

Kentucky Health Insurance Practice Exam (Sample)

Study Guide



Everything you need from our exam experts!

This is a sample study guide. To access the full version with hundreds of questions,

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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. Don't worry about getting everything right, 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, and take breaks to retain information better.

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.

7. Use Other Tools

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!

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Questions

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- 1. Under disability income policies, what is the typical percentage limit of the total weekly benefit payable for time lost to minor surgery or consultations?**
 - A. 10%**
 - B. 15%**
 - C. 20%**
 - D. 25%**
- 2. In health insurance policies, what is the term for a delay in the initiation of an insurance claim?**
 - A. Grace period**
 - B. Waiting period**
 - C. Coverage gap**
 - D. Exclusion period**
- 3. What does an out-of-pocket maximum refer to in health insurance plans?**
 - A. The least amount you can pay for coverage**
 - B. The maximum amount an insured person has to pay in a policy period for covered services**
 - C. The average cost of premiums in a year**
 - D. The total amount paid by insurers during a claim**
- 4. Which of the following plans generally requires referrals to see specialists?**
 - A. Health Maintenance Organization (HMO)**
 - B. Preferred Provider Organization (PPO)**
 - C. Catastrophic plan**
 - D. Short-term health plan**
- 5. An individual who advises persons about their insurance or annuity contracts is called what?**
 - A. An adjuster**
 - B. An agent**
 - C. An administrator**
 - D. A consultant**

6. In health insurance terminology, what is a "subsidy"?

- A. A financial assistance program designed to reduce the cost of premiums for eligible individuals.
- B. A financial incentive for doctors to refer patients.
- C. A discount on medical services offered to insured patients.
- D. A fee charged to provide additional coverage.

7. What does "network" refer to in health insurance?

- A. The facilities, providers, and suppliers contracted with a health insurance plan.
- B. The total number of policies sold by an insurance company.
- C. The number of employees insured under a company program.
- D. The geographic area served by a health insurance provider.

8. Which of the following best describes the purpose of benefits in a health insurance plan?

- A. To set the maximum premium paid by policyholders
- B. To outline the services and products covered by the insurance
- C. To determine the coverage area geographically
- D. To establish the duration of the insurance policy

9. What is a typical deductible for basic surgical expense insurance?

- A. 0
- B. 100
- C. 200
- D. 300

10. Under a key person disability income policy, premium payments are?

- A. Are made by the business and are tax-deductible
- B. Are made by the business and are not tax deductible
- C. Are made by the employee and are not tax deductible
- D. Are made by the employee and are tax free

Answers

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

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Explanations

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1. Under disability income policies, what is the typical percentage limit of the total weekly benefit payable for time lost to minor surgery or consultations?

- A. 10%**
- B. 15%**
- C. 20%**
- D. 25%**

The correct answer reflects typical standards found in disability income policies, where the compensation for time lost due to minor surgery or consultations is often limited to a small percentage of the total weekly benefit. In this case, it is generally established that the limit is set at 10%. This percentage is designed to reflect the lower-risk nature of minor surgery or consultations compared to more severe disabilities or prolonged incapacitation. Policies often have provisions to provide reduced benefits for shorter, less impactful events, ensuring that the coverage addresses significant disabilities while maintaining cost-effectiveness for insurers. By setting the limit at 10%, the policy balances the support of policyholders during brief periods of recovery while discouraging misuse of benefits for less serious claims. Understanding these guidelines is crucial for both insurers and policyholders in comprehending the scope and limitations of disability income benefits.

2. In health insurance policies, what is the term for a delay in the initiation of an insurance claim?

- A. Grace period**
- B. Waiting period**
- C. Coverage gap**
- D. Exclusion period**

The correct term for a delay in the initiation of an insurance claim is the waiting period. This term is commonly used in health insurance to refer to a specified period during which certain benefits will not be payable, even if a claim is made. During this time, the insured must wait before they can access specific coverage, often related to pre-existing conditions or newly added benefits. Understanding waiting periods is crucial for policyholders, as it directly impacts when they can receive coverage after a policy is issued or when specific conditions apply. For instance, some health plans impose a waiting period for new enrollees or for certain benefits to kick in after the policy starts. Hence, being aware of the waiting period helps individuals manage their healthcare needs appropriately within the confines of their policy.

3. What does an out-of-pocket maximum refer to in health insurance plans?

- A. The least amount you can pay for coverage**
- B. The maximum amount an insured person has to pay in a policy period for covered services**
- C. The average cost of premiums in a year**
- D. The total amount paid by insurers during a claim**

An out-of-pocket maximum refers to the cap that an insured individual must pay for covered medical expenses within a specific policy year. Once the insured reaches this limit, the insurance plan takes over, covering 100% of the costs for any additional covered services for the remainder of the policy period. This feature provides financial protection to the insured by limiting their total spending on healthcare, ensuring that out-of-pocket costs do not spiral out of control in the event of significant medical needs. The other options do not accurately define the concept. The least amount for coverage does not relate to out-of-pocket expenses; instead, it pertains to premiums. The average cost of premiums is a separate aspect of health insurance financial considerations. Lastly, the total amount paid by insurers during a claim refers to the insurer's expenses and does not pertain to the out-of-pocket limits for the insured party.

4. Which of the following plans generally requires referrals to see specialists?

- A. Health Maintenance Organization (HMO)**
- B. Preferred Provider Organization (PPO)**
- C. Catastrophic plan**
- D. Short-term health plan**

Health Maintenance Organizations (HMOs) are designed to manage patient care through a structured network of providers and facilities. One of the key features of HMOs is that they typically require members to select a primary care physician (PCP). This PCP serves as a gatekeeper for the patient's healthcare needs and is responsible for coordinating care. When a patient needs to see a specialist, they usually must first obtain a referral from their primary care physician. This process ensures that patients receive appropriate and necessary care while also helping the HMO control costs by directing patients within its network of providers. The referral requirement is a critical aspect of the HMO model, emphasizing a more managed approach to healthcare. In contrast, other plans such as Preferred Provider Organizations (PPOs) allow members greater flexibility to see specialists without needing a referral, while catastrophic and short-term health plans have varying structures that do not typically implement the same referral requirements as HMOs.

5. An individual who advises persons about their insurance or annuity contracts is called what?

- A. An adjuster**
- B. An agent**
- C. An administrator**
- D. A consultant**

The term that accurately describes an individual who advises persons about their insurance or annuity contracts is "consultant." Consultants typically provide expert advice and guidance on various topics, including insurance and annuity products, helping clients understand their options and make informed decisions based on their needs and financial goals. In the context of insurance, a consultant often analyzes different policies and contracts, offering insights on how they fit the client's situation, which is essential during the decision-making process. Unlike other roles such as adjusters, who focus on evaluating and settling claims, or agents, who have a more direct relationship with selling insurance products, consultants provide a broader perspective that can include strategy and planning instead of solely transactional tasks. This role is crucial for individuals looking for tailored advice beyond the standard offerings, enhancing the client's understanding of their insurance needs.

6. In health insurance terminology, what is a "subsidy"?

- A. A financial assistance program designed to reduce the cost of premiums for eligible individuals.**
- B. A financial incentive for doctors to refer patients.**
- C. A discount on medical services offered to insured patients.**
- D. A fee charged to provide additional coverage.**

A subsidy in health insurance terminology refers to a financial assistance program designed to help reduce the cost of premiums for eligible individuals. This mechanism is crucial in making health insurance more affordable, particularly for low- to moderate-income families. Subsidies can lower the monthly payments that individuals must make for their health insurance plans, allowing broader access to necessary medical coverage. In the context of health insurance, these subsidies are often provided through government programs, such as those established under the Affordable Care Act (ACA). By lowering the financial barrier to obtaining health insurance, subsidies play a key role in promoting overall public health and ensuring that more individuals can receive the medical care they need without facing insurmountable costs.

7. What does "network" refer to in health insurance?

- A. The facilities, providers, and suppliers contracted with a health insurance plan.**
- B. The total number of policies sold by an insurance company.**
- C. The number of employees insured under a company program.**
- D. The geographic area served by a health insurance provider.**

In health insurance, the term "network" specifically refers to the collective group of healthcare facilities, providers, and suppliers that have entered into agreements with a health insurance plan. These agreements typically allow the network's providers to offer services to insured members at negotiated rates, which can result in lower out-of-pocket costs for those members when they utilize these providers. Being part of this network means that insured individuals can have access to a range of medical services, including primary care, specialty care, hospitals, and other healthcare resources, often at more favorable pricing due to the contractual arrangements in place. The concept of a network is crucial for plans like Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs), both of which use networks to manage costs and ensure quality care. While the other options describe related concepts, they do not capture the essence of what a "network" is in the context of health insurance. For instance, the total number of policies sold or the number of employees insured pertains more to the business metrics of an insurance company rather than the operational structure of healthcare access. Similarly, the geographic area served by a provider indicates the range of their service rather than specifying the network of providers or facilities associated with a health plan.

8. Which of the following best describes the purpose of benefits in a health insurance plan?

- A. To set the maximum premium paid by policyholders**
- B. To outline the services and products covered by the insurance**
- C. To determine the coverage area geographically**
- D. To establish the duration of the insurance policy**

The purpose of benefits in a health insurance plan is fundamentally to outline the specific services and products that are covered by the policy. This includes detailing what types of medical care, treatments, and preventive services the insurance will pay for, which helps policyholders understand how their health needs will be met under the terms of their plan. By clearly defining the benefits, insurers provide transparency regarding what enrollees can expect when seeking medical care, thereby enabling them to make informed decisions about their health care and financial responsibilities. The other options relate to different aspects of health insurance but do not encompass the core purpose of benefits as crucially as defining coverage does. Setting maximum premiums pertains to cost management, while determining coverage area addresses geographical limits, and establishing policy duration involves the time frame the policy is active. None of these aspects highlight the essential role of benefits in communicating the scope of covered health services.

9. What is a typical deductible for basic surgical expense insurance?

- A. 0**
- B. 100**
- C. 200**
- D. 300**

In the context of basic surgical expense insurance, a typical deductible is often low or even zero. This is because basic surgical expense policies are designed to provide broader access to necessary surgical procedures without the burden of high upfront costs to the insured. By setting a low or zero deductible, these plans aim to encourage individuals to seek surgical care when needed without financial barriers. Typically, the intent is to make essential health services more accessible to policyholders. Higher deductible options, while they may be available, are less common for basic surgical expense insurance, as the focus of this type of coverage is on ensuring that individuals can afford surgeries by minimizing their out-of-pocket expenditures at the time of care.

10. Under a key person disability income policy, premium payments are?

- A. Are made by the business and are tax-deductible**
- B. Are made by the business and are not tax deductible**
- C. Are made by the employee and are not tax deductible**
- D. Are made by the employee and are tax free**

In a key person disability income policy, the correct understanding is that the premiums are made by the business and are not tax-deductible. A key person policy is designed to provide financial protection to a business when an essential employee, such as an executive or owner, becomes disabled and is unable to work. The business pays the premium for the policy to secure the benefit. While the premiums paid by the business are an expense incurred for the purpose of protecting the company's financial interests, they do not qualify as a deductible expense for tax purposes. Thus, when the benefit is paid out due to a key person's disability, the benefits received by the business are typically tax-free, but the premiums themselves do not reduce the taxable income of the business. Understanding this aspect of key person policies is crucial for business owners as it influences their financial planning and tax strategies. The nature of the payments and benefits associated with key person disability income insurance is an important element in grasping how these types of policies function within a business structure.

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://kentuckyhealthinsurance.examzify.com>

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

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