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California Department of Insurance CA-Life-Accident-and-Health

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QUESTION NO: 1

Insurer policy expenses include all of the following EXCEPT

A. taxes.

B. premiums.

C. agent commissions.

D. home office operations.

ANSWER: B

Explanation:

premiums. is correct because a premium is consideration paid by an applicant or policyowner to obtain and maintain insurance coverage. From the insurer's accounting and rate-development perspective, premium is incoming revenue used to fund contractual benefits, operating costs, reserves, and required capital; it is not itself a cost of issuing or servicing a policy. Insurers must distinguish premium income from the expenses incurred in conducting insurance operations when preparing statutory financial information. California's insurance laws require insurers to maintain records and financial statements that allow the Department of Insurance to assess their financial condition, including the insurer's income, disbursements, liabilities, and reserves. This statutory reporting framework reflects the basic distinction tested here: premiums enter the insurer, whereas policy-related expenses are amounts the insurer pays in operating its insurance business. The California Department of Insurance also oversees insurer financial regulation and solvency to ensure that insurers can meet obligations to policyholders. See the California Insurance Code's financial-reporting provisions at California Insurance Code, Division 1, Part 2, Chapter 3 and the Department's insurer oversight information at California Department of Insurance: Insurance Company Financial Information.

QUESTION NO: 2

Which contract provision forgives the payment of all health or disability insurance premiums while the insured is disabled?

A. family leave

B. cost of living

C. waiver of premium

D. guaranteed insurability

ANSWER: C

Explanation:

The **waiver of premium** provision is the contractual feature that keeps specified health or disability coverage in force without requiring premium payments when the insured meets the policy's definition of disability. Its essential purpose is to protect the insured from a lapse in coverage at a time when a disabling illness or injury may prevent the insured from earning income. The provision generally applies only after the insured has been disabled continuously for the policy's stated waiting period and continues only for as long as the qualifying disability persists, subject to the particular policy terms. California's statutory requirements for disability insurance policies recognize waiver-of-premium provisions and require policies to state the conditions under which premiums may be waived. Thus, when a question asks which provision forgives premiums during an insured's disability, "waiver of premium" directly identifies the provision being described. Review the relevant California disability-policy requirements in California Insurance Code section 10271, and consult the California Department of Insurance's health insurance consumer guides for general policy-coverage information.

QUESTION NO: 3

All of the following are characteristics of adverse selection EXCEPT

A. it normally occurs if the premium is low relative to the loss exposure.

B. people with the greatest probability of loss are the ones most likely to buy insurance.

C. insurance companies cannot discriminate against applicants who have a higher probability of loss.

D. poor underwriting results may occur if too many of the applicants accepted for insurance are those most likely to incur serious losses.

ANSWER: C

Explanation:

“insurance companies cannot discriminate against applicants who have a higher probability of loss” is the exception because adverse selection is addressed specifically through underwriting and risk classification. Insurers evaluate information relevant to the proposed coverage—such as health history, occupation, lifestyle, and other legitimate risk factors—to estimate the likelihood and potential severity of loss. Subject to California law, an insurer may use sound underwriting standards to classify risks, set appropriate premiums, limit coverage, or decline a risk that does not meet its underwriting requirements. These practices help prevent a pool from becoming disproportionately composed of applicants who know, or reasonably suspect, that they face an elevated chance of loss.

California law does prohibit *unfair* discrimination, including unfairly discriminating between individuals of the same class and essentially the same hazard. That restriction does not mean an insurer must ignore meaningful differences in expected loss exposure. The distinction is important: legitimate actuarial and underwriting classifications are tools used to control adverse selection, rather than a characteristic of adverse selection itself. See California Insurance Code section 790.03’s unfair-discrimination provisions at California Legislative Information and the California Department of Insurance’s consumer information on life insurance at CDI Life Insurance resources.

QUESTION NO: 4

A life insurance policy written after 1988 that fails to meet the seven-pay test is known as

A. an endowment policy.

B. a modified life policy.

C. a single premium contract.

D. a modified endowment contract.

ANSWER: D

Explanation:

A life insurance policy written after June 20, 1988, that fails the seven-pay test is a modified endowment contract. The seven-pay test compares the cumulative premiums actually paid during the first seven policy years with the cumulative amount that would have been paid to fully fund the policy under seven level annual premiums. When premium payments exceed the permitted amount, the contract is classified as a modified endowment contract (MEC) under Internal Revenue Code section 7702A. This classification does not mean the policy stops being life insurance; rather, it changes the federal income-tax treatment of distributions. Amounts received from a MEC, including withdrawals and policy loans, generally are treated as income first to the extent of gain in the contract. In addition, a distribution received before the taxpayer reaches age 59½ may be subject to an additional 10% tax unless an exception applies. The classification is generally permanent, which makes recognizing the seven-pay rule important when funding a cash-value life policy. California life insurance licensing materials address MECs as a federal tax-rule concept applicable to qualifying life insurance contracts. See 26 U.S.C. § 7702A and the IRS’s Publication 525, Taxable and Nontaxable Income.

QUESTION NO: 5

In the absence of a coordination of benefits clause, all of the following circumstances might result in recovery of more than 100% of actual health care expenses EXCEPT

A. a person working for two employers has insurance through both.

B. spouses are both employed and eligible for group medical benefits.

C. an executive has additional coverage through an association policy.

D. a worker's group medical plan includes a carryover deductible provision.

ANSWER: D

Explanation:

"a worker's group medical plan includes a carryover deductible provision." is correct because a carryover deductible concerns the timing of deductible credit within one health plan, not the existence of a second source of medical coverage. Under such a provision, eligible expenses incurred late in one benefit period may be credited toward the deductible for the following benefit period. This can reduce the amount the insured must pay out of pocket before the plan begins paying covered expenses in the new period, but it does not create a duplicate payment for the same medical expense. Recovery exceeding actual health care expenses is instead a concern when more than one plan potentially pays benefits for the same loss. A coordination-of-benefits provision is designed to establish the order and extent of payment among plans so that combined benefits are coordinated appropriately. California's insurance laws authorize rules addressing coordination of benefits in group disability insurance, while the applicable regulatory framework is maintained in the California Code of Regulations. See California Insurance Code, Group Disability Insurance and the California coordination-of-benefits regulations.

QUESTION NO: 6

Which health insurance contract provision addresses the problem of over insurance?

A. Reinstatement.

B. Incontestability.

C. Assignment of benefits.

D. Coordination of benefits.

ANSWER: D

Explanation:

Coordination of benefits is the health insurance contract provision designed to address overinsurance when an insured is covered by more than one health benefit plan. Its purpose is to establish an orderly method for determining which plan pays first and how the other plan may contribute to covered expenses. Under coordination-of-benefits rules, benefits are coordinated so that the total amount paid by all applicable plans does not exceed the insured's allowable medical expense. This prevents duplicate recovery for the same expense while preserving the insured's access to benefits under each applicable plan. California has adopted coordination-of-benefits regulations for group health insurance policies, requiring plans to include rules for identifying the order of benefit determination and coordinating payments among plans. In practice, one plan is identified as the primary plan and pays benefits according to its terms; another plan, if applicable, then considers the remaining allowable expense under its coordination provisions. This provision is particularly important for people who have employer-sponsored coverage while also being covered as a dependent under another group health plan. See the California coordination-of-benefits regulation at California Code of Regulations, title 10, section 2232.56 and the California Department of Insurance's health insurance consumer information.

QUESTION NO: 7

All of the following statements about mortality tables are true EXCEPT

A. the numbers in the tables are based on past experience.

B. the theory of probability is applied to numbers in the tables.

C. the tables track a group of people from the year they were born until they all die.

D. actuaries use the tables to predict the number of deaths among a given number of people at a given age.

ANSWER: C

Explanation:

The statement that “the tables track a group of people from the year they were born until they all die” is the exception because it inaccurately describes how mortality tables are developed and used. A mortality table is an actuarial statistical tool that summarizes observed or projected rates of death at each age, usually expressed as the probability that a person of a specified age will die before reaching the next age. Its figures are derived from large bodies of mortality data and are adjusted and analyzed using actuarial methods, rather than by waiting for one birth cohort to reach the end of every member’s life. This approach permits insurers to estimate expected mortality for people at particular attained ages and to calculate life insurance premiums, policy reserves, and related values. Mortality studies may use experience from many groups, time periods, and sources, and tables can be revised as mortality patterns change. The Society of Actuaries describes mortality tables and the experience studies used in their construction in its Mortality and Other Rate Tables resource. California’s life-agent education materials similarly treat mortality assumptions as a fundamental actuarial basis for life insurance pricing and policy values; see the California Department of Insurance’s agent licensing information.

QUESTION NO: 8

Who submits Medicare Part A claims?

A. Patients

B. Hospitals

C. Pharmacies

D. Physicians

ANSWER: B

Explanation:

Hospitals is correct because Medicare Part A primarily covers inpatient hospital care, as well as certain other institutional services. For a beneficiary’s inpatient stay, the hospital is the institutional provider that prepares and submits the claim to Medicare, generally through its Medicare Administrative Contractor. The hospital’s claim reports the services furnished during the admission and supports Medicare’s payment determination under the applicable inpatient payment rules. This provider-submitted billing process means beneficiaries ordinarily do not submit their own Part A inpatient hospital claims. Medicare describes Part A as Hospital Insurance and identifies inpatient hospital care as a central covered benefit. The Centers for Medicare & Medicaid Services also publishes the institutional claim form and billing requirements used by facilities, including hospitals, when seeking Medicare payment. See Medicare.gov’s overview of Medicare Parts A and B and CMS’s institutional claim form guidance.

QUESTION NO: 9

Which statement about Medicare is NOT correct?

A. Medicare Part A covers hospital care.

B. Medicare Part C covers long-term care.

C. Medicare Part B covers physician services.

D. Medicare is a federal health insurance program.

ANSWER: B

Explanation:

Medicare Part C covers long-term care is the statement that is not correct. Medicare Part C, usually called Medicare Advantage, is a way for eligible beneficiaries to receive their Medicare-covered benefits through a private health plan approved by Medicare. These plans must cover all medically necessary services covered by Original Medicare Part A and Part B (with limited exceptions such as hospice care, which remains covered by Original Medicare). They may also offer additional benefits, subject to Medicare rules.

Medicare does not generally pay for long-term custodial care—help with activities of daily living, such as bathing, dressing, eating, or using the bathroom—when that is the only care a person needs. This limitation applies whether an individual receives benefits through Original Medicare or a Medicare Advantage plan. Medicare can cover limited skilled nursing facility care after a qualifying inpatient hospital stay when the beneficiary needs skilled nursing or rehabilitation services, but that is distinct from ongoing long-term custodial care. The official Medicare publication on long-term care coverage explains this distinction. CMS also confirms that Medicare Advantage plans provide Medicare-covered Part A and Part B services through private plans in its Medicare Advantage overview.

QUESTION NO: 10

The insured is totally and permanently disabled. The insured's policy continues in force without payment of further premiums because the policy contains a

A. guaranteed insurability provision.

B. waiver of premium provision.

C. reinstatement provision.

D. grace period provision.

ANSWER: B

Explanation:

The correct answer is **waiver of premium provision.** A waiver of premium provision protects an insured whose qualifying total and permanent disability prevents continued premium payments. Once the insured satisfies the policy's disability definition and any required proof-of-disability, the insurer waives premiums that would otherwise become due. The insurance coverage therefore remains in force during the qualifying disability without the insured having to pay those premiums. This is an important life insurance policy benefit because disability may remove or substantially reduce the insured's earning capacity at the same time that maintaining life insurance protection remains important. The precise eligibility requirements, waiting period, age limitations, and proof requirements depend on the terms of the individual policy, so the provision operates according to its stated conditions. California's Insurance Code contains consumer-protection requirements governing life insurance policy provisions and disclosures; policy forms must clearly state the applicable contractual terms. See the California Legislature's Insurance Code, Part 2, Chapter 5 and the California Department of Insurance's life insurance consumer guides for consumer information on life insurance coverage and policy provisions.

QUESTION NO: 11

Which tax advantage is available for individual nonqualified annuities?

A. Fully taxable distributions.

B. Deductibility of contributions.

C. Penalty-free early withdrawals.

D. Tax-deferred accumulation of earnings.

ANSWER: D

Explanation:

Tax-deferred accumulation of earnings. is the tax advantage available for an individual nonqualified annuity. A nonqualified annuity is generally purchased with after-tax funds, so the owner has an investment in the contract (the amount paid in). Although premium payments do not produce an income-tax deduction, interest, dividends, and other gains credited within the annuity generally are not currently included in the owner's taxable income. Instead, taxation of those earnings is deferred until money is distributed from the contract.

This deferral can allow the full amount of accumulated values, including amounts that otherwise would have been paid currently as income tax, to remain invested and potentially compound over time. Under federal tax rules, amounts received from a nonqualified annuity before the annuity starting date are generally treated as earnings first, making that earnings portion taxable as ordinary income when withdrawn. The owner's after-tax investment is not taxed again when recovered. California licensing examinees should recognize tax deferral—not a deduction for contributions—as the central tax feature of a nonqualified annuity. See IRS Publication 575, Pension and Annuity Income and IRS Topic No. 410, Pensions and Annuities.

QUESTION NO: 12

A 67-year-old employee remains actively employed by a company with 50 employees and is covered under the employer's group health plan. The employee is also enrolled in Medicare Part B. For medical expenses covered by both plans, which coverage is generally primary?

A. The employer's group health plan.

B. Medicare Part A.

C. Medicare Part B.

D. The employee's personal disability income policy.

ANSWER: A

Explanation:

The employer group health plan is generally primary when an individual age 65 or older has coverage based on current employment with an employer that has 20 or more employees. Medicare is generally secondary in that situation. The Medicare Secondary Payer rules are intended to prevent Medicare from paying first when an eligible active employee has qualifying large-employer group health coverage.

QUESTION NO: 13

A terminating employee who wants to exercise the conversion privilege must meet all of the following requirements EXCEPT

A. pay the premium.

B. fill out the required forms.

C. supply evidence of insurability.

D. apply within 31 days of termination.

ANSWER: C

Explanation:

The correct answer is "supply evidence of insurability." A group life insurance conversion privilege protects an employee whose coverage ends by allowing the employee to convert the amount of group life coverage specified by the policy to an individual life insurance policy without having to establish acceptable health or provide proof of insurability. This is the central benefit of conversion: eligibility for the individual policy is based on the employee's prior group coverage and timely exercise of the conversion right, rather than the employee's health condition at termination. California Insurance Code section 10209 requires group life policies to provide a conversion right when eligibility terminates, provided that the application and first premium are submitted within the applicable conversion period, which is generally 31 days. The individual policy issued on

conversion is one customarily issued by the insurer and does not require underwriting evidence of the former employee's health. This statutory protection is especially important because a person may seek individual coverage precisely when a change in health would otherwise make insurance difficult to obtain. See California Insurance Code § 10209 and the California Department of Insurance's life insurance consumer guidance.

QUESTION NO: 14

What is the limit of liability in a term life insurance policy?

A. The total cash value.

B. The face amount of the policy.

C. The total amount of premiums paid.

D. The face amount plus the premiums paid.

ANSWER: B

Explanation:

The face amount of the policy is the limit of liability because it is the stated amount of life insurance coverage the insurer promises to pay when the insured dies while the term coverage is in force, subject to the policy's terms and conditions. Term life insurance is designed to provide a specified death benefit for a specified period rather than an investment or savings benefit. Thus, when a policy is described as having a particular face amount, that amount identifies the insurer's basic maximum contractual obligation under the life insurance coverage. California law defines life insurance as insurance on human lives and recognizes benefits payable upon death, which is the fundamental coverage provided by a term life policy. See California Insurance Code section 101. The California Department of Insurance's consumer material also describes term life insurance as protection for a specified period that pays a death benefit if the insured dies during that term. This supports using the policy's stated face amount as the relevant liability limit for this examination question. See the California Department of Insurance life insurance guide.

QUESTION NO: 15

What policy is a savings instrument designed to first accumulate funds and then systematically to liquidate the funds?

A. Term life.

B. Deferred annuity.

C. Mortgage insurance.

D. Disability income insurance.

ANSWER: B

Explanation:

Deferred annuity is correct because it is an insurance contract that separates saving for future income from the eventual distribution of that value. During its accumulation period, the contract owner pays premiums or purchase payments into the annuity. The insurer credits interest in a fixed annuity or allocates value according to selected investment options in a variable annuity, subject to the contract's terms. Earnings generally are not currently taxed while they remain in the contract, which supports the annuity's role as a long-term accumulation vehicle.

At a later date chosen under the contract, the deferred annuity may move into its payout stage. The accumulated value can be systematically liquidated through annuitization, under which the insurer makes periodic income payments according to the selected settlement option, such as payments for life or for a specified period. This two-stage structure—accumulation followed by an income or liquidation period—is the defining concept tested by the question. California regulates annuity transactions and requires insurers and producers to provide specified consumer protections and disclosures. The California

Department of Insurance provides consumer information about annuities at its annuity guide page; general federal tax treatment of annuities is described by the IRS in Publication 575.

QUESTION NO: 16

An insured purchases a Medicare supplement policy after enrolling in Original Medicare. The insured later needs ongoing assistance with bathing, dressing, and eating, but does not require skilled nursing care. Which statement is correct?

A. The Medicare supplement policy provides unlimited custodial long-term care benefits.

B. The Medicare supplement policy pays only after Medicaid has denied the claim.

C. The Medicare supplement policy fills Medicare cost-sharing gaps but does not generally cover custodial long-term care.

D. The Medicare supplement policy replaces Original Medicare when the insured needs assistance with activities of daily living.

ANSWER: C

Explanation:

A Medicare supplement policy is designed to help pay certain deductibles, coinsurance, and other gaps in Original Medicare coverage. It does not convert Medicare's limited coverage of long-term custodial care into broad long-term care insurance. Assistance with activities of daily living alone is custodial care, which Medicare generally does not cover. A long-term care insurance policy is designed to address qualifying long-term care needs, subject to its benefit triggers and policy terms.