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## **Virginia Insurance Virginia Life, Annuities, and Health Insurance Examination Series 11-01 Sample Questions (Q146-Q151):**

### **NEW QUESTION # 146**

A health insurer must generally pay for all of the following types of claims EXCEPT:

- A. Those incurred after termination of coverage
- B. Those incurred before termination of coverage
- C. Those less than \$20 above the deductible amount
- D. Those related to mental or nervous disorders

**Answer: A**

Explanation:

Detailed Answer in Step-by-Step Solution:

\* Health insurance covers claims incurred during the policy period (A), not after termination (B), unless extended benefits (e.g., COBRA) apply, which is not indicated here.

\* Claims above the deductible (C), regardless of amount, are payable if covered.

\* Mental or nervous disorder claims (D) are typically covered unless excluded by the policy, which is not specified.

\* Thus, claims after termination (B) are the exception.

The Virginia study guide states that health insurance liability ends upon policy termination, barring specific continuation provisions, making post-termination claims generally non-payable. Reference: Virginia Life, Annuities, and Health Insurance study guide, section on "Health Insurance Coverage Terms."

**NEW QUESTION # 147**

When a small employer health insurance plan is offered, it must be available:

- A. Only to employees under age 65
- B. Only to employees who provide evidence of insurability
- C. To all eligible employees after a 12-month waiting period
- D. To all eligible employees who apply

**Answer: D**

Explanation:

Virginia Code § 38.2-3431 et seq., aligned with the ACA, requires small employer health plans (1-50 employees) to offer coverage to all eligible employees who apply, without discrimination based on health status or other factors. "Eligible" typically means full-time employees meeting the employer's criteria (e.g.,

30+ hours/week). Option A reflects this guaranteed issue mandate, ensuring broad access. Option B (12- month waiting period) is false; Virginia and federal law cap waiting periods at 90 days (Virginia Code § 38.2-3445), not 12 months. Option C (evidence of insurability) contradicts guaranteed issue rules for small groups, which prohibit medical underwriting. Option D (under age 65) is incorrect; coverage extends to all eligible employees regardless of age, though Medicare coordination may apply post-65. The study guide likely stresses this inclusivity as a cornerstone of small group market reforms, making A the correct answer.

**NEW QUESTION # 148**

All of the following are common features found in health maintenance organizations (HMOs) EXCEPT:

- A. Wellness programs
- B. Twenty-four hour access to emergency care
- C. Outpatient medical services
- D. Discounts on local health spa memberships

**Answer: D**

Explanation:

Virginia Code § 38.2-4306 mandates HMO benefits, focusing on comprehensive care. Option A (wellness programs) is common, promoting prevention (e.g., smoking cessation). Option C (24-hour emergency care) is required, ensuring access via PCP coordination or direct ER services. Option D (outpatient services) is standard, covering clinic visits. Option B (discounts on local health spa memberships) isn't a typical HMO feature; while some plans offer wellness incentives, spa discounts are ancillary, not a core benefit under Virginia law or NAIC HMO models. The study guide likely lists HMO staples (A, C, D) with examples-e.g., annual checkups (D)-contrasting them with optional perks like B, making it the exception.

**NEW QUESTION # 149**

Including a guaranteed insurability rider on a life insurance policy means that:

- A. The company will require evidence of insurability for any future purchase of life insurance.
- B. Any extra premium charged for a health impairment will be discontinued if standard insurability is proved later.
- C. The policyowner may purchase additional life insurance periodically without proving insurability.

- D. The original policy was sold on a non-medical basis.

**Answer: C**

Explanation:

Virginia Code § 38.2-3209 allows a guaranteed insurability rider, enabling the policyowner to buy additional coverage at specified intervals (e.g., every 3 years or life events like marriage) without proving insurability.

Option D matches this definition. Option A is unrelated; non-medical underwriting isn't implied. Option B contradicts the rider's purpose, which waives insurability proof. Option C is false; premium adjustments aren't part of this rider. The study guide describes this rider as a planning tool for future needs, confirming D.

**NEW QUESTION # 150**

To be complete, an application for health insurance must contain all of the following EXCEPT:

- A. Date of application
- **B. Initial premium**
- C. Applicant's signature
- D. Applicant's name and address

**Answer: B**

Explanation:

Virginia Code § 38.2-3501 requires health insurance applications to include essential details for underwriting and contract formation: the applicant's name and address (option A), signature (option B) to affirm accuracy, and date (option C) to establish timing. These are mandatory for a complete application. Option D (initial premium) is not required on the application itself; while payment may accompany it to bind coverage (e.g., via a conditional receipt), it's a separate transaction, not an application component. The study guide likely lists these elements in a sample application, noting that premium submission is optional until acceptance, making D the exception.

**NEW QUESTION # 151**

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