

MEDICAL INSURANCE PRACTICE TEST (SAMPLE)

STUDY GUIDE



**SAMPLE STUDY GUIDE
WITH LIMITED QUESTIONS**

**VISIT US ONLINE FOR
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 action should be avoided to prevent issues with medical billing?**
 - A. Accurate documentation of services performed
 - B. Billing for services not performed or documented
 - C. Maintaining clear communication with insurance providers
 - D. Regularly reviewing billing practices
- 2. What do out-of-network benefits typically result in for the insured?**
 - A. Lower quality care
 - B. Higher out-of-pocket expenses
 - C. Unrestricted access to any provider
 - D. No change in the cost of premiums
- 3. What does the term "policyholder" refer to in insurance?**
 - A. The individual or entity that sells the insurance policy
 - B. The insurance agent responsible for customer service
 - C. The individual or entity that owns an insurance policy
 - D. The healthcare provider contracted with the insurer
- 4. What is the main purpose of a peer review in health insurance?**
 - A. To assess insurance claims for errors
 - B. To evaluate the quality and appropriateness of medical care decisions made by providers
 - C. To ensure compliance with state insurance regulations
 - D. To verify a patient's eligibility for coverage
- 5. What is the purpose of a summary of benefits and coverage (SBC)?**
 - A. To provide detailed legal terms of an insurance plan
 - B. To furnish clear, concise information about coverage offered by a health plan
 - C. To outline the financial history of an insurance company
 - D. To specify medical procedures covered by the policy

6. What is an essential factor in determining the premiums of an insurance policy?

- A. The insurance company's total income
- B. The age and health status of the policyholder
- C. The geographic location of the insurance provider
- D. The number of claims processed by the insurer

7. Supplemental Insurance is used for which of the following?

- A. Covers standard medical procedures
- B. Covers services not normally covered by a primary plan
- C. Provides a cash payout for hospitalization
- D. Offers free preventive care services

8. What is Medicare primarily designed for?

- A. Individuals under 30
- B. Individuals over 65 years old
- C. Those with chronic illnesses
- D. Low-income families

9. What percentage of healthcare costs does Medicare cover?

- A. 50%
- B. 70%
- C. 80%
- D. 90%

10. Which of the following best describes Assignment of Benefits?

- A. Insurance claims are sent directly to the patient
- B. Reimbursement is sent directly from the payer to the provider
- C. Patients must pay upfront for services rendered
- D. Payers have the right to audit claims before payment

Answers

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

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Explanations

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1. What action should be avoided to prevent issues with medical billing?

- A. Accurate documentation of services performed
- B. Billing for services not performed or documented**
- C. Maintaining clear communication with insurance providers
- D. Regularly reviewing billing practices

Billing for services not performed or documented is critical to avoid because it constitutes fraud and can lead to severe legal consequences. Accurate billing relies on the principle that every charge must be supported by proper documentation that proves the service was actually rendered to the patient. This not only protects the integrity of the billing process but also ensures compliance with healthcare laws and regulations. Failure to adhere to this practice can result in denied claims, financial liability for the practice, loss of credibility with insurance providers, and potential investigations. Maintaining ethical standards in billing helps safeguard against hefty fines, litigation, and damage to reputation, which can affect future operations. In contrast, accurate documentation of services performed, clear communication with insurance providers, and regular reviews of billing practices are all essential habits that support proper billing methods and compliance. They enhance accountability and transparency, significantly reducing the likelihood of billing errors.

2. What do out-of-network benefits typically result in for the insured?

- A. Lower quality care
- B. Higher out-of-pocket expenses**
- C. Unrestricted access to any provider
- D. No change in the cost of premiums

Out-of-network benefits typically lead to higher out-of-pocket expenses for the insured. When individuals seek care from providers outside of their insurance plan's network, they often encounter higher deductibles, copayments, and coinsurance. Insurance plans usually negotiate lower rates with in-network providers, which means that when services are received from out-of-network providers, the insured may have to pay the full billed charges, or a significantly larger portion of those charges, leading to increased financial responsibility. In addition, the out-of-network coverage is often less comprehensive compared to in-network coverage, meaning the insurance might only cover a small percentage of the costs or none at all after certain thresholds are met. This is why individuals who utilize out-of-network services often see a substantial increase in their overall healthcare spending, particularly for more significant medical procedures or ongoing care.

3. What does the term "policyholder" refer to in insurance?

- A. The individual or entity that sells the insurance policy
- B. The insurance agent responsible for customer service
- C. The individual or entity that owns an insurance policy**
- D. The healthcare provider contracted with the insurer

The term "policyholder" specifically refers to the individual or entity that owns an insurance policy. This person or organization has entered into an agreement with the insurance company, paying premiums in exchange for coverage under the terms stipulated in the policy. The policyholder has rights and responsibilities associated with the policy, such as the ability to file claims and the obligation to maintain premium payments. They are essentially the central figure in the insurance relationship, as they hold the contract that defines the coverage and benefits provided by the insurer. Other roles mentioned, such as the individual or entity selling the insurance, the insurance agent, or the healthcare provider, do not define the policyholder. The seller of the insurance is typically an agent or broker, the agent focuses on facilitating customer service and managing relationships, and the healthcare provider delivers medical services rather than owning an insurance policy. Thus, the concept of a policyholder is distinct and pivotal in the framework of insurance practices.

4. What is the main purpose of a peer review in health insurance?

- A. To assess insurance claims for errors
- B. To evaluate the quality and appropriateness of medical care decisions made by providers**
- C. To ensure compliance with state insurance regulations
- D. To verify a patient's eligibility for coverage

The main purpose of a peer review in health insurance is to evaluate the quality and appropriateness of medical care decisions made by providers. This process involves the assessment of clinical decisions and practices by other qualified professionals in the same field. It helps to ensure that the care provided is evidence-based, meets established standards, and aligns with best practices. Peer reviews contribute to maintaining high standards of care by providing a structured way for healthcare professionals to review their colleagues' clinical practices. By identifying potential areas for improvement or confirming the effectiveness of treatments, peer reviews play a crucial role in enhancing patient safety and outcomes. This systematic evaluation can lead to modifications in practice that improve the quality of care delivered and can also provide insights into whether the care aligns with the guidelines set by insurance providers. In contrast, the other options focus on different aspects of the administrative or regulatory side of health insurance. Assessing insurance claims for errors relates more to the processing and approval of claims rather than direct quality assessment. Ensuring compliance with state insurance regulations pertains to the legal and operational standards that insurance companies must follow. Verifying patient eligibility for coverage is crucial for enrollment and claims processing but does not address the quality of medical care itself. Thus, choosing the evaluation of medical care decisions aligns with the primary

5. What is the purpose of a summary of benefits and coverage (SBC)?

- A. To provide detailed legal terms of an insurance plan
- B. To furnish clear, concise information about coverage offered by a health plan**
- C. To outline the financial history of an insurance company
- D. To specify medical procedures covered by the policy

The purpose of a summary of benefits and coverage (SBC) is to furnish clear and concise information about the coverage offered by a health plan. The SBC is designed to help consumers understand their health insurance policies by providing an overview of key features, including what services are covered, the limits of coverage, and any costs that may be associated, such as premiums, deductibles, and co-payments. This clarity enables individuals to make informed decisions when selecting a health insurance plan that meets their needs. The other options do not accurately represent the primary function of the SBC. While detailed legal terms, financial history, and specific medical procedures may be important in the broader context of health insurance, they do not encapsulate the main purpose of the SBC, which is to provide a straightforward summary of coverage details for consumers.

6. What is an essential factor in determining the premiums of an insurance policy?

- A. The insurance company's total income
- B. The age and health status of the policyholder**
- C. The geographic location of the insurance provider
- D. The number of claims processed by the insurer

The age and health status of the policyholder are critical factors in determining the premiums of an insurance policy because they directly influence the insurer's assessment of risk. Insurance companies use actuarial tables and statistical data to estimate the likelihood of claims based on these characteristics. Younger individuals typically have lower health risks compared to older individuals, which can result in lower premiums. Similarly, if a policyholder has pre-existing conditions or other health issues, this can significantly increase the risk profile and thus the premium. By evaluating these personal factors, insurers can set premiums that align with the anticipated healthcare costs associated with that individual. This approach ensures that the premiums are adequately reflective of the risk posed by each policyholder, allowing the insurer to maintain financial stability while providing coverage.

7. Supplemental Insurance is used for which of the following?

- A. Covers standard medical procedures
- B. Covers services not normally covered by a primary plan**
- C. Provides a cash payout for hospitalization
- D. Offers free preventive care services

Supplemental insurance is designed to fill in gaps left by a primary insurance policy. It provides coverage for services and expenses that are not typically covered, or are partially covered, by a primary health insurance plan. This can include services such as dental care, vision care, or certain critical illness coverages, which may not be included in standard health plans. While some supplemental plans can provide cash payouts for specific events, like hospitalization, this is not their primary purpose. The focus of supplemental insurance is more about enhancing coverage for services that lead to out-of-pocket expenses or that are outside of the standard offering of health insurance. Free preventive care services are generally covered by many primary health plans as part of preventive care benefits, so they don't fall under supplemental coverage. Therefore, the choice that accurately describes the purpose of supplemental insurance is the one that details its role in covering services not normally covered by a primary plan.

8. What is Medicare primarily designed for?

- A. Individuals under 30
- B. Individuals over 65 years old**
- C. Those with chronic illnesses
- D. Low-income families

Medicare is primarily designed for individuals over 65 years old, making it the most appropriate choice for this question. It serves as a federal health insurance program aimed at providing access to medical care for older adults, which is critical as they often face increased health issues and require various medical services that can be costly. While there are certain segments of the population that Medicare assists, such as younger individuals with disabilities or individuals with specific medical conditions, the cornerstone of Medicare's design is to cater to seniors. This age group represents the largest demographic eligible for the program. Medicare encompasses various parts that tackle different aspects of healthcare, including hospital insurance (Part A) and medical insurance (Part B), providing comprehensive coverage for its enrollees. Understanding the primary design and target demographic of Medicare is crucial for navigating the complexities of health insurance and the services available to older adults.

9. What percentage of healthcare costs does Medicare cover?

- A. 50%
- B. 70%
- C. 80%**
- D. 90%

Medicare is a federal health insurance program primarily designed for individuals aged 65 and older, but it also covers certain younger individuals with disabilities and specific diseases. One of the critical features of Medicare, particularly in relation to Part B (which covers outpatient services), is that it typically covers approximately 80% of allowed charges for covered services after the annual deductible is met. This means that beneficiaries are responsible for the remaining 20%, which they may cover through supplemental insurance or out-of-pocket. Knowing that Medicare's coverage is fundamentally structured around this 80% rule allows individuals to better understand their financial responsibilities when utilizing these services. This percentage is foundational in calculating the costs that beneficiaries will incur, as well as in planning for potential out-of-pocket expenses in conjunction with Medicare coverage. Beyond this, the program is designed to help alleviate the financial burden of healthcare, aligning closely with its goal of promoting access to necessary medical services among the elderly and eligible disabled population.

10. Which of the following best describes Assignment of Benefits?

- A. Insurance claims are sent directly to the patient
- B. Reimbursement is sent directly from the payer to the provider**
- C. Patients must pay upfront for services rendered
- D. Payers have the right to audit claims before payment

Assignment of Benefits is a process where patients authorize their health insurance provider to pay benefits directly to the healthcare provider or facility for services rendered. This means that once patients receive care, the insurance company bypasses the patient and sends the reimbursement directly to the provider. This method simplifies the claims process for patients since they do not have to file claims themselves or wait to be reimbursed after initially paying out of pocket. This arrangement also helps healthcare providers maintain cash flow, as they receive their payment directly from the insurer rather than relying on the patient to pay first and then seek reimbursement. The patient's signature on an Assignment of Benefits form is essential because it establishes the patient's permission for their insurance to make payments directly to the medical service provider. The other options do not accurately describe Assignment of Benefits. For example, having insurance claims sent directly to the patient would mean that the patient has to manage the claim submission themselves, which is contrary to the essence of Assignment of Benefits. Paying upfront for services rendered indicates a traditional transaction where the patient pays before receiving any reimbursement from their insurance, which is also not aligned with the concept of Assignment of Benefits. Lastly, while insurers do have the right to audit claims before payment, this is a standard practice in insurance and does not pertain

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://medicalinsurance.examzify.com>

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

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