

MONTANA HEALTH 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. Who determines the eligibility and contribution limits of a Health Reimbursement Arrangement (HRA)?**
 - A. Insurance regulators
 - B. Policyholders
 - C. Employers
 - D. Employees
- 2. Group disability policies are required to provide well child care coverage until what age?**
 - A. 5
 - B. 6
 - C. 7
 - D. 8
- 3. What might happen if an individual exceeds their flexible spending account limit?**
 - A. They will lose all funds
 - B. They may roll over excess to the next year
 - C. They cannot claim expenses beyond the limit
 - D. They will be subject to penalties
- 4. Under the partially contributory group disability plan, how is the taxable portion of monthly benefits determined?**
 - A. Based on the insured's age
 - B. Calculated from the proportion of premium paid
 - C. Fixed amount for all insureds
 - D. Based solely on the insured's income
- 5. For how long must administrators keep records of all insurance transactions?**
 - A. 3 years
 - B. 5 years
 - C. 7 years
 - D. Indefinitely

- 6. How many hours of continuing education in ethics are required every licensing period for insurers?**
- A. 1 hour
 - B. 3 hours
 - C. 5 hours
 - D. 10 hours
- 7. Which of the following is typically not covered by an HMO?**
- A. Routine check-ups
 - B. Emergency services outside the network
 - C. Preventive health services
 - D. Hospitalization for serious illness
- 8. What does the term "rebating" refer to in insurance practices?**
- A. Offering lower premiums than competitors
 - B. Offering incentives not mentioned in the policy
 - C. Providing refunds at the end of the year
 - D. Allowing policyholders to choose their insurers
- 9. Why are the basic types of coverage (medical, surgical, hospital) referred to as first dollar coverage?**
- A. They do not require prior authorization
 - B. They usually do not require deductibles
 - C. They cover preventive services only
 - D. They have no limits on coverage
- 10. What is the primary purpose of a hospital indemnity policy?**
- A. To cover long-term hospital stays only
 - B. To provide daily cash benefits during hospitalization
 - C. To reimburse for outpatient visits
 - D. To offer discounts on hospital services

Answers

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

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Explanations

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1. Who determines the eligibility and contribution limits of a Health Reimbursement Arrangement (HRA)?

- A. Insurance regulators
- B. Policyholders
- C. Employers**
- D. Employees

The determination of eligibility and contribution limits for a Health Reimbursement Arrangement (HRA) is primarily the responsibility of employers. HRAs are employer-funded health benefit plans that reimburse employees for incurred medical expenses and, unlike health savings accounts (HSAs), the contributions to an HRA are entirely funded by the employer. Employers have the discretion to decide which employees are eligible to participate in the HRA program, meaning they can set criteria such as employment status or length of service. Additionally, employers can determine how much they will contribute to the HRA, establishing limits on reimbursements based on their budget and policy objectives. This employer control over HRAs is a fundamental aspect of how these arrangements are designed and implemented, reflecting the employer's role in offering health benefits to their employees. In contrast, while policyholders, insurance regulators, and employees may have roles or interests in health benefits, it is the employer that ultimately has the authority to define the terms of the HRA.

2. Group disability policies are required to provide well child care coverage until what age?

- A. 5
- B. 6
- C. 7**
- D. 8

Group disability policies in Montana typically follow certain guidelines regarding coverage for children. The requirement to provide well-child care is designed to support the health and development of children during their formative years. In Montana, the law specifies that well-child care coverage must continue until the child reaches the age of seven. This coverage is important because it ensures that children receive regular check-ups, vaccinations, and screenings that are crucial for early detection of health issues and for supporting overall growth and development. By mandating coverage up to this age, the policy aims to promote preventive care and to help parents access essential health services for their children. The emphasis on this particular age limit reflects an understanding of childhood developmental stages and the importance of health maintenance during these critical early years, thereby contributing to better health outcomes as children grow.

3. What might happen if an individual exceeds their flexible spending account limit?

- A. They will lose all funds
- B. They may roll over excess to the next year
- C. They cannot claim expenses beyond the limit**
- D. They will be subject to penalties

When an individual exceeds their flexible spending account (FSA) limit, the primary consequence is that they cannot claim expenses beyond that limit. FSAs are designed with specific contribution limits set by the IRS, and any amount spent over that limit will not be reimbursed. This means it is essential for participants to plan their contributions carefully based on anticipated medical expenses, as any excess claims will simply be ineligible. Additionally, while some other options suggest potential outcomes such as rolling over excess funds or facing penalties, these scenarios do not accurately reflect the functioning of FSAs in relation to exceeding the claim limit. In essence, the primary restriction with an FSA is tied to the actual amount that can be claimed, and exceeding that limit means that those additional expenses will not be reimbursed at all.

4. Under the partially contributory group disability plan, how is the taxable portion of monthly benefits determined?

- A. Based on the insured's age
- B. Calculated from the proportion of premium paid**
- C. Fixed amount for all insureds
- D. Based solely on the insured's income

In a partially contributory group disability plan, the taxable portion of monthly benefits is determined based on the proportion of premium paid by the employer and the employee. This relationship reflects how much of the premium costs are covered by each party, which in turn affects the tax implications of the benefits received. When an employee contributes to the premium, the benefits they receive may be partially taxable since they have effectively paid for part of the coverage. On the other hand, if the employer covers the entirety of the premium, the benefits are typically fully taxable because the employee did not contribute. Hence, calculating the taxable amount based on the proportion of premium paid provides a clear and direct method for determining tax liability. This approach ties directly to how premiums are managed in partially contributory plans, where both employer and employee share the costs. By contrasting this with the other options, it is evident that fixed amounts, age, or solely relying on income do not account for the dynamics of premium contributions and their tax treatment accurately.

5. For how long must administrators keep records of all insurance transactions?

- A. 3 years
- B. 5 years**
- C. 7 years
- D. Indefinitely

The correct answer reflects the industry standard in Montana, where insurance administrators are required to maintain records of all insurance transactions for a period of five years. This duration serves several important purposes. Firstly, it allows for the thorough auditing of transactions, ensuring compliance with regulations and providing a clear paper trail if any disputes arise. Furthermore, retaining these records for five years aligns with many legal and regulatory requirements, striking a balance between operational efficiency and the need for accountability. Keeping records for this period also aids in protecting both consumers and insurers, ensuring that necessary information is available for claims processing or any regulatory inquiries that may take place within that timeframe. While some organizations might retain records for longer, the mandated period emphasizes the need for due diligence while also acknowledging that records older than five years may not be as pertinent for everyday business operations.

6. How many hours of continuing education in ethics are required every licensing period for insurers?

- A. 1 hour
- B. 3 hours**
- C. 5 hours
- D. 10 hours

The requirement for insurers to complete a specific number of hours of continuing education in ethics during each licensing period is established to ensure that licensed professionals maintain a solid understanding of ethical standards and practices within the insurance industry. In Montana, the mandate is set at three hours of continuing education in ethics. This requirement underscores the importance of ethical conduct in insurance, as it encourages agents and insurers to stay updated on ethical guidelines, make informed decisions, and adhere to regulations that protect consumers. By allocating three hours specifically for this purpose, the state aims to reinforce the significance of ethical practice in maintaining public trust and enhancing the professionalism of the insurance sector. Understanding this requirement is crucial for insurance professionals, as fulfilling continuing education requirements ensures compliance with state laws and ongoing competency in the field.

7. Which of the following is typically not covered by an HMO?

- A. Routine check-ups
- B. Emergency services outside the network**
- C. Preventive health services
- D. Hospitalization for serious illness

Health Maintenance Organizations (HMOs) typically have a structured set of benefits that encourage preventive care and focus on wellness. Most preventive health services, routine check-ups, and hospitalizations due to serious illness are usually covered under HMO plans, as these services align with their goal of maintaining members' health and managing costs through a network of providers. However, emergency services outside the network often fall outside of what HMOs will cover. HMOs usually require members to seek care from a specific network of providers and may only cover emergency services if they occur within that network, or only under certain circumstances even if outside the network. This makes coverage for emergency services outside of their designated facilities less likely, requiring members to be mindful of the providers they use in emergency situations to avoid significant out-of-pocket expenses.

8. What does the term "rebating" refer to in insurance practices?

- A. Offering lower premiums than competitors
- B. Offering incentives not mentioned in the policy**
- C. Providing refunds at the end of the year
- D. Allowing policyholders to choose their insurers

The term "rebating" in insurance practices specifically refers to offering incentives that are not explicitly mentioned in the insurance policy itself. This can take various forms, such as providing gifts, discounts, or other benefits to potential clients as a way to entice them to purchase insurance coverage. Rebating is often viewed unfavorably within the industry and may be regulated or prohibited in certain jurisdictions because it can lead to unfair competition and could mislead consumers regarding the value of the insurance being offered. While offering lower premiums than competitors might seem related to providing a better deal, it does not fall under the definition of rebating since it pertains to competition based on price rather than incentives outside the policy terms. Providing refunds at the end of the year may happen as part of various health insurance plans or loyalty programs, but again, this is not a factor of rebating, as it does not involve incentives offered during the sale of insurance. Allowing policyholders to choose their insurers pertains to consumer choice and access within health insurance markets, which is unrelated to the concept of rebating. Thus, the correct understanding is that rebating involves non-policy incentives offered to attract customers, as defined in answer B.

9. Why are the basic types of coverage (medical, surgical, hospital) referred to as first dollar coverage?

- A. They do not require prior authorization
- B. They usually do not require deductibles**
- C. They cover preventive services only
- D. They have no limits on coverage

The term "first dollar coverage" indicates that the insurance benefits begin to pay from the first dollar of covered expenses without the insured having to meet a deductible. This type of coverage is appealing because it provides immediate financial assistance as soon as a medical service is utilized. In the context of basic types of coverage like medical, surgical, and hospital insurance, the absence of a deductible means that insured individuals can access care without having to pay out of pocket up to a certain threshold. This contrasts with other coverage types that may require a deductible before benefits kick in, which can delay access to necessary services and create a financial burden at the outset. First dollar coverage is particularly beneficial in situations where immediate care is essential, as it eliminates the need for upfront costs, ensuring that individuals can seek treatment without financial hesitation.

10. What is the primary purpose of a hospital indemnity policy?

- A. To cover long-term hospital stays only
- B. To provide daily cash benefits during hospitalization**
- C. To reimburse for outpatient visits
- D. To offer discounts on hospital services

The primary purpose of a hospital indemnity policy is to provide daily cash benefits during hospitalization. This type of insurance is designed to help policyholders cover out-of-pocket expenses that may not be fully addressed by their primary health insurance plan. Hospital indemnity policies typically pay a set amount for each day that the insured is hospitalized. This cash benefit can be used at the policyholder's discretion and can help cover costs such as copayments, deductibles, or additional expenses like transportation or non-medical bills that may arise due to the hospitalization. By offering these daily cash benefits, the policy alleviates some financial pressure during a potentially stressful time, making it easier for insured individuals to manage their finances while focusing on recovery.

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://mthealthinsurance.examzify.com>

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

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