

# MEDICAL EXPENSE INSURANCE PRACTICE EXAM (SAMPLE)

## STUDY GUIDE



*Prepare with structure. Pass with confidence*



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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 does a maternity or dental rider do for a base health policy?**
  - A. A separate policy for maternity.
  - B. A rider that restricts coverage to out-of-network services.
  - C. An add-on to expand coverage to include maternity or dental services that the base policy may exclude.
  - D. A discount program for dental services.
- 2. Which of the following is a characteristic of a preferred provider organization (PPO)?**
  - A. Discounted fees for patients
  - B. No network restrictions
  - C. Mandatory primary care physician referral
  - D. Higher premiums only
- 3. In a standard medical expense policy, custodial care is typically:**
  - A. Always covered in full.
  - B. Generally not covered, unless a rider or extended care benefit provides coverage.
  - C. Covered only if provided in a hospital.
  - D. Covered automatically after the deductible is met.
- 4. What best describes the intent of a coinsurance clause in a Major Medical policy?**
  - A. Reduces premiums
  - B. Guarantees full coverage
  - C. Eliminates deductibles
  - D. Discourages overutilization
- 5. How does a calendar-year deductible affect claims?**
  - A. it's always paid by insurer
  - B. it applies per policy period
  - C. it always applies to every visit
  - D. it resets annually

- 6. What does reinstatement in a health policy generally allow?**
- A. Be reinstated after meeting certain conditions, such as paying past due premiums and possibly providing evidence of insurability.
  - B. Be automatically reinstated without any action.
  - C. Terminate the policy permanently.
  - D. Reset the deductible to zero.
- 7. If age was misstated on a policy and corrected later, what might the insurer do?**
- A. Cancel the policy immediately.
  - B. Adjust benefits or premiums based on corrected age.
  - C. Refuse any claims.
  - D. Lock in the original benefits indefinitely.
- 8. Which statement best describes the difference between a group medical expense policy and an individual medical expense policy?**
- A. Group policies cover a defined group such as an employer, while individual policies are purchased by a person independently, with underwriting and eligibility differences.
  - B. Group policies typically have higher premiums but the same underwriting as individual policies.
  - C. Individual policies require underwriting but not eligibility considerations.
  - D. Group policies never require health underwriting or eligibility checks.
- 9. Generally, how long is a benefit period for a Major Medical Expense Plan?**
- A. Indefinitely
  - B. One year
  - C. Two years
  - D. One month
- 10. What is the purpose of an "other insurance" clause in a health insurance policy?**
- A. It increases benefits if other coverage exists.
  - B. It applies only to life insurance.
  - C. It eliminates all other coverage automatically.
  - D. It coordinates with other coverage and prevents duplicate benefits across multiple policies.



## **Answers**

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

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## **Explanations**

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### 1. What does a maternity or dental rider do for a base health policy?

- A. A separate policy for maternity.
- B. A rider that restricts coverage to out-of-network services.
- C. An add-on to expand coverage to include maternity or dental services that the base policy may exclude.**
- D. A discount program for dental services.

*A rider is an endorsement added to a base health policy that changes or expands its benefits. A maternity or dental rider specifically adds coverage for those services when the base plan doesn't cover them or covers them only up to limited amounts. So this rider serves as an add-on that broadens the policy's protection, often for an extra premium, rather than creating a separate policy or offering discounts. For example, if the base plan excludes dental care or pregnancy-related services, the rider would authorize benefits for those services under the same policy, subject to the rider's own deductibles, limits, and coinsurance.*

### 2. Which of the following is a characteristic of a preferred provider organization (PPO)?

- A. Discounted fees for patients**
- B. No network restrictions
- C. Mandatory primary care physician referral
- D. Higher premiums only

*Discounted fees with a network of providers is a hallmark of a PPO. In a PPO, providers agree to lower negotiated rates for members, and the plan passes those savings on when you use in-network doctors and facilities. That makes in-network care less expensive, which is why this option best describes a PPO. You typically can still see out-of-network providers, but at higher out-of-pocket costs, and you don't usually need a referral to see a specialist. The idea of no network restrictions isn't accurate because there is a network you get discount benefits from, just with some flexibility to go outside it. The notion of mandatory primary care physician referrals aligns more with an HMO, not a PPO. And while premiums can be higher for PPOs due to the broader freedom and access, describing it as "higher premiums only" misses the key point about discounted in-network fees.*

### 3. In a standard medical expense policy, custodial care is typically:

- A. Always covered in full.
- B. Generally not covered, unless a rider or extended care benefit provides coverage.**
- C. Covered only if provided in a hospital.
- D. Covered automatically after the deductible is met.

*Custodial care means non-medical assistance with daily living activities like bathing, dressing, dressing, or supervision. In a standard medical expense policy, these services are typically not considered medically necessary treatment, so they're excluded from basic coverage. The only way custodial care would be covered is if you have an added rider or extended care benefit that explicitly includes custodial or long-term care services. Without that add-on, the policy won't pay for custodial care. So, this reflects why custodial care is generally not covered unless a rider or extended care benefit provides coverage. The other ideas—covering it automatically after a deductible is met, or requiring hospital-based care, or promising full coverage—don't align with how standard medical expense policies handle custodial services.*

#### 4. What best describes the intent of a coinsurance clause in a Major Medical policy?

- A. Reduces premiums
- B. Guarantees full coverage
- C. Eliminates deductibles
- D. Discourages overutilization**

*Coinsurance is a cost-sharing feature that starts after you meet the policy deductible. You pay a percentage of covered medical expenses and the insurer pays the rest. This arrangement keeps you invested in the cost of care and encourages you to consider the necessity and cost of services rather than using care indiscriminately. For example, with a \$1,000 deductible and 80/20 coinsurance, on a \$2,500 bill you would pay the deductible first, then 20% of the remaining \$1,500 (which is \$300), while the insurer covers \$1,200. The main purpose is to discourage overutilization by sharing costs. Coinsurance doesn't set premiums or guarantee full coverage, and it doesn't eliminate deductibles.*

#### 5. How does a calendar-year deductible affect claims?

- A. it's always paid by insurer
- B. it applies per policy period
- C. it always applies to every visit
- D. it resets annually**

*A calendar-year deductible means you must pay your covered medical expenses out of pocket up to a specified amount within a single calendar year before the insurer starts paying according to the plan. It isn't tied to visits or to a different policy period; the amount you pay toward the deductible accumulates across all eligible claims in that year. At the start of the next year, the deductible resets to zero, and you begin meeting a new year's deductible again. So, early in the year you may pay most costs yourself until you reach the deductible, after which the plan generally pays according to its coinsurance and benefits until you hit the out-of-pocket maximum.*

#### 6. What does reinstatement in a health policy generally allow?

- A. Be reinstated after meeting certain conditions, such as paying past due premiums and possibly providing evidence of insurability.**
- B. Be automatically reinstated without any action.
- C. Terminate the policy permanently.
- D. Reset the deductible to zero.

*Reinstatement lets you bring a lapsed health policy back into force after you meet certain conditions. Typically you must pay any past-due premiums and may need to provide evidence of insurability to show you're still eligible for coverage. There's usually a reinstatement window and possibly medical underwriting or a waiting period for new benefits, especially for any conditions that occurred after the lapse. It's not automatic—you have to apply and satisfy the requirements. Reinstatement does not terminate the policy, and it does not reset the deductible to zero; deductibles and other copayment terms remain as defined by the policy once reinstated.*

**7. If age was misstated on a policy and corrected later, what might the insurer do?**

- A. Cancel the policy immediately.
- B. Adjust benefits or premiums based on corrected age.**
- C. Refuse any claims.
- D. Lock in the original benefits indefinitely.

*Age is a fundamental factor that determines both premium levels and benefit amounts. When an age was misstated and is corrected, the policy is typically adjusted to reflect the insured's true age, which means recalculating the premiums and the benefits accordingly. This adjustment aligns the coverage with the actual risk the insurer is taking on, and it can be applied from the date of correction or from the policy issue date, depending on the contract. The policy remains in force as long as premiums are paid and the misstatement is corrected, rather than canceling the policy or denying claims outright. So the insurer would adjust benefits or premiums based on the corrected age.*

**8. Which statement best describes the difference between a group medical expense policy and an individual medical expense policy?**

- A. Group policies cover a defined group such as an employer, while individual policies are purchased by a person independently, with underwriting and eligibility differences.**
- B. Group policies typically have higher premiums but the same underwriting as individual policies.
- C. Individual policies require underwriting but not eligibility considerations.
- D. Group policies never require health underwriting or eligibility checks.

*The main idea is that coverage is organized around who is insured. A group medical expense policy is issued to a defined group, such as employees of an employer, so eligibility is based on being part of that group rather than on an individual's health status. The insurer often uses group-level underwriting and may not require individual health questions for each member, which helps keep premiums lower and simplifies enrollment for the group. In contrast, an individual medical expense policy is purchased by a person on their own, and the insurer assesses the individual's insurability through underwriting; eligibility and premium are based on that person's health and risk, not on a group membership. This is why the statement that best describes the difference is that group policies cover a defined group with group-level underwriting and eligibility, while individual policies are purchased independently with individual underwriting and eligibility considerations. It wouldn't be accurate to claim group plans always have higher premiums or that group plans never require any underwriting, and individual policies do involve eligibility considerations in addition to underwriting.*

**9. Generally, how long is a benefit period for a Major Medical Expense Plan?**

- A. Indefinitely
- B. One year**
- C. Two years
- D. One month

*In a Major Medical Expense Plan, the benefit period is the span of time during which benefits for covered services are paid before the clock resets. Most policies use a yearly window—roughly one policy year or calendar year—so claims are paid within that one-year period, with the period then starting anew when the policy renews. This yearly reset is paired with annual maximums, meaning the amount the plan will pay is limited within each year. Choosing one year fits the typical structure of these plans, because a longer indefinite period would imply no reset or annual cap, which isn't how major medical coverage is designed. Shorter periods, like one month, would be unusual and would complicate how benefits accumulate. So the standard and correct understanding is that the benefit period is one year.*

**10. What is the purpose of an "other insurance" clause in a health insurance policy?**

- A. It increases benefits if other coverage exists.
- B. It applies only to life insurance.
- C. It eliminates all other coverage automatically.
- D. It coordinates with other coverage and prevents duplicate benefits across multiple policies.**

*The idea behind an other-insurance clause is coordination of benefits. When you have more than one health coverage, this clause makes the plans work together so benefits aren't paid twice for the same charges. It sets the order of payment—which plan pays first (primary) and how the other plan contributes (secondary)—so total benefits don't exceed the actual medical costs and aren't duplicated across policies. For example, if the total bill is \$1,000 and the primary plan covers \$700, the secondary plan may cover the remaining \$300 (up to its own limits and subject to deductible or coinsurance), but it won't pay more than the bill. This ensures costs are shared fairly and avoids overinsurance. The other options don't reflect this coordination function—they don't increase benefits, aren't limited to life insurance, and don't automatically eliminate other coverage.*

## 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://medexpenseinsurance.examzify.com>

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

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