North Carolina Accident and Health Practice Exam (Sample)

Study Guide

Everything you need from our exam experts!

Questions

1. What is a "health audit" in a health insurance context?

- **A. A review of an insurance policy for renewal purposes**
- **B. A detailed examination of billing practices and health claims for accuracy**
- **C. A survey conducted to assess the public's health needs**
- **D. An investigation into health care facility compliance**

2. What is a medical care provider that typically delivers health services at its own local medical facility?

- **A. Insurance Company**
- **B. Health Maintenance Organization**
- **C. Preferred Provider Organization**
- **D. Independent Practice Association**

3. Which statement is true regarding a group accident and health policy issued to an employer?

- **A. The employer keeps the policy while employees receive nothing**
- **B. Each employee is issued a direct contract with the insurer**
- **C. The employer receives the policy and each employee is issued a certificate**
- **D. All employees share a single policy document**

4. Which type of insurance policy provides coverage that pays a set amount per day during hospitalization?

- **A. Major Medical**
- **B. Term Life**
- **C. Hospital Indemnity**
- **D. Disability Insurance**

5. How many months must approved premium rates for group health insurance be guaranteed by the insurer?

- **A. 6 months**
- **B. 12 months**
- **C. 18 months**
- **D. 24 months**

6. According to the Information and Privacy Protection Act, how many business days must an insurer provide personal information after an adverse underwriting decision?

A. 15

B. 30

C. 45

D. 60

7. When must a Group Health policy provide coverage for a newborn child?

A. Within the first week after birth

B. At the moment of birth

C. After the first month post-birth

D. When the child is added to the policy

8. How long is the standard waiting period for benefits to become available under a Probationary Period?

A. 30 days

B. 60 days

C. Dependent on the policy

D. 90 days

9. What does "explanation of benefits" (EOB) entail?

A. A document sent by insurers detailing what services were covered and how much was paid

B. A summary of denied claims and reasons for denial

C. A list of healthcare providers covered under a policy

D. A guide to understanding insurance policy language

10. When does a Probationary Period provision take effect in a health insurance contract?

A. After the first premium is paid

B. At the policy's inception

C. When a claim is filed

D. After the first year

Answers

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

Explanations

1. What is a "health audit" in a health insurance context?

A. A review of an insurance policy for renewal purposes

B. A detailed examination of billing practices and health claims for accuracy

C. A survey conducted to assess the public's health needs

D. An investigation into health care facility compliance

A health audit in the context of health insurance refers to a detailed examination of billing practices and health claims for accuracy. This process is crucial for ensuring that payments made to healthcare providers are justified and align with services rendered. It involves scrutinizing the claims submitted by healthcare providers to ensure they comply with regulations and policies and that they accurately reflect the care delivered to patients. Such audits are essential for identifying discrepancies, fraud, or billing errors that could lead to financial losses for insurers or unnecessary costs for policyholders. They also help to maintain the integrity of health insurance systems by promoting transparency and accountability in financial transactions related to healthcare. While other options may involve aspects of health insurance, they do not specifically encapsulate the core purpose of a health audit. Renewing an insurance policy, conducting surveys on public health needs, or investigating compliance of healthcare facilities focuses on different areas within the health insurance domain, rather than the specific detailed examination of billing and claims that a health audit entails.

2. What is a medical care provider that typically delivers health services at its own local medical facility?

A. Insurance Company

B. Health Maintenance Organization

C. Preferred Provider Organization

D. Independent Practice Association

A Health Maintenance Organization (HMO) is a type of managed care organization that provides health services primarily through its own network of healthcare providers and facilities. By emphasizing preventive care and providing a range of services at designated locations, an HMO ensures that members receive coordinated treatment. This model encourages members to choose healthcare providers from their network to receive comprehensive care, often at a lower cost, which is a hallmark of how HMOs operate. This answer aligns with the fundamental principles of HMOs, which are designed to enhance the efficiency and effectiveness of healthcare delivery by focusing on easy access to local medical facilities where various services, such as primary care and specialized treatments, are offered under one umbrella. Other options like insurance companies, preferred provider organizations (PPOs), and independent practice associations (IPAs) do not typically operate their own facilities or emphasize a local delivery model in the same way, making them less suitable answers to the question posed.

3. Which statement is true regarding a group accident and health policy issued to an employer?

A. The employer keeps the policy while employees receive nothing

B. Each employee is issued a direct contract with the insurer

C. The employer receives the policy and each employee is issued a certificate

D. All employees share a single policy document

The statement that the employer receives the policy and each employee is issued a certificate is accurate for group accident and health policies. In these policies, the employer typically holds the master policy, which outlines the coverage terms, benefits, and conditions of the insurance. Each employee covered under the plan receives a certificate of insurance, which serves as proof of coverage and details the benefits they are entitled to as part of the group policy. This structure allows the employer to manage the policy while still ensuring that employees have documentation of their individual coverage rights and benefits. The certificate simplifies communication about the policy's provisions without requiring every employee to hold a separate contract with the insurance provider. This setup also indicates collective risk management, as policies are designed for groups, typically resulting in better rates and coverage options compared to individual policies.

4. Which type of insurance policy provides coverage that pays a set amount per day during hospitalization?

A. Major Medical

B. Term Life

C. Hospital Indemnity

D. Disability Insurance

Hospital Indemnity insurance is designed specifically to provide a daily, fixed cash benefit for each day an insured individual is hospitalized. This type of policy serves as a supplemental insurance, helping cover extra expenses associated with hospitalization, such as out-of-pocket costs that traditional health insurance may not fully address, like copayments or deductibles. Unlike major medical insurance, which covers a wide range of healthcare services and usually pays based on the actual costs incurred, hospital indemnity provides a predetermined benefit amount regardless of the specific costs of hospitalization. This benefit provides a sense of financial security by ensuring the insured receives a confirmed benefit for each day of confinement in a hospital. The other types of insurance mentioned serve different purposes. For example, term life insurance provides a death benefit to beneficiaries and does not offer any hospitalization coverage. Major medical insurance is broader and covers comprehensive medical expenses, while disability insurance replaces lost income due to a disability but does not specifically offer daily benefits for hospital stays. Thus, hospital indemnity stands out as the suitable choice for coverage that pays a set amount per day during hospitalization.

5. How many months must approved premium rates for group health insurance be guaranteed by the insurer?

A. 6 months

B. 12 months

C. 18 months

D. 24 months

Group health insurance policies in North Carolina require that approved premium rates be guaranteed by the insurer for a minimum of 12 months. This regulation ensures a level of stability for policyholders, allowing them to predict costs for at least a year without the risk of immediate rate changes. The 12-month guarantee period provides both insurers and policyholders with an appropriate balance, enabling insurers to manage their risk while offering necessary protection and predictability for the members of the group health plan. Other durations, such as 6, 18, or 24 months, do not align with the stipulated requirement, which specifically mandates a 12-month guarantee. While insurers can choose to offer longer guarantee periods, the minimum established by regulation is essential for maintaining a stable market for group health insurance. This standard helps ensure that employers and employees can manage their health care budgets effectively without sudden premium escalations within the first year of coverage.

6. According to the Information and Privacy Protection Act, how many business days must an insurer provide personal information after an adverse underwriting decision?

A. 15

B. 30

C. 45

D. 60

Under the Information and Privacy Protection Act, insurers are required to provide individuals with their personal information within a specified timeframe following an adverse underwriting decision. The correct answer, which is 30 business days, aligns with the legislation's aim to ensure transparency and consumer rights in the insurance process. By mandating this timeframe, the law allows individuals ample opportunity to understand the reasons behind the adverse decision and to take appropriate actions, such as requesting corrections or clarifications regarding their personal information. This requirement reflects a broader commitment to protecting consumer privacy and ensuring that individuals have access to information that impacts their insurance coverage and financial well-being. Keeping the timeframe within 30 days strikes a balance between the insurer's need to operate efficiently and the consumer's right to be informed.

7. When must a Group Health policy provide coverage for a newborn child?

A. Within the first week after birth

B. At the moment of birth

C. After the first month post-birth

D. When the child is added to the policy

A Group Health policy must provide coverage for a newborn child at the moment of birth. This means that as soon as a child is born, they are automatically covered under the mother's health insurance policy without any waiting period. This provision ensures that newborns have immediate access to necessary healthcare services, which is crucial for early medical assessment and any required treatments right after birth. This coverage is part of the policy's obligations to ensure that families are not left vulnerable during the crucial early days of a child's life. It also reflects the recognition of the importance of early healthcare access for infants, including routine check-ups and vaccinations. The other choices suggest coverage after a delay or a conditional basis, which does not align with the typical requirements set for group health insurance policies regarding newborns. Immediate coverage helps safeguard the health of the newborn and supports parents in managing healthcare needs without lapses in coverage.

8. How long is the standard waiting period for benefits to become available under a Probationary Period?

A. 30 days

B. 60 days

C. Dependent on the policy

D. 90 days

The standard waiting period for benefits under a probationary period can indeed vary based on the specific terms outlined in an insurance policy. This is because each insurer designs its policies with distinct provisions, including the duration of the probationary period, which is typically meant to prevent pre-existing conditions from being covered immediately upon policy initiation. Depending on the specific policy, the waiting period might be set at 30 days, 60 days, or even longer, such as 90 days. This flexibility allows insurance companies to manage risk and ensures that benefits are only available for new conditions that arise after the waiting period has concluded. Therefore, the availability of benefits is contingent upon the specifics of the individual policy, making it essential for policyholders to review their contracts carefully to understand the terms that apply to them.

9. What does "explanation of benefits" (EOB) entail?

A. A document sent by insurers detailing what services were covered and how much was paid

B. A summary of denied claims and reasons for denial

C. A list of healthcare providers covered under a policy

D. A guide to understanding insurance policy language

The concept of "explanation of benefits" (EOB) refers to a detailed document provided by health insurers that outlines the services a policyholder received, indicating which of those services are covered under the insurance plan. It includes information on how much the insurer paid, any amounts that the insured may still owe, and any adjustments that were made during the processing of the claim. This document is crucial for policyholders as it provides transparency regarding their benefits and costs, helping them to understand what portion of their medical expenses will be taken care of by the insurance company versus what they are responsible for. The EOB is an essential tool for policyholders to track their health care spending and manage their financial responsibilities effectively. It also often contains information about how to appeal a claim if a certain service was not covered, thus aiding the insured in navigating their insurance benefits further.

10. When does a Probationary Period provision take effect in a health insurance contract?

A. After the first premium is paid

B. At the policy's inception

C. When a claim is filed

D. After the first year

A Probationary Period provision in a health insurance contract is designed to establish a timeframe during which certain benefits, specifically those related to pre-existing conditions or illnesses, may not be covered. The correct understanding is that this provision takes effect at the policy's inception. This means that as soon as the policy officially begins—after the insured pays their first premium—the probationary period starts counting down. This is significant because, during this period, any claims related to specified conditions may be delayed until the probationary period has been satisfied, ensuring that the insurer has a manageable risk during the initial phase of coverage. In contrast, the other choices do not accurately describe the timing of the commencement of a probationary period. For example, stating that it starts when a claim is filed is misleading since claims are typically evaluated based on the policy conditions that were in force at the time of the claim, rather than when they're reported. Similarly, a probationary period does not wait a full year to begin; it is established at the start of coverage, not at any arbitrary future point. Therefore, associating the probationary period with conditions such as after the first premium is paid or after one year would not convey the correct operational mechanism of health insurance contracts as established by