

NORTH CAROLINA HEALTH INSURANCE PRACTICE EXAM (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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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. What does Medicare Part A primarily cover?**
 - A. Doctor's services
 - B. Outpatient care
 - C. Preventive services
 - D. Hospitalization
- 2. What feature allows an insured to defer current health charges to the next year's deductible?**
 - A. Elimination rider
 - B. Carryover provision
 - C. Renewal option
 - D. Pre-existing clause
- 3. 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
- 4. What is the significance of a formulary in a health insurance plan?**
 - A. A list of medications covered by the insurance plan.
 - B. The contact information for healthcare providers.
 - C. The terms and conditions of the insurance contract.
 - D. A summary of patient responsibilities under the plan.
- 5. What is the purpose of a "rider" in an insurance contract?**
 - A. To provide additional coverage options
 - B. To eliminate previous coverage
 - C. To adjust premium payments
 - D. To list excluded services

- 6. What is a catastrophic health insurance plan?**
- A. A high-premium plan with low deductibles
 - B. A low-premium plan with a high deductible that covers essential health benefits after a high out-of-pocket cost is met
 - C. A comprehensive health insurance plan covering all medical expenses
 - D. A plan that only covers preventive services
- 7. What is a pre-existing condition?**
- A. A medical condition that arises after obtaining insurance.
 - B. A medical condition that existed before obtaining health insurance coverage.
 - C. A temporary illness covered by short-term plans.
 - D. A condition that insurance providers handle regardless of the timeline.
- 8. A prepaid application for individual disability income insurance was recently submitted to an insurer. What action would the insurance company not take after receiving the MIB report?**
- A. Send a notice to the MIB that the applicant was declined
 - B. Request additional medical examinations
 - C. Offer a higher premium rate
 - D. Decline the application based on undisclosed information
- 9. What does the term "risk pool" refer to?**
- A. The group of individuals covered by an insurance plan used to determine premiums and coverage
 - B. A fund that pays for health risks associated with insurance
 - C. A method for estimating future healthcare costs
 - D. An organization that evaluates health insurance plans
- 10. Which type of service is usually not covered by health insurance?**
- A. Preventive care
 - B. Routine vaccinations
 - C. Cosmetic surgery unless deemed medically necessary
 - D. Emergency room visits

Answers

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

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Explanations

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1. 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.

2. What feature allows an insured to defer current health charges to the next year's deductible?

- A. Elimination rider
- B. Carryover provision**
- C. Renewal option
- D. Pre-existing clause

The carryover provision is a feature that allows an insured individual to transfer or defer certain health care expenses incurred towards the end of one calendar year, so that those expenses can count towards the following year's deductible. This provision is particularly beneficial for individuals who might have a higher volume of health care expenses in a plan year that could push them closer to meeting their deductible, yet they still have charges just before the year ends that do not allow them to fully utilize their deductible. In essence, if an insured incurs medical expenses after a specific point in a plan year (often in the last few months), the carryover provision enables those expenses to be credited towards the deductible of the next year. This not only provides financial relief but also encourages individuals to seek necessary medical care without the pressure of immediate out-of-pocket costs, knowing some of those costs can be applied to their deductible in the upcoming year. The other options do not pertain to the concept of deferring health charges in a way that would influence the deductible in the subsequent year. An elimination rider typically excludes certain conditions from coverage, a renewal option pertains to the ability to renew an insurance policy, and a pre-existing clause relates to the coverage of health conditions that existed before obtaining the insurance. None of these

3. 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.

4. What is the significance of a formulary in a health insurance plan?

- A. A list of medications covered by the insurance plan.**
- B. The contact information for healthcare providers.
- C. The terms and conditions of the insurance contract.
- D. A summary of patient responsibilities under the plan.

A formulary is significant in a health insurance plan because it is essentially a comprehensive list of prescription medications that are covered by the insurance plan. This list is important for both the insurer and the insured. For the insurer, it helps regulate costs by negotiating prices with drug manufacturers and determining which medications will be covered under different tiers, often associating higher copays with brand-name drugs as opposed to generics. For the insured, understanding the formulary is crucial for making informed decisions about their healthcare. It allows beneficiaries to know which medications they can access without incurring significant out-of-pocket expenses, as those not included in the formulary may require higher out-of-pocket costs or may not be covered at all. Furthermore, adherence to a formulary ensures that patients receive drugs that are considered effective and safe while simultaneously managing healthcare costs for both the insurance provider and the policyholders. In contrast, the other options encompass different aspects of an insurance plan. Contact information for healthcare providers serves to facilitate access to medical services but does not relate directly to the cost or coverage of medications. The terms and conditions of the insurance contract outline the overall agreement between the insured and the insurer but do not specifically pertain to medications. Finally, a summary of patient responsibilities under the plan

5. What is the purpose of a "rider" in an insurance contract?

A. To provide additional coverage options

B. To eliminate previous coverage

C. To adjust premium payments

D. To list excluded services

A rider in an insurance contract serves the purpose of providing additional coverage options. Riders are supplementary provisions that can be added to a standard insurance policy to enhance or modify the coverage provided. They allow policyholders to customize their insurance based on specific needs or circumstances. For example, a health insurance policy might include a rider that covers certain types of alternative treatments that aren't part of the standard coverage. This tailored approach enables policyholders to obtain more comprehensive coverage tailored to their individual situations or preferences. Other options may address different functions but do not correctly describe the essence of a rider. Eliminating previous coverage would fundamentally change the policy rather than enhance it, and adjusting premium payments typically pertains to the overall policy terms rather than the addition of specific coverages. Listing excluded services refers to limitations within the policy rather than the additional benefits provided by a rider. Therefore, a rider is primarily intended to expand the coverage options available within an insurance contract.

6. What is a catastrophic health insurance plan?

A. A high-premium plan with low deductibles

B. A low-premium plan with a high deductible that covers essential health benefits after a high out-of-pocket cost is met

C. A comprehensive health insurance plan covering all medical expenses

D. A plan that only covers preventive services

A catastrophic health insurance plan is characterized by a low-premium structure combined with a high deductible. This means that policyholders pay lower monthly premiums but are responsible for a significant amount of out-of-pocket costs before their insurance begins to cover essential health benefits. The purpose of such plans is to protect individuals against high medical expenses that can arise from serious health issues or accidents while keeping regular healthcare costs manageable. These plans are particularly suitable for young, healthy individuals who may not expect to use medical services frequently but still want insurance coverage for unexpected, high-cost medical incidents. Once the high deductible is met, catastrophic plans typically cover essential health benefits, ensuring that individuals have access to necessary medical care without incurring overwhelming financial burdens. In contrast, high-premium plans with low deductibles provide more comprehensive coverage right from the start but at a higher monthly cost. Comprehensive plans cover a wide array of medical expenses without the limitations seen in catastrophic plans. Preventive services-only plans focus solely on preventive care and do not offer coverage for other medical needs, which is outside the scope of catastrophic insurance.

7. What is a pre-existing condition?

- A. A medical condition that arises after obtaining insurance.
- B. A medical condition that existed before obtaining health insurance coverage.**
- C. A temporary illness covered by short-term plans.
- D. A condition that insurance providers handle regardless of the timeline.

A pre-existing condition refers to a medical issue or illness that was diagnosed or present before an individual secured health insurance coverage. This definition is key in understanding how health insurance works, particularly in terms of eligibility and coverage limits. When applying for health insurance, insurers often assess any pre-existing conditions, as these may impact the terms of coverage, including exclusions or waiting periods before coverage becomes effective for that specific condition. The concept of pre-existing conditions gained significant attention with changes in healthcare laws, primarily to prevent discrimination against individuals who may have chronic illnesses or conditions prior to obtaining insurance. The focus is on protecting individuals seeking coverage from being denied or facing higher premiums due to prior health issues, thus increasing their access to necessary medical care. In contrast, other options address scenarios that do not accurately describe pre-existing conditions. For instance, a medical condition that arises after obtaining insurance would not qualify, as the term specifically includes conditions that existed beforehand. Temporary illnesses generally do not fall under the pre-existing condition classification, especially when they are covered under short-term plans. Lastly, stating that insurance providers handle conditions regardless of the timeline overlooks the importance of when the condition was diagnosed relative to when the insurance was obtained. This nuanced understanding is crucial for anyone studying health insurance principles.

8. A prepaid application for individual disability income insurance was recently submitted to an insurer. What action would the insurance company not take after receiving the MIB report?

- A. Send a notice to the MIB that the applicant was declined**
- B. Request additional medical examinations
- C. Offer a higher premium rate
- D. Decline the application based on undisclosed information

Upon receiving the Medical Information Bureau (MIB) report, an insurer would not take the action of sending a notice to the MIB that the applicant was declined. The MIB serves as a resource for insurance companies to share information about policyholders and applicants to mitigate the risk of insurance fraud and to better assess the risk associated with applicants. If an application is declined, insurers typically do not report this decision to the MIB. Instead, MIB reports focus primarily on medical conditions, history, and other risk-related information rather than the outcome of individual applications. Thus, the action of notifying MIB of a decline would not be a procedural step that the insurer would follow. The other options involve actions that are standard practices in underwriting and risk assessment processes. These actions include requesting further medical exams if there are additional concerns based on the MIB report, adjusting premiums to reflect higher risks, or even declining an application if undisclosed medical information presents a significant risk that cannot be underwritten favorably.

9. What does the term "risk pool" refer to?

- A. The group of individuals covered by an insurance plan used to determine premiums and coverage**
- B. A fund that pays for health risks associated with insurance
- C. A method for estimating future healthcare costs
- D. An organization that evaluates health insurance plans

The term "risk pool" refers to the group of individuals covered by an insurance plan and is crucial for determining premiums and coverage. By aggregating a diverse group of people, insurance companies can predict and manage the overall health care costs more effectively. When individuals with varying health statuses and potential risks come together in a pool, it helps spread the financial risk across all members. This concept is central to the functioning of health insurance, as it allows for healthier individuals to balance the costs incurred by those who may require more medical care. The premiums collected from this risk pool are used to cover the claims of those who need care, thus creating a sustainable system. The larger and more diverse the risk pool, the more stable and equitable the premiums and coverage can be for all members involved, as it diminishes the impact of higher-cost claimants. Other options, while they touch on relevant topics in health insurance, do not encapsulate the precise definition of a risk pool as effectively. For instance, the concept of a fund that pays health risks pertains to a financial aspect, while estimating future healthcare costs is an analytic approach not confined to the concept of a risk pool. Evaluating health insurance plans refers to a separate function performed by organizations, distinct from the

10. Which type of service is usually not covered by health insurance?

- A. Preventive care
- B. Routine vaccinations
- C. Cosmetic surgery unless deemed medically necessary**
- D. Emergency room visits

Cosmetic surgery is typically not covered by health insurance unless it is deemed medically necessary. This means that if the surgery is performed solely for aesthetic reasons, it will usually fall outside the covered services of most health insurance plans. Insurers prioritize covering services that are medically necessary for health outcomes, such as surgeries required to repair injuries or to address functional impairments. In contrast, preventive care and routine vaccinations are often covered fully by health insurance plans as part of initiatives to promote public health and prevent illnesses. Emergency room visits are also generally covered since they involve acute, potentially life-threatening conditions requiring immediate medical attention. The distinction lies primarily in the intent and necessity of the procedure, where cosmetic procedures do not align with the primary goal of health insurance to provide care for essential health needs.

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:

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

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