

# North Carolina Accident and Health Practice Exam (Sample)

## Study Guide



**Everything you need from our exam experts!**

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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

- 1. Which coverage would be considered primary for a 66-year-old injured while walking in the park?**
  - A. Medicare coverage**
  - B. Personal injury protection**
  - C. Her group health plan**
  - D. Workers' compensation**
- 2. Which insurance practice is banned under North Carolina's regulations?**
  - A. Competitive pricing**
  - B. Unfair trade practices**
  - C. Market analysis**
  - D. Consumer feedback**
- 3. What could trigger the Waiver of Premium provision in a policy?**
  - A. Becoming unemployed**
  - B. Injury or illness requiring physician treatment**
  - C. Turning 65 years old**
  - D. Specific accidents only**
- 4. What can an insured do if they believe their claim has been unfairly denied?**
  - A. Seek another insurer**
  - B. File a complaint with the insurance company**
  - C. Wait six months**
  - D. Immediately take legal action**
- 5. 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**

- 6. A disability elimination period is best described as what?**
- A. A waiting period before benefits are paid**
  - B. A time length for premium payments**
  - C. A period for policy application processing**
  - D. A time deductible before insurance coverage begins**
- 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. What is a common limitation found in health insurance policies regarding specific actions and occurrences?**
- A. Deductibles**
  - B. Exclusions**
  - C. Copayments**
  - D. Limitations**
- 9. What is a common characteristic of individual health insurance policies?**
- A. Lower costs than group insurance**
  - B. Higher flexibility in choice of providers**
  - C. No exclusions for pre-existing conditions**
  - D. Guaranteed renewal regardless of health status**
- 10. For which of the following expenses does a Basic Hospital policy pay?**
- A. Emergency room services**
  - B. Hospital room and board**
  - C. Outpatient procedures**
  - D. Prescriptions**



## **Answers**

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

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## **Explanations**

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**1. Which coverage would be considered primary for a 66-year-old injured while walking in the park?**

- A. Medicare coverage**
- B. Personal injury protection**
- C. Her group health plan**
- D. Workers' compensation**

In the context of insurance coverage for a 66-year-old injured while walking in the park, the primary coverage would be the group health plan. When evaluating which insurance will pay first for medical expenses, the principle of coordination of benefits is used. Generally, health care coverage from a group health plan is considered primary coverage for incidents that occur outside of employment, such as walking in the park. Group health plans typically cover a range of medical expenses, including treatment for injuries sustained in non-work-related situations. This means that the medical bills would first be submitted to her group health plan for payment. Medicare coverage, while available due to age, is considered secondary when there is a group health plan in place. Personal injury protection is typically associated with auto insurance and may not apply in this situation, while workers' compensation applies to work-related injuries, which is not relevant here as the injury occurred while walking in a public space. Thus, her group health plan's primary status ensures that it covers her medical expenses first in this specific case.

**2. Which insurance practice is banned under North Carolina's regulations?**

- A. Competitive pricing**
- B. Unfair trade practices**
- C. Market analysis**
- D. Consumer feedback**

Unfair trade practices are explicitly prohibited under North Carolina's insurance regulations to protect consumers and maintain the integrity of the insurance market. These practices can include misleading advertisements, deceptive claims adjusting, and any behavior that creates an unfair advantage or misrepresents an insurance policy to potential policyholders. By banning unfair trade practices, North Carolina seeks to ensure that consumers are treated fairly and that they have access to accurate information when making insurance-related decisions. This regulatory framework is crucial for fostering a competitive and ethical marketplace, where consumers can trust the firms from which they purchase insurance. In contrast, competitive pricing, market analysis, and consumer feedback are practices typically encouraged as they promote transparency and help consumers make informed choices.

**3. What could trigger the Waiver of Premium provision in a policy?**

- A. Becoming unemployed**
- B. Injury or illness requiring physician treatment**
- C. Turning 65 years old**
- D. Specific accidents only**

The Waiver of Premium provision in an insurance policy is designed to relieve the policyholder from paying premiums if they become disabled due to an injury or illness. This provision typically applies when a policyholder is unable to work and requires physician treatment, which indicates a significant level of impairment that justifies waiving premium payments. In the context of the options provided, becoming unemployed does not automatically imply that a person cannot perform their daily activities or requires medical attention; thus, it does not trigger the Waiver of Premium provision. Turning 65 years old may impact other insurance provisions, such as eligibility for Medicare, but not necessarily lead to a waiver of premiums. The notion of specific accidents alone does not encompass all medical conditions or situations that would qualify for a waiver, as the provision is primarily concerned with broader instances of disability due to illness or injury. The emphasis on illness or injury requiring physician treatment aligns clearly with the conditions necessary for invoking the Waiver of Premium.

**4. What can an insured do if they believe their claim has been unfairly denied?**

- A. Seek another insurer**
- B. File a complaint with the insurance company**
- C. Wait six months**
- D. Immediately take legal action**

Filing a complaint with the insurance company is an appropriate action for an insured who believes their claim has been unfairly denied. This process allows the insured to communicate their concerns formally to the insurer, prompting them to review the denial. Most insurance companies have procedures in place for handling complaints and claims disputes, and this step is often required before any further action can be taken, such as requesting an independent review or pursuing legal avenues. This approach provides a structured way to address the issue and may lead to a resolution without escalating to more serious legal measures. It also indicates to the insurance company that the insured is serious about contesting the decision, which might expedite a reevaluation of the claim. Therefore, initiating a complaint is often a necessary first step in addressing grievances with insurance claims.

**5. 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

**6. A disability elimination period is best described as what?**

- A. A waiting period before benefits are paid**
- B. A time length for premium payments**
- C. A period for policy application processing**
- D. A time deductible before insurance coverage begins**

The correct description of a disability elimination period is a waiting period before benefits are paid. This period typically refers to the timeframe that must pass after a disability occurs before the insured can start receiving financial benefits from their policy. During this elimination period, the insured is not eligible for benefits, which serves to mitigate the risk for the insurer while encouraging policyholders to seek help more promptly after a disability. The other options do not accurately define the elimination period. For instance, the description of time length for premium payments relates more to the schedule for policyholders to pay their premiums, rather than any waiting or qualifying period for benefits. A period for policy application processing is unrelated, as it pertains to the time it takes for an application to be approved rather than a scenario involving a claim. Lastly, a time deductible before insurance coverage begins inaccurately mixes terms; in insurance, a "deductible" often refers to the amount an insured must pay before benefits kick in, rather than a period of inactivity before benefits are accessible following a claim.

**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. What is a common limitation found in health insurance policies regarding specific actions and occurrences?**

**A. Deductibles**

**B. Exclusions**

**C. Copayments**

**D. Limitations**

Exclusions refer to specific conditions or circumstances that are not covered by a health insurance policy. These limitations are crucial as they define the scope of the policy and help the insurer manage risk by specifying what is not included in the coverage. Common exclusions might include certain pre-existing conditions, experimental treatments, or injuries sustained in specific situations, such as those resulting from illegal activities. The presence of exclusions in a health insurance policy helps ensure clarity for both the insurer and the insured regarding what services are and are not eligible for reimbursement. By understanding exclusions, policyholders can better assess their risk and may seek additional coverage or riders for the types of services or conditions excluded from their basic policy. This focus on exclusions emphasizes the importance of careful review of policy details to avoid misunderstandings about coverage.

**9. What is a common characteristic of individual health insurance policies?**

- A. Lower costs than group insurance**
- B. Higher flexibility in choice of providers**
- C. No exclusions for pre-existing conditions**
- D. Guaranteed renewal regardless of health status**

A common characteristic of individual health insurance policies is their higher flexibility in choice of providers. Individual health plans generally allow policyholders to select from a broader range of healthcare providers and facilities compared to group insurance plans. This flexibility is beneficial for individuals who may have specific doctors or specialists in mind and allows them to tailor their healthcare options according to personal health needs and preferences. While group insurance often involves a more restrictive network due to employer agreements with specific providers, individual plans frequently provide the option to see a larger variety of healthcare professionals without being confined to a particular network. This adaptability is an attractive feature for those purchasing their own health insurance. Additionally, while individual health insurance may sometimes have higher costs compared to group plans due to the lack of collective purchasing power, and it's true that many newer policies address pre-existing conditions due to regulatory changes, the prime selling point of individual health plans tends to be the increased freedom in provider selection.

**10. For which of the following expenses does a Basic Hospital policy pay?**

- A. Emergency room services**
- B. Hospital room and board**
- C. Outpatient procedures**
- D. Prescriptions**

A Basic Hospital policy is designed primarily to cover essential hospital services and expenses incurred during a hospital stay. This type of policy typically pays for the costs associated with hospital room and board, which includes the fee for the room where the patient stays and the meals provided during the hospitalization period. This coverage is vital since hospital stays can be financially burdensome, and Basic Hospital policies aim to alleviate some of those costs through direct payments for room and board. While emergency room services, outpatient procedures, and prescriptions are significant health-related expenses, they often fall under different types of health insurance coverage or more comprehensive plans rather than being specifically covered by a Basic Hospital policy. In summary, the primary focus of a Basic Hospital policy is to support patients by covering the fundamental costs associated with their stay in the hospital, which makes hospital room and board the correct answer.



## 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](mailto: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!**