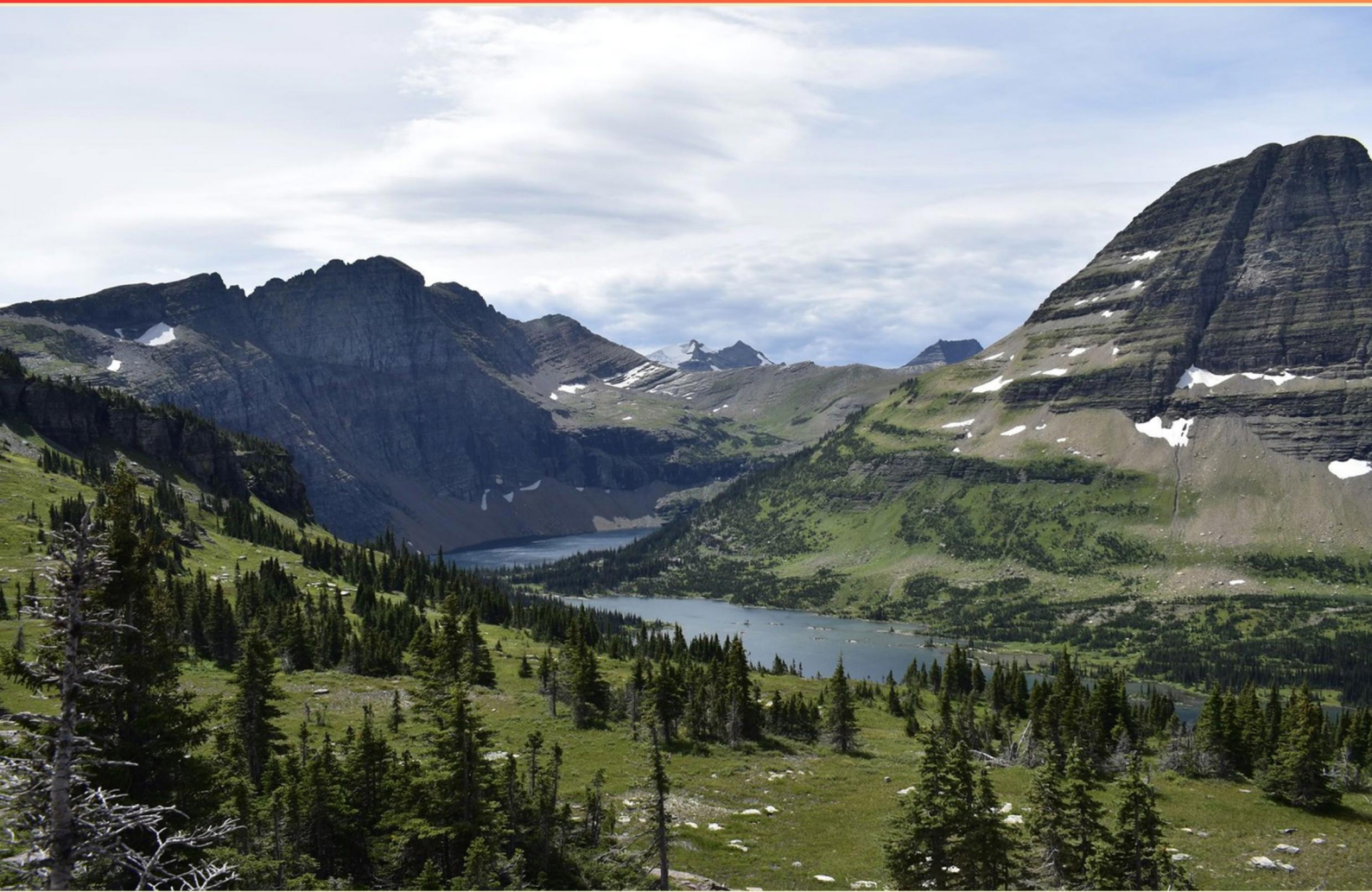


MONTANA HEALTH INSURANCE PRACTICE EXAM (SAMPLE)

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. Under which organization type are practicing providers compensated on a fee-for-service basis?**
 - A. HMO
 - B. PPO
 - C. POS
 - D. Exclusive Provider Organization
- 2. What type of organization is established primarily for the purpose of offering prepaid hospital care and other health services?**
 - A. Insurance company
 - B. Health maintenance organization
 - C. Health service organization
 - D. Preferred provider organization
- 3. What is the legal process that gives an insurer the right to seek recovery from a third party after paying a loss?**
 - A. Litigation
 - B. Subrogation
 - C. Reimbursement
 - D. Indemnification
- 4. 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
- 5. The type of dental plan which is incorporated into a major medical expense plan is called?**
 - A. Standalone dental plan
 - B. Integrated dental plan
 - C. Network dental plan
 - D. Capitation dental plan

- 6. If an employee reduces his working hours, what happens to his group health insurance coverage?**
- A. It remains unchanged
 - B. It becomes more comprehensive
 - C. It is automatically canceled
 - D. He can convert it to an individual policy without proof of insurability
- 7. 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
- 8. What must an insurer provide to an insured when a claim for benefits is denied?**
- A. A written explanation
 - B. A verbal communication
 - C. A refund of premiums
 - D. An option to appeal
- 9. The gatekeeper of an HMO helps to:**
- A. Manage hospital admissions
 - B. Control specialist costs
 - C. Reduce insurance premiums
 - D. Enhance patient satisfaction
- 10. What is true if a 65-year-old HSA holder uses funds for a non-health expense?**
- A. There will be a penalty fee
 - B. There will be tax
 - C. Funds will be lost
 - D. No tax implications

Answers

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

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Explanations

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1. Under which organization type are practicing providers compensated on a fee-for-service basis?

- A. HMO
- B. PPO**
- C. POS
- D. Exclusive Provider Organization

Practicing providers in a Preferred Provider Organization (PPO) are compensated on a fee-for-service basis, which means that they get paid for each service they provide to patients. This payment structure allows providers flexibility in the services they offer, as they are reimbursed individually for each procedure, consultation, or treatment rendered to a patient. In this model, patients typically have the option to see any healthcare provider, but they tend to pay lower out-of-pocket costs when using a provider within the PPO's network. The fee-for-service approach can incentivize providers to deliver more services since their earnings are based on the volume of care they provide, rather than a fixed salary or a capitation arrangement. This distinguishes PPOs from other organizational types such as Health Maintenance Organizations (HMOs) and Exclusive Provider Organizations (EPOs), which often emphasize a more managed care approach with fixed fees or capitation models. Additionally, Point of Service (POS) plans incorporate features of both HMOs and PPOs, but they too typically discourage fee-for-service compensation as their focus is on coordinated care through network providers.

2. What type of organization is established primarily for the purpose of offering prepaid hospital care and other health services?

- A. Insurance company
- B. Health maintenance organization
- C. Health service organization**
- D. Preferred provider organization

The correct answer is a health maintenance organization (HMO). A health maintenance organization is specifically designed to provide comprehensive health services through a network of providers in exchange for a fixed prepaid fee. This model emphasizes preventive care and the management of health services to improve patient outcomes while controlling costs. HMOs typically require members to choose a primary care physician who will be their point of contact for all health needs, coordinating referrals to specialists and other services as necessary. This approach fosters a more managed and systematic method of healthcare delivery, which is focused on maintaining and improving health rather than solely treating illness after it occurs. While other types of organizations, such as insurance companies or preferred provider organizations (PPOs), may also provide health services, they do not operate under the same prepaid model that characterizes HMOs. Insurance companies generally focus more on risk management and providing coverage in exchange for premiums, whereas PPOs offer more flexibility in provider choice but do not emphasize the same level of coordinated care or preventive services. Health service organizations may provide specific services but do not inherently involve the prepaid model that is fundamental to HMOs.

3. What is the legal process that gives an insurer the right to seek recovery from a third party after paying a loss?

- A. Litigation
- B. Subrogation**
- C. Reimbursement
- D. Indemnification

The legal process that grants an insurer the right to seek recovery from a third party after paying a loss is known as subrogation. This principle allows the insurance company to step into the shoes of the policyholder after it has compensated them for their loss and pursue any responsible third parties to recover the amounts paid. For instance, if an insured party is involved in an accident caused by another driver, the insurer may pay the damages to the insured. Following this payment, the insurer can then seek to recover those costs from the at-fault driver or their insurance company through subrogation. This process not only helps mitigate the losses for the insurer but also upholds the principle of the policyholder being compensated for their loss while ensuring that the responsible party ultimately bears the financial burden. In contrast, litigation refers to the process of taking legal action in court, which may occur during the subrogation process but does not specifically define the right to recover that arises after a payment. Reimbursement typically involves the return of premiums or other payments made by the policyholder, while indemnification refers to compensating someone for harm or loss, particularly in relation to insurance coverage but does not inherently involve seeking recovery from third parties. These distinctions clarify why subrogation is

4. 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.

5. The type of dental plan which is incorporated into a major medical expense plan is called?

- A. Standalone dental plan
- B. Integrated dental plan**
- C. Network dental plan
- D. Capitation dental plan

An integrated dental plan is a type of dental insurance that is included as a component of a major medical expense plan. This means that dental coverage is provided alongside other health benefits within a single policy, streamlining the insurance experience for the policyholder. Integrated plans allow for coordinated care, where the management of both medical and dental health can occur seamlessly, often leading to better health outcomes and reduced administrative burdens for both providers and patients. This approach to benefits can provide convenience for members, as they typically deal with one insurance carrier for various health needs—including dental care—eliminating the need for separate policies and paperwork. Furthermore, integrated dental benefits typically encourage preventive care by covering routine check-ups and services, which are crucial for maintaining overall health. Other types of plans, such as standalone or network dental plans, operate independently from major medical coverage. Standalone plans require separate enrollment and management, while network plans depend heavily on the availability of a network of providers. Capitation plans involve paying providers a set amount for patient care, which may or may not focus on integration with broader medical coverage. Each of these alternatives holds its place in the insurance landscape, but the integrated approach aligns dental benefits more closely with overall medical expenses, enhancing both convenience and coordination.

6. If an employee reduces his working hours, what happens to his group health insurance coverage?

- A. It remains unchanged
- B. It becomes more comprehensive
- C. It is automatically canceled
- D. He can convert it to an individual policy without proof of insurability**

When an employee reduces their working hours, there may be implications for their group health insurance coverage, but in many cases, the employee has the option to convert their group policy to an individual policy without having to provide proof of insurability. This means they can maintain their health coverage even if they are no longer eligible for the group plan due to a reduction in work hours. This conversion option is a protective measure that ensures individuals aren't left without coverage during transitions in employment status or hours worked. The ability to convert to an individual policy typically comes with certain conditions, such as the requirement that the individual has been covered under the group plan for a specific period before the reduction in hours. This provision is particularly significant in the context of health insurance, as it provides a safety net for employees who might otherwise face challenges obtaining coverage, especially if they have existing health conditions. In contrast, the other options do not accurately reflect the scenario. For example, remaining unchanged or becoming more comprehensive would not apply because changes in working hours typically affect eligibility for group coverage. Automatic cancellation, on the other hand, might happen in certain circumstances when an employee completely leaves the job, but a mere reduction of hours usually offers options for continuation, like the conversion to an individual policy.

7. 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.

8. What must an insurer provide to an insured when a claim for benefits is denied?

- A. A written explanation**
- B. A verbal communication
- C. A refund of premiums
- D. An option to appeal

An insurer is required to provide a written explanation when a claim for benefits is denied. This written documentation is crucial as it serves multiple purposes: it informs the insured of the specific reasons for the denial, allows the insured to understand the decision-making process, and provides a record that can be referenced in the future. It's essential for transparency and ensuring that the insured has a clear understanding of the insurance policy's terms and conditions, as well as the grounds for the denial. By having this written explanation, the insured can better assess their options, including any potential disputes or appeals they might wish to pursue in regard to the denial. In the context of the other choices, verbal communication does not provide the same level of clarity and permanence that a written explanation does. A refund of premiums is not typically associated with a claim denial; it's more relevant in situations where a policy is canceled. An option to appeal, while important, would usually follow after the insured has received a detailed, written explanation of the denial, as they need to understand the reasoning first to effectively argue against it.

9. The gatekeeper of an HMO helps to:

- A. Manage hospital admissions
- B. Control specialist costs**
- C. Reduce insurance premiums
- D. Enhance patient satisfaction

In a Health Maintenance Organization (HMO), the concept of a gatekeeper primarily revolves around a primary care physician (PCP) who manages the patient's healthcare journey. This PCP acts as a liaison between the patient and the healthcare system, which includes specialists, hospitals, and other healthcare services. The role of the gatekeeper is to ensure that patients receive appropriate care while controlling costs. By requiring patients to obtain referrals from the gatekeeper before seeing a specialist, the HMO is able to manage access to specialists effectively. This process not only helps control costs associated with unnecessary specialist visits but also encourages the use of the PCP for all initial healthcare needs, thus streamlining patient flow and managing expenses more effectively. This approach ultimately leads to cost savings for the HMO, which can be reflected in the premiums charged to members. However, the main function of the gatekeeper is centered around managing specialist costs, ensuring that patients only see specialists when it is deemed medically necessary, therefore preserving the financial health of the HMO and protecting its members from incurring high out-of-pocket expenses.

10. What is true if a 65-year-old HSA holder uses funds for a non-health expense?

- A. There will be a penalty fee
- B. There will be tax**
- C. Funds will be lost
- D. No tax implications

When a 65-year-old Health Savings Account (HSA) holder uses funds for a non-health expense, the correct assertion is that there will be tax implications associated with that withdrawal. Although HSA funds can be used tax-free for qualified medical expenses, using them for non-health-related expenses triggers a tax liability. At the age of 65, HSA holders have the advantage of not facing a penalty for non-qualified distributions, which is typically a 20% penalty for younger account holders. However, the amount withdrawn for non-health expenses is subject to ordinary income tax. This means that any funds taken out of the HSA for purposes other than qualified healthcare expenses will incur taxation at the individual's income tax rate. The other potential outcomes associated with this scenario are not applicable. There is no penalty for the withdrawal at the age of 65, the funds are not lost but rather become taxable income, and while there are no penalties, taxes do indeed apply. Thus, the focus is on the tax implications of the withdrawal.

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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