Addendum: for use with South Carolina Life and Health study guides version number 24939en/24940en, per exam content outline updates effective 5/1/2023.

***Please note that South Carolina is changing its testing provider. Effective 5/1/2023, state insurance exams will be administered by Pearson Vue**. For additional information about exam requirements and complete exam content outlines, please review the Insurance Licensing Candidate Handbook at https://home.pearsonvue.com/sc/insurance.*

Note that the course chapters and exam format are also changing. The new exam will consist of 2 parts: General Knowledge and State Law. However, you will receive one overall score. The new exam breakdown is as follows:

South Carolina Life Insurance Examination
85 Total Questions (75 scored; 10 pretest)

CHAPTERS	PERCENTAGE OF EXAM
General Knowledge:	
Completing the Application, Underwriting, and Delivering the Policy	16%
Types of Life Policies	20%
Life Policy Provisions, Riders and Options	20%
Retirement and Other Insurance Concepts	11%
State Law:	
South Carolina Laws and Regulations Pertinent to All Lines	24%
South Carolina Laws and Regulations Pertinent to Life Insurance	9%

South Carolina Accident and Health Insurance Examination
85 Total Questions (75 scored; 10 pretest)

CHAPTERS	PERCENTAGE OF EXAM
General Knowledge:	
Field Underwriting Procedures	11%
Types of Policies	21%
Policy Provisions, Clauses, and Riders	20%
Social Insurance	8%
Other Insurance Concepts	7%
State Law:	
South Carolina Laws and Regulations Pertinent to All Lines	24%
South Carolina Laws and Regulations Pertinent to Accident and Health Insurance	9%

South Carolina Life and Accident and Health Insurance Examination
145 Total Questions (130 scored; 15 pretest)

CHAPTERS	PERCENTAGE OF EXAM
General Knowledge:	
Completing the Application, Underwriting, and Delivering the Policy	9%
Types of Life Policies	11%
Life Policy Provisions, Riders and Options	11%
Retirement and Other Insurance Concepts	6%
Field Underwriting Procedures	6%
Types of Accident and Sickness Policies	12%
Accident and Sickness Policy Provisions, Clauses, and Riders	12%
Social Insurance	5%
Other Insurance Concepts	4%

State Law:	
South Carolina Laws and Regulations Pertinent to All Lines	14%
South Carolina Laws and Regulations Pertinent to Life Insurance	5%
South Carolina Laws and Regulations Pertinent to Accident and Health Insurance	5%

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

LIFE & HEALTH

Insurance Regulation

A. Licensing

1. Process – *addition to the existing text*

An insurance producer license is not required of any officer, director or employee of an insurer or organizations employed by insurers, provided they are not directly or indirectly involved with the actual sale of an insurance contract and **do not receive any commission**.

Furthermore, the following individuals are **exempt** from the licensing requirements:

- A director or employee of an insurer whose activities are limited to executive, administrative, managerial, or clerical;
- The director or employee of a special agent assisting insurance producers by providing technical advice and assistance to licensed insurance producers;
- A person who secures and furnishes information for group insurance or performs administrative services related to mass-marketed property and casualty insurance;
- An employer or association engaged in the administration or operation of a program of employee benefits for the employer's or association's own employees;
- Employees of insurers or organizations engaging in the inspection, rating or classification of risks, or in the supervision of the training of insurance producers and who are not individually engaged in the sale of insurance;

- A person whose activities are limited to advertising without the intent to solicit insurance;
- A nonresident who sells, solicits or negotiates a contract of insurance for commercial property and casualty risks to an insured with risks located in more than one state insured under that contract; or
- A salaried full-time employee who counsels or advises their employer relative to the insurance interests of the employer or subsidiaries.

Before a license may be issued, an applicant must

- Furnish a complete set of fingerprints to the Director; and
- Undergo a state criminal records check by the South Carolina Law Enforcement Division (SLED) and a national criminal records check by the Federal Bureau of Investigation (FBI).

Licensed insurance producers who wish to renew their current resident producer license are exempt from fingerprinting requirements, as long as the producer has already submitted their fingerprints during the initial licensing period and licenses issued are in good standing on the date of the license renewal.

A producer who allows their license to lapse is also exempt from fingerprint requirements as long as the producer applies for license reinstatement within **6 months** of the compliance date, meets continuing education requirements, and pays a penalty to the Director.

An individual producer license must contain

- The licensee's name, address, and personal identification number;
- The date of issuance;
- The lines of authority; and
- Any other information the Director considers necessary.

The following fees are applicable to producer licenses, appointments, and agency licenses issued in this state:

- Initial producer licensing and biennial renewal fee: **$25**;
- General appointment and biennial fee: **$100**; and
- Initial agency licensing and biennial renewal fee: **$40**.

If payment of a licensing fee is rejected by a bank, the producer must reattempt to pay the fee within **30 days** of the rejection date. If payment is still rejected, the producer's license will be terminated. In order to reinstate the license, the Director may require the producer to pay the license fee, plus any charges resulting from rejection by the bank.

Initial appointment fees are due in advance of the appointment. Biennial appointment fees are due by September 13 of even numbered years. If a biennial appointment fee is not paid, the appointment must be cancelled. An insurer may reactive an appointment by paying a penalty fee of **$250** to the Department by December 1 of the even number year.

2. Types of Licenses

Temporary

The Director may issue a temporary insurance license for a maximum period of **180 days** without requiring an examination if the Director considers the temporary license necessary for the servicing of an insurance business in the following cases:

- To the surviving spouse or court-appointed personal representative of a licensed producer who dies 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 in the business entity application or the license;
- To the designee of a licensed insurance producer entering active service in the U.S. armed forces; or
- Except for continuing education purposes, in any other circumstance that the Director deems necessary.

The Director may limit the authority of any temporary licensee in any way considered necessary to protect insureds and the public. The Director may revoke a temporary license if the interest of insureds or the public are endangered. A temporary license may not continue after the owner or the personal representative disposes of the business for which the temporary license was issued.

B. State Regulation

2. Company Regulation

Unfair Claims Settlement Practices – *addition to the existing text*

Upon receiving notification of a claim, an insurer must provide the necessary claim forms to the insured or beneficiary. If claim forms are not provided within **20 days** of the receipt of the notice, the claimant is considered to have complied with proof of loss requirements under the policy.

4. Unfair and Prohibited Practices

Fraud

A licensed insurance producer may be found guilty of a **felony** and, upon conviction, punished by **imprisonment for up to 5 years or a fine of up to $5,000 dollars, or both**, if the producer, with the intent to injure, defraud, or deceive any insurance company or applicant for insurance:

1. Presents an insurance application knowing that it contains false or misleading information or omissions of material facts pertaining to the underwriting; or
2. Assists, abets, solicits, or conspires with another to prepare or make an application for insurance, knowing that the application contains any false or misleading information or omissions.

LIFE:

Life Insurance Basics

A. Personal Life Insurance

Third-Party Ownership

Most insurance policies are written where the insured and owner of the policy is the same person. However, there are situations in which the contract may be owned by someone other than the insured. These types of contracts are known as **third-party ownership.** *Third-party owner* is a legal term used to identify an individual or entity that is not an insured under the contract, but that has a legally enforceable right under it. Most policies involving third-party ownership are written in business situations or for minors in which the parent owns the policy.

E. Process of Issuing a Life Insurance Policy

Consequences of Incomplete Applications

Before a policy is issued, all of the questions on the application must be answered. If the insurer receives an incomplete application, the insurer must **return it to the applicant for completion**. If a policy is issued with questions left unanswered, the contract will be interpreted as if the insurer waived its right to have an answer to the question. The insurer will not have the right to deny coverage based on any information that the unanswered question might have contained.

Stranger-Originated Life Insurance (STOLI) and Investor-Originated Life Insurance (IOLI)

Stranger-originated life insurance (STOLI) is a life insurance arrangement in which a person with no relationship to the insured (a "stranger") purchases a life policy on the insured's life with the intent of selling the policy to an investor and profiting financially when the insured dies. In other words, STOLIs are financed and purchased solely with the intent of selling them for life settlements.

STOLIs **violate the principle of insurable interest**, which is in place to ensure that a person purchasing a life insurance policy is actually interested in the longevity rather than the death of the insured. Because of this, insurers take an aggressive legal stance against policies they suspect are involved in STOLI transactions.

Note that lawful life settlement contracts do not constitute STOLIs. Life settlement transactions result from existing life insurance policies; STOLIs are initiated for the purpose of obtaining a policy that would benefit a person who has no insurable interest in the life of the insured at the time of policy origination.

Investor-owned life insurance (IOLI) is another name for a STOLI, where a third-party **investor who has no insurable interest in the insured** initiates a transaction designed to transfer the policy ownership rights to someone with no insurable interest in the insured and who hopes to make a profit upon the death of the insured or annuitant.

Social Security Benefits

Social Security, also referred to as **Old Age Survivors Disability Insurance** — OASDI, is a Federal program enacted in 1935, which is designed to provide protection for eligible workers and their dependents against financial loss due to old age, disability, or death. With a few exceptions, almost all individuals are covered by Social Security. In some aspects, Social Security plays a role of federal life and health insurance, which is important to consider when determining an individual's needs for life insurance.

Social Security uses the Quarter of Coverage (QC) system to determine whether or not an individual is qualified for Social Security benefits. The type and amount of benefits are determined by the amount of **credits** or **QCs** a worker has earned. Anyone working in jobs covered by Social Security or operating his/her own business may earn up to a maximum of 4 credits for each year of work.

The term **fully insured** refers to someone who has earned **40 quarters** of coverage (the equivalent of 10 years of work), and is therefore entitled to receive Social Security retirement, premium-free Medicare Part A, and survivor benefits. If an individual is entitled to premium-free Medicare Part A, they are automatically eligible for Medicare Part B, but must pay a monthly premium.

An individual can attain a **currently insured** status (or partially insured), and by that qualify for certain benefits if he or she has earned **6 credits** (or quarters of coverage) during the 13-quarter period *ending with the quarter in which the insured*:

- Dies;
- Becomes entitled to disability insurance benefits; or
- Becomes entitled to old-age insurance benefits.

For younger workers, the number of quarters required to qualify for the benefits differs by age according to a table established by Social Security.

CONDITIONS FOR PAYMENT	PAID TO	TYPE OF PAYMENT
RETIREMENT BENEFIT:		
Fully insured status and age 66* (or reduced benefits at age 62)	Retired individual and eligible dependents	Monthly benefit equal to the primary insurance amount (PIA)
DISABILITY BENEFIT:		
Fully insured status and total and permanent disability prior to the retirement age	Disabled worker and spouse and eligible dependents	Monthly disability benefit after a 5-month waiting period
SURVIVOR BENEFIT:		
Worker's death	Surviving spouse and dependent children	Lump-sum burial benefit if fully or currently insured Monthly income payments if fully insured

**The current full retirement age is 66, and is gradually increasing to age 67.*

USA PATRIOT Act and Anti-Money Laundering

The Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism Act, also known as the **USA PATRIOT Act** was enacted on October 26, 2001. The purpose of the Act is to address social, economic, and global initiatives to fight and prevent terrorist activities. The Act enabled the Financial Crime Enforcement Network (FinCEN) to require banks, broker-dealers, and other financial institutions to establish new **anti-money laundering (AML)** standards. With new rules in place, FinCEN incorporated the insurance industry into this group.

To secure the goals of the Act, FinCEN has implemented an AML Program that requires the monitoring of all financial transactions and reporting of any suspicious activity to the government, along with prohibiting correspondent accounts with foreign shell banks. A comprehensive customer identification and verification procedure is also to be set in place. The AML program consists of the following minimum requirements:

Assimilate policies, procedures and internal controls based on an in-house risk assessment, including:

- Instituting AML programs similar to banks and securities lenders; and
- File suspicious activity reports (SAR) with Federal authorities;
- Appointing a qualified compliance officer responsible for administering the AML program;
- Continual training for applicable employees, producers and other; and
- Allow for independent testing of the program on a regular basis.

Suspicious Activity Reports (SARs) Rules

Any company that is subject to the AML Program is also subject to SAR rules. SAR rules state that procedures and plans must be in place and designed to identify activity that one would deem suspicious of money laundering, terrorist financing and/or other illegal activities. Deposits, withdrawals, transfers or any other business deals involving $5,000 or more are required to be reported if the financial company or insurer "knows, suspects or has reason to suspect" that the transaction:

- Has no business or lawful purpose;
- Is designed to deliberately misstate other reporting constraints;
- Uses the financial institution or insurer to assist in criminal activity;
- Is obtained using fraudulent funds from illegal activities; or
- Is intended to mask funds from other illegal activities.

Some "red flags" to look for in suspicious activity:

- Customer uses fake ID or changes a transaction after learning that he or she must show ID;
- Two or more customers use similar IDs;
- Customer conducts transactions so that they fall just below amounts that require reporting or recordkeeping;
- Two or more customers seem to be working together to break one transaction into two or more (trying to evade the Bank Secrecy Act (BSA) requirements); or
- Customer uses two or more money service business (MSB) locations or cashiers on the same day to break one transaction into smaller transactions (trying to evade BSA requirements).

Relevant SAR reports must be filed with FinCEN within 30 days of initial discovery. Reporting takes place on FinCEN Form 108.

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 Insurance Policies

A. Term Life Insurance

Renewable and Convertible

Most term insurance policies are renewable, convertible, or renewable and convertible (R&C).

The **renewable** provision allows the policyowner the right to renew the coverage at the expiration date *without evidence of insurability*. The premium for the new term policy will be based on the insured's current age. *For example*, a 10-year term policy that is renewable can be renewed at the end

of the 10-year period for a subsequent 10-year period without evidence of insurability. However, the insured will have to pay the premium that is based on his or her attained age. If an individual purchases a 10-year term policy at age 35, he or she will pay a premium based on the age of 45 upon renewing the policy.

The **convertible** provision provides the policyowner with the right to convert the policy to a permanent insurance policy *without evidence of insurability*. The premium will be based on the insured's attained age at the time of conversion.

Return of Premium

Return of premium (ROP) life insurance is an increasing term insurance policy that pays an additional death benefit to the beneficiary equal to the amount of the premiums paid. The return of premium is paid if the death occurs within a specified period of time or if the insured outlives the policy term.

ROP policies are structured to consider the low risk factor of a term policy but at a significant increase in premium cost, sometimes as much as 25% to 50% more. Traditional term policies offer a low-cost, simple-death benefit for a specified term but have no investment component or cash value. When the term is over, the policy expires, and the insured is without coverage. An ROP policy offers the pure protection of a term policy, but if the insured remains healthy and is still alive once the term limit expires, the insurance company guarantees a return of premium. However, since the amount returned equals the amount paid in, the returned premiums are not taxable.

B. Whole Life Insurance

Interest-Sensitive Whole Life

Interest-sensitive whole life, also referred to as **current assumption** life, is a whole life policy that provides a guaranteed death benefit to age 100. The insurer sets the initial premium based on current assumptions about risk, interest and expense. If the actual values change, the company will lower or raise the premium at designated intervals. In addition, interest-sensitive whole life policies credit the cash value with the current interest rate that is usually

comparable to money market rates, and can be higher than the guaranteed levels. The policy also provides for a minimum guaranteed rate of interest.

Interest-sensitive whole life provides the same benefits as other traditional whole life policies with the added benefit of current interest rates, which may allow for either greater cash value accumulation or a shorter premium-paying period.

Indexed Life

The main feature of **indexed whole life** (or equity index whole life) insurance is that the cash value is dependent upon the performance of the equity index, such as S&P 500 although there is a guaranteed minimum interest rate. The policy's face amount increases annually to keep pace with inflation (as the Consumer Price Index increases) without requiring evidence of insurability. Indexed whole life policies are classified depending on whether the policyowner or the insurer assumes the inflation risk. If the policyowner assumes the risk, the policy premiums increase with the increases in the face amount. If the insurer assumes the risk, the premium remains level.

Life Policy Provisions, Riders and Options

A. Standard Provisions

Insuring Clause

The insuring clause (or insuring agreement) sets forth the basic agreement between the insurer and the insured. It states the insurer’s promise to pay the death benefit upon the insured’s death. The insuring clause usually is located on the policy face page, and also defines who the parties to the contract are, how long coverage is in force, and the type of loss insured against.

D. Riders

3. Riders Affecting the Death Benefit Amount

Accidental Death and Dismemberment

The **accidental death and dismemberment rider (AD&D)** pays the **principal** (face amount) for accidental death, and pays a percentage of that amount, or a **capital sum**, for accidental dismemberment.

The accidental death portion is the same as that already discussed with the accidental death rider. The dismemberment portion of the rider will usually determine the amount of the benefit according to the severity of the injury. The full principal amount will usually be paid for the loss of two hands, two arms, two legs or the loss of vision in both eyes. A capital amount is usually limited to half the face value and is payable in the event of the loss of one hand, arm, leg, or eye. The dismemberment can be defined differently by insurance companies, from the actual severance of the limb to the loss of use.

Federal Tax Considerations for Life Insurance and Annuities

Taxation of Group Life and Employer-Sponsored Plans

The **premiums** that an employer pays for life insurance on an employee, whereby the policy is for the employee's benefit, **are tax deductible to the employer** as a business expense. If the group life policy coverage is $50,000 or less, the employee does not have to report the premium paid by the employer as income (not taxable to the employee).

Any time a business is the named beneficiary of a life insurance policy, or has a beneficial interest in the policy, any premiums that the business pays for such insurance are not tax deductible. Therefore, when a business pays the premiums for any of the following arrangements, the premiums are not deductible:

- Key-employee (key-person) insurance;
- Stock redemption or entity purchase agreement;
- Split-dollar insurance.

The **cash value** of a business owned life insurance policy or an employer provided policy accumulates on a tax-deferred basis and is taxed in the same manner as an individually owned policy.

Policy loans are not taxable to a business. Unlike an individual taxpayer, a corporation may deduct interest on a life insurance policy loan for loans up to $50,000.

Policy death benefits paid under a business owned or an employer provided life insurance policy are received income tax free by the beneficiary (in the same manner as in individually owned policies).

If the general requirements for qualified plans are met, the following tax advantages apply:

- Employer contributions are tax deductible to the employer, and are not taxed as income to the employee;
- The earnings in the plan accumulate tax deferred;
- Lump-sum distributions to employees are eligible for favorable tax treatment.

Modified Endowment Contracts (MECs)

Following the elimination of many traditional tax shelters by the Tax Reform Act of 1984, single premium life insurance remained as one of the few financial products offering significant tax advantages. Consequently, many of these types of policies were purchased solely for the purpose of setting aside large sums of money for the tax-deferred growth as well as tax-free cash flow available via policy loans and partial surrenders.

To curtail this activity, and to determine if an insurance policy is overfunded, the Internal Revenue Service (IRS) established what is known as the **7-pay Test**. Any life insurance policy that fails a 7-pay test is classified as a **Modified Endowment Contract (MEC)**, and loses the standard tax benefits of a life insurance contract. In a MEC, the cumulative premiums paid during the first 7 years of the policy exceed the total amount of net level premiums that would be required to pay the policy up using guaranteed mortality costs and interest.

Once a policy fails the 7-pay test and becomes a MEC, it remains a MEC.

All life insurance policies are subject to the 7-pay test, and any time there is a material change to a policy (such as an increase in the death benefit), a new 7-pay test is required. Whether from a life insurance policy or a MEC, the death benefit received by the beneficiary is tax free.

The following are taxation rules that apply to MEC's cash value:

- Tax-deferred accumulations;
- Any distributions are taxable, including withdrawals and policy loans;
- Distributions are taxed on LIFO basis (Last In, First Out) — known as "interest-first" rule; and
- Distributions before age 59 ½ are subject to a 10% penalty.

HEALTH:

Health Insurance Basics

Modes of Premium Payment

In regard to insurance premiums, mode refers to the **frequency** the policyowner pays the premium. An insurance policy's rates are based on the assumption that the premium will be paid annually at the beginning of the policy year and that the company will have the premium to invest for a full year before paying any claims. If the policyowner chooses to pay the premium more frequently than annually, there will be an additional charge because the company will have additional expenses in billing the premium. However, the premium may be paid annually, semi-annually, quarterly, or monthly.

Higher Frequency = Higher Premium
Monthly > Quarterly > Semi-Annual > Annual

D. Limited Policies

2. Types of Limited Policies

Cancer Policy

Cancer policies cover only one illness: cancer, and pay a lump-sum cash benefit when the insured is first diagnosed with cancer. It is a supplemental policy intended to fill in the gap between the insured's traditional health coverage and the additional costs associated with being diagnosed with the illness. There are no restrictions on how the insured spends the funds, so the benefit can be used to pay for medical bills, experimental treatment, mortgage, personal living expenses, loss of income, etc.

Critical Illness

A **critical illness** policy covers multiple illnesses, such as heart attack, stroke, renal failure, and pays a lump-sum benefit to the insured upon the diagnosis (and survival) of any of the illnesses covered by the policy. The policy usually specified a minimum number of days the insured must survive after the illness was first diagnosed.

Short-Term Medical

Short-term medical insurance plans are designed to provide temporary coverage for people in transition (those between jobs or early retirees), and are available for terms from one month up to 11 months, depending on the state. Unlike regular individual major medical plans, short-term health insurance policies are not regulated by the Affordable Care Act and their enrollment is not limited to the open enrollment period; they also do not meet the requirements of the federally mandated health insurance coverage.

Like traditional health plans, short-term plans may have medical provider networks, and impose premiums, deductibles, coinsurance and benefit maximums. They also cover physician services, surgery, outpatient and inpatient care.

Individual Health and Disability Insurance Policy General Provisions

C. Other General Provisions

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.

Exclusions and Limitations

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.

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.

Copayments

A **copayment** provision is similar to the coinsurance feature in that the insured shares part of the cost for services with the insurer. Unlike coinsurance, a copayment has a set **dollar amount** that the insured will pay each time certain medical services are used.

Deductibles

A **deductible** is a specified dollar amount that the insured must pay first before the insurance company will pay the policy benefits. The purpose of a deductible is to have the insured absorb the smaller claims, while the coverage provided under the policy will absorb the larger claims. Consequently, the larger the deductible, the lower the premium that is required to be paid.

Most major medical policies feature an **annual deductible** (also called a calendar year deductible) that, as the name implies, is paid once in any year, regardless of the amount of claims in that year. The policy may contain an **individual deductible**, in which each insured is personally responsible for a specified deductible amount each year, or a **family deductible** (usually 2 to 3 times the individual deductible) whereby the annual deductible is satisfied if two or more family members pay a deductible in a given year, regardless of the amount of claims incurred by additional family members. Some policies contain what is known as a **per occurrence deductible** or **flat deductible** which the insured is required to pay for each claim, possibly resulting in more than one deductible being paid in a given year.

The policy may also contain a provision which applies when more than one family member is injured in a single accident, also called the **common accident provision**. In this case, only one deductible applies for all family members involved in the same accident.

Some supplemental major medical plans also include an **integrated deductible** in which case the amount of the deductible may be satisfied by the amount paid under basic medical expense coverage. For example, if the supplemental coverage included a $1,000 integrated deductible, and the insured incurs $1,000 in basic medical expenses, the deductible will be

satisfied. If the basic policy only covered $800 of the basic expenses, the insured would have to satisfy the remaining $200 difference.

Some policies also include a **carry-over provision** that states that if the insured did not incur enough expenses during the year to meet the deductible, any expenses incurred during the last 3 months may be carried over to the next policy year to satisfy the new annual deductible.

Disability income and long-term care policies usually have a **time deductible** in the form of elimination period.

Eligible Expenses

Eligible expenses are those medical expenses covered by a health insurance plan. The eligible expenses are specified in the policy.

Pre-Authorization and Prior Approval Requirements

Some health insurance policies will require the pre-authorization or prior approval of certain medical procedures, tests, or hospital stays. The insured must obtain the insurer's approval before the procedure, test, or hospital stay to be sure the policy will cover the expenses.

Impairment Rider

The **impairment** (exclusion) rider may be attached to a contract for the purpose of eliminating coverage for a specifically defined pre-existing condition, such as back injuries. Impairment riders may be temporary or may become a permanent part of the policy. Attaching this rider excludes coverage for a condition that would otherwise be covered. Often a person's only means of purchasing insurance at a reasonable cost when they have an existing impairment is through a policy which excludes coverage for the specific impairment.

For example, a physician may have suffered from a back injury prior to applying for a disability policy. The company may agree to issue a disability policy, but with an exclusion rider, excluding coverage for any claim related to his back. The policy would cover any other disability he may incur in the future, as long as it is not related to his back. This may be the only way the insured is able to obtain coverage. The underwriter makes a decision when

writing the contract whether to make the exclusion permanent, or, for a short time only (such as if the insured is able to go a specified period of time with no further treatment). The terms of the rider will be clearly stated in the policy.

Most riders in both life and health insurance add some form of additional coverage and often, there is extra cost added to the premium for the rider. The impairment (exclusion) rider is an exception in that it takes something **away from** standard coverage. There is no extra charge for this, nor is the premium reduced to reflect a reduction in coverage.

Guaranteed Insurability Rider

This policy rider is also referred to as the **Future Increase Option** or the **Guaranteed Purchase Option**. This option, which is also available on life insurance policies, will allow the insured to purchase additional amounts of disability income coverage without evidence of insurability. The insured is usually provided a number of option dates, such as every two years, on which the additional purchase option may be exercised. Most companies do not allow the insured to exercise the additional purchase option beyond a certain age, usually age 50. The premium for the additional amount of insurance will be based on the insured's attained age at the time the option is exercised. In order to prevent over-insurance, the insured must meet an earnings test prior to each purchase. In addition, the insurer will usually limit the amount that may be purchased at each of the option dates to some specified amount, such as $500-$5,000.

Primary and Contingent Beneficiaries

Any death benefits available in a policy will be paid to a beneficiary. A **primary beneficiary** is the first person so designated. However, if the primary beneficiary should die before the benefits become payable, the benefits would go to a **contingent** or **secondary beneficiary**. If no beneficiary is designated, the benefits will be placed in the deceased's estate.

Multiple primary and contingent beneficiaries may be designated in a policy. If multiple primary beneficiaries are named, each individual will receive a proportionate percentage of the death benefit. If one of multiple primary beneficiaries dies, equivalent percentages are re-established.

For example, if there were two primary beneficiaries named in a policy, each would receive 50% of the death benefit. If one of the two beneficiaries died, the remaining beneficiary would receive 100%.

If an individual health insurance policy provides a death benefit, it must also include a **change of beneficiary** provision. This provision gives the policyholder, unless he/she has made an irrevocable designation of a beneficiary, the right to change any primary and/or contingent beneficiary or make any other change without the consent of the beneficiary or beneficiaries.

Medical Plans

B. Types of Plans

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 his or her 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:

- Marital status;
- Number of dependents;
- 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;
- 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);
- Change in dependent care provider; or
- 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.