Health Insurance Exam Practice Questions & Answers

180 multiple-choice questions with the answer key and full explanations

Free from Insurance Exam Practice
https://insuranceexampractice.com

Edition: July 2026

How to use this question bank

- Work in sets of 20-30 questions. Mark your answers on paper before checking the key.
- The answer key at the back explains every correct answer - read the explanation even for questions you got right.
- Note the topic of every question you miss, then focus your handbook reading on those topics.
- For timed, exam-style practice, use the free interactive mock exams for your state at https://insuranceexampractice.com/free-mock-tests - no registration required.
- These questions cover the national content outline. Your state's exam also includes a state-law section - study it from your state's official candidate handbook.

Questions

1. What is the primary purpose of health insurance?

A. To accumulate savings
B. To pay for or reimburse medical expenses
C. To replace lost income
D. To provide a death benefit

2. What is a 'deductible' in health insurance?

A. The monthly premium amount
B. The amount deducted from a claim
C. The amount the insured must pay before insurance begins covering expenses
D. The maximum amount the insurer will pay

3. What is 'coinsurance' in health insurance?

A. The premium sharing between employer and employee
B. The percentage of costs the insured pays after the deductible is met
C. Insurance from two companies
D. Insurance that covers coins and valuables

4. What is a 'copayment' (copay)?

A. A payment shared with another insurer
B. A fixed amount paid for a covered service at the time of service
C. A payment for multiple services
D. The premium payment

5. What is the 'out-of-pocket maximum' in health insurance?

A. The maximum deductible allowed
B. The most you have to pay for covered services in a year before insurance pays 100%
C. The maximum you can pay for premiums
D. The maximum the insurance company will pay

6. What is a 'pre-existing condition'?

A. A prerequisite for insurance application
B. A condition for policy renewal
C. A health condition that existed before coverage began
D. A condition required for coverage

7. What does 'network' mean in health insurance?

A. The insurance company's computer system
B. The facilities, providers, and suppliers a health plan contracts with
C. A group of insurance agents
D. Multiple insurance policies working together

8. What is 'prior authorization' in health insurance?

A. Previous insurance coverage history
B. Authorization given before becoming insured
C. Authorization for premium payments
D. Approval from the insurer before receiving certain services or medications

9. What is an HMO (Health Maintenance Organization)?

A. Hospital maintenance coverage
B. A type of Medicare plan
C. A managed care plan requiring members to use network providers and select a PCP
D. A government health program

10. What is a PPO (Preferred Provider Organization)?

A. A plan that offers more flexibility to see in-network or out-of-network providers
B. A policy for preferred customers only
C. A government-sponsored insurance
D. A provider who offers premium services

11. What is an EPO (Exclusive Provider Organization)?

A. A plan that only covers in-network care except in emergencies
B. An extended payment option
C. A plan for executives only
D. An employee purchase option

12. What is an HDHP (High Deductible Health Plan)?

A. A hospital-focused deductible plan
B. A high-dollar health plan
C. A plan with high premiums and low deductibles
D. A plan with higher deductibles and lower premiums, often paired with an HSA

13. What is a POS (Point of Service) plan?

A. A plan only for point-of-sale purchases
B. A position-based service plan
C. A plan for pharmacies only
D. A plan combining HMO and PPO features with a PCP who can refer out of network

14. What is 'major medical' insurance?

A. Coverage for major hospitals only
B. Insurance for major surgeries only
C. Insurance for military personnel
D. Comprehensive coverage for a wide range of healthcare expenses with high limits

15. What is a 'Health Savings Account' (HSA)?

A. A tax-advantaged account for medical expenses, paired with an HDHP
B. A health insurance policy
C. A savings account at a hospital
D. A government savings program

16. What is a 'Flexible Spending Account' (FSA)?

A. A flexible insurance policy
B. A savings account with flexible interest rates
C. An employer-sponsored account for pre-tax medical expense savings with use-it-or-lose-it rules
D. A flexible payment plan for premiums

17. What is the 'elimination period' in health/disability insurance?

A. The period to remove dependents
B. The waiting period before benefits begin after a covered event
C. The cancellation notice period
D. The time to eliminate a policy

18. What is 'coordination of benefits' (COB)?

A. Coordinating claims with the IRS
B. Coordinating benefits between employer and employee
C. Coordinating doctor appointments
D. Rules determining payment responsibility when insured has multiple health plans

19. What is the 'benefit period' in health insurance?

A. The enrollment period
B. The premium payment schedule
C. The time during which benefits are provided for a covered event
D. The waiting period for benefits

20. What is a 'guaranteed renewable' policy?

A. A policy that renews with lower premiums
B. A policy with guaranteed benefits
C. A policy guaranteed to increase in value
D. A policy the insurer must renew regardless of health changes

21. What does 'noncancellable' mean in health insurance?

A. The insured cannot cancel the policy
B. The insurer cannot cancel or raise premiums as long as premiums are paid
C. The policy cannot be cancelled for any reason
D. Cancellation fees do not apply

22. What is 'subrogation' in health insurance?

A. The insurer's right to recover claim payments from a third party responsible for the loss
B. Substituting one policy for another
C. Reducing coverage amounts
D. A subordinate insurance policy

23. What is the purpose of disability insurance?

A. To replace income when the insured cannot work due to illness or injury
B. To pay for home modifications
C. To pay medical bills
D. To provide a death benefit

24. What is 'own occupation' disability?

A. Any occupation disability
B. Working in your own business
C. Occupational hazard coverage
D. Inability to perform the duties of your specific occupation

25. What is 'any occupation' disability?

A. Multiple occupation coverage
B. The insured is only considered disabled if unable to work in any occupation
C. Coverage for any type of work
D. Working in any available job

26. What is 'short-term disability' insurance?

A. Coverage that replaces income for a limited period, typically 3-6 months
B. Temporary disability from minor injuries
C. Part-time disability coverage
D. Disability coverage for short people

27. What is 'long-term disability' insurance?

A. Lifetime medical coverage
B. Coverage for chronic conditions only
C. Disability coverage for tall people
D. Coverage that provides income for extended periods, often until age 65

28. What is 'residual disability' coverage?

A. Coverage for family members
B. Coverage for remaining medical bills
C. Leftover policy benefits
D. Partial benefits when the insured can work but at reduced capacity or income

29. What is Medicare?

A. Employer-provided insurance
B. Health insurance for low-income families
C. State-run health insurance
D. Federal health insurance program primarily for people 65 and older

30. What does Medicare Part A cover?

A. Prescription drugs
B. Doctor visits and outpatient services
C. Hospital insurance including inpatient care
D. Dental and vision

31. What does Medicare Part B cover?

A. Long-term care
B. Hospital stays
C. Prescription drugs
D. Medical insurance including doctor services and outpatient care

32. What is Medicare Part C (Medicare Advantage)?

A. Cancer treatment coverage
B. Private health plans that provide all Part A and B coverage, often with additional benefits
C. Prescription drug coverage
D. Supplemental coverage only

33. What does Medicare Part D cover?

A. Dental services
B. Prescription drug coverage
C. Disability benefits
D. Hospital stays

34. What is a Medicare Supplement (Medigap) policy?

A. A Medicare Advantage plan
B. A replacement for Medicare
C. Private insurance that helps pay Medicare's gaps like deductibles and coinsurance
D. Medicare for low-income individuals

35. What is Medicaid?

A. A private insurance option
B. A prescription drug program
C. A joint federal-state program providing health coverage to low-income individuals
D. A federal program for seniors

36. Can someone be eligible for both Medicare and Medicaid?

A. Only in certain states
B. Yes, these individuals are called 'dual eligibles'
C. Only for prescription drugs
D. No, you must choose one

37. What is group health insurance?

A. Insurance sold to groups of friends
B. Health coverage provided to a group, typically by an employer
C. A group of policies combined
D. Coverage for group activities

38. What is COBRA?

A. A law allowing continued group health coverage after qualifying events like job loss
B. A type of snake bite coverage
C. A government health program
D. A type of HMO plan

39. How long can COBRA coverage typically last?

A. Indefinitely
B. 18 months for most qualifying events
C. 6 months
D. 12 months

40. Who pays for COBRA coverage?

A. It's always free
B. The employee pays the full premium plus up to 2% administrative fee
C. The former employer pays 100%
D. The government subsidizes it

41. What companies must offer COBRA?

A. Employers with 20 or more employees
B. Only Fortune 500 companies
C. All companies regardless of size
D. Only government employers

42. What is the Affordable Care Act (ACA)?

A. A Medicare supplement plan
B. A state health insurance program
C. Federal law that reformed health insurance and expanded coverage access
D. An employer mandate only

43. What are the 'essential health benefits' under the ACA?

A. Benefits only for essential workers
B. Optional benefits insurers may offer
C. Emergency services only
D. Ten categories of services ACA marketplace plans must cover

44. What is a 'health insurance marketplace' (exchange)?

A. An employer benefits fair
B. A hospital network
C. A place to trade health insurance stocks
D. A platform where individuals can shop for and purchase ACA-compliant health plans

45. What are 'premium tax credits' under the ACA?

A. Subsidies to help eligible individuals afford marketplace health insurance
B. Credits for insurance companies
C. Credits for prescription drugs
D. Tax deductions for employers

46. What is 'guaranteed issue' under the ACA?

A. Guaranteed policy renewal
B. Insurers must accept all applicants regardless of health status or pre-existing conditions
C. Guaranteed approval for all policy changes
D. Guaranteed low premiums

47. What is the ACA's 'open enrollment period'?

A. When anyone can open a health insurance company
B. The annual period when individuals can enroll in or change marketplace plans
C. When employers open new positions
D. When Medicare enrollment opens

48. What is a 'special enrollment period' (SEP)?

A. Enrollment for special needs individuals
B. A time outside open enrollment when someone can enroll due to a qualifying life event
C. Early enrollment for seniors
D. Enrollment for specialized plans

49. What is HIPAA?

A. A hospital association
B. A health savings account
C. A type of health insurance plan
D. Federal law protecting health information privacy and insurance portability

50. What are 'unfair trade practices' in health insurance?

A. Selling insurance without profit
B. Illegal or unethical business practices prohibited by insurance regulations
C. Fair competition between insurers
D. Trading policies between agents

51. What is 'unfair discrimination' in insurance?

A. Competitive pricing
B. Charging different rates based on legitimate risk factors
C. Offering different policy types
D. Treating similarly situated individuals differently based on prohibited factors

52. What is the agent's 'fiduciary duty' to clients?

A. Duty to file taxes for clients
B. Legal and ethical obligation to act in the client's best interest
C. Obligation to sell the most expensive policy
D. Duty to maximize commissions

53. What is a 'formulary' in health insurance?

A. A standard insurance contract
B. A list of prescription drugs covered by a health plan
C. A form for claims
D. A formula for calculating premiums

54. What is 'step therapy' in prescription drug coverage?

A. Gradually increasing medication dosages
B. A therapy for addiction recovery
C. Requiring trial of lower-cost drugs before more expensive options
D. Physical therapy for walking

55. What is 'long-term care' insurance?

A. Health insurance for chronic conditions
B. Extended hospital coverage
C. Coverage for assistance with daily living activities when unable to care for oneself
D. Insurance for long hospital stays

56. What are 'activities of daily living' (ADLs)?

A. Daily work activities
B. Exercise routines
C. Basic self-care tasks used to measure need for long-term care
D. Recreational activities

57. What is a 'benefit trigger' in long-term care insurance?

A. What starts premium payments
B. The criteria that must be met before benefits are paid
C. What cancels the policy
D. A device for dispensing medication

58. What is 'mental health parity'?

A. Mental health screening for insurance
B. Equal premium rates for all members
C. Equivalent mental and physical fitness
D. Requiring equal coverage for mental health as for medical/surgical conditions

59. What is 'community rating' in health insurance?

A. Insurance for community organizations
B. Rating doctors in the community
C. Rating insurance companies by community members
D. Setting premiums based on the entire community rather than individual health status

60. What is 'experience rating' in health insurance?

A. Rating insurance agents' experience
B. Rating based on customer experience
C. Rating medical providers' experience
D. Setting premiums based on a group's actual claims history

61. What is a 'gatekeeper' in managed care?

A. A primary care physician who coordinates and authorizes specialist care
B. An insurance claims reviewer
C. A hospital administrator
D. A security guard at hospitals

62. What is 'step therapy' in prescription drug coverage?

A. Taking medication in steps
B. Requiring use of less expensive drugs before covering more expensive alternatives
C. A physical therapy technique
D. Increasing dosages gradually

63. What is a 'formulary' in health insurance?

A. A mathematical calculation for premiums
B. A list of prescription drugs covered by the plan, often organized by tier
C. A medical formula for treatment
D. The policy application form

64. What does 'creditable coverage' mean?

A. Prior health insurance coverage that reduces or eliminates pre-existing condition exclusions
B. Coverage with a credit card
C. Insurance from a credible company
D. Coverage that earns credit

65. What is a 'high-risk pool'?

A. A group of risky investments
B. State programs providing health insurance to individuals unable to obtain coverage elsewhere
C. A dangerous medical procedure
D. A swimming pool for athletes

66. What is 'CHIP' in health insurance?

A. Children's Health Insurance Program providing coverage for uninsured children
B. A claims processing system
C. A hospital identification system
D. A computer health program

67. What is 'adverse selection' in health insurance?

A. Selecting adverse weather conditions
B. Choosing the wrong plan
C. The tendency for higher-risk individuals to seek more insurance coverage
D. Negative policy selection by insurers

68. What is 'moral hazard' in health insurance?

A. Unethical behavior by insurers
B. A hazardous moral situation
C. Insurance fraud
D. The tendency to use more services because insurance covers them

69. What is 'community rating' in health insurance?

A. Pricing policies the same for all members of a community regardless of health status
B. Rating health facilities in a community
C. Community health surveys
D. Rating insurance agents

70. What is 'experience rating' in health insurance?

A. Evaluating customer experience
B. Pricing group policies based on the group's actual claims history
C. Rating based on years of experience
D. Rating experienced doctors

71. What is 'guaranteed issue' in health insurance?

A. Guaranteed premium amounts
B. A government guarantee of coverage
C. Guaranteed renewal of policies
D. Requirement that insurers accept all applicants regardless of health status

72. What is 'guaranteed renewability'?

A. Guaranteed issue for groups
B. Guaranteed new policy issuance
C. The insurer must renew coverage as long as premiums are paid
D. Renewal of gym memberships

73. What is 'rescission' in health insurance?

A. Retroactive cancellation of coverage due to fraud or intentional misrepresentation
B. Reducing coverage amounts
C. A recession in the economy
D. Policy renewal

74. What is a 'summary of benefits and coverage' (SBC)?

A. A benefits summary for employees
B. A brief policy overview
C. A coverage limitation list
D. A standardized document explaining what a health plan covers in plain language

75. What is 'medical loss ratio' (MLR)?

A. Medical equipment depreciation
B. The ratio of losses to gains
C. The percentage of premiums an insurer must spend on medical care and quality improvement
D. The amount of money lost to medical bills

76. What is a 'qualified health plan' (QHP)?

A. A plan certified by the Marketplace meeting ACA standards
B. A Medicare-approved plan
C. Any health insurance plan
D. A qualified employee benefit plan

77. What are 'essential health benefits'?

A. Basic hospital services only
B. Emergency-only coverage
C. Ten categories of services all Marketplace plans must cover under the ACA
D. Benefits essential for insurance companies

78. What is a 'premium tax credit'?

A. A tax on insurance premiums
B. A credit for paying premiums on time
C. A subsidy to help eligible individuals afford Marketplace health insurance
D. A premium discount

79. What is 'cost-sharing reduction' (CSR)?

A. Sharing medical costs with family
B. Subsidies that lower deductibles, copays, and out-of-pocket limits for eligible individuals
C. Cost reduction strategies for hospitals
D. Reducing costs between insurers

80. What is 'special enrollment period' (SEP)?

A. A period for special students to enroll
B. Early enrollment period
C. Special enrollment for seniors
D. A time outside open enrollment when qualifying life events allow health plan enrollment

81. In a typical HMO plan, what is the main role of a primary care physician?

A. To set the insurance company's premiums
B. To act as the member's main doctor and coordinate care within the network
C. To sell supplemental disability insurance
D. To approve every life insurance beneficiary change

82. Which statement best describes a PPO?

A. It usually gives members more provider flexibility than an HMO
B. It never uses a provider network
C. It only pays benefits after retirement
D. It is a form of life insurance

83. A member in a gatekeeper-style HMO wants to see a specialist. What is commonly required first?

A. A death certificate
B. A referral from the primary care physician
C. A property inspection
D. A workers compensation claim form

84. Why do PPO plans often charge less when a member uses an in-network provider?

A. The provider has agreed to network terms or negotiated rates
B. The provider is not licensed
C. The plan is actually a life annuity
D. The deductible is always illegal

85. What is a point-of-service plan designed to combine?

A. Life insurance and homeowners insurance
B. Managed-care features with some choice to use out-of-network providers
C. Only Medicare Part D and long-term care coverage
D. A fixed annuity and a disability waiver

86. What does a health plan's provider network usually refer to?

A. The insured's list of beneficiaries
B. Doctors, hospitals, and providers that contract with the plan
C. The tax schedule used for life insurance loans
D. The insurer's building-security system

87. What is a common result of using an out-of-network provider under many managed-care plans?

A. The plan always pays 100% with no deductible
B. The member may pay higher out-of-pocket costs or receive reduced benefits
C. The policy automatically becomes a group life contract
D. The insurer must waive every copayment

88. What is utilization review mainly used for in health insurance?

A. To review whether services are medically necessary or appropriate under the plan
B. To decide who receives a life insurance death benefit
C. To appraise a damaged automobile
D. To calculate a property deductible

89. A plan requires approval before a nonemergency hospital admission. What is this requirement usually called?

A. Preauthorization
B. Reinstatement
C. Subrogation
D. Dividend option

90. Why should a candidate be careful with absolute statements about emergency care network rules?

A. Emergency-care protections and plan rules can vary, so the plan and applicable law should be checked
B. Emergency care is never covered by health insurance
C. Emergency care only applies to annuities
D. All plans use the exact same wording in every state

91. What is a deductible in a medical expense policy?

A. The amount the insured pays before the plan begins paying covered expenses
B. The amount paid only after the insured dies
C. A refund paid to every policyholder
D. A penalty for naming a beneficiary

92. What does coinsurance usually mean in health insurance?

A. The insured and insurer share covered costs by percentage after the deductible
B. Two insurers must issue the same policy
C. The insured pays no costs after application
D. The policy only covers coins

93. What is a copayment?

A. A fixed dollar amount the insured pays for a covered service
B. A premium paid by the insurance company
C. A tax on annuity withdrawals
D. A death benefit option

94. What is the purpose of an out-of-pocket maximum?

A. To limit the insured's covered cost sharing during a plan period
B. To increase the producer's commission
C. To remove all provider networks
D. To guarantee every service is covered without review

95. What is a major medical policy generally designed to cover?

A. Large or broad medical expenses subject to deductibles, coinsurance, limits, and exclusions
B. Only funeral expenses
C. Only property damage to a home
D. Only crop insurance losses

96. A hospital expense benefit is most directly related to which type of cost?

A. Room, board, and hospital-related charges covered by the policy
B. A beneficiary's inheritance tax
C. The cash value of a whole life policy
D. Collision damage to a vehicle

97. What does a surgical expense benefit usually help pay for?

A. Covered surgical procedures and related charges
B. Only dental cleanings
C. Only a life insurance premium
D. Only liability claims

98. Why must limited-benefit health policies be explained carefully to applicants?

A. They may pay only specified amounts or cover only specified conditions or services
B. They always replace major medical coverage completely
C. They are the same as homeowners insurance
D. They never contain exclusions

99. What does usual, customary, and reasonable commonly relate to?

A. How a plan determines an allowable charge for a covered medical service
B. How a life policy names a beneficiary
C. How a home is appraised after a fire
D. How a producer calculates auto liability limits

100. Why are exclusions important in a medical expense policy?

A. They identify services or situations the policy does not cover
B. They automatically expand coverage for every condition
C. They guarantee every claim is paid
D. They replace the need for a deductible

101. Why is the definition of disability important in a disability income policy?

A. It determines when the insured may qualify for disability benefits
B. It names the policy's death beneficiary
C. It sets the deductible for homeowners insurance
D. It decides whether a vehicle is totaled

102. What is the elimination period in a disability income policy?

A. The waiting period before disability benefits begin
B. The time before a life policy can name a beneficiary
C. The period when the insurer cannot collect premiums
D. The deadline to file a property claim

103. What does the benefit period in disability income insurance describe?

A. How long benefits may be payable after a covered disability begins
B. How long an auto policy must be kept
C. How long a premium receipt is valid
D. How long a producer license lasts in every state

104. What does a residual disability benefit generally address?

A. Partial loss of income when the insured can work but not at full capacity
B. A total loss of a vehicle
C. A beneficiary dispute after death
D. A property vacancy clause

105. **An own-occupation disability definition most often focuses on the insured's inability to perform what?**

A. The duties of the insured's own occupation
B. Any task in any industry anywhere
C. Only unpaid volunteer work
D. Only household chores

106. **Compared with own-occupation wording, an any-occupation disability definition is generally more restrictive because it considers whether the insured can do what?**

A. Work in another suitable occupation based on policy terms
B. Continue paying life insurance premiums only
C. File a homeowners claim
D. Change a health plan provider network

107. **What is a key feature of a noncancelable disability income policy?**

A. The insurer cannot cancel or raise premiums if the insured pays required premiums, subject to policy terms
B. The insured cannot ever cancel the policy
C. Claims are paid without proof of loss
D. The policy has no benefit period

108. **How does guaranteed renewable disability coverage generally differ from noncancelable coverage?**

A. The insurer usually cannot cancel coverage but may raise rates by class, subject to policy terms
B. The insurer can cancel anytime for any reason
C. The policy automatically becomes property insurance
D. The insured never pays premiums

109. **What does the entire contract provision generally say?**

A. The policy, application, and attached papers make up the full contract
B. Only oral promises are part of the policy
C. The producer can change coverage verbally
D. The beneficiary owns the insurer

110. **What is the purpose of a time limit on certain defenses provision?**

A. To limit how long the insurer can use certain misstatements to void coverage or deny claims
B. To set the time for naming a beneficiary
C. To create a property deductible
D. To require a producer to sell only one policy

111. **What does a grace period allow in a health insurance policy?**

A. Extra time to pay a premium after the due date while coverage may remain in force
B. A time to avoid reading the policy
C. Automatic coverage for every excluded service
D. A guaranteed premium refund after every claim

112. What does reinstatement usually involve?

A. Restoring a lapsed policy after requirements are met
B. Replacing the insurer with a beneficiary
C. Increasing every claim payment automatically
D. Removing all exclusions from the policy

113. What is the purpose of the notice of claim provision?

A. To require timely notice to the insurer after a covered loss begins or occurs
B. To schedule a life insurance exam
C. To name a property appraiser
D. To cancel every deductible

114. What is proof of loss?

A. Documentation submitted to support a claim
B. A policy advertisement
C. A license renewal notice
D. A property inspection certificate only

115. A legal actions provision usually limits what?

A. When a lawsuit may be brought against the insurer over a claim
B. How often a provider network may change
C. The number of beneficiaries in a life policy
D. The insured's ability to ask questions before buying

116. In health insurance, a change of beneficiary provision is most relevant when the policy includes what kind of benefit?

A. A death or survivor benefit payable to another person
B. A provider network directory
C. A property damage deductible
D. A pharmacy copayment card only

117. In group health insurance, who is usually the policyholder?

A. The employer or sponsoring organization
B. Every individual employee separately
C. The hospital that treats the employee
D. The state insurance exam vendor

118. What does a certificate of coverage usually provide to a group member?

A. A summary of the member's benefits and coverage under the group policy
B. A separate individually owned policy in every case
C. A guaranteed license to sell insurance
D. A property claim settlement

119. Why does a group health plan use an eligibility or waiting period?

A. To define when a new employee or member may become eligible for coverage
B. To delay every claim forever
C. To decide who receives a life insurance death benefit
D. To cancel coverage after each doctor visit

120. In a contributory group health plan, what does contributory mean?

A. Covered employees pay part of the premium
B. Only the insurer pays the premium
C. No one pays any premium
D. The provider network pays claims directly without an insurer

121. At a general exam level, what is COBRA continuation coverage designed to do?

A. Allow certain qualified beneficiaries to continue group health coverage for a limited time after qualifying events
B. Replace Medicare for every senior
C. Pay a life insurance death benefit
D. Remove all deductibles from every policy

122. What is the purpose of coordination of benefits in group health insurance?

A. To determine payment order when a person is covered by more than one plan
B. To change a provider's medical license
C. To select a life insurance beneficiary
D. To replace claim forms with advertising

123. What is a group health conversion privilege generally intended to allow?

A. A covered person may change to individual coverage when group coverage ends, if policy terms allow
B. A producer may convert a health policy into auto insurance
C. An insurer may refuse every claim without review
D. A provider may change the insured's deductible

124. At a general level, Medicare Part A is most commonly associated with which coverage?

A. Hospital insurance
B. Prescription-only insurance
C. Dental-only insurance
D. Homeowners liability insurance

125. At a general level, Medicare Part B is most commonly associated with what type of coverage?

A. Medical insurance for services such as doctor visits and outpatient care
B. Only nursing home room charges
C. Only property damage
D. Only producer licensing fees

126. What is Medicare Advantage generally known as?

A. A private-plan alternative for receiving Medicare benefits, also called Part C
B. A state property insurance plan
C. A disability income elimination period
D. A life insurance settlement option

127. What is the basic purpose of a Medicare Supplement policy?

A. To help pay certain out-of-pocket costs under Original Medicare
B. To replace every federal Medicare rule
C. To insure a business building
D. To pay a death benefit to a beneficiary

128. Long-term care insurance is mainly designed to help pay for what?

A. Care services needed because of chronic illness, disability, or inability to perform activities of daily living
B. Routine auto maintenance
C. Homeowners fire damage
D. A life policy's cash value loan

129. Which item is an example of an activity of daily living often used in long-term care insurance?

A. Bathing
B. Driving a commercial truck
C. Filing a property claim
D. Choosing a life insurance beneficiary

130. In long-term care insurance, what is an elimination period?

A. A waiting period before benefits become payable after the insured qualifies for benefits
B. A time when premiums are never due
C. A period when the insurer must cover every excluded service
D. A rule that applies only to auto insurance

131. Which health policy renewability provision gives the insurer the least ability to cancel coverage during the policy term?

A. Optionally renewable
B. Conditionally renewable
C. Noncancelable
D. Cancelable at will

132. In a guaranteed renewable health policy, what right does the insurer usually keep?

A. The right to refuse renewal for any reason
B. The right to change premiums by class, subject to policy terms and law
C. The right to change the insured's benefits every month
D. The right to deny every claim after renewal

133. What does an optionally renewable health policy allow the insurer to do?

A. Renew only if the insured has no claims
B. Cancel during the grace period only
C. Choose not to renew on a policy anniversary or premium due date, subject to the contract
D. Never increase premiums

134. What is the main purpose of a probationary period in a health insurance policy?

A. To delay coverage for certain illnesses after the policy starts
B. To delay payment of every accident claim
C. To reduce the deductible after renewal
D. To extend Medicare eligibility

135. Which statement best describes the time limit on certain defenses provision?

A. It allows the insurer to contest every claim forever
B. It limits the insurer's ability to deny claims based on misstatements after a specified period, except as allowed by the policy and law
C. It applies only to property insurance claims
D. It eliminates the need for premium payments

136. What does a reinstatement provision usually address?

A. How a lapsed policy may be put back in force
B. How a beneficiary is selected
C. How a homeowner claim is adjusted
D. How a producer's commission is paid

137. Under many health policies, what is the purpose of a grace period?

A. To let the insured pay a premium shortly after the due date while coverage may remain in force
B. To erase all exclusions
C. To require a new medical exam after every claim
D. To replace coinsurance with a copayment

138. What does the physical examination and autopsy provision usually permit?

A. The insurer may require reasonable medical examinations related to a claim while it is pending
B. The insured must take a licensing exam
C. The producer may cancel the policy without notice
D. The insurer must pay every claim without proof

139. What is the legal actions provision in a health policy mainly designed to do?

A. Set time limits for bringing a lawsuit over a claim
B. Require all disputes to be posted online
C. Eliminate proof-of-loss requirements
D. Cancel the policy after one claim

140. What does a change of beneficiary provision usually allow in a health or accident policy with death benefits?

A. The policyowner may change the beneficiary unless the beneficiary designation is irrevocable
B. The insurer may choose the beneficiary after death
C. The producer automatically becomes beneficiary
D. Beneficiaries must always be changed every year

141. Why does a health insurer use underwriting?

A. To evaluate risk and decide whether to issue coverage and on what terms
B. To guarantee every applicant the same premium
C. To calculate property replacement cost
D. To choose a hospital for the applicant

142. Which factor is commonly relevant in health insurance underwriting?

A. Medical history
B. Favorite color
C. Type of car owned only
D. Property tax bill

143. What is an exclusion rider sometimes used for in individual health insurance?

A. To exclude or limit coverage for a specified condition or hazard, where allowed
B. To add unlimited benefits for every condition
C. To make the policy noncancelable automatically
D. To remove the premium requirement

144. What is the purpose of a preexisting condition limitation?

A. To limit coverage for a condition that existed before coverage began, subject to policy terms and law
B. To cover every illness immediately with no limits
C. To apply only to auto insurance
D. To replace the deductible with coinsurance

145. What does proof of loss usually mean in a health insurance claim?

A. Documentation submitted to support that a covered loss occurred
B. The producer's sales script
C. A document proving the insurer is profitable
D. A replacement for the policy application

146. If a health policy requires notice of claim, what is the insured generally expected to do?

A. Tell the insurer about a covered loss within the required time period
B. Wait until the policy expires before reporting
C. Report only to the hospital and never to the insurer
D. File a property claim instead

147. What is a common reason an insurer may deny a health claim?

A. The claimed expense is excluded or not covered by the policy
B. The insured submitted the claim on time
C. The policy was active and the service was covered
D. The deductible had already been met and all conditions were satisfied

148. What does coordination of benefits help prevent in group health coverage?

A. Duplicate benefit payments that exceed covered expenses
B. All medical billing
C. Every deductible
D. The need for primary coverage

149. What is subrogation in health insurance?

A. The insurer's right to recover from a responsible third party after paying a covered claim
B. The insured's right to stop paying premiums forever
C. The hospital's right to rewrite the policy
D. The producer's right to approve claims

150. What is utilization review designed to evaluate?

A. Whether healthcare services are medically necessary and appropriate under plan rules
B. Whether the insured owns a home
C. Whether the producer used a paper application
D. Whether a life policy has cash value

151. What is a waiver of premium rider in a disability or health-related policy designed to do?

A. Waive future premiums if the insured meets the policy's disability requirements
B. Pay auto liability claims
C. Increase the deductible after each claim
D. Cancel all exclusions

152. What is the main purpose of a guaranteed insurability rider?

A. Allow the insured to buy additional coverage later without new evidence of insurability, subject to rider terms
B. Guarantee that every claim will be paid
C. Eliminate all waiting periods
D. Replace managed care with Medicare

153. Which policy is designed to pay a specified benefit when the insured is diagnosed with a covered serious illness?

A. Critical illness policy
B. Homeowners policy
C. Workers compensation policy only
D. General liability policy

154. What does a hospital indemnity policy typically pay?

A. A stated benefit related to covered hospitalization, regardless of the exact medical bill in many designs
B. The full replacement cost of a house
C. Only liability judgments
D. A life insurance death benefit only

155. What is accident-only health insurance designed to cover?

A. Covered losses resulting from accidents, not sicknesses
B. All medical expenses from any cause
C. Only long-term nursing home care
D. Only Medicare premiums

156. What is a dental insurance waiting period?

A. A period before certain dental benefits are available
B. A period when premiums are waived automatically
C. A time when all cosmetic procedures are covered
D. A waiting period for auto collision coverage

157. Which statement best describes vision insurance?

A. It often helps pay for routine eye exams, lenses, frames, or contacts subject to plan limits
B. It replaces all major medical coverage
C. It is the same as homeowners insurance
D. It only covers disability income benefits

158. What does a specified disease policy cover?

A. A named disease or group of diseases listed in the policy
B. Every illness and injury with no exclusions
C. Only property damage
D. Only producer licensing fees

159. What is a common purpose of a long-term care inflation protection feature?

A. Help benefits keep pace with rising care costs over time
B. Reduce benefits every year
C. Guarantee no premium can ever change
D. Make the policy accident-only

160. Which feature is most directly related to how long long-term care benefits may be paid?

A. Benefit period
B. Copayment
C. Producer appointment
D. Open enrollment poster

161. In group health insurance, what is the master policy?

A. The contract issued to the employer or group sponsor
B. The ID card issued to each employee
C. A claim form sent to a hospital
D. A Medicare supplement brochure

162. What does a certificate of insurance provide to a group member?

A. Evidence and summary of the member's coverage under the group policy
B. Ownership of the master policy
C. A license to sell insurance
D. A guarantee that all claims are covered

163. What is contributory group health coverage?

A. Employees pay part of the premium cost
B. Only the employer may file claims
C. The insurer contributes to every employee's retirement account
D. Coverage applies only after Medicare begins

164. Why do group health plans often have eligibility requirements?

A. To define who may enroll and when coverage begins
B. To prevent all claims from being filed
C. To eliminate the need for a master policy
D. To convert health insurance into property insurance

165. What is the main purpose of COBRA continuation coverage?

A. Allow certain individuals to continue group health coverage temporarily after qualifying events
B. Replace individual disability coverage
C. Pay benefits only for long-term care facilities
D. Cancel coverage after every claim

166. What is an unfair claims practice?

A. Improper claim-handling conduct prohibited by insurance law or regulation
B. Any claim paid quickly
C. A premium discount approved by the insurer
D. A policyholder asking for claim forms

167. Why must producers avoid misrepresentation when selling health insurance?

A. Consumers rely on accurate explanations of benefits, exclusions, and limitations
B. Misrepresentation only affects property policies
C. It helps avoid paying premiums
D. It lets producers approve medical claims

168. What is twisting in insurance sales?

A. Inducing a policy replacement through misleading or incomplete comparisons
B. Explaining policy exclusions clearly
C. Giving a customer a copy of the outline of coverage
D. Reporting a claim promptly

169. What should a producer do when a health policy has important limitations?

A. Explain the limitations clearly and avoid suggesting the policy covers everything
B. Hide them until after the claim
C. Tell the applicant limitations never matter
D. Remove the limitations by handwriting a note

170. Why is suitability important when discussing health or supplemental coverage?

A. The recommended product should reasonably fit the consumer's needs and circumstances
B. It lets the producer ignore policy exclusions
C. It applies only to property insurance
D. It guarantees the insurer will accept the application

171. A policy has a $1,000 deductible and 80/20 coinsurance after the deductible. If a covered bill is $6,000, how much is subject to coinsurance after the deductible?

A. $1,000
B. $5,000
C. $6,000
D. $7,000

172. In the same scenario, with a $1,000 deductible and 80/20 coinsurance on a $6,000 covered bill, what is the insured's coinsurance amount after the deductible?

A. $500
B. $1,000
C. $1,200
D. $5,000

173. What is an out-of-pocket maximum designed to do?

A. Limit the insured's covered cost-sharing for a policy period
B. Increase every deductible after a claim
C. Eliminate premiums
D. Apply only to life insurance death benefits

174. What does prior authorization usually require?

A. Plan approval before certain services are provided or paid as covered
B. A producer license before visiting a doctor
C. A court order for every prescription
D. Payment of all claims without review

175. A PPO member uses an out-of-network provider. What is a common result?

A. The member may pay more out of pocket than with an in-network provider
B. The service is always free
C. The policy automatically becomes an HMO
D. The provider becomes the policyowner

176. What is a formulary in a prescription drug plan?

A. A list of covered drugs and related cost-sharing rules
B. A list of auto repair shops
C. A life insurance beneficiary form
D. A property inspection report

177. What does a drug tier usually affect?

A. The insured's cost-sharing for that medication
B. The producer's license type
C. The deductible for homeowners insurance
D. The length of a life insurance contestability period

178. What is step therapy?

A. A rule requiring use of a preferred medication before coverage of another medication, when medically appropriate under plan rules
B. A rule that removes all copayments
C. A rule used only in annuity contracts
D. A rule that applies only after death

179. Why are exclusions important in a health insurance policy?

A. They identify services, conditions, or circumstances the policy does not cover
B. They guarantee every loss will be paid
C. They remove the need for claim forms
D. They apply only to workers compensation

180. What is the best first step when a health claim is denied?

A. Review the explanation of benefits and policy provisions to understand the reason for denial
B. Immediately stop paying all premiums
C. Assume the provider must pay the claim
D. File a property insurance claim

Answer Key & Explanations

1. Answer: B
To pay for or reimburse medical expenses
The primary purpose of health insurance is to pay for or reimburse medical expenses including hospitalization, doctor visits, medications, and other healthcare services.

2. Answer: C
The amount the insured must pay before insurance begins covering expenses
A deductible is the amount the insured must pay out-of-pocket for covered healthcare services before the insurance company begins to pay. Higher deductibles generally mean lower premiums.

3. Answer: B
The percentage of costs the insured pays after the deductible is met
Coinsurance is the percentage of covered healthcare costs that the insured pays after the deductible has been met. For example, with 80/20 coinsurance, the insurer pays 80% and the insured pays 20%.

4. Answer: B
A fixed amount paid for a covered service at the time of service
A copayment is a fixed dollar amount that the insured pays for a covered healthcare service at the time of service. For example, a $30 copay for a doctor visit or $10 copay for a generic prescription.

5. Answer: B
The most you have to pay for covered services in a year before insurance pays 100%
The out-of-pocket maximum is the most you'll pay during a policy period for covered services through deductibles, copays, and coinsurance. After reaching this limit, the insurance company pays 100% of covered expenses.

6. Answer: C
A health condition that existed before coverage began
A pre-existing condition is a health problem that existed before the start date of new health coverage. Under the ACA, insurers cannot deny coverage or charge more based on pre-existing conditions.

7. Answer: B
The facilities, providers, and suppliers a health plan contracts with
A network is the group of doctors, hospitals, pharmacies, and other healthcare providers that have contracted with a health insurance plan to provide services at negotiated rates.

8. Answer: D
Approval from the insurer before receiving certain services or medications
Prior authorization (also called pre-authorization) is approval from the insurance company required before the insured can get a specific service or medication. Without it, the insurer may not pay for the service.

9. Answer: C
A managed care plan requiring members to use network providers and select a PCP
An HMO is a type of managed care plan that requires members to use network providers, select a primary care physician (PCP), and get referrals from the PCP to see specialists.

10. Answer: A
A plan that offers more flexibility to see in-network or out-of-network providers
A PPO offers more flexibility than an HMO. Members can see any provider but pay less when using in-network providers. Referrals are typically not required to see specialists.

11. Answer: A
A plan that only covers in-network care except in emergencies
An EPO is a hybrid plan that requires members to use network providers (like an HMO) but typically doesn't require referrals to see specialists (like a PPO). Out-of-network care is only covered in emergencies.

12. Answer: D

A plan with higher deductibles and lower premiums, often paired with an HSA

An HDHP has higher deductibles and lower monthly premiums than traditional plans. HDHPs can be paired with Health Savings Accounts (HSAs) for tax-advantaged savings for medical expenses.

13. Answer: D

A plan combining HMO and PPO features with a PCP who can refer out of network

A POS plan combines features of HMOs and PPOs. Members choose a primary care physician and need referrals for specialists, but can also go out-of-network for higher costs.

14. Answer: D

Comprehensive coverage for a wide range of healthcare expenses with high limits

Major medical insurance provides comprehensive coverage for a wide range of healthcare expenses including hospitalization, surgery, and physician services, typically with high coverage limits.

15. Answer: A

A tax-advantaged account for medical expenses, paired with an HDHP

An HSA is a tax-advantaged savings account for medical expenses available to individuals enrolled in a High Deductible Health Plan. Contributions are tax-deductible, growth is tax-free, and withdrawals for qualified medical expenses are tax-free.

16. Answer: C

An employer-sponsored account for pre-tax medical expense savings with use-it-or-lose-it rules

An FSA is an employer-sponsored benefit that allows employees to set aside pre-tax dollars for medical expenses. Unlike HSAs, FSAs typically have 'use-it-or-lose-it' rules, though some carry-over is allowed.

17. Answer: B

The waiting period before benefits begin after a covered event

The elimination period (also called waiting period) is the time between when a covered event occurs (like disability) and when benefits begin. Longer elimination periods result in lower premiums.

18. Answer: D

Rules determining payment responsibility when insured has multiple health plans

Coordination of benefits determines which insurance plan pays first (primary) and which pays second (secondary) when a person has coverage under more than one health plan, preventing duplicate payments.

19. Answer: C

The time during which benefits are provided for a covered event

The benefit period is the length of time during which benefits are provided for a covered event. For example, a hospital policy might have a 90-day benefit period per hospital stay.

20. Answer: D

A policy the insurer must renew regardless of health changes

A guaranteed renewable policy must be renewed by the insurer as long as premiums are paid, regardless of changes in the insured's health. However, the insurer may increase premiums for the entire class of policyholders.

21. Answer: B

The insurer cannot cancel or raise premiums as long as premiums are paid

A noncancellable policy cannot be cancelled by the insurer, and the insurer cannot raise premiums above what's stated in the policy, as long as premiums are paid on time. This provides maximum protection.

22. Answer: A

The insurer's right to recover claim payments from a third party responsible for the loss

Subrogation is the insurer's right to recover money paid for claims from a third party who caused the insured's injury or illness. For example, if you're injured in a car accident caused by another driver.

23. Answer: A

To replace income when the insured cannot work due to illness or injury

Disability insurance provides income replacement when the insured cannot work due to a covered illness or injury. It helps maintain financial stability during periods of disability.

24. Answer: D

Inability to perform the duties of your specific occupation

Own occupation disability means the insured is considered disabled if they cannot perform the duties of their specific occupation, even if they could work in another occupation.

25. Answer: B

The insured is only considered disabled if unable to work in any occupation

Any occupation disability is a stricter definition where the insured is only considered disabled if they cannot perform the duties of any occupation for which they are reasonably suited by education, training, or experience.

26. Answer: A

Coverage that replaces income for a limited period, typically 3-6 months

Short-term disability insurance provides income replacement for a limited period, typically 3-6 months, during which the insured cannot work due to illness or injury.

27. Answer: D

Coverage that provides income for extended periods, often until age 65

Long-term disability insurance provides income replacement for extended periods, potentially lasting years or until the insured reaches age 65, after short-term disability benefits are exhausted.

28. Answer: D

Partial benefits when the insured can work but at reduced capacity or income

Residual disability coverage provides partial benefits when the insured can return to work but at reduced hours or in a limited capacity, resulting in reduced income.

29. Answer: D

Federal health insurance program primarily for people 65 and older

Medicare is a federal health insurance program primarily for people 65 and older, as well as certain younger people with disabilities and those with End-Stage Renal Disease.

30. Answer: C

Hospital insurance including inpatient care

Medicare Part A is hospital insurance that covers inpatient hospital stays, skilled nursing facility care, hospice care, and some home health care.

31. Answer: D

Medical insurance including doctor services and outpatient care

Medicare Part B is medical insurance that covers physician services, outpatient care, preventive services, durable medical equipment, and some home health care.

32. Answer: B

Private health plans that provide all Part A and B coverage, often with additional benefits

Medicare Part C (Medicare Advantage) plans are offered by private insurers approved by Medicare. They must cover everything Original Medicare covers and often include additional benefits like vision, dental, and prescription drugs.

33. Answer: B

Prescription drug coverage

Medicare Part D provides prescription drug coverage. It's offered through private plans approved by Medicare, either as stand-alone prescription drug plans or as part of Medicare Advantage plans.

34. Answer: C

Private insurance that helps pay Medicare's gaps like deductibles and coinsurance

Medicare Supplement (Medigap) policies are sold by private insurers to help pay for out-of-pocket costs not covered by Original Medicare, such as deductibles, copays, and coinsurance.

35. Answer: C

A joint federal-state program providing health coverage to low-income individuals

Medicaid is a joint federal and state program that provides health coverage to eligible low-income individuals, families, children, pregnant women, elderly, and people with disabilities.

36. Answer: B

Yes, these individuals are called 'dual eligibles'

Yes, some individuals qualify for both Medicare and Medicaid. These 'dual eligible' beneficiaries get Medicare coverage plus Medicaid may pay their Medicare premiums and cover additional services.

37. Answer: B

Health coverage provided to a group, typically by an employer

Group health insurance is health coverage provided to a defined group of people, most commonly employees of a company, under a single master policy. Risk is spread across the group.

38. Answer: A

A law allowing continued group health coverage after qualifying events like job loss

COBRA (Consolidated Omnibus Budget Reconciliation Act) is a federal law that allows employees and their families to continue group health coverage for a limited time after qualifying events like job loss, reduced hours, or divorce.

39. Answer: B

18 months for most qualifying events

COBRA coverage typically lasts 18 months for most qualifying events (job loss, reduced hours). It can extend to 36 months for certain events like divorce or a child losing dependent status.

40. Answer: B

The employee pays the full premium plus up to 2% administrative fee

Under COBRA, the former employee pays the full premium cost (including the portion the employer previously paid) plus up to a 2% administrative fee. This is often significantly more expensive than when employed.

41. Answer: A

Employers with 20 or more employees

COBRA applies to employers with 20 or more employees who offer group health plans. Smaller employers may be subject to state continuation laws (often called 'mini-COBRA').

42. Answer: C

Federal law that reformed health insurance and expanded coverage access

The Affordable Care Act (also known as 'Obamacare') is a comprehensive federal law enacted in 2010 that reformed health insurance markets, expanded Medicaid, created health insurance marketplaces, and established consumer protections.

43. Answer: D

Ten categories of services ACA marketplace plans must cover

Essential health benefits are 10 categories of services that ACA marketplace plans must cover, including hospitalization, prescription drugs, maternity care, mental health services, preventive care, and pediatric services.

44. Answer: D

A platform where individuals can shop for and purchase ACA-compliant health plans

A health insurance marketplace (also called an exchange) is a platform, either state-run or federally-facilitated (HealthCare.gov), where individuals and families can shop for, compare, and purchase ACA-compliant health insurance plans.

45. Answer: A

Subsidies to help eligible individuals afford marketplace health insurance

Premium tax credits are subsidies available to individuals who purchase health insurance through the marketplace and have income within certain limits. They reduce monthly premium costs.

46. Answer: B

Insurers must accept all applicants regardless of health status or pre-existing conditions

Guaranteed issue means health insurers must accept all applicants during open enrollment periods regardless of health status, pre-existing conditions, age (within limits), or gender.

47. Answer: B

The annual period when individuals can enroll in or change marketplace plans

The open enrollment period is the annual timeframe (typically in the fall) when individuals can enroll in new marketplace health plans or make changes to existing coverage. Outside this period, enrollment requires a qualifying life event.

48. Answer: B

A time outside open enrollment when someone can enroll due to a qualifying life event

A special enrollment period allows individuals to enroll in marketplace coverage outside the open enrollment period due to qualifying life events such as marriage, birth of a child, loss of other coverage, or moving.

49. Answer: D

Federal law protecting health information privacy and insurance portability

HIPAA (Health Insurance Portability and Accountability Act) is a federal law that protects the privacy of health information and ensures portability of health coverage when changing jobs.

50. Answer: B

Illegal or unethical business practices prohibited by insurance regulations

Unfair trade practices are illegal activities prohibited by state insurance regulations, including misrepresentation, false advertising, defamation, unfair discrimination, and rebating.

51. Answer: D

Treating similarly situated individuals differently based on prohibited factors

Unfair discrimination occurs when an insurer treats similarly situated individuals differently based on factors not related to risk, such as race, religion, or national origin, rather than legitimate underwriting factors.

52. Answer: B

Legal and ethical obligation to act in the client's best interest

An agent's fiduciary duty is a legal and ethical obligation to act in the best interest of the client, putting the client's needs before the agent's own financial interests.

53. Answer: B

A list of prescription drugs covered by a health plan

A formulary is a list of prescription drugs covered by a health insurance plan. Drugs are often organized into tiers, with different cost-sharing amounts for each tier.

54. Answer: C

Requiring trial of lower-cost drugs before more expensive options

Step therapy requires patients to try one or more lower-cost medications (typically generics) before the plan will cover a more expensive brand-name drug for a condition.

55. Answer: C

Coverage for assistance with daily living activities when unable to care for oneself

Long-term care insurance covers services needed when a person cannot perform activities of daily living (like bathing, dressing, eating) due to chronic illness, disability, or cognitive impairment.

56. Answer: C

Basic self-care tasks used to measure need for long-term care

Activities of daily living (ADLs) are basic self-care tasks including bathing, dressing, eating, toileting, transferring (moving), and continence. Inability to perform ADLs often triggers long-term care benefits.

57. Answer: B

The criteria that must be met before benefits are paid

A benefit trigger is the condition that must be met before long-term care insurance benefits begin. Common triggers include inability to perform a certain number of ADLs or cognitive impairment.

58. Answer: D

Requiring equal coverage for mental health as for medical/surgical conditions

Mental health parity requires health insurers to provide the same level of benefits for mental health and substance use disorder treatment as they do for medical and surgical treatments.

59. Answer: D

Setting premiums based on the entire community rather than individual health status

Community rating is a method of setting premiums where everyone in a geographic area pays the same base rate, regardless of individual health status. The ACA requires modified community rating.

60. Answer: D

Setting premiums based on a group's actual claims history

Experience rating bases premium rates on the actual claims history and experience of a specific group. Groups with fewer claims may receive lower rates, while those with more claims pay higher rates.

61. Answer: A

A primary care physician who coordinates and authorizes specialist care

In managed care plans, particularly HMOs, the gatekeeper is the primary care physician who coordinates all patient care and must authorize referrals to specialists to ensure medical necessity and cost control.

62. Answer: B

Requiring use of less expensive drugs before covering more expensive alternatives

Step therapy is a cost-control strategy requiring patients to try less expensive, often generic medications first before the plan will cover more expensive brand-name or specialty drugs.

63. Answer: B

A list of prescription drugs covered by the plan, often organized by tier

A formulary is a list of prescription drugs covered by a health insurance plan, typically organized into tiers based on cost. Drugs on the formulary are covered; those off-formulary may not be or have higher costs.

64. Answer: A

Prior health insurance coverage that reduces or eliminates pre-existing condition exclusions

Creditable coverage is prior health insurance coverage that can reduce or eliminate pre-existing condition exclusion periods when switching to new coverage. HIPAA established rules for crediting prior coverage.

65. Answer: B

State programs providing health insurance to individuals unable to obtain coverage elsewhere

High-risk pools are state-sponsored health insurance programs designed to cover individuals who cannot obtain coverage in the private market due to pre-existing conditions. The ACA reduced their need.

66. Answer: A

Children's Health Insurance Program providing coverage for uninsured children

CHIP (Children's Health Insurance Program) is a federal-state program providing health coverage to uninsured children in families with incomes too high for Medicaid but too low for private insurance.

67. Answer: C

The tendency for higher-risk individuals to seek more insurance coverage

Adverse selection occurs when individuals with higher health risks are more likely to purchase insurance, while healthier people may decline coverage, leading to a disproportionate number of claims.

68. Answer: D

The tendency to use more services because insurance covers them

Moral hazard in health insurance is the tendency for insured individuals to use more medical services or take less care of their health because they don't bear the full cost of their decisions.

69. Answer: A

Pricing policies the same for all members of a community regardless of health status

Community rating is a method of pricing health insurance where all members in a geographic area pay the same premium regardless of health status, age, or other individual factors.

70. Answer: B
Pricing group policies based on the group's actual claims history
Experience rating sets premiums for groups based on their actual claims history. Groups with fewer claims may pay lower premiums, while those with more claims pay higher premiums.

71. Answer: D
Requirement that insurers accept all applicants regardless of health status
Guaranteed issue requires insurers to accept all applicants regardless of health status during specified enrollment periods. Under the ACA, individual and small group plans must offer guaranteed issue.

72. Answer: C
The insurer must renew coverage as long as premiums are paid
Guaranteed renewability means the insurer cannot refuse to renew coverage as long as premiums are paid. The insurer can increase premiums for the entire class but cannot single out individuals.

73. Answer: A
Retroactive cancellation of coverage due to fraud or intentional misrepresentation
Rescission is the retroactive cancellation of a health insurance policy, typically due to fraud or intentional misrepresentation on the application. Under the ACA, rescissions are limited to fraud cases.

74. Answer: D
A standardized document explaining what a health plan covers in plain language
The SBC is a standardized document required by the ACA that explains health plan coverage in plain language using a consistent format, making it easier to compare different plans.

75. Answer: C
The percentage of premiums an insurer must spend on medical care and quality improvement
MLR is the percentage of premium dollars insurers must spend on medical care and quality improvement. The ACA requires 80% for individual/small group and 85% for large group plans.

76. Answer: A
A plan certified by the Marketplace meeting ACA standards
A QHP is a health insurance plan certified by the Health Insurance Marketplace to meet ACA standards, including essential health benefits, cost-sharing limits, and other consumer protections.

77. Answer: C
Ten categories of services all Marketplace plans must cover under the ACA
Essential health benefits are 10 categories of services that ACA-compliant plans must cover: ambulatory, emergency, hospitalization, maternity, mental health, prescription drugs, rehabilitative, lab, preventive, and pediatric services.

78. Answer: C
A subsidy to help eligible individuals afford Marketplace health insurance
Premium tax credits are subsidies provided under the ACA to help eligible individuals and families with moderate incomes afford health insurance purchased through the Marketplace.

79. Answer: B
Subsidies that lower deductibles, copays, and out-of-pocket limits for eligible individuals
Cost-sharing reductions are subsidies that lower out-of-pocket costs (deductibles, copays, coinsurance) for eligible individuals who choose Silver tier Marketplace plans and meet income requirements.

80. Answer: D
A time outside open enrollment when qualifying life events allow health plan enrollment
A SEP is a time outside the regular open enrollment period when you can enroll in health coverage due to a qualifying life event such as marriage, birth of a child, loss of other coverage, or moving.

81. Answer: B
To act as the member's main doctor and coordinate care within the network
In many HMO arrangements, the primary care physician coordinates routine care and may provide referrals to specialists within the network.

82. Answer: A

It usually gives members more provider flexibility than an HMO

A preferred provider organization usually lets members use network providers at better cost sharing while still offering some coverage for out-of-network care.

83. Answer: B

A referral from the primary care physician

Gatekeeper HMO models commonly require the primary care physician to coordinate specialist referrals so care stays within the plan's managed network.

84. Answer: A

The provider has agreed to network terms or negotiated rates

PPO networks are built around participating providers that agree to plan terms, which can reduce the member's cost sharing compared with out-of-network care.

85. Answer: B

Managed-care features with some choice to use out-of-network providers

A point-of-service plan often blends HMO-style coordination with the option to use providers outside the network, usually at a higher cost.

86. Answer: B

Doctors, hospitals, and providers that contract with the plan

A provider network is the group of medical providers and facilities that have a contractual relationship with the health plan.

87. Answer: B

The member may pay higher out-of-pocket costs or receive reduced benefits

Many managed-care plans encourage network use. Out-of-network care may be covered at a lower level or may create higher out-of-pocket costs, depending on the plan.

88. Answer: A

To review whether services are medically necessary or appropriate under the plan

Utilization review is a cost-control and care-management process used to evaluate whether covered services are medically necessary or appropriate.

89. Answer: A

Preauthorization

Preauthorization means the plan requires approval before certain services are provided, often to confirm coverage and medical necessity.

90. Answer: A

Emergency-care protections and plan rules can vary, so the plan and applicable law should be checked

Emergency care rules may involve federal law, state law, and plan terms. Exam answers usually focus on the general concept, while exact requirements should be verified.

91. Answer: A

The amount the insured pays before the plan begins paying covered expenses

A deductible is the amount the insured must pay for covered services before the plan starts paying according to the policy terms.

92. Answer: A

The insured and insurer share covered costs by percentage after the deductible

Coinsurance is a cost-sharing percentage. For example, after the deductible, the plan may pay a percentage and the insured pays the remaining percentage.

93. Answer: A

A fixed dollar amount the insured pays for a covered service

A copayment is usually a fixed amount, such as a set charge for an office visit or prescription, depending on the plan.

94. Answer: A
To limit the insured's covered cost sharing during a plan period
An out-of-pocket maximum caps the insured's covered cost sharing for a plan period. Premiums and noncovered services may not count, depending on plan terms.

95. Answer: A
Large or broad medical expenses subject to deductibles, coinsurance, limits, and exclusions
Major medical coverage is designed for a broad range of medical expenses, often including hospital, physician, surgical, and related services under the policy.

96. Answer: A
Room, board, and hospital-related charges covered by the policy
Hospital expense benefits are associated with covered hospital charges such as room, board, and related inpatient services, depending on policy terms.

97. Answer: A
Covered surgical procedures and related charges
Surgical expense benefits are designed to help pay for covered surgical services, subject to the policy's limits and exclusions.

98. Answer: A
They may pay only specified amounts or cover only specified conditions or services
Limited-benefit policies may provide narrower coverage than major medical policies. Applicants should understand what is and is not covered.

99. Answer: A
How a plan determines an allowable charge for a covered medical service
UCR concepts are used by some plans to evaluate reasonable charges for covered medical services in a geographic or market context.

100. Answer: A
They identify services or situations the policy does not cover
Exclusions limit coverage by identifying items, services, or circumstances that are not covered. Candidates should read policy language carefully.

101. Answer: A
It determines when the insured may qualify for disability benefits
The policy's definition of disability controls whether the insured meets the requirement for benefits. Definitions can differ by policy.

102. Answer: A
The waiting period before disability benefits begin
The elimination period is the waiting period after disability begins before benefits become payable under the policy.

103. Answer: A
How long benefits may be payable after a covered disability begins
The benefit period is the maximum period that disability benefits may be paid, subject to policy terms.

104. Answer: A
Partial loss of income when the insured can work but not at full capacity
Residual disability benefits may provide partial benefits when the insured returns to work but suffers reduced earnings due to disability.

105. Answer: A
The duties of the insured's own occupation
An own-occupation definition focuses on whether the insured can perform the substantial duties of the occupation they were working in, subject to exact policy wording.

106. Answer: A
Work in another suitable occupation based on policy terms
Any-occupation definitions generally look beyond the insured's own job and may consider other suitable work, depending on policy wording.

107. Answer: A
The insurer cannot cancel or raise premiums if the insured pays required premiums, subject to policy terms
A noncancelable disability income policy generally protects both renewability and premium rates when premiums are paid as required.

108. Answer: A
The insurer usually cannot cancel coverage but may raise rates by class, subject to policy terms
Guaranteed renewable coverage protects continued coverage, but premiums may be increased for a class of insureds under the policy's terms.

109. Answer: A
The policy, application, and attached papers make up the full contract
The entire contract provision identifies the documents that make up the full insurance contract and limits reliance on outside statements.

110. Answer: A
To limit how long the insurer can use certain misstatements to void coverage or deny claims
This provision limits the time period for the insurer to contest certain statements, subject to fraud and policy terms.

111. Answer: A
Extra time to pay a premium after the due date while coverage may remain in force
A grace period gives the policyowner a limited time after the due date to pay the premium, subject to policy terms.

112. Answer: A
Restoring a lapsed policy after requirements are met
Reinstatement is the process of restoring a lapsed policy after the insured satisfies the policy's reinstatement requirements.

113. Answer: A
To require timely notice to the insurer after a covered loss begins or occurs
Notice of claim provisions require the insured or claimant to notify the insurer within the policy's required time frame.

114. Answer: A
Documentation submitted to support a claim
Proof of loss is information or documentation the insurer uses to evaluate whether a claim is payable under the policy.

115. Answer: A
When a lawsuit may be brought against the insurer over a claim
Legal actions provisions often set timing rules for lawsuits related to claim disputes, subject to applicable law and policy terms.

116. Answer: A
A death or survivor benefit payable to another person
Some health or accident policies may include death benefits. A beneficiary provision explains how the named recipient may be changed.

117. Answer: A
The employer or sponsoring organization
In group coverage, the employer or sponsoring organization commonly owns the master policy, while covered members receive certificates or coverage summaries.

118. Answer: A
A summary of the member's benefits and coverage under the group policy
Group members commonly receive certificates or summaries that explain their benefits under the master group policy.

119. Answer: A
To define when a new employee or member may become eligible for coverage
Eligibility or waiting periods set timing rules for when employees or members may enroll in group coverage.

120. Answer: A
Covered employees pay part of the premium
A contributory plan requires covered employees to contribute toward the cost of coverage, while a noncontributory plan is fully paid by the employer or sponsor.

121. Answer: A
Allow certain qualified beneficiaries to continue group health coverage for a limited time after qualifying events
COBRA generally allows eligible people to continue group health coverage temporarily after qualifying events, subject to federal rules and plan requirements.

122. Answer: A
To determine payment order when a person is covered by more than one plan
Coordination of benefits helps prevent duplicate overpayment and determines how multiple health plans share payment responsibility.

123. Answer: A
A covered person may change to individual coverage when group coverage ends, if policy terms allow
A conversion privilege may allow a person losing group coverage to obtain individual coverage without the same underwriting process, subject to plan and legal requirements.

124. Answer: A
Hospital insurance
Medicare Part A is commonly described as hospital insurance, though exact benefits, costs, and eligibility should be verified through official Medicare resources.

125. Answer: A
Medical insurance for services such as doctor visits and outpatient care
Medicare Part B is commonly described as medical insurance for certain doctor, outpatient, and related services, subject to official program rules.

126. Answer: A
A private-plan alternative for receiving Medicare benefits, also called Part C
Medicare Advantage, or Part C, is generally a private-plan way to receive Medicare benefits, subject to federal rules and plan details.

127. Answer: A
To help pay certain out-of-pocket costs under Original Medicare
Medicare Supplement, or Medigap, policies are designed to help with certain out-of-pocket costs under Original Medicare, subject to standardized plan rules.

128. Answer: A
Care services needed because of chronic illness, disability, or inability to perform activities of daily living
Long-term care insurance helps cover certain long-term care services when the insured meets benefit triggers such as needing help with activities of daily living.

129. Answer: A
Bathing
Activities of daily living commonly include basic self-care functions such as bathing, dressing, eating, toileting, transferring, and continence.

130. Answer: A
A waiting period before benefits become payable after the insured qualifies for benefits
The elimination period in long-term care insurance is a waiting period before benefits are payable once the insured otherwise qualifies, depending on policy terms.

131. Answer: C

Noncancelable

A noncancelable policy generally cannot be canceled by the insurer during the stated term as long as premiums are paid, and premiums usually cannot be changed for that policy alone.

132. Answer: B

The right to change premiums by class, subject to policy terms and law

Guaranteed renewable coverage generally requires the insurer to renew the policy if premiums are paid, but premiums may be changed for a class of insureds under the policy terms.

133. Answer: C

Choose not to renew on a policy anniversary or premium due date, subject to the contract

Optionally renewable policies give the insurer more discretion not to renew at specified times, subject to the policy language and applicable rules.

134. Answer: A

To delay coverage for certain illnesses after the policy starts

A probationary period is a waiting period after policy issuance before coverage begins for certain sicknesses, helping the insurer avoid immediate claims for existing conditions.

135. Answer: B

It limits the insurer's ability to deny claims based on misstatements after a specified period, except as allowed by the policy and law

The time limit on certain defenses provision restricts how long an insurer may use certain application misstatements to deny claims, while still allowing exceptions such as fraud where permitted.

136. Answer: A

How a lapsed policy may be put back in force

Reinstatement provisions explain the conditions under which a lapsed health policy may be restored, such as application, premium payment, and insurer approval rules.

137. Answer: A

To let the insured pay a premium shortly after the due date while coverage may remain in force

A grace period gives the policyowner limited extra time to pay a premium after its due date. Coverage handling depends on policy terms and applicable law.

138. Answer: A

The insurer may require reasonable medical examinations related to a claim while it is pending

This provision allows the insurer to require reasonable examinations related to a claim, and autopsy where not prohibited by law, to verify claim information.

139. Answer: A

Set time limits for bringing a lawsuit over a claim

The legal actions provision limits when a lawsuit may be brought, usually requiring time for claim review and setting an outside deadline after proof of loss.

140. Answer: A

The policyowner may change the beneficiary unless the beneficiary designation is irrevocable

A revocable beneficiary can usually be changed by the policyowner. An irrevocable beneficiary generally has stronger rights and may need to consent.

141. Answer: A

To evaluate risk and decide whether to issue coverage and on what terms

Underwriting helps the insurer evaluate an applicant's risk characteristics and determine acceptance, rating, exclusions, or other policy terms where allowed.

142. Answer: A

Medical history

Medical history is commonly relevant because it may affect expected health claims. The exact use of underwriting factors depends on the product and legal requirements.

143. Answer: A

To exclude or limit coverage for a specified condition or hazard, where allowed

An exclusion rider may limit coverage for a named condition or risk. Candidates should remember that legality and use vary by product and jurisdiction.

144. Answer: A

To limit coverage for a condition that existed before coverage began, subject to policy terms and law

A preexisting condition limitation addresses conditions that existed before the policy effective date. Modern rules vary by policy type, so candidates should avoid assuming one rule applies everywhere.

145. Answer: A

Documentation submitted to support that a covered loss occurred

Proof of loss is claim documentation submitted to the insurer so it can evaluate whether benefits are payable under the policy.

146. Answer: A

Tell the insurer about a covered loss within the required time period

Notice-of-claim provisions require timely notification so the insurer can start the claim process and request needed forms or information.

147. Answer: A

The claimed expense is excluded or not covered by the policy

Claims can be denied when the expense falls outside policy coverage, is excluded, lacks required proof, or fails another policy condition.

148. Answer: A

Duplicate benefit payments that exceed covered expenses

Coordination of benefits rules determine payment order when more than one health plan covers the same person, helping avoid duplicate recovery beyond covered expenses.

149. Answer: A

The insurer's right to recover from a responsible third party after paying a covered claim

Subrogation allows an insurer that paid benefits to seek recovery from a legally responsible third party, subject to policy terms and law.

150. Answer: A

Whether healthcare services are medically necessary and appropriate under plan rules

Utilization review examines the medical necessity, appropriateness, or efficiency of services under the health plan's rules.

151. Answer: A

Waive future premiums if the insured meets the policy's disability requirements

A waiver of premium rider can keep coverage in force without premium payments if the insured satisfies the rider's disability definition and waiting-period requirements.

152. Answer: A

Allow the insured to buy additional coverage later without new evidence of insurability, subject to rider terms

Guaranteed insurability riders allow future increases at specified times or events without new medical underwriting, subject to the rider's limits.

153. Answer: A

Critical illness policy

Critical illness insurance pays a defined benefit when the insured meets the policy requirements for a covered illness such as cancer, heart attack, or stroke.

154. Answer: A
A stated benefit related to covered hospitalization, regardless of the exact medical bill in many designs
Hospital indemnity coverage typically pays a set benefit for covered hospitalization events, such as per day or per admission, depending on policy terms.

155. Answer: A
Covered losses resulting from accidents, not sicknesses
Accident-only policies limit benefits to covered accidental injuries or losses. They generally do not cover sickness unless specifically provided.

156. Answer: A
A period before certain dental benefits are available
Some dental policies use waiting periods before certain services, especially major services, become covered. The exact waiting period depends on the policy.

157. Answer: A
It often helps pay for routine eye exams, lenses, frames, or contacts subject to plan limits
Vision coverage is typically a limited-benefit plan for routine eye care and eyewear, subject to allowances, copays, networks, and frequency limits.

158. Answer: A
A named disease or group of diseases listed in the policy
Specified disease policies provide benefits for named conditions, such as cancer, according to policy definitions and limits.

159. Answer: A
Help benefits keep pace with rising care costs over time
Inflation protection can increase benefit amounts over time so long-term care benefits are less likely to lose purchasing power as care costs rise.

160. Answer: A
Benefit period
The benefit period describes the maximum length of time or total pool of benefits available under a long-term care policy, depending on the policy design.

161. Answer: A
The contract issued to the employer or group sponsor
In group coverage, the master policy is issued to the employer or group sponsor, while covered individuals usually receive certificates or summaries of coverage.

162. Answer: A
Evidence and summary of the member's coverage under the group policy
A certificate explains the member's coverage under the group plan, but the master policy controls the full contract terms.

163. Answer: A
Employees pay part of the premium cost
In a contributory plan, covered employees pay part of the premium. Participation rules may apply to reduce adverse selection.

164. Answer: A
To define who may enroll and when coverage begins
Eligibility rules identify which employees or members qualify for coverage, such as full-time status, waiting period completion, or class membership.

165. Answer: A
Allow certain individuals to continue group health coverage temporarily after qualifying events
COBRA gives eligible individuals the right to continue group health coverage for a limited time after qualifying events, usually by paying the required premium.

166. Answer: A

Improper claim-handling conduct prohibited by insurance law or regulation

Unfair claims practices involve improper conduct such as unreasonable delays, misrepresentation, or failure to handle claims according to applicable standards.

167. Answer: A

Consumers rely on accurate explanations of benefits, exclusions, and limitations

Misrepresentation can mislead consumers about what a policy does or does not cover. Producers should explain coverage accurately and avoid false or exaggerated claims.

168. Answer: A

Inducing a policy replacement through misleading or incomplete comparisons

Twisting generally involves using misleading statements to persuade a consumer to replace existing coverage. Replacement discussions should be accurate and complete.

169. Answer: A

Explain the limitations clearly and avoid suggesting the policy covers everything

Clear disclosure helps consumers understand what they are buying. Producers should not imply that limited-benefit or supplemental policies are comprehensive major medical coverage.

170. Answer: A

The recommended product should reasonably fit the consumer's needs and circumstances

Suitability focuses on whether a recommendation is appropriate for the consumer's needs, objectives, and situation, based on available information.

171. Answer: B

$5,000

The insured first satisfies the $1,000 deductible. The remaining $5,000 is the amount subject to the 80/20 coinsurance split.

172. Answer: B

$1,000

After the $1,000 deductible, $5,000 remains. The insured's 20% coinsurance share of $5,000 is $1,000, before considering any out-of-pocket maximum.

173. Answer: A

Limit the insured's covered cost-sharing for a policy period

An out-of-pocket maximum caps covered cost-sharing, such as deductibles, coinsurance, and copayments, according to the plan's rules.

174. Answer: A

Plan approval before certain services are provided or paid as covered

Prior authorization requires advance plan approval for certain services, drugs, or procedures. Lack of authorization may affect coverage or payment.

175. Answer: A

The member may pay more out of pocket than with an in-network provider

PPOs usually provide stronger benefits for in-network care and may impose higher cost-sharing, balance-billing exposure, or different rules for out-of-network care.

176. Answer: A

A list of covered drugs and related cost-sharing rules

A formulary lists covered medications and may place them into tiers with different copayments, coinsurance, or prior authorization requirements.

177. Answer: A

The insured's cost-sharing for that medication

Prescription plans often use tiers. Preferred generic drugs may have lower cost-sharing, while nonpreferred or specialty drugs may cost more.

178. Answer: A

A rule requiring use of a preferred medication before coverage of another medication, when medically appropriate under plan rules

Step therapy may require trying a lower-cost or preferred drug before the plan covers another option, subject to exceptions and plan rules.

179. Answer: A

They identify services, conditions, or circumstances the policy does not cover

Exclusions define what is not covered. Understanding exclusions helps consumers avoid assuming a policy pays for every possible expense.

180. Answer: A

Review the explanation of benefits and policy provisions to understand the reason for denial

The explanation of benefits and policy language help identify whether the denial relates to coverage, coding, missing information, network rules, or appeal rights.

Ready for exam conditions?

Take a free timed mock exam for your state - interactive, instant scoring, and an explanation for every question.

https://insuranceexampractice.com/free-mock-tests