

Delaware Health Insurance Practice Exam (Sample)

Study Guide



Everything you need from our exam experts!

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 - 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

- 1. What is covered by a disability income policy?**
 - A. Funeral expenses**
 - B. Lost income due to disabling injury**
 - C. Medical expenses only**
 - D. Long-term care services**
- 2. In insurance, what is the main purpose of underwriting?**
 - A. To investigate claims**
 - B. To assess risk**
 - C. To sell policies**
 - D. To handle customer service**
- 3. Which of the following best defines "primary payer"?**
 - A. The last insurer to process a claim**
 - B. The insurer that pays claims first before any other**
 - C. The insurer offering the best coverage options**
 - D. The policyholder's employer insurance**
- 4. What is typically not covered under most health insurance plans?**
 - A. Routine physical exams**
 - B. Cosmetic surgery not deemed medically necessary**
 - C. Maternity care**
 - D. Emergency room visits**
- 5. What characterizes a reimbursement contract in insurance?**
 - A. It pays a fixed sum regardless of the loss**
 - B. It pays based on the loss actually incurred**
 - C. It provides cash benefits immediately**
 - D. It covers future health expenses**

- 6. What is the effect of misstatement of age or sex in an insurance application?**
- A. It voids the policy**
 - B. It adjusts benefits based on correct age and sex**
 - C. It has no effect on benefits**
 - D. It leads to increased premium rates**
- 7. Who typically has the authority to enforce insurance regulations in a state?**
- A. Insurance company executives**
 - B. Insurance agents**
 - C. State insurance commissioners**
 - D. Federal agencies**
- 8. Which group typically benefits from Medicaid expansion?**
- A. High-income families**
 - B. Low-income adults without children**
 - C. Individuals with employer-provided insurance**
 - D. Students living away from home**
- 9. Which types of health insurance plans are primarily offered in Delaware?**
- A. Health Maintenance Organizations (HMOs) and Life Insurance**
 - B. Preferred Provider Organizations (PPOs) and Medicare**
 - C. Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Exclusive Provider Organizations (EPOs)**
 - D. Exclusive Provider Organizations (EPOs) and Disability Insurance**
- 10. How does the HMO model control healthcare costs?**
- A. By encouraging members to use non-network providers**
 - B. By providing comprehensive coverage without limits**
 - C. By requiring referrals for specialist services**
 - D. By allowing unlimited doctor visits**

Answers

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

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Explanations

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1. What is covered by a disability income policy?

- A. Funeral expenses
- B. Lost income due to disabling injury**
- C. Medical expenses only
- D. Long-term care services

A disability income policy is specifically designed to provide financial support to individuals who are unable to work due to a disabling injury or illness. This type of policy replaces a portion of the lost income during the period when the insured is disabled and cannot perform their job duties. It is tailored to help individuals meet their living expenses and maintain their standard of living while they are recovering. The other options do not align with the primary purpose of a disability income policy. Funeral expenses are typically covered under life insurance, while medical expenses are usually addressed through health insurance rather than disability income policies. Long-term care services, like nursing home or assisted living care, are covered under long-term care insurance, not disability income policies. Therefore, the choice highlighting lost income due to a disabling injury accurately reflects the core function of a disability income policy.

2. In insurance, what is the main purpose of underwriting?

- A. To investigate claims
- B. To assess risk**
- C. To sell policies
- D. To handle customer service

The main purpose of underwriting in insurance is to assess risk. Underwriting involves evaluating the potential risk associated with insuring a person or entity and deciding the terms and conditions of coverage. This process is crucial because it helps insurers determine how likely it is that a claim will occur based on various factors, such as the applicant's health history, lifestyle choices, and other relevant information. By accurately assessing risk, underwriters can help ensure that premiums are appropriately matched to the level of risk, ultimately maintaining the financial stability of the insurance company while providing coverage for policyholders. While investigating claims, selling policies, and handling customer service are all important functions within the insurance industry, they do not encapsulate the fundamental role of underwriting. Investigating claims relates to ensuring that when a claim is made, it is valid and should be paid. Selling policies is about marketing and providing insurance products to consumers. Customer service encompasses assisting clients with inquiries and support throughout their relationship with the insurer. These functions enhance the customer experience but are secondary to the critical task of risk assessment performed by underwriters.

3. Which of the following best defines "primary payer"?

- A. The last insurer to process a claim
- B. The insurer that pays claims first before any other**
- C. The insurer offering the best coverage options
- D. The policyholder's employer insurance

The definition of "primary payer" is best represented by the insurer that pays claims first before any other. In health insurance, when an individual has multiple insurance policies, one insurer is designated as the primary payer. This means that the primary payer is responsible for paying the healthcare expenses up to the coverage limits, before any other insurance is involved. In situations where there are multiple sources of coverage, determining which policy is primary ensures that claims are processed efficiently and without duplicative payments. This concept is vital for understanding how claims are managed in scenarios involving multiple insurance providers. It ensures that patients have access to their benefits without undue delay. In contrast, the other options do not accurately reflect the function of a primary payer: - The last insurer to process a claim does not define the payer's role, as the order of claim processing can vary based on the specific circumstances surrounding each individual's coverage. - The insurer offering the best coverage options does not directly relate to the prioritization of payments and reflects more on the quality of a plan rather than its role in payment sequences. - The policyholder's employer insurance may play a part in a broader context of coverage, but it does not specifically identify a payer's role as the first to handle claims financially. Understanding the

4. What is typically not covered under most health insurance plans?

- A. Routine physical exams
- B. Cosmetic surgery not deemed medically necessary**
- C. Maternity care
- D. Emergency room visits

The correct answer highlights that cosmetic surgery not deemed medically necessary is typically excluded from most health insurance plans. This exclusion exists because health insurance is designed primarily to cover expenses related to medical care that have a clear health benefit or necessity, rather than procedures that are performed largely for aesthetic reasons. Cosmetic surgery is often viewed as elective and not essential to the overall health or medical condition of the patient, thus insurance companies generally do not cover these procedures unless they are required to correct a medical issue, such as reconstructive surgery following an accident or illness. On the other hand, items like routine physical exams, maternity care, and emergency room visits are generally considered essential health services. Most health insurance plans typically include coverage for these services because they play a crucial role in preventive care and overall health management, aligning with the broader objectives of health insurance to provide necessary medical care and support. This distinction is key in understanding how health plans categorize various procedures and the justifications for what is covered or excluded.

5. What characterizes a reimbursement contract in insurance?

- A. It pays a fixed sum regardless of the loss**
- B. It pays based on the loss actually incurred**
- C. It provides cash benefits immediately**
- D. It covers future health expenses**

A reimbursement contract in insurance is characterized by its payment structure, where the insurer compensates the insured based on the actual loss incurred. This means that the policyholder must provide evidence of the expenses or losses they have faced, and the insurer will reimburse those costs up to the agreed limit specified in the policy. This approach is common in many types of insurance, particularly health insurance, where the insured may need to submit bills or receipts to demonstrate the medical expenses they have covered. The focus here is on the actual financial impact on the insured rather than a predetermined sum, which can provide a more accurate reflection of the losses faced. This characteristic allows for flexibility and ensures that insured individuals receive compensation proportional to their true expenses. The other options present payment structures that do not align with the nature of reimbursement contracts. For instance, fixed-sum payments regardless of the loss or immediate cash benefits do not require the insured to demonstrate actual losses incurred. These are separate forms of insurance policy arrangements that are based on different principles.

6. What is the effect of misstatement of age or sex in an insurance application?

- A. It voids the policy**
- B. It adjusts benefits based on correct age and sex**
- C. It has no effect on benefits**
- D. It leads to increased premium rates**

The effect of a misstatement of age or sex in an insurance application primarily results in an adjustment of benefits based on the corrected information. Insurance policies are often priced and benefits calculated based on the insured's age and sex because these factors significantly influence the risk and cost associated with providing coverage. When the correct age or sex is disclosed after a misstatement, the insurance company will adjust the policy accordingly to reflect what the benefits would have been had the correct information been provided at the time of application. This could mean an increase or decrease in benefits, depending on the specific terms of the policy and the misstatement. For instance, if a younger applicant was mistakenly stated as older, the benefits might be reduced to match those that would have been applied to the correct age. Conversely, if the misstatement favored the insured (e.g., making an older applicant appear younger), the insurer would adjust benefits to align with the facts as per the coverage terms that apply to their actual age or sex. This makes the understanding of how information is processed in insurance applications crucial for both insurers and insured parties, emphasizing the importance of accuracy in application submission.

7. Who typically has the authority to enforce insurance regulations in a state?

- A. Insurance company executives**
- B. Insurance agents**
- C. State insurance commissioners**
- D. Federal agencies**

The correct choice reflects that state insurance commissioners hold the authority to enforce insurance regulations within their respective states. These commissioners are appointed or elected officials responsible for overseeing the insurance industry, ensuring that companies comply with state laws, protecting consumers, and maintaining a stable marketplace. Their role includes monitoring insurance practices, approving rates, and addressing consumer complaints. This authority is grounded in the concept of state regulation of insurance, which is uniquely positioned at the state level, allowing commissioners to tailor regulations that address specific needs and circumstances of the state's residents and market conditions. Federal agencies, while they play a significant role in aspects of healthcare insurance and interstate commerce, do not have direct enforcement powers related to state-specific insurance regulations. Insurance company executives and agents operate within the system under the regulations set forth by these commissioner offices, rather than enforcing such rules themselves.

8. Which group typically benefits from Medicaid expansion?

- A. High-income families**
- B. Low-income adults without children**
- C. Individuals with employer-provided insurance**
- D. Students living away from home**

Medicaid expansion primarily aims to provide healthcare coverage to low-income individuals, particularly those who do not have dependent children. One of the key goals of expanding Medicaid under the Affordable Care Act was to include more low-income adults in the health care safety net, as many were previously ineligible for Medicaid due to stringent income and categorical requirements. Low-income adults without children often struggle to access affordable healthcare. By expanding Medicaid, states can cover these individuals, ensuring they have access to medical services and preventive care. This expansion not only addresses immediate health care needs but also supports long-term health outcomes and financial stability for this vulnerable population. In contrast, high-income families, individuals with employer-provided insurance, and students living away from home do not typically rely on Medicaid as they usually have access to other forms of health insurance or resources that make them ineligible for state-sponsored programs. Therefore, the correct choice highlights the specific demographic that benefits directly from Medicaid expansion initiatives.

9. Which types of health insurance plans are primarily offered in Delaware?

- A. Health Maintenance Organizations (HMOs) and Life Insurance**
- B. Preferred Provider Organizations (PPOs) and Medicare**
- C. Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Exclusive Provider Organizations (EPOs)**
- D. Exclusive Provider Organizations (EPOs) and Disability Insurance**

The correct answer encompasses a range of common health insurance plan types that are typically available in Delaware, particularly focusing on HMOs, PPOs, and EPOs. Health Maintenance Organizations (HMOs) are popular due to their emphasis on preventive care and lower costs, which can be very appealing for consumers looking for affordable health insurance. They require members to choose a primary care physician and obtain referrals for specialists, ensuring coordinated care and managing healthcare expenses effectively. Preferred Provider Organizations (PPOs) offer more flexibility compared to HMOs. Members can see any healthcare provider, but they receive better coverage when they use providers within the PPO network. This type of plan allows for a higher degree of choice which is advantageous for consumers who may want to see specialists without needing a referral. Exclusive Provider Organizations (EPOs) are similar to PPOs but do not provide coverage for out-of-network care except in emergencies. This plan type typically has lower premiums compared to PPOs due to the restricted network of providers, and it is becoming increasingly prevalent among consumers who seek cost-effective options. The combination of these three plan types reflects the diversity of health insurance options available in Delaware, catering to various needs and preferences of residents. Each of these plans has its unique features

10. How does the HMO model control healthcare costs?

- A. By encouraging members to use non-network providers**
- B. By providing comprehensive coverage without limits**
- C. By requiring referrals for specialist services**
- D. By allowing unlimited doctor visits**

The HMO (Health Maintenance Organization) model controls healthcare costs primarily through the requirement for referrals for specialist services. This system is designed to manage and contain costs by ensuring that primary care physicians assess and coordinate care before patients see specialists. When patients need to see a specialist, they must first consult their primary care physician, who evaluates the necessity of that referral. This adds a layer of oversight that can help prevent unnecessary specialist visits, which can be more costly. By streamlining the process and focusing on primary care, HMOs can effectively manage the overall expenses associated with patient care, leading to reduced healthcare costs for both the organization and its members. The other options presented do not align with the cost-containment strategies of the HMO model. Allowing unlimited doctor visits could lead to increased costs, while encouraging the use of non-network providers generally results in higher expenses for the HMO. Comprehensive coverage without limits might enhance patient benefits but does not specifically address cost control. Therefore, requiring referrals is a fundamental aspect of the HMO structure that helps maintain financial efficiency within the healthcare system.

Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

<https://dehealthinsurance.examzify.com>

We wish you the very best on your exam journey. You've got this!