

ILLINOIS ACCIDENT AND 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 an "insurance binder"?

- A. A permanent insurance policy agreement
- B. A temporary agreement providing coverage until the policy is issued
- C. A type of policy that covers property damage
- D. A form of insurance renewal documentation

2. What is "group health insurance" commonly provided through?

- A. Individual policies purchased directly from insurers
- B. A network of independent healthcare providers
- C. An employer offering coverage under a single policy
- D. A combination of private and public insurance programs

3. In health insurance, what does the term "premium" refer to?

- A. The total cost of medical procedures during a policy year
- B. The fixed amount paid by a policyholder for insurance coverage
- C. The amount covered by the insurance for every claim
- D. The deductible that must be paid before benefits are activated

4. How long can a pre-existing condition be excluded from coverage in a health insurance policy?

- A. 6 months
- B. No limit
- C. 2 years
- D. 1 year

5. In accident and health insurance, who is referred to as the "beneficiary"?

- A. The person who pays the premium
- B. The person designated to receive benefits
- C. The insurance agent handling the policy
- D. The insurance company underwriting the policy

- 6. In a Health Maintenance Organization (HMO), what is required before seeing a specialist?**
- A. No restrictions are in place
 - B. Referral from a general practitioner
 - C. Direct appointment with the specialist
 - D. Approval from the insurance company
- 7. Define "medical underwriting".**
- A. A method of determining the cost of premiums based on income
 - B. The process of evaluating an applicant's medical history
 - C. A strategy for reducing overall insurance costs
 - D. Offering insurance without any investigation into health status
- 8. What is the deductible amount for Medicare Part A?**
- A. \$185
 - B. \$1350
 - C. \$183
 - D. \$400
- 9. What happens to the coverage under COBRA if an employee's hours are reduced?**
- A. The coverage ends immediately
 - B. The coverage is maintained for a limited time
 - C. The coverage can be applied for bankruptcy
 - D. The coverage must be transferred to another employer
- 10. What is COBRA in the context of health insurance?**
- A. A type of health savings account
 - B. A law that allows continued health coverage after leaving employment
 - C. A health incentive program for employees
 - D. A federal health insurance exchange

Answers

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

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Explanations

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1. What is an "insurance binder"?

- A. A permanent insurance policy agreement
- B. A temporary agreement providing coverage until the policy is issued**
- C. A type of policy that covers property damage
- D. A form of insurance renewal documentation

An insurance binder is an important temporary agreement that provides coverage between the time an application is submitted and the formal insurance policy is issued. This binder serves to ensure that the applicant is covered during this interim period, which can be crucial, especially if a loss occurs before the policy is officially in place. The primary purpose of an insurance binder is to provide immediate insurance coverage, which is why it is commonly used when a policyholder is in transit towards obtaining a formal policy, especially with time-sensitive situations such as purchasing a home or car. The other options refer to concepts that do not align with the function of an insurance binder. For instance, a permanent insurance policy agreement indicates a finalized, long-term arrangement, while a type of policy covering property damage looks at specific coverage types rather than the temporary status of a binder. Lastly, renewal documentation pertains to the process of extending an existing policy, which is again distinct from the temporary nature of binders.

2. What is "group health insurance" commonly provided through?

- A. Individual policies purchased directly from insurers
- B. A network of independent healthcare providers
- C. An employer offering coverage under a single policy**
- D. A combination of private and public insurance programs

Group health insurance is commonly provided through an employer offering coverage under a single policy. This type of insurance allows a group, such as employees of a company, to be covered under one collective insurance plan. Employers typically purchase group health policies to provide health benefits to their employees, often at a lower cost than individual plans due to the risk being spread across many people. This arrangement not only simplifies the administration of health benefits but also usually provides access to a broader range of services at more favorable terms. Additionally, group plans can sometimes include dependent coverage, allowing employees to add family members to their health insurance at a lower cost than individual plans. While individual policies and networks of healthcare providers do exist, they don't align with the concept of group health insurance, which is fundamentally based on collective coverage offered by an organization or employer. Conversely, public-private insurance combinations do not specifically address the structure and intent of group health insurance as provided through employer policies.

3. In health insurance, what does the term "premium" refer to?

- A. The total cost of medical procedures during a policy year
- B. The fixed amount paid by a policyholder for insurance coverage**
- C. The amount covered by the insurance for every claim
- D. The deductible that must be paid before benefits are activated

The term "premium" in health insurance specifically refers to the fixed amount that a policyholder is required to pay to maintain their insurance coverage. This payment is typically made on a monthly or annual basis. Premiums are essential for keeping the policy active and ensuring that the insurer assumes the financial risk associated with future healthcare costs incurred by the policyholder. Premiums do not correspond to the total costs of medical procedures or the amounts covered by insurance claims; these aspects relate to benefits and out-of-pocket expenses. Similarly, deductibles represent a different part of the financial arrangement in health insurance, specifically the amount a policyholder must pay out-of-pocket before the insurance coverage kicks in. Thus, understanding that premiums are a fixed cost for maintaining coverage is critical for comprehending the overall structure of health insurance policies.

4. How long can a pre-existing condition be excluded from coverage in a health insurance policy?

- A. 6 months
- B. No limit
- C. 2 years
- D. 1 year**

In health insurance policies, pre-existing conditions can indeed be subject to exclusion; however, the specific duration for which a pre-existing condition may be excluded can vary based on federal regulations and specific state laws. In Illinois, as in many states, pre-existing conditions can typically be excluded for a period of up to one year following the effective date of the coverage. This means that if an individual sought coverage for a condition that was diagnosed or treated before the policy began, the insurance company could choose not to cover the treatment for that condition for one year. This limit ensures that insurance companies can manage risk while also providing protection for individuals with previous health issues once they have endured the waiting period. Exceeding this duration could lead to prohibitive practices that would adversely affect individuals seeking insurance coverage. Therefore, the one-year exclusion period aligns with the average practices seen in the industry and is grounded in the regulatory framework that governs health insurance policies.

5. In accident and health insurance, who is referred to as the "beneficiary"?

- A. The person who pays the premium
- B. The person designated to receive benefits**
- C. The insurance agent handling the policy
- D. The insurance company underwriting the policy

In accident and health insurance, the term "beneficiary" specifically refers to the individual or entity designated to receive benefits under the policy. This designation is crucial as it determines who will benefit financially from the insurance policy in the event of a claim. The beneficiary is typically named by the policyholder at the time of purchasing the insurance and can be a family member, friend, trust, or organization. Understanding this role is essential for policyholders, as it directly impacts how benefits are distributed upon the occurrence of an illness or accident. The clarity of this designation helps prevent potential disputes or delays when benefits are needed the most. Other roles involved in the insurance process, such as the premium payer, insurance agent, or the insurance company itself, do not serve the function of a beneficiary in this context. These roles or parties have different responsibilities that do not include receiving the benefits defined in the accident and health insurance policy.

6. In a Health Maintenance Organization (HMO), what is required before seeing a specialist?

- A. No restrictions are in place
- B. Referral from a general practitioner**
- C. Direct appointment with the specialist
- D. Approval from the insurance company

In a Health Maintenance Organization (HMO), a referral from a general practitioner is typically required before seeing a specialist. This process is intended to ensure coordinated care and proper management of the patient's health needs. The primary care physician (PCP) serves as the main point of contact for the patient and is responsible for assessing their condition, determining whether a specialist is necessary, and guiding them through the healthcare system. This model helps to control costs and improve patient outcomes by directing patients to the most appropriate and necessary care. It also streamlines the process of receiving specialized treatment and ensures that the specialist is aware of the patient's overall health status, including any relevant medical history or ongoing treatments. The structure of an HMO emphasizes preventive care and encourages patients to build a relationship with their PCP, which can lead to better health management. The requirement for a referral supports this focus on coordinated care, making it an essential part of the HMO framework.

7. Define "medical underwriting".

- A. A method of determining the cost of premiums based on income
- B. The process of evaluating an applicant's medical history**
- C. A strategy for reducing overall insurance costs
- D. Offering insurance without any investigation into health status

The definition of "medical underwriting" pertains to the process of evaluating an applicant's medical history. This practice involves a thorough assessment of the individual's health records, existing medical conditions, and other relevant health information to determine the level of risk the applicant presents to the insurance company. Medical underwriters analyze this data to decide not only if coverage will be offered but also at what premium rate and under what terms. In the context of health insurance, this process is crucial because it helps insurers appropriately price their plans based on the anticipated healthcare costs associated with the insured individuals. A comprehensive understanding of an applicant's health status enables insurance companies to make informed decisions that balance the need for coverage with the financial viability of the insurance pool. The other choices present misinterpretations of the term. For instance, assessing premiums based on income does not involve medical history, and strategies aimed at cost reduction do not dig into the specifics of an individual's health background. Lastly, providing insurance coverage without reviewing health status would contradict the purpose of underwriting, which is to evaluate and manage the risk associated with insuring a given group of individuals.

8. What is the deductible amount for Medicare Part A?

- A. \$185
- B. \$1350**
- C. \$183
- D. \$400

The deductible amount for Medicare Part A is significant in understanding patient responsibility before Medicare begins to cover eligible hospital or skilled nursing facility services. Medicare Part A provides coverage primarily for inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care. The correct deductible amount for Medicare Part A, which is set annually by the Centers for Medicare and Medicaid Services (CMS), is \$1,350 for the year 2023. Beneficiaries must pay this deductible for each benefit period before Medicare begins to pay for covered services. A benefit period begins when a patient is admitted to a hospital or skilled nursing facility and ends when the patient has been out of the hospital or facility for 60 days in a row. Understanding the deductible amount is crucial for beneficiaries as it impacts their financial planning for healthcare costs. In contrast, the other amounts listed (such as \$185, \$183, and \$400) do not accurately represent the Part A deductible as set by Medicare for the relevant year.

9. What happens to the coverage under COBRA if an employee's hours are reduced?

- A. The coverage ends immediately
- B. The coverage is maintained for a limited time**
- C. The coverage can be applied for bankruptcy
- D. The coverage must be transferred to another employer

When an employee experiences a reduction in hours, COBRA (Consolidated Omnibus Budget Reconciliation Act) allows them to maintain their health insurance coverage for a limited time. Under COBRA, eligible employees and their families can continue their group health insurance coverage under certain qualifying events, including termination of employment (except for gross misconduct) or a reduction in the hours of employment. The entitlement to maintain coverage under COBRA is designed to prevent gaps in health insurance for employees and their dependents during times when they are dealing with job status changes, such as a decrease in work hours that does not result in job loss. This limited continuation of coverage can typically last up to 18 months. While there are other scenarios related to health insurance coverage that might arise in different contexts, in the case of a reduction in hours, maintaining coverage under COBRA is the primary aspect and the correct answer in this scenario.

10. What is COBRA in the context of health insurance?

- A. A type of health savings account
- B. A law that allows continued health coverage after leaving employment**
- C. A health incentive program for employees
- D. A federal health insurance exchange

COBRA, or the Consolidated Omnibus Budget Reconciliation Act, is a law that provides individuals with the right to continue their health insurance coverage for a limited period after leaving employment, experiencing a reduction in hours, or undergoing other qualifying events. This provision is especially important for those who would otherwise lose their health insurance due to changes in their employment status. Under COBRA, eligible employees and their families can maintain their group health insurance coverage, but they must pay the full premiums themselves, which may include the employer's portion. This option is accurate because it captures the essence of COBRA's purpose, which is to ensure that individuals do not lapse in their health coverage when they transition out of jobs or face other life-changing circumstances. It also emphasizes the importance of continuity of care during potentially challenging times.

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://ilaccidenthealthinsurance.examzify.com>

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

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