Accident and Health Insurance Agent/Broker Practice Exam (Sample)

Study Guide

Everything you need from our exam experts!

Questions

1. What primarily provides hospital or medical policies or plans in health insurance?

A. Wellness cooperative plans

B. Cafeteria wellness plans

C. Health benefit plans

D. Annuitized wellness cooperatives

2. Waiver of premium is a common benefit option associated with which type of policies?

A. Disability and long term care plans

B. Disability and medical plans

C. Limited benefit plans

D. Dread disease policies

3. Which of the following is NOT a characteristic of an individual disability?

A. The company may be able to increase premiums

B. The benefit may be paid annually

C. The premium is based on occupation and health status

D. The benefit is a stated dollar amount

4. Which of the following statements about Blue Cross and Blue Shield plans is NOT true?

A. Blue Cross generally pays benefits for hospitals

B. Voluntary non-profit organizations

C. Both are exempt from insurance regulations

D. Blue Shield generally pays benefits for physicians

5. Which of the following is a primary reason for the establishment of the Affordable Care Act?

A. To enhance private insurance profits

B. To reduce the number of uninsured individuals

C. To increase premium costs

D. To eliminate Medicaid entirely

6. At what age may long-term care insurers require a physical examination of any applicant?

- **A. Age 70 or older**
- **B. Age 65 or older**
- **C. Age 75 or older**
- **D. Age 80 or older**

7. When can an insurer accept applications from a producer not associated with them?

- **A. If the insurer can issue the insurance with specific rider conditions**
- **B. The insurer cannot until they have been appointed**
- **C. Immediately if the producer's license originates from Maryland**
- **D. If the insurer has appointed the producer and updated the register within 30 days**

8. Which of the following will Abraham NOT find in the outline of coverage of his health policy?

- **A. Future policy value**
- **B. Limitations and exclusions**
- **C. Renewal provisions**
- **D. Benefits**

9. Under what condition does a new spell of illness for Medicare Part A begin?

- **A. The patient has been discharged from a prior stay and 45 days have elapsed**
- **B. The patient has been discharged from a prior stay and 30 days have elapsed**
- **C. The patient has been discharged from a prior stay and 60 days have elapsed**
- **D. The patient has been discharged from a prior stay and 90 days have elapsed**

10. The Uniform Provisions Law requires all of the following as mandatory EXCEPT:

A. Grace Period

B. Waiver of Premium

C. Physical examination and autopsy

D. Entire Contract

Answers

1. C
2. A
3. B
4. C
5. B
6. D
7. D
8. A
9. C
10. B

Explanations

1. What primarily provides hospital or medical policies or plans in health insurance?

A. Wellness cooperative plans

B. Cafeteria wellness plans

C. Health benefit plans

D. Annuitized wellness cooperatives

The chosen answer, health benefit plans, is correct because these plans are specifically designed to cover medical expenses and provide hospital services. They encompass a variety of coverage options, including hospital stays, physician services, outpatient care, and various other medical needs. Health benefit plans are integral components of health insurance, aiming to support individuals in managing healthcare costs. Wellness cooperative plans and annuitized wellness cooperatives focus more on wellness and preventive care, rather than providing comprehensive coverage for hospital or medical services. Cafeteria wellness plans offer a selection of benefits that employees can choose from based on their needs but typically do not focus directly on hospital or medical policy provisions. In contrast, health benefit plans are tailored specifically for those who need coverage for medical and hospital-related expenses, making them the most relevant and comprehensive option available.

2. Waiver of premium is a common benefit option associated with which type of policies?

A. Disability and long term care plans

B. Disability and medical plans

C. Limited benefit plans

D. Dread disease policies

The waiver of premium benefit is most commonly associated with disability and long-term care plans. This feature allows policyholders to suspend premium payments without losing coverage in the event they become disabled and are unable to work. The premise behind this benefit is that if a person is unable to earn income due to their disability, they should not have the additional burden of paying premiums for their insurance policy. By waiving premiums, the policy remains in force, ensuring that individuals maintain their coverage during a critical time when they may need it most. Other types of policies listed, such as medical, limited benefit, and dread disease plans, do not typically include a waiver of premium feature. Medical plans may have different stipulations regarding coverage and payments, while limited benefit and dread disease policies are more specific in nature and may not address permanent disabilities in the same manner as disability and long-term care plans. Thus, the primary association of the waiver of premium feature lies with disability and long-term care insurance coverage.

3. Which of the following is NOT a characteristic of an individual disability?

A. The company may be able to increase premiums

B. The benefit may be paid annually

C. The premium is based on occupation and health status

D. The benefit is a stated dollar amount

The characteristic that is not associated with individual disability insurance is that the benefit may be paid annually. Typically, individual disability insurance benefits are paid on a monthly basis, reflecting the regular income replacement needs of the insured. This approach helps align the benefits with common monthly expenses, such as rent or mortgage payments, utilities, and other recurring costs. In contrast, the other characteristics are indeed relevant to individual disability insurance. Premiums can be adjusted based on the insurer's underwriting process, meaning they may increase over time due to various factors, including age or changes in risk. The premium itself is determined by individual factors such as the insured's occupation and health status, ensuring that the cost reflects the person's unique risk profile. Additionally, benefits under individual disability policies are often specified as a stated dollar amount, providing clarity and ensuring that the policyholder understands exactly what their coverage entails.

4. Which of the following statements about Blue Cross and Blue Shield plans is NOT true?

A. Blue Cross generally pays benefits for hospitals

B. Voluntary non-profit organizations

C. Both are exempt from insurance regulations

D. Blue Shield generally pays benefits for physicians

The statement regarding Blue Cross and Blue Shield plans being exempt from insurance regulations is not true. In reality, these plans are subject to a range of insurance regulations which vary by state and can include licensing, solvency requirements, and consumer protection laws. These regulations are in place to ensure that these organizations operate fairly and maintain financial stability to meet the health care needs of their members. In contrast, the other statements accurately reflect the functioning of Blue Cross and Blue Shield. Blue Cross is primarily associated with hospital benefits, providing coverage for inpatient and outpatient services. Blue Shield, on the other hand, primarily provides benefits for physician services, encompassing outpatient care and professional services rendered by physicians. Moreover, the non-profit status of these organizations enables them to focus on providing affordable healthcare rather than on generating profit for shareholders, which aligns with their foundational mission. Therefore, the claim regarding exemption from insurance regulations is the only one that does not hold true.

5. Which of the following is a primary reason for the establishment of the Affordable Care Act?

A. To enhance private insurance profits

B. To reduce the number of uninsured individuals

C. To increase premium costs

D. To eliminate Medicaid entirely

The Affordable Care Act (ACA) was primarily established to reduce the number of uninsured individuals in the United States. One of the key goals of the ACA was to expand access to health insurance coverage through various measures, including the creation of health insurance marketplaces, the expansion of Medicaid eligibility, and the implementation of provisions that require individuals to have health insurance. By addressing barriers to obtaining insurance, such as pre-existing conditions and guarantees of coverage regardless of health status, the ACA aimed to ensure that more individuals could obtain affordable healthcare. This focus on expanding coverage is central to the law's purpose and highlights the intent to make healthcare more accessible to all Americans, thereby reducing the overall number of uninsured.

6. At what age may long-term care insurers require a physical examination of any applicant?

A. Age 70 or older

B. Age 65 or older

C. Age 75 or older

D. Age 80 or older

Long-term care insurers typically require a physical examination for applicants starting at age 80 or older. This age threshold is set because as individuals age, they typically have an increased risk of health issues that could impact their eligibility for coverage or the type of policy they can obtain. By ensuring a physical examination is part of the application process for this age group, insurers can accurately assess the health status and potential care needs of the applicant. This practice helps to mitigate risk for the insurance provider while ensuring that coverage options are appropriate for the individual's current health situation. Age 80 is a standard benchmark in the industry reflecting considerations of actuarial data and health care analytics relevant to that demographic. Other age options would not align with common underwriting practices within the insurance industry, as they typically occur at a later age when health risks become more pronounced.

7. When can an insurer accept applications from a producer not associated with them?

A. If the insurer can issue the insurance with specific rider conditions

B. The insurer cannot until they have been appointed

C. Immediately if the producer's license originates from Maryland

D. If the insurer has appointed the producer and updated the register within 30 days

The correct answer is that an insurer can accept applications from a producer not associated with them if the insurer has appointed the producer and updated the register within 30 days. This is significant because the appointment of a producer is a formal process that signifies the insurer's recognition of that producer to act on their behalf. Updating the register ensures that all parties are aware of which producers are authorized to solicit and take applications for the insurer. This system of appointment and registration offers protection to both consumers and the insurer by ensuring that only qualified, officially recognized individuals can sell insurance products on behalf of the company, thereby maintaining standards of professionalism and compliance with regulatory requirements.

8. Which of the following will Abraham NOT find in the outline of coverage of his health policy?

A. Future policy value

B. Limitations and exclusions

C. Renewal provisions

D. Benefits

In the context of health insurance, the outline of coverage is designed to provide policyholders with essential information regarding their health insurance plan. Typically, this includes details about the benefits available, limitations and exclusions, and renewal provisions. These components serve to clarify what is covered by the policy and under what circumstances, allowing consumers like Abraham to understand the scope of their coverage. The future policy value, however, is not typically included in the outline of coverage. This is because the outline focuses on the specific provisions and the operational aspects of the health policy rather than projecting future value or costs associated with the policy. Future policy value can refer to benefits or cash values in certain insurance products, particularly in life insurance or investment-related products, but it is not a standard element relevant to health insurance outlines. Thus, Abraham would not find this information included in the outline of coverage for his health policy.

9. Under what condition does a new spell of illness for Medicare Part A begin?

A. The patient has been discharged from a prior stay and 45 days have elapsed

B. The patient has been discharged from a prior stay and 30 days have elapsed

C. The patient has been discharged from a prior stay and 60 days have elapsed

D. The patient has been discharged from a prior stay and 90 days have elapsed

A new spell of illness for Medicare Part A begins when a patient has been discharged from a prior stay in a hospital or skilled nursing facility, followed by a lapse of 60 days. This framework is important because it helps define how Medicare handles successive hospitalizations and helps ensure that the patient receives appropriate coverage for ongoing medical needs without interruptions. Specifically, after a patient is discharged, if they experience a new illness or exacerbation of an existing condition requiring hospitalization and at least 60 days have passed since their last discharge, Medicare recognizes this as a new spell of illness. This rule is in place to prevent continuous coverage for related conditions that may not necessitate a new hospitalization, and it also helps manage resource utilization effectively. Understanding this specific timeframe assists healthcare providers in navigating Medicare billing and coverage options accurately, ensuring both patient care and compliance with Medicare regulations.

10. The Uniform Provisions Law requires all of the following as mandatory EXCEPT:

A. Grace Period

B. Waiver of Premium

C. Physical examination and autopsy

D. Entire Contract

The Uniform Provisions Law sets out essential standards that insurance contracts must adhere to in order to ensure fairness and transparency in the insurance process. Among the provisions that are typically mandated are the grace period, physical examination and autopsy, and the entire contract clause. A grace period is essential because it allows policyholders to make premium payments without losing coverage, fostering customer trust and reliability. The requirement for a physical examination and autopsy, when relevant, ensures that claims are substantiated through accurate medical assessments, providing an objective basis for underwriting and claims decisions. The entire contract clause guarantees that the insurance policy constitutes the whole agreement between the insurer and insured, preventing any conflicting external agreements from affecting its terms. On the other hand, while a waiver of premium can be a valuable provision in cases of disability or certain situations, it is not mandated universally by the Uniform Provisions Law. Insurers may choose to offer this feature, but it is not a requirement for all health insurance policies. This flexibility allows insurers to determine how they design their products, which can lead to variations in coverage across different policies. This distinction highlights that not every aspect of an insurance policy has to be included by law.