

Ohio 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 of the following is typically excluded from Medicare Part B coverage?**
 - A. Routine outpatient care**
 - B. Cosmetic surgery**
 - C. Mental health treatments**
 - D. Preventive healthcare services**
- 2. What characterizes a Multiple-Employer Trust (MET) for insurance purposes?**
 - A. One large employer providing insurance for all employees**
 - B. Two or more employers joining to purchase a benefits plan**
 - C. A single employer offering multiple plans**
 - D. An association of unrelated businesses buying insurance together**
- 3. Respite care is designed primarily to do which of the following?**
 - A. Serve as a long-term care solution**
 - B. Provide relief to the family caregiver**
 - C. Offer daily medical assistance**
 - D. Assist with rehabilitation services**
- 4. What does a disability buy-sell policy specify?**
 - A. How a business will handle financial investments**
 - B. How the business will pass between owners when one dies or becomes disabled**
 - C. The tax implications of business ownership transfers**
 - D. How to determine business valuation**
- 5. How long is the waiting period for Social Security disability benefits?**
 - A. 3 months**
 - B. 5 months**
 - C. 6 months**
 - D. 1 year**

6. What is a characteristic of Health Insuring Corporations regarding their operational scope?

- A. They have an unlimited service area**
- B. They typically serve a restricted geographic area**
- C. They are global health service providers**
- D. They exclusively provide in-hospital services**

7. In relation to the Payment of claims provision, which of the following is true regarding benefit payments?

- A. All benefits are payable to the beneficiary**
- B. All benefits are payable to the insured while living**
- C. Benefits can be held until the insured is deceased**
- D. Benefits must be returned to the insurer if not claimed within a year**

8. What does Evidence of Coverage typically include?

- A. Marketing materials for health plans**
- B. Clearance for clinical trials**
- C. Certificates or agreements detailing subscriber coverage**
- D. General estimates of healthcare costs**

9. What is the benefit of being fully insured under Social Security?

- A. Eligibility for lower premiums on private insurance**
- B. Access to Social Security retirement, Medicare, and survivor benefits**
- C. Automatic approval for disability benefits**
- D. Guaranteed lifetime insurance coverage**

10. What does Part C of Medicare, also known as Medicare Advantage, allow beneficiaries to do?

- A. Access only specialist care**
- B. Receive all their health care services through available provider organizations**
- C. Only receive hospital services**
- D. Purchase additional insurance outside of Medicare**

Answers

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

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Explanations

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1. Which of the following is typically excluded from Medicare Part B coverage?

- A. Routine outpatient care**
- B. Cosmetic surgery**
- C. Mental health treatments**
- D. Preventive healthcare services**

Cosmetic surgery is typically excluded from Medicare Part B coverage because this type of surgery is generally considered elective and not medically necessary. Medicare is designed to cover services that are essential for the diagnosis, treatment, or prevention of health conditions, and cosmetic procedures do not meet this criterion. In contrast, routine outpatient care, mental health treatments, and preventive healthcare services can be covered under Medicare Part B when they are deemed medically necessary. For example, Medicare provides coverage for outpatient mental health services and various preventive services like vaccinations and yearly wellness visits to help maintain beneficiaries' health. Understanding these distinctions is crucial for navigating Medicare coverage and recognizing what services may or may not be available.

2. What characterizes a Multiple-Employer Trust (MET) for insurance purposes?

- A. One large employer providing insurance for all employees**
- B. Two or more employers joining to purchase a benefits plan**
- C. A single employer offering multiple plans**
- D. An association of unrelated businesses buying insurance together**

A Multiple-Employer Trust (MET) is characterized by two or more employers coming together to jointly purchase a benefits plan. This collaborative approach allows smaller employers who may not have the resources to negotiate favorable insurance rates on their own to pool their resources and achieve better coverage and costs through collective bargaining. By participating in a MET, employers can offer their employees benefits similar to those provided by larger companies, which can improve employee satisfaction and retention. This arrangement is particularly beneficial in situations where individual employers might face higher premiums or limited options due to their size or the nature of their workforce. The other potential answers do not accurately reflect the nature of a MET. A single employer providing insurance for all employees describes a traditional employer-sponsored health plan. Conversely, an association of unrelated businesses may indicate a different type of cooperative arrangement that is not specific to a trust structured for benefit purchases. Lastly, a single employer offering multiple plans does not involve the collaboration aspect essential to METs, which is about pooling resources across multiple employers.

3. Respite care is designed primarily to do which of the following?

- A. Serve as a long-term care solution
- B. Provide relief to the family caregiver**
- C. Offer daily medical assistance
- D. Assist with rehabilitation services

Respite care is specifically designed to provide temporary relief to family caregivers who are regularly responsible for caring for an individual, often a loved one with a chronic illness, disability, or aging-related needs. The focus of respite care is to give caregivers a break, allowing them time to rest, recharge, or attend to their own needs without the constant demands of caregiving. This short-term care service can be a vital resource, enabling caregivers to maintain their well-being and avoid burnout. The other options, while potentially related to aspects of care for individuals, do not capture the primary purpose of respite care. Long-term care solutions typically focus on ongoing support and daily living assistance for individuals over extended periods rather than providing temporary relief. Daily medical assistance implies a focus on continuous healthcare needs rather than the flexibility and respite aspect that caregivers require. Rehabilitation services are specifically aimed at helping individuals recover and regain skills after an illness or injury, and while important, are not the central aim of respite care, which is more about supporting caregivers than treating patients.

4. What does a disability buy-sell policy specify?

- A. How a business will handle financial investments
- B. How the business will pass between owners when one dies or becomes disabled**
- C. The tax implications of business ownership transfers
- D. How to determine business valuation

A disability buy-sell policy is specifically designed to outline the procedures for transferring ownership of a business in the event that an owner becomes disabled or dies. This type of policy is crucial for ensuring that the business continues to operate smoothly and that the remaining owners can buy out the disabled or deceased owner's interest in the business without unnecessary complications. In this context, a disability buy-sell policy typically sets forth the terms and conditions under which the buyout occurs, including who is responsible for purchasing the owner's share and at what price. This ensures that the interests of both the disabled owner and the continuing owners are protected and that the business can transfer its ownership in an organized manner. Other answer choices, while related to business operations and ownership, do not address the specific focus of a disability buy-sell policy. For instance, financial investments and business valuation are crucial elements for understanding a business's overall health but are not the primary focus of what a disability buy-sell policy aims to achieve. Similarly, while tax implications may arise from ownership transfers, they are not outlined or specified by this type of policy. Thus, the correct choice accurately captures the essence of what a disability buy-sell policy is designed to accomplish.

5. How long is the waiting period for Social Security disability benefits?

- A. 3 months**
- B. 5 months**
- C. 6 months**
- D. 1 year**

The waiting period for Social Security disability benefits is five months. This means that even if a claimant is found to be disabled and eligible for benefits, there is a mandatory waiting period before they can start receiving their monthly disability payments. The five-month waiting period starts from the onset date of the disability as established by the Social Security Administration (SSA). This period is put in place to help ensure that benefits are not paid for disabilities that may resolve in a shorter timeframe, thereby assisting with better management of the Social Security Trust Fund. While the claimant may experience financial hardship during this time, the five-month wait serves as a guideline for when benefits appropriately begin, reflecting the SSA's assessment of long-term disability.

6. What is a characteristic of Health Insuring Corporations regarding their operational scope?

- A. They have an unlimited service area**
- B. They typically serve a restricted geographic area**
- C. They are global health service providers**
- D. They exclusively provide in-hospital services**

Health Insuring Corporations, often referred to as Health Maintenance Organizations (HMOs) or similar entities, are primarily designed to serve specific geographic areas. This characteristic allows them to manage healthcare services more effectively by focusing on a defined community or region. By concentrating their resources and partnerships with local healthcare providers, they can streamline care, reduce costs, and maintain a network of services that meet the needs of their members within that restricted area. The focus on a limited service area also enables Health Insuring Corporations to establish more personalized relationships with healthcare providers and members, ensuring that they can deliver tailored health resources and support. This model helps in promoting preventive care and health maintenance strategies, which can lead to better health outcomes for the population they serve. In contrast, options implying an unlimited service area or claims of global service provision are not accurate in this context since Health Insuring Corporations are not designed to operate on such a broad scale. Similarly, stating that they exclusively provide in-hospital services is misleading, as they often cover a range of healthcare services including outpatient care, preventive services, and more, rather than being limited to in-patient settings.

7. In relation to the Payment of claims provision, which of the following is true regarding benefit payments?

- A. All benefits are payable to the beneficiary**
- B. All benefits are payable to the insured while living**
- C. Benefits can be held until the insured is deceased**
- D. Benefits must be returned to the insurer if not claimed within a year**

In the context of health insurance policies, the provision related to the Payment of claims is essential for understanding who receives benefits and how they are distributed. The correct choice highlights that benefits are typically payable to the insured while they are alive. This reflects the general principle that health insurance is designed to cover medical expenses incurred by the policyholder during their lifetime, providing financial support for healthcare needs. When the insured is alive, they can directly receive benefits to help offset medical costs, expenses related to treatment, and other healthcare-related charges. This is crucial, as it allows policyholders to utilize their insurance coverage effectively when they need it most. The focus on payment during the insured's lifetime underscores the purpose of health insurance as a means of financial protection against medical expenditures. Other options, although they address aspects of benefit payments, do not capture the primary purpose of the insurance benefit and the preference for payment to the living insured. For instance, while some benefits might be payable to a beneficiary after the insured's death, health insurance policies typically emphasize payments while the insured is alive, along with the right for the insured to choose how benefits are directed. This foundational understanding enhances the grasp of health insurance policies and their implications for policyholders.

8. What does Evidence of Coverage typically include?

- A. Marketing materials for health plans**
- B. Clearance for clinical trials**
- C. Certificates or agreements detailing subscriber coverage**
- D. General estimates of healthcare costs**

The correct answer focuses on the importance of documentation in health insurance. Evidence of Coverage (EOC) is a crucial document provided by health insurance plans that details the specific benefits, coverage options, and limitations that a subscriber has under their plan. It serves to inform policyholders about what services are covered, any associated costs, such as co-payments or deductibles, and the rights and responsibilities of both the insurer and the insured. Having a clear and comprehensive EOC promotes transparency and understanding, enabling subscribers to make informed decisions regarding their healthcare. It ensures that subscribers understand the specifics of their coverage, including any exclusions or restrictions. This is essential for navigating the complex landscape of health insurance and utilizing the benefits effectively. In contrast, marketing materials primarily aim to attract potential customers rather than inform existing subscribers about their coverage specifics. Clearance for clinical trials does not relate directly to the general benefits provided by a health insurance policy but instead pertains to specific eligibility in research contexts. General estimates of healthcare costs provide broader financial insights but do not detail the specific coverage that an Evidence of Coverage document would include.

9. What is the benefit of being fully insured under Social Security?

- A. Eligibility for lower premiums on private insurance
- B. Access to Social Security retirement, Medicare, and survivor benefits**
- C. Automatic approval for disability benefits
- D. Guaranteed lifetime insurance coverage

Being fully insured under Social Security means that an individual has attained the necessary work credits, which are earned through employment and payment of Social Security taxes. This status provides eligibility for a range of benefits that include Social Security retirement benefits, Medicare coverage when reaching retirement age, and survivor benefits for family members in the event of the insured individual's death. Access to these benefits is a significant advantage, as they provide financial security during retirement, medical coverage through Medicare, and support for dependents left behind. This comprehensive safety net is a primary purpose of the Social Security program, designed to assist individuals and families in maintaining a certain standard of living throughout different stages of life. Other options, while relevant to health and insurance, do not accurately reflect the primary benefits associated with being fully insured under Social Security. For instance, lower premiums on private insurance, automatic approval for disability benefits, or guaranteed lifetime insurance coverage do not directly correlate to the full insurance status under Social Security. Instead, they pertain to either private insurance terms or other social assistance programs and do not encompass the holistic benefit of retirement, Medicare, and survivor benefits that fully insured status provides.

10. What does Part C of Medicare, also known as Medicare Advantage, allow beneficiaries to do?

- A. Access only specialist care
- B. Receive all their health care services through available provider organizations**
- C. Only receive hospital services
- D. Purchase additional insurance outside of Medicare

Part C of Medicare, commonly referred to as Medicare Advantage, is designed to provide beneficiaries with a different way to receive their Medicare benefits. This option allows individuals to receive all of their healthcare services through private insurance plans that contract with Medicare. These plans often include a variety of medical services beyond just hospital or specialist care, such as preventive services, outpatient care, and sometimes additional benefits like vision or dental coverage. Beneficiaries choosing Medicare Advantage are not limited to accessing only specialized care or merely hospital services; rather, they can utilize the comprehensive healthcare services that the plan offers. Additionally, while purchasing additional insurance outside of Medicare is permitted, it is not a defining feature of Medicare Advantage itself. Therefore, the correct answer highlights the holistic approach of Part C, making it clear that beneficiaries can manage their healthcare in a more integrated manner through these plans.

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://ohhealthinsurance.examzify.com>

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

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