits are paid in the following order: the plan covering the custodial parent, the plan covering the custodial parent's spouse, the plan covering the noncustodial parent, and then the plan covering the noncustodial parent's spouse.
- 3.) **Active employee or retired or laid-off employee** The plan covering an active employee is the primary plan. The plan covering a retired or laid-off employee as a dependent of such an employee is the secondary plan.
 - 4.) **COBRA** Coverage under COBRA is secondary to any other plan covering the same person.
 - 5.) **Length of time** The plan that has covered the person for the longest period of time is the primary plan, and the plan that has covered the person for the shortest period of time is the secondary plan.
 - 6.) **No determination** If the preceding rules do not determine the order of benefits, the expenses are shared equally between the plans.

Part II
New Sample Questions

There are no new questions at this time.

Part III
Answers and Rationales

There are no new answers or rationales at this time.

On page 186, replace the last sentence of paragraph b with the following:

Self-employed individuals 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.

On page 295, replace “\$41,000” in the heading “Amount of Each Monthly Payment per \$41,000 of Proceeds—Options C and D” with “\$1,000.”

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

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