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Addendum: for use with Missouri Life and Health online ExamFX courses and study guides version 25685en and 25686en, per exam content outline updates effective 4/26/2023.

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

LIFE AND HEALTH:

Introduction

Exam Breakdown – *revised exam breakdown*

Missouri Life and Health Insurance Examination
155 Total Questions (145 scored; 10 pretest)

CHAPTERS	PERCENTAGE OF EXAM
General Knowledge:	
Completing the Application, Underwriting, and Delivering the Policy	8%
Types of Life Policies	11%
Life Policy Provisions, Riders and Options	11%
Retirement and Other Insurance Concepts	6%
Field Underwriting Procedures	6%
Types of Health Policies	11%
Health Policy Provisions, Clauses, and Riders	10%
Social Insurance	4%
Other Insurance Concepts	3%
State Law:	
Missouri Statutes, Rules and Regulations Common to All Lines	10%
Missouri Statutes, Rules and Regulations Pertinent to Life Insurance Only	10%
Missouri Statutes, Rules and Regulations Common to Accident and Health Only	10%

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Missouri Statutes, Rules and Regulations Common to All Lines

A. Director of Commerce and Insurance – *changed to Director of Commerce and Insurance*

2. Examination of Records — *addition to the existing text*

It is illegal for any person in any investigation, examination, inquiry, or other proceeding to

- Knowingly make or cause to be made a false statement upon oath or affirmation or in any record that is submitted to the Director or used in any proceeding; or
- Make any false certificate or entry or memorandum upon any of the books or papers of any insurance company, or upon any statement or exhibit offered, filed or offered to be filed in the department, or used in the course of any examination, inquiry, or investigation.

3. Cease and Desist Orders — *addition to the existing text*

A hearing resulting from a cease and desist order may not be held sooner than 10 days after the notice of hearing is served.

4. Penalties — *addition to the existing text*

If the violation committed was flagrant and in conscious disregard of the law, the person will be fined up to $25,000 for each violation, not the exceed $250,000 in any 12-month period.

Court Action

The Director may take action through the courts to enjoin any existing or threatened violation of any provision of the Insurance Code, or to enforce any proper order made or action taken by the Director.

The court may

- Issue a permanent or temporary injunction, restraining order, or declaratory judgment;
- Order other appropriate or ancillary relief (such freezing assets or imposing a penalty); or
- Order such other relief as the court considers necessary or appropriate.

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Records Expunged

All records of disciplinary actions against an insurance producer that resulted in a monetary penalty of $200 or less and places no other legal duty on the producer will be expunged after 5 years from the date of the execution of the order or settlement agreement by the Director.

B. Licensing Requirements

Temporary License

If necessary, the Director may issue a temporary producer's license without requiring a written examination in any of the following cases for the continuation of a producer's existing business:

- To the surviving spouse or court-appointed personal representative of a producer who is deceased or becomes mentally or physically disabled;
- To a member or employee of a business entity licensed as an insurance producer, upon the death or disability of an individual designated on the business entity application;
- To the designee of a licensed producer who enters active service in the armed forces of the United States;
- In any other circumstance in which the Director deems that public interest will best be served by the issuance of the license.

Producers with a temporary license can perform all of the functions of a regularly licensed producer. Temporary licenses cannot exceed **90 days**. The Director may revoke a temporary license if the interests of insureds or the public are endangered. A temporary license may not continue after the owner or the personal representative disposes of the business.

Producer Appointment and Termination of Appointment

An insurance producer cannot act as an agent of an insurer unless the insurance producer is appointed by that insurer. An insurance producer who is not acting as an agent of an insurer is not required to be appointed.

To appoint a producer as its agent, the appointing insurer must enter the name and license number of the producer into the company register within **30 days** of authorizing the producer to transact business on its behalf. There

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is no charge associated with changing a producer's appointment status on the register. The register must be maintained electronically and be open to inspection by the Director.

An insurer that terminates the appointment, employment, contract, or other insurance business relationship with a producer must notify the Director within **30 days** following the effective date of the termination. The insurer must also update the company register within 30 days of appointment termination.

All documents, records, and statements provided to the Director are deemed confidential and absolutely privileged. The Director must provide all obtained written material associated with the appointment or termination of appointment to the producer.

LIFE:

Introduction

Exam Breakdown – *revised exam breakdown*

Missouri Life Insurance Examination
100 Total Questions (90 scored; 10 pretest)

CHAPTERS	PERCENTAGE OF EXAM
General Knowledge:	
Completing the Application, Underwriting, and Delivering the Policy	13%
Types of Life Policies	17%
Life Policy Provisions, Riders and Options	17%
Retirement and Other Insurance Concepts	9%
State Law:	
Missouri Statutes, Rules and Regulations Common to All Lines	22%
Missouri Statutes, Rules and Regulations Pertinent to Life Insurance Only	22%

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Completing the Application, Underwriting, and Delivering the Policy

Gramm-Leach-Bliley Act (GLBA) Privacy

The Gramm-Leach-Bliley Act stipulates that in general, an insurance company may not disclose nonpublic personal information to a nonaffiliated third party except for the following reasons:

- The insurance company clearly and conspicuously discloses to the consumer in writing that information may be disclosed to a third party;
- The consumer is given the opportunity, before the time that information is initially disclosed, to direct that information not be disclosed to the third party; or
- The consumer is given an explanation of how the consumer can exercise a nondisclosure option.

The Gramm-Leach-Bliley Act requires 2 disclosures to a customer (a consumer who has an ongoing financial relationship with a financial institution):

1. When the customer relationship is established (a policy is purchased); and
2. Before disclosing protected information.

The customer must also receive an annual privacy disclosure, and have the right to opt out, or choose not to have their private information shared with other parties.

Life Policy Provisions, Riders and Options

A. Policy Provisions

Beneficiary Designations

Designation by Class

A class of beneficiary is using a designation such as "my children." This term can be vague if the insured has been married more than once, has adopted children, or has children out of wedlock.

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An example of a class that is less vague is "children of the union of Jane Smith and James Smith." Many insurers encourage the insured to name each child specifically and to state the percentage of benefit they are to receive.

When naming beneficiaries, it is most prudent to be specific by naming each individual and by designating the exact amount to be given for that individual. Two class designations are available for use when an insured chooses to "group" the beneficiaries: per capita and per stirpes**. Per capita**, meaning by the head, evenly distributes benefits among the living named beneficiaries.

Per stirpes, meaning by the bloodline, distributes the benefits of a beneficiary who died before the insured to that beneficiary's heirs.

B. Policy Riders – *additional riders*

Disability Income

With the **disability income** rider, in the event of disability the insurer will waive the policy premiums and pay a monthly income to the insured. The amount paid is normally based on a percentage of the face amount of the policy to which it is attached.

Cost of Living

The **cost of living** rider addresses the inflation factor by automatically increasing the amount of insurance *without evidence of insurability* from the insured. The face value of the policy may be increased by a cost of living factor tied to an inflation index such as the Consumer Price Index (CPI).

Taxation, Retirement, and Other Insurance Concepts – *chapter renamed as “Retirement and Other Insurance Concepts”*

Viatical Settlements – *topic deleted from the General Knowledge outline*

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Missouri Statutes, Rules and Regulations Pertinent to Life Only

E. Variable Products

1. Company Qualifications – *addition to content*

Every individual annuity contract must have the following provisions in place once premium payments are stopped:

- The insurer must grant a paid-up annuity benefit;
- If a contract provides for a lump-sum settlement at maturity, the company will pay a cash surrender benefit instead of any paid-up annuity benefit upon surrender or prior to commencement of annuity payments;
- A statement of the mortality table and interest rates used in calculating any minimum paid-up annuity, cash surrender, or death benefits that are guaranteed; and
- A statement that any paid-up annuity, cash surrender, or death benefits that may be available are not less than the minimum benefits required.

HEALTH:

Introduction

Exam Breakdown – *revised breakdown*

Missouri Accident and Health Insurance Examination
100 Total Questions (90 scored; 10 pretest)

CHAPTERS	PERCENTAGE OF EXAM
General Knowledge:	
Field Underwriting Procedures	9%
Types of Health Policies	18%
Health Policy Provisions, Clauses, and Riders	17%
Social Insurance	7%
Other Insurance Concepts	5%

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State Law:	
Missouri Statutes, Rules and Regulations Common to All Lines	22%
Missouri Statutes, Rules and Regulations Pertinent to Health Only	22%

Types of Health Insurance Policies

A. Medical Expense Insurance

Health Reimbursement Accounts (HRAs)

Health Reimbursement Accounts (HRAs) consist of funds set aside by employers to reimburse employees for qualified medical expenses, such as deductibles or coinsurance amounts. Employers qualify for preferential tax treatment of funds placed in an HRA in the same way that they qualify for tax advantages by funding an insurance plan. Employers can deduct the cost of a health reimbursement account as a business expense.

The following are key characteristics of HRAs:

- They are contribution healthcare plans, not defined benefit plans;
- Not a taxable employee benefit;
- Employers' contributions are tax deductible;
- Employees can roll over unused balances at the end of the year;
- Employers do not need to advance claims payments to employees or healthcare providers during the early months of the plan year;
- Provided with employer dollars, not employee salary reductions;
- Permit the employer to reduce health plan costs by coupling the HRA with a high-deductible (and usually lower-cost) health plan; and
- Balance the group purchasing power of larger employers and smaller employers.

HRAs are open to employees of companies of all sizes; however, the employer determines eligibility and contribution limits.

An HRA has no statutory limit. Limits may be set by employer, and rollover at the end of the year based on employer discretion. Former employees, including retirees, can have continued access to unused HRAs, but this is

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done at the employer's discretion. HRAs remain with the originating employer and do not follow an employee to new employment.

Long-Term Care — Eligibility for Benefits

Normally to be eligible for benefits from a long-term care policy, the insured must be unable to perform some of the activities of daily living (ADLs). Activities of daily living include *bathing, dressing, toileting, transferring positions (also called mobility), continence,* and *eating.*

Other Health Insurance Concepts

Cost Containment

With the dramatic rise in the cost of medical care over the past few decades, the concept of **managed care** has become a necessity for insurance companies. Managed care plans, such as HMOs and PPOs, are designed to control costs by controlling the behavior of the plan participants.

Cost-Saving Services

Cost-saving services or case-management provisions provide plans with controlled access of providers, large claim management, preventive care, hospitalization alternatives, second surgical opinions, preadmission testing, catastrophic case management, risk sharing, and providing high quality of care. Insurance companies use the services of case managers for large, ongoing claims through a process of utilization management. The case manager evaluates the appropriateness, necessity, and quality of health care, and may include prospective and concurrent review.

Preventive Care

Managed care plans encourage preventive care and living a healthier lifestyle. Annual physical exams, mammograms, and other procedures used to detect medical problems before symptoms appear can result in a considerable cost savings if a problem is detected early and treated quickly.

Hospital Outpatient Benefit

Because hospital confinement has become so costly, many plans require the patient to take advantage of outpatient services when possible.

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Alternatives to Hospital Services

Alternatives to hospital care might include home health care where the patient stays at home and is visited periodically by a health professional. A home health aide that could work in conjunction with a family member may meet daily needs. Terminally ill patients may elect hospice care rather than a hospital stay. Hospice attends to the patient's daily needs and provides pain relief but attempts no curative procedures. Within cost containment, painkillers and special hospital beds are paid for, but operations or antibiotics are not.

Utilization Management

Utilization management is a system for reviewing the appropriateness and efficient allocation of health care services and resources that are being given or are proposed to be given to an insured. It also covers the review of claims for services that may be covered by a health care provider. There are different types of utilization management reviews: prospective, retrospective, or concurrent review.

Prospective Review

Under the **prospective review** or **precertification process**, the physician can submit claim information prior to providing treatment to know in advance if the procedure is covered under the insured's plan and at what rate it will be paid.

Concurrent Review

Under the concurrent review process, the insurance company will monitor the insured's hospital stay to make sure that everything is proceeding according to schedule and that the insured will be released from the hospital as planned.

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Missouri Statutes, Rules and Regulations Pertinent to Health Only

A. Required Provisions and Benefits

5. Coverage for Mental Health Services – *addition to the existing text*

Health care plans must also ensure timely access to care with the following guidelines:

- **Routine care, without symptoms** — within 30 days from the time the enrollee contacts the provider;
- **Routine care, with symptoms** — within 5 business days from the time the insured contacts the provider;
- **Urgent care (for situations that require immediate care, but are not emergencies)** — within 24 hours from the time the insured contacts the provider;
- **Emergency care** — an appropriate mental health provider or emergency care facility must be available 24 hours per day, 7 days per week; and
- **Telephone access** — a licensed mental health care professional must be available 24 hours per day, 7 days per week.

Systems for delivery of treatment for mental health conditions must have enough mental health care providers to meet timely access to care requirements. If the network does not, coverage of mental health treatment outside of the network must be the same as if the treatment had been inside the network.

10. Grievance Procedures

First- and Second-Level Grievance Review

A health carrier that offers managed care plans must establish a first-level and second-level grievance review process for its managed care plans. A grievance may be submitted by an enrollee, an enrollee's representative or a provider acting on behalf of an enrollee.

Upon receipt of a request for first-level grievance review, a health carrier must

- Acknowledge receipt of the grievance in writing within 10 working days;
- Conduct a complete investigation of the grievance within 20 working days after receiving it;

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    - If the investigation cannot be completed within 20 working days, the enrollee must be notified in writing on or before the 20th working day. The investigation must then be completed within the next 30 working days. The notice must include the specific reasons additional time is needed;
- Within 5 working days of the completion of the investigation, have someone not involved in the grievance or its investigation decide the appropriate resolution of the grievance and notify the enrollee in writing of the health carrier's decision regarding the grievance and of the right to file an appeal for a second-level review; and
- Within 15 working days after the investigation is completed, notify the person who submitted the grievance of the carrier's resolution of the grievance.

Upon receipt of a request for second-level review, a health carrier must submit the grievance to a grievance advisory panel consisting of

- Other enrollees; and
- Representatives of the health carrier that were not involved in the circumstances giving rise to the grievance or in any subsequent investigation or determination of the grievance.

If the grievance advisory panel decides to uphold an adverse determination, the health carrier must submit the grievance for review to two independent clinical peers in the same or similar specialty. If both independent reviews concur with the decision, the panel's decision will stand. If both independent reviewers disagree with the decision, the initial adverse determination will be overturned. If one of the two independent reviewers disagrees with the decision, the panel must reconvene and make a final decision.

Independent Review

If an insured's health coverage is denied, reduced, modified or terminated by their carrier, and, after having exhausted the carrier's grievance processes, the insured may request their case to be reviewed by a certified independent review organization. The review organizations must be established and placed in a rotating schedule by the Commissioner.

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The review agency may request the following information from the carrier:

- Any medical records of the insured that are relevant to the review;
- Any documents used by the carrier in making the determination to be reviewed by the certified independent review organization;
- Any documentation and written information submitted to the carrier in support of the appeal; and
- A list of each physician or health care provider that has provided care to the insured, and that may have medical records relevant to the appeal.

Health information or other confidential or proprietary information in the custody of a carrier may be provided to an independent review organization, subject to rules adopted by the commissioner.

All documents requested by the reviewing organization must be received from the carrier within 3 business days of notification. Once a request for an independent review determination has been made, the independent review organization must proceed to a final determination, unless requested otherwise by both the carrier and the insured or the insured's representative. Carriers must implement the certified independent review organization's determination in a timely fashion and must also pay the certified independent review organization's charges. If the reviewing organization finds a pattern of substandard or egregious conduct by a carrier, they should report their findings to the Office of the Insurance Commissioner.

Expedited Review

An enrollee or enrollee’s representative or health carrier may request an expedited external review if the adverse determination

- Concerns an admission, availability of care, continued stay, or health care service for which the enrollee received emergency services, but has not been discharged from a facility; or
- Involves a medical condition for which the delay occasioned by the standard external review time frame would jeopardize the life or health of the enrollee or jeopardize the enrollee’s prognosis or ability to regain maximum function.

For cases like that, a health carrier must establish written procedures for the expedited review of a grievance involving a situation where the standard time

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frame of the grievance process would seriously jeopardize the life or health of an enrollee or would jeopardize the enrollee's ability to regain maximum function. A request for an expedited review may be submitted orally or in writing. However, the request will not be considered a grievance unless submitted in writing.

A health carrier must notify an enrollee orally within 72 hours of receiving a request for an expedited review, and must provide written confirmation of its decision covering an expedited review within 3 working days of providing notification of the determination.

11. Chiropractic Services – *addition to the existing text*

Copayments for chiropractic services may not exceed 50% of the total cost of providing a single chiropractic service.

B. Required Offers

1. Speech and Hearing – *addition to the existing text*

Necessary care and treatment includes services to identify, assess, diagnose and consult about any treatment needed for the loss or impairment of speech or hearing.

These services include evaluation of hearing; determining range, nature and degree of hearing function; testing, adjusting and evaluating auditory prosthetic devices; and evaluating and treating children with delayed or impaired speech or language disorders.

C. Medicare Supplement

4. Commissions – *change to content; commissions must be provided for no fewer than 5 renewal years*

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E. Group Policies

5. Association and Discretionary Group Coverage – *addition to the existing text*

Any sales materials, policy and other plan documents issued to the group, and certificates or other evidence of coverage delivered to covered members must clearly disclose

- Whether there are mechanisms established to effect different premium rates for an individual unit covered by the group policy and, if so, how often a unit may be reclassified for a different rate and the formula or amount by which these rate level classifications differ;
- Whether renewal rates will be calculated on the basis of experience for the group or for individual units, or a combination of both;
- To what extent individual units within the group can be cancelled or nonrenewed solely on the basis of deterioration of health of one or more covered members within the unit; and
- The period of time in advance of the premium due date within which notification is provided as to any premium rate change applicable to the policyholder or any individual unit to which the change applies.

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