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QUESTION NO: 1

Under a Disability policy, the Elimination period is:

A. usually longer for accidents than for sickness

B. predetermined by the insurance company

C. similar to a deductible but expressed in terms of time rather than dollars

D. the same as a Probationary period

ANSWER: C

Explanation:

An elimination period is the waiting period that an insured must satisfy after a disability begins before disability-income benefits become payable. It functions like a deductible, but instead of requiring the insured to absorb a stated dollar amount of loss, it requires the insured to absorb a specified period of lost income. For example, with a 30-day elimination period, no benefit is payable for the first 30 days of a qualifying disability; benefits begin only after that period has been met, subject to the policy's other terms. Longer elimination periods generally reduce premium because the insurer's benefit-paying period starts later. The exact period is selected from the policy's available choices at issue and is stated in the contract. This concept is distinct from a probationary period, which is a period at the beginning of coverage during which sickness-related claims may be excluded or limited. Nevada's disability-insurance regulations identify the elimination period as a policy provision that must be described in the policy form. See the Nevada Administrative Code, Chapter 689B and the NAIC's Accident and Sickness Insurance Minimum Standards Model Act.

QUESTION NO: 2

A surgeon has a Disability Income policy with a $4,000 monthly benefit and a residual disability provision. Before the disability, the surgeon earned $8,000 per month. After returning to limited practice, the surgeon earns $4,000 per month. Assuming all other policy conditions have been met and benefits are proportionate to lost income, what residual monthly benefit is payable?

A. $1,000

B. $2,000

C. $4,000

D. $8,000

ANSWER: B

Explanation:

$2,000 is correct. The surgeon has experienced a 50% loss of income, falling from $8,000 to $4,000 per month. A residual benefit provision pays a partial disability benefit based on the percentage of income lost. Therefore, a 50% loss applied to the $4,000 monthly disability benefit produces a $2,000 residual benefit.

Residual benefits are designed for an insured who can resume some work but continues to suffer a qualifying loss of earnings because of disability. They do not require the insured to remain totally unable to work.

QUESTION NO: 3

An individual Accident and Health policy contains a provision stating that no agent may change the policy or waive any of its provisions. A producer tells an insured that a late premium will be accepted without affecting coverage, but the insurer has not approved that statement. Which of the following is correct?

A. The producer's oral statement automatically extends the grace period.

B. The producer may waive the premium requirement if the insured has had no prior late payments.

C. Only an authorized insurer officer may waive or change a policy provision.

D. The policy provision applies only to disability income insurance.

ANSWER: C

Explanation:

The producer cannot bind the insurer by waiving a policy provision. Under the standard policy-provision concept, a change to the policy or waiver of a policy requirement must be made by an authorized officer of the insurer and generally must be in writing. A producer may explain policy provisions and submit a request to the insurer, but cannot independently alter the contract or excuse noncompliance with a premium requirement.

QUESTION NO: 4

The Coinsurance clause in an individual Medical Expense policy refers to the:

A. insured ' s rights to have another person, such as a spouse or child, insured on the same policy

B. insurance company ' s right to join with another company to carry excessive coverage on a particular individual

C. insurance company ' s right to share claim experience with another company

D. insurance company ' s right to require the insured to share a certain percentage of the cost of each claim

ANSWER: D

Explanation:

“insurance company ' s right to require the insured to share a certain percentage of the cost of each claim” correctly describes a coinsurance clause in an individual medical expense policy. Coinsurance is a percentage-based cost-sharing provision: after the insured satisfies any applicable deductible, the insurer and insured each pay stated portions of covered expenses. For example, under an 80/20 arrangement, the insurer generally pays 80 percent of eligible covered charges and the insured is responsible for 20 percent. The policy specifies how covered expenses are determined, the applicable percentage, and whether an annual out-of-pocket maximum limits the insured’s cost sharing. This mechanism allows the policyholder to retain meaningful protection against substantial medical bills while participating in the cost of care. Coinsurance is a standard feature of health insurance benefit design and is distinct from the deductible, which is generally a specified amount paid before benefits begin. Nevada’s individual accident and health insurance provisions are found in Nevada Revised Statutes Chapter 689A. For a consumer-oriented explanation of coinsurance as health-plan cost sharing, see the HealthCare.gov coinsurance glossary.

QUESTION NO: 5

Which rider allows a terminally ill insured to receive part of the death benefit while still alive, subject to the policy terms?

A. Guaranteed insurability rider

B. Accelerated death benefit rider

C. Payor benefit rider

D. Accidental death rider

ANSWER: B

Explanation:

The **Accelerated death benefit rider** is designed to provide a living benefit when an insured meets the rider's eligibility requirements, commonly including a terminal illness. It allows the insurer to advance a portion of the life insurance policy's death benefit before the insured dies. The payment is not separate or additional insurance; it is an advance against the policy proceeds. Therefore, the amount ultimately payable to the beneficiary is reduced in accordance with the contract, including any applicable administrative charges, interest, or actuarial adjustment.

For a terminal illness, eligibility generally requires medical certification that the insured has a limited life expectancy, as defined by the particular policy and applicable law. Funds received under the rider may help the insured address medical treatment, care needs, household expenses, or other financial demands during a serious illness. The precise amount available, qualifying conditions, documentation, and effect on the remaining death benefit are controlled by the policy terms. Nevada's insurance statutes address accelerated benefits in connection with life insurance policies, and the National Association of Insurance Commissioners provides the model framework commonly used for these benefits. See Nevada Revised Statutes, Chapter 688A and the NAIC Accelerated Benefits Model Regulation.

QUESTION NO: 6

A policyowner replaces an existing individual health insurance policy with a new policy. The existing policy has already satisfied its pre-existing-condition limitation. The new policy contains a pre-existing-condition limitation that would apply to the insured's ongoing condition. Which provision is designed to prevent the replacement from causing a new period of limited coverage for that condition?

A. Continuity-of-coverage provision

B. Coordination of Benefits provision

C. Probationary-period provision

D. Grace-period provision

ANSWER: A

Explanation:

The **continuity-of-coverage provision** is designed to preserve credit for prior coverage when an individual replaces health insurance. Its purpose is to prevent an insured who maintained qualifying coverage from being subjected again to a pre-existing-condition waiting or exclusion period merely because the insured changed policies.

The decisive fact is that the earlier policy's limitation had already been satisfied. A replacement policy may have its own terms, but continuity-of-coverage rules protect against loss of previously earned credit for continuous coverage. A probationary period concerns losses caused by sickness during an initial period of a policy and is not the same as crediting prior coverage. Coordination of benefits addresses payment order when more than one plan covers the same loss, not replacement coverage.

QUESTION NO: 7

Medicaid is best described as:

A. A federal retirement program funded only by payroll taxes

B. A joint federal-state program that provides medical assistance to eligible individuals

C. A private insurance policy sold by producers

D. A Medicare supplement insurance plan

ANSWER: B

Explanation:

Medicaid is correctly described as a joint federal-state program that provides medical assistance to eligible individuals. It is a public health coverage program established under Title XIX of the Social Security Act. The federal government sets core

statutory and regulatory requirements and contributes matching funds, while each state administers its own Medicaid program, determines many operational details within federal limits, and may offer coverage beyond mandatory benefit categories. Eligibility is generally based on financial and categorical standards established by federal and state law, and the program serves groups that can include low-income children, pregnant individuals, parents, older adults, and people with disabilities. Nevada administers its Medicaid program through the Nevada Department of Health and Human Services, Division of Health Care Financing and Policy. Because states operate their own programs within the federal framework, eligibility pathways, covered services, enrollment processes, and managed-care arrangements can vary by state. For an insurance producer, accurately identifying Medicaid as public medical assistance is important when discussing government-sponsored health programs and possible coordination with private coverage. Eligibility determinations should be referred to the appropriate Medicaid agency rather than assumed based on income alone. See Medicaid.gov beneficiary resources and the Nevada Division of Health Care Financing and Policy.

QUESTION NO: 8

The Fair Credit Reporting Act requires that:

A. interest charged on premium loans be limited to a specified amount

B. applicants be advised that a consumer report may be requested

C. insurance companies treat insureds fairly and not discriminate

D. insurance companies pay interest on claims that are paid late

ANSWER: B

Explanation:

The Fair Credit Reporting Act requires meaningful consumer notice when an insurer obtains an investigative consumer report in connection with an insurance application. Therefore, “applicants be advised that a consumer report may be requested” is the best and intended answer. For insurance underwriting, the Act permits a consumer reporting agency to furnish a report to an insurer evaluating eligibility for insurance or setting premiums. When the report is an investigative consumer report—one based on personal interviews concerning a consumer’s character, reputation, personal characteristics, or mode of living—the person procuring it must clearly and accurately disclose to the consumer that such a report may be made. The disclosure must be provided no later than three days after the report is first requested. The consumer also has statutory rights to request additional information about the nature and scope of the investigation. These notice requirements promote transparency by ensuring that applicants understand that information relevant to their insurance eligibility may be collected and reviewed. See the investigative-consumer-report disclosure requirement in 15 U.S.C. § 1681d and the insurance-underwriting permissible purpose in 15 U.S.C. § 1681b.

QUESTION NO: 9

Under a Gold health insurance plan, an insurer would be expected to pay which percentage of medical costs?

A. 60%

B. 70%

C. 80%

D. 90%

ANSWER: C

Explanation:

80% is correct because a Gold-level qualified health plan has an actuarial value of approximately 80%. Actuarial value is the percentage of the total allowed costs of covered essential health benefits that the plan is expected to pay for a standard population of enrollees. Accordingly, enrollees as a group are expected to pay the remaining approximately 20% through plan cost-sharing features, including deductibles, copayments, and coinsurance.

This measure is an overall plan-design standard, not a promise that the insurer will pay exactly 80% of each covered person's bills. An individual's actual share can vary based on the health services received, the plan's specific cost-sharing design, and whether the annual out-of-pocket maximum is reached. Under the Affordable Care Act metal-tier framework, Gold coverage is designed to provide a relatively higher level of insurer payment for covered care than Bronze or Silver plans, generally in exchange for a higher premium. Nevada health insurance licensing candidates should recognize Gold as the 80% actuarial-value metal level. See HealthCare.gov's plan category overview and the federal actuarial-value standards at 45 C.F.R. § 156.140.

QUESTION NO: 10

A life policy has been in force during the insuredâ€™s lifetime for more than two years. Which circumstance may still permit the insurer to deny a claim under the policyâ€™s incontestability provision?

A. An innocent misstatement on the original application

B. A material misrepresentation unrelated to the policy

C. A change in the insuredâ€™s occupation after issue

D. Nonpayment of premium

ANSWER: D

Explanation:

Nonpayment of premium is correct because Nevada's required life-insurance incontestability provision expressly preserves the insurer's right to deny liability when premiums have not been paid. After a policy has been in force during the insured's lifetime for the applicable contestability period—no more than two years from issuance—the insurer generally may no longer challenge the validity of the policy based on application representations or underwriting matters. This rule gives policyowners and beneficiaries certainty that coverage will not be reopened indefinitely after the insurer has issued the policy and accepted premiums.

However, incontestability does not keep a policy in force when the policyowner fails to meet the continuing obligation to pay the required premium. If the premium is not paid by the end of any applicable grace period, the policy may lapse. A lapsed policy does not provide death-benefit coverage, so the insurer may deny a later claim on the basis of nonpayment. Nevada law specifically requires that the incontestability clause be subject to the exception for nonpayment of premiums. The statute also permits separately stated exceptions involving disability benefits or additional accidental-death benefits, but the direct and general circumstance tested here is nonpayment of premium. See NRS 688A.080 and the Nevada Division of Insurance's life insurance consumer information.

QUESTION NO: 11

Which of the following characteristics is typical of group insurance?

A. Medical examinations are required.

B. Each employee receives an individual contract.

C. All full-time employees are eligible for coverage.

D. Employees may automatically enroll for coverage at any time.

ANSWER: C

Explanation:

All full-time employees are eligible for coverage is the typical group-insurance characteristic intended here. Group health insurance is issued to a policyholder, commonly an employer, to insure a defined class of people rather than being individually negotiated and underwritten person by person. Full-time employees are a common objectively defined eligible class because employment status and regularly scheduled work hours provide an administratively practical,

nondiscriminatory basis for determining who may participate. The employer's group plan can also establish such features as a probationary or waiting period, minimum-hours requirement, and enrollment procedures, so eligibility generally begins only after the employee satisfies the plan's stated terms. This group structure allows the insurer to evaluate and price risk based largely on the characteristics and experience of the covered group. Nevada's group health insurance statutes recognize employer groups and provide the legal framework for group blanket and group health coverage. The master policy is held by the policyholder, while covered employees receive evidence describing their insurance. For additional statutory context, see the Nevada Legislature's NRS Chapter 689B, Group and Blanket Health Insurance and the Nevada Division of Insurance's Health Insurance consumer information.

QUESTION NO: 12

Which person is generally eligible to establish and contribute to a health savings account (HSA)?

A. A person enrolled in any health plan with no deductible

B. A person covered by a qualified high-deductible health plan and meeting other eligibility requirements

C. A person enrolled in Medicare Part A

D. A person claimed as another taxpayerâ€™s dependent

ANSWER: B

Explanation:

A person covered by a qualified high-deductible health plan and meeting other eligibility requirements is generally eligible to establish and contribute to an HSA. Federal tax law requires an HSA-eligible individual to have coverage under an HDHP that satisfies the IRS deductible and out-of-pocket maximum requirements for the applicable calendar year. The individual must also satisfy the additional federal eligibility conditions at the relevant time, including not having disqualifying non-HDHP coverage, not being enrolled in Medicare, and not being claimable as another taxpayer's dependent. The HSA is individually owned, meaning the eligible person establishes the account; contributions can then be made by the account holder, an employer, or another person, subject to annual IRS limits. Eligibility is evaluated under federal rules, and plan deductibles or labels alone do not determine qualification—the underlying coverage must meet the current HDHP standards. Amounts in a properly established HSA may generally be used tax-advantaged for qualified medical expenses, and unused funds remain in the account rather than being forfeited at year-end. Current requirements, contribution limits, and the definition of qualifying HDHP coverage are published by the IRS in Publication 969, Health Savings Accounts and Other Tax-Favored Health Plans and its Health Savings Accounts guidance.

QUESTION NO: 13

What is the principal purpose of Medicare supplement insurance?

A. To replace Medicare Part A and Part B entirely

B. To help pay certain deductibles, coinsurance, and other gaps in Original Medicare

C. To provide Medicaid eligibility

D. To pay only long-term custodial care

ANSWER: B

Explanation:

To help pay certain deductibles, coinsurance, and other gaps in Original Medicare is correct because Medicare supplement insurance, commonly called Medigap, is private insurance specifically designed to supplement Original Medicare coverage. Original Medicare Part A and Part B pays a substantial share of covered hospital and medical expenses, but beneficiaries can remain responsible for cost sharing such as deductibles, coinsurance, and copayments. A standardized Medigap policy helps pay some or all of these remaining costs, subject to the benefits provided by the particular plan and applicable Medicare rules.

Medigap works alongside Original Medicare rather than taking its place: Medicare pays its approved share of a covered claim first, and the Medigap insurer may then pay its contractual share of the beneficiary's remaining covered costs. This helps make out-of-pocket medical expenses more predictable for individuals enrolled in Original Medicare. Depending on the policy, Medigap may also provide certain additional benefits, such as limited coverage for emergency care during foreign travel. Federal consumer guidance explains that a Medicare Supplement Insurance policy helps pay its share of costs not paid by Original Medicare. See Medicare.gov: What is Medigap? and the Nevada Division of Insurance Medicare Supplement Insurance information.

QUESTION NO: 14

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 prospect ' s statement on an application that is held to be substantially true describes a representation. In insurance, an applicant provides factual information to help the insurer assess the proposed risk and decide whether to issue coverage and at what premium. These application statements are generally representations: they must be made in good faith and be substantially accurate to the applicant's knowledge and belief, rather than guaranteed with literal perfection. Nevada law expressly provides that statements made in an application for an insurance policy are representations, not warranties. The law further recognizes the importance of materiality: a misrepresentation, omission, concealment of fact, or incorrect statement affects recovery under a policy only under the circumstances specified by statute, including when it is fraudulent or material to the acceptance of the risk or the hazard assumed. This treatment reflects the underwriting purpose of the application while recognizing that an applicant's answers are ordinarily based on information reasonably known at the time of application. For the licensing exam, connect "representation" with an applicant or prospect's substantially true statement in the application. See Nevada Revised Statutes § 687B.110 and the NAIC insurance basics resource.

QUESTION NO: 15

An Outline of Coverage for Medicare Supplement policies must be provided to a prospective insured at which of the following times?

A. When the policy is delivered

B. At the time of application

C. When the premium is paid

D. At the time a claim is submitted

ANSWER: B

Explanation:

At the time of application is correct because Nevada's Medicare Supplement insurance disclosure rules require delivery of an Outline of Coverage when the application is taken. This timing gives the prospective insured a standardized, plain-language summary of the Medicare Supplement policy before committing to purchase it. The outline identifies key information such as the policy's benefits, premiums, exclusions, limitations, and relationship to Medicare, enabling an informed comparison with other available coverage.

The disclosure is intended to support a consumer’s decision at the point of sale, rather than merely provide information after the insurance transaction has been completed. It is a summary document and does not replace the policy contract; the issued policy remains the controlling document for contractual terms. When a policy issued differs from the coverage described in the original outline, Nevada’s rules also address providing an appropriate substitute outline upon delivery. The fundamental examination rule, however, is that the initial Outline of Coverage is furnished with the application. See NAC 687B.250 and the Centers for Medicare & Medicaid Services’ Medigap overview.