

PSI Ohio Insurance Practice Exam (Sample)

Study Guide



Everything you need from our exam experts!

This is a sample study guide. To access the full version with hundreds of questions,

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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. Don't worry about getting everything right, 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, and take breaks to retain information better.

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.

7. Use Other Tools

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!

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Questions

- 1. Which of the following best describes the principle of indemnity in insurance?**
 - A. Compensation must equal the loss, not profit the insured.**
 - B. The insurer pays a fixed amount regardless of the loss.**
 - C. Insured can claim amounts for both direct and indirect losses.**
 - D. The principle does not apply to life insurance.**
- 2. What is the term for the dollar amount beyond which the insured does not pay medical expenses?**
 - A. Deductible**
 - B. Stop Loss Limit**
 - C. Out-of-Pocket Maximum**
 - D. Co-insurance Amount**
- 3. What is a primary objective of key employee life insurance?**
 - A. To provide income for the employee**
 - B. To secure financing for the business**
 - C. To replace lost income for beneficiaries**
 - D. To cover operational losses from employee absence**
- 4. How do most disability policies treat a recurrent disability occurring at least 90 days after the first claim?**
 - A. It is treated as a continuation of the previous claim.**
 - B. It must be handled as a new claim requiring a new elimination period.**
 - C. It is automatically covered under the original policy.**
 - D. It will not require any new documentation.**
- 5. A Basic Hospital Policy pays which of the following expenses?**
 - A. Outpatient surgical costs**
 - B. Hospital room and board**
 - C. Emergency room visits**
 - D. Physician's fees**

- 6. Which of the following is a common feature of term life insurance policies?**
- A. Cash value accumulation**
 - B. Flexible premium payments**
 - C. Coverage only for a specified period**
 - D. Guaranteed renewability**
- 7. How can an individual qualify for Social Security Disability Insurance?**
- A. By showing financial need**
 - B. Through previous work credits and disability status**
 - C. By being over the age of 65**
 - D. Through the purchase of a private policy**
- 8. The group conversion option is not allowed during which of the following times?**
- A. After leaving a group plan**
 - B. Upon reaching retirement age**
 - C. During the annual benefits enrollment period**
 - D. Upon termination of employment**
- 9. In order to avoid being classified as a Modified Endowment Contract (MEC), a policy must pass which of the following?**
- A. Five-pay test**
 - B. Seven-pay test**
 - C. Ten-pay test**
 - D. Annual premium test**
- 10. Which of the following cannot be used to qualify for Medicare Parts A and B?**
- A. Age**
 - B. Disability status**
 - C. Financial need**
 - D. End-stage renal disease**

Answers

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

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Explanations

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1. Which of the following best describes the principle of indemnity in insurance?

A. Compensation must equal the loss, not profit the insured.

B. The insurer pays a fixed amount regardless of the loss.

C. Insured can claim amounts for both direct and indirect losses.

D. The principle does not apply to life insurance.

The principle of indemnity in insurance is centered on the idea that an insured person should be compensated for their loss, but not in a way that allows them to profit from that loss. This principle is fundamental to the functioning of insurance, ensuring fairness and preventing moral hazard—the risk that the insured will take more risks because they are protected. When an insured entity suffers a loss, the goal of the indemnity is to restore them to their financial position prior to the loss, not to provide an opportunity for gain. This serves to maintain the integrity of the insurance system by ensuring that claims do not exceed the actual loss suffered. This principle does not apply similarly in all areas of insurance; for instance, in life insurance, the payouts are predetermined and do not directly correlate to any specific loss, which aligns with the nature of the insurance product. Hence, understanding that indemnity is about equating compensation with loss, rather than profit, is crucial for the principles governing most insurance policies.

2. What is the term for the dollar amount beyond which the insured does not pay medical expenses?

A. Deductible

B. Stop Loss Limit

C. Out-of-Pocket Maximum

D. Co-insurance Amount

The term that refers to the dollar amount beyond which the insured does not pay any further medical expenses is the Stop Loss Limit. This limit is a critical component in medical insurance as it protects the insured by capping their total out-of-pocket expenses for a defined period, typically a year. Once the insured's medical expenses reach this limit, the insurance company covers 100% of any additional eligible expenses. This protection is especially vital in scenarios involving catastrophic health events or significant medical needs, where costs can quickly escalate. In contrast, the deductible is the amount the insured must pay out of pocket before the insurance plan starts to pay. The out-of-pocket maximum, while related, specifically refers to the highest amount an individual would pay in total or cumulative expenses during a coverage period, including deductibles, co-payments, and co-insurance. Co-insurance, on the other hand, pertains to the shared costs between the insured and the insurer after the deductible has been met, typically expressed as a percentage. Together, these concepts shape a comprehensive understanding of how out-of-pocket expenses and insurance coverage work in medical insurance.

3. What is a primary objective of key employee life insurance?

- A. To provide income for the employee
- B. To secure financing for the business
- C. To replace lost income for beneficiaries
- D. To cover operational losses from employee absence**

The primary objective of key employee life insurance is to cover operational losses from employee absence. This type of insurance is designed to protect a business in the event of the untimely death of a key employee whose skills, knowledge, or leadership are crucial to the organization's success. When a key employee dies, a business may face various challenges, including loss of productivity, disruption in operations, and potential financial instability. The insurance payout can be used to cover the costs associated with finding and training a replacement or to help maintain cash flow while the business recovers from this significant loss. By providing financial support in such challenging times, key employee life insurance helps ensure the continuity of the business and mitigates risks associated with the loss of critical personnel. This objective emphasizes the policy's role as a strategic tool for business sustainability rather than a direct benefit for the employee or their family. While the other options touch on important aspects of insurance and employee benefits, they do not capture the specific purpose of key employee life insurance in relation to business operations and continuity planning.

4. How do most disability policies treat a recurrent disability occurring at least 90 days after the first claim?

- A. It is treated as a continuation of the previous claim.
- B. It must be handled as a new claim requiring a new elimination period.**
- C. It is automatically covered under the original policy.
- D. It will not require any new documentation.

When a disability policy treats a recurrent disability that occurs at least 90 days after the first claim as requiring a new claim and a new elimination period, it reflects the standard practices in disability insurance. Most policies differentiate between an ongoing disability and a recurrent one that arises after a significant gap, such as the specified 90 days. By structuring it this way, insurance companies ensure that they properly assess the new circumstances surrounding the recurrent disability. The requirement for a new claim and a fresh elimination period allows the insurer to evaluate the claimant's current health status, determine if the previous condition has truly recurred, and assess any changes in benefits that might need to be applied. This approach can help in establishing that the recurrent disability is not merely a continuation of the prior condition, which may have been resolved or improved. It also assists in managing the overall risk and liability of the insurer, ensuring they have the latest and most relevant information to make fair assessments on benefits and coverage.

5. A Basic Hospital Policy pays which of the following expenses?

- A. Outpatient surgical costs**
- B. Hospital room and board**
- C. Emergency room visits**
- D. Physician's fees**

A Basic Hospital Policy primarily covers expenses associated with the actual use of hospital facilities, specifically focusing on hospital room and board. This type of insurance is designed to provide financial assistance for patients who require inpatient care, ensuring that they can cover the costs of being admitted to a hospital, including their stay and meals during that time. While outpatient surgical costs, emergency room visits, and physician's fees may be related to an overarching medical treatment plan, they typically fall under different types of policies or additional coverage. Basic Hospital Policies do not generally encompass these expenses; they emphasize inpatient services rather than outpatient or ancillary services. Therefore, the focus on hospital room and board is a key aspect of what a Basic Hospital Policy is structured to cover.

6. Which of the following is a common feature of term life insurance policies?

- A. Cash value accumulation**
- B. Flexible premium payments**
- C. Coverage only for a specified period**
- D. Guaranteed renewability**

A common feature of term life insurance policies is that they provide coverage only for a specified period. This means that the insurance protection is in place for a predetermined time frame, which can often range from one year to several decades, depending on the policy selected. If the insured passes away during this term, the beneficiaries receive the death benefit; however, if the term expires and the insured is still alive, the coverage ends, and there is typically no payout or accumulation of value. This feature distinguishes term life insurance from whole or universal life policies, which include benefits like cash value accumulation and often have a permanent coverage aspect. Policies with flexible premium payments are more common in permanent life insurance, as term policies usually have fixed premium structures for the duration of the term. While some term policies offer guaranteed renewability, meaning they can be renewed without additional health assessments at the end of the term, this is not a universal characteristic of all term life policies. Therefore, the definitive aspect of term life is its limited duration of coverage.

7. How can an individual qualify for Social Security Disability Insurance?

- A. By showing financial need**
- B. Through previous work credits and disability status**
- C. By being over the age of 65**
- D. Through the purchase of a private policy**

An individual qualifies for Social Security Disability Insurance (SSDI) through previous work credits and proving a qualifying disability status. SSDI is designed for individuals who have previously worked in jobs covered by Social Security and have earned enough work credits, which are based on how long and how much they have worked. To qualify, an applicant must demonstrate that they have a medical condition that meets the Social Security Administration's definition of disability, which generally means that the condition significantly impairs their ability to perform basic work activities and is expected to last at least 12 months or result in death. The other options highlight important concepts but do not align with the requirements for SSDI. Financial need is not a criterion for SSDI, as it is an insurance program based on prior work. Simply being over the age of 65 does not qualify someone for SSDI, as this program is specifically designed for individuals who are disabled and unable to work, regardless of age. Lastly, purchasing a private disability policy is a separate matter and does not relate to the SSDI qualification process.

8. The group conversion option is not allowed during which of the following times?

- A. After leaving a group plan**
- B. Upon reaching retirement age**
- C. During the annual benefits enrollment period**
- D. Upon termination of employment**

The group conversion option is a provision that allows members of a group insurance plan to convert their coverage to an individual policy upon leaving the group. However, this option is not available during specific times, particularly during the annual benefits enrollment period. During this enrollment period, individuals are typically given the opportunity to review and select their benefits for the upcoming year. Since group coverage is still in effect during this time, any conversions to individual plans can interfere with the established group policy and the options available to employees under that plan. This means that during the annual benefits enrollment period, individuals are expected to make selections from the available group options rather than converting their coverage to an individual policy. The other scenarios, such as leaving a group plan, reaching retirement age, or terminating employment, usually present valid opportunities to convert to an individual plan because those events signify a change in eligibility for group coverage, allowing for the conversion option to take effect.

9. In order to avoid being classified as a Modified Endowment Contract (MEC), a policy must pass which of the following?

- A. Five-pay test**
- B. Seven-pay test**
- C. Ten-pay test**
- D. Annual premium test**

To avoid being classified as a Modified Endowment Contract (MEC), a policy must pass the seven-pay test. This test is a crucial measure established by the Internal Revenue Code to ensure that life insurance policies do not accumulate cash value too quickly. The seven-pay test determines whether the total premiums paid in the first seven years of the policy will exceed the total net level premiums that would have been paid for the same amount of insurance over a seven-year period. If a policy fails this test, it will be classified as a MEC, which has different tax implications. For instance, withdrawals and loans taken against a MEC can be taxed differently from those taken against a standard life insurance policy. This classification is important for both insurers and policyholders, as it affects the policy's tax treatment and overall financial strategy. Understanding the significance of the seven-pay test is essential for anyone involved in the sale or management of life insurance products, as it helps ensure compliance with tax regulations while maximizing the benefits of the policy for the insured.

10. Which of the following cannot be used to qualify for Medicare Parts A and B?

- A. Age**
- B. Disability status**
- C. Financial need**
- D. End-stage renal disease**

To qualify for Medicare Parts A and B, individuals generally fall into specific categories including age, disability status, and specific health conditions such as end-stage renal disease. Age is a primary factor, as individuals become eligible for Medicare when they reach 65 years old. Additionally, individuals under 65 may qualify based on disability status if they have received Social Security Disability Insurance (SSDI) for at least 24 months. Those with end-stage renal disease also qualify, regardless of age, allowing them access to Medicare benefits. Financial need, however, is not a qualifying criterion for Medicare Parts A and B. While low-income individuals may be eligible for additional assistance programs, such as Medicaid, the basic eligibility for Medicare itself does not take financial status into account. This distinction is crucial in understanding the fundamental eligibility requirements for the program.

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://psi-ohio.examzify.com>

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