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Practice Questions

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Exam : **InsNV_Health02**

Title : NV Accident and Health

Version : DEMO

1.Most insurance companies use the usual, customary, and reasonable (UCR) charges to:
A. reimburse the employee for expenses charged by the medical facilities
B. reimburse physicians for excess expense
C. pay dollars direct to the employers for health insurance
D. limit the insurance company claims liability
Answer: D
Explanation:
Usual, customary, and reasonable charges are payment standards used to determine the portion of a medical charge that a health insurer recognizes as eligible for reimbursement.
Choice D is correct because UCR standards limit the insurer's claim liability to an amount considered appropriate for the service in the relevant geographic area. "Usual" refers to the fee commonly charged by a particular provider; "customary" refers to fees generally charged by comparable providers in the area; and "reasonable" considers the circumstances and complexity of the service. If a provider's charge exceeds the plan's allowed amount, the insurer may pay only the UCR amount, and the patient may remain responsible for the difference unless a network agreement or other policy provision prevents balance billing. UCR does not mean that insurers reimburse excess charges, pay funds to employers, or reimburse every amount billed by a medical facility. This concept is tested as a cost-control mechanism within medical expense coverage and should be distinguished from deductibles, coinsurance, copayments, and maximum benefit limits.
Study Guide References/Topics: Policy Provisions, Clauses, and Riders; Medical Expense Insurance; Usual, Customary, and Reasonable Charges.

2.Which of the following situations describes a representation?
A. An insurance company guarantees that policy benefits will be paid promptly on receipt of a Proof of Loss
B. An insurance company guarantees that premiums paid will be refunded within 30 days after the policy's effective date if an insured is dissatisfied with the policy
C. A prospect's statement on an application that is held to be substantially true
D. A prospect's statement on an application that is held to be absolutely true
Answer: C
Explanation:
A representation is a statement made by an applicant on an insurance application that is believed to be true to the best of the applicant's knowledge and is required to be substantially true.
Choice C correctly states that principle. A representation differs from a warranty. A warranty is a statement or promise that must be literally and absolutely true; choice D describes that stricter standard rather than a representation. Application answers help the insurer evaluate risk during underwriting, so material misrepresentations can affect coverage or the insurer's decision to issue the policy. However, not every immaterial or innocent inaccuracy has the same legal effect. The significance of a misstatement depends on its materiality and the applicable policy and insurance-law rules.
Choices A and B describe potential policy promises or contract features, not statements made by a prospect in the application. For licensing purposes, remember that insurance applications are generally treated as containing representations, not warranties, unless the policy or law provides otherwise.
Study Guide References/Topics: Completing the Application, Underwriting, and Delivering the Policy; Representations and Warranties; Underwriting.

3.What is the primary purpose of a waiver-of-premium rider on a life insurance policy?
A. It eliminates all future policy loans.
B. It waives required premiums if the insured becomes totally disabled as defined by the rider.
C. It guarantees a higher death benefit every year.
D. It converts term insurance automatically into whole life insurance.
Answer: B
Explanation:
A waiver-of-premium rider keeps qualifying life insurance coverage in force by waiving required premiums when the insured becomes totally disabled as defined in the rider. The rider protects against the risk that disability will interrupt income and make premium payments unaffordable. Once the rider's requirements are satisfied, the insurer pays or waives the premium according to the policy terms, allowing the coverage and any applicable cash-value features to continue.
The definition of total disability, the waiting period, the age limitation, proof-of-disability requirements, and the duration of the waiver are contractual matters. The rider does not usually mean that premiums are waived for every illness, injury, or temporary work interruption. The insured must meet the stated definition and provide required evidence. Some riders also require that disability begin before a specified age.
This rider should not be confused with disability-income insurance. Disability income pays a periodic benefit to replace a portion of income. Waiver of premium does not provide an income payment; it protects the life policy from lapse due to qualifying disability. It also differs from a payor-benefit rider, which is commonly used with juvenile policies and protects the policy when the premium-paying adult dies or becomes disabled.
References/topics from the Study Guide: Waiver of Premium Rider; Total Disability; Disability Income; Payor Benefit Rider; Policy Continuation.

4.An insurer shall not issue an individual long-term care insurance contract in Nevada unless the insurer has received from the applicant:
A. a written designation of at least one person, in addition to the applicant, who must receive notice of any lapse or termination of coverage under the policy for nonpayment of premium
B. a notarized waiver dated and signed by the applicant stating that the applicant has chosen not to designate another person to receive notice of any lapse or termination of coverage for nonpayment of premium
C. a designation by at least one person, in addition to the applicant, to accept liability for services provided to the applicant
D. a written designation by the applicant to pay premium for long-term care insurance through either a payroll or pension deduction plan
Answer: A
Explanation:
Nevada requires an individual long-term care insurer to obtain a written designation of at least one additional person who will receive notice if coverage is about to lapse or terminate for nonpayment of premium. This protection is intended to reduce unintended lapses, particularly when an insured experiences cognitive decline, illness, disability, or another circumstance that interferes with managing premiums.

The applicant may instead submit a written waiver, dated and signed, stating that the applicant chooses not to designate another person. The waiver is not required to be notarized. Because option B incorrectly adds a notarization requirement, option A is the best answer as written.
The designated person does not become responsible for paying premiums and does not assume liability for the applicant's care. The person's role is simply to receive notice, allowing the person an opportunity to alert the insured or help address an overlooked payment. Payroll or pension deduction is not a required payment method.
Before an individual long-term care policy can lapse for nonpayment, notice requirements apply to both the policyholder and the designated person. This is a key long-term-care consumer-protection provision.
Study Guide references/topics: long-term care insurance; lapse protection; nonpayment of premium; designation of another person; NAC 687B.0681.

5.Under federal COBRA continuation rules, an employee who loses group health coverage because of termination of employment or reduction in hours will generally be offered continuation coverage for up to:
A. 6 months
B. 12 months
C. 18 months
D. 60 months
Answer: C
Explanation:
COBRA generally gives qualified beneficiaries the right to continue employer-sponsored group health coverage after certain qualifying events. For termination of employment, other than gross misconduct, or a reduction in work hours, the standard maximum continuation period is generally 18 months. Other qualifying events, such as death of the covered employee, divorce, legal separation, or a dependent child's loss of dependent status, may result in a longer maximum continuation period, commonly 36 months.
Continuation coverage is not free coverage. The qualified beneficiary typically pays the full group premium plus a permitted administrative charge. COBRA can preserve the same group coverage and provider access for a limited time, but it may be expensive because the employer is no longer subsidizing premiums. Enrollment deadlines, election notices, payment rules, and employer-plan size requirements are important.
COBRA should not be confused with conversion coverage or an Affordable Care Act marketplace plan. Conversion coverage is an individual policy issued after group coverage ends under stated conditions. Marketplace coverage is a separate individual-market option that may be available following loss of employer-sponsored coverage. Producers should explain options carefully and avoid presenting one continuation route as automatically best for every consumer.
References/topics from the Study Guide: COBRA; Group Health Continuation; Qualifying Events; Conversion Privilege; Employer-Sponsored Health Insurance.