Addendum: for use with Oregon Life and Health online courses and study guides version 27718en/27719, per exam content outline updates effective 5/1/2023.

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

Introduction

Exam Breakdown – *revised exam breakdowns*

Oregon Life Insurance Examination
100 Questions

CHAPTERS	PERCENTAGE OF EXAM
General Insurance Concepts	7%
Life Insurance Basics	20%
Life Insurance Policies	20%
Life Insurance Policy Provisions, Riders and Options	25%
Annuities	11%
Federal Tax Considerations for Life Insurance and Annuities	6%
Insurance Regulation	8%
Federal Laws and Regulations	3%

Note that in your online course, Federal Laws and Regulations are part of the Insurance Regulation chapter.

Oregon Health Insurance Examination
100 Questions

CHAPTERS	PERCENTAGE OF EXAM
General Insurance	10%
Accident and Health Insurance	15%
Individual Health Insurance Policy General Provisions	14%
Disability Income and Related Insurance	10%
Medical Plans	18%
Group Health Insurance	6%
Specialized Health Insurance for Qualified Individuals	9%
Federal Tax Considerations for Health Insurance	4%
Insurance Regulation	10%
Federal Laws and Regulations	4%

Note that in your online course, Federal Laws and Regulations are part of the Insurance Regulation chapter.

Prior to May 1, 2023, the state exam will also include questions pertaining to Dental Insurance. Please refer to that chapter in your online course for review.

Oregon Life and Health Insurance Examination
150 Questions

CHAPTERS	PERCENTAGE OF EXAM
General Insurance	4%
Life Insurance Basics	7%
Life Insurance Policies	13%
Life Insurance Policy Provisions, Options and Riders	7%
Annuities	11%
Health Insurance Basics	6%
Individual Health Insurance Policy General Provisions	5%
Disability Income and Related Insurance	3%
Medical Plans	8%
Group Health Insurance	14%
Specialized Health Insurance for Qualified Individuals	12%
Federal Tax Considerations for Life and Health Insurance	4%
Insurance Regulation	4%
Federal Laws and Regulations	2%

Note that in your online course, Federal Laws and Regulations are part of the Insurance Regulation chapter.

Prior to May 1, 2023, the state exam will also include questions pertaining to the following topics: Qualified Plans and Dental Insurance. Please refer to those chapters in your online course for review.

Life Insurance Policies

A. Term Life Insurance

Increasing Term

Increasing term features level premiums and a death benefit that increases each year over the duration of the policy term. The amount of the increase in the death benefit is usually expressed as a specific amount or a percentage of the original amount. Increasing term is often used by insurance companies to fund certain riders that provide a *refund of premiums* or a gradual increase in total coverage, such as the cost of living or return of premium riders.

This type of policy would be ideal to handle inflation and the increasing cost of living. It is also often added to another policy as a rider, such as with return of premium policies.

C. Flexible Premium Policies

Indexed Universal Life

Indexed universal life is a universal life policy with an equity index as its investment feature. It has many of the same characteristics as the variable universal life (flexible premiums, an adjustable death benefit, the policyowner decides where the cash value will be invested) with the primary difference being the investment feature. Under a variable universal life policy, the policy's cash value is dependent upon the performance of one or more investment funds. Under the equity index universal policy, the policy's **cash value is dependent upon the performance of the equity index**. Cash values and death benefit are not guaranteed. Sale of the equity indexed universal life product does not require a securities license (whereas the sale of variable universal life does require a securities and life license).

D. Variable Life

Variable Universal Life

Variable universal life is a combination of universal life and variable life. Like universal life, it provides the policyowner with flexible premiums and an adjustable death benefit. Like variable life, the policyowner rather than the insurer, decides where the net premiums (cash value) will be invested. Also, like

variable life, the cash values are not guaranteed, and the death benefit is not fixed. The cash value and/or death benefit may increase or decrease over the life of the policy depending on the investment performance of the underlying sub-account. The death benefit, however, generally cannot decrease below the initial face amount of the policy. A producer must also be **licensed for both securities and life insurance** in order to sell variable universal life.

Annuities

C. Annuity Products – Investment Options

Variable Annuities

A **variable annuity** serves as a hedge against inflation, and is variable from the standpoint that the annuitant may receive different rates of return on the funds that are paid into the annuity. Listed below are the 3 main characteristics of variable annuities:

- **Underlying Investment** — the payments that the annuitant makes into the variable annuity are invested in the insurer's separate account, not their general account. The separate account is not part of the insurance company's own investment portfolio, and is not subject to the restrictions that are applicable to the insurer's own general account.
- **Interest Rate** — issuing insurance company does not guarantee a minimum interest rate.
- **License Requirements** — a variable annuity is considered a **security** and is regulated by the Securities Exchange Commission (SEC) in addition to state insurance regulations. An agent selling variable annuities must hold a securities license in addition to a life insurance license. Agents or companies that sell variable annuities must also be properly registered with FINRA.

Variable premiums purchase **accumulation units** in the fund, which is similar to buying shares in a Mutual Fund. Accumulation units represent ownership interest in the separate account. Upon annuitization, the accumulation units are converted to **annuity units**. The income is then paid to the annuitant based on the value of the annuity units. The number of annuity units received remains level, but the unit values will fluctuate until actually paid out to the annuitant.

E. Uses of Annuities

Long-Term Care Rider

Under the Pension Protection Act of 2006, annuitants are allowed to transfer money from an annuity to pay for long-term care insurance premiums, tax free. In the past, distributions from nonqualified annuities were taxed; however, now, distributions can be used to pay for long-term care premiums and, in many cases, eliminate the taxes on the annuity gains. As a result, many insurers now offer a hybrid annuity with a long-term care feature. These policies provide for income, long-term care, or both.

Qualified Plans – *chapter deleted from the outline*

Health Insurance Basics

F. Producer Responsibilities in Individual Health Insurance

Statement of Good Health

In many cases, the initial premium is not paid until the policy is delivered. Most insurance companies require that when collecting the premium, the agent must also obtain a statement signed by the insured testifying to continued good health.

Effective Date of Coverage

Under the terms of the insurability conditional receipt, the insurance coverage becomes effective as of the date of the receipt, provided the application is approved. This receipt is generally provided to the applicant when the initial premium is paid at the time of application.

Premium Collection

All premiums, return premiums, or other funds received by an agent must be kept in a fiduciary capacity. An agent must, in the regular course of business, account for and pay these funds when due to the insurer, insured, or the insured's assignee.

All funds received by an agent must be kept in a fiduciary account which is separate from all other business and personal funds. Funds deposited into the separate fiduciary account must not be commingled or combined with other funds except for the purpose of advancing premiums.

Premiums can be paid physically (by check or cash) or electronically. Payments submitted electronically are considered electronic funds transfers (EFTs) and are made through the **Automated Clearing House (ACH)**.

Individual Health Insurance Policy General Provisions

A. Uniform Required Provisions

Entire Contract; Changes

The entire contract provision states that the health insurance policy, together with a copy of the signed application and attached riders and amendments, constitutes the **entire contract**. No changes may be made to the policy without the express written agreement of both parties, and any changes must also be made a part of the contract. Only an executive officer of the company, not an agent, has authority to make any changes to the policy.

Time Limit on Certain Defenses

This provision is similar to the *incontestability* provision found in life insurance policies. No statement or misstatement (except fraudulent misstatements) made in the application at the time of issue will be used to deny a claim after the policy has been in force for 2 years. Unlike life insurance policies, fraudulent misstatements can be contested at any time.

Physical Examinations and Autopsy

The physical exam and autopsy provision gives the insurer the right to examine the insured, at its own expense, as often as may be reasonably necessary while a claim is pending. The insurer also usually has the right to conduct an autopsy, if not forbidden by a state law.

Legal Actions

This provision limits the time during which a claimant may seek recovery from an insurer under a policy. The insured must wait **60 days**, but not later than 3 years (in most states) after proof of loss, before legal action can be brought against the company.

Change of Beneficiary

The change of beneficiary provision stipulates that the policyowner may change the beneficiary at any time by providing a written request to the insurer. The consent of the beneficiary is not required. However, if the

beneficiary designation is irrevocable, the policyholder must first obtain the permission of the beneficiary before any change can be made.

B. Uniform Optional Provisions

Intoxicants and Narcotics

The insurer is not liable for any claims that result while the insured is intoxicated or under the influence of drugs (unless administered by a physician). Treatment for substance abuse is usually a covered benefit under health insurance policies. This provision simply excludes any injury or sickness that results from the insured's intoxication.

Illegal Occupation

This provision states that liability will be denied if the insured is injured while committing an **illegal act** or is engaged in an **illegal occupation**.

C. Other General Provisions

Insuring Clause

The insuring agreement or clause is usually located on the first page of the policy. It is simply a general statement that identifies the basic agreement between the insurance company and the insured. It **identifies the insured** and the **insurance company** and states what **kind of loss (peril) is covered**.

Probationary Period

The **probationary period** provision states that a period of time must lapse before coverage for specified conditions goes into effect. This provision is most commonly found in disability income policies. The probationary period also applies to new employees who must wait a certain period of time before they can enroll in the group plan. The purpose of this provision is to avoid unnecessary administrative expenses in cases of employee turnover.

Elimination Period

The **elimination period** is a type of deductible that is commonly found in disability income policies. It is a period of days which must expire after the onset of an illness or occurrence of an accident before benefits will be payable. The longer the elimination period, the lower the cost of coverage.

Coinsurance

Most major medical policies include a **coinsurance** provision that provides for the sharing of expenses between the insured and the insurance company. After the insured satisfies the policy deductible, the insurance company will usually pay the majority of the expenses, typically **80%**, with the insured paying the remaining **20%**. Other coinsurance arrangements exist such as 90/10; 75/25; or 50/50. The larger the percentage that is paid by the insured, the lower the required premium will be. The purpose of the coinsurance provision is for the insurance company to control costs and discourage overutilization of the policy.

Most policies also limit the amount of *out-of-pocket* expenses the insured can incur during a policy year. A stop-loss limit is a specified dollar amount beyond which the insured no longer participates in the sharing of expenses. The insurance company pays 100% of the expenses that are above the specified stop-loss limit.

Exclusions

Exclusions specify for what the insurer will not pay. These are causes of loss that are specifically excluded from coverage. **Reductions** are a decrease in benefits because of certain specified conditions. The most common exclusions in health insurance policies are injury or loss that results from any of the following:

- War;
- Military duty;
- Self-inflicted injury;
- Dental expense;
- Cosmetic medical expenses;
- Eye refractions; or
- Care in government facilities.

In addition, most policies will temporarily suspend coverage while an insured resides in a foreign country or while serving in the military.

Mental and Emotional Disorders — Usually the lifetime benefit for major medical coverage limits the amount payable for mental or emotional disorders. The benefit is usually expressed as a separate lifetime benefit and there is frequently a limit on the number of outpatient visits per year. The

benefit may also pay a maximum limit per visit. These limitations usually do not apply to inpatient treatment.

Substance abuse — As with mental and emotional disorders, outpatient treatment of substance abuse is usually limited to a maximum limit.

Disability Income and Related Insurance

A. Qualifying for Disability Benefits

Permanent Disability

A **permanent disability** is a mental or physical illness or a condition that affects a major life function long term. The phrase is used mainly regarding workers compensation and describes any impairment that remains after a worker has received medical treatment and has had time for optimum recovery (reached maximum medical improvement).

Permanent total disability refers to an individual's total inability to work ever again.

Residual Disability

Residual disability is the type of disability income policy that provides benefits for loss of income when a person returns to work after a total disability, but is still not able to work as long or at the same level he/she worked before becoming disabled. Many companies have replaced partial disability with residual disability. Residual disability will help pay for loss of earnings. If the person can only work part-time or at a lesser paying position, residual disability will make up the difference between their present earnings and what they were **earning prior** to disability.

Federal Tax Considerations for Health Insurance

Flexible Spending Accounts (FSAs)

A **Flexible Spending Account (FSA)** is a form of cafeteria plan benefit funded by salary reduction and employer contributions. The employees are allowed to deposit a certain amount of their paycheck into an account before paying income taxes. Then, during the year, the employee can be directly reimbursed from this account for eligible health care and dependent care expenses. FSA benefits are subject to annual maximum and "use-or-lose" rule. This plan does not provide a cumulative benefit beyond the plan year.

There are 2 types of Flexible Spending Accounts: a Health Care Account for out-of-pocket health care expenses, and a Dependent Care Account (subject to annual contribution limits) to help pay for dependent's care expenses which makes it possible for an employee and their spouse to continue to work.

An FSA is exempt from federal income taxes, Social Security (FICA) taxes and, in most cases, state income taxes, saving 1/3 or more in taxes. If the plan favors highly compensated employees, the benefits for the highly compensated employees are not exempt from federal income taxes.

Child and dependent care expenses must be for the care of one or more qualifying persons:

- A dependent who was under age 13 when the care was provided and who can be claimed as an exemption on the employee's Federal Income Tax return;
- A spouse who was physically or mentally not able to care for himself or herself; or
- A dependent who was physically or mentally not able to care for himself or herself and who can be claimed as an exemption (as long as the person is earning gross income less than an IRS-specified amount).

Persons who cannot dress, clean, or feed themselves because of physical or mental problems are considered not able to care for themselves. Also, persons who must have constant attention to prevent them from injuring themselves or others are considered not able to care for themselves.

The insured may change benefits during open enrollment. After that period, generally, no other changes can be made during the plan year. However, the insured might be able to make a change under one of the following circumstances, referred to as *qualified life event* changes:

1. Marital status;
2. Number of dependents;
3. One of dependents becomes eligible for or no longer satisfies the coverage requirements under the Medical Reimbursement plan for unmarried dependents due to attained age, student status, or any similar circumstances;

4. The insured, the insured's spouse's or qualified dependent's employment status that affects eligibility under the plan (at least a 31-day break in employment status to qualify as a change in status);
5. Change in dependent care provider; or
6. Family medical leave

The IRS limits the annual contribution for Dependent Care Accounts to a specified amount that gets adjusted annually for cost of living. This is a family limit, meaning that even if both parents have access to flexible care accounts, their combined contributions cannot exceed the amount.

High-Deductible Health Plans (HDHPs)

High-deductible health plans (HDHPs) are often used in coordination with Medical Savings Accounts (MSAs), Health Savings Accounts (HSAs), or Health Reimbursement Accounts (HRAs). The high-deductible health plan features higher annual deductibles and out-of-pocket limits than traditional health plans, which means lower premiums. Except for preventive care, the annual deductible must be met before the plan will pay benefits. Preventive care services are usually first dollar coverage or paid after copayment. The HDHP credits a portion of the health plan premium into the coordinating MSA, HSA, or HRA on a monthly basis. The deductible of the HDHP may be paid with funds from the coordinating account plan.

High-deductible health plans (HDHPs) are taxed in the same manner as other traditional health plans.

Insurance Regulation

B. State Regulation

2. Company Regulation

Suitability

Each insurer that uses an insurance producer must maintain a system of supervision and control to insure compliance with the requirements for insurance product suitability. The system must do the following:

- Inform producers of the requirements and incorporate them into all relevant producer training materials prepared by the insurer;

- Provider to each producer a written statement of the insurer's position with respect to the acceptability of replacements, providing guidance to its insurance producer as to the appropriateness of these transactions;
- Include a system for reviewing the appropriateness of each replacement transaction that the insurance producer does not indicate is in accord with this regulation;
- Include procedures that confirm the requirements have been met; and
- Include procedures to detect transactions that are replacements of existing policies or contracts by the existing insurer, but that have not been reported as such by the applicant or insurance producer.

Insurers must also have the capacity to monitor each insurance producer's life insurance policy and annuity contract replacements, and upon request, must have these records available to the Director

C. Federal Regulation

Privacy Protection (Gramm-Leach-Bliley)

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 (i.e., 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.

CAN-SPAM

CAN-SPAM legislation was established to set the rules for commercial e-mail, and to give recipients the right to reject commercial messages. CAN-SPAM covers all commercial electronic messages, including business-to-business messages, the purpose of which is the commercial advertisement or promotion of a product or service.

CAN-SPAM requires that any commercial email must contain an opt-out mechanism; all opt-out requests must be honored **within 10 business days**. To be in compliance with this legislation, the entity that sends out e-mails must do the following:

- Make sure that the advertiser is identified in the from line;
- Not use misleading subject lines;
- Include an opt-out mechanism and honor all opt-out requests within 10 days;
- Include the advertiser's valid physical postal address; and
- If the message is unsolicited, it must be identified as an advertisement somewhere in the e-mail.

Each violation of the above provisions is subject to fines of up to $16,000. On top of that is a penalty of $250 per each noncompliant e-mail, with a cap of $2 million dollars.

National Do Not Call List

In 2003, the Federal Trade Commission (FTC) and the Federal Communications Commission (FCC) worked together to create the **National Do Not Call Registry**, allowing consumers to include their telephone numbers on the list to which solicitation calls cannot be made by telemarketers. Insurance companies need to comply with this regulation when making solicitation phone calls.

To comply with the telemarketing sales rules, telemarketers must not do any of the following:

- Call any number on the National Do Not Call Registry or on that seller's Do Not Call list;
- Deny someone a right to be placed on any Do Not Call Registry;
- Call outside permissible calling hours (before 8 a.m. and after 9 p.m.);
- Abandon calls;
- Fail to transmit caller ID information;
- Threaten or intimidate a consumer or use obscene language; or
- Cause any telephone to ring or engage a person in conversation with the intent to annoy, abuse, or harass the person called.

Some **exceptions** to the Do Not Call Registry include the following calls:

- From or on behalf of organizations which have established a business relationship with the consumer (for the last 18 months from the date of a sale or transaction);
- For which the consumer has given prior written permission;
- Not commercial or that do not include unsolicited advertisements; and
- By or on behalf of tax-exempt nonprofit organizations.

To keep in compliance with the Do Not Call rules, organizations must consult the registry every **31 days.** Any phone numbers on the registry must be dropped from the organization's call lists.