

PEARSONVUE HEALTH INSURANCE PRACTICE EXAM (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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THE FULL VERSION STUDY GUIDE

<https://pearsonvuehealthinsurance.examzify.com>



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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 is the function of a claims audit in the insurance industry?**
 - A. To determine the eligibility of policyholders
 - B. To verify the financial status of the insurer
 - C. To ensure claims are processed correctly
 - D. To evaluate the effectiveness of health programs
- 2. What does "experience rating" mean in health insurance pricing?**
 - A. It bases rates solely on community averages
 - B. It considers only historical trends from the insurance company
 - C. It bases rates on an individual or group's historical claims
 - D. It involves calculating premiums based on age and gender
- 3. What is the purpose of an Explanation of Benefits (EOB)?**
 - A. A document provided by insurers detailing what services were billed, covered, and the amounts owed by the insured
 - B. A summary report of annual health expenses for tax purposes
 - C. An outline of insurance premiums due each month
 - D. A notification of upcoming changes to health insurance policies
- 4. How do insurers use risk management techniques to control claim costs?**
 - A. By increasing premiums for all policyholders
 - B. By employing preventive care incentives and care coordination
 - C. By limiting access to certain medical services
 - D. By outsourcing claims processing to third-party vendors
- 5. What is the purpose of the underwriting process in health insurance?**
 - A. To evaluate the financial stability of an insurer
 - B. To assess applicant risk and determine eligibility
 - C. To investigate fraud in claims
 - D. To analyze the coverage options available
- 6. How does reinsurance help health insurance companies manage risk?**
 - A. By pooling together all claims from insurers
 - B. By transferring portions of risk to other insurers
 - C. By guaranteeing a minimum payout for every claim
 - D. By limiting the number of insured individuals

- 7. How does a high-deductible health plan (HDHP) work with an HSA?**
- A. An HDHP is a plan with low premiums only
 - B. Individuals cannot contribute to an HSA with HDHP
 - C. An HDHP allows for higher contributions to an HSA
 - D. HSA funds can only be used for preventive care
- 8. In health insurance, what does a referral typically indicate?**
- A. A request to see a primary care physician
 - B. A recommendation for medical equipment
 - C. A formal request to see a specialist
 - D. An order for lab tests
- 9. What is the stop-loss feature in a major medical policy?**
- A. It allows for a temporary suspension of coverage
 - B. It is the point at which the insured pays only a portion of expenses
 - C. It is the point at which the insurer pays 100% of covered expenses once the insured's out-of-pocket limit is reached
 - D. It provides coverage only for catastrophic events
- 10. What distinguishes a self-funded (self-insured) plan from a fully insured plan?**
- A. The employer bears the financial risk in a self-funded plan
 - B. The insurer bears the financial risk in a self-funded plan
 - C. Self-funded plans have set premiums each year
 - D. Fully insured plans are limited to only state regulations

Answers

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

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Explanations

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1. What is the function of a claims audit in the insurance industry?

- A. To determine the eligibility of policyholders
- B. To verify the financial status of the insurer
- C. To ensure claims are processed correctly**
- D. To evaluate the effectiveness of health programs

The function of a claims audit in the insurance industry is primarily to ensure claims are processed correctly. This process involves reviewing a sample of claims submitted to the insurance company to assess their accuracy and adherence to established policies and regulations. By conducting audits, insurers can identify any discrepancies, errors, or potential fraudulent activities in claims processing. These audits help maintain the integrity of the claims process, ensuring that policyholders receive the benefits they are entitled to while also protecting the insurer from financial losses due to incorrect payments or fraud. Moreover, a claims audit can provide insights into the overall efficiency of the claims management system, leading to improvements and refinements in procedures. The other options, while related to various aspects of the insurance industry, do not capture the primary purpose of a claims audit. Determining eligibility focuses on policyholder qualifications rather than claims accuracy. Verifying the financial status of the insurer involves financial audits rather than claims audits. Evaluating the effectiveness of health programs pertains to program assessment rather than the specific critique of claims processing practices.

2. What does "experience rating" mean in health insurance pricing?

- A. It bases rates solely on community averages
- B. It considers only historical trends from the insurance company
- C. It bases rates on an individual or group's historical claims**
- D. It involves calculating premiums based on age and gender

Experience rating refers to a method of determining health insurance premiums based on the historical claims experience of an individual or a specific group. This approach takes into account the actual medical expenses incurred by the insured individuals over a defined period. By using this method, insurance providers can tailor premiums more closely to the risk associated with the particular group or individual, reflecting their unique usage of healthcare services. The underlying principle is that groups or individuals with a higher volume of claims may pay higher premiums to account for their greater risk, while those with fewer claims may benefit from lower premiums. This contrasts with community rating, which pools risk across a larger population without considering individual or group claims history. Additionally, experience rating encourages healthier behaviors withingroups as they can see a direct correlation between their health outcomes and their insurance costs, thereby incentivizing preventive care.

3. What is the purpose of an Explanation of Benefits (EOB)?

- A. A document provided by insurers detailing what services were billed, covered, and the amounts owed by the insured
- B. A summary report of annual health expenses for tax purposes
- C. An outline of insurance premiums due each month
- D. A notification of upcoming changes to health insurance policies

An Explanation of Benefits (EOB) serves a specific purpose in the health insurance process by providing important information about the services that were billed, what the insurance company has covered, and what amounts are owed by the insured person. An EOB details the specific treatments or services received, along with the corresponding costs, how much the insurer is responsible for, and any remaining balance that the insured must pay out of pocket. This document not only helps the insured understand their health care expenses but also serves as a way for the insurer to communicate with the insured about their benefits and financial obligations. It ensures transparency and helps insured individuals keep track of their health care usage and expenses over time, facilitating better financial planning regarding health costs. In the context of other options, while some may touch on relevant aspects of health insurance documentation, they do not encapsulate the core function of the EOB as effectively as the correct choice does.

4. How do insurers use risk management techniques to control claim costs?

- A. By increasing premiums for all policyholders
- B. By employing preventive care incentives and care coordination
- C. By limiting access to certain medical services
- D. By outsourcing claims processing to third-party vendors

Insurers utilize risk management techniques to control claim costs by employing preventive care incentives and care coordination. This approach focuses on reducing the overall incidence of claims by promoting and facilitating preventive measures among policyholders. By encouraging individuals to engage in regular health screenings, vaccinations, and healthy lifestyle choices, insurers can detect potential health issues early on, resulting in lower medical expenses over time. Additionally, care coordination helps ensure that patients receive appropriate and timely medical services, which can prevent complications and the need for more expensive treatments down the line. This proactive strategy not only enhances the health and well-being of policyholders but also helps insurers manage their financial liabilities effectively by reducing the frequency and severity of claims.

5. What is the purpose of the underwriting process in health insurance?

- A. To evaluate the financial stability of an insurer
- B. To assess applicant risk and determine eligibility
- C. To investigate fraud in claims
- D. To analyze the coverage options available

The underwriting process in health insurance is primarily designed to assess the risk associated with an applicant and determine their eligibility for coverage. Underwriters review various factors, such as the applicant's medical history, lifestyle choices, and any pre-existing conditions, to evaluate the likelihood of future claims. This evaluation enables insurers to make informed decisions about whether to offer coverage, what types of plans may be suitable, and the appropriate premium rates. By assessing the risk accurately, insurers can ensure that they maintain a balanced risk pool, which is crucial for their financial sustainability and ability to provide coverage to all policyholders. This process serves to protect both the insurer and the insured, ensuring that individuals are assessed fairly based on their health profile and potential health care needs.

6. How does reinsurance help health insurance companies manage risk?

- A. By pooling together all claims from insurers
- B. By transferring portions of risk to other insurers**
- C. By guaranteeing a minimum payout for every claim
- D. By limiting the number of insured individuals

Reinsurance is a fundamental strategy used by health insurance companies to manage risk effectively. By transferring portions of risk to other insurers, a primary insurer can protect itself from large losses that may occur from high-cost claims or catastrophic events. This process involves entering into agreements with reinsurers, who take on a share of the risks associated with certain policies. When a health insurance company sells a policy, it assumes the risk of having to pay out claims. However, if an unusually high number of claims arise, or if the claims exceed a certain threshold, the financial impact can be significant. Reinsurance mitigates this risk; for example, if a health plan is faced with unexpected high claims, the reinsurer would step in to cover a portion of those costs, leading to greater stability for the primary insurer's finances. This risk-sharing structure allows health insurance companies to offer coverage more confidently, knowing that they have a safety net in place. It ultimately enables them to maintain solvency and continue operating without facing overwhelming financial burdens due to unforeseen claims. As a result, reinsurance makes it possible for insurers to provide more robust health coverage options while effectively managing their risk exposure.

7. How does a high-deductible health plan (HDHP) work with an HSA?

- A. An HDHP is a plan with low premiums only
- B. Individuals cannot contribute to an HSA with HDHP
- C. An HDHP allows for higher contributions to an HSA**
- D. HSA funds can only be used for preventive care

A high-deductible health plan (HDHP) is specifically designed to work in conjunction with a Health Savings Account (HSA). The key aspect of this relationship is that HDHPs have higher deductibles than traditional insurance plans, which means that they typically have lower monthly premiums and may leave more out-of-pocket expenses for the insured until the deductible is met. The correct response indicates that an HDHP allows for higher contributions to an HSA because individuals who are enrolled in an HDHP can contribute to an HSA up to certain limits set by the IRS. These contribution limits can be higher compared to those for other types of health plans, providing individuals with the ability to save more pre-tax dollars for medical expenses. HSAs are particularly beneficial in this context because they encourage saving for future medical costs, often without the complications of other savings and investment options. In contrast, the other options present misunderstandings about the nature of HDHPs and HSAs. For instance, HDHPs are not solely defined by low premiums, nor do they prevent individuals from contributing to an HSA. Furthermore, HSA funds can be used for a wide range of qualifying medical expenses, not just preventive care, making it a flexible tool in managing healthcare costs

8. In health insurance, what does a referral typically indicate?

- A. A request to see a primary care physician
- B. A recommendation for medical equipment
- C. A formal request to see a specialist**
- D. An order for lab tests

In health insurance, a referral typically indicates a formal request to see a specialist. This process is usually initiated by a primary care physician who assesses a patient's condition and determines that specialized care is necessary. By issuing a referral, the primary care provider helps ensure that the patient sees a provider who has the appropriate expertise for their health issue. Referrals serve several purposes in the health insurance framework. They help coordinate care, ensure that patients receive the right treatment from qualified professionals, and may also be a requirement of the health insurance plan for coverage of services. Many insurance plans require this initial step to manage costs and streamline patient care, ultimately providing a structured way to address more complex health needs. This process contrasts with other options presented, such as requesting to see a primary care physician, recommending medical equipment, or ordering lab tests. These activities do not necessitate a referral to a specialist and pertain to different aspects of patient care and management. Hence, recognizing the role of referrals in directing patients toward specialized medical services is crucial for understanding the overall health insurance landscape.

9. What is the stop-loss feature in a major medical policy?

- A. It allows for a temporary suspension of coverage
- B. It is the point at which the insured pays only a portion of expenses
- C. It is the point at which the insurer pays 100% of covered expenses once the insured's out-of-pocket limit is reached**
- D. It provides coverage only for catastrophic events

The stop-loss feature in a major medical policy is designed to provide financial protection for the insured. It refers to a predetermined threshold in terms of out-of-pocket expenses. Once the insured individual's total costs for covered medical care reach this limit, the insurance policy takes over by covering 100% of any additional covered expenses. This feature is crucial for managing high healthcare costs because it caps the amount the insured has to spend out-of-pocket, providing peace of mind and financial security, especially in the event of serious illnesses or extensive medical treatments. The intention is to protect the insured from excessive financial burden after they have reached a specified point in their medical spending. Therefore, once the out-of-pocket maximum is reached, the insurer becomes fully responsible for the remaining covered expenses, reducing the insured's continuing financial liability.

10. What distinguishes a self-funded (self-insured) plan from a fully insured plan?

A. The employer bears the financial risk in a self-funded plan

B. The insurer bears the financial risk in a self-funded plan

C. Self-funded plans have set premiums each year

D. Fully insured plans are limited to only state regulations

In a self-funded (self-insured) plan, the employer takes on the financial risk for providing health benefits to its employees. This means that instead of paying a fixed premium to an insurance company for coverage, the employer directly funds the cost of claims as they arise. This approach allows employers greater control over their health benefits and can lead to potential cost savings, particularly if claims are lower than anticipated. In self-funded plans, employers may also choose to purchase stop-loss insurance to protect against unexpectedly high claims, but the primary responsibility for paying claims lies with the employer. This contrasts with fully insured plans, where the insurance company assumes the financial risk and is responsible for paying all claims in exchange for a premium. Understanding this distinction is crucial for evaluating different health plan options in the context of financial management and employee benefits.

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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://pearsonvuehealthinsurance.examzify.com>

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

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