

North Dakota Health Insurance Practice Test (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. How do insurers handle a loss claim when multiple insurers are involved?**
 - A. One insurer pays the entire claim amount**
 - B. Each insurer pays a proportionate amount of the claim**
 - C. The insured receives a full benefit from the primary insurer only**
 - D. The claim is denied until all insurers are settled**
- 2. Which of the following is a requirement for insurance plans under the ACA?**
 - A. High deductibles for all plans**
 - B. No coverage for children's medical needs**
 - C. Guaranteed issue of health insurance policies**
 - D. Exclusions for non-emergency services**
- 3. Which of the following best describes 'Limited Coverage' in insurance?**
 - A. Covers all medical expenses**
 - B. Provides benefits for specific perils only**
 - C. Offers unlimited coverage amounts**
 - D. Is available to everyone regardless of health**
- 4. Preventive care is usually designed to do what?**
 - A. Provide treatment for existing conditions**
 - B. Reduce the need for emergency care**
 - C. Diagnose diseases after symptoms appear**
 - D. Encourage hospitalization**
- 5. What is the time frame in which written proof of loss must be submitted to the insurer?**
 - A. 30 days**
 - B. 60 days**
 - C. 90 days**
 - D. 120 days**

6. Who designates the Primary Health Care Provider (PHCP) in a health insurance plan?

- A. The insurance company**
- B. The healthcare system administrator**
- C. The insured individual**
- D. The government**

7. What types of perils are covered by health insurance?

- A. Accident and emergency**
- B. Accident and sickness**
- C. Health and wellness**
- D. Pre-existing conditions and accidents**

8. Medicaid serves which of the following populations?

- A. Only children under the age of 18**
- B. Aids to persons with mental health issues**
- C. People who cannot afford health care services**
- D. All military personnel**

9. What does the term "physician care requirement" refer to in the context of disability insurance?

- A. Physical condition severity**
- B. Activity limitations or participation restrictions**
- C. Patient's treatment history**
- D. Availability of medical specialists**

10. What is the purpose of a second surgical opinion in cost containment care?

- A. To confirm the initial diagnosis**
- B. To assess quality of care**
- C. To reduce unnecessary surgeries**
- D. To increase hospital revenue**

Answers

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

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Explanations

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- 1. How do insurers handle a loss claim when multiple insurers are involved?**
 - A. One insurer pays the entire claim amount**
 - B. Each insurer pays a proportionate amount of the claim**
 - C. The insured receives a full benefit from the primary insurer only**
 - D. The claim is denied until all insurers are settled**

When multiple insurers are involved in handling a loss claim, the approach taken is typically to have each insurer pay a proportionate amount of the claim. This is in line with the principle of indemnity, which ensures that the insured does not profit from the loss but is made whole again. In scenarios where multiple policies cover the same loss, the insurers will collaborate to determine their respective liabilities based on the coverage limits and conditions set in each policy. This means that if a claim is valid, then all relevant insurers will contribute to the settlement based on the proportion of coverage they provide. This method is advantageous because it prevents any single insurer from shouldering the total burden of the loss, thereby distributing the financial responsibility equitably among all insurers involved. It also encourages policyholders to maintain proper coverage levels across different insurers without fear of being underinsured or over-insured, as they can count on joint participation from multiple sources in the event of a claim. The other approaches typically do not align with standard insurance practices. For instance, one insurer paying the entire claim might lead to disputes over liability and coverage, while only receiving benefits from the primary insurer would not account for overlapping insurance policies. Meanwhile, denying the claim until all insurers are settled would create unnecessary

- 2. Which of the following is a requirement for insurance plans under the ACA?**
 - A. High deductibles for all plans**
 - B. No coverage for children's medical needs**
 - C. Guaranteed issue of health insurance policies**
 - D. Exclusions for non-emergency services**

Under the Affordable Care Act (ACA), one of the pivotal requirements is the concept of guaranteed issue for health insurance policies. This means that insurers are required to offer health insurance to all applicants, regardless of their health status or pre-existing conditions. This was a significant change from previous practices where individuals with health issues could be denied coverage or charged exorbitant premiums. The guaranteed issue requirement ensures that individuals cannot be refused coverage based on factors such as medical history, age, gender, or any other discriminatory practices. This provision was designed to increase access to healthcare and prevent insurers from excluding those who may need it most, thereby promoting broader and more equitable health coverage across the population. The other options do not align with the ACA's requirements. For instance, high deductibles are not mandated, nor is there a stipulation for insurers to exclude coverage for children's medical needs. Furthermore, the ACA emphasizes the importance of providing essential health benefits, often including emergency services without unnecessary exclusions. Thus, guaranteed issue stands out as a fundamental element of the ACA's goals of expanding coverage and protecting consumers.

3. Which of the following best describes 'Limited Coverage' in insurance?

- A. Covers all medical expenses**
- B. Provides benefits for specific perils only**
- C. Offers unlimited coverage amounts**
- D. Is available to everyone regardless of health**

Limited coverage in insurance typically refers to policies that provide benefits only for specific types of risks or perils, rather than broad or comprehensive protection. This means that the coverage is not exhaustive and will only apply in certain situations predefined by the policy. For example, a limited coverage plan might cover only hospital stays from an accident but exclude coverage for other medical expenses such as preventive care or chronic illness treatments. This is in contrast to broader coverage options that aim to cover a wider range of medical services and expenses, often including preventive care, outpatient services, and a variety of treatment types. Limited coverage is designed to manage costs and risks by restricting the circumstances under which benefits can be claimed, making it vital for consumers to understand the specific limitations of their insurance plan. The other options describe characteristics that do not accurately represent limited coverage. Comprehensive coverage would apply to a greater array of medical expenses, while unlimited coverage implies there are no caps on the financial assistance provided, and availability to everyone regardless of health status pertains to eligibility criteria rather than the scope of coverage itself.

4. Preventive care is usually designed to do what?

- A. Provide treatment for existing conditions**
- B. Reduce the need for emergency care**
- C. Diagnose diseases after symptoms appear**
- D. Encourage hospitalization**

Preventive care focuses on measures that are aimed at preventing health problems before they occur, rather than addressing issues once they have developed. The primary goal of preventive care is to identify and mitigate risk factors that could lead to serious health issues, thereby reducing the likelihood of emergency situations arising. By emphasizing early interventions, screenings, and lifestyle counseling, preventive care helps individuals maintain better health and avoid complications that would necessitate emergency services. For instance, regular check-ups, vaccinations, and screenings can detect potential health issues long before they escalate, significantly reducing the need for emergency care. In contrast, treatment for existing conditions, diagnosing diseases after symptoms appear, and encouraging hospitalization do not align with the fundamental purpose of preventive care. Preventive strategies aim to keep individuals healthy and minimize the circumstances that lead to emergencies or serious health interventions.

5. What is the time frame in which written proof of loss must be submitted to the insurer?

- A. 30 days**
- B. 60 days**
- C. 90 days**
- D. 120 days**

The correct answer indicates that written proof of loss must be submitted to the insurer within 90 days. This time frame is standard in many health insurance policies and aligns with the requirement that policyholders provide documentation of a claim in a timely manner so that the insurer can process it without unnecessary delays. Submitting proof of loss within 90 days ensures that the insurer has all the relevant information needed to assess the claim accurately with respect to coverage and benefits. Failing to provide this documentation within the specified time might lead to delays or potential denial of the claim, which underscores the importance of adhering to this timeframe. Other time frames like 30, 60, or 120 days may not adequately balance expediency with thoroughness. The 90-day period is generally seen as sufficient for individuals to gather the necessary documentation, while also allowing insurers to efficiently manage their claim processing workloads.

6. Who designates the Primary Health Care Provider (PHCP) in a health insurance plan?

- A. The insurance company**
- B. The healthcare system administrator**
- C. The insured individual**
- D. The government**

The correct answer indicates that the insured individual typically designates the Primary Health Care Provider (PHCP) in a health insurance plan. This approach empowers the individual to choose a provider with whom they have a personal connection or that fits their healthcare needs best. By allowing the insured person to select their PHCP, health insurance plans acknowledge the importance of patient preference in the provider-patient relationship, which can lead to more satisfactory health care experiences and outcomes. While insurance companies may have networks of providers that are eligible within the plan, the final choice of the PHCP lies with the insured. This flexibility facilitates personalized healthcare management, making it essential for individuals to be involved in their healthcare decision-making. The other options involve entities such as insurance companies, healthcare system administrators, and the government, which may influence provider networks or regulations but do not typically have the authority to designate an individual's primary care provider. Each of these parties may set guidelines or have preferred providers, but the insured individual ultimately retains the decision-making power regarding their healthcare provider selection.

7. What types of perils are covered by health insurance?

- A. Accident and emergency**
- B. Accident and sickness**
- C. Health and wellness**
- D. Pre-existing conditions and accidents**

Health insurance typically provides coverage for a wide range of medical expenses, primarily focusing on perils associated with accident and sickness. This means that health insurance plans are designed to financially assist policyholders in the event of unforeseen accidents, such as injuries from falls or car accidents, as well as illnesses that could require medical attention, hospital stays, or ongoing treatment. This focus on both accident and sickness ensures that individuals have access to necessary medical services when they face health-related challenges, which can range from acute illnesses like infections to chronic conditions requiring ongoing management. By covering these perils, health insurance plays a critical role in reducing financial burdens associated with healthcare, allowing individuals to seek necessary care without the fear of incurring overwhelming costs. Other options include various terms that do not accurately capture the fundamental coverage focus of health policies. For instance, while health and wellness may reflect preventative care, they do not encompass the direct medical perils insurance primarily intends to cover. Similarly, pre-existing conditions and accidents might imply some level of coverage under certain circumstances, but they don't present a comprehensive view of the types of perils typically covered in standard health insurance policies.

8. Medicaid serves which of the following populations?

- A. Only children under the age of 18**
- B. Aids to persons with mental health issues**
- C. People who cannot afford health care services**
- D. All military personnel**

Medicaid is a government program designed to provide health care coverage to individuals and families with low income. It assists a variety of vulnerable populations, allowing them access to necessary health care services they might otherwise be unable to afford. By focusing on those with limited financial resources, Medicaid plays a crucial role in ensuring that essential medical services are available to individuals who may struggle to pay for them. The program is not limited to children, people with mental health issues, or military personnel; rather, it encompasses a broader demographic. This includes pregnant women, individuals with disabilities, elderly people needing long-term care, and working families who meet specific income criteria. Therefore, the premise that it serves "people who cannot afford health care services" accurately captures the overarching mission of Medicaid in providing necessary health care access to those in financial need.

9. What does the term "physician care requirement" refer to in the context of disability insurance?

- A. Physical condition severity**
- B. Activity limitations or participation restrictions**
- C. Patient's treatment history**
- D. Availability of medical specialists**

The term "physician care requirement" in the context of disability insurance primarily relates to "activity limitations or participation restrictions." This term denotes the necessity for patients to provide documentation from their physician regarding how their health condition impacts their ability to perform daily activities or participate in societal roles. In disability insurance, insurers want to evaluate how a person's disability affects their functionality in everyday life, which is inherently tied to the physical activities they are able or unable to engage in. Understanding this aspect is crucial because it allows insurers to assess the degree of impairment caused by an individual's health issue. This requirement often includes assessments of how specific medical conditions limit a person's capabilities in working, engaging in social activities, or performing tasks they were able to do prior to their disability. Such assessments are vital in determining eligibility for benefits and the amount of benefits provided. While the other options may seem relevant in different contexts, they do not directly correlate to the "physician care requirement" as it is understood in disability insurance. For instance, physical condition severity might refer to the intensity of a medical issue but does not involve how it affects daily activities directly. Patient treatment history could include past medical interventions but does not inherently measure functional limitations. Availability of medical specialists, while important in a broader

10. What is the purpose of a second surgical opinion in cost containment care?

- A. To confirm the initial diagnosis**
- B. To assess quality of care**
- C. To reduce unnecessary surgeries**
- D. To increase hospital revenue**

The purpose of a second surgical opinion in cost containment care is primarily to reduce unnecessary surgeries. This practice allows patients to seek additional verification regarding the necessity and appropriateness of a proposed surgical intervention. By obtaining a second opinion, patients can ensure that the recommended surgery is truly needed, which can help avoid procedures that may not be clinically indicated. This approach not only protects patients from potential risks associated with unnecessary surgeries but also contributes to a broader effort in the healthcare system to control costs. When patients are empowered to make informed decisions based on multiple professional assessments, it can lead to better health outcomes and decrease the likelihood of surgeries that might have been performed without adequate justification. While confirming the initial diagnosis, assessing quality of care, and increasing hospital revenue might play roles in the healthcare system, they do not align as directly with the primary goal of the second surgical opinion within the context of cost containment. The focus on reducing unnecessary surgeries highlights its significance in promoting efficient and responsible healthcare practices.

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://ndhealthinsurance.examzify.com>

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

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