

MONTANA HEALTH INSURANCE PRACTICE EXAM (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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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. If an employee is enrolled in a noncontributory group disability income plan with a 30-day elimination period and suffers a covered disability lasting 7 months, how much will they receive?**
 - A. \$12,000 all taxable
 - B. \$12,000 partially taxable
 - C. \$14,000 tax-free
 - D. \$10,000 all tax-free
- 2. What is the unlawful practice of offering inducements to the insured that are not specified in the insurance policy called?**
 - A. Kickback
 - B. Rebating
 - C. Premium discounting
 - D. Coercive selling
- 3. What is the name of the section in a health policy that outlines the causes of eligible loss under which an insured is considered disabled?**
 - A. Insuring clause
 - B. Exclusion clause
 - C. Coverage statement
 - D. Benefit provision
- 4. What is the initial waiting period specified in a disability income policy before a loss can be covered?**
 - A. Elimination period
 - B. Probationary period
 - C. Waiting period
 - D. Grace period
- 5. Which of the following elements does not directly influence health insurance premiums?**
 - A. Claims history of the insured
 - B. Coverage type selected
 - C. Number of dependents
 - D. Education level of the insured

- 6. In relation to disability income policies, what is the relationship between waiting periods and premiums?**
- A. Shorter waiting period equals lower premium
 - B. Shorter waiting period equals higher premium
 - C. Longer waiting period equals higher premium
 - D. Waiting period does not affect premium costs
- 7. On what basis are benefits for individual disability insurance typically determined?**
- A. Flat amount
 - B. Hourly wages
 - C. Percentage of income
 - D. Standard salary
- 8. Group disability policies are required to provide well child care coverage until what age?**
- A. 5
 - B. 6
 - C. 7
 - D. 8
- 9. What is the main objective of underwriting in health insurance?**
- A. To set premiums based on demographic factors
 - B. To determine the risk of insuring an individual
 - C. To evaluate medical claims
 - D. To provide customer service
- 10. What type of contract does not allow negotiations and is prepared solely by the insurer?**
- A. Variable contract
 - B. Unilateral contract
 - C. Adhesion contract
 - D. Bilateral contract

Answers

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

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Explanations

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1. If an employee is enrolled in a noncontributory group disability income plan with a 30-day elimination period and suffers a covered disability lasting 7 months, how much will they receive?

A. \$12,000 all taxable

B. \$12,000 partially taxable

C. \$14,000 tax-free

D. \$10,000 all tax-free

In a noncontributory group disability income plan, the employer typically pays the entire premium without requiring contributions from employees. This means that any benefits paid out under such a plan are generally considered taxable income. Given a 30-day elimination period, the employee would begin receiving benefits after this period has passed. If the employee suffers a disability lasting 7 months, the benefit payout would cover the duration post-elimination period. Assuming the monthly benefit amount totals \$2,000, over 7 months, the total benefit amount would be \$14,000. However, because the premiums are paid solely by the employer in a noncontributory plan, the entire benefit amount of \$14,000 would be subject to income tax. Therefore, the employee would receive the total benefit of \$14,000 as taxable income. The correct answer reflects this understanding that, under a noncontributory plan, all benefits received by the employee will be taxed. It's important to be aware that any scenario leading to a figure such as \$10,000 or partially taxable amounts would not apply here, as they do not align with the nature of noncontributory plans or the total benefit calculation based on duration of the disability.

2. What is the unlawful practice of offering inducements to the insured that are not specified in the insurance policy called?

A. Kickback

B. Rebating

C. Premium discounting

D. Coercive selling

The practice of offering inducements to the insured that are not specified in the insurance policy is referred to as rebating. This involves providing something of value to the policyholder, such as cash, gifts, or other benefits, in order to entice them to purchase or retain an insurance policy. Such practices are deemed illegal in many jurisdictions, including Montana, because they can undermine the fairness and integrity of the insurance marketplace. By offering inducements that are not outlined in the policy, it creates an uneven playing field among insurers and could lead to consumers making decisions based on incentives rather than the quality of coverage or price. Rebating is closely monitored and regulated to protect consumers and maintain the professionalism of the insurance industry. This prevention of unlawful inducements ensures that consumers make informed decisions based on the actual terms of the insurance policies they are considering, rather than being influenced by outside incentives.

3. What is the name of the section in a health policy that outlines the causes of eligible loss under which an insured is considered disabled?

- A. Insuring clause**
- B. Exclusion clause
- C. Coverage statement
- D. Benefit provision

The section in a health policy that outlines the causes of eligible loss under which an insured is considered disabled is known as the insuring clause. This clause is crucial because it establishes the conditions under which the insurer agrees to provide coverage and the specific terms of the insurance contract. It details the scope of coverage, including what constitutes a disability and the types of incidents that will be covered, which directly ties to the insured's eligibility for benefits. By clearly defining these terms, the insuring clause helps both the insurer and the insured understand the boundaries of the policy. This section plays a critical role in determining the rights and responsibilities of both parties, establishing a fundamental understanding of what scenarios will lead to a claim for disability benefits. Other options do not play the same role: the exclusion clause generally lists what is not covered or situations that would negate the policy, while coverage statements and benefit provisions describe the benefits provided but do not specify the conditions of disability eligibility like the insuring clause does.

4. What is the initial waiting period specified in a disability income policy before a loss can be covered?

- A. Elimination period
- B. Probationary period**
- C. Waiting period
- D. Grace period

The initial waiting period specified in a disability income policy before a loss can be covered is commonly referred to as the probationary period. This period is set by the insurer and denotes a specific timeframe following the policy's start date in which no claims will be paid for disabilities that occur. Essentially, the purpose of the probationary period is to protect the insurer from individuals who might purchase a policy and immediately file claims for pre-existing conditions or injuries. During the probationary period, if a policyholder experiences a disability, benefits will not be provided. After this initial waiting period has passed, the policy will cover any eligible disabilities that occur thereafter, allowing the policyholder to access the benefits for which they have paid premiums. This structure helps to ensure that policies are utilized fairly and that the risks to the insurer are minimized at the outset of the coverage. The elimination period, on the other hand, typically refers to a separate waiting period that follows a disability claim, during which no benefits are paid until the policyholder has been disabled for a specified period. Other terms mentioned, such as waiting period and grace period, relate to different aspects of insurance policies, further emphasizing the specific nature of the probationary period in relation to initial claim eligibility.

5. Which of the following elements does not directly influence health insurance premiums?

- A. Claims history of the insured
- B. Coverage type selected
- C. Number of dependents
- D. Education level of the insured**

The education level of the insured does not directly influence health insurance premiums because insurance companies typically base premiums on factors that are related to the risk of healthcare costs. The other options represent critical factors that insurers evaluate when determining policy rates. Claims history of the insured is a significant element, as it reflects past usage of healthcare services and indicates how likely the insured is to make claims in the future. A history of frequent or costly claims can lead to higher premiums because it suggests increased risk. The type of coverage selected also plays a vital role in premium calculations. Different plans come with various levels of benefits, cost-sharing structures, and coverage limits, which can significantly affect the overall cost of the premium. Similarly, the number of dependents is an important determinant when assessing premiums. More dependents typically lead to higher premiums since there is an increased likelihood of claims due to additional healthcare needs among family members. In contrast, while education may have some indirect effects on health (such as income level or access to preventative care), it is not a direct factor considered in the actuarial calculations for health insurance premiums. Insurance companies focus on concrete, measurable factors that demonstrate risk and potential costs associated with the insured.

6. In relation to disability income policies, what is the relationship between waiting periods and premiums?

- A. Shorter waiting period equals lower premium
- B. Shorter waiting period equals higher premium**
- C. Longer waiting period equals higher premium
- D. Waiting period does not affect premium costs

Disability income policies typically have a waiting period, also known as an elimination period, before benefits start being paid. The duration of this waiting period is directly related to the premium cost of the policy. When an insured chooses a shorter waiting period, they will usually encounter higher premiums. This is because the insurer is taking on additional risk by having to pay benefits sooner if the policyholder becomes disabled. Since the insurer may need to cover costs for a longer period of time with a shorter waiting period, they charge a higher premium to compensate for that risk. Conversely, opting for a longer waiting period generally results in lower premium costs. In this scenario, the policyholder assumes more risk by waiting longer for benefits to kick in, which decreases the insurer's financial exposure and thus, allows them to lower the premium. Therefore, the connection between waiting periods and premiums is a critical aspect of how disability income policies are structured, influencing both coverage options and affordability for consumers.

7. On what basis are benefits for individual disability insurance typically determined?

- A. Flat amount**
- B. Hourly wages
- C. Percentage of income
- D. Standard salary

In the context of individual disability insurance, benefits are typically determined based on a percentage of an individual's income, rather than a flat amount, hourly wages, or standard salary. The purpose of disability insurance is to replace lost income due to a disabling condition, making the percentage of income a critical factor. This approach ensures that the benefits align with the insured individual's financial needs and lifestyle, reflecting their earnings capacity prior to the disability. A benefit structure based on a flat amount would not take into account the varying earning levels individuals may have, leading to inequities in coverage. Also, determining benefits based on hourly wages would not accurately reflect the full income picture for those who may earn a salary or have income that includes additional compensation beyond hourly rates. Similarly, basing benefits on a standard salary could overlook the actual income that an individual earns which may differ significantly based on various factors such as bonuses, commissions, or overtime. Thus, the correct basis for determining benefits under individual disability insurance is a percentage of income, which effectively provides a safety net proportional to the financial situation of the insured.

8. 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.

9. What is the main objective of underwriting in health insurance?

- A. To set premiums based on demographic factors
- B. To determine the risk of insuring an individual**
- C. To evaluate medical claims
- D. To provide customer service

The main objective of underwriting in health insurance is to determine the risk of insuring an individual. Underwriting involves evaluating the health status, medical history, lifestyle choices, and other relevant factors that can affect an individual's health and potential claims. This assessment allows insurance companies to decide whether to accept or decline an application for coverage and to set appropriate premiums based on the calculated risk associated with insuring that individual. By thoroughly analyzing these factors, insurers can predict the likelihood of future claims and manage their financial exposure effectively. An accurate underwriting process is vital for maintaining the sustainability of the insurance pool, as it helps ensure that the premiums collected will cover the expected claims and administrative costs. While setting premiums based on demographic factors might be a component of the wider underwriting process, the primary focus remains on the individual risk assessment. Evaluating medical claims and providing customer service are important functions of an insurance company but are not directly tied to the underwriting process.

10. What type of contract does not allow negotiations and is prepared solely by the insurer?

- A. Variable contract
- B. Unilateral contract
- C. Adhesion contract**
- D. Bilateral contract

An adhesion contract is a type of agreement where one party, typically the insurer, writes the terms and conditions without any negotiation from the other party, usually the insured. In this scenario, the insured must accept the contract as-is, meaning they cannot alter the stipulations of the policy. This characteristic inherently creates a power imbalance because the insurer dictates the terms. This concept is especially relevant in the context of insurance, as policyholders often receive pre-drafted contracts that they have little to no power to negotiate. The insurer's role is to create a standardized contract that outlines the coverage, limitations, and obligations without input from the consumer. Thus, the correct answer accurately reflects the nature of the relationship between insurers and insureds in such contracts, highlighting the non-negotiable aspect inherent in adhesion contracts.

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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