NORTH CAROLINA MEDICARE SUPPLEMENT AND LONG-TERM CARE AGENT PRACTICE TEST (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED 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.

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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!

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Questions

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1. Which Medicare plan typically limits enrollees to a network of providers?

A. Medicare Preferred Provider Organizations (PPOs)

B. Medicare Health Maintenance Organizations (HMOs)

C. Medicare Indemnity Plans

D. Original Medicare

2. What is Medicare Assignment?

A. A system to assign patients to specialists

B. Agreement to accept Medicare-approved payment

C. A form of Medicaid coverage

D. A plan for premium payments

3. What type of care does Part A of Medicare primarily provide?

A. Outpatient care

B. Doctor services

C. Inpatient care in hospitals

D. Preventative services

4. At what stage in the Medicare Part D coverage do insureds face a 25% cost for medications?

A. Initial coverage period

B. Coverage gap

C. Catastrophic coverage

D. Annual deductible phase

5. Which of the following is a requirement for Medicare PPO enrollees?

A. They must have a primary care physician

B. They need referrals to see specialists

C. They can see any doctor that accepts Medicare

D. They are not allowed to go out of network

6. What context is respite care primarily associated with?

A. Hospitalization care

B. Recreational activities

C. Caregiving relief

D. Physical therapy support

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7. How many home health care visits does Medicare typically cover if medically required?

A. Unlimited

B. 28 hours per week

C. 12 visits per month

D. 15 hours per week

8. What does the Specified Low-Income Medicare Beneficiary (SLMB) program cover?

A. Both Medicare Part A and Part B premiums

B. Medicare Part A premiums only

C. Medicare Part B premiums only

D. Long-term care facility charges

9. What does Medigap Plan A cover?

A. Basic coverage, including Medicare Part B's 80%

B. Standardized coverage for emergency services only

C. 100% of Medicare Part A hospital costs and Part B copayments

D. Limited coverage for outpatient therapy

10. What types of services does Medicare Part B cover?

A. Routine dental care and preventive services

B. Oxygen tanks and supplies, ambulance services, and physician services

C. Long-term care and assisted living services

D. Vision care and hearing aids

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Answers

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

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Explanations

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1. Which Medicare plan typically limits enrollees to a network of providers?

A. Medicare Preferred Provider Organizations (PPOs)

B. Medicare Health Maintenance Organizations (HMOs)

C. Medicare Indemnity Plans

D. Original Medicare

Medicare Health Maintenance Organizations (HMOs) are designed to provide care through a specific network of doctors, hospitals, and other providers. Enrollees are typically required to choose a primary care physician within this network and need referrals to see specialists. This structure encourages coordinated care and usually results in lower costs for consumers, but it limits the flexibility in choosing healthcare providers compared to other Medicare plans. In contrast, Medicare Preferred Provider Organizations (PPOs) also have a network but typically offer more flexibility, allowing enrollees to see out-of-network providers, albeit at a higher cost. Medicare Indemnity Plans and Original Medicare do not restrict beneficiaries to a network, giving them the freedom to see any provider that accepts Medicare. Thus, the defining characteristic of HMOs is the limitation to a network of providers, making this choice the correct answer.

2. What is Medicare Assignment?

A. A system to assign patients to specialists

B. Agreement to accept Medicare-approved payment

C. A form of Medicaid coverage

D. A plan for premium payments

Medicare Assignment refers to the agreement between a healthcare provider and Medicare under which the provider agrees to accept the Medicare-approved amount as full payment for covered services. This means that if a provider is "accepting assignment," they will bill Medicare directly, accept the amount Medicare pays as payment in full, and cannot charge the beneficiary more than the Medicare co-payment or deductible. This is important as it protects beneficiaries from higher charges and ensures that they only pay the predetermined amounts set by Medicare. When a provider does not accept assignment, they can charge higher prices, which may result in additional out-of-pocket costs for the patient. In contrast, the other options describe unrelated concepts. For instance, assigning patients to specialists or describing forms of Medicaid coverage do not pertain to the Medicare assignment process, nor does a plan for premium payments directly relate to this agreement. Thus, understanding Medicare Assignment is crucial for navigating healthcare costs and ensuring proper billing practices within the Medicare system.

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3. What type of care does Part A of Medicare primarily provide?

A. Outpatient care

B. Doctor services

C. Inpatient care in hospitals

D. Preventative services

Part A of Medicare primarily provides inpatient care in hospitals, which includes services related to emergency room visits, hospital stays, and some types of skilled nursing facility care after a hospitalization. This part of Medicare is designed to cover the costs of necessary inpatient treatments, which can involve both medical and surgical procedures, as well as hospice care and limited home health services under specific conditions. Inpatient care is critical for individuals who require close monitoring and extensive medical treatment, such as surgeries or serious health conditions that cannot be managed safely in an outpatient setting. The comprehensive nature of inpatient care under Part A reflects the program's focus on addressing acute medical needs that require hospitalization. This coverage helps ensure that beneficiaries have access to necessary care when facing significant health issues. The other options, such as outpatient care, doctor services, and preventative services, are primarily associated with Part B of Medicare, which focuses on maintaining health and providing necessary treatments in less acute settings.

4. At what stage in the Medicare Part D coverage do insureds face a 25% cost for medications?

A. Initial coverage period

B. Coverage gap

C. Catastrophic coverage

D. Annual deductible phase

The phase in which insureds face a 25% cost for medications is actually during the coverage gap in the Medicare Part D plan. This stage is also commonly known as the "donut hole." During the coverage gap, beneficiaries are responsible for a higher percentage of their prescription drug costs compared to the initial coverage period. In the initial coverage period, beneficiaries pay a fixed copayment or coinsurance until they reach a certain limit on their covered prescription drug costs. After reaching this limit, they enter the coverage gap, where they are required to pay a percentage of the cost of their prescriptions—25% of the cost for both brand-name and generic drugs as of the latest policies. Once their out-of-pocket costs reach a specific threshold, beneficiaries then move into catastrophic coverage, where they'll only pay a small copayment or coinsurance for medications for the rest of the year. Understanding this structure helps clarify the financial responsibilities at different stages of Medicare Part D coverage and emphasizes the significance of the coverage gap in the overall plan.

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5. Which of the following is a requirement for Medicare PPO enrollees?

A. They must have a primary care physician

B. They need referrals to see specialists

C. They can see any doctor that accepts Medicare

D. They are not allowed to go out of network

The requirement for Medicare PPO enrollees is that they can see any doctor that accepts Medicare. This flexibility is a hallmark of Medicare Preferred Provider Organization (PPO) plans. Enrollees are not restricted to a network of providers; they have the freedom to choose healthcare providers, including specialists, without needing a referral and regardless of whether those providers are within the plan's preferred network or not. This attribute is particularly appealing to individuals who desire a broader choice of medical providers or those who might travel frequently and require care from various physicians across different locations. The other choices do not reflect the key features of a PPO plan. For example, requiring a primary care physician or needing referrals to see specialists is more characteristic of Health Maintenance Organization (HMO) plans, which emphasizes coordinated care through a primary doctor. Additionally, while there may be out-of-network costs associated with seeing providers outside of the network, PPOs do allow members to receive care from out-of-network providers, which is not permitted in certain plan types.

6. What context is respite care primarily associated with?

A. Hospitalization care

B. Recreational activities

C. Caregiving relief

D. Physical therapy support

Respite care is primarily associated with caregiving relief because it is designed to give primary caregivers a temporary break from their caregiving responsibilities. This respite allows caregivers to take time off to rest, recharge, or attend to their own needs, while ensuring that the individual they care for receives professional care. This type of care can take place in various settings, such as at home, in adult day care centers, or in residential facilities, and it typically involves trained professionals or volunteers who step in to provide support. By alleviating the demands placed on caregivers, respite care plays a crucial role in helping sustain the caregiver's physical and emotional well-being, thereby improving their ability to provide ongoing care. The other contexts mentioned, such as hospitalization care, recreational activities, and physical therapy support, do not encompass the primary focus of respite care, which is centered specifically around offering relief to caregivers.

7. How many home health care visits does Medicare typically cover if medically required?

A. Unlimited

B. 28 hours per week

C. 12 visits per month

D. 15 hours per week

Medicare typically covers home health care visits as long as they are deemed medically necessary and provided under the supervision of a physician. There is no strict limit on the number of visits, which means that if the health care provider recommends more visits based on the patient's condition and needs, Medicare can continue to cover these services. The key factor is the patient's eligibility and medical necessity, rather than a specific numerical cap on visits. This flexibility is crucial because some patients may require frequent visits for changing conditions or rehabilitation needs. Understanding the nuances of home health care under Medicare is essential for both health care providers and beneficiaries to ensure that necessary services are delivered without unnecessary financial burden.

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8. What does the Specified Low-Income Medicare Beneficiary (SLMB) program cover?

A. Both Medicare Part A and Part B premiums

B. Medicare Part A premiums only

C. Medicare Part B premiums only

D. Long-term care facility charges

The Specified Low-Income Medicare Beneficiary (SLMB) program is designed specifically to assist eligible individuals by paying for their Medicare Part B premiums. This program is aimed at helping those who may struggle to afford their Part B costs, which provide essential coverage for outpatient care, doctor visits, and other services that are not covered by Medicare Part A. Participants in the SLMB program do not receive assistance for Medicare Part A premiums or for any long-term care facility charges, which means that they need to manage those costs independently. This focus on Part B premiums is crucial for low-income beneficiaries who might otherwise forgo necessary medical care due to financial concerns. Thus, the correct understanding of the SLMB program centers around its role in alleviating the financial burden associated with Medicare Part B, making it easier for eligible beneficiaries to access critical healthcare services.

9. What does Medigap Plan A cover?

A. Basic coverage, including Medicare Part B's 80%

B. Standardized coverage for emergency services only

C. 100% of Medicare Part A hospital costs and Part B copayments

D. Limited coverage for outpatient therapy

Medigap Plan A provides foundational benefits that play a vital role in covering healthcare costs that Medicare doesn't fully pay. Specifically, this plan covers the costs associated with Medicare Part A hospital services after the beneficiary meets their deductible. It includes coverage for hospital stays, skilled nursing facility care, and certain home health services. Additionally, Medigap Plan A covers Medicare Part B copayments, meaning it helps pay for costs that are incurred when a beneficiary receives outpatient care and services. This plan is designed to offer a basic level of protection against the out-of-pocket costs that can arise from using Medicare services, making it a suitable choice for those seeking essential coverage without the additional features that some other plans might provide. Understanding these benefits allows beneficiaries to better manage their healthcare expenses and choose a Medigap plan that aligns with their needs.

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10. What types of services does Medicare Part B cover?

A. Routine dental care and preventive services

B. Oxygen tanks and supplies, ambulance services, and physician services

C. Long-term care and assisted living services

D. Vision care and hearing aids

Medicare Part B is designed to cover a wide range of outpatient services and supplies that are essential for maintaining health and managing medical conditions. The correct answer highlights services such as oxygen tanks and supplies, ambulance services, and physician services, all of which fall within the domain of Part B coverage. Oxygen tanks and supplies are crucial for patients with respiratory conditions, allowing them to receive necessary treatment in their homes or elsewhere. Ambulance services are also covered under Part B when transport is medically necessary, providing access to hospital services when urgent care is needed. Furthermore, physician services include a variety of physician office visits, outpatient care, preventive services, certain types of surgeries, and many other essential medical treatments. In contrast, the other options do not accurately reflect the services covered by Medicare Part B. Routine dental care and preventive services are typically not fully covered under Part B; similarly, long-term care and assisted living services are outside of Part B's coverage, often requiring separate insurance or Medicaid assistance. Lastly, while Medicare may cover certain vision care services, routine eyeglasses or vision checks are not included in Part B, and hearing aids are also generally not covered. Therefore, the specifics of the services listed in the correct choice align well with the benefits provided by

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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:

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

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