

North Carolina Accident and Health Practice Exam (Sample)

Study Guide



Everything you need from our exam experts!

This is a sample study guide. To access the full version with hundreds of questions,

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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. Don't worry about getting everything right, 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, and take breaks to retain information better.

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.

7. Use Other Tools

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!

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Questions

- 1. What aspect of a health insurance policy is often modified by a rider?**
 - A. Coverage terms or limits**
 - B. Claims processing speed**
 - C. Healthcare provider eligibility**
 - D. Premium pricing structure**
- 2. What defines a mutual insurance company?**
 - A. A company that is owned by shareholders**
 - B. A company that is owned by its policyholders**
 - C. A company that offers only government-funded health programs**
 - D. A company that provides insurance exclusively to corporations**
- 3. What does the term "sick pool" mean in the context of health insurance?**
 - A. A group of policyholders with a higher likelihood of requiring medical care**
 - B. A pool of funds reserved for high-risk individuals**
 - C. A collective of healthy individuals seeking lower premiums**
 - D. A group of claims that have been denied by the insurance company**
- 4. What do Medicare Parts A and B cover?**
 - A. Part A covers outpatient care; Part B covers inpatient care**
 - B. Part A covers hospitalization; Part B covers doctor's services**
 - C. Part A covers dental services; Part B covers vision services**
 - D. Part A covers preventive care; Part B covers emergency services**
- 5. Which type of healthcare service is typically provided by a "provider" as defined in insurance terms?**
 - A. Medical treatment or related services**
 - B. Legal advice regarding insurance claims**
 - C. Account management for insurance policies**
 - D. Financial planning for healthcare expenses**

- 6. What fund ensures policyholders receive death benefits on Life Policies if the company is insolvent at the time of claim?**
- A. National Insurance Fund**
 - B. Life Insurance Protection Fund**
 - C. Life and Health Insurance Guaranty Association**
 - D. Health Insurance Safety Net Fund**
- 7. Which document is crucial for understanding what portion of a medical service an insurance will cover?**
- A. Explanation of Benefits (EOB)**
 - B. Claim Form**
 - C. Insurance Contract**
 - D. Provider Directory**
- 8. Which of the following is a typical exclusion in Health Insurance policies?**
- A. Injuries sustained in an accident**
 - B. Intentionally self-inflicted injuries**
 - C. Injuries occurring at work**
 - D. Injuries occurring during sports activities**
- 9. How does the loss ratio impact health insurance providers?**
- A. It determines the amount of deductibles in a policy**
 - B. It measures the efficiency of claims processing**
 - C. It measures the percentage of premiums used for paying claims**
 - D. It helps in establishing the number of providers in a network**
- 10. What differentiates an HMO from a PPO?**
- A. An HMO requires members to choose a primary care physician**
 - B. A PPO requires referrals for specialists**
 - C. An HMO covers more out-of-network services**
 - D. A PPO has a lower deductible**

Answers

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

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Explanations

1. What aspect of a health insurance policy is often modified by a rider?

- A. Coverage terms or limits**
- B. Claims processing speed**
- C. Healthcare provider eligibility**
- D. Premium pricing structure**

A rider is a provision in a health insurance policy that adds, modifies, or excludes certain coverage elements. This means that riders specifically pertain to coverage terms or limits, which is why the first choice is the most appropriate answer. By adding a rider, an insured person can enhance their policy by increasing coverage, adjusting limits, or providing additional benefits that are not included in the standard terms of the policy. For instance, a common type of rider might expand coverage for specific health conditions or treatments that would otherwise be excluded under the base policy. This flexibility allows policyholders to tailor their health insurance to better fit their individual needs, addressing specific concerns that may arise not initially covered. Other aspects like claims processing speed, healthcare provider eligibility, or premium pricing structure are typically determined by the original terms of the health insurance policy and are not directly modified by riders. Each of these areas is generally more fixed, influenced instead by broader policy guidelines or the insurance company's internal operations rather than specific enhancements or changes made through a rider.

2. What defines a mutual insurance company?

- A. A company that is owned by shareholders**
- B. A company that is owned by its policyholders**
- C. A company that offers only government-funded health programs**
- D. A company that provides insurance exclusively to corporations**

A mutual insurance company is defined as one that is owned by its policyholders. This ownership structure means that the individuals who purchase insurance from the mutual company also have a stake in the organization's success and decision-making processes. Policyholders can vote on important company matters and may receive dividends based on the company's performance, which is not typically the case in stock companies owned by shareholders for profit. The other options describe different types of insurance organizations. For instance, a company owned by shareholders is commonly known as a stock insurance company, where the primary goal is to provide returns to investors rather than benefits to policyholders. The mention of government-funded health programs refers to public insurance or government programs like Medicare or Medicaid, which do not fit the definition of a mutual insurance company. Lastly, the option that suggests an exclusive focus on providing insurance to corporations pertains to commercial insurance firms or certain types of specialized insurers, which does not align with the mutual ownership model centered on individual policyholders.

3. What does the term "sick pool" mean in the context of health insurance?

- A. A group of policyholders with a higher likelihood of requiring medical care**
- B. A pool of funds reserved for high-risk individuals**
- C. A collective of healthy individuals seeking lower premiums**
- D. A group of claims that have been denied by the insurance company**

The term "sick pool" refers to a group of policyholders with a higher likelihood of requiring medical care. In health insurance, this concept is critical to understanding risk management and underwriting practices. Insurers use risk pools to categorize policyholders based on their health status and the expected frequency and cost of claims. When a group is described as a "sick pool," it indicates that the individuals within that group are more likely to utilize medical services, which can lead to higher overall claims costs for the insurer. This situation can result from various factors like chronic illnesses, age, or other health indicators prevalent within that group. This understanding informs how insurers set premiums and manage the risks associated with covering different populations. Insurers must carefully balance the pool by attracting healthier individuals to offset the costs incurred by higher-risk policyholders. The presence of a sick pool can impact overall insurance strategies significantly, including pricing, coverage options, and the sustainability of health plans.

4. What do Medicare Parts A and B cover?

- A. Part A covers outpatient care; Part B covers inpatient care**
- B. Part A covers hospitalization; Part B covers doctor's services**
- C. Part A covers dental services; Part B covers vision services**
- D. Part A covers preventive care; Part B covers emergency services**

Medicare Parts A and B together form the core of the original Medicare program, which provides crucial health coverage for individuals aged 65 and older, as well as certain younger individuals with disabilities. Medicare Part A primarily provides coverage for inpatient care, such as hospital stays, skilled nursing facility care, hospice, and some home health care. This aspect covers the costs associated with being admitted to hospitals and receiving necessary services while there, which is vital for individuals who require significant medical attention due to serious health issues. Medicare Part B, on the other hand, is focused on outpatient care and preventive services. It covers a wide range of medical services, including doctor's visits, certain outpatient services, preventive screenings, and necessary medical supplies. This part is essential for maintaining health after discharge from a hospital and for addressing ongoing health management. This particular distinction is fundamental to understanding how Medicare works and what patients can expect from their coverage under these two parts. Understanding the correct coverage areas can help beneficiaries navigate their healthcare needs effectively, ensuring they receive the appropriate medical attention without unexpected costs.

5. Which type of healthcare service is typically provided by a "provider" as defined in insurance terms?

- A. Medical treatment or related services**
- B. Legal advice regarding insurance claims**
- C. Account management for insurance policies**
- D. Financial planning for healthcare expenses**

The correct response indicates that a "provider" in insurance terms refers to an entity or individual that delivers medical treatment or related services to patients. In the context of health insurance, providers include physicians, hospitals, clinics, and other healthcare professionals who directly administer healthcare services. These services can encompass a variety of aspects, such as preventive care, diagnosis, treatment, rehabilitation, and nursing care. The other options represent different functions that are not directly related to the delivery of healthcare services. Legal advice concerning insurance claims pertains to understanding and navigating legal aspects of health insurance but does not involve the provision of medical care. Account management for insurance policies focuses on managing the policy aspects rather than medical treatment, while financial planning for healthcare expenses deals with budgeting and financial aspects of healthcare rather than the provision of actual medical services. Therefore, the definition of a "provider" is accurately captured by the choice that refers to medical treatment or related services.

6. What fund ensures policyholders receive death benefits on Life Policies if the company is insolvent at the time of claim?

- A. National Insurance Fund**
- B. Life Insurance Protection Fund**
- C. Life and Health Insurance Guaranty Association**
- D. Health Insurance Safety Net Fund**

The Life and Health Insurance Guaranty Association is specifically designed to protect policyholders in the event that an insurance company becomes insolvent. This organization acts as a safety net, ensuring that consumers receive the benefits they are entitled to under their life and health insurance policies even if the insurer can no longer fulfill its obligations due to financial difficulties. This means that if a life insurance policyholder files a death claim and the company is unable to pay because it is insolvent, the Guaranty Association steps in to pay out the death benefit so that families are not left without this crucial financial support. Other options do not serve the same protective function. The National Insurance Fund typically refers to broader insurance schemes and does not address life insurance specifically. The Life Insurance Protection Fund might sound relevant, but it does not exist under the same framework; rather, it is the Guaranty Association that provides the necessary protections. Lastly, the Health Insurance Safety Net Fund is generally more focused on providing access to health care rather than securing death benefits from life insurance policies. Consequently, the role of the Life and Health Insurance Guaranty Association is clearly defined and critical in this context.

7. Which document is crucial for understanding what portion of a medical service an insurance will cover?

A. Explanation of Benefits (EOB)

B. Claim Form

C. Insurance Contract

D. Provider Directory

The Explanation of Benefits (EOB) is a crucial document for understanding what portion of a medical service an insurance company will cover. The EOB provides detailed information following the processing of a claim, including how much the insurance paid, how much the insured is responsible for, and any adjustments made on the claim. It breaks down the costs associated with a particular service, delineating between covered services, non-covered services, coinsurance, deductibles, and copayment amounts. Using an EOB, policyholders can clearly see the breakdown of charges and understand what their financial responsibility will be regarding the service received. This empowers individuals to make informed decisions about their healthcare and manage their costs effectively. Other documents, like the claim form, primarily serve as a request for payment to the insurer and do not provide the comprehensive breakdown of benefits and costs that the EOB offers. While the insurance contract lays out the broad terms and conditions of coverage, it doesn't itemize the specifics of what has been billed and how it has been processed. Similarly, a provider directory serves the purpose of listing available healthcare providers but does not directly address the specifics of coverage for services rendered.

8. Which of the following is a typical exclusion in Health Insurance policies?

A. Injuries sustained in an accident

B. Intentionally self-inflicted injuries

C. Injuries occurring at work

D. Injuries occurring during sports activities

Health insurance policies often include specific exclusions to limit the scope of coverage, and one common exclusion is for intentionally self-inflicted injuries. This exclusion is in place because health insurance is designed to cover unforeseen accidents and illnesses; allowing coverage for injuries that are self-inflicted would go against the principle of insuring against risks that are unintended and beyond the control of the insured. By excluding coverage for intentionally self-inflicted injuries, insurers aim to mitigate risks associated with moral hazard, where an individual might take greater risks or engage in harmful behavior if they know those actions would be financially covered by insurance. This helps maintain the integrity and affordability of health insurance for all policyholders. Injuries sustained in an accident, injuries occurring at work, and injuries occurring during sports activities often have specific provisions or conditions under which they can be covered. However, intentionally self-inflicted injuries are clearly delineated as excluded from health insurance policies, making it a typical exclusion.

9. How does the loss ratio impact health insurance providers?

- A. It determines the amount of deductibles in a policy
- B. It measures the efficiency of claims processing
- C. It measures the percentage of premiums used for paying claims**
- D. It helps in establishing the number of providers in a network

The correct answer highlights that the loss ratio is a crucial metric for health insurance providers because it measures the percentage of premiums that are spent on paying claims. This ratio is typically calculated by dividing the total amount of claims paid by the total premiums collected over a certain period. A higher loss ratio indicates that a significant portion of the premiums is being used to cover claims, which can inform the insurer about their risk management and pricing strategies. Understanding the loss ratio is essential for health insurance companies since it directly impacts their profitability and sustainability. If the loss ratio is too high, it may indicate that the insurer is not charging enough in premiums to cover the costs of claims, which could lead to financial instability. Conversely, a low loss ratio might suggest that an insurance provider is pricing their products too high or that they are effectively managing claims, which can be beneficial for their overall financial health. The other options relate to different aspects of insurance operations but do not directly define the loss ratio's role. For instance, deductibles are determined by policy design rather than loss ratios, claims processing efficiency pertains to operational performance, and the number of providers in a network is influenced by negotiations and market dynamics rather than loss metrics. The loss ratio specifically focuses on the financial relationship between claims

10. What differentiates an HMO from a PPO?

- A. An HMO requires members to choose a primary care physician**
- B. A PPO requires referrals for specialists
- C. An HMO covers more out-of-network services
- D. A PPO has a lower deductible

An HMO, or Health Maintenance Organization, is characterized by its requirement for members to select a primary care physician (PCP). This PCP serves as the main point of contact for all healthcare needs and is responsible for coordinating all care within the HMO network. Members must go through their PCP for referrals to see specialists, making the process more centralized and typically simpler. This structure promotes a more managed and preventive approach to healthcare, often leading to lower costs for members due to the agreements that HMOs have with network providers. Therefore, the requirement of having a primary care physician is fundamental to the way HMOs operate and is a key distinction from other plan types, such as PPOs (Preferred Provider Organizations), which offer more flexibility in choosing healthcare providers without the need for a referral. In the context given, the other options reflect features of PPOs or general misconceptions about how these plans operate, but they do not accurately describe the defining characteristics that separate HMOs from PPOs.

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://ncaccidenthealth.examzify.com>

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