

Health and Accident 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. How do insurance companies generally determine premiums?**
 - A. Based solely on the applicant's income level**
 - B. By analyzing risk factors, including age, health status, and medical history**
 - C. Through customer surveys about satisfaction with health services**
 - D. By offering a flat rate for all applicants regardless of risk**
- 2. Which of the following plans does NOT fall under Coordination of Benefits regulations?**
 - A. Health Maintenance Organization Plan**
 - B. Exclusive Provider Organization Plan**
 - C. Preferred Provider Organization Plan**
 - D. Indemnity Plan**
- 3. What is a common reason for claim denial in health insurance?**
 - A. Failure to pay premiums on time**
 - B. Lack of a referral in HMO plans**
 - C. Transferring coverage to another provider**
 - D. Switching to a different medication**
- 4. Which of the following is NOT a common type of health insurance plan?**
 - A. HMO**
 - B. PPO**
 - C. EPO**
 - D. CPA**
- 5. What does "tail coverage" provide in health insurance?**
 - A. Coverage for health services within a specific policy term**
 - B. Insurance for claims made before the policy starts**
 - C. Coverage for claims arising after a policy has ended**
 - D. Additional benefits for long-term care insurance**

6. What are essential health benefits as mandated by the Affordable Care Act?

- A. A set of luxury services provided with every health plan**
- B. A list of optional services covered at an additional cost**
- C. A set of health care service categories that must be covered by certain plans, including emergency services and preventive services**
- D. A type of funding available for uninsured individuals**

7. What does community rating ensure in health insurance?

- A. Lower premiums for healthy individuals**
- B. Premiums based on health status**
- C. All individuals pay the same premium**
- D. Increased premiums for those with claims**

8. What effect does a deductible have on health insurance claims?

- A. It is the amount paid by the insurer**
- B. It is the fixed amount before coverage starts**
- C. It reduces all future premiums**
- D. It is only applicable to group plans**

9. What does "maximum coverage" refer to in health insurance?

- A. The total number of insured patients a provider can have**
- B. The most an insurer will pay for health care services within a set time**
- C. The least amount an insured must pay out of pocket**
- D. The age limit for insurance coverage eligibility**

10. What does the insurance commissioner specifically focus on?

- A. Consumers' insurance choices**
- B. Regulatory compliance in the insurance industry**
- C. Setting competitive insurance prices**
- D. Developing new insurance products**

Answers

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

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Explanations

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1. How do insurance companies generally determine premiums?

- A. Based solely on the applicant's income level**
- B. By analyzing risk factors, including age, health status, and medical history**
- C. Through customer surveys about satisfaction with health services**
- D. By offering a flat rate for all applicants regardless of risk**

Insurance companies determine premiums primarily by analyzing risk factors associated with the applicant. This process involves evaluating various factors, such as the individual's age, health status, medical history, and sometimes lifestyle choices. Each of these elements helps insurers assess the likelihood of a policyholder needing medical care and the potential costs that could arise from this care. For instance, younger individuals typically have lower health risks, while older individuals may have higher premiums due to an increased likelihood of health issues. Similarly, a person's health status and medical history, such as any chronic conditions or past surgeries, are critical in determining how much risk the insurer takes on. This tailored approach allows insurers to set premiums that accurately reflect the level of risk they are assuming and ensures that those who present a higher risk contribute more towards the costs associated with their care. In contrast, determining premiums based solely on income does not provide a comprehensive view of the risk involved. Customer surveys about satisfaction with health services are not related to risk assessment for premium calculation. Offering a flat rate for all applicants disregards individual differences in health and risk, which is not practical for a system designed to balance costs across a diverse group of policyholders.

2. Which of the following plans does NOT fall under Coordination of Benefits regulations?

- A. Health Maintenance Organization Plan**
- B. Exclusive Provider Organization Plan**
- C. Preferred Provider Organization Plan**
- D. Indemnity Plan**

The correct choice pertains to a category of health insurance plans that operate independently when it comes to coordinating benefits. Coordination of Benefits (COB) regulations are designed to prevent overpayment when an individual is covered by multiple insurance plans. In this context, the Preferred Provider Organization Plan allows insured individuals to seek care from a network of providers who have agreed to provide services at specific rates. While it does have some characteristics that might align with coordination of benefits, such as a structured payment system and possibly overlapping coverage scenarios, it primarily emphasizes flexibility and individual choice. The other plan types typically engage in coordination of benefits in a more systematic manner. Health Maintenance Organization Plans are designed to limit coverage to specific providers and require referrals, thus necessitating coordination. Exclusive Provider Organization Plans function similarly, focusing on network providers and related benefits. Indemnity Plans, while less coordinated than managed care plans, still often require coordination to determine payment responsibility when more than one plan is involved. Thus, the nature of the Preferred Provider Organization Plan is such that it tends to operate more independently regarding benefit coordination, which is why it is the correct answer to this question.

3. What is a common reason for claim denial in health insurance?

- A. Failure to pay premiums on time**
- B. Lack of a referral in HMO plans**
- C. Transferring coverage to another provider**
- D. Switching to a different medication**

A common reason for claim denial in health insurance is the lack of a referral in Health Maintenance Organization (HMO) plans. HMO plans typically require members to select a primary care physician (PCP) who coordinates their healthcare and provides referrals to specialists. If a patient seeks specialty care or services without obtaining a referral from their PCP, the health insurance company may deny the claim on the basis that the required protocol was not followed. This structure is designed to manage costs and ensure that patients receive appropriate care within the network. The obligation to obtain a referral helps to streamline services and prevent unnecessary or potentially overlapping treatments. Therefore, when patients bypass this process, claims for related services often cannot be processed, leading to denials. In contrast, while failing to pay premiums on time can lead to a lapse in coverage, it is not a reason for denying a claim that was submitted while the policy was active. Transferring coverage and switching medications are also not valid reasons for denying a claim; rather, they may necessitate adjustments in coverage or prior authorizations but do not inherently lead to the refusal of claims.

4. Which of the following is NOT a common type of health insurance plan?

- A. HMO**
- B. PPO**
- C. EPO**
- D. CPA**

The choice of CPA as the answer is correct because CPA, which typically stands for Certified Public Accountant, is not related to health insurance plans. In the context of health insurance, commonly known plan types include HMO (Health Maintenance Organization), PPO (Preferred Provider Organization), and EPO (Exclusive Provider Organization). These models offer distinct features related to how patients access care and utilize healthcare services. HMOs generally require members to choose a primary care physician and provide services primarily through that physician. PPOs offer greater flexibility in choosing healthcare providers and do not require referrals for specialists but may have higher out-of-pocket costs for out-of-network services. EPOs are similar to PPOs but usually limit coverage to providers within their network without requiring a primary care physician. In contrast, CPA does not fit within the framework of health insurance plans and is therefore the correct response to this question, demonstrating a clear distinction between types of health insurance plans and unrelated professional designations.

5. What does "tail coverage" provide in health insurance?

- A. Coverage for health services within a specific policy term
- B. Insurance for claims made before the policy starts
- C. Coverage for claims arising after a policy has ended**
- D. Additional benefits for long-term care insurance

Tail coverage is a specific type of insurance protection that is designed to provide coverage for claims arising after a policy has ended, particularly in situations where the incident that led to the claim occurred during the term of the policy. This type of coverage is particularly important in the health insurance context, as it protects policyholders from potential liabilities that may emerge after they have ceased coverage under a particular policy. For instance, when a healthcare provider or practitioner has a claims-made policy, they are provided coverage only for claims that are reported while the policy is in effect. Once the policy is terminated, any claims that arise from incidents that happened during the policy period but are reported afterward would not be covered unless tail coverage is in place. This ensures that the insured is not left without any protection against claims that may surface long after they thought their liability had ended. In contrast, the other options do not accurately reflect what tail coverage provides. Coverage for health services within a specific policy term refers to standard policy provisions during the active term of an insurance policy. Insurance for claims made before the policy starts does not relate to tail coverage, as tail coverage specifically concerns claims made after the policy ends. Additional benefits for long-term care insurance also do not pertain to tail coverage, as they

6. What are essential health benefits as mandated by the Affordable Care Act?

- A. A set of luxury services provided with every health plan
- B. A list of optional services covered at an additional cost
- C. A set of health care service categories that must be covered by certain plans, including emergency services and preventive services**
- D. A type of funding available for uninsured individuals

Essential health benefits, as outlined by the Affordable Care Act (ACA), refer to a specific set of health care service categories that must be covered by health insurance plans offered through the Health Insurance Marketplace. These benefits include, but are not limited to, emergency services, hospitalization, maternity and newborn care, mental health services, prescription drugs, preventive and wellness services, and pediatric services. The inclusion of these essential health benefits is designed to ensure that individuals have access to comprehensive care that prioritizes overall health and well-being, rather than just addressing acute health issues. By mandating these categories, the ACA aims to provide a baseline of critical health services that all health plans must cover, ensuring that individuals have access to necessary care without facing excessive costs or gaps in coverage. Other options presented, such as luxury services or optional additional coverage, do not align with the essential health benefits mandate, which focuses on essential care rather than luxury or optional services. Additionally, while funding for uninsured individuals could be related to different programs under the ACA, it does not specifically define the concept of essential health benefits.

7. What does community rating ensure in health insurance?

- A. Lower premiums for healthy individuals
- B. Premiums based on health status
- C. All individuals pay the same premium**
- D. Increased premiums for those with claims

Community rating in health insurance is a pricing structure where the premiums for health insurance are set based on the collective risk of the entire community rather than individual risk factors. This approach ensures that all individuals, regardless of their health status, age, or other personal metrics, pay the same premium for coverage. This method is particularly designed to promote equity in health insurance access and to support those who might otherwise face prohibitively high costs due to pre-existing conditions or health issues. By utilizing community rating, insurers spread the risk across a diverse group, which helps to avoid discrimination against individuals with higher health risk profiles. This leads to more stable and predictable pricing for everyone within the community, encouraging broader participation in health insurance programs. The other options reflect principles that do not align with community rating. Charging lower premiums for healthy individuals would introduce a tiered pricing structure based on individual health status, which community rating specifically seeks to eliminate. Similarly, assessing premiums based on health status or increasing premiums for individuals who have filed claims contradicts the foundation of community rating, which is designed to ensure a uniform premium across all members of the community.

8. What effect does a deductible have on health insurance claims?

- A. It is the amount paid by the insurer
- B. It is the fixed amount before coverage starts**
- C. It reduces all future premiums
- D. It is only applicable to group plans

The correct understanding of a deductible in health insurance is that it represents the fixed amount that insured individuals must pay out-of-pocket for healthcare services before their insurance coverage kicks in. This means that when a policyholder incurs medical expenses, they are responsible for paying up to the deductible amount, and only after this threshold is met does the insurance company begin to cover eligible expenses according to the terms of the policy. By requiring the insured to pay the deductible first, insurers help manage healthcare costs, as it discourages frivolous claims and promotes responsible use of medical services. This shared cost responsibility also helps keep premiums more affordable, as higher deductibles typically correlate with lower monthly premiums. Understanding other options provides additional context. The amount paid by the insurer is actually the benefit that the insurance company disburses after the deductible and any co-payments or coinsurance are taken into account. Some may conflate the deductible with the total payment by the insurer, but that misses the key function of the deductible. The notion that a deductible reduces all future premiums is misleading, as the deductible is one specific cost-sharing feature that influences premium rates but does not automatically lead to future premium reductions. Additionally, while deductibles apply to both individual and group plans, suggesting that they are only

9. What does "maximum coverage" refer to in health insurance?

- A. The total number of insured patients a provider can have
- B. The most an insurer will pay for health care services within a set time**
- C. The least amount an insured must pay out of pocket
- D. The age limit for insurance coverage eligibility

"Maximum coverage" in health insurance specifically refers to the upper limit of financial protection that an insurer will provide for healthcare services during a specified time frame, often defined on an annual basis. This term is critical as it sets boundaries on how much an insurance company will reimburse for medical expenses incurred by a policyholder. This concept is essential for both insurers and insured individuals, as it helps manage risk and costs associated with healthcare. Policyholders should understand that once their medical expenses reach this predefined limit, they may be responsible for all subsequent costs or may need to seek different plans or providers for additional care needs. Understanding the limitations imposed by maximum coverage can significantly affect patient care decisions, financial planning, and overall comprehension of personal health insurance policies. In contrast, the other options mention unrelated aspects of health insurance, such as provider capacity, out-of-pocket costs, and age eligibility, which do not directly define the term "maximum coverage."

10. What does the insurance commissioner specifically focus on?

- A. Consumers' insurance choices
- B. Regulatory compliance in the insurance industry**
- C. Setting competitive insurance prices
- D. Developing new insurance products

The insurance commissioner primarily focuses on regulatory compliance in the insurance industry. This role involves overseeing and enforcing the laws and regulations that govern how insurance companies operate, ensuring that they adhere to standards that protect consumers and maintain the integrity of the market. The insurance commissioner is responsible for licensing insurance companies, monitoring their financial health, and ensuring that they fulfill their obligations to policyholders. By prioritizing regulatory compliance, the commissioner plays a crucial role in safeguarding public interest and ensuring that insurance practices are fair and transparent. The other options relate to aspects of the insurance industry but do not capture the primary focus of the insurance commissioner. For example, while consumer choices, pricing, and product development are important, they are not the core responsibilities of the commissioner, who emphasizes regulation and compliance above all.

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:

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

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