

Marvelous Latest NY-Life-Accident-and-Health Test Answers | Easy To Study and Pass Exam at first attempt & Accurate Insurance Licensing New York Life, Accident and Health Insurance Agent/Broker Examination Series 17-55



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Insurance Licensing New York Life, Accident and Health Insurance Agent/Broker Examination Series 17-55 Sample Questions (Q75-Q80):

NEW QUESTION # 75

With respect to a life settlement contract, no person shall directly or indirectly pay a referral or finders fee to any person other than the

- A. owner ' s accountant.
- B. insurance consultant.
- C. life settlement broker.
- D. owner ' s physician.

Answer: C

Explanation:

The correct answer is life settlement broker . Under New York Insurance Law Article 78 , the life settlement rules prohibit paying a referral or finder's fee to most persons connected with the policyowner, including the owner's physician, attorney, accountant, insurance producer, insurance consultant, or other person providing medical, legal, or financial planning services . The statute specifically states that such compensation may not be paid to any of those persons, or to any other person representing the owner, other than a life settlement broker .

This rule is designed to prevent conflicts of interest and to ensure that recommendations about life settlements are not improperly influenced by side compensation. New York permits compensation only where it is paid in connection with the role of a licensed life settlement broker , because that person is regulated under the state's life settlement framework. The broker is the recognized professional authorized to represent the owner in the transaction and receive compensation in that capacity.

NEW QUESTION # 76

The policy provision describing the responsibilities of the master policyowner is in

- A. group health policies.
- B. individual health policies.
- C. certificate of coverage.
- D. individual medical policies.

Answer: A

Explanation:

The correct answer is A. group health policies . In a group health insurance plan , the actual contract is issued to the master policyowner , usually an employer, association, or trust. Because that party owns the master contract, the policy contains provisions describing the policyowner's responsibilities, such as premium remittance, eligibility administration, enrollment procedures, and notice requirements. Those duties belong in the group policy itself , not in the individual evidence given to insured members.

A certificate of coverage is provided to each covered employee or member to summarize benefits, exclusions, and rights under the group plan, but it is not the master contract and does not serve as the document that sets out the policyowner's contractual responsibilities. Choices C and D are incorrect because individual health or individual medical policies are issued directly to an individual policyowner, so there is no separate "master policyowner" structure as found in group insurance.

On licensing examinations, whenever the question refers to the master policyowner , it is a strong indicator that the subject is group insurance , making group health policies the correct choice.

NEW QUESTION # 77

Under the Affordable Care Act, an insurer may place dollar limits on coverage for

- A. laboratory services.
- B. routine adult dental services.
- C. maternity and newborn care.
- D. mental health services.

Answer: B

Explanation:

The correct answer is D. routine adult dental services. The Affordable Care Act (ACA) prohibits health insurers from placing lifetime

or annual dollar limits on coverage for Essential Health Benefits (EHBs) .

These essential health benefits include services such as laboratory services, mental health and substance use disorder services, and maternity and newborn care . Because these categories are designated as essential health benefits, insurers are not allowed to impose annual or lifetime dollar caps on them under ACA- compliant health plans.

However, routine adult dental services are not included in the ACA's list of essential health benefits . While pediatric dental services are included as an essential health benefit category, routine dental coverage for adults is generally offered as an optional or separate benefit. Because it is not classified as an essential health benefit under the ACA, insurers may legally apply dollar limits or other coverage limitations to routine adult dental services depending on the policy design.

Therefore, under ACA regulations applicable to health insurance policies and marketplace plans beginning in 2014, dollar limits are prohibited for essential health benefits but may still apply to non-essential benefits , such as routine adult dental care .

NEW QUESTION # 78

When a provider does NOT have an agreement with the insurer for payment, they will be reimbursed

- A. a usual, customary, and reasonable fee.
- B. a non-scheduled plan customary fee.
- C. an absolute fee.
- D. a relative fee.

Answer: A

Explanation:

When a medical provider does not have a contract or payment agreement with an insurer (often called a nonparticipating or out-of-network provider), the insurer generally does not pay based on a negotiated contract rate. Instead, reimbursement is commonly determined using a UCR methodology- Usual, Customary, and Reasonable charges. "Usual" refers to the typical charge a provider makes for a service;

"customary" reflects what providers in the same geographic area commonly charge for that service; and

"reasonable" considers whether the charge is appropriate given the circumstances and local market norms.

Under many major medical plans, the insurer pays a percentage of the UCR amount (subject to deductibles and coinsurance), and the patient may be responsible for any difference between the provider's billed charge and the insurer's allowed UCR amount (often referred to as balance billing , where permitted).

The other choices do not match standard insurer payment terminology: "absolute" and "relative" fee are not the typical reimbursement basis described for noncontracted providers, and "non-scheduled plan customary fee" is not the recognized standard method used in these plan provisions.

NEW QUESTION # 79

Which type of annuity guarantees a level benefit payment?

- A. Limited Life.
- B. Universal.
- C. Variable.
- D. Fixed.

Answer: D

Explanation:

The correct answer is Fixed . A fixed annuity guarantees a level benefit payment because the insurer promises to pay a stated amount or to credit a guaranteed rate of interest, which produces predictable and stable income payments. This makes fixed annuities especially suitable for individuals who want security, stability, and certainty of income , particularly during retirement.

In contrast, a variable annuity does not guarantee level payments because its benefits fluctuate based on the performance of the underlying investment accounts, usually separate accounts invested in securities. As investment results rise or fall, the annuity payment amount can increase or decrease. "Universal" is not the standard annuity classification used to describe guaranteed level income payments, and "Limited Life" is not a recognized annuity type for this purpose.

This question tests the distinction between guaranteed income and market-dependent income . In life insurance and annuity licensing materials, fixed annuities are consistently associated with guaranteed principal, guaranteed interest, and predictable benefit payments . Therefore, when asked which type of annuity guarantees a level benefit payment, the correct and expected answer is D. Fixed .

NEW QUESTION # 80

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