

DELAWARE HEALTH INSURANCE PRACTICE EXAM (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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THE FULL VERSION STUDY GUIDE

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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

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- 1. What is the primary purpose of a waiting period in health insurance policies?**
 - A. To encourage policyholders to maintain coverage
 - B. To prevent adverse selection from high-risk applicants
 - C. To manage claim processing efficiency
 - D. To create a lapse in policy renewals
- 2. What constitutes a qualifying event for COBRA coverage?**
 - A. Becoming eligible for Medicare
 - B. Receiving a promotion at work
 - C. Job loss, reduction in hours, or other life events causing loss of health coverage
 - D. Getting married
- 3. Which health insurance model typically requires a primary care physician referral to see a specialist?**
 - A. PPO
 - B. HMO
 - C. Indemnity Plan
 - D. Medicare Advantage
- 4. What are "essential health benefits" as defined by the ACA?**
 - A. Optional services that can be included in health plans
 - B. The minimum services that must be included in qualified health plans
 - C. Services aimed at mental health treatment
 - D. Additional coverages for high-risk individuals
- 5. What kind of services do supplemental insurance policies typically cover?**
 - A. Services that are primarily preventive
 - B. Exclusively emergency services only
 - C. Costs that exceed the limits of primary health insurance coverage
 - D. Services that are offered by public health programs

6. What is meant by "network" in health insurance?

- A. A group of healthcare providers contracted to provide services at negotiated rates
- B. The geographic area where services are available
- C. The total number of policyholders enrolled
- D. A term for emergency service vendors

7. How does the open enrollment period impact health insurance options for individuals?

- A. It restricts changes to insurance plans to one time a year
- B. It allows individuals to enroll, change, or cancel plans
- C. It is the time for insurance companies to raise premiums
- D. It automatically renews all existing plans

8. What is the basic function of health savings accounts (HSAs)?

- A. To invest in long-term insurance plans
- B. To provide tax advantages for medical expenses
- C. To lower insurance premiums over time
- D. To fund retirement savings specifically

9. What is the role of the underwriter in health insurance?

- A. To treat patients directly
- B. To assess risk and determine the terms and pricing of insurance policies
- C. To market the insurance products
- D. To manage patient claims

10. Define "deductible" in health insurance.

- A. The total amount covered by insurance
- B. The percentage of costs shared by the insured
- C. The amount a policyholder must pay out of pocket before the insurance coverage kicks in
- D. The monthly payment for coverage

Answers

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

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Explanations

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1. What is the primary purpose of a waiting period in health insurance policies?

- A. To encourage policyholders to maintain coverage
- B. To prevent adverse selection from high-risk applicants**
- C. To manage claim processing efficiency
- D. To create a lapse in policy renewals

The primary purpose of a waiting period in health insurance policies is to prevent adverse selection from high-risk applicants. During a waiting period, which is a specified time frame before coverage for certain conditions or benefits takes effect, insurers protect themselves against individuals who might only seek coverage when they anticipate needing immediate care, particularly for pre-existing conditions. By implementing a waiting period, insurers can encourage applicants to maintain continuous coverage, rather than selectively obtaining insurance after experiencing a health issue. This helps to stabilize the risk pool and ensure that premiums remain affordable for all policyholders. Furthermore, the waiting period discourages individuals with known illnesses from only purchasing insurance to cover their anticipated medical needs. This mechanism supports the insurance model, where risk is spread among all policyholders.

2. What constitutes a qualifying event for COBRA coverage?

- A. Becoming eligible for Medicare
- B. Receiving a promotion at work
- C. Job loss, reduction in hours, or other life events causing loss of health coverage**
- D. Getting married

A qualifying event for COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage is defined as an event that results in the loss of health insurance benefits. The correct answer focuses on situations such as job loss, a reduction in work hours, or significant life changes that lead to the loss of health coverage. These events trigger the right to continue health insurance benefits for a limited period under COBRA, allowing individuals and their families to maintain their health coverage despite changes in employment status or family circumstances. In contrast, other scenarios such as becoming eligible for Medicare or receiving a promotion do not qualify as COBRA events because they do not lead to the loss of coverage. Similarly, getting married is a life event that may allow individuals to add coverage or change plans, but it does not result in losing existing health insurance, thus not qualifying for COBRA. Understanding the specific qualifying events helps insured individuals know their rights and options for maintaining health insurance after such life changes.

3. Which health insurance model typically requires a primary care physician referral to see a specialist?

- A. PPO
- B. HMO**
- C. Indemnity Plan
- D. Medicare Advantage

The health insurance model that typically requires a primary care physician (PCP) referral to see a specialist is a health maintenance organization (HMO). In an HMO plan, members are generally required to choose a primary care physician who serves as the gatekeeper for their healthcare. This means that any referrals to specialists must be initiated by the PCP, ensuring that care coordination is maintained and that services provided align with the member's overall health plan. This model emphasizes preventive care and often results in lower out-of-pocket costs for members, as the HMO typically negotiates rates with healthcare providers and ensures that they provide care within a network. As a result, members have less flexibility in choosing specialists compared to other models like PPOs, which offer a broader choice of providers and do not require referrals. In contrast, other options like PPOs allow members to see specialists without needing a referral, indemnity plans provide a greater degree of freedom in accessing different types of care and specialists, and Medicare Advantage varies in referral requirements based on plan specifics but generally may not adhere strictly to the primary care referral model.

4. What are "essential health benefits" as defined by the ACA?

- A. Optional services that can be included in health plans
- B. The minimum services that must be included in qualified health plans**
- C. Services aimed at mental health treatment
- D. Additional coverages for high-risk individuals

Essential health benefits, as defined by the Affordable Care Act (ACA), refer to the minimum set of services that must be included in all qualified health plans. This includes a broad range of categories such as emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services, laboratory services, preventive and wellness services, and pediatric services. The requirement for essential health benefits ensures that insurance plans provide comprehensive coverage that meets the basic healthcare needs of individuals and families. This was a significant change in the health insurance landscape, aimed at increasing access to necessary medical care and preventing the discrimination found in many prior insurance practices that excluded critical services. Options that suggest services are optional or specifically targeted at high-risk individuals do not align with the ACA's intention, which mandates these benefits must be universally included in plans to ensure broad access to crucial health services.

5. What kind of services do supplemental insurance policies typically cover?

- A. Services that are primarily preventive
- B. Exclusively emergency services only
- C. Costs that exceed the limits of primary health insurance coverage**
- D. Services that are offered by public health programs

Supplemental insurance policies are designed to enhance the coverage provided by primary health insurance plans. They typically cover additional costs that exceed the limits set by the primary insurance, such as co-pays, deductibles, and services that might not be fully covered by the primary policy. This type of insurance can help alleviate the financial burden on the insured by covering expenses that arise during medical treatments, ensuring that individuals have access to necessary healthcare without facing significant out-of-pocket costs. For example, if a primary health insurance plan has a high deductible or only covers a portion of hospital costs, a supplemental policy can step in to help pay the remaining balance, making it a valuable resource for those seeking more comprehensive healthcare coverage.

6. What is meant by "network" in health insurance?

- A. A group of healthcare providers contracted to provide services at negotiated rates**
- B. The geographic area where services are available
- C. The total number of policyholders enrolled
- D. A term for emergency service vendors

In health insurance, the term "network" refers to a specific group of healthcare providers—such as doctors, hospitals, and specialists—that have entered into contracts with a health insurance plan to offer services at predetermined rates. This arrangement allows the insurance company to negotiate lower costs for their members while ensuring that these members have access to a coordinated system of care. When a health insurance plan is described as "in-network," it indicates that it covers services provided by these contracted providers at a higher benefit level, meaning lower out-of-pocket costs for policyholders who utilize these services. Understanding the significance of a health insurance network is crucial, as it not only affects the cost of care for the insured but also impacts the availability and quality of healthcare services they receive. Members generally benefit from reduced copayments, deductibles, and overall costs when they seek care from in-network providers, reinforcing the importance of choosing a plan that aligns with their healthcare needs and preferred providers.

7. How does the open enrollment period impact health insurance options for individuals?

- A. It restricts changes to insurance plans to one time a year
- B. It allows individuals to enroll, change, or cancel plans**
- C. It is the time for insurance companies to raise premiums
- D. It automatically renews all existing plans

The open enrollment period is a designated time frame during which individuals have the opportunity to enroll in a health insurance plan, make changes to their existing plan, or even cancel their coverage. This period is critical because it provides a structured opportunity for individuals to assess their health insurance needs and make informed choices based on their personal circumstances or changes in healthcare requirements. During this time, typically occurring once a year, individuals can evaluate their current health insurance options, compare different plans, and switch to a plan that may better suit their needs. This flexibility is essential as it allows individuals to adjust their coverage based on factors like changes in income, healthcare needs, or family status. The open enrollment period does not allow for random enrollment outside of this timeframe, which is why it is important for individuals to take advantage of this window. Plans enrolled during this period typically begin coverage on a specified date, giving consumers the opportunity to ensure they have appropriate coverage for the upcoming year. In contrast, while it is true that premiums may fluctuate year-to-year, the primary aim of the open enrollment period is not related to premium increases or automatic renewals of existing plans. Therefore, understanding the purpose of the open enrollment period is crucial for making informed decisions regarding health insurance options.

8. What is the basic function of health savings accounts (HSAs)?

- A. To invest in long-term insurance plans
- B. To provide tax advantages for medical expenses**
- C. To lower insurance premiums over time
- D. To fund retirement savings specifically

Health Savings Accounts (HSAs) are designed primarily to offer tax advantages for medical expenses. When individuals contribute to an HSA, they can do so with pre-tax dollars, which lowers their taxable income for the year. Moreover, the money in the account grows tax-free, and withdrawals used for qualified medical expenses are also tax-exempt. This triple tax benefit—deductible contributions, tax-free growth, and tax-free withdrawals for qualifying expenses—makes HSAs a powerful tool for managing healthcare costs. In contrast, while investing in long-term insurance plans, lowering insurance premiums, and funding retirement savings may be parts of broader financial strategies, they do not accurately capture the primary role of HSAs. HSAs are specifically tailored to allow individuals to save funds for out-of-pocket medical expenses while enjoying significant tax incentives. This distinct focus on tax advantages is what sets HSAs apart in the realm of personal finance and health care savings.

9. What is the role of the underwriter in health insurance?

- A. To treat patients directly
- B. To assess risk and determine the terms and pricing of insurance policies**
- C. To market the insurance products
- D. To manage patient claims

The role of the underwriter in health insurance is critical as it involves assessing risk and determining the terms and pricing of insurance policies. Underwriters evaluate applicants' health histories, lifestyle choices, and other risk factors to estimate the likelihood that an applicant will require significant medical care. This assessment helps insurers calculate premiums and decide what coverage can be offered to applicants. By effectively managing this risk, underwriters ensure that the insurance company remains financially viable while providing adequate coverage options for policyholders. This function is essential to the overall operation of insurance companies, as it directly affects both the affordability of policies for consumers and the profitability of the insurer.

10. Define "deductible" in health insurance.

- A. The total amount covered by insurance
- B. The percentage of costs shared by the insured
- C. The amount a policyholder must pay out of pocket before the insurance coverage kicks in**
- D. The monthly payment for coverage

A deductible in health insurance refers to the amount a policyholder must pay out of pocket for healthcare services before their insurance plan starts to cover costs. This means that if an individual has a deductible of, for example, \$1,000, they are responsible for paying that amount for their medical expenses before the insurance will begin to contribute. Deductibles can vary significantly between different insurance plans and can also apply to specific types of coverage, such as individual or family plans. This concept is an essential part of understanding health insurance because it affects how much individuals need to budget for their healthcare expenses. Once the deductible is met, insurance typically covers a larger portion of the costs, though there may still be copayments or coinsurance involved, which are different from the deductible. The nature of deductibles is pivotal for insured individuals to plan their healthcare expenses wisely, as it directly influences their out-of-pocket costs before receiving financial assistance from their insurance provider.

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!

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