CERTIFIED INSURANCE COUNSELORS

Life & Health

The National Alliance 2022

Online Learning Guide

CERTIFIED INSURANCE COUNSELORS

Life & Health

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THE NATIONAL ALLIANCE
for Insurance Education & Research

A Letter from William J. Hold, President/CEO

We know that choosing the right professional development programs to strengthen your career can be challenging. There are many options for you to choose from; so how can you be sure that your time, efforts, and money are being invested and not wasted?

By becoming a committed participant of The National Alliance, you can rest assured that you are also making the best educational choice for your career—no matter what step of your learning path you are on.

For the last 50 years, our designations have been regarded throughout the industry as symbols of quality and trust. Our practical insurance and risk management courses are taught by active insurance practitioners, include polices and forms currently used in the field, and guide you through real-world scenarios to give you a deeper understanding of what your clients are facing today. The knowledge and skills you develop in any one of our courses (or designation programs) can be put to use immediately.

You will build long-lasting relationships with your clients, stay ahead of industry trends, emerging risks, and products that are constantly evolving in our dynamic market. You will have access to the industry's latest learning materials and will be the first to hear about new courses. With a learning path customized to fit your needs, you will be better equipped to protect your clients.

Have no doubt that your success is our priority. Whether you are new to your career, or a seasoned professional, you are about to embark on a wonderful professional development journey. Thank you for choosing The National Alliance for Insurance Education & Research as your guide toward a thriving career.

Let's take the first step.

William J. Hold, M.B.A., CRM, CISR
President/CEO

DISCLAIMER

This outline is intended as a general guideline and may not apply in each situation.

For any matters of legal and/or tax issues, one should consult with competent counsel or advisor for the matter in question and in the jurisdiction in question.

The Society of CIC and any organization for which this seminar is conducted shall have neither liability nor responsibility to any person or entity with respect to any loss or damage alleged to be caused directly or indirectly as a result of the information contained in this outline.

Insurance policy forms, clauses, rules, court decisions, and laws change constantly. Policy forms and underwriting rules vary from company to company.

THE NATIONAL ALLIANCE
for Insurance Education & Research

EXAM INFORMATION

Examination Techniques

During the Program

1. **Listen Professionally**
   Adjust the way you listen to the pace of the instructor. Listen actively for the "big ideas" and search for facts to back them up. Listen for key words and clue phrases like "You should know…," "Three steps are…," etc. Listen to the speaker's inflection and tone. If you intend to take the examination, study and review each evening while it is fresh—don't wait for the night before the exam.

2. **Take Careful Notes**
   During the lectures, take clear notes on each topic and be sure to ask the instructor if you need clarification on a point. Each evening, review these notes, as well as the materials to be covered next. Compose your own exam questions from the material. Study with others and concentrate on the areas you are least certain of—but don't forget to get a good night's rest before the examination.

During the Examination

1. **Remain Calm**
   Some of you may have had experiences in your previous schooling that have caused you to feel anxious at the thought of taking an examination. Relax and you will do much better. You will have more access to your memory if you take the examination as a confirmation of your understanding of the material and not as a test of your value as a person. Even if you do not pass the examination the first time, you cannot fail an institute! Your mere presence here is proof of your dedication to professional education and improvement.

2. **Understand the Examination Format**
   The examination period is two hours long for the CIC institutes and CPRM courses, and two and one- half hours long for the CRM courses. It is an essay-type exam with a total value of 200 points. In order to pass the exam a participant must score at least 140 points. The examination questions are in the order of presentation of the topics and are weighted to the length of the presentations. To work at a proper pace within the two-hour or two and one-half hour period, you should allow approximately six to eight minutes to answer each question. To work slower may mean that some questions might not be answered. It is a good rule of thumb in exam writing to NEVER LEAVE AN ANSWER BLANK.

During the Examination *(continued)*

3. **Understand Each Question**
   Read the question carefully, looking for clues contained in it. Look for action words, such as: compare, contrast, define, summarize, explain, etc. Underline key points or questions. Be sure that you answer the question that is asked and not the one that you wish had been asked.

4. **Plan Before You Write**
   It makes sense to briefly outline your answer before you begin writing. This will help you make sure you understand the full scope of the question and make it less likely that you will leave something important out of your answer. Be specific and give reasons. "Yes" or "No," "Covered" or "Not Covered" are not adequate answers. Rarely will a question require only a short, one-sentence answer. Take the time to explain.

5. **Use All of Your Time**
   Even if you finish your examination early, use the extra time to carefully review both the questions and the answers. Have you really answered the question that was asked? Is your answer as complete as it should be to convey your understanding? Use all of your time. Have you answered ALL of the questions?

Sample Examination Questions and Composite Answers

Note to Candidates:

This composite set of answers to the Certified Insurance Counselors examinations is published for CIC candidates and others interested in the CIC study program. The answers have been taken from actual student papers and have been edited by the staff of the Society. The questions and answers are ***illustrative only;*** the answers are not necessarily perfect.

It should be understood that these answers may be longer and more complete than necessary to receive a high grade. Your answers will be graded on the factual response to the question asked, the instructions given, and the completeness of the answer. You should not use this set of questions and answers as a substitute for a thorough study of the subject matter.

Agency Management Institute

Sample Examination Questions and Composite Answers

Sample Question 1:

Agency planning should be conducted through a formal process that includes several steps. Please identify the five formal steps in the planning process.

Sample Answer 1:

1. *Conduct a situation analysis*
2. *Review the agency's mission statement*
3. *Write the agency plan*
4. *Implement*
5. *Monitor/evaluate and adjust*

Sample Question 2:

Agent Best placed a Commercial Property policy with the Fire and Casualty Company. Subsequently, Agent Best's client suffered a large fire loss covered by the policy. However, because of financial difficulties, Fire and Casualty could not pay. Explain the possible liability of the agent in this case.

Sample Answer 2:

One of the agent's legal responsibilities to clients is the duty to investigate the solvency of an insurance company. This can include not only the initial placement, but also an ongoing duty.

Commercial Casualty Institute

Sample Examination Questions and Composite Answers

Sample Question 1:

Your insured states that he understands his Commercial General Liability (CGL) Policy provides coverage for an "insured contract." He then asks, "What is an 'insured contract'?" Answer your insured's question by listing the six "insured contracts" found in the CGL policy.

Sample Answer 1:

1. *Lease of premises, except for fire damage to the rented premises.*
2. *Sidetrack agreement.*
3. *Easement or license agreement, except construction or demolition on or within 50 feet of a railroad.*
4. *An obligation to indemnify a municipality as required by ordinance, except in connection with work for municipality.*
5. *Elevator maintenance agreement.*
6. *That part of any other contract, pertaining to an insured's business, assuming tort liability of another to pay a third party.*

Sample Question 2:

The Workers Compensation and Employers Liability Insurance Policy is composed of three coverages. Name each coverage and briefly describe the purpose of one of the coverages.

Sample Answer 2:

Must Name All Three Coverages:

Workers Compensation Insurance
Employers Liability Insurance
Other States Insurance

Provide Any One Description:

Workers Compensation Insurance provides coverage for workers compensation benefits to employees as required by state law.

or

Employers Liability Insurance provides coverage for liability other than state mandated benefits arising out of an employee's work-related injuries.

or

Other States Insurance provides temporary automatic coverage for new operations in other states, plus coverage for incidental exposures in other states. The states must be listed in Item 3C on the Information Page for other states insurance to apply.

Commercial Property Institute

Sample Examination Questions and Composite Answers

Sample Question 1:

MAP Company insures its corporate headquarters under an unendorsed Building and Personal Property Coverage Form with the Special Causes of Loss Form. The building is insured for $600,000 and the business personal property for $200,000. The 80% coinsurance requirement is satisfied. Ms. Peterson, the comptroller, asks the following questions. How would you respond to each question? Support your answer.

A. "Part of our premises includes an unattached retaining wall for decorative effects. The value of this wall is $15,000. What coverage applies if someone runs their car into the wall?"
B. "Will our policy pay for loss to our employees' belongings while they are at work?"

Sample Answer 1A:

No coverage. Retaining walls that are not part of the building are defined as Property Not Covered.

Sample Answer 1B:

Covered. Under the Coverage Extension Personal Effects And Property of Others coverage applies up to $2,500 at each described premises. However, loss or damage by theft is not covered.

Sample Question 2:

A prospect of yours decides to purchase Business Income Coverage from your agency. This prospect asks you the following question: "How is the term 'Business Income' defined?" Please respond to the client's question.

Sample Answer 2:

Business Income is defined as Net Income that would have been earned/incurred and continuing normal operating expenses including payroll.

Life & Health Institute

Sample Examination Questions and Composite Answers

Sample Question 1:

The following policy provisions are commonly found in most major medical insurance policies: (a) coinsurance clause, (b) deductible. Describe each provision.

Sample Answer 1:

(a) The coinsurance clause requires that the insured pay a portion of each dollar loss after the deductible has been exceeded.

(b) A deductible is an amount of money paid by the insured. It must be satisfied before the insurance contract responds.

Sample Question 2:

One of the standard provisions found in most life insurance contracts is the reinstatement provision. Explain the reinstatement provision and list the requirements needed to reinstate a policy.

Sample Answer 2:

After the expiration of the grace period, the insured may request the reinstatement of the contract. Requirements: proof of insurability, payment of all back premiums, interest, and policy loans.

Personal Lines Institute

Sample Examination Questions and Composite Answers

Sample Question 1:

John has his home insured on a Homeowner 3 - Special Policy that has a $200,000 Coverage A – Dwelling limit and a $300,000 Coverage E - Liability coverage.

A. John has an apartment above his detached garage that he rents to a college student. The tenant accidently starts a fire that causes $25,000 damage to the garage/apartment. The fire also causes $6,000 damage to the tenant's personal property. Ignoring any deductible, how much of this loss is covered by John's Homeowners Policy? Include the reason for your answer.

B. While John was on vacation, a neighbor cared for his dog as a favor. When the neighbor failed to shut the gate to the fence, John's dog got out of the yard and bit a child. The parents of the injured child have fire a$500,000 lawsuit against both John and his neighbor for the bodily injury to the child. Will John's Homeowner Policy provide coverage to both him and his neighbor? Explain your answer.

Sample Answer 1:

A. While fire is a covered peril, the homeowners policy does not cover another structure rented or held for rental to others unless used solely as a private garage. The tenant's property is not covered as the homeowner policy excludes property of tenants.

B. John is an insured and is provided coverage for bodily injury caused by his dog. The neighbor is also an insured while caring for John's dog as the neighbor is not in the business of caring for animals. The maximum the policy will pay is the $300,000 per occurrence limit.

Sample Question 2:

Sue is the named insured on a Personal Auto Policy on which she insures her 2014 Toyota. The policy has Part A – Liability limits of 50,000/100,000/25,000. Sue also has a company car provided by her employer.

A. Sue has an at-fault accident while driving her company car. The driver of the other car is seriously injured, and the other vehicle is totaled. Explain whether or not Sue's Personal Auto Policy will provide liability coverage for the injury to the other driver and the damage to the other vehicle.

B. Sue is helping her friend move. While driving her Toyota, Sue has an accident and the friend's property in her car is damaged. Explain whether or not Sue's Personal Auto Policy will pay for the $1,500 damage to her friend's property.

Sample Answer 2:

A. Sue's policy does not provide liability coverage while she is driving her company car. There is an exclusion for a vehicle furnished or available for her regular use.

B. Sue's policy will not cover the damage to her friend's property. There is an exclusion for property damage to property being transported.

The Society of
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Section 1

LIFE AND ANNUITY POLICIES

THE NATIONAL ALLIANCE
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Resources

Available at:
scic.com/LHResources

- Glossary of Terms
- Insurance Needs Worksheets
- Estate Planning Videos
- Sample Annual Statement
- Sample Conditional Receipt
- Brief History of Annuities
- Customer Advocate Video

Life and Annuity Policies

Section Goal

The Life and Annuity Policies and Concepts section provides participants with the core knowledge and tools necessary to deliver transformative information and counsel regarding life and annuity products to their clients and prospects.

Learning Objectives

1. Participants will use knowledge of the **general uses**, and **legal elements** of life insurance contracts to provide counsel to clients and prospects.

2. Participants will use knowledge of the **various methods of determining the appropriate type and amounts** of life insurance coverage to help a client or prospect develop a financial plan.

3. Participants will apply knowledge of the **components** of **Term Insurance, Universal Life Insurance, and Whole Life Insurance** policies to advise clients and prospects on selecting the life insurance products to best meet their needs.

4. Participants will apply knowledge of **riders, provisions, beneficiary designations, settlement options, and conditional receipts** to a variety of client needs in various scenarios.

5. Participants will use their understanding of **income tax aspects** of **annuities and life insurance** to determine the most appropriate annuity product(s) to meet client needs.

6. Participants will use their understanding of **classifications, types, provisions, and payout options** of annuities to determine the most appropriate annuity product(s) to meet client needs.

Life Insurance Concepts

Learning Objective 1:
Participants will use knowledge of the general uses, and legal elements of life insurance contracts to provide counsel to clients and prospects.

General Uses of Life Insurance

Protect Your Clients: "Build a wall around them!"

Create an Estate: (Provides a lump sum of cash) Where time or other circumstances have kept the estate owner from accumulating sufficient assets to care for his or her loved ones, life insurance can create an instant (income-tax-free) estate. Most people simply do not have a large estate and if they do, it is usually illiquid, not easily converted to cash.

Pay Estate (Death) Taxes: (Prevents the erosion of estate values because of settlement costs) Due to the current exemption rules, very few estates are subject to estate taxes. Those that are may see as much as 50% erosion of the total estate value because of the tax and associated settlement cost. Federal estate taxes are generally due nine months after death.

Fund A Business Transfer, Business Continuation, Or Buy-Sell Agreement: Business owners often agree to buy a deceased owner's share from his or her estate after death. Life insurance provides ready cash to finance the transaction.

Pay Off A Home Mortgage: Many people would like to pass the family residence to their spouse or children free of any mortgage. Often a decreasing term policy is used, which decreases in face amount as the mortgage balance is paid down.

Provide an Education Fund – College Fund for Children or Grandchildren: Cash value increases in a policy on the parent's life (or child's life) can be used to accumulate funds for college. If the insurance is on the parent's life, the death benefit could also fund this expense should death occur prematurely. A grandparent could "gift" the premium on such a policy.

Protect a Business from The Loss of a Key Person: (Valuable Employee) Key employees are difficult to attract and retain. Untimely death of a key person may cause a severe financial strain on the business.

Create or Supplement a Retirement Fund: Current insurance products provide competitive returns and are a prudent way of accumulating necessary funds for retirement years.

Comply with a Court Order: A divorce settlement with minor children involved may include a court-ordered life insurance policy on the payor with the payee as the irrevocable beneficiary. This life insurance would continue the child support in the event of the death of the payor before support order ends.

Make a Gift: Life insurance is often used to make gifts to individuals or charities.

Rewarding and Retaining Valuable Employees: Life insurance (and its cash value) can be used for rewarding and retaining valuable employees. An Executive Bonus (162 Plan) is a simple, discriminatory and tax-advantaged way employers can accomplish this goal.

Equalize Inheritances: When the family business passes to children who are active in it, life insurance can give an equal amount to the other children.

Use Any Cash Value as an Emergency Cash Fund: Cash value in permanent life insurance is liquid and usually easily accessed.

Replace Lost Income: Anyone who depends on another individual for income contribution to the household, such as a working spouse or partner, should consider life insurance as protection from the loss of that income.

Final Expenses: Funeral expenses are not cheap and the sudden loss of a loved one will be compounded by the cost of a funeral and associated expenses.

Legal Elements of a Life Insurance Contract

Agreement:

1. Offer
2. Acceptance
3. Consideration (premium)

Competent Parties:

1. Parties to the contract must have the legal capacity to enter into the contract
2. Those not considered legally competent to enter into a contract include:
    - Anyone under the influence
    - Anyone considered mentally incompetent
    - Minors – "age of majority" is 18 in most states, except for certain activities such as drinking alcoholic beverages

Legal Purpose

1. Insurance cannot be issued for an illegal or immoral purpose
2. There must be **insurable interest**, meaning a relationship that exists between parties that justifies one owning life insurance on the other, at the time of **application**, which is defined as the statement of information given when a person applies for life, health, or disability insurance
3. Property-Casualty coverage at the time of loss

Applying Contract Knowledge to Client Needs

Learning Objective 2:
Participants will use knowledge of the various methods of determining the appropriate type and amounts of life insurance coverage to help a client or prospect develop a financial plan.

Planning for Personal Needs

Appropriate steps to implement during the planning phase:

1. Identify issues by gathering information via a fact finder discussion:
   - Worksheets
   - Questioning techniques
   - Listening techniques

2. Assign priorities establishing goals and objectives:
   - Replace lost income
   - Final expenses
   - Pay off home mortgage
   - Provide an education fund

To see an Insurance Needs Worksheet, visit scic.com/LHResources

3. Analyze the information and suggest solutions and a plan

- If complete and accurate information has been obtained (including goals and objectives in priority order), then the process is ready to begin
- Many life insurance companies have advanced sales specialists in the home office who can assist in the analysis and recommendations for an agent who has not really worked in this area before
- Remember – your prospects want recommendations!
  Sound recommendations come from understanding what they have and what they want to achieve:

What unforeseen events could jeopardize or totally derail their plans?

Early death	Disability
Unemployment	Inflation
Tax law changes	

4. Develop plan with client involvement

- Life insurance, annuities, etc., require a life/annuity license
- Securities and other investment vehicles (e.g., variable annuities, stocks, bonds, CDs, real estate) will obviously require agents/brokers have the proper state (or FINRA) license
- Some "non-funding" choices may be necessary – with wills, trusts, tax planning, etc. the use of competent professionals may be necessary (e.g., attorneys, CPAs, trust officers)

5. Implement the plan/solution

6. Periodically repeat the process to monitor and revise as needed due to:

- Death or divorce
- Sale of a business
- Receiving an inheritance
- Job change

To view the Estate Planning videos, visit scic.com/LHResources

Determining the Proper Amount of Life Insurance

Note:
Virtually every life insurance company, agent, financial planner, association, etc., has developed their own approach for determining the amount of life insurance a person might need.

Total Needs Analysis

1. This method determines the present and future funds necessary to accomplish certain financial goals and income needs of the family unit; several goals should be considered (Refer back to the General Uses of Life Insurance)

2. This method requires in-depth questioning on the part of the agent – usually a detailed fact finder is used; all sources of current and future income are considered, including current insurance, eligible social security benefits, potential inheritance, etc.

3. Assumptions of interest rates, taxes and inflation are necessary; **always use the client's assumptions, not yours**

4. Situations to consider (not an exhaustive list):

    - Last expense
    - Readjustment income
    - Dependency period
    - Education

- Blackout period – the time during which a surviving spouse stops receiving Social Security survivor's benefits (when the youngest child is no longer eligible for benefits) and begins receiving Social Security retirement benefits

- Mortgage

- Income for parents

5. Advantages of using this method

   - More realistic numbers

   - Client involvement

6. Disadvantages of using this method

   - Time-consuming

   - Results can be overwhelming

   - Client may be reluctant to share information

For a Total Needs Analysis Worksheet, visit scic.com/LHResources

Multiple of Gross Earning Method

1. This method uses the pre-tax annual earnings and multiplies them by a factor, such as 6, 8, or some other number

2. Advantages to using this method

   - Quick and simple for the agent
   - Easy to understand for the client

3. Disadvantages to using this method

   - Less accurate than the income needs approach
   - Large mortgages, loans, numerous children, and special considerations **may** not be accounted for
   - Social Security benefits are not included
   - Current-in-force is not considered

"Scientific" Guess Method

1. Advantages – quick, simple and easy to understand

2. Disadvantages – tends to be the least accurate approach of the three methods

Knowledge Check 1

You are sitting with a prospect who has no idea about his social security benefits or his employee benefit amounts. He is concerned with family debt in the event of premature death or disability and is limited as to the amount of time he can spend with you.

Which planning method would be most appropriate given the information above?

Why?

Types of Life Insurance Contracts

Learning Objective 3:
Participants will apply knowledge of the components of Term Insurance, Universal Life Insurance, and Whole Life Insurance policies to advise clients and prospects on selecting the life insurance products to best meet their needs.

Term Insurance

Definition: "Term" is precisely what the name would imply: insurance for a term of time or temporary period.

Characteristics

1. Face amount payable only if death occurs during the stipulated years
2. Protection is only for a limited number of years
3. Pays nothing if the insured lives past the end of the term coverage period

Purpose and Uses

1. Identifiable or specific need (mortgage or loans)
2. Often sold when the need is great, but the money is little
3. Protects future insurability if converted

Features and Advantages

1. Easy for buyer to understand

2. May be renewable and/or convertible

   An important feature to look for in a term contract is its renewability or convertibility. Can the policy be *renewed*, and if so, how many times or until what age?

   Convertibility means the policy can be exchanged for a permanent type of coverage, without the need to prove **insurability** (attributes that applicants possess that qualify them as insurable risks). When a term policy is renewed or converted, the premium for the new contract will be based on the insured's attained age, which is the age at the time of renewal or conversion.

3. Initial low cost

4. Return of premium

Disadvantages

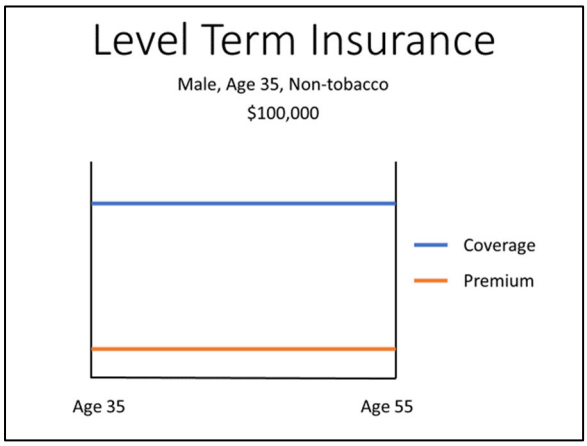
1. No cash value

2. Coverage is designed to end before death

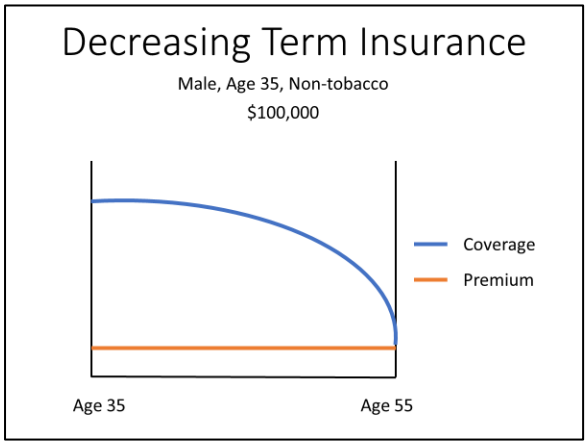
Types of Term Insurance

1. Level term: The premium and face amount remain level. However, the policy is only for a specified number of years, such as 5, 10, 15, 20, or 30 years. Some companies write a level term to age 65, and some allow level term of short duration (e.g., 5 years) to be renewed but only to a certain age, such as 65.

   Note:
   Many insurance carriers that issue level term insurance can also issue the contract with a "return of premium" feature.



2. Decreasing term: The face amount decreases as the premium remains level. Normally this type is used for mortgage insurance. While the traditional decreasing term declines on a straight line, many companies can design a contract's face amount to decrease consistent to the unpaid balance of a mortgage. The mortgage interest rate and years remaining on the note determine the amortization schedule.



Note:
Many companies that issue term policies can also issue a **term rider** that can be added to a permanent policy.

Whole Life Insurance

Definition: This policy type includes those forms where the face amount is paid on the death of the insured whenever death occurs. Should the owner pay all the premiums – which will contractually never increase – the policy will remain in force until death.

Characteristics

1. The face amount will be paid regardless of the age at death of the insured

2. Continuous or limited premium payments

3. Growth of cash values

Purpose and Uses

1. Permanent protection

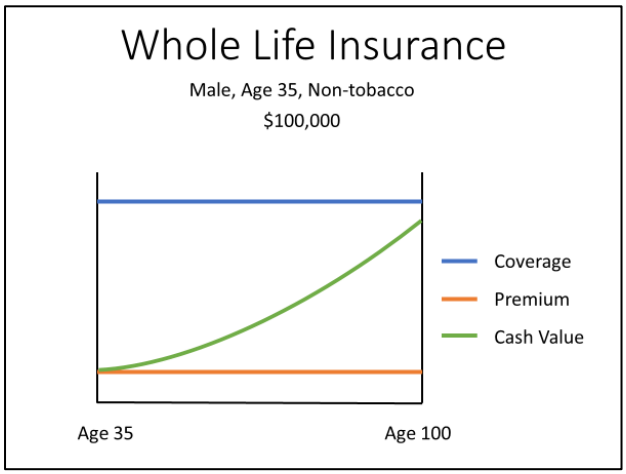
2. College planning

3. Estate protection

4. Retirement planning

Features and Advantages

1. The premium remains the same throughout the life of the contract

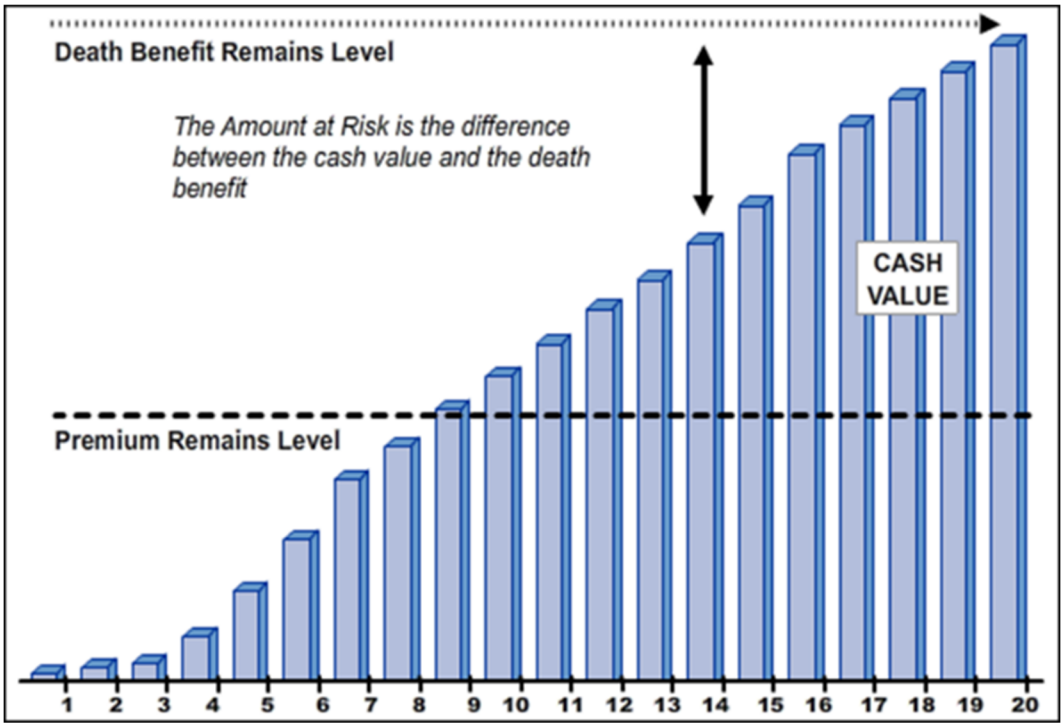


2. In case of a lapse, the policy may stay in force via Automatic Premium Loan (APL)

Automatic Premium Loan
▪ Applies only to whole life policies and is usually elected on the application or in some cases automatically included by the insurance company.
▪ The premium will be paid by the cash value after the grace period expires.
▪ This provision keeps the policy in force and prevents the automatic use of the non-forfeiture clause.

3. Cash values (growing tax-deferred) are available for loans, assignment, emergency use, etc.

4. **Net amount at risk**, which is the difference between the face amount of insurance and the accumulated cash value, decreases as insured grows older



Disadvantages

1. Initial cost is higher than term insurance

2. Cash value NOT paid in addition to death benefit – However, dividend options (discussed later) may address this

3. Lost investment opportunity

Non-forfeiture Benefits (Whole Life Policies Only)

After the contract has built cash values, the owner may wish to exercise one of the options below to stop premium payments or to terminate the contract. If the owner does not select an option, the company will select one (normally extended term). A non-forfeiture option is a choice that the owner of a life insurance policy has regarding the disposition of the cash values when they surrender a life insurance policy. Once a non-forfeiture option has been selected, it cannot be changed.

1. **Cash**: Values are stated on the schedule page of the policy. The owner may use the cash as they wish – full surrender ("cash it in"), loan, policy assignment, etc.

2. **Reduced Paid-up Insurance**: The cash value is used to purchase a reduced death benefit that is fully paid-up. No future premiums are payable by the owner.

3. **Extended Term Insurance**: Cash value is used to "one-pay" for a term contract. The full death benefit will be paid if the insured dies within the scheduled time period. If the owner does not select a non-forfeiture option, this is the option the company usually invokes. If the grace period expires and the automatic premium loan provision has not been elected, this option is normally invoked by the insurance company.

Age 35 male, $100,000 original face amount NON-FORFEITURE TABLE — TABLE OF GUARANTEED VALUES				
END OF POLICY YEAR	GUARANTEED MINIMUM CASH VALUE	PAID-UP INSURANCE AMOUNT	PERIOD OF EXTENDED TERM INSURANCE	
1	0.00	0.00	YEARS	DAYS
2	0.00	0.00		
3	200.00	1,500.00	0	233
4	1,000.00	6,800.00	2	326
5	**1,900.00**	**12,200.00**	**4**	**364**
6	2,800.00	17,100.00	6	263
7	3,700.00	21,600.00	8	58
8	4,700.00	26,200.00	9	192
9	5,700.00	30,300.00	10	222
10	**6,700.00**	**34,000.00**	**11**	**162**
11	7,800.00	37,800.00	12	84
12	8,900.00	41,200.00	12	305
13	10,000.0	44,200.00	13	105
14	11,200.0	47,400.00	13	262
15	**12,500.00**	**50,600.00**	**14**	**41**
16	13,800.00	53,500.00	14	134
17	15,100.00	56,000.00	14	185
18	16,500.00	58,600.00	14	235
19	17,900.00	61,000.00	14	254
20	**19,400.00**	**63,400.00**	**14**	**276**
At Age 60	27,200.00	72,900.00	14	100
At Age 65	35,900.00	80,200.00	13	19

Limited Payment Contracts

Definition: These contracts provide for the payment of the face amount upon the death of the insured, regardless of the age at death. However, they differ from the whole life policy in that the premium payments are contractually charged for a limited number of years. After the stipulated number of years have been paid (usually 10 or 20 years, or to age 65) the policy becomes fully paid-up

Universal Life

Definition: A flexible premium, adjustable death benefit life insurance contract. Introduced in the early 1970's because high interest rates on money market accounts and aggressive sales by competing financial services and other non-insurance financial products forced life insurance companies to become somewhat competitive regarding financial returns.

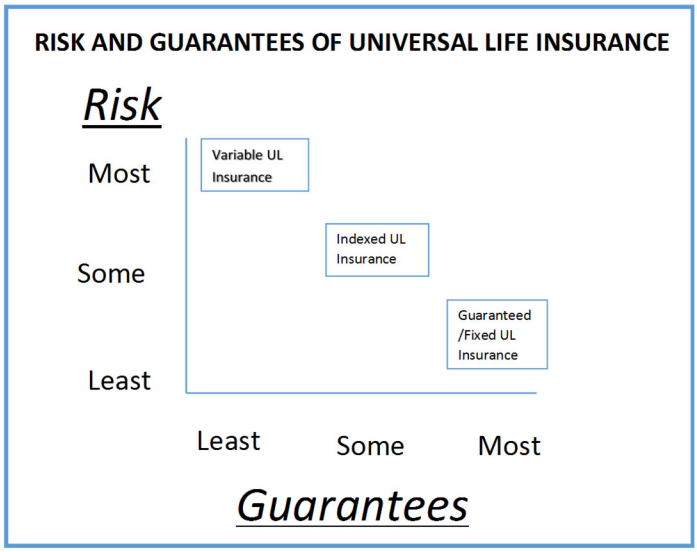
Purpose and Use: The contract can function just like term or whole life. A Universal Life (UL) contract can be a high premium or low premium.

Types of Universal Life

1. Guaranteed/Fixed – Guarantee principal with interest credited on a fixed basis. Although the interest earned is considered fixed, the company may adjust the rate of interest payable based on current assumptions of rate of investment return and/or mortality.

2. Indexed – A form of fixed universal life insurance. The principal is guaranteed if the client holds the contract for a certain period of time. Gains can be attractive, with minimal investment risk.

3. Variable – Principal, for the most part, is not guaranteed; the individual investor assumes the investment risk in that he or she may lose principal if the market turns downward. HOWEVER, the attraction for any investors interested in variable universal life is the dollars invested should be able to keep pace with inflation.



Features and Advantages

1. Contract flexibility

2. Insured can assist in the design of the plan

Disadvantages

1. Non-guaranteed mortality charges

2. Low guaranteed interest rate

Option A vs. Option B

Option A - Includes the cash value within the death benefit – cash values grow FASTER than option B

Option B - Pays the cash value in addition to the death benefit – cash values grow SLOWER than option A

The Bill Carter Story
For Illustration Only

The Flexibility of the Universal Policy

(Illustrated at 7%)

	End of Year	Age	Premiums	Guaranteed Cash Value	Cash Value	Death Benefit
Age 31. Bill purchases a $150,000 Universal Life policy. Annual Payments are $1,600.	1	31	1,600	0	0	150,000
	2	32	1,600	667	778	150,000
	3	33	1,600	2,179	2,417	150,000
Age 34. Bill takes a new job and loses his Group Life Insurance. He increases the face amount on the Universal Life policy to $250,000. No change to premium.	4	34	1,600	1,932	2,392	250,000
	5	35	1,600	3,394	4,139	250,000
	6	36	1,600	5,013	6,118	250,000
	7	37	1,600	6,680	8,220	250,000
	8	38	1,600	8,500	10,570	250,000
	9	39	1,600	10,447	13,573	250,000
	10	40	1,600	12,656	16,591	250,000
	11	41	1,600	14,770	19,638	250,000
Age 43. Bill receives a company bonus. He puts $7,000 into his UL plan.	12	42	1,600	17,141	23,063	250,000
	13	43	7,000	25,376	32,711	250,000
Age 44. He increased his contributions to $2,400.	14	44	2,400	28,500	37,488	250,000
	15	45	2,400	31,881	42,774	250,000
	16	46	2,400	35.353	48,454	250,000
	17	47	2,400	38,584	54,204	250,000
	18	48	2,400	41,910	60,397	250,000
	19	49	2,400	45,330	67,065	250,000
	20	50	2,400	48,845	74,252	250,000
Between **Ages 51-54**, he withdraws $5,000 each year for his child's college education. Contributions are suspended during this period.	21	51	-5,000	44,707	74,005	245,000
	22	52	-5,000	40,290	73,697	240,000
	23	53	-5,000	35,566	73,327	235,000
	24	54	-5,000	30,505	72,877	230,000
Age 55. College is over! Bill resumes contributions, increasing them to $3,500 a year. He is concerned about retirement.	25	55	3,500	33,985	81,541	230,000
	26	56	3,500	37,497	90,876	230,000
	27	57	3,500	41,034	100,943	230,000
	28	58	3,500	44,595	111,792	230,000
	29	59	3,500	48,170	123,506	230,000
	30	60	3,500	51,743	136,163	230,000
Age 61. Bill has an insurance tune up and decreases his insurance to $200,000.	31	61	3,500	55,710	150,130	200,000
	32	62	3,500	59,712	165,266	211,540
	33	63	3,500	63,733	181,567	228,775
	34	64	3,500	67,759	199,126	246,916
	35	65	3,500	71,779	218,035	266,003
Age 66. When he retires, he stops making payments and withdraws $15,000 each year. His death benefit is $262,158	36	66	-15,000	56,362	218,465	262,158
	37	67	-15,000	39,917	218,883	260,471
	38	68	-15,000	22,341	219,288	258,760
	39	69	-15,000	3,508	219,684	257,031
	40	70	-15,000	0	220,073	255,285
	41	71	-15,000	0	220,466	253,535
	42	72	-15,000	0	220,920	249,639
	43	73	-15,000	0	221,462	245,822
	44	74	-15,000	0	222,119	242,110
	45	75	-15,000	0	222,918	238,522
Age 79. Bill still has cash remaining of $226,969 and his death benefit is $238,317.	46	76	-15,000	0	223,892	235,087
	47	77	-15,000	0	224,895	236,139
	48	78	-15,000	0	225,922	237,218
	49	79	-15,000	0	226,969	238,317

Guaranteed Interest rate 4.5%. Illustrated rate 7.0%

Adopted from the John Murray story. Allstate Life Insurance Company.

Six Components of a Universal Life Insurance Policy

1. CASH (premium or any additional deposit) is paid into the policy account.

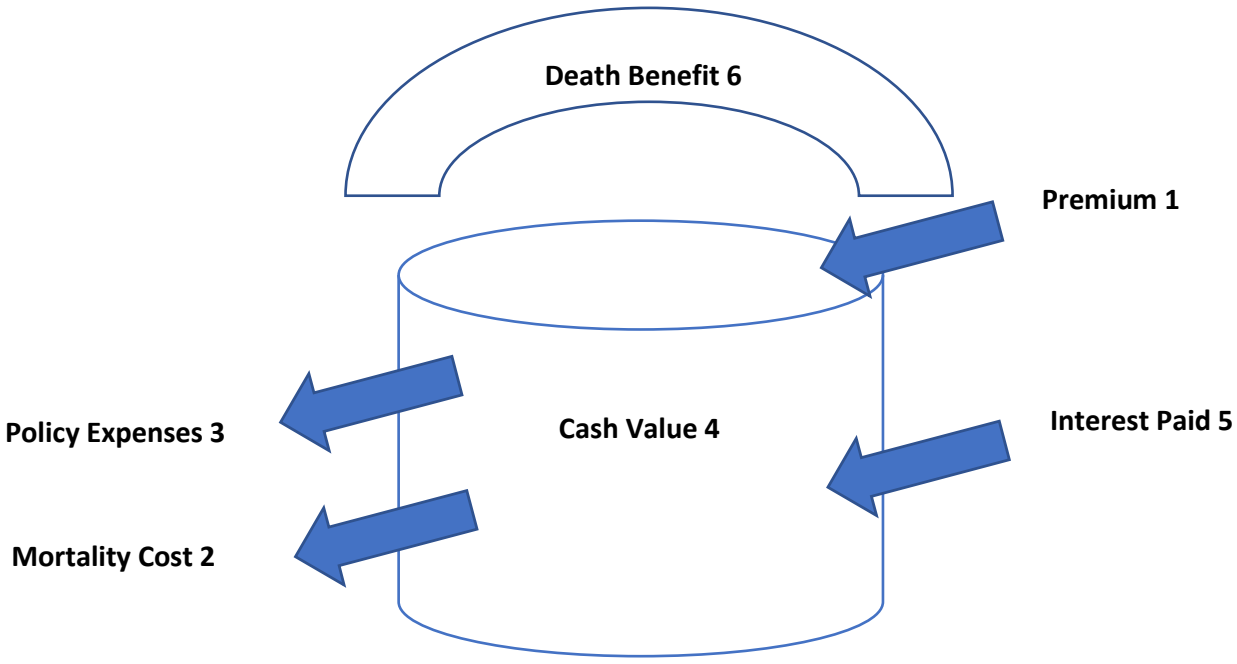
2. MORTALITY CHARGE (cost of term life insurance needed to pay death benefit) is deducted from the policy account.

3. POLICY EXPENSES (to cover the insurance company's administrative costs) are deducted from the policy account.

4. CASH VALUE (what is left after the mortality charge and policy expense are subtracted from the premium payment) accrues in the policy.

5. INTEREST is credited to the cash value (accrued cash value is invested in a combination of bonds [to cover the guaranteed interest rate] and other options [such as mutual funds] to maximize earnings so a higher than guaranteed interest rate can be paid).

6. DEATH BENEFIT (Life Insurance) is maintained in the policy.



The Flexibility of a Universal Life Policy

Premiums can be skipped. The contract may become fully "self-supporting" if the level of cash value is sufficient to cover the future mortality charges. Changes in the policy's expense charges and interest rates can also impact the future of the contract. Among the flexible features are the ability to:

1. Increase or decrease the face amount

   If the amount of insurance is increased, then normal underwriting would be required for the new "at-risk" amount.

2. Lengthen or shorten the protection period

   For example, initially design the policy to look like a ten-year term policy paying only mortality costs and expenses. This gives the owner (usually the insured) the option to make larger deposits, create cash value and have a permanent plan of insurance.

3. Increase or decrease the level of premiums

   Insurance companies will impose a minimum amount of required premium the first 1 to 3 years. After that time, the owner may decrease (or suspend) premiums as they wish. In the late 1970's the federal government imposed a maximum amount premium that can be paid into universal life to keep the cash value growth tax-deferred.

4. Lengthen or shorten the premium paying period

   Pre-pay with larger sums of cash to be able to stop payments at some future date and make the policy self-sustaining.

5. Contribute or withdraw lump sums of money and have either partial surrenders or loans

Universal Life	Whole Life
Face amount can vary	Face amount fixed
Flexible premium/mortality cost	Fixed premium/mortality cost
Minimum guaranteed rate of interest plus additional rate tied to market	Guaranteed cash value
Option "A" or "B"	Cash values are not paid in addition to death benefit
Loans or partial surrender	Loans only; interest charged

Annual Reports

Due to the flexibility and transparency of a UL contract, an annual report is prepared for the insured/owner.

The following two pages illustrate the six components, as well as showing the difference between Option A and Option B death benefits and cash values.

For a Sample Annual Statement, visit **scic.com/LHResources**

THE CRAWDAD LIFE INSURANCE COMPANY

1234 Main Street · Anytown, TX 12345 · (888) 999-1000

THE ANNUAL REPORT FOR YOUR UNIVERSAL LIFE POLICY

Annual report for the policy year ending July 28, 2017. Version - UL01

Policy Issue Date: 07/29/2010
Planned Periodic Premium: $150.00
For: **Jonathan O. Doe**
555 Bay Street
Big City, TX 12345

Specified Death Benefit Amount:
"Option A"

SUMMARY OF TRANSACTIONS

Month Ended	Premiums Received	Expense Charges	Cost of Insurance	Interest Credit	Cash Value (Excluding Loans)	Death Benefit
Jul 16	$150.00	$13.50	$26.61	$44.56	$6,849.84	$150,000.00
Aug 16	150.00	13.50	26.61	44.70	7,004.43	150,000.00
Sep 16	150.00	13.50	26.61	45.53	7,159.85	150,000.00
Oct 16	150.00	13.50	26.61	45.56	7,315.30	150,000.00
Nov 16	150.00	13.50	26.61	46.58	7,471.77	150,000.00
Dec 16	150.00	13.50	26.61	47.60	7,629.26	150,000.00
Jan 17	150.00	13.50	26.61	48.64	7,787.79	150,000.00
Feb 17	150.00	13.50	26.61	49.68	7,947.36	150,000.00
Mar 17	150.00	13.50	26.61	50.74	8,107.99	150,000.00
Apr 17	150.00	13.50	26.61	51.79	8,269.67	150,000.00
May 17	150.00	13.50	26.61	52.86	8,432.42	150,000.00
Jun 17	150.00	13.50	26.61	53.93	8,596.24	150,000.00
Total	$1800.00	$162.00	$319.32	$582.17		

The current rate of 5.00% may increase or decrease but will never be below 4.5%. The current rate on that part of the cash value which equals any loan is 4.5%. The interest rate on the first $1,000 of cash value in excess of any loan is 3.0% lower than the current interest rate.

This illustration is a snapshot of one year. The cost of insurance will typically change annually based on the decreased "net amount at risk" combined with the increasing age of the insured. Whether this is a net increase or decrease in the cost of insurance is unknown.

THE CRAWDAD LIFE INSURANCE COMPANY

1234 Main Street · Anytown, TX 12345 · (888) 999-1000

THE ANNUAL REPORT FOR YOUR UNIVERSAL LIFE POLICY

Annual report for the policy year ending July 28, 2017. Version - UL01

Policy Date: 07/29/2010
Planned Periodic Premium: $208.00
For: **Jonathan O. Doe**
555 Bay Street
Big City, TX 12345

Specified Death Benefit Amount:
"Option B"

SUMMARY OF TRANSACTIONS

Month Ended	Premiums Received	Expense Charges	Cost of Insurance	Interest Credit	Cash Value (Excluding Loans)	Death Benefit
Aug 16	$208.00	$18.72	$29.50	$23.82	$6,349.84	$156,349.84
Sep 16	208.00	18.72	29.50	23.65	6,504.43	156,504.43
Oct 16	208.00	18.72	29.50	24.11	6,659.85	156,659.85
Nov 16	208.00	18.72	29.50	24.93	6,815.30	156,815.30
Dec 16	208.00	18.72	29.50	25.82	6,971.77	156,971.77
Jan 17	208.00	18.72	29.50	26.71	7,129.26	157,129.26
Feb 17	208.00	18.72	29.50	27.37	7,287.79	157,287.79
Mar 17	208.00	18.72	29.50	27.95	7,447.36	157,447.36
Apr 17	208.00	18.72	29.50	29.42	7,607.99	157,607.99
May 17	208.00	18.72	29.50	30.35	7,769.67	157,769.67
Jun 17	208.00	18.72	29.50	30.60	7,932.42	157,932.42
Jul 17	208.00	18.72	29.50	31.89	8,096.24	158,096.24
Total	$2496.00	$224.64	$354.00	326.62		

The current rate of 5.00% may increase or decrease but will never be below 4.5%. The current rate on that part of the cash value which equals any loan is 4.5%. The interest rate on the first $1,000 of cash value in excess of any loan is 3.0% lower than the current interest rate.

This is a snapshot of one year. Pure cost of insurance will typically change annually. The cost will increase due to increasing age of insured.

Knowledge Check 2

Your clients would like to have a permanent insurance program but are concerned about additional expenses the family will incur while their children are in college in the next ten years.

Explain how the flexibility of universal life would allow for coverage to remain while premiums could be adjusted during years with higher family expenses.

Group Life

Group Term Life Insurance Plans

Plan	Overview	Features
Basic Term Life	Employer-paid benefits can give employees a sense of added security, as well as engagement with the company	• Varying level of available coverage • Accelerated benefits for terminal illness • Benefits for death of spouse and children
Supplemental Term Life	By providing coverage above and beyond the basic term life plan, this optional, employee-paid solution offers additional peace of mind	• Optional Accidental Death & Dismemberment (AD&D) coverage • Accelerated benefits for terminal illness • Benefits for death of spouse and children

Available in a variety of supplement and contribution options, group term insurance provides benefits to employees' beneficiaries in the event of death or a disabling accident.

Benefit Schedules

Flat schedule

Earnings schedule (most common)

Occupation or position schedule

Benefit Schedule for Group Life and AD&D

	Life Benefits*	AD&D Benefits*
Plan 1 **Flat Schedule**	$10,000	Same as life amount
Plan 2 **Salary Base** (Multiple of annual salary)	1 x Income Min – $10,000 Max – $50,000	Same as life amount
Plan 3 **By Occupation** Partner/Owner/Proprietor Manager/ Supervisory/All Other	$30,000 $15,000 $10,000	Same as life amount

**The maximum Life and AD&D coverage for employees enrolling at age 60 or older is $10,000. An employee's Life and AD&D coverage will terminate on his or her 70th birthday.*

Life Insurance Contract

Learning Objective 4:
Participants will apply knowledge of riders, provisions, beneficiary designations, settlement options and conditional receipts to a variety of client needs in various scenarios.

Standard Provisions of a Life Insurance Contract

Each state has enacted standard policy provision laws, which require life insurance companies to include certain provisions in every life insurance policy. The company may select the actual language, but the state department of insurance must approve the wording. State insurance codes impose requirements that specific provisions must be included in all life insurance policies sold and/or delivered in that state.

Incontestable Clause: Claims cannot be denied after two years from the date of issue.

Entire Contract Clause: The application becomes part of the policy, so the insured has a copy. Without it, the incontestable clause could not be used. If a copy of the application was not attached to the policy, the company is prohibited from denying a death claim in the first two years due to a misstatement of a material fact.

Grace Period: This is a stated time-period (usually 30 or 31 days) in which the premium must be paid to prevent the policy from lapsing. The policy will continue in force during the grace period and any death benefits are payable if death occurs during the grace period. The unpaid premium will be deducted from the death benefit. ***Reminder:*** An automatic premium loan in a whole life policy may pay a late premium.

Misstatement of Age or Sex: If the age (or sex) of the insured has been misstated in the application, the contract stays in force. The future death benefit will be adjusted to reflect the benefit that the premium would have purchased had the age/sex been stated correctly (or in event of overpayment, a refund is paid).

Suicide: A death benefit will not be paid if suicide occurs during the first one or two years of the contract. The company usually will refund all premiums.

Note:

Individual state statute determines length of the suicide clause.

Reinstatement: Allows for the reinstatement of a lapsed policy generally up to 2-3 years. It does require that the owner repay all back premiums (plus interest), repay any loans, and prove to be insurable.

Right to Examine (also called the Free-Look Provision): Allows the applicant a specified number of days following *physical* receipt of the policy to examine it and, if dissatisfied for any reason, can return the contract to the company for a full refund of the deposit premium (if any). The free-look period can vary by state and is generally no fewer than 10 days.

Exclusions: Generally speaking, an un-endorsed life contract has no exclusions. Some contracts may allow the company the right to invoke a *war clause exclusion*. This clause will provide no benefit other than return of premium plus interest should the insured be killed as the result of a war-like action. This clause cannot be added to an existing contract. It is only for new applications and is normally removed after the war ends. Other "*cause-of-death exclusions*" can only be added at the time of issuance, such as a hazardous sports exclusion or an unusually hazardous occupation exclusion.

Ownership Rights: The named insured does not have to be the owner of their policy. A parent can be the owner of a policy on their child. A spouse can be the owner of a life policy on their spouse. A business can be the owner of life insurance on "key executives". A trust can be the owner of a grantor's policy. The **owner** has the exclusive right to exercise the following:

C	Change beneficiary (unless irrevocable, in which case the beneficiary cannot be changed without the consent of the benefiting party)
R	Receive dividends, returns on excess premium and favorable loss experience on participating life insurance policies
A	Assignment of policy
B	Borrow cash value
S	Surrender policy

Assignment or Sale of Life Contracts: The policy owner has the right to assign or sell a life policy. There are two types of **assignment,** which is the transfer of all or part of policy owner's legal rights under the policy contract to another person or entity**:**

1. ***Absolute assignment***: the owner gives up the policy irrevocably and cannot recover rights (permanent).

2. ***Collateral assignment***: the owner gives up some policy rights, but only temporarily, to fulfill the requirements of a loan; once the loan is satisfied, the total ownership reverts back to the owner

Regarding the assignment of a life insurance policy by the owner:

1. The insurance company must be notified or is not bound by the assignment

2. The insurance company is not responsible for the validity of the assignment

3. Most states require the assignee (the bank) to be notified of the premiums due and receive any lapse notice

Premium Paying Options

1. Modal premium payment

	ANNUAL	SEMI-ANNUAL	QUARTERLY	MONTHLY
	$1,000	X .51 = $510	X .26 = $260	X .086 = $86
TOTAL	$1,000	$1,020	$1040	$1036

2. Pre-payment: Paying a multiple of annual premiums at one time will result in a discount, subject to individual insurance company policy

3. Policy Fee: An annual fee that may be as low as $25 and as high as $125 that is added to the base premium of life policies. This fee does **not** contribute to the cash values. It may or may not be subject to commissions.

Dividends: This is a distinguishing feature between participating (mutual) policies and non-par (stock) policies. Non-par polices do not pay dividends. A dividend being paid on a participating policy is classified as a *return of excess premium*. Depending on the insurance company, there may be numerous options the owner can choose from at the time of application. The most common dividend options are:

C	Cash (not subject to income tax)
A	Accumulation of interest (interest is taxable)
R	Reduce premium
P	Paid-up additional insurance*
O	One-year level term

*What are Paid-Up Additions?

Paid-up additions are amounts of permanent insurance with their own cash value, which generate their own dividends. Each year the base policy dividend is used to buy a single-premium paid-up policy at the insured's attained age. The base policy death benefit is then increased by the face amount of the paid-up addition and the guaranteed cash value is increased by the cash value of the paid-up addition. Since paid-up additions are whole life insurance, they in turn earn dividends which are then credited in the same manner as the base policy dividend.

Beneficiary

The **owner** may change the beneficiary at any time after policy issue to whomever he or she wishes. The only exception relates to an irrevocable beneficiary.

EXAMPLES OF COMMONLY USED BENEFICIARY DESIGNATIONS

(1) *Insured's Estate*: The Executor (individual named in a will and approved by a Probate Court to carry out the provisions of the will) or Administrator (person appointed by a Probate Court to handle the disbursement and settlement of an estate if no executor is named in a will) of the Estate of the Insured.

(2) *One Beneficiary:* Mary E. Doe, Wife.

(3) *Two Primary Beneficiaries:* John A. Doe, father and Jane M. Doe, mother, share alike, or survivor.

(4) *Several Named and Unnamed Children, Primary Beneficiary:* Allen S. Doe, son, Bo J. Doe, son and Jo Ann Doe, daughter, and any other children hereafter born of the union of the Insured and said wife, share alike, survivors or survivor.

(5) *Wife, Primary Beneficiary; Named Children and Unborn Children, Contingent Beneficiary:* Mary E. Doe, wife, if living, otherwise Allen S. Doe, son, Jo Ann Doe, daughter, and any other children hereafter born of the union of the Insured and said wife, share alike, survivors or survivor.

(6) *Wife, Primary Beneficiary (No Children living); Unborn Children, Contingent Beneficiary:* Mary E. Doe, wife, if living, otherwise any children hereafter born of the union of the Insured and said wife, share alike, survivors or survivor.

(7) *One Primary and One Contingent Beneficiary:* Mary E. Doe, wife, if living, otherwise Bo J. Doe, son.

(8) *One Primary Beneficiary and Two or More Contingent Beneficiaries:* Mary E. Doe, wife, if living, otherwise Allan S. Doe, son, and Jo Ann Doe daughter, share alike, or survivor

(9) *One Primary, One First Contingent and One Second Contingent Beneficiary:* Mary E. Doe, wife, if living, otherwise Frank J. Doe, son, if living, otherwise Jane M. Doe, mother.

(10) *Trustee as Beneficiary Under a Written Trust Agreement:* The First National Bank of Gotham City, as Trustee, under Agreement of Trust dated June 11, 1999, if said agreement shall then be in force, and if not, the Executors or Administrators of the Estate of the Insured.

(11) *Unequal Distribution; Use fractions with a Common Denominator:* Three-fourths (3/4) of the proceeds to Mary E. Doe, wife, if living, and one-fourth (1/4) of the proceeds to Jo Ann Doe, daughter, if living, otherwise all to the survivor.

Primary (Jane S. Doe**,** wife)

1. May list more than one primary beneficiary

2. If listing more than one primary beneficiary, the owner must designate the percentage of benefit each is to receive; the company will normally not allow dollar amounts

3. Listing more than one beneficiary can create problems; consider what happens to the benefit due to a primary beneficiary, if they predecease the insured (See the exhibit "How are Life Insurance Proceeds Paid Should a Named Beneficiary Die Before the Named Insured's Death?")

4. Consider restrictions if a minor becomes a beneficiary

5. It is unadvisable to name "the estate of" as a beneficiary – general creditors may attach the proceeds

How are Life Insurance Proceeds Paid, Should a Named Beneficiary Die Before the Named Insured's Death?	
Per Capita – A method of paying life insurance proceeds to those equally related to the decedent without regard to the lines of descent. Meaning, unnamed children of the deceased beneficiary will receive nothing. This is the default method of a life insurance policy.	Per Stirpes – A stipulation that, should a beneficiary predecease the named insured, the beneficiary's share of the proceeds will go to his or her heirs in equal percentages. This method must be specifically added to a life insurance policy.

Contingent (e.g., Jane S. Doe, wife, if living; otherwise, Mary C. Jones, sister)

1. This person (or persons) will become the beneficiary if the primary beneficiary predeceases the named insured

2. The same considerations as pertains to primary beneficiaries need to be addressed

Common Disaster Clause: If the named insured and beneficiary die in a common accident, and it cannot be determined who died first, this provision allows the benefits to be paid directly to the contingent beneficiary regardless of the sequence of deaths

Uniform Simultaneous Death Act – USDA (1993): The act provides rules for passage of joint property, for when death legally occurs, and for exceptions to the 120-hour rule. It is possible in wills and other instruments to waive or vary the rule. **USDA (1993)** also provides for a presumption of death after five years if a person is missing or a body cannot be found.

Revocable: The owner is free to change the designation as desired

Irrevocable: The owner may change the designation **only** with the beneficiary's consent

Who and **why** do we name certain beneficiaries?

- **Estate**: 1) Creditors may attach proceeds, and 2) proceeds are added to the insured's estate for federal estate tax purposes and subject to probate

- **Named persons**: Proceeds are added to the insured's estate for FET purposes should the insured also be the owner

- **Classes of persons**: For example, "all my children." However, an unknown illegitimate child may surface and make claim as a beneficiary unless the designation is qualified, as in *"all children of this said union of marriage."*

- **Business organizations**: Buy/sell agreements, key persons, executive bonuses, etc.

- **Trust**: 1) Excellent tool to avoid FET on proceeds, 2) distribution of proceeds is professionally managed and funds are prudently invested, and 3) trust costs, fees, and taxes must be considered

OWNERSHIP & BENEFICIARY CONSIDERATIONS OF LIFE INSURANCE					
Owner/ Beneficiary	Insured Controls the Policy?	Unsecured Creditor Problems?	Cash Value Included in Beneficiary Estate?	Death Benefit Included in Insured's Estate?	Extra Cost?
Insured/Estate	Yes	Yes	No	Yes	No
Insured Owns/ Individual Beneficiary	Yes	No	No	Yes	No
Insured Does Not Own/Individual Beneficiary	No	No	Yes	No	No
Insured Owns/ Trustee Beneficiary	Yes	No	No	Yes	Yes
Trust Owns/ Trust Beneficiary	No	No	No	No	Yes

Life Insurance Settlement Options

Death Claim Settlements: The following primarily applies to death claim settlements as elected by a beneficiary or pre-selected by the owner, prior to death. However, some options apply for distributions of cash values to the owner while still living. The insured may have accrued a substantial cash value over the life of the contract. Perhaps they would want the funds paid to them in a manner other than lump sum. These are the same options available from an **annuity**, a periodic payment beginning at a specific date and continuing for a specific period or for the remainder of a designated life, and will be described in greater detail during the Retirement/Annuities presentation.

1. Cash

   The beneficiary receives the death benefit in a lump sum. Normally the life insurance company opens a checking account with a balance equal to the death benefit. A checkbook is then presented to the beneficiary. The beneficiary can write a check for the entire amount or draft money as needed. Any remaining balance normally earns a modest interest rate.

2. Interest Income

   The death benefit is left with the insurance company and the interest it earns is paid to the beneficiary. This option is normally used for a short period of time, giving the beneficiary time to make a decision on a permanent settlement option.

3. Fixed Period or Fixed Time

   The insurance company pays periodic installments to the beneficiary for a specific period of time. An example would be quarterly payments for the next 10 years. The amount paid is determined by the death benefit and the interest it earns during the time period. The interest is taxable to the beneficiary.

4. Fixed Amount or Installments

   The insurance company pays equal installments until all proceeds (death benefit and earned interest) are paid out. An example would be that the beneficiary will receive $1,000 a month.

5. Life Income or Annuity

   The death benefit is used to purchase an annuity and equal installments will be paid during the lifetime of the beneficiary. The pay-out may include a guaranteed payment period. More on annuity pay-out options will be discussed in the annuity chapter.

6. Life Income with Period Certain

7. Installment with Refund

LIFE INSTALLMENT TABLE – OPTIONAL METHOD 3					
Age of Payee When 1st Installment is Payable		Monthly Installment for Life That $1000 Will Obtain			Life With Installment Refund
Male	Female	Life	10 Yr. Certain	20 Yr. Certain	
50	55	$ 4.61	4.50	4.18	4.18
51	56	4.72	4.60	4.24	4.26
52	57	4.83	4.69	4.30	4.34
53	58	4.95	4.79	4.36	4.42
54	59	5.07	4.90	4.41	4.50
55	60	5.20	5.01	4.47	4.59
56	61	5.34	5.12	4.53	4.68
57	62	5.48	5.23	4.59	4.77
58	63	5.64	5.35	4.64	4.87
59	64	5.80	5.48	4.70	4.98
60	65	5.97	5.61	4.75	5.09
61	66	6.15	5.74	4.80	5.20
62	67	6.34	5.87	4.85	5.32
63	68	6.54	6.01	4.90	5.44
64	69	6.75	6.16	4.94	5.57
65	**70**	**6.97**	**6.30**	**4.98**	**5.70**
66	71	7.21	6.45	5.02	5.84
67	72	7.46	6.60	5.05	5.99
68	73	7.73	6.76	5.09	6.15
69	74	8.02	6.91	5.12	6.31

Riders

Guaranteed Insurability Rider (GIR): A rider that can be attached to a whole life, endowment, or universal life contract. The policyholder is guaranteed the right, without medical or occupational examination, to make periodic additions to his or her life insurance at standard rates. The options can be exercised at stated ages *or* events (marriage or the birth of a child) in specified amounts. This amount usually is the face amount of the original policy, not to exceed a contract-set maximum such as $50,000.

GUARANTEED INSURABILITY RIDER

The benefit shown below can be purchased by the policyholder/owner **without evidence of insurability**, any statement of health, finances, occupation, lifestyle, and/or hobbies made by applicants that underwriters use in deciding if the risk is acceptable for insurance.

Age at Original Policy Issue	Maximum Benefit Each Option Age/Date is the Lesser of Face Amount of Base Policy, Or:	Option Ages
0-24	$35,000	25,28,31,34,37,40
25-27	$40,000	28,31,34,37,40
28-30	$45,000	31,34,37,40
31-33	$50,000	34,37,40
34-36	$60,000	37,40
37-40	$70,000	40

Regular option periods begin 30 days before and end 30 days after regular option date. The option date is always the anniversary date of the contract.

Waiver of Premium: Should the insured become totally disabled by bodily injury or disease, the payment of subsequent premium is waived by the insurer. There is normally a 90- or 180-day waiting period before the company will waive the premiums. If the insured is still totally disabled after the waiting period, most companies will reimburse the insured for the premiums paid during the waiting period. When this rider is attached to a UL Policy, it must define exactly what portion of the contribution is being waived, since premiums to the plan can vary. Some waive *only* the cost of insurance while others waive the entire planned periodic payment.

Accidental Death Benefit: This rider provides for the payment of an amount in addition to the standard benefit payable in the event of an **accidental death**, or a death resulting from a sudden, unexpected, and unintentional injury. Accidental death is usually defined as "a death resulting directly and independently of all other causes from bodily injuries affected solely through external, violent, and accidental means and occurring within 90 days from the date of such accident".

Payor Benefit: This rider waives the premium should the "payor" (usually the mother or father) die or be totally disabled while paying the premium for an "insured" (child). This rider normally terminates at the insured's (child's) age of 25.

Accelerated Death Benefit: The insured can collect on their own life insurance policy if diagnosed with a terminal illness. Generally, it must be certified by an attending physician that the individual has one year (or less) to live. Some companies will pay up to 90% of the face amount.

Family Insurance: A family rider allows the purchase of term insurance for a spouse and/or children of the insured. Insureds purchase units of coverage (i.e., $1,000, $2,000, $5,000, etc.). Under specific conditions, many policies allow conversion to a permanent life insurance policy without evidence of insurability.

Term Rider: A term insurance rider provides an additional amount of temporary coverage, which may be attached to an existing permanent policy for a specified period of time. Typically, the insurer offers this option when the policy is originally issued.

Return of Premium: When a return of premium rider is attached to term life insurance policies, the **policy owner** – the individual or entity controlling all rights, benefits, and privileges of a life insurance contract – is returned the premium paid if the insured outlives the term. One disadvantage of term insurance is that it is designed to expire before the insured dies. This rider, if the policy is kept in force for a specified time period, refunds some or all of the premium paid. A return of premium rider may increase a standard premium by 25% to 50%.

Long Term Care/LB will be addressed.

Knowledge Check 3

The client has ten grandchildren and wants to leave each of them a $50,000 death benefit from the same life insurance policy. If a grandchild predeceases the client, the client wants that grandchild's heirs to inherit the money.

How would this objective best be achieved?

Conditional Receipt

Note:
Failing to understand and follow the insurance company rules regarding the conditional receipt is a potential E & O exposure for the writing agent!

1. Issued by the agent after completing the application and receiving money

2. Coverage is in force as of the application date or medical exam date, if later

3. If death occurs during underwriting, the face amount is payable if the risk would have been accepted by the company

4. Amount paid under a conditional receipt is limited to the face amount, not to exceed a company maximum

5. Conditional receipt wording is non-standard and can vary greatly; it is critical that the agent understand the exact conditions and limitations of each insurance company for which they place business

Banner Life® Insurance Company

1701 Research Boulevard
Rockville, Maryland 20850-3191
(301) 279-4800

CONDITIONAL RECEIPT

NOTICE TO PROPOSED INSURED AND OWNER. No coverage will become effective prior to delivery of the policy applied for unless and until all the conditions of this receipt are met. No agent or broker has the authority to alter the terms or conditions of this receipt. This receipt shall be void if altered or modified.

No payment may be accepted with the application if, within the last 24 months, any person proposed for coverage has been treated for or diagnosed by a member of the medical profession as having: AIDS or any other immunological disorder; heart trouble; stroke; cancer; alcoholism; drug dependency; insulin dependent diabetes; or any blood pressure condition requiring medication.

CONDITIONS WHICH MUST BE MET BEFORE INSURANCE MAY BECOME EFFECTIVE PRIOR TO DELIVERY OF THE POLICY:

1. An amount equal to the modal premium indicated on the application must be submitted; the mode must be either annual, semi-annual, quarterly or pre-authorized check plan (two months' premium required); and
2. All medical examinations, test, x-rays and electrocardiograms initially required by the Company's published rules with regard to age and amount requested must be completed within ninety (90) days from the date of this receipt; and
3. The proposed insureds are, on the Effective Date indicated below, risks acceptable for insurance exactly as applied for on a standard premium basis according to the Company's rules and practices, without modification of plan, premium rate or amount; and
4. On the Effective Date the state of health and all factors affecting the insurability of each person proposed for coverage must be as stated in applications required by the Company, and;
5. Any check or money order given in payment is honored when first presented.

EFFECTIVE DATE. If all the conditions above are met, then insurance, subject to all the terms and conditions of the policy applied for and as if the policy applied for had already been issued and delivered, will become effective on the latest of: (a) the date of application; (b) the date of application - part II; (c) the date of completion of all underwriting requirements stated in (2) above; or (d) the special policy date requested in the application, if any.

MAXIMUM AMOUNT. The total amount of life insurance available under this receipt shall be the amount shown in Part 1, Question 25 of the application. This amount, together with any insurance now applied for or pending issue with the Company, including Accidental Death Benefits, shall not exceed $1,000,000 to issue age seventy (70).

There is no coverage beyond age seventy (70); there is no coverage for any Last Survivor product applied for.

RETURN OF MONEY. If any of the above conditions is not met, the liability of the Company will be limited to the return of the amount remitted with this receipt. All returns will be made without interest to or for the benefit of the owner.

AGREEMENT. I agree that: (1) the limited amount of insurance that may begin prior to policy delivery will not exceed the Maximum Amount as defined above; (2) this limited amount of insurance will not begin unless all of the CONDITIONS listed above are first met exactly; (3) this receipt will be void if the application or this receipt contains any material misrepresentation or the Proposed Insured dies by suicide; and (4) this receipt will be of no legal effect on and after the earliest of the following: (a) the date the entire amount remitted with this receipt is returned, or (b) the date a policy is delivered to the Owner; and I further agree to any remaining terms, limits, and conditions of the Conditional Receipt and the Agreement in the Application.

_____	___/___/___	_____
Signature of Proposed Insured	Date of this Receipt	Signature of Owner (if other than Proposed Insured)

BROKER STATEMENT.

Amount Remitted: $_____ Person from whom Received: _____

On the Date of this Receipt, I received the amount indicated above in exchange for this receipt. This receipt bears the same date as the Application - Part 1. I have accurately represented the terms and conditions of this receipt to the Proposed Insured and Owner. I know of no reason why any person to be covered may not be eligible for insurance.

_____
Signature of Broker

LU1271 (3/08)

Taxation of Life Insurance

Learning Objective 5:
Participants will use their understanding of income tax aspects of annuities, and life insurance to determine the most appropriate annuity product(s) to meet client needs.

Taxation of Premiums, Death Benefits, and Cash Value

Life insurance premiums are not tax deductible. An exception exists for the premiums paid by an employer for the benefit of employees in a group life policy.

Generally, death proceeds are not subject to federal income tax when received by the beneficiary. There are minor exceptions to this rule, and they generally only apply when a non-group policy is transferred to an employee/owner under the transfer-for-value rule.

<table>
<tr><th>PREMIUM</th><th>DEATH BENEFIT</th><th>CASH VALUE</th></tr>
<tr><td rowspan="2">Premiums paid for personal life insurance are NOT tax deductible</td><td>The death benefit is NOT subject to federal income tax</td><td rowspan="2">Cash value grows income tax deferred (FIFO), and distributions are not subject to such tax until withdrawals exceed the basis</td></tr>
<tr><td>The death benefit can be arranged to avoid inclusion for federal estate tax (the insured must not be the owner)</td></tr>
</table>

The proceeds will be included in the estate of the owner for federal estate tax purposes should the policy be owned by the insured. Certain credits do apply, and proper planning can minimize (or even eliminate) this estate tax problem. To properly eliminate the life insurance proceeds from the estate of the owner, there must be no "incidents of ownership" by the insured. An in-force policy that is transferred to an irrevocable trust will still be included in the estate of the owner if death occurs within three years of the transfer.

Cash values grow tax-deferred until received (First In, First Out — FIFO). When cash values are withdrawn, those that exceed the premium outlay are subject to ordinary income tax. Cash values that are paid in addition to a death benefit, such as Option B in universal life, are considered death benefits and are not normally subject to income tax.

Example of FIFO, as it relates to life insurance cash value:

Over the years John has paid premiums totaling $7,000 to his universal life policy. His policy has $8,000 in cash value. John needs to take all $8,000 due to an emergency and cancel (surrender) his policy.

The first $7,000 of his withdrawal is considered a tax-free return of premium (FIFO) and the balance will be taxed as ordinary income. Taxation of income earned that exceeds the paid premiums is deferred until actual distribution.

Had he taken a *loan* (as required in the case of a whole life policy), federal income tax would not be due in this tax year. It would be deferred to a later date, and if death occurred before it was due, then no tax would be imposed.

Note:
A loan would have to be less than the full $8,000 to keep the policy in force. Any full surrender with cash value greater than basis (premium paid) will create a taxable event.

Annuities

Learning Objective 6:
Participants will use their understanding of classifications, types, provisions, and payout options of annuities to determine the most appropriate annuity product(s) to meet client needs.

What is an Annuity?

The term "annuity" derives from a Latin term meaning annual and generally refers to circumstances where principal and interest are liquidated through a series of regular payments made over a period of time.

Annuities can be used as a long-term savings plan, accumulating assets on a tax-deferred basis, for retirement and then liquidated over a period of time. An annuity is a contract between a person (or trust) and an insurance company.

- Life Insurance provides financial protection against the risk of dying prematurely

- An annuity provides financial protection against the risk of living too long and being without income during retirement

For a Brief History of Annuities, visit scic.com/LHResources

Two Main Objectives of an Annuity

To accumulate retirement assets on a tax-deferral basis
If you are already contributing the maximum to an employer-sponsored retirement plan and/or IRA and want to save more money, this may be an option for you!

To convert retirement assets into a stream of income you cannot outlive
Annuities also provide a unique death benefit

Phases of an Annuity

Accumulation Phase (Savings)
Annuity premiums, less any applicable charges, accumulate in the contract on a tax-deferred basis until the annuity starting date (payout) (Premiums and Interest Growth)

Distribution Phase (Withdrawal Phase) (Payout Phase) (Income Phase)
The time the value of the annuity is converted into a stream of income (annuitized)

Parties to an Annuity

Insurance Company: The entity that guarantees the contract benefits. Financial strength and stability of the insurance company are important.

Policy Owner: The individual or entity that contributes the funds. They typically have the right to terminate the annuity, to gift it to someone else, to withdraw funds from it, and to change the annuitant or beneficiary.

Annuitant: The individual whose life (mortality) is used to determine the payments during the payout phase (may or may not be the same person as the owner).

Beneficiary: The individual or entity that receives any proceeds payable on the death of the annuitant.

Features of an Annuity

In its most general sense, an annuity is an agreement for one person or organization to pay another a stream or series of payments. Usually the term "annuity" relates to a contract between an individual and a life insurance company, but a charity or trust can take the place of the insurance company.

Tax Deferral on Investment Earnings

Many investments are taxed year by year, but the investment earnings in annuities – capital gains and investment income – aren't taxable until you withdraw money. This tax deferral is also true of 401(k)s and IRAs; however, unlike these products, there are no limits on the amount you can put into an annuity. Moreover, the minimum withdrawal requirements for annuities are much more liberal than they are for 401(k)s and IRAs.

Protection from Creditors

If you own an immediate annuity (that is, you are receiving money from an insurance company), generally the most that creditors can access is the payments as they're made, since the money you gave the insurance company now belongs to the company. Some state statutes and court decisions also protect some or all the payments from those annuities. And your money in tax-favored retirement plans, such as IRAs and 401(k)s, are generally protected, whether invested in an annuity or not.

An Array of Investment Options, Including "Floors"

Many annuity companies offer a variety of investment options. You can invest in a fixed annuity which would credit a specified interest rate, similar to a bank CD. If you buy a variable annuity, your money can be invested in stock or bond (or other) mutual funds. In recent years, annuity companies have created various types of "floors" that limit the extent of investment decline from an increasing reference point.

Tax-Free Transfer

In contrast to mutual funds and other investments made with after-tax money, variable annuities have no tax consequences if you change how your funds are invested. This can be particularly valuable if you are using a strategy called "rebalancing," which is recommended by many financial advisors. Under rebalancing, you shift your investments periodically to return them to the proportions that you determine represent the risk/return combination most appropriate for your situation.

Lifetime Income (Guaranteed)

A lifetime immediate annuity converts an investment into a stream of payments that last as long as you do. In concept, the payments come from three "pockets": your investment, investment earnings, and money from a pool of people in your group who do not live as long as actuarial tables forecast. It's the pooling that's unique to annuities, and it's what enables annuity companies to be able to guarantee you a lifetime income.

Benefits to Heirs

There is a common misconception about annuities that goes like this: If you start an immediate lifetime annuity and die soon after that, the insurance company keeps all of your investment in the annuity. That can happen, but it doesn't have to. To prevent it, buy a "guaranteed period" with the immediate annuity. A guaranteed period commits the insurance company to continue payments after you die to one or more beneficiaries you designate; the payments continue to the end of the stated guaranteed period – usually 10 or 20 years (measured from when you start receiving the annuity payments). Moreover, annuity benefits that pass to beneficiaries don't go through probate and aren't governed by your will.

Source: Insurance Information Institute, "Annuities Basics" – http://www.iii.org/article/annuities-basics

Annuity Classifications

Classifications are Based on Four Categories:

1. **Number of lives covered:**

   - Single life
   - More than one life (joint and survivor)

2. **Time benefits begin:**

   - Immediate – benefit begins immediately after purchase
   - Deferred – benefit deferred for several years

3. **Premium payment method:**

   - Single premium – may be used with immediate and deferred
   - Installment payments – (fixed or flexible premiums) deferred annuities only

4. **Tax treatment:** (Whether qualified or non-qualified, accumulations are on a tax deferred basis.)

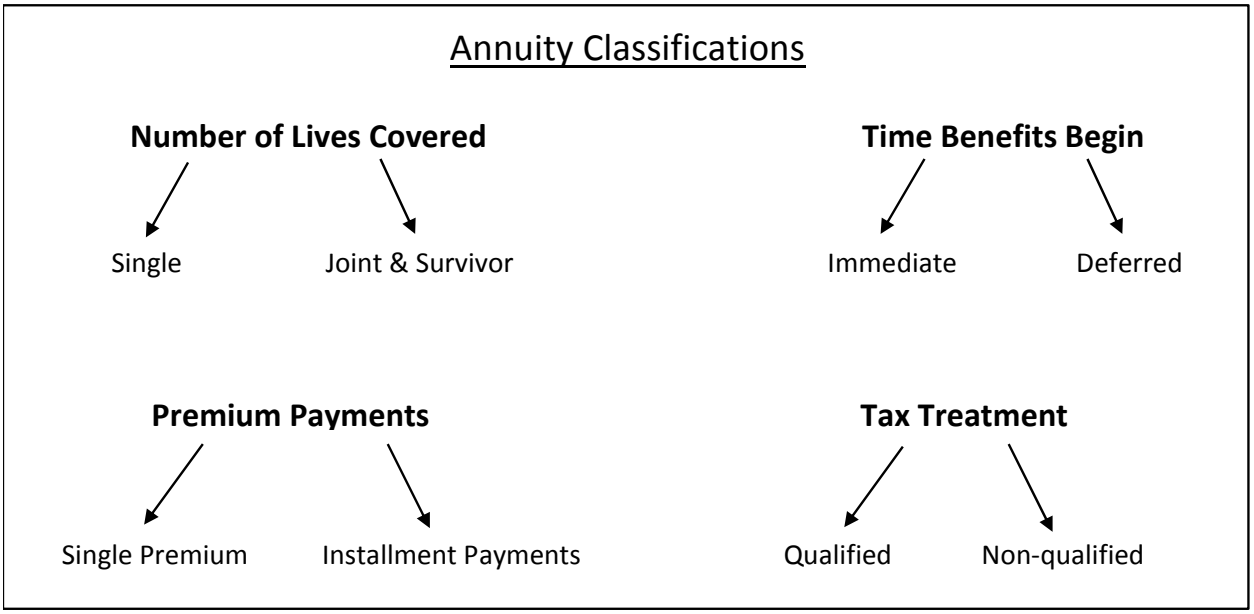
   - Non-qualified or after-tax annuities
     - Annuities purchased outside qualified pension plans do not receive tax favored treatment of premium payments (non-deductible)
     - Non-qualified annuities can be purchased by any individual or entity, but premium payments are NOT tax deductible

- Qualified or pre-tax annuities

  – Provisions of the IRS code pertaining to qualified retirement plans (401(k) plans, 403(b) tax sheltered annuity plans, traditional IRAs, etc.) permit annuities used to accumulate money in such plans to receive tax-favored treatment of premium payments.

    For additional information go to www.irs.gov/retirement-plans/a-guide-to-common-qualified-plan-requirements

  – Such premium payments (contributions) to the account are tax deductible



Types of Annuities

Fixed Annuities

1. Accumulation Phase (deferred annuity)

   - Principal is guaranteed by the insurance company (subject to surrender charges)

   - Minimum guaranteed interest rate

   - Interest growth is tax-deferred

   - Death benefit

2. Distribution phase (deferred and immediate annuities)

   - Annuitization – payout options that provide guaranteed income for life or a specific period of time. With qualified annuities the entire distribution is subject to ordinary income tax. For non-qualified annuities, part of each annuitization payment is a tax-free return of premium and part is subject to ordinary income tax.

   - Partial income withdrawals – fully taxable as ordinary income until the interest earned has been taxed (LIFO – last in first out), then tax-free withdrawal of premium, a 10% penalty may apply if withdrawal is taken prior to age 59 ½

3. Regulation

   - Fixed annuities sales are regulated by the state department of insurance

   - Sales person must have a valid life insurance license to sell fixed annuities

Variable Annuities

1. Accumulation phase (deferred annuity)

    - Annuity owner assumes investment risks, including loss of principal
    - Growth potential through market participation
    - Annuity owner can choose from a broad array of variable investment options or subaccounts, very similar to mutual funds, plus guaranteed interest accounts
    - Optional income riders (GLWB – Guaranteed Lifetime Withdrawal Benefit)
    - Death benefit

2. Distribution phase (deferred and immediate annuity)

    - Annuitization – same as fixed annuities
    - Partial income withdrawals – same as fixed annuities

3. Regulation

    - Sale of variable annuity products, which are classified as securities, is regulated by the state department of insurance AND the Securities and Exchange Commission (SEC) through the Financial Industry Regulatory Authority (FINRA)
    - The sales person must have a valid life insurance license for the states where they do business AND they must also have a registration with FINRA (Series 6 or Series 7 license)

Indexed Annuities

1. Accumulation Phase (deferred annuity and characteristics of the fixed annuity and the variable annuity)

    - Principal is guaranteed and protected against financial market declines (if the annuity is held through the surrender period)

    - Indexed interest rate credited is based upon a company-specific formula applied to changes in one or more linked indexes (S&P 500) subject to a maximum rate of interest; a minimum interest may be credited, but if the specified index has a negative return, the annuity is credited 0% for that crediting period. ZERO is HERO – *If the index goes up you get it, but if the index goes down you don't lose anything. How can an insurance company do that? When it goes up you don't get all of it!*

    - Indexed interest rate crediting methods

        – Cap rate – insurance company may impose a maximum rate of interest (e.g. 7%) that can be earned in a crediting period

        – Participation rate – insurance company decided the percentage of participation in the growth rate of the index (e.g. 55%); may be combined with cap rate

        – Spread – insurance company may impose a fee (2%) before the annuity is credited

    - Optional income riders

    - Death benefit

2. Distribution phase (deferred and immediate annuity)

    - Annuitization – same as fixed annuities

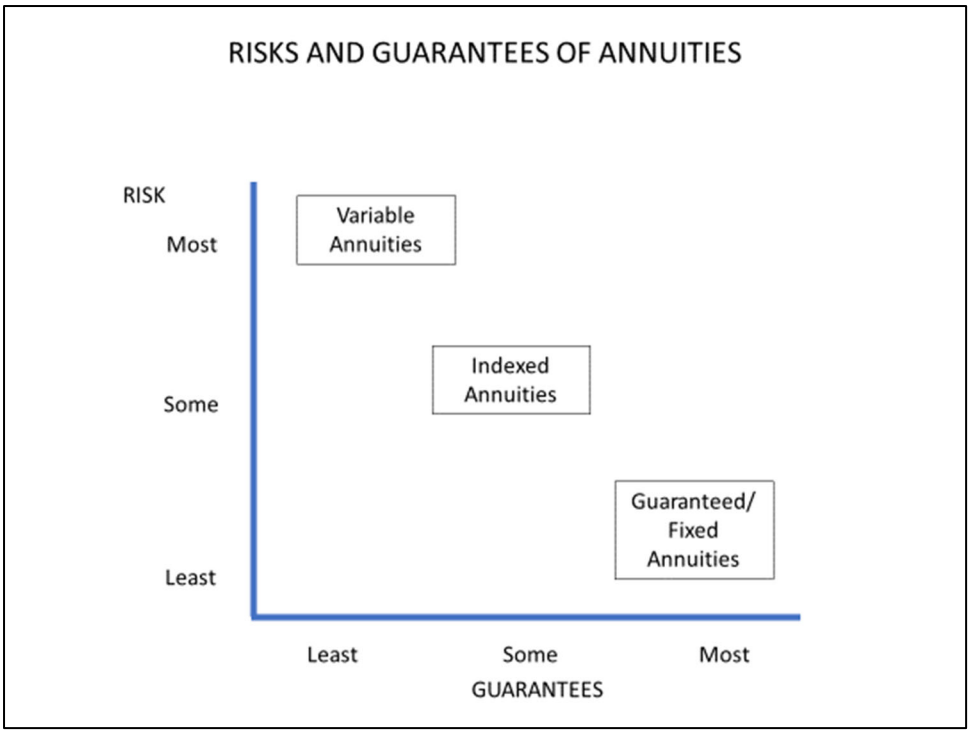
    - Partial income withdrawals – same as fixed annuities

3. Regulation

    Because indexed annuities are structured as fixed annuity products (sometimes called fixed indexed annuities), sales are regulated by the state department of insurance; sales person must have a valid life insurance license to sell indexed annuities

Annuity Comparisons			
	Fixed Annuities	Variable Annuities	Indexed Annuities
Minimum Guaranteed Return	YES[1]	NO[2]	YES[1]
Choice of Investment Options	NO	YES	NO
Opportunity to Earn A Higher Return	NO	YES	YES
Possibility of Losing Principal	NO[1]	YES	MAYBE[3]
Tax-Deferred Growth	YES	YES	YES
Minimum Death Benefit	YES[1]	YES[1]	YES[1]

1 Subject to the claims paying ability of the issuing insurance company.
2 Unless 100% of premiums are place in a guaranteed fixed interest subaccount.
3 It is possible to lose principal while a surrender charge is in effect.



Policy Provisions

Age Restrictions

1. Issue ages

   - This is more a function of the underwriting process than a policy provision, but most contracts will have maximum age limits over which a contract cannot be issued. Age 85 is typical, although a few companies will issue policies up to age 95.

   - Some contracts impose a lower maximum age for the annuitant than the owner and some contracts only impose maximum age requirements on annuities that will be paid out over the annuitant's lifetime

2. Maximum age for benefits to begin

   This provision states that the annuitant must begin benefits before reaching the maximum age stated in the contract; *this is not the same as the requirements imposed by the IRS on qualified plans*

Surrender Charges (Deferred Sales Charges)

1. Charges are designed to make moving money out of the annuity less attractive to the owner. With fixed annuities and some indexed annuities, a surrender charge allows the entire premium to go to work in the annuity (no up-front sales charges).

2. Charges, expressed as a percentage, are usually applied to a surrender (full or partial) made within a certain number of years; many annuity contracts waive the charges in the event of death or disability; a*lso, many annuity contracts allow a free 10% of account value once a year*

YEAR	SURRENDER CHARGE
1	7%
2	6%
3	5%
4	4%
5	3%
6	2%
7	1%
8	0%

Note:
Various states have maximum percentages and durations regarding surrender charges. Surrender charge maximums can be set by states.

Surrender Charge Waivers Found in Some Annuities

Death Benefit Waiver

This waiver passes on your annuity to your beneficiary if you die before you annuitize; that is, you die before you begin to receive payments from your annuity, presumably at retirement. For example, Prudential's Discovery Select Variable Annuity will pay the greater of the following: the fund value as of the date proof of death is received; the total of all payments made into the annuity less withdrawals and related withdrawal charges; or the highest contract fund value, as calculated every third year on your contract anniversary date (adjusted for withdrawals you may have made). Your annuity contributions remain unchanged even if your subaccounts have lost value.

Terminal Illness Waiver

Your annuity might contain a provision that waives surrender charges if you become terminally ill, thus allowing you access to your money when you may need it most. While the definition of terminally ill may vary slightly from company to company, it's generally a condition that will result in your death within six months to a year. Security Benefit Life's Variflex annuity, for instance, defines a terminal illness as "an incurable condition that, with medical certainty, will result in death within one year." Prudential's Discovery Select Critical Care Access provides annuity income for either terminal illness or nursing home confinement. Prudential's waivers are triggered when you're diagnosed with a life expectancy of six months or less, or after a three-month nursing home stay. As with the nursing home waiver, an insurance company will want certification from your doctor, and perhaps from their doctor as well, that your life expectancy is indeed only a matter of months.

Disability Waiver

The risk of disability is greater than the risk of death at all ages between 20 and 65. That said, it makes sense to protect yourself financially if you do become disabled, and that includes annuity considerations. Unfortunately, relatively few insurers offer a disability waiver. Allmerica Financial, however, does offer it on its Delaware Medallion III and purposefully leaves the definition of "disability" fluid. The company simply states that if you're unable to work, and thus can't earn a living, and your doctor attests to this, Allmerica will allow you full access to your annuity without imposing surrender charges. This is unique, as many other companies impose a more stringent definition of disability.

Nursing Home Waiver

When you use a nursing home waiver, you won't be charged surrender fees and you'll be allowed access to some or all of your annuity if you're confined to a nursing facility. While a 90-day confinement period before benefits kick in may be typical, Lincoln Benefit Life, for example, imposes a 180-day confinement period to a "licensed nursing facility." Your doctor will normally be asked to then submit an attending physician's statement, along with a completed claim form. The insurer will want to be certain of your incapacitation and it's not unusual that they will have their doctor examine you.

Optional Riders: Living Benefit Riders (Available in some variable and indexed annuities)

1. **Guaranteed Lifetime Withdrawal Benefit (GLWB)**: This rider guarantees that regardless of stock market or index performance, the entire principal invested plus interest earned will be returned to you over your lifetime through withdrawals of a fixed percentage of the account even if the account value is depleted. (Sometimes called a Guaranteed Minimum Withdrawal Benefit rider (GMWB).

2. **Guaranteed Minimum Income Benefit (GMIB):** After a vesting period, such as 10 years the rider guarantees a minimum income benefit, regardless of market or index performance. If the value of the contract grows, the stream of income may be higher, but it can never be lower than the guaranteed amount.

3. **Guaranteed Minimum Accumulation Benefit (GMAB):** Guarantees that after a specified period, typically 10 years, the value of the annuity will be equal to or greater than the guaranteed accumulation amount.

These living benefit riders are optional and require payment of an additional fee.

Accessing the Cash Value of an Annuity

Annuitization

- Straight life – Lifetime income payments guaranteed until the annuitant's death. Maximum income for the lowest cost. No beneficiary.

- Life and refund certain – Lifetime income payments until the annuitant's death. If total income payments received by the annuitant are less than the account value of the annuity, balance is paid to the annuitant's beneficiary either in a lump sum or in installments.

- Life and period certain – Lifetime income payments guaranteed until the annuitant's death. If annuitant dies prior to the end of the minimum period certain (10 or 20 years) payments continue to the beneficiary for the remainder of the guaranteed period.

- Joint and survivorship life – Lifetime income payments for two or more annuitants. Income payments continue until the death of the second annuitant.

- Joint and survivorship life with period and refund certain – Lifetime income payments guaranteed for two or more annuitants. Income payments continue until the death of the second annuitant. If total income payments received by the annuitants at death are less than the account value, balance is paid to the annuitant's beneficiary either in a lump sum or installments.

- Joint and survivor life with period certain – Lifetime income payments guaranteed for two or more annuitants. Income payments continue until the death of the second annuitant. If annuitants die prior to the end of the minimum guaranteed period (10 or 20 years) payments continue to the annuitant's beneficiary for the remainder of the guaranteed period.

Simple Systematic Withdrawals

- Set amount – The annuity owner can sometimes elect to withdraw a set amount each month or year without any contract fee or surrender charges being applied.

- Living benefits – This type of benefit allows you to receive a percentage, usually 4% to 6%, of your original investment for as long as you live. These benefits also allow your income to increase if you experience positive investment performance. These benefits are usually age based, so you may be able to take out a greater percentage of your original investment if you are older.

- These benefits are pretty straight forward. As long as you live we will pay you. So, if you invest $100,000 and your age-based withdrawal rate is 5% you are able to take out $5,000 per year for the rest of your life. There are many variations on this type of benefit, and every company has a different name for it. Remember this is an income benefit not a lump sum benefit. The benefit is available on indexed and variable annuities and there is a charge for the benefit.

Lump Sum Cash Out

Income Tax Aspects

Premium Payments

- Premiums paid into a non-qualified annuity are generally not deductible

- Premiums paid into qualified annuities, such as Tax-Sheltered Annuities (TSAs) and IRAs or Keogh plans funded by annuities, are deductible subject to IRS rules

Accumulations

For non-qualified annuities, the interest credited to an annuity each year is generally not taxable at the time the interest is credited. Income tax WOULD, however, be due at the time annuity benefits are received, but tax would only be assessed on the interest portion of the benefit. (See withdrawal discussion later.)

Loans

Amounts received as loans or as value of part of an annuity contract pledged or assigned to cover a loan are taxable. Amounts assigned from the annuitant to another individual are still taxable as income to the original annuitant.

Ten Percent Premature Distribution Penalty Tax

- Tax is imposed to discourage the use of annuity contracts as short-term tax-sheltered investments

- The 10% tax applies to the portion of any payment that is taxable

- The tax is imposed on taxpayers under age 59 ½ who receive distributions from annuities; see the "Exceptions to the Early Distribution Penalty Rule Imposed by the IRS" table

Exceptions to the Early Distribution Penalty Rule Imposed by the IRS

- Distributions made as a result of the death of the annuity owner
- Distributions made as a result of the disability of the taxpayer
- Distributions made under an immediate annuity
- Distributions from a qualified retirement plan (IRAs, TSAs, etc.), but it should be noted that these plans are subject to a 10% penalty
- Distributions made under a qualified funding asset (structured annuity purchased to pay for damages as a result of a liability from a physical injury or illness)
- Distributions made under an annuity purchased and held by an employer upon the termination of a qualified retirement plan
- Distributions which are part of a series of substantially equal periodic payments, made not less frequently than annually, for the life or life expectancy of the taxpayer or the joint lives or joint life expectancies of taxpayer and his/her designated beneficiary

Withdrawals

Withdrawals are received as interest out first. Therefore, payments (until all interest is paid out) are subject to income taxation as ordinary income in the year in which payments are received. In addition:

- For persons under age 59 ½, there is also a tax penalty of 10% of the taxable amount received

- For persons over age 59 ½, the tax penalty does not apply

Taxation of Annuity Benefit Payments

- For a non-qualified annuity, payments are considered to be part principal (cost basis) and part interest (the interest portion of each payment is considered to be taxable as income in the year in which it is received); calculation is done by the insurance company and is called the "exclusion ratio"

- For a qualified annuity, the entire payment is taxable as income in the year it is received since a qualified contract has had the benefit of a tax deduction

Knowledge Check 4

Your best friend, Lucky Luciano, has just hit it big at the casino winning $100,000 cash on a slot machine! He decides to invest the entire amount in an annuity with you to supplement his personal retirement when he plans to retire 20 years from now.

1. List the four annuity classifications that Lucky needs to consider in purchasing an annuity.

2. Lucky also asks you about payout options when he does retire 20 years from now. Describe for him what is the difference in payout benefits between a straight life and the 10-year period certain option?

To view the Life Insurance Customer Advocate video, visit scic.com/LHResources

Review of Learning Objectives

1. Participants will use knowledge of the general uses, and legal elements of life insurance contracts to provide counsel to clients and prospects.

2. Participants will use knowledge of the various methods of determining the appropriate type and amounts of life insurance coverage to help a client or prospect develop a financial plan.

3. Participants will apply knowledge of the components of Term Insurance, Universal Life Insurance, and Whole Life Insurance policies to advise clients and prospects on selecting the life insurance products to best meet their needs.

4. Participants will apply knowledge of riders, provisions, beneficiary designations, settlement options and conditional receipts to a variety of client needs in various scenarios.

5. Participants will use their understanding of income tax aspects of annuities, and life insurance to determine the most appropriate annuity product(s) to meet client needs.

6. Participants will use their understanding of classifications, types, provisions, and payout options of annuities to determine the most appropriate annuity product(s) to meet client needs.

Knowledge Check 1 – ANSWERS

You are sitting with a prospect who has no idea about his social security benefits or his employee benefit amounts. He is concerned with family debt in the event of premature death or disability. He is limited as to the amount of time he can spend with you.

Which planning method would be most appropriate given the information above?

Answer:

Multiple of earnings method

Why?

Answers will vary, here is a sample opinion:

As a courtesy to him and his limited time, multiple of earnings will at least allow a calculation of how much lost income family suffers. And if the decision is, say, 5 times annual income, family can continue income stream for a time to pay bills that would be paid if he lived longer.

Knowledge Check 2 – ANSWERS

Your clients would like to have a permanent insurance program but are concerned about additional expenses the family will incur while their children are in college in the next ten years.

Explain how the flexibility of universal life would allow for coverage to remain while premiums could be adjusted during years with higher family expenses.

Answer:

Overfunding the policy early (as much as possible) will allow excess cash value to be utilized later, keeping the policy in force during years of higher family expenses. After that period of time, the family can return to increased premiums and return the coverage to replicate WL permanent insurance.

Knowledge Check 3 – ANSWERS

The client has ten grandchildren and wants to leave each of them a $50,000.00 death benefit from the same life insurance policy. If a grandchild predeceases the client, the client wants that grandchild's heirs to inherit the money.

How would this objective best be achieved?

Answer:

Purchase a $500,000 life policy (preferably permanent), name the ten grandchildren beneficiaries for 10% each, and request the beneficiary designation be listed as "per stirpes". That will allow proceeds to go to a beneficiary's heirs if they pre-decease the insured.

Knowledge Check 4 – ANSWERS

Your best friend, Lucky Luciano, has just hit it big at the casino winning $100,000 cash on a slot machine! He decides to invest the entire amount in an annuity with you to supplement his personal retirement when he plans to retire 20 years from now.

1. Describe the four annuity component classifications that would make up the annuity that you would sell to Lucky.

Answers:

Number of lives covered

Premium payment

Time when benefits begin

Tax treatment

2. Lucky also asks you about payout options when he does retire 20 years from now. Describe for him what is the difference in payout benefits between a straight life and the 10-year period certain option?

Answer:

A straight life annuity pays a monthly sum but only until the annuitant dies.

A ten-year certain annuity also pays a monthly sum until, the annuitant dies.

AND

It guarantees that at least 10 years of payments to a designated beneficiary if the annuitant dies before 10 years are paid.

The Society of
Certified Insurance Counselors

a proud member of The National Alliance for Insurance Education & Research

Section 2

BUSINESS LIFE CONCEPTS

THE NATIONAL ALLIANCE
for Insurance Education & Research

Resources

Glossary of Terms

Link to fillable IRS Form 8925 https://www.irs.gov/pub/irs-pdf/f8925.pdf

Sample Buy-Sell Agreement

Business Life Concepts

Section Goal

The Business Life Concepts section provides participants with core knowledge and tools necessary to deliver transformative information and counsel regarding business life concepts to their clients.

Learning Objectives

1. Participants will use knowledge of the steps an agent should take when advising a client on placing Employer-Owned Life Insurance (EOLI) on an employee.

2. Participants will use knowledge of the features of a key person life insurance policy to evaluate the product in relation to client needs.

3. Participants will explain using an Executive Bonus (162 plan) as a means for an employer to provide an employee benefit.

4. Participants will use knowledge of the various issues created by the death of a partner or shareholder to help develop a process of business succession.

5. Participants will use knowledge of buy-sell agreements, their funding methods, and the structures of life insurance policy ownership to provide advice as a member of the client's succession planning team.

Learning Objective 1:
Participants will use knowledge of the steps an agent should take when placing Employer-Owned Life Insurance (EOLI) on an employee to advise a client.

Employer-Owned Life Insurance

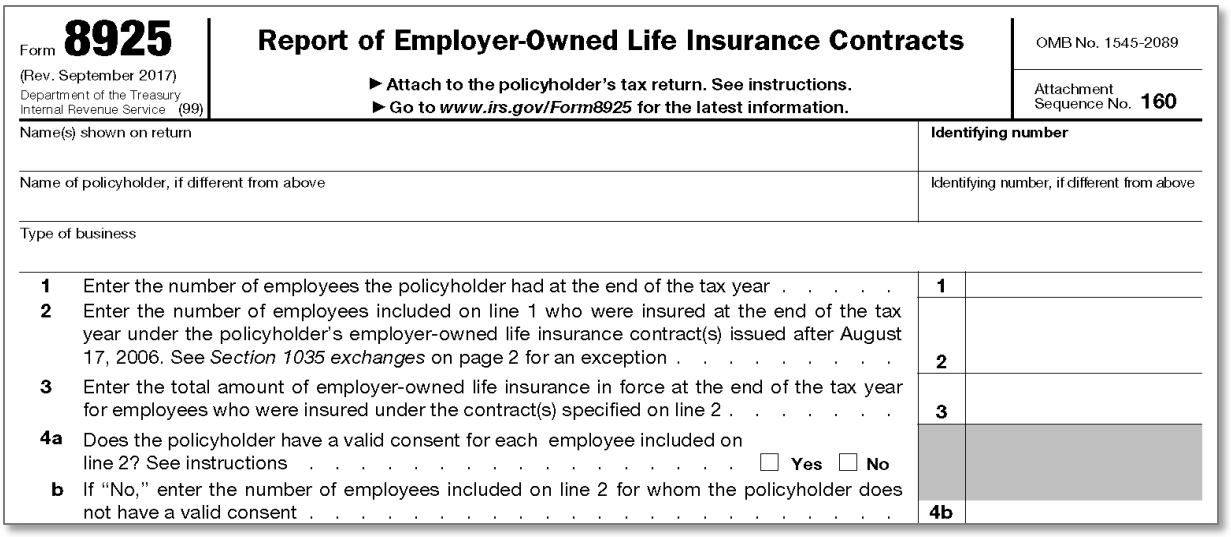
The concept known as Employer-Owned Life Insurance (EOLI) came under close federal scrutiny in the early to mid-2000's. The revised law is the IRC 101(j)(4). This Internal Revenue Code section may affect any EOLI, including key person and buy-sell funded contracts. You should be aware of the following:

Effective date: Generally, the law applies to contracts issued on August 18, 2006 or later. These rules also apply to policies issued before that date ("grandfathered policies") that undergo material increases in the death benefit or other material changes.

Penalty: The death benefit will be subject to ordinary income tax.

Exemptions: It is essential that life insurance agents NOT render specific tax or legal advice in these cases and strongly urge their clients to seek competent guidance. Contracts that an employee/owner pays for, and is the beneficiary, on the life of another employee/owner (such as a cross-purchase buy-sell) might be exempt.

IRS form:



Form **8925** (Rev. September 2017)
Department of the Treasury
Internal Revenue Service (99)

Report of Employer-Owned Life Insurance Contracts

► Attach to the policyholder's tax return. See instructions.
► Go to *www.irs.gov/Form8925* for the latest information.

OMB No. 1545-2089

Attachment Sequence No. **160**

Name(s) shown on return	**Identifying number**
Name of policyholder, if different from above	Identifying number, if different from above
Type of business	

1	Enter the number of employees the policyholder had at the end of the tax year	**1**	
2	Enter the number of employees included on line 1 who were insured at the end of the tax year under the policyholder's employer-owned life insurance contract(s) issued after August 17, 2006. See *Section 1035 exchanges* on page 2 for an exception	**2**	
3	Enter the total amount of employer-owned life insurance in force at the end of the tax year for employees who were insured under the contract(s) specified on line 2	**3**	
4a	Does the policyholder have a valid consent for each employee included on line 2? See instructions ☐ **Yes** ☐ **No**		
b	If "No," enter the number of employees included on line 2 for whom the policyholder does not have a valid consent	**4b**	

Specified EOLI Exceptions

In general, if the "Notice and Consent" requirements of the law are satisfied, policy death proceeds may be received income-tax-free (subject to existing transfer for value and alternative minimum tax rules) if any of the following exceptions are met:

Recent Employees Exception: If the insured is no longer employed, but the insured was an employee during the 12 months period before death, the death proceeds will keep their income-tax-free status.

Directors and Highly Compensated Employees Exception

If at the time the policy was issued, the insured was:

1. A director

2. A highly compensated employee, as defined by the IRS:

   - Owned more than 5% of the interest in the business at any time during the year, or the preceding year, regardless of how much compensation that person earned or received

     OR

   - For the preceding year, received compensation from the business of more than $125,000 (2019)

3. A highly compensated individual under the rules for self-insured medical reimbursement plans, looking at the highest paid 35% of employees (i.e., generally one of the five highest paid officers; among the highest paid 35% of employees; or more than 10% owner by value of employer stock)

Death Benefits Paid to Heirs Exception

Benefits are payable to the extent that death proceeds paid in the taxable year are received:

1. By a family member of the insured

2. By an individual who is the designated beneficiary of the insured (other than employer)

3. By a trust established for the benefit of any such family member or designated beneficiary

4. By the estate of the insured

Buy-Sell Exception: This exception applies to the extent that death proceeds are used in the taxable year they are received to purchase an equity (or partnership capital or profits interest) in the employer from a family member, beneficiary, trust, or estate

Notice and Consent Form

Requirements

The following requirements must be satisfied **before** the policy is issued or **before** there is a material increase or other material change to a grand-fathered policy:

1. Employee is notified in writing that the employer intends to insure the employee's life

2. Employee is notified in writing of the maximum face amount for which the employee will be insured at the time the policy is issued

3. Employee provides written consent to being insured under the policy and that such coverage may continue after the insured terminates employment

4. Employee is informed in writing that the employer will be a beneficiary of any insurance proceeds payable on the death of the employee

Agent Responsibilities

What should the agent do?

The employee and employer must sign a "Notice and Consent" form. If received, **AND** certain specified exemptions are met, the death benefit of a life insurance policy, owned and payable to an employer on the life of an employee, will generally remain income-tax-free. *If these rules are not satisfied, the death benefit will generally be taxable.*

Knowledge Check 1

While visiting a commercial account during an annual review of their business insurance, your client asks if it is possible for the business to have a life insurance policy written on their sales director.

What relevant concerns would you address with your client regarding the business having life insurance on an employee?

Key Person Life Insurance

Learning Objective 2:
Participants will use knowledge of the features of a key person life insurance policy to evaluate the product in relation to client needs.

Definition of a Key Person: One whose death or disability prior to retirement will have an adverse economic effect on the business, evidenced by a loss of profits or credit standing and the extra expense of hiring a capable replacement.

Characteristics of a Key Person: In most businesses, this is the OWNER!

- Size of salary
- Decision making powers
- Ability to get things done
- Source of capital to the business
- Possesses unique talent

Rationale for Purchasing Key Person Insurance

The key person is integral to the success of the organization. Replacing such a unique talent is costly and time consuming.

Employer Insurable Interest established: In the case of Emeloid Co., Inc. v. Commissioner of Internal Revenue, U.S. Court of Appeals, 3rd Circuit (1951), the judge stated: "What corporate purpose could be more essential than key man insurance? The business that insures its buildings, machinery, and automobiles from every possible hazard can hardly be expected to exercise less care in protecting itself against the loss of two of its most vital assets – ***managerial skill and experience***."

Benefits of Key Person Insurance While an Employee is Alive

- Bolsters credit of the business
- Accumulates cash value (available for borrowing)
- Makes a good investment for surplus funds
- Improves morale

Benefits of Key Person Life Insurance at the Death of the Employee

- Indemnifies employer for shrinking revenues and business value due to loss of key person's services and abilities
- Provides funds to attract and pay for capable succession
- Provides cash value (if it is a permanent type policy) that can be used to fund **deferred compensation**
  - Deferred compensation allows selected individuals to defer the receipt of income in accordance with a written agreement with their employer
- Provides cash value or death benefits that can be used to hire a replacement

Methods for Determining Key Person Life Insurance Amount

The following may be used alone or in combination:

- **Earnings approach** – Determine what portion of net business profits is attributable to each key person, then multiply this figure by the number of years needed to find and train a replacement

- **Replacement cost approach** – Key person's *excess salary* (calculated as the difference between the key person's salary and the salary that would be paid to someone performing the routine duties of the key person) multiplied by the number of years needed to find and train a replacement

- **Present value method** – Determine present value of each key person (retirement age minus current age multiplied by profit per year) and then discount by a reasonable rate of interest

- **Seat-of-the-pants approach** – Nothing scientific here – the owner simply picks a figure, such as, "You are worth $250,000"

Steps in Implementing a Key Person Insurance Plan

1. Written agreement or board resolution

2. Business applies for insurance on key person

3. Business pays the premium (not deductible)

4. Business owns the policy

5. Business is the beneficiary (death benefit is not subject to income tax)

6. Business retains all ownership rights

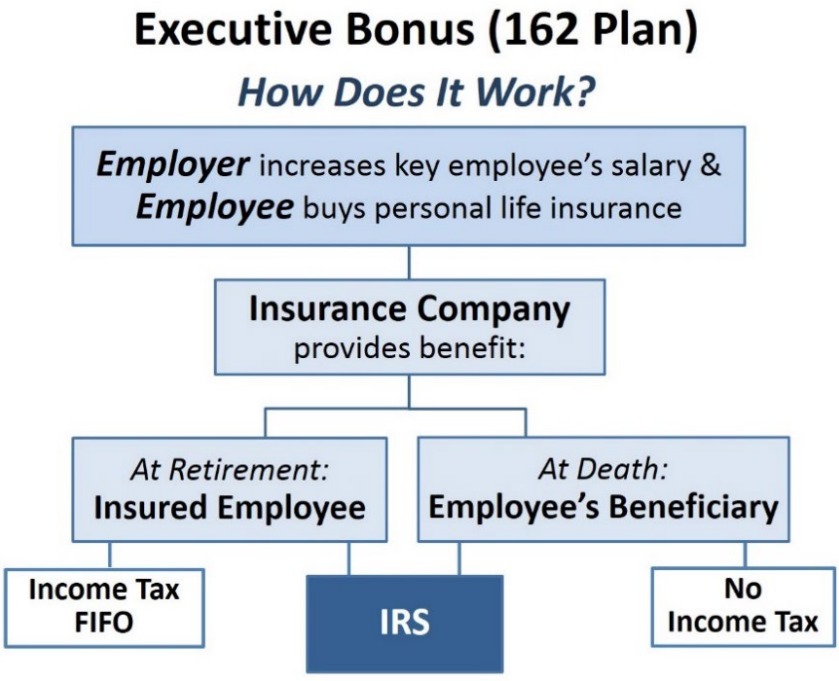
Non-Qualified Bonus Plan – Executive Bonus (162 Plan)

Learning Objective 3:
Participants will explain using an Executive Bonus (162 plan) as a means for an employer to provide an employee benefit.

Definition of Executive Bonus: A non-qualified plan under which the key executive owns a permanent life insurance policy on his or her life. The employer pays the life insurance premium either directly or indirectly to the insurance company by means of a bonus paid to the executive.

The additional income used to pay the premium is deductible by the employer and reported by the executive as compensation. (The IRS may apply a "reasonable compensation for services rendered" test to the total bonus paid to the executive.)

Often, the employer will "gross up" the income to cover the extra taxes associated with the increased income. This is referred to as a "double bonus."



Disadvantage to the Employer: Should the employee leave the employment of the company, the paid premiums (actually classified as paid compensation) cannot be recovered by the employer from the employee, nor from the life insurance policy. See "restrictive bonus plan" on the next page.

Features & Advantages to the Employer

- Employer has a key executive (can be himself or herself)
- Should the executive be a non-owner, the issue of "golden handcuffs" may be a key concern
- Employer wants a simple, easy to understand plan
- Employer would like to discriminate (offer the plan to whom they wish)
- Employer likes the idea that it is tax deductible
- Simple to understand and implement – no IRS approval needed
- Discrimination allowed – no minimum nor maximum covered lives
- Employer determines the amount of contribution
- Plan gives the employer some measure of control and helps provide an incentive for long-term employment
- A "restrictive bonus plan" can be implemented to place a degree of control on the employee's access to loans, cash values, etc.
- Minimal paperwork required

Advantages to the Executive/Employee

- Simple to understand and implement

- Flexibility of life insurance plans (Whole Life, Universal Life, Variable Life)

- Employee is the owner of the contract and has full control, including naming and amending of the beneficiary

- Should the plan be arranged as a "restrictive bonus plan," there will be certain restrictions placed on the owner/employee, such as the right to make loans, or assignments and access to cash values

- A very inexpensive way to buy or own life insurance as the employer is paying for it; should a double bonus arrangement be used, there is no cost to the employee

- The death benefit is received income-tax-free by the beneficiary

- Future cash values are received FIFO (first in first out) for income tax purposes

- Policy cash values can be a source of retirement income for the executive

Hypothetical Life Insurance Contract for Use in an Executive Bonus (162 Plan)

Key Executive: Doug Brady, Vice President of Sales
Age at Issue: 40
Employer: ABC, Inc.

Base Policy Face Amount = $507,912 (amount stated in the policy that is payable at the death of the named insured or at policy maturity)
Annual Premium = $10,000.

Participating Whole Life Insurance – Life Paid up at 65
Dividends Used to Purchase Paid-Up Additions

Age	Total Employer Bonus (Premium)	Annual Dividend End of Year	Death Benefit Payable to Beneficiary	Total Cash Value End of Year (Non-Guaranteed)
40	$10,000.00/yr	$498	$509,831	$498
45	$10,000.00/yr	$581	$517,591	$32,633
50	$10,000.00/yr	$2,318	$542,007	$93,800
55	$10,000.00/yr	$5,410	$594,457	$173,764
60	$10,000.00/yr	$10,208	$685,822	$287,371
65	Paid Up @ 65	$15,011	$810,585	$442,101

Illustration shown is from a major US life insurance company and is for an LP65 which is a whole life contract that is "paid-up" at age 65. **No additional premium due.**

Dividends are not guaranteed and are subject to significant fluctuations over the lifetime of a policy. Non-guaranteed cash value numbers assume use of a 2012 dividend scale to purchase Paid-Up Additions (PUAs).

Note that beyond age 65, dividends continue to grow each year at a rate of approximately $1,000 per year creating more cash value and death benefit through PUAs (e.g., at age 70, annual dividend is $18,928). At any point, the insured/owner can choose to leave dividends, buying PUAs, or begin to take the dividends in cash, perhaps as a retirement supplement. **And the insured/owner still has a sizeable life insurance policy, paid-up.**

Knowledge Check 2

Explain using an Executive Bonus (162 plan) as a means of an employer providing an employee benefit.

You have a commercial client who owns a C-corporation and is thinking about purchasing additional personal life insurance. Your client has asked if it is possible for them to deduct personal life insurance premiums as a company business expense.

What counsel would you provide?

Learning Objective 4:
Participants will use knowledge of the various issues created by the death of a partner or shareholder to help develop a process of business succession.

Issues Created by the Death of a Business Owner

Sole Proprietor

1. Loss of value or goodwill

   - Liquidating or selling the business – At the death of a sole proprietor, the value of goodwill will likely be lost. Because a successful business consists of more than its physical assets, this loss diminishes the value of the business.

   - A major asset of any business is the favorable reputation the business has built up over the years – the willingness of customers to continue doing business with the firm. The death of the proprietor could jeopardize that goodwill.

   - Another reason the real value may not be fully realized has to do with the price a buyer would be willing to pay for the physical assets. Prices at liquidation sales are often much lower. The buyers know the executor must sell the assets quickly and is usually not in a position to demand the full market value that the asset might command in an ongoing business situation.

2. Executor operates the business temporarily
   (Be aware: executor may be held liable for any losses)

3. Business interest could be transferred to others by a will

4. Business interest could be sold to employees as an on-going business (*but at what price?*)

5. Creditors will be concerned

General Partner

1. **Dissolution or continuation**

   - In the absence of a continuation of agreement, the death of a general partner, by operation of state law, usually dissolves the partnership of which the deceased was a member

   - If a continuation agreement is in effect, the partnership can be reorganized; survivors could accept decedent's heirs into the business

     – Other options would be for the decedent's heirs to sell their interest to an outsider; for survivors to accept the outsider into business; or for survivors to buy out the heir's interest

2. **Dissolution and winding up**

   Because the partnership creates an agreement in which the partners are bound together, share profits, and have a voice in management, the death of a partner dissolves the partnership. This does not necessarily mean the termination of the business. The partnership must continue until the winding up of the partnership affairs is completed.

3. **Changes roles and responsibility of surviving partners**

   Surviving partners become the **liquidating trustees** and must, without delay, perform such functions as completing partnership transactions entered into before the partner's death, collecting accounts receivable, paying partnership debts, converting the remaining assets to cash, and paying the deceased's share of the partnership funds to the heirs.

Limited Partner

- Death does not dissolve partnership

- Termination follows the same steps as that in a general partnership

Shareholder

1. Death of a majority shareholder – When a majority shareholder dies, the surviving shareholders and the heirs of the deceased shareholder are faced with several possibilities:

   - The surviving shareholders could continue the business with the heirs; in a corporation, unlike a partnership, the owners may be forced to accept persons they do not want as co-owners

   - The surviving shareholders could buy out the heirs or vice versa; the purchasing party must have the cash with which to make the purchase.

   - The heirs or the surviving shareholders could sell their stock to outsiders. Often, however, there is no market among outsiders for close corporation stock, especially when it is a minority interest.

2. Death of a minority shareholder – The deceased minority shareholder's immediate family will often find that their income from the corporation has stopped if that income was in the form of the deceased officer's salary. The heirs' minority interest will not be enough to guarantee that another family member will become an officer or employee of the corporation, nor is the minority interest large enough to force dividend payments.

   From the surviving shareholders' point of view, there may be no reason to pay dividends or to give a job in the corporation to someone who is not familiar with the business.

   Because of the minority shareholder's right to inspect the books and vote the shares, the family could still cause inconvenience for the surviving shareholders. If the heirs sell their shares to an outsider, especially a competitor, the outsider might harass the controlling shareholders from within the corporation.

   The most practical solution is, of course, for the heirs to sell their interest to surviving shareholders, provided the survivors have the cash to make the purchase.

LLC Member

- Operating agreement determines whether the LLC is continued or dissolved

- Operating agreement typically determines the ability of a member to transfer their membership

- If the agreement doesn't address the death of a member, the consequences may be governed by the remaining members' decisions and state laws – most state laws will default to dissolution of the LLC

Knowledge Check 3

Ralph owns a very successful fast food franchise and has recently taken on a partner in the business. Ralph is 55 and a widower with two grown sons. His new partner who bought into the business is Jason, age 35, married with three young children. Jason's wife is an attorney currently serving as counsel for a group of local physicians.

Use knowledge of the various issues created by the death or disability of a partner/shareholder to help develop a process of business succession. Consider the issues you would discuss with Ralph and Jason.

What is your counsel?

Buy-Sell Agreement

Learning Objective 5

Participants will use knowledge of buy-sell agreements, their funding methods, and the structures of life insurance policy ownership to provide advice as a member of the client's succession planning team.

Definition: a legally binding agreement used to reallocate a share of a business should an owner die or leave the business

Role of the Insurance Agent in a Buy-Sell Agreement

- Understand the basics of the Buy-Sell Agreement
- Know how life insurance fits in
- Encourage collaboration of client with competent legal and accounting advisors
- Collaborate with the succession planning team

Valid Buy-Sell Agreement should consider an appropriate course of action for the following risk contingencies:

- Death
- Disability
- Retirement
- Termination of employment
- Valuation method
- First right of refusal to purchase business
- Possible terms of finance

Succession Planning Video

Valuation of a Business

- **IRS guidelines:** While it is possible to follow IRS guidelines in making the valuation, it is impossible to say for certain that the IRS will be in 100% agreement when the estate is settled. That is why the valuation itself should be left to the specialists in the field (IRS Revenue Ruling 59-60).

- Eight factors for valuation of the business

    1. History and nature
    2. National economy and specific industry
    3. Financial condition
    4. Earning capacity
    5. Dividend paying capacity
    6. Goodwill
    7. Previous sale of stock
    8. Fair market value of publicly traded stock in a comparable business

Sample Buy-Sell Agreement

Funding the Buy-Sell Agreement

Personal Funds: Most successful business owners do not have large sums of liquid assets. They normally have their money "working" in the business.

Sinking Fund: A method of depositing funds on a regular basis so as to accumulate the amount necessary to fund the buy-sell.

- Such a fund will be inadequate if death is premature; also, the time of need is uncertain, and any such investments would be subject to tax on the growth and also subject to the claims of creditors

- This may be the only option for an uninsurable situation

Borrowed Funds

- Loss of a key person may impair credit and interest cost may be excessive

Installment Payments to Heirs

- Business may fail, which is a risk for the note holder

- Principal and interest are burdensome and a risk to the business

Life Insurance

1. Complete financing is guaranteed from the beginning

2. Proceeds are income-tax-free

3. Cash values can be used for buyout due to retirement or disability

4. Most economical method, because it uses discounted dollars; also, the cost is a known quantity and can be budgeted each month/year

5. Credit is strengthened

6. Everyone benefits from an INSURED buy-sell

   - Before the death of an owner

     – Peace of mind and family security

     – Business can use cash values for an emergency, to expand or for any other business need

     – Creditors, suppliers, customers, and employees are assured that death of business owner will not disrupt day-to-day business operations

   - After owner's death

     – All surviving business principals are given the opportunity and CASH to purchase deceased principal's interest at a fair price

     – Deceased owner's heirs are virtually guaranteed to have a “market” for their newly inherited business interest

     – Deceased owner's estate is now liquid; this is most useful if there is an estate tax problem

Options to Structure Ownership of Life Insurance in a Buy-Sell Agreement

Sole Proprietor: Agreement entered with a key employee or friendly competitor. If no such person exists, a policy should be sold to the proprietor for the value of the business. Heirs may be able to use funds to hire someone to run the business.

Partnership

- **Cross purchase plan:** Each partner purchases (owns, pays and is beneficiary of) a life policy on the other partner(s)

- **Entity purchase plan:** Partnership (the entity) purchases (owns, pays and is beneficiary of) a separate life policy on each partner

Corporation

- **Cross purchase plan**: Each stockholder purchases life insurance on the other stockholders

- **Stock redemption plan**: The corporation purchases life insurance on all stockholders

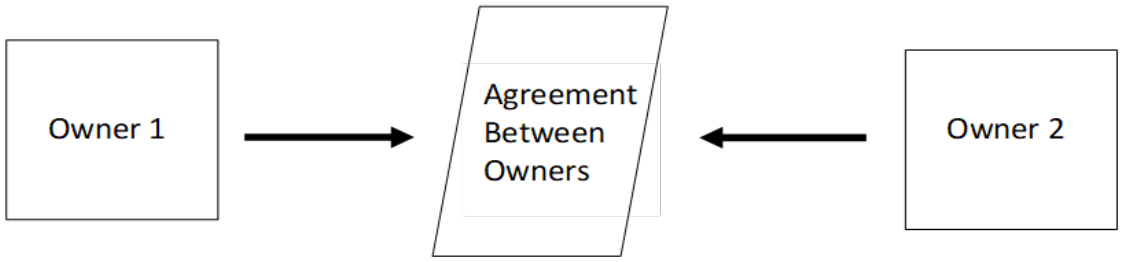
LLC – Cross Purchase Plan (life insurance policies on all members)

Cross Purchase – Partnership

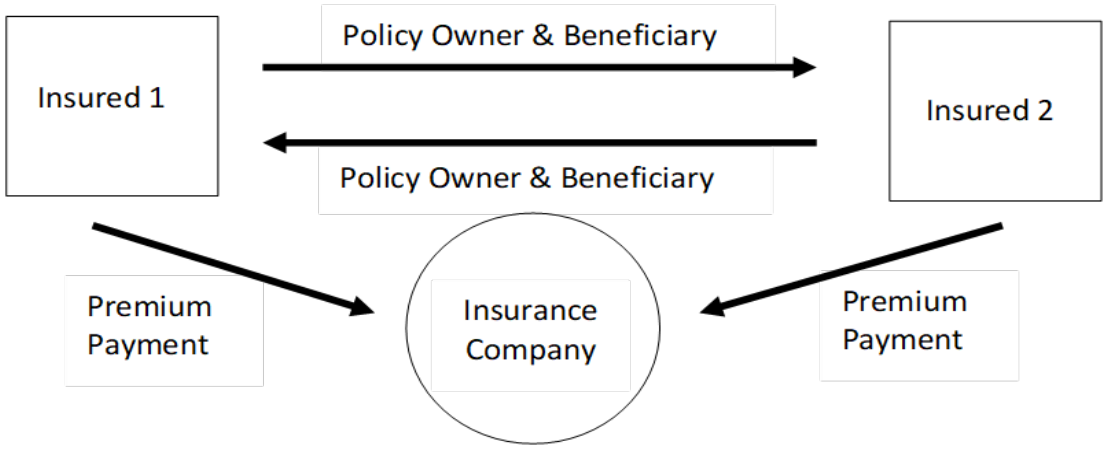
Stock Purchase – Corporation

(Same process for both entities)

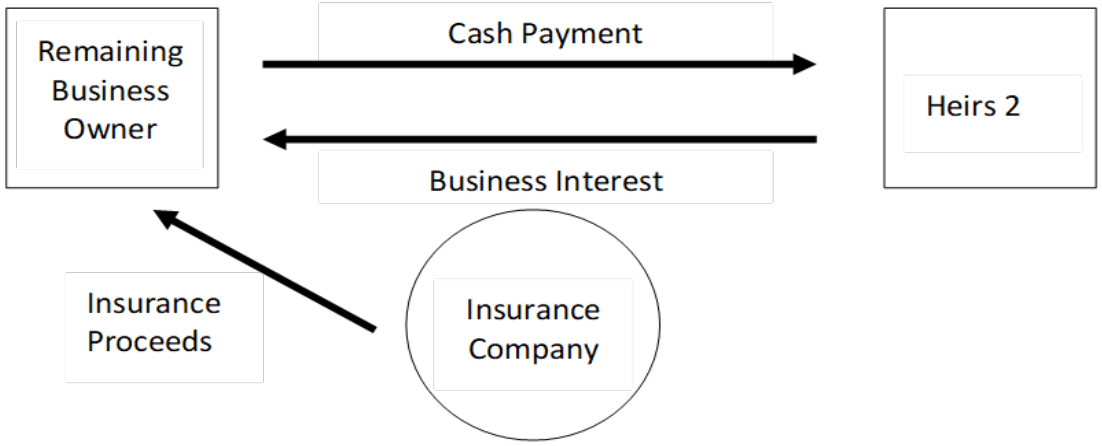
Agreement Structure



Insurance Structure

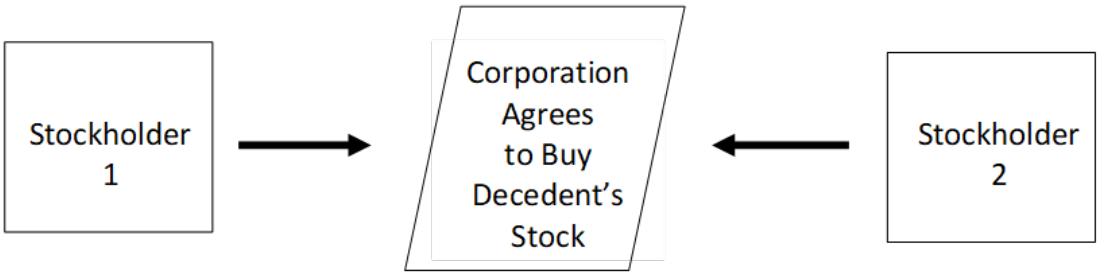


Execution or Outcome

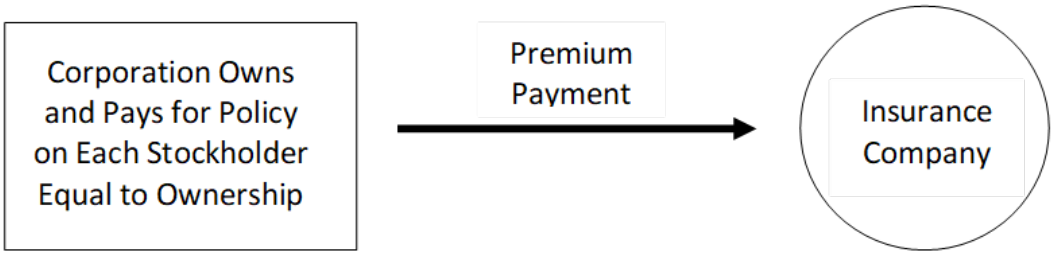


Entity Purchase – Partnership
Stock Redemption – Corporation
(Same process for both entities)

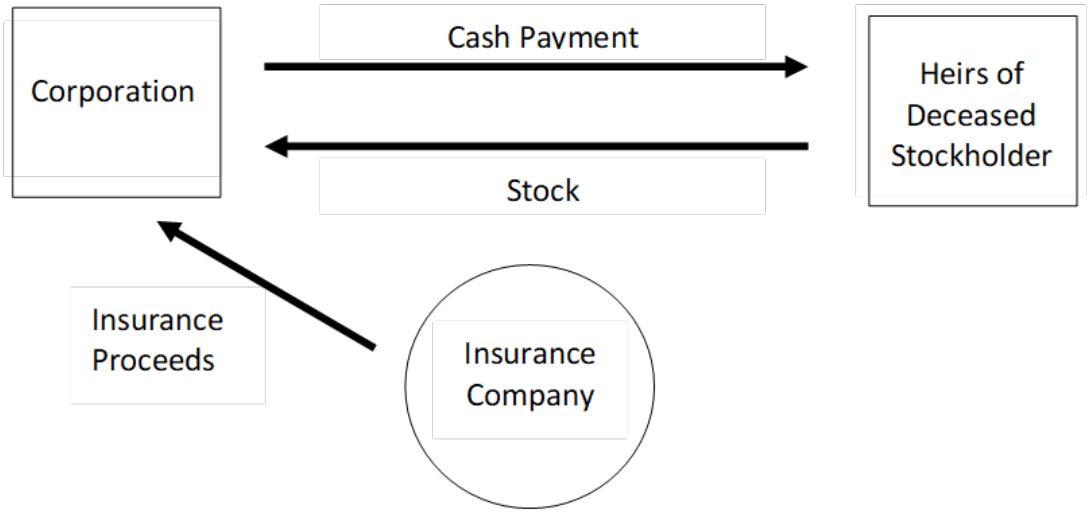
Agreement Structure



Insurance Structure



Execution or Outcome



Knowledge Check 4

Use your knowledge of buy-sell agreements, their funding methods, and the structure of life insurance/disability policy ownership to provide advice and council, as a member of the client' s succession planning team.

Your client has informed you that five years ago her company had a buy-sell agreement drafted and the consensus was they did not need to purchase life insurance because their banker would loan them the money to fund the agreement.

Their banker just left the bank under suspicion of embezzlement and the shareholders are now concerned that they will not be able to get a loan.

How would you advise the client on available funding options and the advantages of each?

Review of Learning Objectives

1. Participants will use knowledge of the steps an agent should take when placing Employer-Owned Life Insurance (EOLI) on an employee to advise a client.

2. Participants will use knowledge of the features of a key person life insurance policy to evaluate the product in relation to client needs.

3. Participants will explain using an Executive Bonus (162 plan) as a means for an employer to provide an employee benefit.

4. Participants will use knowledge of the various issues created by the death of a partner or shareholder to help develop a process of business succession.

5. Participants will use knowledge of buy-sell agreements, their funding methods, and the structures of life insurance policy ownership to provide advice as a member of the client's succession planning team.

Knowledge Check 1 – ANSWERS

While visiting a commercial account during an annual review of their business insurance, your client asks if it is possible for the business to have a life insurance policy written on their sales director.

What relevant concerns would you address with your client regarding the business having life insurance on an employee?

Answer:

Establish that the sales director is in fact a major contributor to the success of the company. If so, discuss what impact his untimely death would have on the business and possibly continue the discussion by offering one of the four methods of establishing a key person value. Describe to the owner the issues involved with EOLI and suggest a course of action with an application for life insurance to determine if employee is insurable.

Knowledge Check 2 – ANSWERS

Explain using an Executive Bonus (162 plan) as a means of an employer providing an employee benefit.

Answer:

Employer paid life insurance, tax free benefits to the heirs in event of untimely death and cash value accumulation for the insured employee. "Golden handcuffs"

You have a commercial client who owns a C corporation and is thinking about purchasing additional personal life insurance. Your client has asked if it is possible for them to deduct personal life insurance premiums as a company business expense.

What counsel would you provide?

Answer:

First, remind him that <u>usually</u> life insurance premiums are not tax deductible. However, as a C corporation the company can increase compensation/bonus in an amount equal to the desired premium paid for a policy and therefore deduct that amount as W2 compensation or bonus.

Knowledge Check 3 – ANSWERS

Ralph owns a very successful fast food franchise and has recently taken on a partner in the business. Ralph is 55, a widower with two grown sons. His new partner who bought into the business is Jason, age 35, married with three young children. Jason's wife is an attorney currently serving as counsel for a group of local physicians.

Use knowledge of the various issues created by the death or disability of a partner/shareholder to help develop a process of business succession. Consider the issues you would discuss with Ralph and Jason.

What is your counsel?

Answer:

Buy sell agreement needs to be drafted between Ralph and Jason. Ralph does not want Jason's wife as a new partner in event of his death, and Jason likewise does not want Ralph's two sons in the business as heirs to Ralph's estate. Business value and appropriate amount necessary to buy out is first order of business. Then suggest life insurance as best method to create necessary cash. The issue of the difference in age between Ralph and Jason regarding Life policies and premium payment needs to be addressed as well.

Knowledge Check 4 – ANSWERS

Use your knowledge of buy-sell agreements, their funding methods, and the structure of life insurance/disability policy ownership to provide advice and council, as a member of the client' s succession planning team.

Your client has informed you that five years ago her company had a buy-sell agreement drafted and the consensus was they did not need to purchase life insurance because their banker would loan them the money to fund the agreement.

Their banker just left the bank under suspicion of embezzlement and the shareholders are now concerned that they will not be able to get a loan.

How would you advise the client on available funding options and the advantages of each?

Answer:

Since borrowing is out, list for him other options such as sinking fund or payments to heirs and describe problems with each. Describe to him that life insurance is the only method that creates immediate cash to solve the problem.

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Section 3

HEALTH INSURANCE AND EMPLOYEE BENEFITS CONCEPTS

THE NATIONAL ALLIANCE
for Insurance Education & Research

Resources

Glossary of Terms

2018 IRS Publication 502

LTCI Chart

Health Insurance and Employee Benefits Concepts

Section Goal

The Health Insurance and Employee Benefits Concepts section provides participants with the core knowledge and tools necessary to deliver transformative information and counsel regarding health insurance concepts and products to their practice.

Learning Objectives

1. Participants will use knowledge of health and medical contracts to evaluate their appropriateness for various client needs.

2. Participants will use knowledge of the benefits afforded by the Affordable Care Act (ACA) and ACA-compliant and noncompliant medical health plans to advise clients of the advantages ACA can provide in meeting their needs.

3. Participants will apply knowledge of tax-advantaged accounts and tax implications to meet a variety of prospect and client needs.

4. Participants will apply knowledge of federal laws to provide appropriate counsel to clients and prospects.

5. Participants will apply knowledge of Medicare, Medicare supplements, and Medicaid to correctly select which is the most appropriate product to meet the needs of a client.

6. Participants will use knowledge of the reasons for long-term care insurance to evaluate client needs and provide appropriate counsel in contract selection.

7. Participants will use knowledge of policy provisions, benefit triggers, qualified and non-qualified contracts, state-endorsed programs and medical underwriting issues to determine the possibilities for payout in given scenarios.

8. Participants will use knowledge of other products available to insure long-term care needs to determine the best products to meet a particular client's needs.

9. Participants will use knowledge of disability definitions, the statistical risk of becoming disabled and potential sources of income after disability to evaluate client needs and provide appropriate counsel.

10. Participants will use knowledge of types of disability policy provisions, optional riders and underwriting considerations to determine the appropriate product to meet client needs in a variety of situations.

11. Participants will use knowledge of Business Overhead Expense disability income policies and their tax considerations to advise clients about contract options for reimbursement of qualifying expenses if an owner becomes disabled.

Essentials of Health and Medical Contracts

Learning Objective 1:
Participants will use knowledge of health and medical contracts to evaluate their appropriateness for various client needs.

Coverages and Policy Provisions

Types of Coverage

The term "health insurance" is a broadly defined term that includes coverages for major medical or comprehensive coverage, disability, accident, and illness. It also encompasses dental, vision and other types of coverages. Health insurance can provide individual or family coverage written either on an individual or group insurance basis. Specific policy language will vary from state to state due to mandates imposed by both state and federal laws.

The following are broad categories of health insurance:

Health or Comprehensive Major Medical (designed for catastrophic coverage)	Dental Insurance	Supplemental Health (critical illness, cancer, etc.)
Vision Care	Travel Accident or Occupational Accident	Medicare Supplements/ Medicare Advantage
Drug/Pharmacy Plans	Short-Term Medical	Employee Assistance Programs (EAPs)
Wellness Programs	Disability Insurance*	Long-Term Care Insurance*

*Note:
Disability Insurance and Long-Term Care Insurance (LTCI) will be covered in depth later in this section.

Policy Provisions

1. **Deductible:** The portion of insured or covered expenses to be borne by the insured before the insurance plan begins to pay, which is designed as a "financial incentive" for the insured to assume the cost of small claims in exchange for a lesser premium

Deductibles

Expressed as dollar amounts, in health insurance they can be applied in a number of ways:

Per Occurrence:

Similar to deductibles found on property or auto policies, these deductibles apply to each covered incident or occurrence. They are different from copays in that they are applied to the whole incident (heart attack or flu) as opposed to a specific coverage (office visit). In health insurance they are not encountered very often. They tend to be found in travel/visitor medical, short-term medical or limited benefit plans. Generally, there is also a time limitation (policy period) to the incident accumulation period.

Calendar Year:

As the name infers, the insured has the entire year (1/1 – 12/31) to accumulate covered medical expenses before the insurance company starts paying. This is the most common deductible found in medical plans. The deductible does not include copays, coinsurance, or noncovered medical expenses. The advantage over a *per occurrence* is that all of the covered medical expenses incurred during the year apply to the calendar-year deductible.

Plan Year:

Virtually the same as the *calendar year* deductible, but for a different 12-month time frame; the most common usage is in plans incorporating a Health Reimbursement Account (HRA), also called a Section 105 plan.

Deductibles (continued)

Expressed as dollar amounts, in health insurance they can be applied in a number of ways:

Aggregate Deductible:

The dollar amount of covered medical expenses the family must pay before the health insurance plan will begin sharing in the cost of covered medical expenses (with exception of preventive medical services). An aggregate deductible provision is most commonly found in family coverage under a high deductible health plan (HDHP). The amount of out-of-pocket costs the family pays for covered medical services is credited toward the family's aggregate deductible. The aggregate deductible is satisfied after the combined total of these expenses during the plan year reaches the dollar amount of the aggregate deductible. The health plan then begins to pay for the covered medical expenses of the family either in full or in combination with a coinsurance provision. One member of the family can satisfy the aggregate deductible if his or her out-of-pocket expenses are large enough to meet the aggregate deductible. Under new ACA rules that begin in 2016, a health plan can't require any individual covered by a family plan to pay a deductible that is higher than the ACA out-of-pocket maximum (OOPM) for individual coverage ($8,550 for 2021) – see below.

Embedded Deductible:

Combines two deductibles in family coverage: an individual deductible and family deductible. The individual deductible applies to each family member. The family deductible applies to all family members. The family deductible is usually twice the size of the individual deductible (e.g., $2,000 individual deductible embedded into a $4,000 family deductible). Any covered health care expenses incurred by an individual family member is credited toward both the individual deductible and the family deductible. Once each family member meets the individual deductible, he or she will usually only be required to pay a copayment or coinsurance for covered medical services in excess of the individual deductible, regardless of whether the family deductible is met. The after-deductible payments for this individual will not be applied toward the family deductible. The family deductible will only be met once more than one family member has paid enough towards the individual deductible that the family deductible has been met. An embedded deductible is not required for family coverage but may help ensure that there is coverage for individual family members once they meet their individual deductible, regardless of whether the family deductible has been met.

2. **Accumulation period:** Time frame in which incurred charges can be applied against the deductible and is most frequently stated on a calendar year (or plan year) basis

3. **Deductible credit provision**: Benefit provides whatever portion of the insured's deductible had been met on their old policy to be given as a credit against the new policy's deductible. This provision allows companies and insureds to change insurance plans or carriers midyear without having the covered individuals (the employees) meet the deductible again. The new insurance carrier gives credit for the amount (dollars, not %) of the deductible met with the prior carrier. This is also referred to as "no loss/no gain."

4. **Deductible carryover**: Provision found in some group health insurance plans. Allows any covered medical expenses paid by the plan participants toward the deductible in the fourth quarter of the current plan year (usually October – December 20XX) to be credited for the deductible in the current year and the next year. For example, if a plan participant satisfied $750 of the $2,000 annual deductible in the fourth quarter, the $750 would carry over to the following calendar year deductible. The plan participant would start the new plan year needing only to satisfy the remaining $1,250 annual deductible.

5. **Copay:** Charges incurred by the insured each time a specified service is utilized. Most commonly used for physician office visits, prescriptions and emergency room care.

6. **Coinsurance**: The percentage of covered medical expenses (e.g., 20%) the insured pays after the deductible has been paid. Coinsurance is purchased at levels to be applied to every claim during the applicable phase after the deductible has been paid. The term itself refers to the policy's cost sharing portion of coverage. Both the insurance company and the insured pay (coinsure) their respective percentages of the incurred cost in this segment of the policy.

    - Most commonly seen as percentages of *100/0, 90/10, 80/20, 70/30, and 50/50*; however, it is possible to have any split.

    - Coinsurance percentages are generally different when applied to in-network vs. out-of-network charges. References where the two numbers don't add up to 100 are referring to in-network vs. out-of-network levels. (*example*: a *100/70* plan means that in-network coinsurance is 100% (with no participation by the insured) and has a *70/30* split on out-of-network charges)

      In property & casualty insurance, coinsurance is a penalty applied to a claim and generally unintended on the part of the insured. This is not so in health insurance.

7. **Out-of-Pocket Maximums (OOPMs):** The Affordable Care Act (ACA) imposes annual OOPMs on the amounts that participants can be required to pay for covered Essential Health Benefits (EHBs) through cost sharing in non-grandfathered health plans. The OOPM includes the annual deductible, copayments, and coinsurance. It does not include premiums or out-of-network cost sharing. The U.S. Department of Health and Human Services (HHS) establishes the annual OOPMs. The 2021 OOPM limits are $8,550 for self-only coverage and $17,100 for family coverage (2x self-only and applies to other than self-only coverage). Beginning in 2016, for family coverage only, an embedded OOPM is required and applies to each individual enrolled in family coverage if the plan's family OOPM exceeds the ACA's OOPM for self-only coverage ($8,550 for 2021). An embedded OOPM is an individual OOPM inside a family OOPM – the plan's individual OOPM applies to each covered individual, whether the individual has self-only coverage or family coverage.

   For example, if a plan has an OOPM of $4,000 for self-only and $8,000 for a family, an individual who is part of a family plan won't pay more than $4,000 (the OOPM for self-only under the plan) during the year. Other members of the family plan would be subject to the same $4,000 OOPM until combined cost sharing expenses for the entire family reach the $8,000 family OOPM. **The Internal Revenue Service (IRS) annually issues separate OOPMs specific to HDHPs that can be linked to Health Savings Accounts (HSAs). The OOPMs for HDHPs will be covered later in this section.**

PRACTICE EXERCISE

- $22,500 total hospital and physician bill
- Consider any items "not covered"
- Deductible – $1,000
- Coinsurance amount – 80/20
- Out-of-pocket maximum (stop-loss) – $2,000
  *(For this exercise, we will assume the deductible is **not** included in the OOPM)*

Total payable by the insurance company $_____

Description		Insured's Responsibility	Insurer's Responsibility
Total hospital and surgical bill	$22,500		
Total **not covered**	1,500	(1,500)	
Amount covered by MM policy	21,000		
Deductible	1,000	(1,000)	
Amount subject to MM policy	20,000		
Amount paid by MM policy subject to *Coinsurance* before applying *stop-loss*	16,000		(16,000)
Amount paid by insured before applying *stop-loss*	4,000	(4,000)	
Stop-loss credited to insured	2,000	2,000	
Stop-loss debited from insurance company	2,000		(2,000)
Total bill	22,500		
Total paid by insured		4,500	
Total paid by insurance company			18,000

8. **Cost Containment Provision**: A policy provision that requires the insured to receive permission from a company-approved medical review service before proceeding with most nonemergency medical services or hospital confinements. It can also include post-service medical review. Incentives may be provided for utilization. A premium reduction incentive of 5% to 15% over standard plans is common. Penalties, such as a reduction in benefits by 25% to 50%, are imposed if permission is not received before proceeding. The following are examples of typical cost containment requirements:

   - Pre-admission certification
   - Securing second surgical opinions
   - Notification within 24 hours of an emergency admission
   - Discharge from the hospital by a pre-set schedule date
   - Preapprovals for hospital stay extensions
   - Concurrent review
   - Retrospective review
   - Outpatient (ambulatory) surgery units

9. **Preexisting conditions:** Effective January 1, 2014, the ACA prohibits insurers from imposing ANY preexisting condition exclusions in health insurance contracts. The ACA has no impact (underwriting, policy language, etc.) on health insurance contracts that are not ACA-compliant (long-term care insurance, dental, vision, and disability plans – group and individual).

   Additionally, health insurance carriers that participate in ACA health insurance plans may not use any insured person's medical history in the rate calculation for any individual or group health insurance contract. Only certain criteria may be used in rate calculation for ACA plans. These are age, family composition, tobacco usage, and the location where the applicant resides.

   Note:
   ACA-compliant health insurance plans can no longer use gender in rate calculations.

   Be aware that variations to the rules shown above do exist for partially self-funded group plans regarding the stop-loss insurance that can be purchased by the group administrator (employer).

10. **General exclusions:** Normally found in medical policies (including group policies)

□ *Occupational disease and injury	□ Eyeglasses and vision care
□ Suicide or intentional self-inflicted injury	□ Cosmetic surgery (*exception* – caused by an accident)
□ War	□ U. S. government hospitals
□ Service while in the armed forces	
□ Dental, unless an accident	

**Agents (both p/c and health) need to be aware there is a possibility of E&O action if a person – usually a self-employed individual – rejects workers compensation, has an on-the-job injury, and then learns his/her health insurance excludes Occupational Disease and Injury. This exclusion varies from state to state and carrier to carrier.*

Group Coverage vs. Individual Coverage

Depending on the environment in which these two delivery systems operate, their tax treatment or applicability of state mandates may vary, while federal mandates will apply nationwide. As discussed in upcoming pages, the ACA substantially changed numerous provisions of health insurance relating to coverage, underwriting, rate making, and cancellation, just to name a few. Insurance carriers can issue group and/or individual plans of insurance. The ACA does not mandate where a carrier must write health insurance. Some do not participate in some states. Some only issue contracts in certain counties within certain states.

Group definition: A plan of insurance where the unit is the group, NOT an individual

- The employer receives the master contract (association, union, co-op, etc.)
- Each participant (employee, association member, union member, etc.) receives, or has online access to, a certificate that describes the coverage, deducible, out-of-pocket maximum, etc.; the certificate will also describe any additional coverage, such as dental or vision

Note:
The ACA does not mandate that an employer, of any size, must provide health insurance. However, penalties may be levied on employers of 50 or more full-time employees whether they do or do not provide ACA-compliant health insurance. The rules and calculations are complex.

Underwriting Considerations

1. Under the ACA, any individual and/or fully insured group plan that is provided must be made available on a guaranteed issue basis, with no preexisting condition limitations, and the coverage cannot have any restrictions on annual or lifetime limits

2. All fully insured individual and small groups with up to 100 employees will be required to abide by strict modified community rating standards; experience rating will be prohibited

   Note:
   Experience rating may be used with "stop-loss" insurance in partially self-funded plans.

3. Insurance is incidental to group formation, meaning the group cannot be formed for the express purpose to purchase insurance; it must be a valid group, such as employer-employee, association, union, etc.

4. Those eligible to participate are defined, and there is a flow of lives through the group

5. Minimum participation may be required; example: 75% of eligible employees

6. Automatic benefit determination – everyone has access to at least some nondiscriminatory coverage. The ACA has four plan options: Platinum, Gold, Silver, and Bronze. Health Savings Accounts are also approved coverage plans; thus, some employees may have HSAs while others have Gold Plans.

7. Third-party cost sharing – employers are required to pay a minimum of 50% of the employee premium, for example, more favorable benefits and rates may be given to "non-contributory" or employer-pay-all contracts in group life and disability plans, but this is not the case in group health under the ACA

8. Efficient administration – most forms are now online and paperless; normally premiums are paid via EFT, with no paper billing sent to the plan administrator

9. Power to make contract changes belongs to the group administrator; an individual's decision is limited to whether to participate or not, coverage is automatic

Individual Coverage: contract is between the individual and the insurer

Individual health insurance is coverage that you purchase on your own.

It can be purchased both on and off the exchange.

Consumers can buy coverage during an Open Enrollment Period (OEP), although some states offer deadline extensions.

Outside of the OEP, you must have a special enrollment period to enroll.

Individual health plans were medically underwritten prior to 2014 and the level of coverage was traditionally less than what group plans offered.

The Affordable Care Act's reforms required individual plans to offer essential health benefits and made coverage guaranteed issue.

ACA's subsidies help millions of people pay lower premiums if they purchase through the Exchange.

Source: *What is Individual Health Insurance?*
www.healthinsurance.org/glossary/individual-health-insurance

Renewability Provisions

Medical contracts are guaranteed renewable, as ACA now dictates. The health insurance company cannot cancel the contract. However, the insurer can raise the premium as long as it does so in a nondiscriminatory manner. Rates and rate increases must be approved by each state's department of insurance. Generally, premiums for individual and group plans will be guaranteed for 12 months.

Taxation of Group Insurance

Are insurance premiums tax deductible by the employer?

Generally, **YES**

1. Insurance premiums are classified as ordinary business expenses if total compensation is reasonable.

2. Premiums for both individual and group health, disability, dental, and vision insurance are usually deductible if paid on behalf of employees. Premiums for group life insurance are also deductible if paid for employees. These deductions do not apply personally to owners of sole proprietorships or partnerships, and do not apply to owners of S-corporations. For these individuals, a portion of their individual and/or group health, dental and vision insurance premiums are deductible on their personal income tax returns, as long as the amount exceeds the percentage of income guidelines in the IRS rules. Individual life insurance premiums are generally not deductible for employers or employees.

Table I: Are Premiums Tax Deductible by the EmployER?

EmployEE Class	Life	Medical	DI	Other
Employ**EE**s	YES[1]	YES[5]	YES[5]	YES[5]
Owner/**EE** of a "C" Corporation	YES[1]	YES[5]	YES[5]	YES[5]
Owner/**EE** of an "S" Corporation	NO[2]	NO[6]	NO[6]	NO[6]
Owners of a Partnership	NO[3]	NO[7]	NO[7]	NO[7]
Owner of a Sole Proprietorship	NO[3]	NO[7]	NO[7]	NO[7]
Retired Employ**EE**s and Dependents	YES[1]	YES[5]	YES[5]	YES[5]
Dependents of Deceased Employ**EE**s	YES[1]	YES[5]	YES[5]	YES[5]
Non-Employ**EE**s (Contractors)	YES[4]	YES[4]	YES[4]	YES[4]

Are the premiums paid by the employer reported as income to the employee?

Generally, **NO**

Table II: Are Premiums Reported as Income to the EmployEE?

EmployEE Class	Life	Medical	DI	Other
Employ**EE**s	NO[8]	NO[13]	NO[13]	NO[13]
Owner/**EE** of a "C" Corporation	NO[8]	NO[13]	NO[13]	NO[13]
Owner/**EE** of an "S" Corporation	NO[9]	NO[14]	NO[14]	NO[14]
Owners of a Partnership	NO[10]	NO[15]	NO[15]	NO[15]
Owner of a Sole Proprietorship	NO[10]	NO[15]	NO[15]	NO[15]
Retired Employ**EE**s and Dependents	NO[8]	NO[16]	NO[16]	NO[16]
Dependents of Deceased Employ**EE**s	NO[11]	NO[13]	NO[13]	NO[13]
Non-Employ**EE**s (Contractors)	YES[12]	YES[12]	YES[12]	YES[12]

Are the benefits that are received by employees and beneficiaries taxable?

Generally, benefits are tax free to employees and/or their beneficiaries.

An exception exists for employer-paid disability insurance.

Table III: Are Benefits Taxable to the EmployEE or Beneficiaries?

EmployEE Class	Life	Medical	DI	Other
Employ**EE**s	NO[17]	NO[18]	YES[22]	NO[18]
Owner/**EE** of a "C" Corporation	NO[17]	NO[18]	YES[22]	NO[18]
Owner/**EE** of a "S" Corporation	NO[17]	NO[19]	NO[23]	NO[19]
Owners of a Partnership	NO[17]	NO[20]	NO[24]	NO[20]
Owner of a Sole Proprietorship	NO[17]	NO[20]	NO[24]	NO[20]
Retired Employ**EE**s and Dependents	NO[17]	NO[18]	YES[22]	NO[18]
Dependents of Deceased Employ**EE**s	NO[17]	NO[18]	YES[22]	NO[18]
Non-Employ**EE**s (Contractors)	NO[17]	NO[21]	NO[24]	NO[21]

Definitions relating to TABLES I, II, and III: Group heading for "Medical" includes those contracts paid by an employer for dental and vision care. Group headings for "Other" includes policies for, but not limited to, accidental death and dismemberment, and travel accident insurance. Pension laws are not considered.

Source: page 34 Employee Benefits Producer Training Program, Dynamics of Selling

Notice:
This information is a general statement of current law and should not be construed as tax advice.
Please consult a competent tax attorney/advisor regarding questions on taxation of group insurance.

1 Employer may deduct full and unlimited actual premium. (IRC 162 (a) (1) Rev. Rul. 56-400) No deduction is allowable if the employer is directly or indirectly a beneficiary.

2 Shareholder employees (2% or less stock-ownership) of an "S" corporation will be treated the same as #1. If more than 2% ownership, they will be treated as #3.

3 Not deductible. IRC 264 (a); Reg. 1.264-1.

4 To be deductible the expense of coverage provided must relate directly to a business relationship between the corporation and independent contractor. (IRC sect. 79)

5 Deductible as per Reg. 1.162-10 (a). This includes those forms known as Business Overhead Expense.

6 Shareholder employees (2% or less stock-ownership) of an S corporation will be treated the same as #5. If more than 2% ownership, they will be treated as #7.

7 Since this classification is not an "employee", they are under the personal health insurance tax rules. IRC 162 (2).

8 The actual employer paid premium cost of term life up to $50,000 is not reportable to the employee. The "cost" (not actual premium, but Uniform Government Table of Premium) in excess of $50,000 coverage is reportable to the employee for both withholding and FICA (IRC Section 79). Coverage can be provided through either a "group term contract" or an individual policy(s).

9 Shareholder-employees (2% or less stock-ownership) of an "S" corporation will be treated the same as #8 above. If more than 2% ownership, they will be treated as #10.

10 Not reportable. Not classified as an "employee".

11 Not reported as long as coverage does not exceed $2,000 per dependent/spouse of employee. Premiums on any amount that exceeds $2000 are reportable. "Cost" is from the Uniform Government Table of Premiums.

12 All employer paid premiums are reported as income to a non-employee.

13 IRC Sec. 106

14 Shareholder-employees (2% or less stock-owner) of an S Corporation will be treated the same as #13. More than 2% owner will be treated as #15.

15 Not classified as an "employee".

16 IRC 106. Rev. Rul. 62-199, 1962-2 CB 38.

17 Benefits must meet "life insurance" definition. IRC 7702.

18 Benefits received are excluded from gross income whether paid through health insurance policy or cash reimbursement paid by the employer. If reimbursement exceeds actual expenses, the excess must be included in gross income. (IRC 105 (b), Reg. 1.105-2)

19 Shareholder-employees (2% or less stock-ownership) of an "S" corporation will be treated the same as #18. If more than 2% ownership, they will be treated as #20.

20 Benefits are not taxable (unlimited) if premiums are personally paid. {IRC Sec. 104 (a) (3)}.

21 Benefits are not taxable (unlimited) since employer reported full premium to non-employee.

22 Wage continuation benefits, including sick pay plans, will be included in gross income and taxable to the employee. If the plan is a Business Overhead Expense contract, the benefits are taxable to the owner, which is usually the corporation.

23 Shareholder-employees (2% or less stock-ownership) of an "S" corporation will be treated the same as #22. More than 2% ownership will be treated as #24.

24 Benefits from personally owned disability income policies are received income tax free. {IRC Sec. 104 (a) (3}). Disability premiums will not be tax deductible since the insured was not an "employee".

IRS Tax Implications for:	
Group Health	Employer contributions are tax deductible, tax-free to employee
Group Dental	Employer contributions are tax deductible, tax-free to employee
Group Vision	Employer contributions are tax deductible, tax-free to employee
Group Rx	Employer contributions are tax deductible, tax-free to employee
Group Term Life	Employer contributions are tax deductible, tax-free to beneficiary up to $50,000
Group Disability	Employer contributions are tax deductible and benefits are taxable to employee
Voluntary Products	No employer contributions. Employee contributions are best as post-tax – let's discuss!
Wellness	Employer can provide incentives for the employee to participate

Knowledge Check 1

The prospect is concerned about the rising costs of health care and is considering not having any coverage.

What options would be available that could substantially reduce the monthly health care premium cost?

Affordable Care Act

Learning Objective 2:
Participants will use knowledge of the benefits afforded by the Affordable Care Act and ACA-compliant and noncompliant medical health plans to advise clients of the advantages ACA can provide in meeting their clients' needs.

The ACA (also known as PPACA or "Obamacare") is a comprehensive health care reform law enacted in March 2010 that sets minimum standards (Essential Health Benefits) for health insurance.

Two of the primary goals of the ACA were (1) to make affordable health insurance available to more people and (2) to expand Medicaid to all non-Medicare eligible adults with incomes below 138% of the Federal Poverty Level (FPL). The law provides premium credits and cost-sharing subsidies to eligible individuals and families with incomes between 100-400% FPL to purchase insurance through the Exchange. Both income and citizenship status verification are required. Employees who are offered coverage by an employer are not eligible for premium credits unless the employer plan does not have an actuarial value of at least 60% or if the employee share of the premium exceeds 9.83% of income (2021). The 2012 Supreme Court ruling on the constitutionality of the ACA upheld the Medicaid expansion, but limited the ability of HHS to enforce it, thereby making the decision to expand Medicaid optional for states. The ACA with its many provisions continues to be a "work in progress" as the government agencies involved (HHS, IRS, etc.) interpret the statute and provide "guidance and directives" as to its implementation.

Essential Health Benefits (EHBs)

The "10 Essential Health Benefits" of the ACA are services that all qualified health insurance plans must provide to comply with the ACA.

The 10 broad categories are:

1. Ambulatory patient services
2. Emergency care
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance abuse care
6. Rehabilitative services and devices
7. Laboratory services
8. Preventive and wellness services/chronic disease management
9. Prescription drugs
10. Pediatric services (children under age 19), including oral and vision care

Notable Health Care Reform Provisions

Unlimited limits on annual and lifetime maximum benefits

Elimination of preexisting conditions exclusion

Addition of a "Summary of Benefits and Coverage"

Dependent coverage for children up to age 26

Guaranteed issue and renewability; allows premiums variation based only on age (limited to 3 to 1 ratio), premium rating area, family composition, and tobacco use (limited to 1.5 to 1 ratio)

Minimum Medical Loss Ratios (MLRs – 85% group, 80% individual) and requires consumer rebate rules for insurance companies

Waiting periods for new employees cannot exceed 90 days

Health insurance marketplaces

Health Insurance Marketplace

The Health Insurance Marketplace (also called the "Exchange") provides a way for consumers to purchase affordable health coverage on their own. Premium tax credits are available to some individuals and families to make health insurance more affordable. These tax credits can only be used to purchase health insurance for marketplace plans. In addition to the tax credits, cost-sharing reductions may also be available to help them pay their cost-sharing charges. Individuals and families with incomes up to 250 percent of FPL are eligible for cost-sharing reductions. Cost sharing reductions include lower deductibles, out-of-pocket maximums, and copayments.

Health insurance plans offered in the Marketplace (and the individual market outside the marketplace) fall under four "metal" categories: Bronze, Silver, Gold, and Platinum. These categories are distinguished by Actuarial Value (AV), which is defined by how much of a typical population's medical spending a health insurance plan would cover. Cost-sharing reductions increase the AV of the Silver Plan. In addition to the metal plans, Catastrophic plans are also available to certain individuals.

1. Bronze

   - Lowest monthly premium
   - Highest costs when you need care
   - Bronze Deductibles — the amount of medical costs you pay yourself before your insurance plan starts to pay — can be thousands of dollars a year
   - Good choice if you want a low-cost way to protect yourself from worst-case medical scenarios, like serious sickness or injury; your monthly premium will be low, but you'll have to pay for most routine care yourself

2. Silver

- Moderate monthly premium
- Moderate costs when you need care
- Silver Deductibles – usually lower than those of Bronze plans.
- **IMPORTANT:** If you qualify for cost-sharing reductions, you must pick a Silver plan to get the extra savings; you can save hundreds or even thousands of dollars per year if you use a lot of care.
- Good choice if: You qualify for "extra savings" — or if you don't, you're willing to pay a slightly higher monthly premium than Bronze to have more of your routine care covered.

3. Gold

- High monthly premium
- Low costs when you need care
- Gold Deductibles – are usually low
- Good choice if you are willing to pay more each month to have more costs covered when you get medical treatment; if you use a lot of care, a Gold plan could be a good value

4. Platinum

- Highest monthly premium
- Lowest costs when you need care
- Platinum Deductibles are very low, meaning your plan starts paying its share earlier than for other categories of plans
- Good choice if you usually use a lot of care and are willing to pay a high monthly premium, knowing nearly all other costs will be covered

Employer Mandates

The employer shared responsibility under the ACA applies to all Applicable Large Employers (ALEs). In general, an ALE is any employer who on average employed at least 50 or more full-time employees on business days during the preceding year. The ACA requires ALEs to offer Minimum Essential Coverage (MEC) to at least 95% of full-time employees and their child dependents under age 26. Such coverage must meet the Minimum Value (MV) requirement and be affordable for the employee or the employer is subject to penalties. Employers with fewer than 50 employees are exempt from penalties.

Applicable Large Employers (ALEs)

An employer that employed an average of at least 50 full-time or "Full-Time Equivalent" (FTE) employees on business days during the preceding year. The total number of hours worked each month by part-time employees is used in calculating FTE.

Minimum Essential Coverage (MEC) that has Minimum Value (MV) and is affordable

The ACA specifies the Minimum Essential Coverage that a health insurance plan provided through an employer must offer. The employer-provided health plan must also satisfy the "MV" requirement under the ACA. Minimum Value means the health care plan's share of the total allowed cost of benefits provided under the plan is at least 60% of the actuarial costs. "Affordability" means the plan's cost for self-only coverage is no more than 9.83% (2021) of the employee's household income. The Employer Shared Responsibility (mandate) requires ALEs to offer MEC to at least 95% of full-time employees and child dependents under age 26 that meets MV requirements and is affordable or be subject to penalties.

Affordability

To meet the ACA's affordability threshold, the employee's required contribution to the lowest-cost monthly premium for self-only coverage providing MV should not exceed 9.83% of either (1) the employees rate of pay, (2) the employee's W-2 Box 1 wages, or (3) the Federal Poverty Level (FPL) for a household of one.

Employer Penalties (4980H)

1. Employer Shared Responsibility Payment for Failure to Offer Minimum Essential Coverage (MEC) [4980H(a) Penalty]

   Applies to each month the Applicable Large Employer (ALE) (1) failed to offer MEC to at least 95% of its full-time employees and child dependents under age 26 AND (2) at least one full-time employee received Premium Tax Credits (PTC) for purchasing coverage through the Marketplace for that month. The annualized penalty for the 2021 tax year is the sum of $2,700/12 X (number of full-time employees – 30 full-time employees) X each month that at least one full-time employee received PTCs.

2. Employer Shared Responsibility Payment for Failure to Offer Coverage that Meets Affordability and Minimum Value (MV) [4980H(b) Penalty]

   Applies each month for every full-time employee that (1) did not receive an offer of coverage from the ALE or received such an offer but the offer was either unaffordable or did not provide MV (or both) AND (2) the employee received a Premium Tax Credit (PTC) for that month. The annualized penalty for the 2021 tax year is the sum of $4,060/12 X (number of full-time employees receiving PTCs for each month).

Employer Responsibility

Source:
Questions and Answers on Employer Shared Responsibility Provisions Under the Affordable Care Act: https://www.irs.gov/affordable-care-act/employers/questions-and-answers-on-employer-shared-responsibility-provisions-under-the-affordable-care-act

Individual Mandates

The ACA individual shared responsibility penalty for being uninsured has been removed under the Tax Cuts and Jobs Act, enacted by Congress in December 2017. This act effectively eliminated the individual health insurance mandate under the ACA. However, this provision didn't take effect until January 1, 2019. Penalties for the 2018 tax year still apply, but starting in tax year 2019, the Form 1040 will no longer require you to make a shared responsibility payment with your tax return if you fail to have minimum essential coverage for all or part of 2019.

Compliant and Noncompliant Plans

The ACA mandates that an employer group plan will fail to meet the minimum value test if its coverage pays less than 60% of medical costs. Basically, this (and other rules) means a plan of insurance provided by an employer must have certain coverage components and meet all the rules and regulations mandated by the ACA. As an example: an employer's accidental medical plan, or "mini-med" plan, would not be considered ACA-compliant coverage since it violates numerous provisions of the "minimum value" test. Should an employee have such a plan, the ACA would view this as NOT having met the provisions of the law and the employer would be subject to the individual or family penalty.

! IMPORTANT NOTE:

Key provisions of the ACA are currently undergoing litigation in the U.S. courts. The U.S. Court of Appeals heard arguments in the case on July 9, 2019. The Supreme Court is expected to take the case and oral arguments in case will take place later in the fall of 2020 or early 2021.

Knowledge Check 2

Your good friend, Jennifer, is about to open a bagel and sandwich shop. You are discussing property and casualty options. She states: “I plan to have 5-6 full-time employees (30+ hours per week) and about the same number of part-time employees (less than 30 hours per week). I have heard I will be required to provide my employees health insurance, as per the Affordable Care Act. Is that true?”

Tax-Advantaged Accounts

Learning Objective: 3

Participants will apply knowledge of tax-advantaged accounts and tax implications to meet a variety of prospect and client needs.

Consumer-Driven Health Plans

Flexible Spending Accounts (FSAs)

Also known as Cafeteria Plans or 125 Plans, health care FSAs are employer-established benefit plans that pay or reimburse participating employees for **Qualified Medical Expenses (QMEs) as defined by IRS Publication 502**. The employee contributes funds to the account through a salary reduction agreement and is able to withdraw the funds to pay for QMEs. The salary reduction agreement means that any funds set aside in a flexible spending account escape both income tax and Social Security tax. Employers may contribute to these accounts as well.

- The ACA limits the maximum contribution by an employee to a medical FSA to $2,750 during the 2021 plan year; there is no statutory limit placed on an employer's contribution, but employer contributions may not discriminate

- The maximum annual contribution, or annual election, limit for a dependent care FSA is $5,000 (2021); an open enrollment period occurs once a year when an employee can sign-up, stop contributions, or amend the amount of the contribution

- Once the annual election has been made, the employee is not allowed to change the amount or drop out of the plan during the year unless he or she experiences a change of family status; by law, the employee forfeits any unspent funds ("use it or lose it") in the account at the end of the plan year

IRS Publication 502

In November of 2013, the IRS issued a ruling (effective in 2014) that allows employers to amend their FSA plans so employees can carry over a portion of these funds from one year to the next, thus changing the "use it or lose it" rule. In 2021, this amount was increased to $550. The ruling goes on to clarify as follows:

- The carryover amount does not count against the annual limit
- FSA plan document cannot offer both a grace period AND a carryover
- Carryover only applies to FSAs and does not apply to the dependent care benefit

Note:

Coronavirus Aid, Relief and Economic Security Act (CARES ACT) permanently reinstated over-the-counter (OTC) products as qualified medical expenses (QME's) for HSA, FSA and HRA accounts reversing the ACA law which stated that (OTC) drugs were only eligible with a prescription. Menstrual care products were also added to the eligible list. These changes are retroactive to January 1, 2020.

Limited Purpose FSA

A limited purpose health FSA is much like a general-purpose health FSA. The main difference is that the limited purpose FSA may only be used to cover qualifying dental and vision expenses, such as:

- Vision exams, LASIK surgery, contact lenses, and eyeglasses
- Dental cleanings, X-rays, fillings, crowns, and orthodontia

Many employers offer limited purpose FSAs for their employees who have health savings accounts. That's because IRS rules state that you cannot have an HSA and a general-purpose health FSA since both apply funds toward your medical expenses. A limited purpose FSA allows you to continue to contribute to an HSA. You maximize your savings and tax benefits by restricting your FSA reimbursement to only vision and dental expenses.

Your entire annual election ($2,750 during the 2021 plan year) is available on the first day of the plan year, but your total FSA annual election amount is deducted from your paycheck in equal amounts throughout the year

Example:

Let's say your limited purpose health FSA election is $1,200 and your plan year begins on January 1. Assuming you are paid once a month, $100 will be deducted from your paycheck each month throughout the year. On the first day of the FSA plan year, which would be January 1, you can use $1,200 immediately to pay for eligible FSA expenses.

Health Reimbursement Arrangements (HRAs)

HRAs, also known as Section 105 plans, are not insurance plans. They are a tax-advantaged way for an employer to pay medical expenses on behalf of an employee. An HRA allows the employer to consider the payments of any benefits as an ordinary business expense, and the employee does not have to declare as income any plan reimbursement for a QME.

- HRAs consist of funds set aside by employers for their employees on a non-discriminatory basis; they are used to pay, or reimburse, employees for QMEs
- Can be used for any QMEs such as deductibles, copays, dental, vision, etc.
- If an insurance contract pays for the QME, the HRA cannot duplicate; it can only be used for what the insurance plan (or no plan) fails to pay or reimburse
- HRA funds are not subject to the "use it or lose it" rule as seen with the FSA; employees do not contribute to the HRA – only the employer

Note:
Should an employee terminate from an employer that funded an HRA, the funds remain with the employer. They do not follow the employee.

As of January 1, 2020, there are 2 new options for HRAs:

1. An Individual Coverage HRA (ICHRA) that allows an employee to pay for individual health coverage and reimburse other eligible expenses. It cannot be offered to employees who are eligible for group coverage.
2. An Excepted Benefit HRA (EBHRA) that is a stand-alone HRA with an annual maximum benefit limit that can reimburse medical expenses for employees and their dependents. It can only be offered to employees who are eligible for a group health plan sponsored by their employer.

Health Savings Accounts (HSAs)

Health Savings Accounts are arrangements used to pay for unreimbursed health care expenses. These accounts can accumulate tax-deferred interest similar to Individual Retirement Accounts (IRAs).

Funds are controlled and owned by the account holder. Anyone can make a contribution into the account on behalf of the account holder. To qualify, the insured taxpayer must be covered by a High-Deductible Health Plan (HDHP). For 2021, the annual deductible limitations for qualifying HDHPs are:

- INDIVIDUAL – minimum deductible is $1,400 with $7,000 maximum out-of-pocket

- FAMILY – minimum deductible is $2,800 with $14,000 maximum out-of-pocket

Savings are rolled over every year and are portable since the account is "owned" by the insured/accountholder, regardless of employment status. Funds can be used on a pretax basis to pay for long-term care insurance premiums, health insurance premiums paid while unemployed, and COBRA premiums.

Funds can accumulate earnings, which are not taxed unless funds are used for non-medical expenses. Such use would trigger ordinary income taxes in addition to a 20 percent penalty. If the employee becomes disabled or reaches Medicare eligibility age, distributions for non-medical expenses from the account are subject only to ordinary income tax, not the penalty.

Note:
There is never a tax (or penalty) if the funds are used to pay for QMEs, regardless of the age of the account holder.

The maximum contribution to an HSA is now statutorily set at $3,600 for single and $7,200 for a family, plus an additional $1,000 "catch-up" contribution for those age 55 or older **(2021 numbers)**, regardless of the individual's HDHP deductible.

Purpose and Flow of an HSA

- To allow the account holder (the insured under the HSA) the flexibility of choosing their own medical providers

- A High Deductible Health Plan is required ***(The Insurance Part)***

- Sets aside a tax-deductible contribution that can be used to pay the deductible and other allowable QMEs
  (The Cash Account Part – optional but a key component of an HSA)

Eligible Account Holder

HSAs are allowed only for eligible account holders. This is defined as:

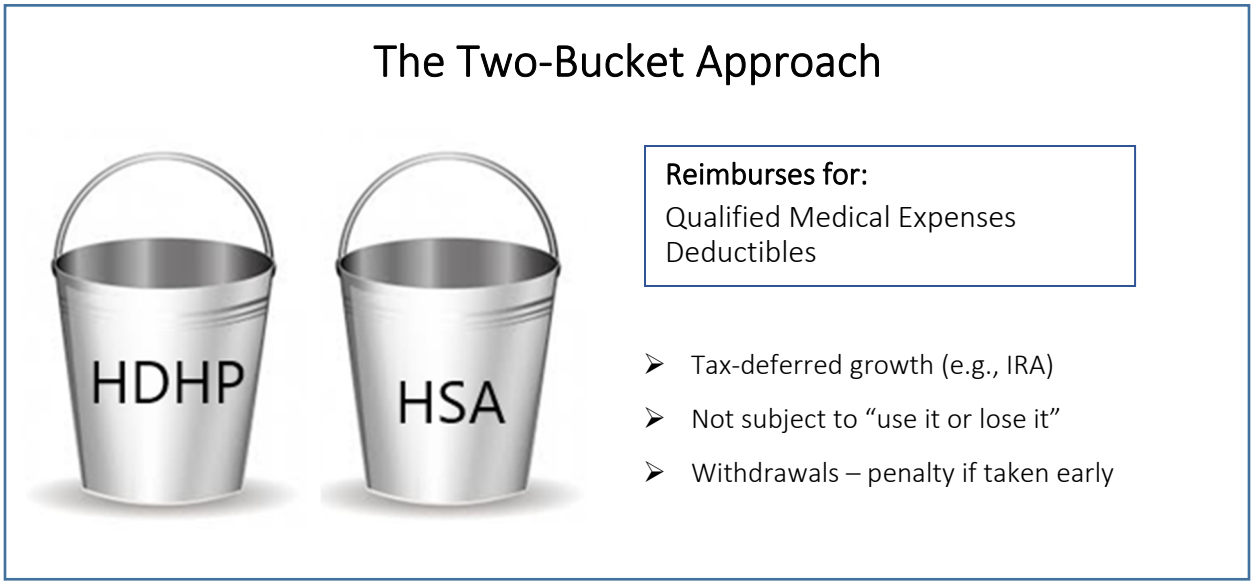
- Any individual (self-employed individuals, employees, etc.) – but that person (or family) may **not** be also covered under another health insurance plan, nor may they be entitled to Medicare benefits

Requirements for Establishing an HSA

- Purchase a qualified HDHP
- Have **a written document** from an **approved HSA trustee** (life insurance company, mutual fund company, bank or other approved administrator for the contributed funds)
- Fund with cash contributions to cover unreimbursed claims (optional)

1. As stated previously, there are maximum allowable amounts regardless of the actual deductible elected by the insured
2. If a couple – both age 55 or older – have a family plan HSA, only one $1,000 "catch-up" contribution can be made
3. Contributions can be made by the employee or anyone on behalf of the employee, including the employer – but total deposits from ALL sources cannot exceed the annual maximum contribution limits
4. If the employer is the contributor, there must be "comparable" contributions for all participating employees for each period

Note:
Distributions from HSAs and FSAs will not be allowed to reimburse the cost of OTC medications without a prescription.



2021 HSA Contribution Limits and
Out-of-Pocket Maximums for High-Deductible Heatlh Plans (HDHP)

	2021	2020	Change
Annual HSA Contribution Limit (employer and employee)	Self-only: $3,600 Family: $7,200	Self-only: $3,550 Family: $7,100	Self-only: +$50 Family: +$100
HSA catch-up contributions (age 55 or older)	$1,000	$1,000	No change
Minimum Annual HDHP Deductible	Self-only: $1,400 Family: $2,800	Self-only: $1,400 Family: $2,800	No change
Maximum Out-of-Pocket for HDHP (deductibles, co-payment & other amounts except premiums)	Self-only: $7,000 Family: $14,000	Self-only: $6,900 Family: $13,800	Self-only: +$100 Family: +$200

Source: https://benefitadvisorsnetwork.com/blog/irs-releases-2021-hsa-contribution-limits-and-hdhp-deductible-and-out-of-pocket-limits/

Comparison of Health Care Accounts

Connect Your Care

	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA)	Health Flexible Spending Account (FSA)	DCAP Dependent Care Assistance Program (DCAP)	Limited Purpose Flexible Spending Account (LPFSA)
Account ownership	Employee/ individual	Employer (held in employee's name)	Employer (held in employee's name)	Employer (held in employee's name)	Employer (held in employee's name)
Deposits made by	Employer, employee or both	Employer	Employer, employee or both	Employer, employee or both	Employer, employee or both
Separate account	Required; IRA-type account	Not required; paid from employer assets	Not required; paid from employer assets	Not required; paid from employer assets	Not required; paid from employer assets
Expenses covered	Medical, dental, vision, prescription and over-the-counter expenses. COBRA, retiree medical insurance premiums, LTC premiums or expenses *Reference: IRC § 213(d)*	Medical, dental, vision, prescription and over-the-counter expenses. Post-tax insurance premiums *Reference: IRC § 213(d)*	Medical, dental, vision, prescription and over-the-counter expenses *Reference: IRC § 213(d)*	Caregiver costs for dependent care expenses while at work *Reference: IRC § 129*	Typically limited to qualifying dental and vision expenses only; can also cover post-deductible medical and prescription expenses *Reference: IRC § 213(d)*
Accompanying plan requirements	Must be covered by qualified HDHP and not covered by any plan that covers medical expenses under the deductible **HDHP Minimum Deductible 2019:** $1,350 single; $2,700 family **HDHP Minimum Deductible 2020:** $1,350 single; $2,700 family	Generally, must be integrated with group medical plan meeting health care reform requirements	None	None	None, though usually paired with HSA and qualified HDHP
Contribution limits	Calendar year limits: • **2019:** $3,500 single; $7,000 family; $1,000 Catch Up • **2020:** $3,550 single; $7,100 family; $1,000 Catch Up	None	$2,750 per plan year with potential for annual inflation increases. The limit is per person. Employers may elect a lower contribution limit.	$5,000 per calendar year if single or married filing jointly, $2,500 if married filing separately	$2,700 per plan year with potential for annual inflation increases. The limit is per person. Employers may elect a lower contribution limit.
Portability	Full portability required	Portability allowed at employer's discretion	None	None	None
Rollover	Full rollover required	Rollover allowed at employer's discretion	$500 rollover allowed at employer's discretion	None	$500 rollover allowed at employer's discretion
Funds availability	As deposits are credited	As deposits are credited; may be credited in a lump sum	Full annual election available on first day of coverage (uniform coverage)	As deposits are credited	Full annual election available on first day of coverage (uniform coverage)
Claim adjudication	Not allowed; though participants must retain receipts	Required	Required	Required	Required
Compatibility with other savings accounts	May be paired with HRA, FSA if they are limited to amounts over deductible, or to dental/ vision only; may be paired with DCAP, PRA	May be paired with FSA, DCAP, PRA. If paired with an HSA, must be limited to amounts over the deductible or to dental/vision only	May be paired with HRA, DCAP, PRA. If paired with an HSA, must be limited to amounts over the deductible or to dental/vision only	May be paired with HSA, HRA, FSA, PRA	May be paired with HSA to stay compliant with IRS regulations. Limited to amounts over the deductible and/or to dental/vision only.
Employer contributions	Can be made on behalf of current employees (account extends to spouse and dependents)	Can be made on behalf of current and former employees, their spouses and dependents, and spouses and dependents of deceased employees	Can be made on behalf of current employees (account extends to spouse and dependents)	Can be made on behalf of current employees (account extends to spouse and dependents)	Can be made on behalf of current employees (account extends to spouse and dependents)
ERISA plan	Generally no	Yes	Yes	No	Yes
COBRA	Does not apply	Applies	Applies	Does not apply	Applies
Retirees	Can be covered	Can be covered	Cannot be covered	Cannot be covered	Cannot be covered
Debit card usage	Yes	Yes	Yes	No	Yes
Contributions for Medicare participants	Contributions cannot be made once an individual has Medicare coverage.	No limits on contributions	No limits on contributions	No limits on contributions	No limits on contributions
Usage for ineligible expenses	Allowed. Amounts included in income; and subject to 20% penalty unless after account beneficiary's death, disability or attaining age 65	Not allowed	Not allowed	Not allowed	Not allowed
Distributions for expenses incurred after individual is no longer eligible	Can be made	Can be made at employer's discretion, or if COBRA is elected	Can be made if COBRA is elected	Can be made for remainder of plan year at employer's discretion	Can be made if COBRA is elected
Coverage for sole proprietors, partners and 2% or more S-corp owners	Yes, but not eligible to participate in pre-tax cafeteria plan used to fund HSA in the workplace	Cannot be covered	Cannot be covered	Cannot be covered	Cannot be covered

Source: https://www.connectyourcare.com/tools/account-comparison/

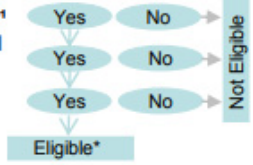
IRA to HSA Worksheet

Purpose: Use this Worksheet to gain a better understanding of the special rules for moving funds from an Individual Retirement Account (IRA) into a Health Savings Account (HSA). Please see IRS Notice 2008-51 for additional information. We do not provide tax or legal advice. Please seek tax or legal advice from your own tax or legal advisors.

IRA to HSA Overview. The law allows you to move money from your IRA into your HSA and avoid the taxation and penalties generally associated with early withdrawals from an IRA. HSA owners face a potentially troubling issue of large medical expenses without the funds to pay for it. Allowing HSA owners to access their IRA funds provides another option to fund the HSA. This option; however, is limited by the rules discussed below and on page 2.

1 Are You Eligible for an IRA to HSA Contribution?

A. **Are you eligible for an HSA?[1]**
B. **You have <u>not</u> already moved an IRA to an HSA?[2]**
C. **You have an IRA?[3]**



*You must answer all questions "Yes" to be eligible.

<u>Footnotes</u>

[1] You must be eligible for an HSA to move money from an IRA to an HSA. Please see the HSA Eligibility and Contribution Worksheet to determine your HSA eligibility.

[2] You are only allowed to do an IRA to HSA qualified funding distribution once-in-a-lifetime. See "change in HDHP status" in the next step for an exception and see p.2 for additional details.

[3] You can only move money from a traditional or Roth IRA and in some cases a SEP or SIMPLE IRA into an HSA. You <u>cannot</u> move funds directly from a 401(k) to an HSA. See p.2 for details.

2 How Much of the IRA Can You Move to the HSA? See definitions and examples on page 2 for help.

A. **Federal HSA Limits Apply**. You cannot contribute more than the applicable HSA federal limit: $3,550 for individuals in 2020 ($3,500 for 2019) and $7,100 for family HDHP coverage in 2020 ($7,000 for 2019) plus a catch up of $1,000 if you are over age 55. You can contribute any amount up to the applicable federal HSA limit for the year taking into account the paragraphs immediately below. See HSA Eligibility and Contribution Worksheet for details on your eligible amount.
B. **IRA to HSA Contribution Counts Against Federal Limit.** Your IRA to HSA contribution counts against the applicable federal limit. All of the following types of contributions count against the HSA federal limit: IRA to HSA funding, employer HSA contributions, payroll deferral HSA contributions and regular HSA contributions.
C. **Change in HDHP Status.** If your status changes from self-only HDHP coverage to family HDHP coverage during the year of the contribution, you may be able to move additional funds from your IRA to your HSA. See page 2 for details.

3 What Are the Tax Ramifications? See additional tax issues on p.2 – plus consult with your tax advisor.

A. **HSA Treatment - Not Deductible.** IRA to HSA contributions are not tax deductible as an HSA contribution.
B. **IRA Treatment - Not Taxable.** A qualified HSA funding distribution from an IRA enjoys an exception to the normal rule that IRA distributions are subject to income tax and possibly a 10% penalty. The law allows for the basis (after-tax dollars) to remain in the IRA to the extent that such amount does not exceed the aggregate amount which would have been so included if there were a total distribution from the IRA or Roth IRA owner's accounts. Basis is an important, but confusing, tax concept - See p. 2 for details.
C. **Testing Period.** You will be subject to a testing period if you complete an IRA to HSA qualified funding distribution. If you fail to maintain your HSA eligibility for the testing period, taxes and penalties apply. See p.2 for details.

4 How Do I Move My IRA to My HSA?

The IRA to HSA funding must be done as a "direct transfer." That means the IRA assets must move directly to the HSA and cannot be paid to the IRA owner. A common approach is for you to request and complete a "transfer form" from your HSA provider. The HSA provider forwards the form to the IRA provider. The IRA provider then writes a check directly to the HSA provider for the benefit of the HSA owner and sends the check directly to the HSA provider. The rules permit the IRA/HSA owner to hand carry a check made payable to the HSA custodian or trustee.

Source: http://www.yourhsaadmin.com/MC/pdf/IRA_to_HSA_Worksheet.pdf

Tax Treatment of Contributions and Distributions

1. Contributions to an HSA:

   - Account-holder contributions may be made by anyone

   - Employer contributions are tax deductible to the employer and excludable from income to the individual

   - Individual contributions are deductible "above the line". That is, a taxpayer does not have to itemize deductions in order to take the contribution as a deduction

   - Those contributions made by someone other than the individual or their employer are deductible to the accountholder

Note:
Contributions can be made via pre-tax payroll deduction in which case they are NOT deductible on the account holder's federal income tax return.

2. Distributions from an HSA:

   - Distributions for "qualified medical expenses" are not taxed, provided they do not duplicate payment from other health insurance coverage

> From IRS Publication 969 (Cat. No. 24216S)
>
> Health Savings Accounts and Other Tax-Favored Health Plans
>
> "Qualified medical expenses. Qualified medical expenses are those expenses that would generally qualify for the medical and dental expenses deduction. These are explained in Publication 502, Medical and Dental Expenses."
>
> www.irs.gov/pub502

- Embedded Deductibles
  - Embedded deductibles are not required
  - Carriers will put these into plans to make the plans more competitive
  - Challenge of embedded deductibles in HDHP:

    No family member/s may be reimbursed for covered annual expenses from an HDHP until the family has incurred covered annual expenses in excess of the minimum annual deductible ($2,800 for 2021)
  - Embedded Out-of-Pocket Maximums (OOPMs) for HDHP
    - OOPMs work like the embedded deductibles
    - However, they are required
    - Individual OOPMs apply to each covered individual whether individual covers self-only or family ($7,000 for 2021)
    - Rule applies to all HDHP plans whether insured or self-funded
    - Plan years 2016 and beyond either:

      Incorporate an individual embedded OOPM under family OOPM ($14,000 for 2021)

      Or

      Maintain an aggregate deductible no greater than the individual OOPM ($7,000 for 2021)

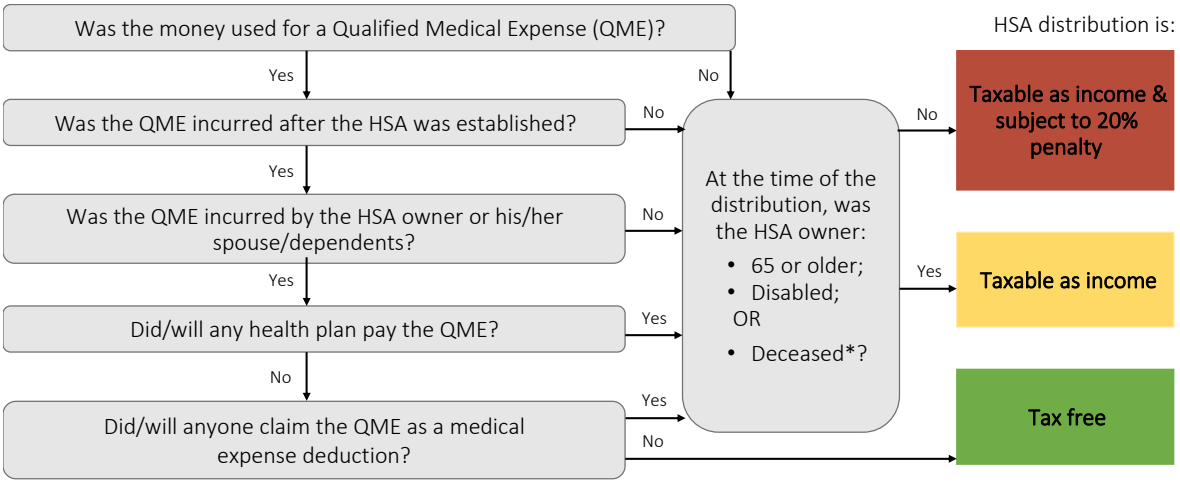
3. Other distributions from an HSA:

- Death or disability of account holder – if designated beneficiary is the surviving spouse, then HSA is treated as the account of the holder. If account holder is not the surviving spouse, then income tax is due.

- Non-medical before age 65 – income tax plus 20% penalty

- Non-medical after age 65 – income tax only

- Amounts not used by year end are not forfeited (they accumulate year-to-year)



Employee Benefits Interview Video

Knowledge Check 3

Your client is familiar with FSA plans, but wants their employees to have more of their own money involved in their health care programs.

What plans, if any, are available for the employer to offer?

Federal Legislation

Learning Objective 4:
Participants will apply knowledge of federal laws to provide appropriate counsel to clients and prospects.

Federal Employer Laws

Many think federal legislation is where group insurance administration is involved in insurance law. It is not. It is "employer law" and the employee benefit plan is 100% responsible for compliance.

Federal Employer Laws	
ERISA	DOMA
NMHPA	GINA
WHCRA	USERRA
MHPA	CHIP
COBRA	MICHELLE'S LAW
HIPAA	
FMLA	
QMCSO	
ACA	

Explanations of Select Federal Employer Laws

COBRA (Consolidated Omnibus Budget Reconciliation Act)

COBRA allows for the temporary continuation of group medical insurance (including any FSA or HRA plans), dental and vision coverage for certain former employees, retirees not eligible for Medicare, spouses, former spouses and dependent children. It began in 1986 and is only for groups of a minimum size and only for certain covered events. COBRA does not apply to Group Life, Disability or Accidental Death & Dismemberment plans.

Some states have their own versions, which can be more liberal, but not more restrictive, than federal COBRA. For more information, see www.COBRAinsurance.com.

Note:
Should an employer discontinue a group health insurance plan, COBRA would not apply (exception for asset purchases where the purchaser is taking on the seller's employees and has a group medical plan in force on their current employees).

Features of COBRA

- For groups of 20 or more employee equivalents, as defined by COBRA
- Allows for continuation of health insurance coverage at covered person's expense
- 36 months for spouse/family due to death or divorce (or legal separation) of employee
- 29 months (in some situations) if Social Security disability applies
- 18 months for separation of service – additional time may be available to spouse and/or dependents

> "When the qualifying event is the end of employment or reduction of the employee's hours, and the employee became entitled to Medicare less than 18 months before the qualifying event, COBRA coverage for the employee's spouse and dependents can last until 36 months after the date the employee becomes entitled to Medicare.
>
> For example, if a covered employee becomes entitled to Medicare 8 months before the date his/her employment ends (termination of employment is the COBRA qualifying event), COBRA coverage for his/her spouse and children would last 28 months (36 months minus 8 months)," according to the Department of Labor.

- Employer or administrator may collect 102% of cost of coverage
- Employer has 30 days to notify COBRA administrator of any terminations

COBRA FAQ can be found at:
https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/cobra-continuation-health-coverage-consumer.pdf

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

HIPAA is a broad federal law passed in the 1990s that addresses certain health insurance issues, including guaranteed issue of certain health coverage plans, preexisting condition issues, Certificates of Creditable Coverage, and others. It also mandated numerous new rules specific to the medical care community. Most of the law relating to health insurance has been replaced by the ACA.

There is still one key area of HIPAA that is a major concern for health insurance agents and companies – **PRIVACY**

- The law is very specific that anyone who has, or obtains, Private Health Information (PHI) needs to protect the access to and release of such data; this can include medical history and information obtained during the application process with the following: life insurance, health insurance, disability insurance, and long-term care insurance

- Agents, insurance companies, MGAs and others must make certain that safeguards are in place to protect the information from unauthorized individuals

- Employers need to discuss the issue with their employees, so they understand the potential dangers to themselves and the employer should there be a breach

- An insured's medical data on an application of insurance (health history, medications, alcohol and drug usage, etc.) is PHI and is to **NEVER** be discussed or released to unauthorized individuals; the following site can offer helpful information: http://www.hipaa-101.com/

Creditable Coverage

A Certificate of Creditable Coverage was necessary prior to the implementation of the ACA. This allowed a covered person (and those covered under the plan – such as the spouse and dependents) to move from one plan or coverage to another without preexisting condition restrictions. Because preexisting condition limitations on health insurance plans were not permitted after the start of the 2014 plan year, **Certificates of Creditable Coverage are no longer necessary.**

Note:
More information is available at Health Care Reform Digest: https://tinyurl.com/jkfhe4q

Mental Health Parity Act of 1996 (MHPA)

The MHPA provides coverage for either mental health or substance use disorders and medical/surgical benefits; it generally applies to group health plans and health insurance issuers

- Requires mental illness benefits to be provided under the same terms and conditions as other medical conditions IF mental illness benefits are part of the current plan (and the group has 51 or more employees)
- Must provide equal lifetime and annual maximums
- Cannot impose dollar limits on hospital stays but can impose day limits
- Excludes substance abuse and chemical dependency for equal maximums

Note:
The ACA has overridden numerous provisions noted above in HIPAA and MHPA

Family and Medical Leave Act of 1993 (FMLA)

Under the FMLA, covered employers (generally, groups with 50 or more employees) must grant an eligible employee (generally, one who has worked for the employer for at least one full year) up to a total of 12 work weeks of **unpaid** leave during any 12-month period for one or more of the following reasons:

- For the birth and care of a newborn child of the employee;
- For placement with the employee of a child for adoption or foster care;
- To care for an immediate family member (spouse, child or parent) with a serious health condition; or
- To take medical leave when the employee is unable to work because of a serious health condition

The military family leave provisions of the FMLA entitle eligible employees of covered employers to take FMLA leave for any:

- "Qualifying exigency" arising from the foreign deployment of the employee's spouse, son, daughter, or parent with the Armed Forces; or
- To care for a servicemember with a serious injury or illness if the employee is the service member's spouse, son, daughter, parent, or next of kin

Employee Retirement Income Security Act of 1974 (ERISA)

ERISA is a federal law that sets minimum standards for most voluntarily established pension and health plans offered by private sector employers to provide protection for individuals in these plans. The following provisions are required:

- Participants must be provided with plan information including important information about plan features and funding
- Fiduciary responsibilities for those who manage, and control plan assets are outlined
- Plans for a participant grievance and appeals process must be established
- Participants have the right to sue for benefits and breaches of fiduciary duty
- Does not apply to governmental entities or churches

Newborns and Mothers Health Protection Act of 1996 (NMHPA)

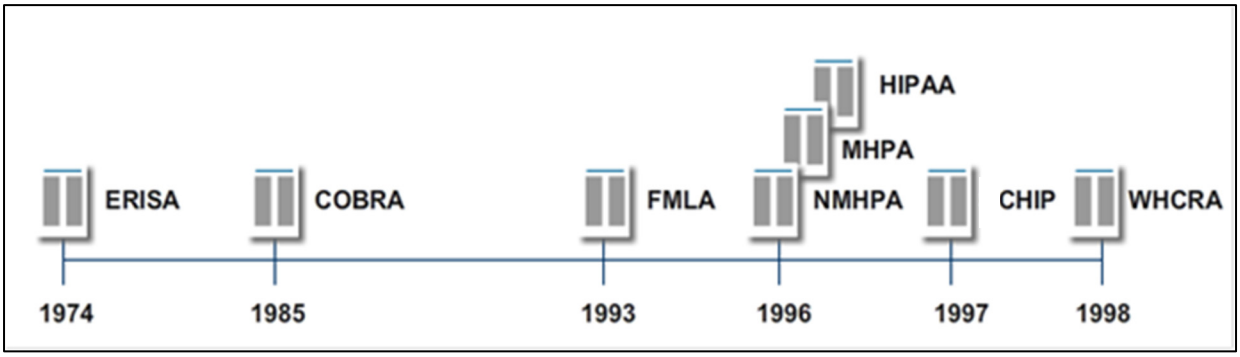
The NMHPA provides protections for mothers and their newborn children relating to the length of their hospital stays following childbirth:

- Mandates health benefits for post-childbirth hospital stays
- No less than 48 hours for both mother and child
- Up to 96 hours for cesarean section birth
- Can be adjusted based on circumstances

Women's Health Cancer Rights Act of 1998 (WHCRA)

This act provides protections for individuals who elect breast reconstruction after a mastectomy:

- Mandates coverage for mastectomy patients
- Requires coverage for reconstruction of breast
- Requires coverage for other breast for symmetrical appearance
- Coverage for prostheses if necessary



Provisions in ACA have resulted in COBRA and HIPAA rules being less of an issue for the consumer. The ACA requires that health plans and issuing companies cannot impose any preexisting condition exclusions and policies must be provided on a guaranteed issue basis.

Medicare and Medicaid

Learning Objective: 5

Participants will apply knowledge of Medicare, Medicare supplements, and Medicaid to correctly select which is the most appropriate product to meet the needs of a client.

Medicare

DISCLAIMER

The following information covers the basic rules, regulations, eligibility, and coverage available under Medicare plans. This material is intended as a general information guideline and is not intended as legal advice. This material is not intended to market any of the plans within this section.

Medicare has strict rules regarding the marketing of Medicare health plans. For a complete overview of Medicare's marketing guidelines, please visit: https://tinyurl.com/pd247wj

Purpose

- Enacted in 1965 to provide insurance for medical, surgical and related services to eligible participants

- For coverage to apply, costs must be ***reasonable and necessary*** and approved by Medicare

Eligibility

1. Persons aged 65 and older:

    - Automatically entitled if one already gets benefits from Social Security
    - Voluntarily if NOT eligible for Social Security; must pay monthly premium

2. Persons of any age who:

    - Have received Social Security disability for 24 months, or
    - Have end-stage renal disease or Amyotrophic Lateral Sclerosis (ALS)

Initial Enrollment Period

- Seven-month enrollment period that begins three months before one's 65th birthday, includes one's birth month and ends three months later

Coverage Trigger

- Medically necessary and showing signs of improvement

Medicare Coverage Parts

- Part A – Hospital Insurance
- Part B – Medical Insurance
- Part C – Medicare Advantage
- Part D – Prescription Drug Benefit

Medicare Benefits (2021)

Part A – Hospital insurance
(no premium for eligible beneficiaries; if not an eligible beneficiary, premium is $458 per month)

1. **Inpatient Hospital Care**

In 2021, after a $1,484 deductible, Medicare pays all "reasonable and approved expenses" of a hospital stay for the first 60 days of each benefit period. A ***benefit period*** begins the day one is admitted as an inpatient to a hospital or skilled nursing facility. The benefit period ends when one has not received any inpatient care for 60 days in a row. A new admission as an inpatient begins a new benefit period. There is no limit to the number of benefit periods.

The following applies per benefit period (2021):

- Days 1-60 insured pays $0 coinsurance
- Days 61-90, $371 daily copayment paid by the insured
- Day 91 and beyond, daily copay of $742 for each *lifetime reserve day* (lifetime reserve days are additional days that Medicare will pay beyond 90 days, with a maximum of 60 reserve days per lifetime)
- Patient bears the expense of all costs beyond lifetime reserve days

2. **Skilled Nursing Facility (SNF) Care**

To qualify, one must satisfy a three-day inpatient hospital stay requirement. In-hospital observation days do not count as inpatient days. One must then enter a Medicare-approved SNF facility within 30 days after being discharged from the hospital.

- Medicare pays 100% of approved charges for days 1-20 in a benefit period
- Days 21-100, patient pays $185.50 per day in a benefit period as a copayment (2021)
- Days 101 and beyond are the patient's responsibility

Part B – Medical insurance

1. **What Part B costs**

Part B is optional. The standard Part B monthly premium amount in 2021 is $148.50 (or higher, depending on your income). Persons who fail to qualify for Part A can still receive Part B benefits.

Part B Monthly Premium by Income			
If your filing status and yearly income in 2019 was:			You pay each month (in 2021)
File individual tax return	File joint tax return	File married & separate tax return	
$88,000 or less	$176,000 or less	$88,000 or less	$148.50
above $88,000 up to $111,000	above $176,000 up to $222,000	not applicable	$207.90
above $111,000 up to $138,000	above $222,000 up to $276,000	not applicable	$297.00
above $138,000 up to $165,000	above $276,000 up to $330,000	not applicable	$386.10
above $165,000 up to $500,000	above $330,000 up to $750,000	above $88,000 and less than $412,000	$475.20
above $500,000	Above $750,000	above $412,000	$504.90

2. **Part B covers:**

- Medical expenses (doctor's services)
- Home health care;
- Outpatient care

Part C – Advantage plans

Provide all of your Medicare Part A (hospital insurance) and Medicare Part B (medical insurance) coverage. Additional benefits are generally offered, such as vision, hearing, dental, and health and wellness programs. Most include Medicare Part D prescription drug coverage. The cost varies by plan.

Part D – Prescription drug benefit

1. The Medicare Prescription Drug, Improvement and Modernization Act was passed on December 8, 2003. Also known as the Medicare Modernization Act, it established a *voluntary drug benefit* for Medicare beneficiaries and created Medicare Part D.

2. Medicare Part D plans are government-sponsored insurance policies issued by commercial insurance companies that are designed to help protect Medicare beneficiaries against the ever-rising cost of prescription drugs. Anyone with Medicare Part A or Part B can purchase a prescription drug benefit plan through private insurance companies as of January 1, 2006.

3. The premium will vary by the prescription drug plan purchased and income as reported on one's IRS tax return from two years ago and last year. Higher-income consumers may pay a plan premium of $13 to $78 more per month.

The following chart shows estimated Prescription Drug – Part D plan monthly premiums based on income as reported on one's IRS tax return from two years ago. If one's income is above a certain limit, an income-related monthly adjustment amount is required in addition to the plan premium.

Part D – Rx Plan Additional Premium by Income			
If your filing status and yearly income in 2019 was:			You pay each month (in 2021)
File individual tax return	File joint tax return	File married & separate tax return	
$88,000 or less	$176,000 or less	$88,000 or less	your plan premium
above $88,000 up to $111,000	above $176,000 up to $212,000	not applicable	$12.30 + your plan premium
above $111,000 up to $138,000	above $222,000 up to $276,000	not applicable	$31.80 + your plan premium
above $138,000 up to $165,000	above $276,000 up to $330,000	not applicable	$51.20 + your plan premium
above $165,000 up to $500,000	above $330,000 up to $750,000	above $88,000 and less than $412,000	$70.70 + your plan premium
above $500,000	Above $750,000	above $412,000	$77.10 + your plan premium

Source: http://www.medicare.gov/part-d/costs/premiums/drug-plan-premiums.html

4. Part D – Prescription drug coverage description (2021)

- **Beneficiary pays a monthly plan premium** – generally, $33 per month but higher premiums (surcharges) will apply if income exceeds certain limits as shown in the table.

- **Annual deductible** – beneficiary pays the first $445 (2021) of plan-covered drugs.

- **Initial coverage period** – begins after beneficiary satisfies the $435 annual deductible. The initial coverage phase is exhausted by the combination of two costs: member copays ($10 or 25% coinsurance) and insurer's plan cost of the drugs (75%). When the sum of both member and insurer costs reaches $4,130 (2021), the member moves into the coverage gap. The amount of time it takes a member to exhaust this limit will vary widely based on the cost of their particular medications.

- **Coverage gap** ("donut hole") – begins once the initial coverage period ends. In the gap, costs are 100%-member responsibility until the out-of-pocket reaches $6,550 (2021). The beneficiary pays only 37% of the plan's cost for covered generic/25% for brand name while in the coverage gap due to the plan discount for covered drugs. The yearly deductible, copayments, coinsurance, discounted costs from the plan and coverage gap ("donut hole") costs all count toward reaching the out-of-pocket.

- **Catastrophic benefit period** – once the $6,550 (2021) out-of-pocket has been reached in the coverage gap, the catastrophic benefit period begins. Under the catastrophic benefit, the beneficiary pays a small copay or coinsurance amount for the rest of the plan year.

Note:
The deductibles, gap coverage, surcharges and discounts are extremely complex. A Medicare Part D beneficiary needs to consult a knowledgeable certified agent for assistance. These numbers reflect the 2021 limits.

Medicare Supplement (Medigap)

A Medigap policy helps pay some of the health care costs that Original Medicare (Part A and Part B) doesn't cover, like:

1. Copayments
2. Coinsurance
3. Deductibles

Some Medigap policies also cover services that Original Medicare doesn't cover, like medical care when you travel outside the U.S. If you have Original Medicare and you buy a Medigap policy, here's what happens:

- Medicare pays its share of the Medicare-approved amount for covered health care costs, then your Medigap policy pays its share
- A Medigap policy is different from a Medicare Advantage Plan, which is a way to get all Medicare benefits; a Medigap policy only supplements your Original Medicare benefits
- In some situations, an insurance company cannot deny Medigap coverage because of guaranteed issue rights

Excerpt from the ***2020 Social Security and Medicare Facts*** book from the National Underwriter Company:

1202. Is Medicare Supplement Plan F being Eliminated?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) passed by Congress and signed into law on April 16, 2015 changed the law on various aspects of health care, including some Medicare Supplement plans. The new law states that on or after January 1, 2020, a Medicare Supplement policy that provides coverage of the Part B deductible may not be sold or issued to a newly eligible Medicare beneficiary. Anyone whose birthday is December 31, 1954 (turning sixty-five on December 31, 2019) may be the last group able to enroll in Medicare Supplement Plan F. **After January 1, 2020, individuals will not be able to enroll in Medicare Supplement Plan C, one of the closest alternatives to Plan F, either, since it also covers the Part B deductible**. Those who already have Plan F, can keep it. The law only affects new enrollees.

The chart below shows basic information about the different benefits Medigap policies cover.

Benefits Offered by Each Medigap Plan										
Medigap Benefits	Medigap Plans									
	A	B	C	D	F*	G	K	L	M	N
Part A coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used up	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Part B coinsurance or copayment	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes***
Blood (first 3 pints)	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Part A hospice care coinsurance or copayment	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Skilled nursing facility care coinsurance	No	No	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Part A deductible	No	Yes	Yes	Yes	Yes	Yes	50%	75%	50%	Yes
Part B deductible	No	No	Yes	No	Yes	No	No	No	No	No
Part B excess charge	No	No	No	No	Yes	Yes	No	No	No	No
Foreign travel exchange (up to plan limits)	No	No	80%	80%	80%	80%	No	No	80%	80%
Out-of-pocket limit**	N/A	N/A	N/A	N/A	N/A	N/A	$6,220	$3,110	N/A	N/A

* Plan F also offers a high-deductible plan. If you choose this option, you must pay for Medicare-covered costs up to the deductible amount of $2,370 in 2021 before your Medigap plan pays anything.

** For plans K and L, after you meet your out-of-pocket yearly limit and your yearly Part B deductible, the Medigap plan pays 100% of covered services for the rest of the calendar year.

*** Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to $50 for emergency room visits that don't result in inpatient admission.

Note:

If you live in Massachusetts, Minnesota or Wisconsin, Medigap policies are standardized in a different way. https://www.medicare.gov/supplements-other-insurance/how-to-compare-medigap-policies

Medicare Advantage Plans
Not always available in every location.

1. **Preferred Provider Organization (PPO) plans**

   - A Medicare PPO Plan is a type of Medicare Advantage Plan (Part C) offered by a private insurance company; in a PPO plan, you pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network, and you pay more if you use doctors, hospitals and providers outside of the network

   - A PPO plan isn't the same as Original Medicare or a Medicare Supplement Insurance (Medigap) policy

   - PPO plans usually offer more benefits than Original Medicare, but you may have to pay extra for these benefits

2. **Health Maintenance Organization (HMO) plans**

   - In HMO plans, you generally must get your care and services from doctors, other health care providers and hospitals in your plan's network; you may also need to get a referral from your primary care doctor to see other providers

   - If your doctor or other health care provider leaves the plan, your plan will notify you; you can then choose another doctor in the plan

   - If you get health care outside the plan's network, you may have to pay the full cost

   - Insureds must follow the plan's rules, like getting prior approval for certain services

Private Fee-For-Service (PFFS) plans

1. A PFFS plan is a type of Medicare Advantage Plan (Part C) offered by a private insurance company; PFFS plans aren't the same as Original Medicare or Medigap

2. The plan determines how much it will pay doctors, other health care providers, and hospitals and copayments or coinsurance you must pay when you get care; Original Medicare won't pay for your health care while you're in the Medicare PFFS Plan

3. Some PFFS plans contract with a network of providers who agree to always treat you even if you've never seen them before

4. Out-of-network doctors, hospitals and other providers may decide not to treat you even if you've seen them before (a provider can choose at every visit whether to accept your plan's terms and conditions of payment)

5. For **each service** you get, you need to make sure the doctors, hospitals and other providers agree to treat you under the plan and accept the plan's payment terms

6. In an emergency, doctors, hospitals, and other providers must treat you

Qualifying events that allow a change from Medicare Advantage to Original Medicare

1. Anyone enrolling in an Advantage plan has a 12-month trial period

2. Moving to an area that has no network

3. Your network becomes insolvent

Medicaid

Medicaid (Medi-Cal in California) provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. Medicaid is administered by states, according to federal requirements. The program is funded jointly by states and the federal government.

Qualifications for Medicaid

State Application Form

Limits of assets and income vary by state but there are two tests that must be passed

1. Income rules test:
    - What is and is not income under Medicaid's rules?
    - How is Social Security income viewed under Medicaid?
2. Level of care eligibility test:
    - Assisted living
    - Nursing home

Rules for Singles and Married Couples

1. Income/assets

2. "Spend down"

3. "Community spouse resource allowance"

4. "Institutionalized spouse"

Deficit Reduction Act of 2005, effective February 8, 2006

1. Look-back period for all transfers is 60 months

    - Begins at time of application
    - If penalized for a violation of transfer of assets rule, the qualification time frame begins at the date of application, not the date of violation

2. Penalty period created by a transfer will not begin until transferor:

    - Has moved to a nursing home,
    - Has spent down to the asset limit for Medicaid eligibility,
    - Has applied for Medicaid coverage, **and**
    - Has been approved for coverage but for the transfer

Permitted Asset Transfers

1. Your spouse (but this may not help you become eligible since the same asset limit on both spouses' assets will apply)

2. Your child who is blind or permanently disabled or into a trust for the sole benefit of anyone under age 65 and permanently disabled

3. In addition, you may transfer your home to those listed above, as well as to the following individuals:

    - Your child who is under age 21 (unusual for nursing home residents)

    - Your child who has lived in your home for at least two years prior to your moving to a nursing home and who provided you with care that allowed you to stay at home during that time (often referred to as the "caretaker child")

    - A sibling who already has an equity interest in the house and who lived there for at least a year before you moved to a nursing home

Income and Asset Rules for the Top 5 Medicaid States

2021 California Medicaid/Medi-Cal Long-Term Care Eligibility for Seniors									
Type of Medicaid	**Single**			**Married (both spouses applying)**			**Married (one spouse applying)**		
	Income Limit	Asset Limit	Level of Care Required	Income Limit	Asset Limit	Level of Care Required	Income Limit	Asset Limit	Level of Care Required
Institutional/ Nursing Home Medicaid	*No income limit	$2,000	Nursing Home	*No income limit	$3,000	Nursing Home	*No income limit	$2,000 for applicant & $130,380 for non-applicant	Nursing Home
Medicaid Waivers/ Home and Community Based Services	$1,468/ Mth increased in August	$2,000	Help with 2 ADLs	$1,983 Mth increased in August	$3,000	Help with 2 ADLs	$1,486/ Mth increased in August for applicant	$2,000 for applicant & $130,380 for non-applicant	Help with 2 ADLs
Regular Medicaid/ Aged Blind and Disabled	$1,468/ Mth increased in August	$2,000	None	$1,983/ Mth increased in August	$3,000	None	$2,068/ Mth increased in August	$3,000	None

Source: https://www.medicaidplanningassistance.org/medicaid-eligibility-california

2021 Texas Medicaid Long-Term Care Eligibility for Seniors									
Type of Medicaid	**Single**			**Married (both spouses applying)**			**Married (one spouse applying)**		
	Income Limit	Asset Limit	Level of Care Required	Income Limit	Asset Limit	Level of Care Required	Income Limit	Asset Limit	Level of Care Required
Institutional/ Nursing Home Medicaid	$2,382/ mth	$2,000	Nursing Home	$4,764/ mth	$3,000	Nursing Home	$2,382/ mth for applicant	$2,000 for applicant & $130,380 for non-applicant	Nursing Home
Medicaid Waivers/ Home and Community Based Services	$2,382/ mth	$2,000	Nursing Home	$4,764/ mth	$3,000	Nursing Home	$2,382/ mth for applicant	$2,000 for applicant & $130,380 for non-applicant	Nursing Home
Regular Medicaid/ Aged Blind and Disabled	$794/ mth	$2,000	None	$1,191/ mth	$3,000	None	$1,191/mth	$3,000	None

Source: https://www.medicaidplanningassistance.org/medicaid-eligibility-texas

2020* Florida Medicaid Long-Term Care Eligibility for Seniors									
Type of Medicaid	**Single**			**Married (both spouses applying)**			**Married (one spouse applying)**		
	Income Limit	Asset Limit	Level of Care Required	Income Limit	Asset Limit	Level of Care Required	Income Limit	Asset Limit	Level of Care Required
Institutional/ Nursing Home Medicaid	$2,349/ mth	$2,000	Nursing Home	$4,698/ month (Each spouse is allowed up to $2,349/ month)	$3,000	Nursing Home	$2,349/ mth for applicant	$2,000 for applicant & $128,640 for non-applicant	Nursing Home
Medicaid Waivers/ Home and Community Based Services	$2,349/ mth	$2,000	Nursing Home	$4,698/ month (Each spouse is allowed up to $2,349/ month)	$3,000	Nursing Home	$2,349/ mth for applicant	$2,000 for applicant & $128,640 for non-applicant	Nursing Home
Regular Medicaid/ Aged Blind and Disabled	$961/mth	$5,000	None	$1,261/ mth	$6,000	None	$1,261/ mth	$6,000	None

Source: https://www.medicaidplanningassistance.org/medicaid-eligibility-florida

2020 New York Medicaid Long-Term Care Eligibility for Seniors									
Type of Medicaid	Single			Married (both spouses applying)			Married (one spouse applying)		
	Limit	Asset Limit	Level of Care Required	Income Limit	Asset Limit	Level of Care Required	Income Limit	Asset Limit	Level of Care Required
Institutional/ Nursing Home Medicaid	$875/ mth	$15,750	Nursing Home	$1,284/ mth	$23,100	Nursing Home	$875/ mth for applicant	$15,750 for applicant & $128,640 for non-applicant	Nursing Home
Medicaid Waivers/ Home and Community Based Services	$875/ mth	$15,750	Help w/ 2 ADLs	$1,284/ mth	$23,100	Help w/ 2 ADLs	$875/ mth for applicant	$15,750 for applicant & $128,640 for non-applicant	Help w/ 2 ADLs
Regular Medicaid/ Aged Blind and Disabled	$875/ mth	$15,750	None	$1,284/ mth	$23,100	None	$1,284/ mth	$23,100	None

Source: https://www.medicaidplanningassistance.org/medicaid-eligibility-New%20York

2020 Illinois Medicaid Long-Term Care Eligibility for Seniors									
Type of Medicaid	**Single**			**Married (both spouses applying)**			**Married (one spouse applying)**		
	Income Limit	Asset Limit	Level of Care Required	Income Limit	Asset Limit	Level of Care Required	Income Limit	Asset Limit	Level of Care Required
Institutional/ Nursing Home Medicaid	$1,063/ mth	$2,000	Nursing Home	$1,437/ mth	$3,000	Nursing Home	$1,063/ mth for applicant	$2,000 for applicant & $109,560 for non-applicant	Nursing Home
Medicaid Waivers/ Home and Community Based Services	$1,063/ mth	$2,000	Help w/2 ADLs	$1,437/ mth	$3,000	Help w/2 ADLs	$1,063/ mth for applicant	$2,000 for applicant & $109,560 for non-applicant	Help w/2 ADLs
Regular Medicaid/ Aged Blind and Disabled	$1,063/ mth	$2,000	None	$1,437/ mth	$3,000	None	$1,437/ mth	$3,000	None

Source: https://www.medicaidplanningassistance.org/medicaid-eligibility-illinois

For additional states:
https://www.medicaidplanningassistance.org/state-medicaid-resources

Mandatory Benefits

Mandatory Medicaid Benefits				
Facilities	Inpatient hospital services	Outpatient hospital services	Nursing facility services, including skilled nursing, rehabilitation, and long-term care	
Services	Home health services	Physician services	Certified pediatric and family nurse practitioner services	Transportation to medical care
Clinics	Rural health clinic services	Federally qualified health center services		
Diagnostic	Laboratory and X-ray services	Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) for children		
Pregnancy	Nurse- midwife services	Family planning	Freestanding birth center services (when licensed or otherwise recognized by the state)	Tobacco cessation counseling for pregnant women

Optional Benefits

Optional Medicaid Benefits			
Facilities	**Services**	**Other**	**Therapy**
Services for individuals age 65 or older in an Institution for Mental Disease (IMD)	Clinic, optometry and dental services	Prescription drugs	Physical therapy
Services in an intermediate care facility for individuals with intellectual disability	Chiropractic, respiratory care and podiatry services	Dentures, prosthetics and eyeglasses	Occupation therapy
Inpatient psychiatric services for individuals under age 21	Private duty nursing, personal care, hospice, case management and TB-related services	State plan home and community-based services – 1915(i) and Community First Choice Option 1915(k)	Speech, hearing and language disorder services
Health homes for enrollees with chronic conditions – Section 1945	Other diagnostic, screening, preventative and rehabilitative services	Other services approved by the secretary of HHS	

Knowledge Check 4

The prospect is turning sixty-five in three months and is receiving a lot of mail regarding Medigap.

He wants to know if Medigap is mandatory and what the difference is between the AARP Plan F and the Blue Cross Blue Shield Plan F.

Essentials of Long-Term Care Insurance (LTCI)

Learning Objective 6:
Participants will use knowledge of the reasons for long-term care insurance to evaluate client needs and provide appropriate counsel in contract selection.

Life Expectancy Trends

Much longer life expectancy than our great-grandparents

Quality of life at older ages is a real question mark!

Family dynamics:

- Smaller families with fewer siblings to care for parents
- Families spread out geographically across the country or even the world

Long Term Care Interview Video

Women in the workforce and unable to care for a family member

Baby boomers coming of age into long-term care needs

U.S. Life Expectancy

Year	Male	Female
1900	48	51
1920	56	58
1940	63	67
1960	68	74
1980	71	78
2000	75	80
2040	84	87
* Age rounded to nearest whole number		

Reasons for LTCI

1. Preserve independence

2. Guarantee choice of care and caregivers (allowing one to stay at home as long as possible)

3. Protect assets and standard of living

4. Avoid being a burden on family

5. Leave more assets to family, church, school or worthy cause

6. Peace of mind

Genworth Cost of Care Survey 2019

HOME

Homemaker Services: Services providing help with household tasks that cannot be managed alone. Homemaker services includes "hands-off"care such as cooking, cleaning and running errands.

NATIONAL MEDIAN HOURLY RATE	CHANGE SINCE 2018	FIVE-YEAR ANNUAL GROWTH[3]
$22.50	7.14%	3.44%

Home Health Aide Services: Home health aides offer services to people who need more extensive care. It is "hands-on" personal care, but not medical care. The rate listed here is the rate charged by a non-Medicare certified, licensed agency.

NATIONAL MEDIAN HOURLY RATE	CHANGE SINCE 2018	FIVE-YEAR ANNUAL GROWTH[3]
$23	4.55%	3.09%

COMMUNITY

Adult Day Health Care (ADC): Provides social and support services in a community-based, protective setting. Various models are designed to offer socialization, supervision and structured activities. Some programs may provide personal care, transportation, medical management and meals.

NATIONAL MEDIAN DAILY RATE	CHANGE SINCE 2018	FIVE-YEAR ANNUAL GROWTH[3]
$75	4.17%	2.90%

FACILITY

Assisted Living Facility (ALF): Residential arrangements providing personal care and health services. The level of care may not be as extensive as that of a nursing home. Assisted living is often an alternative to a nursing home, or an intermediate level of long term care.

NATIONAL MEDIAN MONTHLY RATE	CHANGE SINCE 2018	FIVE-YEAR ANNUAL GROWTH[3]
$4,051	1.28%	2.97%

Nursing Home Care: These facilities often provide a higher level of supervision and care than Assisted Living Facilities. They offer residents personal care assistance, room and board, supervision, medication, therapies and rehabilitation, and on-site nursing care 24 hours a day.

Semi-Private Room

NATIONAL MEDIAN DAILY RATE	CHANGE SINCE 2018	FIVE-YEAR ANNUAL GROWTH[3]
$247	0.96%	3.10%

Private Room

NATIONAL MEDIAN DAILY RATE	CHANGE SINCE 2018	FIVE-YEAR ANNUAL GROWTH[3]
$280	1.82%	3.13%

Source: https://pro.genworth.com/riiproweb/productinfo/pdf/131168.pdf

Funding Sources for LTCI

Out-of-Pocket

These family-funded sources include: cash, savings, retirement plans, reverse mortgages, senior life settlements, etc.

The Government

1. **Veterans Administration (VA)**

   Veterans of foreign wars may be eligible for in-home care or nursing home benefits provided by subsidized VA programs. The Department of Veterans Affairs handles such inquiries.

2. **Medicare**

   - Website: http://www.medicare.gov/

   - Medicare primarily provides short-term and rehab care

   - Medicare does have long-term care coverage, BUT it provides coverage only if several requirements are met:

     – A consecutive three-day hospital stay must precede entry into a skilled nursing facility and for the same medical condition

     – Care needed by the patient must be skilled nursing

     – Facility must be certified by Medicare

     – Physician must certify the need

     – Patient's condition must be improving

- Medicare response to LTC need
  - Medicare nursing home requirement rules
  - Medicare at-home requirement rules
  - Various degrees of therapy provided
  - Certain necessary equipment

- There is a sliding scale of coverage payments from Medicare that will likely result in significant monetary outlay by the patient; in addition to copayments, Medicare *only provides 100 days of coverage per admission:* it is NOT long-term coverage
  - First 20 days in facility – Medicare pays in full
  - Days 21-100 – Patient pays $185.50 per day (in 2021) as a copayment
  - Days 101 and beyond – Medicare pays nothing

- Medicare Supplement Insurance – fills in the coverage "gaps" from Medicare (Part A or B)

3. **Medicaid**

- Certainly, the method of last resort but does pay for LTC services for those at or below poverty level

- Anyone who still has assets and applies for Medicaid will be required to divest many of those assets to their state's Medicaid program

- Amount of assets and income that one can keep when applying for Medicaid is minimal and varies by state

Benefits Provided by LTCI

In-Home Coverage

- Home health care – medically necessary skilled care performed by trained medical personnel
- Home care – more custodial in nature

Assisted Living Facility/Group Home

- Coverage form and benefits can vary greatly among insurance companies

Nursing Home Coverage

- Skilled care – requires trained medical personnel authorized by a physician
- Intermediate care – similar to skilled care but on a less frequent basis

Adult Day Care Coverage

- Not usually every day but sufficient to give regular caregiver a break and to give the patient welcome interaction outside the home

Hospice Care

- Not location-specific but pays benefits for symptom control for terminally ill patients

Types of LTCI Policies

Most long-term care insurance policies today are “reimbursement” type contracts where benefits are paid only for expenses incurred, up to a predetermined amount. “Indemnity” contracts typically pay the entire predetermined amount of a daily or monthly benefit.

Comprehensive: provides for nursing home facilities, assisted living facilities, home health care, adult day care, respite care, and care coordination.

Nursing home only: may include assisted living facilities

Home care only: may include adult day care

Note:
Not all carriers offer all three. The marketing trend the last few years is for companies to offer a Comprehensive policy only.

LTCI Policy Provisions and Coverage Options (Riders)

Learning Objective 7:

Participants will use knowledge of policy provisions, benefit triggers, qualified and non-qualified contracts, state-endorsed programs, and medical underwriting issues to determine the possibilities for payout in given scenarios.

Bed Reservation

A policy provision that provides 30 to 50 days annual coverage for daily room expense in an assisted living facility or nursing home should the covered person require a stay at a hospital. This ensures the facility will not rent the room to someone else should a medical emergency arise.

Daily/Weekly/Monthly Benefit Amount

Most contracts are issued as a *daily benefit*. This type of policy would pay covered expenses, but no more than a daily maximum limit. A broader contract would be one issued as a weekly benefit or even a monthly benefit (many carriers accomplished this via a rider). The extra premium for a broader contract is usually no more than 7% to 12% annually.

Reimbursement vs. Indemnity

Most contracts are sold as *reimbursement*. These policies pay the lesser of the covered expense, not to exceed the daily (or weekly/monthly) benefit purchased. An indemnity contract pays the daily (or weekly/monthly) benefit purchased regardless of actual claims expense. The *claim trigger* number of ADLs (activities of daily living) and *elimination period* would have to be satisfied.

Guaranteed Benefit Increase (Inflation Rider)

A rider which increases the daily (or weekly/monthly) benefit on a systematic basis (usually annually). Available on either a simple or compounded basis.

Joint Waiver of Premium Rider

Also referred to as a *dual waiver of premium,* this rider is available only when coverage has been purchased by a couple (married or partner). A standard policy provision with some carriers, this rider waives the premium on both contracts when one spouse or partner satisfies the ADL coverage trigger and the elimination period and begins collecting benefits.

Policy Sharing Benefit

This is a benefit added via a rider. It is only available when contracts have been purchased by a couple (married or partner) ***and*** has a benefit period that is *less* than lifetime. Allows you to access up to one-half of your spouse or partner's benefits when your own policy benefits have been exhausted.

Elimination Period

The time frame the insured must wait before collecting benefits from the contract. This is represented in a number of days after the ADLs (or severe cognitive impairment) are satisfied. The longer the elimination period, the lower the premium.

Benefit Period

The number of years the benefit is payable once the claim trigger and elimination period are met. Years such as 2, 3, 5, and 10 are the usual options available.

Premium Discounts and Options

Carriers offer a wide variety of premium discounts. Some carriers make them available only for contracts covering both a husband and wife. Others make them available for partners with a common address. Some carriers will have a paid-up policy, such as a 10-pay or age 65.

Coverage Outside the United States

Many carriers allow some restricted coverage outside the United States or Canada. Carriers that provide coverage usually do so by limiting the maximum payout to a percentage of the daily benefit – such as 75% – and then further limit the coverage to a maximum number of years – such as five or six.

Caregiver Training and Respite Care Service

Many carriers provide some benefit for caregiver training. This would be training of a family member wishing to be the caregiver. Also, a benefit is usually available to provide for another person to relieve the primary caregiver, so they may have some time off. This is called respite care service.

Compensation for Family Member as the Caregiver

This is available through some carriers, but generally only as a rider.

Nonforfeiture Benefit

This benefit is different than the nonforfeiture benefit in whole life. A standard policy provision with some carriers (but a rider with most) that allows coverage to continue in force for some period of time or may allow a reduced paid-up contract should the premiums be terminated by the insured.

Benefit Triggers in a Qualified LTCI Policy

Six Activities of Daily Living

Benefits are triggered by the inability to perform any **two** of these ADLs:

1. Eating: Feeding yourself by getting food into your body from a receptacle such as a plate, cup or table, or from a feeding tube or intravenously

2. Dressing: Putting on and taking off all items of clothing and necessary braces, fasteners or artificial limbs

3. Bathing: Washing yourself by sponge bath or in either a tub or shower, including the task of getting in or out of the tub or shower

4. Toileting: Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene

5. Transferring: Moving into or out of a bed, chair or wheelchair

6. Maintaining continence: Ability to maintain control of bowel or bladder function, or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene, including caring for a catheter or colostomy bag

OR

Cognitive Impairment

"Severe cognitive impairment" means a loss or deterioration in intellectual capacity that is: (1) comparable to Alzheimer's disease and similar forms of irreversible dementia and (2) determined by clinical evidence and standardized tests that reliably measure impairment in the individual's (1) short-term or long-term memory; (2) orientation to people, places, or time; and (3) deductive or abstract reasoning

HIPAA and Tax-Qualified vs. Non-Qualified LTCI Contracts

Qualified vs. Non-Qualified Contracts

Deductibility of Premiums:

- Qualified LTCI**:** premiums may be deductible, subject to current tax codes
- Non-qualified LTCI: premiums are never deductible

ADLs and Coverage Triggers:

- Qualified LTCI: coverage triggers must be 2 of 6 ADLs (or cognitive impairment)
- Non-qualified LTCI: ADLs are usually more liberal – 1 of 6, or even 1 of 7 ADLs (or cognitive impairment).

Cost of Coverage:

- Qualified LTCI: generally, will have a lower cost than a non-qualified
- Reason: the non-qualified is easier to meet the claims trigger

State-Endorsed LTCI Partnership Programs

- Most states are instituting Long-Term Care Insurance Partnership Programs, which are designed to mitigate significant drains on Medicaid funds in the individual states

- Insurance companies agree to participate by offering LTCI policies that meet state and federal requirements

- Policyholders who own these contracts could be entitled to *asset disregard*, meaning the amount of a policyholder's assets equal to the amount of insurance benefits received under the qualified partnership policy will be disregarded for the purpose of determining the insured's eligibility for Medicaid

- Asset disregard encourages people to purchase long-term care coverage which could minimize the number of applicants who would otherwise apply for Medicaid to fund their long-term care

- See the HHS LTCI website at https://longtermcare.gov for state-specific information

Factors Affecting Cost

The cost of a long-term care policy depends on the following factors:

1. Health
2. Age – the average purchaser's age is 59
3. Marital status
4. Benefits chosen
5. Eligible discounts

Medical Underwriting Issues

Questions on a typical application that are answered "yes" will most often preclude issuance of a policy to the applicant. Certainly, this is dependent on an individual company's policy, but following are examples of the kinds of conditions or situations that tend to be deal breakers.

Does the applicant currently have, or have they ever been diagnosed with:

- Alzheimer's
- ALS
- Dementia
- Huntington's chorea
- Memory loss
- Multiple sclerosis
- Parkinson's disease

Does the applicant require assistance in any of the ADLs?

Does the applicant require any assistance in walking, such as use of a cane, walker, wheelchair, or other device?

Tax Legislation

Individual Purchase

Tax-qualified LTCI premiums are considered a medical expense. For an individual who itemizes tax deductions, medical expenses are deductible to the extent that they exceed the current amount required to meet the individual's adjusted gross income. The amount of the LTCI premium treated as a medical expense is limited to the eligible LTCI premium, as defined by IRC 213(d). Any portion of the LTCI premium that exceeds the eligible LTCI premium is not a deductible medical expense.

Individual taxpayers can treat premiums paid for tax-qualified long-term care insurance for themselves, their spouse or any tax dependents (such as parents) as a personal medical expense.

The yearly maximum deductible amount for each individual depends on the insured's attained age at the close of the taxable year (see **Table 1** for current limits). These deductible maximums are indexed and increase each year for inflation.

2021 Long-Term Care Insurance Federal Tax-Deductible Limits (Table 1)

Taxpayer's Age at End of Tax Year – Deductible Limit	
40 or less	$ 450
More than 40 but not more than 50	$ 850
More than 50 but not more than 60	$1,690
More than 60 but not more than 70	$4,520
More than 70	$5,640

Source: https://www.forbes.com/advisor/life-insurance/2021-ltc-deduction-limits/

Self-Employed

Self-employed individuals can deduct 100% of their out-of-pocket LTCI premiums, up to the eligible premium amounts listed in Table 1. The portion of LTCI premiums that exceeds the eligible premium amount is not deductible as a medical expense. The deductible amount includes eligible premiums paid for spouses and dependents per IRC 162(l). It is not necessary to meet Adjusted Gross Income (AGI) thresholds to take this deduction.

However, self-employed individuals may not deduct LTCI premiums during any calendar month in which they or their spouse are eligible to participate in a subsidized LTCI plan (where the employer pays all or part of the premiums for LTCI).

Partnerships, LLCs, and Subchapter S Corporations

Partners in a partnership, members of a Limited Liability Company (LLC) that is taxed as a partnership and shareholders/employees of Subchapter S corporations who own more than 2% of the corporation, are taxed as self-employed individuals. The partnership, LLC, or Subchapter S corporation pays the premium.

The partner, member, or shareholder/employee includes the LTCI premium in his or her adjusted gross income, but may deduct up to 100% of the age-based eligible premium, as listed in Table 1. It is not necessary to meet an AGI threshold.

C Corporations

When a business purchases a tax-qualified LTCI policy on behalf of any of its employees, or their spouses and dependents, the C corporation is entitled to take a 100% deduction as a business expense on the total premiums paid. The deduction is not limited to the aged-based eligible premiums.

The purchase of a tax-qualified LTCI policy is not subject to any nondiscrimination rules, allowing an employer to be selective in the classification of employees it elects to cover.

The premium paid by the business is excluded from the employee's AGI (not reported) even if the premium exceeds the eligible premium amount listed in Table 1.

Employer-Pay Contributory Arrangement on Behalf of an Employee

If an employer pays all or a portion of a tax-qualified LTCI premium on behalf of an employee, the amount paid is deductible by the employer as a business expense. The deduction is not limited by the age-based limits. The entire employer contribution is also excluded from the employee's AGI.

If the employer only pays a portion of the premium, employees are able to apply the balance that they pay towards their medical expenses, up to the eligible premium amount, and are entitled to a deduction for medical expenses that exceed 10% of AGI in 2021.

Knowledge Check 5

A personal lines client you have worked with for many years has just called you to inquire about the cost of LTCI. His mother passed away six months ago and was in a Medicaid-certified nursing facility for two and a half years prior to her death.

Now the state is telling your client they will be liquidating his mother's assets to recover Medicaid expenses for the last two years.

The client wants your help in conserving his family assets to prevent this from happening to him and his children and is concerned about adding LTCI to his budget because his youngest child is getting ready to go to college.

How would you counsel him?

Questions to Ask Before Purchase of an LTCI Policy

1. Are there friends or family who would willingly provide care?
2. Are you too young or too old to purchase an LTC policy?
3. Are there any health issues affecting eligibility?
4. What is the cost of care expected to be?
5. Are there sufficient assets available to self-insure?

Learning Objective 8:

Participants will use knowledge of other products available to insure long-term care needs to determine the best products to meet a particular client's needs.

Additional Insurance Products for Funding Long-Term Needs

Life Insurance Policy With an LTC Rider

- Normally allows the insured to receive an advance on the death benefit
- Inflation adjustment riders may be available
- Some contracts include automatic waiver of premium triggered by insured qualifying for LTC benefits
- Long-term care benefit periods may range from a few years to lifetime

LTC Chart

Linked Benefit Life Insurance

- A linked-benefit life insurance policy provides assets, combining life insurance with LTC benefits; if insured needs long-term care, the policy helps pay those expenses; if insured does not need LTC, the policy provides a death benefit (almost always free of income tax)

- Most are written on a single-premium basis (can be flexible premium) which leverages the premium into a higher benefit, e.g., a $50,000 single premium purchases $125,000 of benefit that can be used for LTC or passed to heirs at death (if no LTC benefit is used, full amount is passed on to heirs; if LTC benefit is used, unused amount is passed to heirs)

- Optional riders may increase LTC benefits

- Some companies also offer second-to-die (survivorship) life policies that provide insureds with both LTC benefits and a death benefit on unused amount

Linked Benefit Annuity

- A linked benefit annuity works much the same way as a linked benefit life insurance policy and might be a choice if the applicant cannot qualify for life insurance

- Most are written on a single-deposit basis with a percentage of the annuity's value available for LTC; if annuitant does not need LTC, any taxable death benefit passes to the named beneficiary

Short-Term Care Insurance Products

Some companies are offering this product as a pre-long-term care benefit. It generally provides 100 to 360 days of benefits, has a limited benefit amount of up to $300 per day, short elimination periods, such as 0, 15, 30, or 60 days, and minimal underwriting requirements. It is NOT, however, approved for sale in all 50 states.

Long-Term Care Funding Options		
Client's Top Priority	Solution	Considerations
Protecting assets from an extended health care event	Traditional LTCI	PRO: Maximizes LTC leverage while minimizing premium commitment. Potentially tax deductible for businesses. CON: Premiums not guaranteed, lack of flexibility
Protecting assets from an extended health care event while retaining maximum flexibility	Asset-Based LTCI	PRO: Maximized flexibility while still retaining a primary objective of providing for an LTC event. Provides Return of Premium Death benefit, and LTCI. Guaranteed level premiums. CON: Reduced death benefit compared to Life with rider option. Reduced LTC poll compared to traditional LTCI.
Maximizing death benefits while retaining some flexibility	Traditional Life Insurance with an Accelerated Benefit Rider	PRO: Provides largest death benefit while retaining flexibility to pay for LTC costs. Better suited to pay for monthly basis if needed. CON: Reduced LTC benefit compared to Traditional LTC and Asset-based LTC. Typically, does not offer 110% ROP.
Long-term care options late in life with potential health concerns	Fixed on Indexed Annuity with LTC Rider	PRO: Provides streamlined underwriting for clients with health concerns while turning tax-deferred to potentially tax-free growth CON: No immediate leverage of the base asset and limited growth opportunities compared to alternative annuity options
Access to money	Self-Fund	PRO: Zero upfront cost while retaining liquidity CON: Pay dollar for dollar for any care needed. Estate serves as primary funding source.

Learning Objective 9:
Participants will use knowledge of disability definitions, the statistical risk of becoming disabled and potential sources of income after disability to evaluate client needs and provide appropriate counsel.

The Nature and Risk of Becoming Disabled

- **56 million Americans, or 1 in 5, live with a disability**
  Social Security Administration Fact Sheet, January 2017

- **38 million disabled Americans, or 1 in 10, live with a severe disability**
  Social Security Administration Fact Sheet, January 2017

- **More than 1-in-4 20-year-olds become disabled before reaching retirement age**
  Social Security Administration Fact Sheet, January 2017

- **Nearly half of adults (48%) indicate they have set aside an emergency fund that would cover three months of expenses**
  Report on the Economic Well-Being of U.S. Households in 2016 – May 2017, Federal Reserve Board

- **Approximately 30% of all people ages 35 to 65 will suffer a disability that lasts at least 90 days**
  www.doctordisability.com/disability-statistics/

Your Age	Chances of suffering a long-term disability	Average length of disability
30	51%	4.7 years
35	48%	5.1 years
45	40%	5.8 years
50	34%	6.2 years

Source: *Commissioners Individual Disability Tables, CSO/Society of Actuaries, the National Safety Council, and/or The Million Dollar Round Table.*

If my disability has lasted one year, what is the probability the disability will last:

Your Age	1 More Year	2 More Years	5 More Years
25	67%	57%	47%
35	76%	67%	57%
45	79%	72%	62%
55	81%	73%	62%

Source: *Commissioners Individual Disability Tables, CSO/Society of Actuaries*

Potential Sources of Income After a Disability

1. Savings account
2. Loan from relatives
3. Loan from the bank or other lending institution
4. Liquidation of assets (retirement accounts, investments, home, cars, etc.)
5. Disability insurance policy
6. Social Security

Social Security's Definition of Disability

The inability to engage in any gainful activity by reason of any medically determinable physical or mental impairment which has lasted or could be expected to last for a continuous period of 12 months or result in death. The impairment must be so severe that the individual is unable to engage in substantial gainful work that exists in the national economy regardless of whether or not such work exists in the immediate area in which the applicant lives.

Program Description:

"The Social Security Administration (SSA) administers two programs that provide benefits based on disability: The Social Security disability insurance program (title II of the Social Security Act) and the Supplemental Security Income (SSI) program (title XVI of the Act).

"Title II provides for payment of disability benefits to disabled individuals who are 'insured' under the Act by virtue of their contributions to the Social Security trust fund through the Social Security tax on their earnings, as well as to certain disabled dependents of insured individuals. Title XVI provides SSI payments to disabled individuals (including children under age 18) who have limited income and resources."

"The Act and SSA's implementing regulations prescribe rules for deciding if an individual is 'disabled.' SSA's criteria for deciding disability may differ from the criteria applied in other government and private disability programs."

Disabilities covered fall under the following categories:

Musculoskeletal System	Skin Disorders
Special Senses and Speech	Endocrine Disorders
Respiratory Disorders	Congenital Disorders Affecting Multiple Body Systems
Cardiovascular System	Neurological Disorders
Digestive System	Mental Disorders
Genitourinary Disorders	Cancer (Malignant Neoplastic Diseases)
Hematological Disorders	Immune System Disorders

Total Disability Definitions

Any Occupation

- If because of accident or sickness the main duties of **any occupation** cannot be done; requires physician's care

Own Occupation

- If because of accident or sickness, the main duties of one's **own occupation** cannot be done

Insuring Agreement of a Disability Contract

Claim trigger:

1. **Accident** – an accidental bodily injury that happens on or after the effective date of the contract

2. **Sickness** – a sickness or disease that first appears on or after the effective date of the contract; includes a disability from a transplant surgery

Recurrent Disability

If a sickness or injury qualifies as a recurrent disability, it will actually be a continuation of a prior claim. No new waiting period will be required. The same related condition must cause the recurrent disability. Most contracts require less than six months to lapse between the claims.

Presumptive Disability

Total disability will be presumed, and no waiting period required, if the insured suffers the total and complete loss of any of the following:

1. Speech
2. Hearing in both ears
3. Sight in both eyes
4. Use of both hands
5. Use of both feet
6. Use of one hand and one foot
7. Sight in one eye and the total loss of one foot or hand

Example of the restrictive nature that one (or two) word(s) can have in determining the payment of a claim:

"We will pay the monthly benefit if the named insured suffers the total loss of any one, or a combination of the following: speech, hearing in both ears, etc."

"We will pay the monthly benefit if the named insured suffers the total, and irrecoverable, loss of any one, or a combination of the following: speech, hearing in both ears, etc."

Partial Disability

Some insurers offer a partial disability option for their disability income insurance policies that is intended to help cover reduced income. If the insured is working on a part-time basis, he or she is eligible to receive 50% of the otherwise payable benefit for a specified period of time. If the monthly benefit in the policy is $4,000 and the actual covered expenses in a month total $3,000, the partial benefit is 50% of the covered expenses, or $1,500.

Partial vs. Residual Disability – This may be a policy provision in some contracts. It allows benefits to be paid even though the insured is not totally disabled.

1. Partial disability – based on occupational performance
2. Residual disability – based on lost percentage of income

Disability Policy Provisions

Learning Objective 10:

Participants will use knowledge of types of disability policy provisions, optional riders, and underwriting considerations to determine the appropriate product to meet client needs in a variety of situations.

Elimination Period

This is similar to a deductible. The longer one waits to receive benefits, the lower the premium, all other coverage being equal. The elimination period is generally defined as the number of days immediately following the start of a disability in which no benefits are payable. In individual plans the normal wait is 30, 60, 90, 180, or 365 days. The waiting period will always be shown on the coverage page of the policy.

Benefit Period

This is the length of time the carrier will pay benefits as per the schedule selected by the insured. Two- and five-year benefits are common with all companies. The lower hazard occupations (attorneys, physicians, etc.) are eligible for coverage to age 65, or even lifetime. The longer the benefit period, the higher the premium. Benefits can be payable for either total disability or residual disability. The benefit period should be the same for both an accident and sickness.

Grace Period

A grace period of 30 or 31 days is found in all contracts.

Waiver of Premium

After 90 days of total disability, no further premiums are payable. Some carriers refund the three months of premium back to the insured.

Benefit Amount

This is the total amount of benefit payable. Most carriers will insure up to 60% or 70% of pretax income. Benefits received from personally paid, individual contracts are income-tax-free. Some carriers will insure up to a $20,000 monthly benefit.

Refund After Death

All companies refund any unearned premium. Some pay an additional three to six months benefit as a lump sum to a named beneficiary but only if the named insured is not currently on an active claim.

Misstatement of Age or Sex

The company will adjust the benefits to what the true and accurate age (or sex) would have purchased.

Named Exclusions in a Disability Contract

The fewer the better – some companies have no named exclusions (or only War). Most companies, however, have some or all of the following:

- War
- Normal pregnancy
- Normal childbirth
- Self-inflicted injuries
- Alcoholism
- Drug addiction

Continuing Coverage Past Age 65

Most DI contracts end at age 65. Some have a provision that allows the insured to continue coverage past age 65, usually to age 72 or 75. The language requires a certain number of hours at work each week. No additional riders are normally allowed.

Incontestability Clause

This policy provision is similar to the language as found in life contracts of two years.

Cancellation or Renewability Provisions

1. **Cancellable**:

   - Once issued, and until the end of the policy period, no restrictive riders can be added;
   - the premium may be increased on renewal, if increased for all in that class;

     AND

   - the contract can be canceled if withdrawn from an entire class, such as a state

2. **Guaranteed renewable**:

   - Once issued, no restrictive riders may be added by the company;
   - the premium may be increased on renewal if increased for all in that class;

     AND

   - the contract cannot be canceled by the company

3. **Noncancellable** (non-can):

   - The contract cannot be canceled by the insurance company;
   - after issuance no restrictive riders may be attached;

     AND

   - the rates cannot be increased

Renewability

The policy provision that details the conditions for which the insurance company agrees to continue to insure the disability income policy, e.g., *noncancelable*, *guaranteed renewable,* or *conditionally renewable*.

Proof of Loss

Also known as proof of claim, proof of loss requirements vary from policy to policy but are usually contained in the policy's definitions section or in a section explaining how to submit a claim. It consists of the information you must provide to support a claim.

Other Insurance

Coordination of benefits: Some policies offset Disability Income (DI) payments dollar-for-dollar, while others have a maximum dollar limit. Many will offset against the following types of income sources:

1. Workers compensation

2. State disability income (CA, HI, NJ, RI, and PR)

3. Social Security disability benefits

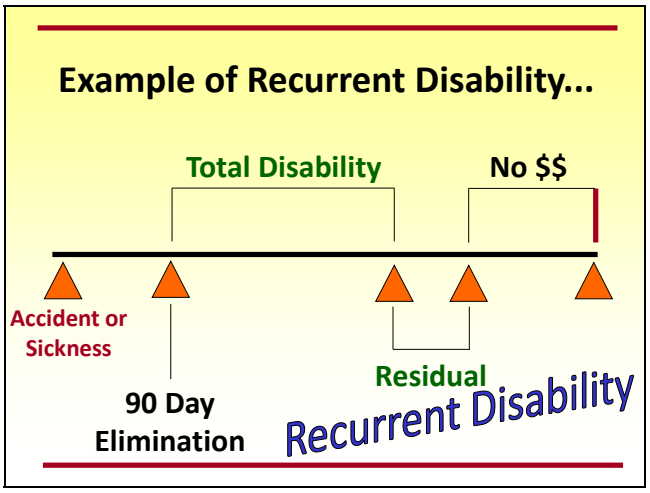
4. State no-fault auto wage laws

Profit restrictions

Some carriers have a provision that contractually prevents an insured from making a profit (too much DI in relation to income).

Recurrent disability

If a sickness or injury qualifies as a recurrent disability, it will actually be a continuation of a prior claim. No new waiting period will be required. The same or related condition must occur again to qualify as a recurrent disability. Most contracts require less than six months (12 months with some) to lapse between the two claims.



DI Riders

Cost of Living Rider

An excellent, but reasonably expensive rider that increases the coverage based on the Cost Of Living Adjustment (COLA), or another inflation rate, *after* the disability begins. There is usually a wait of one or two years until benefits increase.

Guaranteed Issue Rider (GIR)

A reasonably inexpensive rider (a policy provision with some carriers) that allows the insured to purchase additional coverage at certain ages; a GIR is usually in one- to three-year increments that cease at age 50. No medical or occupational underwriting is performed. However, a major difference in this GIR from the one found in the life policies is financial underwriting. The carrier will only insure for about 60% to 70% of coverage to gross income. All forms of in-force individual and group coverage are considered for this percentage.

Social Insurance Substitute Rider

This provides additional benefits when the inured is disabled and receiving no social insurance benefits, such as workers compensation, no-fault, state DI and/or Social Security DI benefits.

Return of Premium

This is a provision that returns all or a portion of the paid premium to the owner. The amount returned depends on the number of years the policy was in force and number of claims paid.

Occupational Rehabilitation

This rider helps pay for vocational training after a disability which can be helpful if you have an own-occupation policy that allows collection of benefits while working another job.

Catastrophic Disability Benefit

A rider that pays an additional benefit amount if you have a catastrophic disability, typically defined as one where you are unable to perform two activities of daily living.

Unemployment Premium Suspension

This rider suspends premiums while unemployed, allowing the policyholder to stop paying premiums, but to continue to own the policy. Coverage is suspended during unemployment. If the policyholder becomes disabled during this time, he or she won't receive a benefit.

Underwriting Considerations

Considerations Other Than Medical

Underwriting will take into account the following: age, sex, nicotine use, hobbies, pretax income (earned and passive) and occupation.

Occupation

Because the duties of a job may contain more risk than the job title indicates, it is important to get a thorough job description.

Medical History

A healthy insured who qualifies for standard life may be rejected for disability. For preexisting conditions, the underwriting options are to endorse, rate up or reject entirely.

Knowledge Check 6

You have a friend in your Rotary Club who is a pediatric hand surgeon and associate professor at a large university medical school hospital. She has been concerned about disability income issues since a colleague of hers was involved in a boating accident, resulting in a recovery period of several years.

She has requested your counsel with the following question:

What is the best disability coverage for her to purchase that will not require her to take another job to pay for the premium?

Essentials of Business Overhead Expense (BOE) Disability Income

Learning Objective 11:
Participants will use knowledge of Business Overhead Expense disability income policies and their tax considerations to advise clients about contract options for reimbursement of qualifying expenses if an owner becomes disabled.

BOE DI Contracts

Primary Purposes

A BOE policy provides for reimbursement of eligible expenses in the event of disability of the person named in the policy (the owner and primary revenue earner in the business).

- Allows the business to receive income while the insured person is disabled
- Qualifying expenses include:

1. Payroll (employees)
2. Rent
3. Utilities
4. Professional licenses and dues
5. Accounting and legal fees
6. Forms and supplies
7. Business insurance premiums
8. Miscellaneous (see the *Sample BOE Worksheet*)

- Allows the business to hire capable replacements
- Keeps the business open
- If the disability will be long-term, a BOE policy can be a mechanism to allow the business to be sold as a “going concern”

Characteristics of BOE DI Contracts

- Waiting periods are short: usually 30, 60, or 90 days
- Benefit periods are short: 12, 18, or 24 months
- Benefit amounts: up to $20,000 per month is available with many major companies

Sample Business Overhead Expense Worksheet

Prepared For:	Jan Jones, DVM	**By:**	Joe Agent
Name of Business:	Northeast Animal Hospital	**Date:**	01/12/18

Eligible Business Expense	Monthly Expense
Salaries of non-income producing employees	$5,000.00
Rent or interest on your business mortgage	1,500.00
Utilities (telephone, electricity, heat, and water)	500.00
Business depreciation	500.00
Business related taxes	200.00
Leasing or installment payment on equipment, furniture, and business auto	1,000.00
Professional licenses and dues	200.00
Laundry and maintenance	100.00
Accounting, legal fees, billing, and collection services	100.00
Business forms and supplies (not inventory stock)	50.00
Business insurance premiums (including malpractice)	200.00
Telephone answering service and/or paging system	30.00
Other expenses (itemize)	
Veterinary Assistant	2,000.00
Monthly Total	$11,380.00
Your Share of Total	$11,380.00

General Tax Guidelines: [IRS ruling 55-264, C.B. 1955-1, 11] 1) The premiums are tax deductible regardless of whether your business is a sole proprietorship, partnership, or corporation. 2) The benefits from this policy are taxable as income, but when these benefits are used to pay for deductible business expenses, the tax liability is offset by the business deduction.

Note: This information is a general statement of current law and should not be construed as tax advice. Please consult your attorney or tax advisor about the particulars of your own situation.

Knowledge Check 7

Your accountant has a client who is a dentist and just lost his dental practice because of an illness that took him away from work for nine months.

Your accountant, who is a sole practitioner, has asked you if there is any type of insurance that will pay her expenses if she becomes disabled.

What recommendations would you present to your accountant?

Review of Learning Objectives

1. Participants will use knowledge of health and medical contracts to evaluate their appropriateness for various client needs.

2. Participants will use knowledge of the benefits afforded by the Affordable Care Act (ACA) and ACA-compliant and noncompliant medical health plans to advise clients of the advantages ACA can provide in meeting their needs.

3. Participants will apply knowledge of tax-advantaged accounts and tax implications to meet a variety of prospect and client needs.

4. Participants will apply knowledge of federal laws to provide appropriate counsel to clients and prospects.

5. Participants will apply knowledge of Medicare, Medicare supplements, and Medicaid to correctly select which is the most appropriate product to meet the needs of a client.

6. Participants will use knowledge of the reasons for long-term care insurance to evaluate client needs and provide appropriate counsel in contract selection.

7. Participants will use knowledge of policy provisions, benefit triggers, qualified and non-qualified contracts, state-endorsed programs and medical underwriting issues to determine the possibilities for payout in given scenarios.

8. Participants will use knowledge of other products available to insure long-term care needs to determine the best products to meet a particular client's needs.

9. Participants will use knowledge of disability definitions, the statistical risk of becoming disabled and potential sources of income after disability to evaluate client needs and provide appropriate counsel.

10. Participants will use knowledge of types of disability policy provisions, optional riders and underwriting considerations to determine the appropriate product to meet client needs in a variety of situations.

11. Participants will use knowledge of Business Overhead Expense disability income policies and their tax considerations to advise clients about contract options for reimbursement of qualifying expenses if an owner becomes disabled.

Knowledge Check 1 – ANSWERS

The prospect is concerned about the rising costs of health care and is considering not having any coverage.

What options would be available that could substantially reduce the monthly health care premium cost?

Answer:

Increase the portion of insured or covered expenses before the insurance plan begins to pay (deductible). Increase the percentage of medical expenses the insured pays after the deductible has been paid (coinsurance).

Knowledge Check 2 – ANSWERS

Your good friend, Jennifer, is about to open a bagel and sandwich shop. You are discussing property and casualty options. She states: "I plan to have 5-6 full-time employees (30+ hours per week) and about the same number of part-time employees (less than 30 hours per week). I have heard I will be required to provide my employees health insurance, as per the Affordable Care Act. Is that true?"

Answer:

No, that is not true. Since you will be under 50 full-time employees, you will not have any potential penalty under the ACA for not offering coverage.

You handle a small manufacturing risk, owned by Bob. They employee 65 full-time employees. Bob has just received the renewal notice from their health insurance carrier which provides an ACA-compliant coverage plan. All full-time employees are afforded coverage. The premium has increased dramatically. Bob current pays 90% of the employee's self-only premium. He is thinking of dropping that to 50%. He asks; "Do you see any potential problems with that plan?"

Answer:

There are at least two potential problems with this Large Employer: 1) Should a full-time employee, that is covered under the plan, have to pay greater than 9.83% (2021) of their income for their self-only coverage, it will be deemed as "unaffordable". If their income is below 400% Federal Poverty Level, they are then eligible for a federal subsidy for their health insurance. Should they come off your plan and get a subsidy for an individual policy, you (the business) will be looking at a healthy penalty – exceeding $2,700 (2021) every month, for every full-time employee that obtains coverage and receives a subsidy. 2) Employee Benefits – such as health insurance – are a major factor in hiring and retaining good employees. Should an employee's contribution for health insurance premiums become very high, it may seriously affect hiring and retention.

Knowledge Check 3 – ANSWERS

Your client is familiar with FSA plans but wants their employees to have more of their own money involved in their health care programs

What plans, if any are available for the employer to offer?

Answer:

Health Savings Accounts (HSA) that allow for payment of unreimbursed health care expenses with a tax-qualified fund controlled and owned by the account holder (employee). Offer a HDHP high deductible health plan to provide insurance coverage. Also offer a limited purpose FSA to offer vision and dental coverage. IRS does not allow a general-purpose FSA offered with an HSA.

Knowledge Check 4 – ANSWERS

The client/prospect is turning sixty-five in three months and is receiving a lot of mail regarding Medigap.

The prospect wants to know if Medigap is mandatory?

Answer:

What is the difference between the AARP Plan F and the Blue Cross Blue Shield Plan F?

Answer:

Benefits are the same, but the premiums could be different.

Knowledge Check 5 – ANSWERS

A personal lines client you have worked with for many years has just called you to inquire about the cost of long-term care. His mother passed away six months ago and was in a Medicaid-certified nursing facility for two and a half years prior to her death.

Now the state is telling your client they will be liquidating his mother's assets to recover Medicaid expenses for the last two years.

The client wants your help in conserving his family assets to prevent this from happening to him and his children and is concerned about adding long-term care insurance to his budget because his youngest child is getting ready to go to college.

How would you counsel him?

Answer:

Look into adding a life insurance policy that allows for LTC payments. Also, look into annuities with LTC options. Advise to discuss setting up trusts that allow for sheltering assets. Will need advice from a trust attorney.

Knowledge Check 6 – ANSWERS

You have a friend in your Rotary Club who is a pediatric hand surgeon and associate professor at a large university medical school hospital. She has been concerned about disability income issues since a colleague of hers was involved in a boating accident, resulting in a recovery period of several years.

She has requested your counsel on the following question:

What is the best disability coverage for her to purchase that will not require her to take another job to pay for the premium?

Answer:

Review the current disability income policy through her university group program. Consider adding to it to cover any uncovered exposure, look at own occupation definition, non-cancellable, with an extended elimination period.

Knowledge Check 7 – ANSWERS

Your accountant has a client who is a dentist and just lost his dental practice because of an illness that took him away from work for nine months.

Your accountant, who is a sole practitioner, has asked you if there is any type of insurance that will pay her expenses if she becomes disabled.

What recommendations would you present to your accountant?

Answer:

Discuss business overhead expense coverage. Recognizing that it is designed to pay only qualifying expenses (not lost profits) and that benefit periods are short term, usually 2 years at most.

List of Resources

These are the links to the QR codes found throughout the Life & Health text:

Life Insurance Needs Worksheet
https://www.scic.com/pub/media/docs/lt-care/QR-Worksheets.docx

Insurance Evolution Video
https://scic.hosted.panopto.com/Panopto/Pages/Viewer.aspx?id=2bf0886a-6efb-45e2-bfb9-a9b50165a405

Sample Conditional Receipt
https://tinyurl.com/y9mnqbj5

Estate Planning Video #1
https://scic.hosted.panopto.com/Panopto/Pages/Viewer.aspx?id=15f33226-bbfd-442c-8199-a9b501656184

Estate Planning Video #2
https://scic.hosted.panopto.com/Panopto/Pages/Viewer.aspx?id=814c358c-3549-4119-8e83-a9b5016580a7

Example of a Total Needs Analysis
https://www.scic.com/pub/media/docs/lt-care/QR-Life-Insurance-Needs-Analysis.pdf

Annual Report Demonstrating Rebalancing
https://www.scic.com/pub/media/docs/lt-care/QR-Rebalancing-Annual-Report.pdf

Brief History of Annuities
https://www.scic.com/pub/media/docs/HISTORY_OF_ANNUITIES.pdf

Life Insurance Video
https://scic.hosted.panopto.com/Panopto/Pages/Viewer.aspx?id=cc04c30c-cf25-4172-b24e-a9b501650e99

Business Life Glossary of Terms
https://www.scic.com/pub/media/docs/lt-care/Business-Life-Concepts-Glossary.doc

Fillable IRS Form 8925
https://www.irs.gov/pub/irs-pdf/f8925.pdf

Succession Planning Video
https://scic.hosted.panopto.com/Panopto/Pages/Viewer.aspx?id=370daf6c-18a5-4f92-9da2-a9b501650e50

Sample Buy-Sell Agreement
https://www.scic.com/pub/media/docs/lt-care/QR-Sample-Buy-Sell.pdf

Health Concepts Glossary of Terms
https://www.scic.com/pub/media/docs/lt-care/Day-TwoGlossary.docx

SS Disability Fact Sheet
https://www.ssa.gov/disabilityfacts/materials/pdf/factsheet.pdf

Council for Disability Awareness
http://www.disabilitycanhappen.org/chances_disability/disability_stats.asp

IRS Publication 502
https://www.scic.com/pub/media/docs/lt-care/QR-Publication-502.pdf

Employee Benefits Interview
https://scic.hosted.panopto.com/Panopto/Pages/Viewer.aspx?id=65b04be4-273a-4ded-9359-a9b501650e6e

Long Term Care Interview
https://scic.hosted.panopto.com/Panopto/Pages/Viewer.aspx?id=0f44851f-ca36-4a8c-a857-a9b501650ec7

LTC Chart
https://www.scic.com/pub/media/docs/lt-care/QR-LTC-chart-8898.pdf


Thank
You!