

MEDICAL EXPENSE INSURANCE PRACTICE EXAM (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED 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. 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 the difference between indemnity payment and service-based payment?**
 - A. Service-based payment reimburses the insured.
 - B. Indemnity payment reimburses the insured; service-based pays the provider directly according to the policy terms.
 - C. They are the same.
 - D. Indemnity payment pays the provider directly.

- 2. What is a typical reason rehabilitation services coverage varies?**
 - A. Medically necessary status; varies by policy.
 - B. Always covered at 100%.
 - C. Only available during hospitalization.
 - D. Depends on the provider network.

- 3. In medical expense insurance, when is a claim considered incurred?**
 - A. The service or charge is billed for and received by the insured; typically the date of service.
 - B. The claim is approved by the insurer.
 - C. The policy is in force.
 - D. The provider is in-network.

- 4. What is typically true about out-of-network costs compared to in-network?**
 - A. They are typically lower and may involve higher deductibles or coinsurance.
 - B. They are always identical to in-network benefits.
 - C. They never require deductibles.
 - D. They guarantee no out-of-pocket costs.

- 5. What is the primary purpose of a deductible in a medical expense insurance policy?**
 - A. To share initial costs with the insured and reduce premium costs; benefits begin after the deductible is satisfied.
 - B. To cap the total benefits at a fixed amount each year.
 - C. To determine whether expenses are medically necessary.
 - D. To provide unlimited coverage from day one.

- 6. In a Major Medical policy with an 80/20 coinsurance, after the deductible is satisfied, what percentage of eligible expenses is typically paid by the insurer?**
- A. 20%
 - B. 80%
 - C. 100%
 - D. 60%
- 7. What happens if a policyholder cannot pay premiums?**
- A. The policy automatically cancels immediately.
 - B. Coverage may lapse; most policies have grace periods and reinstatement options.
 - C. Premiums are refunded automatically after nonpayment.
 - D. The insurer will cover all outstanding charges to maintain coverage.
- 8. How does assignment of benefits interact with provider billing?**
- A. The insured pays all costs upfront and files a reimbursement claim.
 - B. The provider can bill the insurer directly; the insured's responsibility is to pay any remaining balance such as deductible or coinsurance.
 - C. The insurer pays the full amount regardless of bills.
 - D. The provider cannot bill the insurer directly.
- 9. Which of the following BEST describes a hospital indemnity policy?**
- A. Coverage that pays a stated amount per day of a covered hospitalization
 - B. Pays the actual hospital charges
 - C. Covers only medical bills
 - D. Reimburses for physician visits
- 10. Which of these options can an individual use their medical flexible spending account to pay for?**
- A. Cosmetic surgery
 - B. Prescription drugs
 - C. Gym memberships
 - D. Life insurance premiums

Answers

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

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Explanations

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1. What is the difference between indemnity payment and service-based payment?

- A. Service-based payment reimburses the insured.
- B. Indemnity payment reimburses the insured; service-based pays the provider directly according to the policy terms.**
- C. They are the same.
- D. Indemnity payment pays the provider directly.

At the heart of this distinction is who receives the payment and how claims are settled. In an indemnity arrangement, the insurer reimburses the insured for eligible medical expenses. The insured may pay the provider upfront and then submit a claim to get reimbursed, and the payment typically goes to the insured (subject to deductible, coinsurance, and limits). In a service-based arrangement, the plan pays the provider directly for services rendered, usually under contract terms with the provider network. The insured's role is mainly to pay any required copayments or coinsurance, with the provider receiving payment from the insurer rather than from the patient. So the best description is that indemnity payments reimburse the insured, while service-based payments are made directly to the provider according to policy terms. The other statements misstate who is paid or imply they're the same, which isn't correct.

2. What is a typical reason rehabilitation services coverage varies?

- A. Medically necessary status; varies by policy.**
- B. Always covered at 100%.
- C. Only available during hospitalization.
- D. Depends on the provider network.

Coverage for rehabilitation services varies because insurance coverage hinges on medical necessity as defined in the policy. Each plan specifies what counts as rehabilitative care, where it can be provided (inpatient, outpatient, home health), and any limits or requirements (preauthorization, duration, dollar caps). Because the definition of medical necessity and the benefit design differ across policies, the same rehab service may be covered in one plan but limited or excluded in another. This is the primary reason coverage isn't universal or tied to a single setting, and why it can change from policy to policy or even for different cases within the same policy. Other options aren't the main reason: coverage isn't guaranteed at 100% for rehab, since most plans apply deductibles, coinsurance, and limits; rehab isn't restricted only to hospitalization (outpatient and other settings are common); and while provider networks can affect access and costs, the fundamental driver is medical necessity as defined by the policy.

3. In medical expense insurance, when is a claim considered incurred?

- A. The service or charge is billed for and received by the insured; typically the date of service.**
- B. The claim is approved by the insurer.
- C. The policy is in force.
- D. The provider is in-network.

The date of service is the moment incurrence occurs—the service is performed and billed to the insured. Incurrence means the insured becomes liable for the expense, which usually happens when the medical service is provided and the bill is issued, so the claim is considered incurred at that time. Approval by the insurer happens after the service and does not define when the expense was incurred. The policy being in force is a prerequisite for coverage, but it doesn't establish the incurrence date. Whether the provider is in-network affects cost-sharing and networked payment amounts, not when the claim is incurred.

4. What is typically true about out-of-network costs compared to in-network?

- A. They are typically lower and may involve higher deductibles or coinsurance.**
- B. They are always identical to in-network benefits.
- C. They never require deductibles.
- D. They guarantee no out-of-pocket costs.

The main idea here is that network status affects how much you pay out of pocket. In-network providers have negotiated rates with the insurer, so the allowed charges are lower and your share — through deductibles, coinsurance, and copays — is typically smaller. Out-of-network providers don't have those negotiated rates, so the insurer may reimburse a higher amount only after you've met a deductible or paid higher coinsurance, and you can even face balance billing. So the typical reality is that out-of-network costs are higher, not lower, and you may still owe substantial amounts even after meeting any deductible. The option suggesting lower out-of-network costs is inconsistent with how cost sharing usually works, and the other choices—claims that costs are identical to in-network, that deductibles are never required, or that there will be no out-of-pocket costs—do not fit the reality of how out-of-network coverage operates.

5. What is the primary purpose of a deductible in a medical expense insurance policy?

- A. To share initial costs with the insured and reduce premium costs; benefits begin after the deductible is satisfied.**
- B. To cap the total benefits at a fixed amount each year.
- C. To determine whether expenses are medically necessary.
- D. To provide unlimited coverage from day one.

The deductible represents cost sharing: the insured pays a portion of initial medical costs out of pocket, and only after meeting that amount do the insurer begins to pay benefits. This setup helps keep premiums lower because the insurer isn't covering the early, predictable costs for everyone. Once the deductible is satisfied, the policy typically pays according to its coinsurance or copay structure, and the insured's remaining cost-sharing continues as defined by the plan. This isn't about determining medical necessity, nor about capping benefits, nor about providing unlimited coverage from day one—those aspects are governed by different features of the policy.

6. In a Major Medical policy with an 80/20 coinsurance, after the deductible is satisfied, what percentage of eligible expenses is typically paid by the insurer?

- A. 20%
- B. 80%**
- C. 100%
- D. 60%

Coinsurance after the deductible is met: in a Major Medical policy with an 80/20 arrangement, once you've satisfied the deductible, the insurer pays 80% of eligible (covered) expenses and you pay 20% until you hit the out-of-pocket maximum. For example, if a covered bill is \$1,000 and the deductible is already satisfied, the insurer would cover \$800 and you would owe \$200.

7. What happens if a policyholder cannot pay premiums?

- A. The policy automatically cancels immediately.
- B. Coverage may lapse; most policies have grace periods and reinstatement options.**
- C. Premiums are refunded automatically after nonpayment.
- D. The insurer will cover all outstanding charges to maintain coverage.

When a policyholder can't pay premiums, protection isn't simply erased instantly. Most medical expense policies include a grace period—a short window after the due date during which the policy remains in force and claims can still be paid. If the payment isn't made by the end of that grace period, the policy may lapse or terminate. Reinstatement options are commonly available within a defined period after lapse, allowing the policy to be brought back by paying the overdue premiums (often with interest) and sometimes requiring new evidence of insurability. This combination—grace periods to preserve coverage temporarily and reinstatement to restore it after a lapse—best matches how premium nonpayment is typically handled, rather than an immediate cancellation, automatic refunds, or the insurer paying the overdue charges.

8. How does assignment of benefits interact with provider billing?

- A. The insured pays all costs upfront and files a reimbursement claim.
- B. The provider can bill the insurer directly; the insured's responsibility is to pay any remaining balance such as deductible or coinsurance.**
- C. The insurer pays the full amount regardless of bills.
- D. The provider cannot bill the insurer directly.

Assignment of benefits means the patient signs over the right to receive payment for covered services to the provider. With this arrangement, the provider can bill the insurer directly for services, and the insured is responsible only for any remaining amount such as the deductible or coinsurance, plus any noncovered charges. This setup simplifies payment and often reduces or eliminates the need for the patient to pay the full bill upfront and seek reimbursement later. In other words, the insurer's payment goes straight to the provider, and the patient's out-of-pocket costs are limited to the plan-defined deductible, coinsurance, and any noncovered services.

9. Which of the following BEST describes a hospital indemnity policy?

- A. Coverage that pays a stated amount per day of a covered hospitalization**
- B. Pays the actual hospital charges
- C. Covers only medical bills
- D. Reimburses for physician visits

Hospital indemnity insurance provides a fixed daily cash benefit for each day you are hospitalized, paid regardless of the actual hospital charges. That per-day, stated amount is exactly what describes a hospital indemnity policy, making it the best choice. It doesn't reimburse the hospital for actual charges, nor is it limited to paying medical bills or reimbursing physician visits—the latter describe other types of medical expense coverage. The cash benefit can be used for any purpose, such as covering nonmedical costs, which is a key feature of hospital indemnity coverage.

10. Which of these options can an individual use their medical flexible spending account to pay for?

- A. Cosmetic surgery
- B. Prescription drugs**
- C. Gym memberships
- D. Life insurance premiums

Medical FSAs are designed to cover expenses that diagnose, treat, or prevent a health condition. Prescription drugs fall into this category because they are prescribed to treat or manage a medical issue, so they are eligible for reimbursement from an FSA. Cosmetic surgery is generally not eligible because it is typically elective and aimed at improving appearance rather than treating a medical condition. A gym membership isn't considered a medical expense since it's about wellness or fitness rather than addressing a diagnosed illness or treatment, and life insurance premiums aren't medical expenses because they're for financial protection rather than medical care. If in doubt, check the plan's list of eligible expenses, but the standard expectation is that prescription drugs are reimbursable.

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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://medexpenseinsurance.examzify.com>

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

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