

# Georgia 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**

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- 1. What is a characteristic of Preferred Provider Organizations (PPOs)?**
  - A. Higher out-of-pocket costs for patients**
  - B. Mandatory referrals for specialists**
  - C. Discounted fees for the patient**
  - D. Limited provider choice**
- 2. According to the Time Payment of Claims provision, how frequently must the insurer pay Disability Income benefits?**
  - A. Weekly**
  - B. Monthly**
  - C. Quarterly**
  - D. Annually**
- 3. What is the next step the insurance company will take after an agent collects a premium and issues a conditional receipt for an individual Disability Income application?**
  - A. Determine if the applicant is an acceptable risk by completing standard underwriting procedures**
  - B. Immediately issue a policy to the applicant**
  - C. Initiate a claims process for any past disabilities**
  - D. Refund the premium if the application is declined**
- 4. Which of the following best describes coinsurance?**
  - A. This is the fixed amount paid at the time of service**
  - B. This is the portion of medical costs that the insured pays after the deductible is met**
  - C. This is the total amount an insured pays before their insurance starts**
  - D. This is the limit on out-of-pocket expenses**
- 5. What role does documentation play in appealing a denied claim?**
  - A. It complicates the appeal process**
  - B. It is essential for demonstrating necessity**
  - C. It is rarely reviewed during appeals**
  - D. It has no impact on the decision**

**6. How does provider network tiering affect patient choices?**

- A. It increases the number of available providers**
- B. It limits patients to only their primary care physician**
- C. It encourages using more cost-effective services**
- D. It mandates the use of specialists for all treatments**

**7. A comprehensive major medical health insurance policy contains an Eligible Expenses provision. Which of the following is typically NOT covered?**

- A. Emergency services**
- B. Laboratory services**
- C. Preventative care**
- D. Experimental and investigative services**

**8. What is the term for the unethical practice of inducing an insured to surrender an existing policy through misrepresentation?**

- A. Redlining**
- B. Twisting**
- C. Churning**
- D. Rebating**

**9. What is "open enrollment" in the context of health insurance?**

- A. A period during which only new applicants can apply**
- B. A time frame for insurance companies to raise premiums**
- C. A specific period during which individuals can enroll in or change their health insurance plans**
- D. A moment when insurance policies are automatically renewed**

**10. Comprehensive Major Medical policies usually combine which types of coverage?**

- A. Basic Hospital/Surgical and Home Health coverage**
- B. Major Medical and Basic Hospital/Surgical coverage**
- C. Global Health and Travel Insurance coverage**
- D. Supplemental and Catastrophic coverage**

## **Answers**

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

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## **Explanations**

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## 1. What is a characteristic of Preferred Provider Organizations (PPOs)?

- A. Higher out-of-pocket costs for patients**
- B. Mandatory referrals for specialists**
- C. Discounted fees for the patient**
- D. Limited provider choice**

Preferred Provider Organizations (PPOs) are designed to allow more flexibility in choosing healthcare providers. A key characteristic of PPOs is that they offer discounted fees to patients who use the plan's network of preferred providers. This means that when a member receives care from these preferred providers, they benefit from lower out-of-pocket costs. While PPOs do allow out-of-network services, choosing providers outside of the network typically results in higher costs for the patient. This aspect differentiates PPOs from other managed care plans, such as Health Maintenance Organizations (HMOs), which usually require members to stay within a specific network for their care. In summary, PPOs provide a structure that incentivizes using in-network providers through discounted fees, making it advantageous for individuals to seek care within the network whenever possible.

## 2. According to the Time Payment of Claims provision, how frequently must the insurer pay Disability Income benefits?

- A. Weekly**
- B. Monthly**
- C. Quarterly**
- D. Annually**

The Time Payment of Claims provision in disability income insurance specifies that benefits should be paid on a monthly basis. This requirement is in place to provide a steady source of income for policyholders who may be unable to work due to a disability. Monthly payments are aligned with common household financial obligations, such as rent or mortgage payments, utility bills, and other recurring expenses. This frequency ensures that recipients have timely access to funds necessary to cover their living costs while they recover or adapt to their situation. In contrast, other payment frequencies like weekly, quarterly, or annually may not align effectively with the immediate financial needs of individuals who may be relying on these benefits to navigate their daily expenses.

**3. What is the next step the insurance company will take after an agent collects a premium and issues a conditional receipt for an individual Disability Income application?**

- A. Determine if the applicant is an acceptable risk by completing standard underwriting procedures**
- B. Immediately issue a policy to the applicant**
- C. Initiate a claims process for any past disabilities**
- D. Refund the premium if the application is declined**

The correct next step for the insurance company after an agent collects a premium and issues a conditional receipt for an individual Disability Income application is to determine if the applicant is an acceptable risk by completing standard underwriting procedures. This process is critical because it evaluates the applicant's health status, lifestyle, occupation, and other risk factors to assess whether the insurance company is willing to provide coverage. Underwriting helps the insurer make informed decisions about policy issuance based on the likelihood of future claims. The conditional receipt indicates that coverage may begin while the application is being processed, but the policy is not finalized until underwriting is complete and the application has been approved. Other options like immediately issuing a policy or initiating a claims process do not follow standard industry practices. A policy cannot be issued without first determining the applicant's risk level, and claims are only processed for existing policies rather than potential future claims based on applications. Similarly, refunding the premium if the application is declined is not the immediate next step, as the underwriting process must first be completed to make that determination.

**4. Which of the following best describes coinsurance?**

- A. This is the fixed amount paid at the time of service**
- B. This is the portion of medical costs that the insured pays after the deductible is met**
- C. This is the total amount an insured pays before their insurance start**
- D. This is the limit on out-of-pocket expenses**

Coinurance refers to the arrangement in which an insured individual is responsible for paying a specific percentage of medical expenses after they have met their deductible. This means that once the insured has satisfied their deductible requirement, which is the predetermined amount they must pay out of pocket for covered services, they will then share the costs of further medical services with their insurance company based on the agreed-upon percentage. For example, if a health insurance policy has a coinsurance provision of 20%, after the deductible is met, the insured will pay 20% of the medical costs, while the insurance company covers the remaining 80%. This arrangement often encourages patients to be mindful of healthcare costs since they have a financial responsibility for a percentage of the expenses incurred. The other options describe different elements of health insurance. A refers to a copayment, which is a fixed amount paid for a specific service, while C describes a deductible, which is the total amount payable before insurance benefits kick in. D pertains to the out-of-pocket maximum, which caps the total costs an insured person might pay in a policy year, after which the insurance covers 100% of the costs. Each of these terms is distinct from coinsurance, highlighting the unique role that coinsurance plays in cost-sharing.

## 5. What role does documentation play in appealing a denied claim?

- A. It complicates the appeal process**
- B. It is essential for demonstrating necessity**
- C. It is rarely reviewed during appeals**
- D. It has no impact on the decision**

Documentation plays a critical role in appealing a denied claim because it provides the necessary evidence to demonstrate that the services received were medically necessary and justified. When a claim is denied, the insurer typically cites reasons related to the lack of medical necessity, insufficient information, or failure to meet specific policy requirements. Quality documentation can include a variety of elements, such as patient medical records, doctor's notes, test results, and any other relevant information that supports the treatment provided. By presenting thorough and detailed documentation, the claimant can effectively counter the insurer's reasoning and show that the claim meets the criteria outlined in the health policy. This substantiation can significantly influence the outcome of the appeal, making it much more likely for the claim to be reconsidered and potentially approved. The other options underestimate the importance of documentation. For instance, suggesting that it complicates the appeal process overlooks how organized and clear documentation can actually streamline the proceedings. The notion that it is rarely reviewed during appeals is inaccurate, as insurers rely heavily on documentation to make informed decisions. Lastly, claiming it has no impact disregards the pivotal role that comprehensive documentation plays in supporting the validity of the claim being appealed. Overall, the correct answer highlights the indispensable nature of proper documentation in successfully navigating the appeals process.

## 6. How does provider network tiering affect patient choices?

- A. It increases the number of available providers**
- B. It limits patients to only their primary care physician**
- C. It encourages using more cost-effective services**
- D. It mandates the use of specialists for all treatments**

Provider network tiering significantly influences patient choices by encouraging the use of more cost-effective services. In a tiered network system, providers are classified into different tiers based on various factors, such as the cost of services, quality of care, and patient satisfaction. Patients typically incur lower out-of-pocket costs when they choose providers from higher tiers, which are often those who provide more cost-effective services and have better performance metrics. This structure helps patients make informed decisions about their healthcare because it incentivizes them to select providers who offer high-quality care at lower costs, ultimately promoting overall healthcare savings. By understanding the cost implications of their choices, patients are more likely to seek out providers in the higher tiers, resulting in better management of their healthcare expenses. In contrast, the other options do not accurately reflect the effects of provider network tiering. Increasing the number of available providers is not a direct result of tiering, nor does tiering limit patients to their primary care physician or mandate the use of specialists for all treatments. Instead, tiering focuses on balancing cost and quality in provider selection.

**7. A comprehensive major medical health insurance policy contains an **Eligible Expenses** provision. Which of the following is typically NOT covered?**

- A. Emergency services**
- B. Laboratory services**
- C. Preventative care**
- D. Experimental and investigative services**

In a comprehensive major medical health insurance policy, the **Eligible Expenses** provision outlines the types of medical services and treatments that are covered. Typically, experimental and investigative services are not included under this provision. This is because these services often lack sufficient clinical evidence of their efficacy, safety, and necessity for patient care. Such treatments may not have received regulatory approval or established medical guidelines that indicate they are standard practice in the healthcare field. On the other hand, emergency services, laboratory services, and preventative care are generally recognized as essential components of healthcare that contribute to the diagnosis, treatment, and overall wellness of patients. Insurance policies are designed to provide coverage for these types of services because they are well established in clinical practice and have demonstrated benefits to patient outcomes.

**8. What is the term for the unethical practice of inducing an insured to surrender an existing policy through misrepresentation?**

- A. Redlining**
- B. Twisting**
- C. Churning**
- D. Rebating**

The term for the unethical practice of inducing an insured to surrender an existing policy through misrepresentation is known as "twisting." This practice occurs when agents or brokers encourage a policyholder to terminate their current insurance policy in order to take out a new one, often by providing false or misleading information about the benefits of the new policy compared to the existing one. Twisting is considered unethical because it may lead the insured to make a decision that is not in their best financial interest, often resulting in a loss of benefits or higher costs. It undermines the trust relationship between the insured and the insurance professional, as the primary motive behind twisting is often financial gain for the agent rather than the welfare of the insured. The other terms mentioned are distinct from twisting; for instance, redlining refers to the discriminatory practice of denying services based on the racial or ethnic composition of a neighborhood. Churning involves the practice of repeatedly replacing insurance policies to generate commissions for agents without providing any real benefit to the insured. Rebating pertains to giving a portion of the premium back to the insured, which is often considered illegal in many states as it can create unfair competition. Each of these terms highlights different unethical behaviors within the insurance industry, but twisting specifically targets the act of misleading

## 9. What is "open enrollment" in the context of health insurance?

- A. A period during which only new applicants can apply
- B. A time frame for insurance companies to raise premiums
- C. A specific period during which individuals can enroll in or change their health insurance plans**
- D. A moment when insurance policies are automatically renewed

Open enrollment refers to a specific period during which individuals have the opportunity to enroll in or make changes to their health insurance plans. This timeframe is crucial because it allows consumers to review their existing health insurance options, compare different plans, and select one that best suits their needs without facing restrictions or penalties. During the open enrollment period, individuals can apply for new coverage, switch plans, or drop existing coverage. It typically occurs annually and varies depending on the type of insurance, such as public exchanges under the Affordable Care Act or employer-sponsored plans. Understanding this timeframe is essential for consumers because outside of the open enrollment period, options for changing plans or enrolling in new insurance are limited unless qualifying for a special enrollment period due to certain life events, such as marriage, birth of a child, or loss of other coverage. This structured period is designed to help both consumers and insurers manage enrollment efficiently, ensuring that everyone has the opportunity to secure health insurance coverage when they need it most.

## 10. Comprehensive Major Medical policies usually combine which types of coverage?

- A. Basic Hospital/Surgical and Home Health coverage
- B. Major Medical and Basic Hospital/Surgical coverage**
- C. Global Health and Travel Insurance coverage
- D. Supplemental and Catastrophic coverage

Comprehensive Major Medical policies are designed to provide a broad range of health insurance coverage, which typically includes both Basic Hospital/Surgical coverage and Major Medical coverage. Basic Hospital/Surgical coverage provides fundamental benefits for hospital stays and necessary surgical procedures, ensuring that the insured has access to essential healthcare services without incurring excessive out-of-pocket costs. On the other hand, Major Medical coverage is intended to cover higher costs associated with serious illnesses and injuries that exceed the limits set by basic plans. This combination results in a robust policy that addresses a wide spectrum of medical needs, offering protection against both routine care and significant medical expenses. The other options do not represent the standard structure of Comprehensive Major Medical insurance. Home Health coverage is a specific type of care that isn't typically bundled with basic medical coverage in the same way. Global Health and Travel Insurance are specialized plans that don't align with the comprehensive nature of Major Medical policies. Lastly, Supplemental and Catastrophic coverage generally refer to additional policies that work in conjunction with a primary plan but do not constitute the primary coverage types in a Comprehensive Major Medical policy.

# 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](mailto:hello@examzify.com).**

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

**<https://gahealthinsurance.examzify.com>**

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

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