

Illinois Accident and Health Insurance Practice Exam (Sample)

Study Guide



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SAMPLE

Questions

- 1. What does the term "medicare" refer to?**
 - A. A federal health insurance program for individuals aged 65 and older, or those with certain disabilities**
 - B. A state-based insurance program for low-income individuals**
 - C. A private health insurance plan offering comprehensive coverage**
 - D. A healthcare subsidy for families with children**
- 2. What does "co-payment" mean in a health insurance policy?**
 - A. A percentage of the medical bill that the insured must cover**
 - B. A fixed amount that a policyholder pays for a covered service at the time of service**
 - C. The amount that the insurance company pays for the claim**
 - D. The total annual premium for insurance coverage**
- 3. What is the maximum deductible range for a High Deductible Health Plan (HDHP)?**
 - A. Up to \$2000**
 - B. \$1350-\$6750**
 - C. From \$500 to \$3000**
 - D. \$1000-\$5000**
- 4. How does Blue Cross typically categorize its services?**
 - A. Outpatient services**
 - B. Hospital services**
 - C. Prescription services**
 - D. Home care services**
- 5. What is the standard coinsurance for Major Medical insurance?**
 - A. 90/10**
 - B. 70/30**
 - C. 80/20**
 - D. 50/50**

- 6. Residual Benefits in disability insurance are based on what?**
- A. The total amount of disability income**
 - B. The proportion of income lost due to disability**
 - C. The age of the insured**
 - D. The duration of the disability**
- 7. What is one of the key benefits of a PPO over other insurance plans?**
- A. Mandatory referrals for specialists**
 - B. Limited choice of healthcare providers**
 - C. Flexibility in choosing healthcare providers and services**
 - D. Higher out-of-pocket maximums**
- 8. What does Major Medical insurance provide coverage for?**
- A. Only hospital stays**
 - B. Private duty nursing and preventative care**
 - C. Routine check-ups only**
 - D. Accidental injuries only**
- 9. How do annual limits function in health insurance policies?**
- A. They set a maximum number of visits per year**
 - B. They establish the minimum coverage amount**
 - C. They define the maximum amount the insurer will pay for covered healthcare services within a policy year**
 - D. They are penalties for exceeding service limits**
- 10. What type of coverage does long-term care insurance typically provide?**
- A. Only for medication expenses**
 - B. For short-term rehabilitation following surgery**
 - C. Covers costs of services such as nursing homes or in-home care**
 - D. Only for hospitalization services**

Answers

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

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Explanations

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1. What does the term "medicare" refer to?

- A. A federal health insurance program for individuals aged 65 and older, or those with certain disabilities**
- B. A state-based insurance program for low-income individuals**
- C. A private health insurance plan offering comprehensive coverage**
- D. A healthcare subsidy for families with children**

The term "medicare" refers to a federal health insurance program specifically designed for individuals who are aged 65 and older, as well as for certain younger individuals who have disabilities or specific health conditions such as end-stage renal disease or amyotrophic lateral sclerosis (ALS). This program is essential because it provides access to healthcare services and can significantly reduce the financial burden of medical expenses for older adults and qualifying individuals with disabilities. It encompasses various parts, including hospital insurance (Part A) and medical insurance (Part B), which cover a wide array of healthcare needs. In contrast, the other options pertain to different types of insurance programs that do not align with the definition of Medicare. For instance, a state-based insurance program for low-income individuals is more accurately described by Medicaid. Private health insurance plans, while they can offer comprehensive coverage, are distinct from government-sponsored programs. Lastly, healthcare subsidies for families with children generally refer to programs designed to assist families rather than addressing the specific needs of the elderly or disabled, which is the primary focus of Medicare. Thus, the correct choice accurately captures the essence of what Medicare is and who it serves.

2. What does "co-payment" mean in a health insurance policy?

- A. A percentage of the medical bill that the insured must cover**
- B. A fixed amount that a policyholder pays for a covered service at the time of service**
- C. The amount that the insurance company pays for the claim**
- D. The total annual premium for insurance coverage**

In a health insurance policy, "co-payment," often referred to as "copay," is a fixed amount that a policyholder pays for a specific covered service at the time the service is rendered. This means that when an individual visits a healthcare provider or uses a specific health service, they are required to pay a predetermined fee, while the insurance company covers the remainder of the costs associated with that service. The purpose of co-payments is to share the financial responsibility between the insurer and the insured, making health services more accessible and incentivizing users to seek necessary care without overwhelming costs. For example, a policy may stipulate that a doctor's visit carries a co-payment of \$20, which the insured pays upfront, while the insurance company handles the rest of the bill. Understanding co-payments is crucial for policyholders, as they impact out-of-pocket costs and dictate how much individuals can expect to pay for various medical services, contributing to their overall healthcare expenses.

3. What is the maximum deductible range for a High Deductible Health Plan (HDHP)?

- A. Up to \$2000**
- B. \$1350-\$6750**
- C. From \$500 to \$3000**
- D. \$1000-\$5000**

A High Deductible Health Plan (HDHP) is defined by the IRS based on specific deductible and out-of-pocket maximum levels. For the given time frame relevant to the question, the IRS sets maximum deductible limits for HDHPs appropriate to the coverage tier - either self-only or family coverage. The correct range of \$1350 to \$6750 aligns with these federal guidelines. For self-only plans, the minimum deductible for a HDHP is \$1,350, while the maximum out-of-pocket expense is generally regulated to not exceed \$7,050. For family coverage, the figures are higher: the minimum deductible is set at \$2,700, with a maximum out-of-pocket limit of \$14,100. This framework establishes a clear range for deductibles under HDHPs, allowing for consistent understanding and expectations for both insurers and insured individuals. The other options do not meet the defined thresholds set forth by the IRS and therefore do not accurately represent the eligibility criteria for an HDHP.

4. How does Blue Cross typically categorize its services?

- A. Outpatient services**
- B. Hospital services**
- C. Prescription services**
- D. Home care services**

Blue Cross typically categorizes its services primarily under hospital services because it originated as a hospital insurance plan designed to cover inpatient hospital stays and associated costs. This categorization reflects the organization's historical focus on providing coverage for expenses incurred during hospital admissions, including room, board, and various hospital-related services. Hospital services are a foundational aspect of health insurance, ensuring that members have access to necessary medical care when admitted to a facility. While outpatient services, prescription services, and home care services are also important components of a comprehensive health insurance offering, hospital services remain central to Blue Cross's mission and coverage plans, as they have traditionally been a significant financial burden for patients. This focus has evolved over time to include a broader range of services, but the core of Blue Cross's origin and service categorization lies in hospital care.

5. What is the standard coinsurance for Major Medical insurance?

- A. 90/10
- B. 70/30
- C. 80/20**
- D. 50/50

The standard coinsurance arrangement for Major Medical insurance is typically set at an 80/20 split. This means that after the insured has satisfied their deductible, the insurance company will cover 80% of the eligible medical expenses, while the insured is responsible for the remaining 20%. This structure is designed to share the financial burden of healthcare costs between the insurer and the insured, incentivizing the insured to engage in cost-effective healthcare decisions while also ensuring that a significant portion of costs is covered by the insurance provider. The 80/20 coinsurance model allows for a balance between adequate insurance protection and shared responsibility, which can help keep premiums manageable. The insured still has a cost-sharing element, but it allows for substantial insurance coverage. Other options represent different coinsurance structures, which may not align with the common practices established in Major Medical plans. For example, a 90/10 coinsurance would imply a very high level of coverage with lower out-of-pocket costs for the insured, while a 70/30 model would result in a larger share of costs being borne by the insured. A 50/50 split would suggest an equal burden of costs that is less common for Major Medical insurance, which aims to provide greater coverage to mitigate the risk of

6. Residual Benefits in disability insurance are based on what?

- A. The total amount of disability income
- B. The proportion of income lost due to disability**
- C. The age of the insured
- D. The duration of the disability

Residual benefits in disability insurance are designed to provide support for individuals who have a partial disability that prevents them from working full-time but allows them to earn some income. These benefits are based on the proportion of income lost due to the disability, reflecting the financial reality of the insured's reduced earning capacity. If an individual is able to work part-time or at a reduced capacity, the residual benefits will compensate them for the income they have lost as a direct result of their disability. This approach helps ensure that individuals can maintain a certain level of financial stability while they recover or adapt to their new circumstances. By focusing on the proportion of lost income, these benefits allow for a more tailored and fair response to the complexity of disability situations, acknowledging that not all disabilities result in a complete inability to work. The other options, while relevant to some aspects of disability insurance, do not accurately capture the essence of residual benefits. For instance, total amount of disability income focuses on the maximum payout without regard to earnings lost, age may influence policy terms but does not directly relate to residual benefits, and duration of the disability pertains more to how long benefits are payable rather than how they are calculated.

7. What is one of the key benefits of a PPO over other insurance plans?

- A. Mandatory referrals for specialists**
- B. Limited choice of healthcare providers**
- C. Flexibility in choosing healthcare providers and services**
- D. Higher out-of-pocket maximums**

One of the key benefits of a Preferred Provider Organization (PPO) is the flexibility it offers in choosing healthcare providers and services. Unlike other plans, such as Health Maintenance Organizations (HMOs), PPOs do not require members to select a primary care physician or obtain referrals to see specialists. This means that individuals can directly access a wider range of healthcare providers and specialists without needing prior authorization, which can save time and provide more responsive care. Additionally, while staying within the network typically results in lower costs, PPO members still maintain the option to seek care from out-of-network providers, albeit at a higher cost. This level of flexibility and choice is particularly appealing to those who prioritize having a range of options for their healthcare needs.

8. What does Major Medical insurance provide coverage for?

- A. Only hospital stays**
- B. Private duty nursing and preventative care**
- C. Routine check-ups only**
- D. Accidental injuries only**

Major Medical insurance is designed to provide comprehensive coverage for a wide range of healthcare services, making it a critical component of many health insurance plans. This type of insurance generally covers significant medical expenses that extend beyond standard policies, including hospital stays, surgeries, outpatient care, and more. Option B is correct because Major Medical insurance encompasses a variety of medical services, including private duty nursing and preventive care. Preventive care is an essential aspect of healthcare, aimed at preventing diseases and ensuring early detection of health issues, while private duty nursing provides specialized nursing care that individuals may require, often on a long-term basis. This broad coverage is essential for addressing serious health conditions and ensuring that individuals can access the necessary care without facing overwhelming financial burdens. This comprehensive nature distinguishes Major Medical insurance from plans that offer limited coverage, addressing more narrow elements of healthcare, such as hospital stays, routine check-ups, or accidental injuries alone, which do not reflect the full scope of services typically covered under Major Medical policies.

9. How do annual limits function in health insurance policies?

- A. They set a maximum number of visits per year**
- B. They establish the minimum coverage amount**
- C. They define the maximum amount the insurer will pay for covered healthcare services within a policy year**
- D. They are penalties for exceeding service limits**

Annual limits in health insurance policies define the maximum amount that the insurer will pay for covered healthcare services within a policy year. This means that once the total benefits paid out by the insurer reach this specified limit, the insured individual will be responsible for any additional costs incurred for covered services for the remainder of that policy year. This function is significant because it helps to manage the risk for insurance companies by capping their financial liability. From the perspective of policyholders, understanding annual limits is crucial so they can plan for potential out-of-pocket expenses, especially for costly treatments or ongoing care that may exceed the limit. Other options do present aspects of insurance, such as service limits or minimum coverage amounts, but they do not accurately represent the purpose and function of annual limits as established in health insurance policies. Therefore, the correct understanding revolves around how annual limits specifically cap the insurer's payment obligations, impacting both insurer risk management and policyholder financial planning.

10. What type of coverage does long-term care insurance typically provide?

- A. Only for medication expenses**
- B. For short-term rehabilitation following surgery**
- C. Covers costs of services such as nursing homes or in-home care**
- D. Only for hospitalization services**

Long-term care insurance is designed specifically to cover the costs associated with prolonged care needs that typically arise from chronic illnesses, disabilities, or cognitive impairments. This type of insurance focuses on providing financial support for services that assist individuals with activities of daily living, such as bathing, dressing, or eating, which may not be covered by other types of health insurance. The correct choice emphasizes that long-term care insurance covers expenses for services such as nursing homes or in-home care. This is essential for individuals who require extended assistance over time, which often includes custodial care in various settings. By dealing with such personal and care-specific needs, long-term care insurance helps alleviate the financial burden on families and individuals who would otherwise have to pay out-of-pocket for these necessary services. The other options provided do not accurately reflect the scope of coverage that long-term care insurance offers. They focus on limited types of care, such as medications or short-term rehabilitation, which do not address the ongoing and comprehensive nature of the care that long-term care insurance aims to support. Additionally, focusing solely on hospitalization services neglects the broader context of personal and custodial care as defined within long-term care coverage.