

Maryland Life and Health Insurance License 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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Table of Contents

Copyright	1
Table of Contents	2
Introduction	3
How to Use This Guide	4
Questions	6
Answers	9
Explanations	11
Next Steps	17

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

- 1. What may be a result of adverse selection in health insurance?**
 - A. Higher premiums for everyone**
 - B. Lower overall claims**
 - C. Improved risk assessments**
 - D. Increased customer trust**
- 2. What is a common exclusion found in Vision plans?**
 - A. Routine eye exams**
 - B. Lasik surgery**
 - C. Prescription eyeglasses**
 - D. Contact lenses**
- 3. Which three levels of care are generally provided under Long-Term Care policies?**
 - A. Residential, hospice, and rehabilitation**
 - B. Skilled nursing, intermediate, and custodial care**
 - C. In-home, assisted living, and hospitalization**
 - D. Emergency, routine, and respite care**
- 4. What is covered by Medicare Part B?**
 - A. Doctor's charges**
 - B. Long-term care services**
 - C. Preventive health services only**
 - D. Vision care expenses**
- 5. According to the Affordable Care Act, which metal tier is required to have an actuarial value of 70%?**
 - A. Bronze Plan**
 - B. Silver Plan**
 - C. Gold Plan**
 - D. Platinum Plan**

- 6. Under COBRA, what is true about a terminated employee's benefits?**
- A. Must include reduced premiums**
 - B. Can change based on new employment**
 - C. Must remain the same and premiums cannot exceed 102%**
 - D. Are eliminated immediately**
- 7. What does the free-look provision in an insurance policy provide the policyowner?**
- A. The option to waive the next premium**
 - B. The right to modify coverage**
 - C. The right to return the policy for a full refund**
 - D. The ability to borrow against the policy**
- 8. Which of the following is NOT considered an eligible dependent on an Accident and Health policy?**
- A. A spouse**
 - B. A 27-year-old married child**
 - C. A dependent child under 26 years old**
 - D. An adopted child**
- 9. What does the Group Life underwriting risk selection process help protect against?**
- A. Underinsurance**
 - B. Adverse selection**
 - C. Overinsurance**
 - D. Premium escalation**
- 10. If Shirley has a \$500,000 10-year non-renewable level term life policy and dies 15 years after it starts, how much will her beneficiary receive?**
- A. \$500,000**
 - B. \$250,000**
 - C. \$0**
 - D. \$100,000**

Answers

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

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Explanations

1. What may be a result of adverse selection in health insurance?

- A. Higher premiums for everyone**
- B. Lower overall claims**
- C. Improved risk assessments**
- D. Increased customer trust**

Adverse selection occurs when there is an imbalance in risk among the insured population, often because those with higher health risks are more likely to purchase insurance or seek more coverage. This can result in a situation where only those with a greater likelihood of needing medical care enroll in a health insurance plan while healthier individuals opt out or choose minimal coverage. As a consequence of this increased enrollment of higher-risk individuals, insurance companies may find that they are paying out more in claims than anticipated. To manage this financial strain, insurers often respond by raising premiums across the board. This adjustment is necessary to maintain the insurer's financial viability and ensure that they can cover the higher claims costs associated with a less healthy risk pool. Consequently, the result of adverse selection is typically higher premiums for everyone in the insurance plan. It underscores the importance of balancing risk in the insurance market to keep premiums stable and affordable for all policyholders.

2. What is a common exclusion found in Vision plans?

- A. Routine eye exams**
- B. Lasik surgery**
- C. Prescription eyeglasses**
- D. Contact lenses**

One common exclusion found in vision plans is the coverage for Lasik surgery. Vision insurance typically focuses on routine eye care and corrective lenses, such as glasses and contact lenses. Lasik surgery, being an elective procedure designed to permanently correct vision, often falls outside the scope of regular vision coverage. This exclusion exists because Lasik is seen as a cosmetic enhancement rather than a preventive or necessary healthcare service, which vision plans usually prioritize. The other options, which involve routine eye exams, prescription eyeglasses, and contact lenses, are generally covered by vision insurance plans as they are integral to maintaining eye health and vision correction. Therefore, the exclusion of Lasik surgery aligns with the common coverage structure of vision plans.

3. Which three levels of care are generally provided under Long-Term Care policies?

- A. Residential, hospice, and rehabilitation**
- B. Skilled nursing, intermediate, and custodial care**
- C. In-home, assisted living, and hospitalization**
- D. Emergency, routine, and respite care**

Long-Term Care policies are designed to cover various types of care that individuals may need due to chronic illness, disability, or age-related issues. The three levels of care typically addressed in these policies are skilled nursing care, intermediate care, and custodial care. Skilled nursing care involves 24-hour supervision by trained medical professionals and is often provided in nursing facilities. This level of care is necessary when individuals have complex medical needs that require regular monitoring and treatments administered by licensed personnel. Intermediate care is less intensive than skilled nursing care and may include supervision and assistance with daily activities, but not constant medical attention. It is designed for individuals who do not require the full spectrum of medical care but still need help as they recover or manage their conditions. Custodial care is primarily focused on assistance with personal daily activities such as bathing, dressing, and eating. This level of care is essential for individuals who may not have complex medical needs but cannot perform these activities independently. Understanding these three distinct levels of care is crucial for evaluating Long-Term Care policies effectively, as they determine the type of services and environments covered under these insurance plans.

4. What is covered by Medicare Part B?

- A. Doctor's charges**
- B. Long-term care services**
- C. Preventive health services only**
- D. Vision care expenses**

Medicare Part B primarily covers outpatient care, which includes a range of medical services and supplies that are necessary for the diagnosis or treatment of a medical condition. This includes doctor's charges, making it a crucial aspect of the Medicare program for beneficiaries needing regular medical attention or specialist services. While it is true that Medicare Part B does include coverage for preventive health services, its scope is much broader than just preventive care; it also encompasses a variety of other essential services, like laboratory tests, outpatient mental health services, and certain vaccinations. Long-term care services, in contrast, are not covered under Medicare Part B; these services typically require different types of insurance or personal funding options. Similarly, while some vision care services may be covered under Part B, such as specific eye exams related to medical conditions, general vision care expenses, like routine eye exams and glasses, are largely excluded from coverage. The emphasis on doctor's charges as a key component of Part B highlights its role in ensuring beneficiaries have access to necessary medical professional services, affirming that Option A accurately represents a core function of Medicare Part B.

5. According to the Affordable Care Act, which metal tier is required to have an actuarial value of 70%?

- A. Bronze Plan**
- B. Silver Plan**
- C. Gold Plan**
- D. Platinum Plan**

The correct answer is that the Bronze Plan is required to have an actuarial value of 60%, while the Silver Plan is designated with a 70% actuarial value. The actuarial value indicates the percentage of total healthcare costs that a plan will cover on average for a standard population. The Silver Plan strikes a balance between premium costs and out-of-pocket expenses, ensuring that while premiums are lower than those of higher tiers like the Gold and Platinum Plans, it provides a reasonable level of coverage that meets the ACA standards. This tier was specifically designed to appeal to a wide range of consumers, especially those who may be eligible for cost-sharing reductions, leading to improved affordability in accessing healthcare. The Gold and Platinum Plans offer higher actuarial values of 80% and 90% respectively, making them more comprehensive but also more expensive. The Bronze Plan, on the other hand, focuses on lower premiums at the cost of higher out-of-pocket expenses, which means it would attract a different demographic looking primarily for budget-friendly options rather than comprehensive coverage. Thus, the Silver Plan stands out as the correct choice for a required actuarial value of 70% under the ACA guidelines.

6. Under COBRA, what is true about a terminated employee's benefits?

- A. Must include reduced premiums**
- B. Can change based on new employment**
- C. Must remain the same and premiums cannot exceed 102%**
- D. Are eliminated immediately**

The correct answer highlights an important component of the Consolidated Omnibus Budget Reconciliation Act (COBRA), which ensures that employees who have lost their jobs can continue to receive health insurance benefits. Under COBRA, when an employee is terminated, their health insurance benefits must remain the same as they were prior to their employment termination. This means that the coverage continues without changes to the plan itself, thus allowing the terminated employee to keep the same benefits they had while employed. In regard to premiums, the Act states that while the employee is responsible for paying their premiums, these costs cannot exceed 102% of the premium rate. This allows for a slight increase to account for administrative costs but ensures that the former employee is not priced out of maintaining their health insurance coverage. It's crucial to understand that under COBRA, benefits are not eliminated immediately, ensuring individuals have a safety net during their transition after job loss. While changes can occur due to new employment, this specific framework ensures continuity of benefits rather than alterations as a result of changing jobs or other circumstances.

7. What does the free-look provision in an insurance policy provide the policyowner?

- A. The option to waive the next premium**
- B. The right to modify coverage**
- C. The right to return the policy for a full refund**
- D. The ability to borrow against the policy**

The free-look provision in an insurance policy provides the policyowner the opportunity to review their policy and decide whether to keep it or return it for a full refund. This provision is a consumer protection feature designed to give policyholders a specified period, usually 10 to 30 days, to examine the policy and ensure it meets their needs. During this time, the policyholder can assess the terms, conditions, and coverage details without risk. If the policyholder finds that the policy is not what they expected or doesn't fulfill their needs, they can return it and receive a complete refund of any premiums paid. This option does not involve modifying the policy, waiving premiums, or borrowing against the policy, which are separate aspects of insurance contracts. Instead, the free-look provision specifically guarantees the policyholder the right to cancel their contract within a set timeframe, ensuring they feel confident about their purchase.

8. Which of the following is NOT considered an eligible dependent on an Accident and Health policy?

- A. A spouse**
- B. A 27-year-old married child**
- C. A dependent child under 26 years old**
- D. An adopted child**

In the context of Accident and Health insurance policy eligibility, a 27-year-old married child typically does not fall under the definition of an eligible dependent. Most health insurance policies define dependent children as individuals who are primarily under the care of the insured and usually restrict that definition to individuals under the age of 26. This standard aligns with the provisions of the Affordable Care Act (ACA), which requires insurers to allow coverage for dependents until they are 26, regardless of marital status or whether they live with the parent. On the contrary, a spouse, a dependent child under 26 years old, and an adopted child are typically classified as eligible dependents. Spouses are commonly included in family coverage plans, dependent children under the age of 26 fall within the eligibility guidelines established to ensure access to healthcare for young adults, and adopted children are treated the same as biological children when determining eligibility for coverage. Thus, a 27-year-old married child does not meet these criteria, making it the correct response in this scenario.

9. What does the Group Life underwriting risk selection process help protect against?

- A. Underinsurance
- B. Adverse selection**
- C. Overinsurance
- D. Premium escalation

The Group Life underwriting risk selection process is designed to mitigate adverse selection, which occurs when individuals with a higher likelihood of claiming insurance tend to enroll in the insurance plan more than those with a lower likelihood. This phenomenon can lead to an unbalanced risk pool where the number of high-risk individuals exceeds low-risk individuals, resulting in increased claims and potential financial instability for the insurer. By implementing a thorough underwriting risk selection process, insurance companies can evaluate the health and demographics of the group as a whole rather than solely assessing individual applicants. This collective assessment allows insurers to set premiums based on the overall risk profile of the group while maintaining a diverse mix of risk. Ultimately, this process helps keep premiums stable and the insurance product viable for the entire group, reducing the chances of adverse selection impacting the insurer's financial health. While the other options relate to aspects of insurance practices, they do not directly address the protection against the specific risks posed by adverse selection. Underinsurance pertains to insufficient coverage levels, overinsurance refers to excessive coverage leading to unnecessary costs, and premium escalation involves increasing premiums over time regardless of the group's risk characteristics, none of which are the primary focus of the underwriting risk selection process in group life insurance.

10. If Shirley has a \$500,000 10-year non-renewable level term life policy and dies 15 years after it starts, how much will her beneficiary receive?

- A. \$500,000
- B. \$250,000
- C. \$0**
- D. \$100,000

In the scenario presented, Shirley has a 10-year non-renewable level term life insurance policy. This type of policy provides coverage for a specific term—in this case, 10 years—at a fixed death benefit amount of \$500,000. However, once the term expires at the end of the 10 years, the coverage ends, and no death benefit is payable thereafter. Since Shirley dies 15 years after the policy starts, this is well beyond the 10-year coverage period. After the term expires, the life insurance policy does not provide any benefits. Therefore, despite the initial value of the policy, the beneficiary will not receive any payout because the policy is no longer in effect at the time of Shirley's death. The correct conclusion is that her beneficiary will receive \$0.

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://marylandlifeandhealthinsurance.examzify.com>

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