

# HEALTH INSURANCE POLICY PROVISIONS 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. Explain the "claims process" in health insurance.**
  - A. The procedure for appealing a denied claim.
  - B. The steps a policyholder takes to request payment for medical services.
  - C. The method for selecting a healthcare provider.
  - D. The calculation of out-of-pocket expenses.
- 2. What often influences the decision to assign benefits to a healthcare provider?**
  - A. The provider's specialty
  - B. The policyholder's understanding of the insurance policy
  - C. The policyholder's financial situation at the time of treatment
  - D. The insurance company's reputation
- 3. What will happen to a claim submitted for a condition not disclosed at the time of application?**
  - A. The claim will be denied
  - B. The claim will be paid and coverage will remain in force
  - C. The claim will be paid but coverage will be terminated
  - D. The claim will require additional investigation
- 4. The clause identifying which losses resulting from an accident or sickness are insured by the policy is known as the:**
  - A. Exclusion Clause
  - B. Insuring Clause
  - C. Conditions Clause
  - D. Benefit Clause
- 5. Under which provision may an insurer refuse to pay a claim based on a pre-existing condition?**
  - A. Pre-existing Condition Exclusion
  - B. Fair Claim Settlement Provision
  - C. Exemptions Clause
  - D. Claims Review Clause

- 6. What does ACA stand for?**
- A. American Care Act.
  - B. Affordable Care Act.
  - C. Advanced Coverage Act.
  - D. Accessible Care Act.
- 7. What must an insured do if the insurer does not furnish forms after a notice of loss?**
- A. Contact their broker
  - B. File written proof of loss
  - C. Wait for the insurer's response
  - D. Submit an oral declaration
- 8. What is the purpose of the Federal Employee Health Benefits Program (FEHBP)?**
- A. Providing health insurance for state employees
  - B. Health insurance for federal employees, retirees, and their dependents
  - C. A program to train healthcare providers
  - D. A plan for employers to reduce health insurance costs
- 9. Which scenario will likely result in an insurer denying a claim in a personal injury case?**
- A. Claim filed within the required timeframe
  - B. Insured contributing cause of the injury
  - C. Causation is directly linked to policy coverage
  - D. Claim submitted with necessary documentation
- 10. What is a primary feature of long-term care insurance?**
- A. It covers routine doctor's visits.
  - B. It provides funding for personal care services and assistance.
  - C. It is only available for seniors over the age of 65.
  - D. It typically has a waiting period for benefits to begin.



## **Answers**

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

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## **Explanations**

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## 1. Explain the "claims process" in health insurance.

- A. The procedure for appealing a denied claim.
- B. The steps a policyholder takes to request payment for medical services.**
- C. The method for selecting a healthcare provider.
- D. The calculation of out-of-pocket expenses.

*The claims process in health insurance is defined as the steps a policyholder takes to request payment for medical services. This typically involves several key activities, such as notifying the insurance company about the incurred medical expenses, submitting the required documentation (like claim forms, bills, and medical records), and following up to ensure the claim is processed correctly. During this process, the insurer reviews the submitted claims to determine whether the services provided are covered under the policy. Depending on the terms of the insurance plan, the claims process may also involve verifying eligibility, assessing deductibles or copayments, and ultimately issuing payment for the covered services. This step is fundamental in ensuring that patients receive the benefits they are entitled to under their health insurance policies, making it a vital aspect of health insurance management. In contrast, appealing a denied claim refers specifically to addressing instances where a claim is not approved, while selecting a healthcare provider pertains to choosing doctors or facilities for medical care. The calculation of out-of-pocket expenses involves understanding personal costs incurred during the claims process but does not encompass the overall procedure for submitting a claim.*

## 2. What often influences the decision to assign benefits to a healthcare provider?

- A. The provider's specialty
- B. The policyholder's understanding of the insurance policy
- C. The policyholder's financial situation at the time of treatment**
- D. The insurance company's reputation

*The decision to assign benefits to a healthcare provider is often influenced by the policyholder's financial situation at the time of treatment. When individuals face medical expenses, they may choose to assign benefits directly to their provider to ensure that their healthcare costs are covered, particularly if they do not have the financial means to pay out-of-pocket at that moment. This arrangement allows the provider to receive payment directly from the insurance company, which can alleviate the financial burden on the patient. The other factors mentioned, such as the provider's specialty or the policyholder's understanding of the insurance policy, may play roles in the broader landscape of healthcare decisions, but they do not directly influence the assignment of insurance benefits. The insurance company's reputation can impact the overall trust and usability of the policy, but it does not dictate the financial arrangements made during the treatment process. Thus, while these aspects are important, they do not specifically relate to the practice of assigning benefits to a healthcare provider.*

**3. What will happen to a claim submitted for a condition not disclosed at the time of application?**

- A. The claim will be denied
- B. The claim will be paid and coverage will remain in force**
- C. The claim will be paid but coverage will be terminated
- D. The claim will require additional investigation

*When a claim is submitted for a condition not disclosed at the time of application, it typically results in a denial of the claim. This is because insurance policies often include provisions that require full disclosure of medical history during the application process. Failure to disclose relevant information can lead insurers to view the application as misrepresented, which affects the integrity of the contract. Selecting the option suggesting the claim will be paid and coverage will remain in force ignores the fundamental principle of insurability and risk assessment. Insurance companies rely on accurate data to underwrite policies correctly and manage risk. If a condition was not disclosed initially, it usually leads to the conclusion that the insurer was not adequately informed of the risk they were taking on, which can invalidate the contract's terms. Consequently, the correct understanding is that the claim would be denied due to non-disclosure.*

**4. The clause identifying which losses resulting from an accident or sickness are insured by the policy is known as the:**

- A. Exclusion Clause
- B. Insuring Clause**
- C. Conditions Clause
- D. Benefit Clause

*The insuring clause is a fundamental part of an insurance policy that outlines the coverage provided under the policy. It specifies what types of losses due to accidents or sickness are covered, making it clear to the policyholder what risks the insurer is assuming liability for. This clause essentially defines the boundaries of the coverage, listing the specific events or conditions under which the insurer will provide benefits. In contrast, other clauses may serve different purposes. The exclusion clause identifies particular situations or risks that are not covered by the policy, focusing more on limitations rather than on what is insured. The conditions clause outlines the responsibilities of both the insurer and the insured, detailing procedural requirements for making a claim or maintaining coverage. Finally, the benefit clause typically describes the monetary benefits or amounts payable under the policy, rather than specifying what losses are covered. Therefore, the insuring clause is specifically the section that identifies which losses resulting from an accident or sickness are insured, making it the correct choice.*

**5. Under which provision may an insurer refuse to pay a claim based on a pre-existing condition?**

- A. Pre-existing Condition Exclusion**
- B. Fair Claim Settlement Provision
- C. Exemptions Clause
- D. Claims Review Clause

*The correct choice is related to the Pre-existing Condition Exclusion, which is a common clause found in health insurance policies. This provision allows insurers to deny claims for medical conditions that existed prior to the effective date of the policy. Insurers typically impose this exclusion to manage risk, as they aim to avoid covering costs for conditions that the insured had before acquiring the insurance. This helps protect the insurer from individuals who may seek insurance primarily to cover known health issues that could lead to significant medical expenses. It is essential for policyholders to understand the implications of this provision, as it directly affects their coverage, especially when they have ongoing health issues when they sign up for a new policy. The other options, while related to claims processing, do not specifically address the aspect of pre-existing conditions that allows for claim denial based on historical health issues. Each of those options covers different aspects of claims management and policy provisions but does not specifically relate to the insurer's ability to refuse payment for claims due to pre-existing conditions. Understanding how the Pre-existing Condition Exclusion operates is critical for anyone navigating the world of health insurance.*

**6. What does ACA stand for?**

- A. American Care Act.
- B. Affordable Care Act.**
- C. Advanced Coverage Act.
- D. Accessible Care Act.

*The acronym ACA stands for the Affordable Care Act. This significant piece of legislation, enacted in 2010, aimed at expanding health insurance coverage, reducing healthcare costs, and improving the healthcare system in the United States. The Affordable Care Act introduced various provisions, such as the establishment of health insurance marketplaces, the expansion of Medicaid eligibility, and the requirement for individuals to have health insurance or face a tax penalty. Understanding the correct terminology is crucial, as it reflects the formal title of the law and its implications for health insurance policies and coverage options. The other choices may sound plausible, but they do not accurately represent the legislation associated with ACA. The term "American Care Act," for example, is not a recognized piece of legislation; "Advanced Coverage Act" does not correspond to any known act related to healthcare, and "Accessible Care Act" misrepresents the formal name of the law. It's important for individuals studying health insurance provision to be familiar with the correct terms and their meanings.*

**7. What must an insured do if the insurer does not furnish forms after a notice of loss?**

- A. Contact their broker
- B. File written proof of loss**
- C. Wait for the insurer's response
- D. Submit an oral declaration

*In the situation where the insurer fails to furnish forms after a notice of loss, the insured has a responsibility to file written proof of loss. This requirement is integral to the claims process, ensuring that the insurer is formally made aware of the necessary details surrounding the incident that resulted in the loss. Filing written proof of loss allows the insurer to evaluate the claim based on documented evidence. This documentation typically includes information such as the date and nature of the loss, the circumstances surrounding it, and any other relevant details that support the validity of the claim. In many insurance policies, there are provisions that stipulate that written proof of loss must be submitted within a specific timeframe, signaling to the insured the urgency and importance of making this submission. While contacting a broker, waiting for the insurer's response, or submitting an oral declaration may seem like options, they do not align with the requirements set forth in insurance policies regarding the proof of loss process. Adequate written documentation is critical to prevent delays and ensure that the claim is handled effectively.*

**8. What is the purpose of the Federal Employee Health Benefits Program (FEHBP)?**

- A. Providing health insurance for state employees
- B. Health insurance for federal employees, retirees, and their dependents**
- C. A program to train healthcare providers
- D. A plan for employers to reduce health insurance costs

*The Federal Employee Health Benefits Program (FEHBP) serves the essential purpose of providing health insurance to federal employees, retirees, and their dependents. This program is specifically designed to offer a variety of health plans that cater to the unique needs of federal personnel, ensuring they have access to necessary healthcare services. Established in 1960, the FEHBP is one of the largest employer-sponsored health insurance programs in the United States, emphasizing comprehensive coverage and affordability for those who have dedicated their careers to public service. The relevance of this program lies in its role in enhancing the well-being of federal employees and their families by offering a range of options, which helps to manage healthcare costs while providing quality care. The program's structure allows federal workers to choose from numerous health insurance plans, reflecting the diverse needs of its members. Other options mention state employee insurance, training of healthcare providers, and a focus on cost reduction strategies for employers. However, these do not align with the specific mission and functions of the FEHBP, which is firmly centered on supporting federal personnel and their dependents with health insurance coverage.*

**9. Which scenario will likely result in an insurer denying a claim in a personal injury case?**

- A. Claim filed within the required timeframe
- B. Insured contributing cause of the injury**
- C. Causation is directly linked to policy coverage
- D. Claim submitted with necessary documentation

*In a personal injury case, if the insured is found to be a contributing cause of the injury, this can lead to the insurer denying the claim. This principle is often rooted in the legal concept of negligence, where the actions or failure to act on the part of the insured may have contributed to the incident or injury in question. Many insurance policies contain clauses that pertain to the behavior of the insured. If it can be demonstrated that the insured's actions were a significant factor in causing the injury, the insurer may invoke these clauses to deny the claim, arguing that coverage does not extend to injuries where the insured's negligence played a role. In contrast, filing a claim within the required timeframe, having causation linked directly to the policy coverage, and submitting a claim with the necessary documentation are all elements that typically support rather than hinder a claim. Insurers generally appreciate timely submissions and complete documentation, and clear connections between the incident and the covered events enhance the validity of a claim. Therefore, these scenarios are unlikely to result in a denial, while the insured's contribution to the injury presents a valid reason for a possible claim denial.*

**10. What is a primary feature of long-term care insurance?**

- A. It covers routine doctor's visits.
- B. It provides funding for personal care services and assistance.**
- C. It is only available for seniors over the age of 65.
- D. It typically has a waiting period for benefits to begin.

*Long-term care insurance is specifically designed to provide financial support for services that individuals may need over an extended period due to chronic illness, disability, or other conditions that impair their ability to perform daily activities. This insurance offers funding for personal care services, which may include help with bathing, dressing, eating, and other activities of daily living. This assistance is crucial for individuals who cannot live independently and need support to maintain a certain quality of life. The other options do not accurately reflect the distinct purpose of long-term care insurance. Routine doctor's visits are generally covered under standard health insurance plans rather than long-term care policies. While many recipients of long-term care insurance are seniors, the coverage is not limited strictly to those over the age of 65, as younger individuals can also require these services due to various medical conditions or accidents. Lastly, while some long-term care policies may have waiting periods before benefits become available, this feature is not universal and does not define the primary function of the insurance itself. The hallmark of long-term care insurance lies in its provision for personal care services and assistance, which makes option B the most accurate choice.*



## 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://healthinsurancepolicyprovisions.examzify.com>

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

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