

North Carolina Health Insurance 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

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- 1. Which type of insurer reimburses its insureds for covered medical expenses?**
 - A. Non-profit organizations**
 - B. Commercial insurers**
 - C. Government programs**
 - D. Health maintenance organizations**

- 2. What does Medicare Part A primarily cover?**
 - A. Doctor's services**
 - B. Outpatient care**
 - C. Preventive services**
 - D. Hospitalization**

- 3. Who benefits from "high-risk pools"?**
 - A. Individuals with excellent health records**
 - B. People who can easily obtain conventional insurance**
 - C. Individuals unable to obtain traditional insurance due to pre-existing conditions**
 - D. Those looking to reduce their insurance costs**

- 4. What is the term for a situation where physicians are salaried employees at an HMO facility?**
 - A. Open panel**
 - B. Closed panel**
 - C. Network model**
 - D. Individual practice association**

- 5. What right does COBRA provide to workers whose employment has been terminated?**
 - A. The right to seek new employment**
 - B. The right to a severance package**
 - C. The right to continue group health benefits**
 - D. The right to claim unemployment benefits**

6. What is Medicaid expansion?

- A. A reduction of Medicaid services**
- B. The option for states to expand Medicaid eligibility**
- C. A federal program to decrease health costs**
- D. The mandatory enrollment of all citizens in Medicaid**

7. What is a copayment (copay)?

- A. A fixed amount paid by a policyholder for a specific medical service**
- B. The total cost of a medical procedure before insurance payment**
- C. The percentage of costs that the policyholder must pay after the deductible**
- D. A financial penalty for using out-of-network providers**

8. According to the Information and Privacy Protection Act, how many business days must an insurer provide access to recorded personal information after a denial of coverage?

- A. 10 days**
- B. 20 days**
- C. 30 days**
- D. 40 days**

9. Which of the following involves analyzing a case before admission to determine what type of treatment is necessary?

- A. Prospective Review**
- B. Retrospective Review**
- C. Concurrent Review**
- D. Assessment Review**

10. Which federal law allows an insurer to obtain an inspection report on a potential insured?

- A. Fair Credit Reporting Act**
- B. Health Insurance Portability and Accountability Act**
- C. The Affordable Care Act**
- D. Consumer Protection Act**

Answers

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

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Explanations

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1. Which type of insurer reimburses its insureds for covered medical expenses?

- A. Non-profit organizations**
- B. Commercial insurers**
- C. Government programs**
- D. Health maintenance organizations**

The correct answer is commercial insurers because they function primarily to provide coverage for medical expenses incurred by their insureds. Commercial insurers enter into contracts—often referred to as policies—with individuals or groups, where they agree to cover certain medical costs in exchange for premium payments. When a policyholder incurs a medical expense that is covered under their policy, they may submit a claim to the insurer. The insurer then reviews the claim against the terms of the policy and, if approved, reimburses the insured for the qualified medical expenses up to the limits specified in the policy. This reimbursement model is a fundamental aspect of how commercial health insurance operates, ensuring that insured individuals have access to financial support for necessary medical care. Other types of insurers, such as health maintenance organizations (HMOs), operate on a different model—typically requiring members to utilize a network of preferred healthcare providers and may require copayments for services rather than providing direct reimbursement for expenses. Non-profit organizations and government programs, while they may also provide coverage, have different operational structures and may not adhere strictly to a reimbursement model.

2. What does Medicare Part A primarily cover?

- A. Doctor's services**
- B. Outpatient care**
- C. Preventive services**
- D. Hospitalization**

Medicare Part A primarily covers hospitalization costs, providing essential coverage for both inpatient and related services. This includes expenses incurred during stays in accredited hospitals, skilled nursing facilities, hospice care, and limited home health services. The main objective of Part A is to ensure that beneficiaries have access to necessary hospital care without bearing the full financial burden, which can be substantial. The focus of Part A on hospital-related services distinguishes it from other parts of Medicare. For example, doctors' services and outpatient care are primarily addressed by Medicare Part B, while preventive services are also predominantly linked to Part B coverage. Understanding this division helps clarify the specific roles of each part of Medicare and the associated benefits for beneficiaries.

3. Who benefits from "high-risk pools"?

- A. Individuals with excellent health records**
- B. People who can easily obtain conventional insurance**
- C. Individuals unable to obtain traditional insurance due to pre-existing conditions**
- D. Those looking to reduce their insurance costs**

High-risk pools are specifically designed to provide coverage for individuals who have difficulties obtaining conventional health insurance, primarily due to pre-existing medical conditions. These individuals may find themselves denied coverage or facing exorbitantly high premiums from standard insurers, as traditional insurance plans often assess risk based on health status and medical history. High-risk pools offer a safety net in such scenarios, ensuring that people with significant health challenges can still access necessary healthcare without the barriers posed by typical insurance underwriting practices. The primary audience for high-risk pools is those who are unable to secure traditional insurance due to their health status, making this option clearly the most appropriate. By offering them a pathway to insurance coverage, high-risk pools help alleviate the financial burden and ensure they receive necessary medical care.

4. What is the term for a situation where physicians are salaried employees at an HMO facility?

- A. Open panel**
- B. Closed panel**
- C. Network model**
- D. Individual practice association**

The term for a situation where physicians are salaried employees at a Health Maintenance Organization (HMO) facility is referred to as a "closed panel." In a closed panel HMO, the healthcare providers, including physicians, are typically employed directly by the HMO or are part of a specific network of providers who agree to provide services to members. This structure allows the HMO to have greater control over costs and the quality of care, as the physicians are on salary and have a direct incentive to manage resources effectively. Conversely, in an open panel HMO, patients may see a wider range of providers who are not necessarily employed by the HMO, and these providers may bill the insurance separately. The network model involves a range of contracts with providers, while the individual practice association offers a more independent practice arrangement for physicians. However, the key characteristic of a closed panel is the employment relationship between the HMO and its physicians, making it the correct term in this context.

5. What right does COBRA provide to workers whose employment has been terminated?

- A. The right to seek new employment
- B. The right to a severance package
- C. The right to continue group health benefits**
- D. The right to claim unemployment benefits

COBRA, which stands for the Consolidated Omnibus Budget Reconciliation Act, provides individuals who have been terminated from their employment the right to continue their group health insurance benefits for a limited period. This is significant because, upon losing a job, individuals often face a sudden gap in health coverage, which can lead to financial difficulties and health risks due to the inability to afford necessary medical care. Under COBRA, eligible employees can maintain their existing health insurance plan, although they may have to pay the full premium themselves, which can be higher than what they paid while employed. The important aspect of this law is that it allows former employees and their families to keep their health benefits for up to 18 months following the termination of employment, and in some cases even longer for certain qualifying events, such as disability. This provision ensures that individuals do not have to face a significant lapse in healthcare coverage during a transitional period, allowing them to seek new employment or address their healthcare needs without the burden of being uninsured.

6. What is Medicaid expansion?

- A. A reduction of Medicaid services
- B. The option for states to expand Medicaid eligibility**
- C. A federal program to decrease health costs
- D. The mandatory enrollment of all citizens in Medicaid

Medicaid expansion refers to the option provided under the Affordable Care Act (ACA) for states to broaden eligibility for Medicaid to include more individuals, primarily those with incomes up to 138% of the federal poverty level. This expansion allows states to extend healthcare coverage to low-income adults who were previously ineligible. By opting for Medicaid expansion, states can receive federal funding to cover the newly eligible individuals, which helps to reduce the number of uninsured and improve access to necessary healthcare services. This initiative aims to increase the number of people receiving healthcare coverage, thereby enhancing public health and potentially reducing overall healthcare costs in the long run. Understanding Medicaid expansion is crucial for recognizing how states can address healthcare disparities and provide support to vulnerable populations within their communities.

7. What is a copayment (copay)?

- A. A fixed amount paid by a policyholder for a specific medical service**
- B. The total cost of a medical procedure before insurance payment**
- C. The percentage of costs that the policyholder must pay after the deductible**
- D. A financial penalty for using out-of-network providers**

A copayment, often referred to as a copay, is a predetermined, fixed amount that a policyholder pays for specific medical services at the time of receiving care. This arrangement allows the insured individual to manage their healthcare expenses more predictably, as the copayment amount does not vary based on the total cost of the service being provided. In various health insurance plans, copay amounts can differ based on the type of service received, such as a routine doctor's visit, specialist consultation, or prescription medication. This structure makes it easier for both patients and providers to understand financial responsibilities upfront, as the copay is typically visible on the health insurance card and is collected at the time of service. Understanding copayments is crucial for policyholders in managing healthcare costs and making informed decisions about where and when to seek medical care.

8. According to the Information and Privacy Protection Act, how many business days must an insurer provide access to recorded personal information after a denial of coverage?

- A. 10 days**
- B. 20 days**
- C. 30 days**
- D. 40 days**

The Information and Privacy Protection Act establishes regulations concerning individuals' rights to their personal information, particularly in the context of access following a denial of coverage. Under this Act, insurers are required to grant access to recorded personal information within a specific timeframe after providing a denial of coverage. The stipulated timeframe for an insurer to provide this access is 30 days. This requirement is designed to ensure transparency and allow individuals to understand the basis for the denial, thereby promoting accountability within the insurance industry. By allowing a 30-day period, the law balances the need for prompt access to information with the operational capabilities of insurers to gather and compile relevant personal data.

9. Which of the following involves analyzing a case before admission to determine what type of treatment is necessary?

- A. Prospective Review**
- B. Retrospective Review**
- C. Concurrent Review**
- D. Assessment Review**

Prospective Review is the process of assessing a patient's case before they are admitted to a healthcare facility, focusing on determining the necessary type of treatment or services required based on medical necessity and appropriateness. This review is conducted prior to the patient's actual admission, allowing healthcare providers to ensure that the recommended treatments align with established guidelines and protocols. By analyzing the details of the case beforehand, insurance companies and healthcare administrators can make informed decisions about coverage and resource allocation, ultimately leading to more effective patient care and managing costs effectively. This proactive approach benefits both the patient and the healthcare system as it helps to prevent unnecessary admissions and ensures that patients receive the appropriate level of care right from the start. In contrast, other types of reviews, such as Retrospective Review, focus on cases after treatment has occurred to determine if the services provided were appropriate and necessary. Concurrent Review takes place during the patient's treatment to evaluate the ongoing necessity of care. There is also no standard term known as Assessment Review in this context. Understanding these distinctions is key in navigating the medical review process within health insurance frameworks.

10. Which federal law allows an insurer to obtain an inspection report on a potential insured?

- A. Fair Credit Reporting Act**
- B. Health Insurance Portability and Accountability Act**
- C. The Affordable Care Act**
- D. Consumer Protection Act**

The Fair Credit Reporting Act (FCRA) is the correct choice as it provides the legal framework that allows insurers to obtain inspection reports or consumer reports about potential insured individuals. Under the FCRA, insurance companies can request reports that give them insight into the individual's credit history, driving records, and other personal information relevant to assessing risk for coverage. This legislation is designed to promote fair and accurate credit reporting while also ensuring consumer privacy. Insurers must adhere to specific guidelines when using consumer reports, including obtaining permission from the applicant before seeking such reports and providing the applicant with information about how they can dispute inaccuracies. The other options are related to health insurance but do not focus on the ability of insurers to obtain inspection reports. The Health Insurance Portability and Accountability Act (HIPAA) mainly addresses the privacy and security of health information. The Affordable Care Act (ACA) primarily focuses on healthcare coverage and access rather than underwriting practices. The Consumer Protection Act involves regulations meant to protect consumers from unfair or deceptive business practices but does not pertain specifically to inspection reports for insurance purposes.

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://nchealthinsurance.examzify.com>

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

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