UNITED HEALTH COVERAGE (UHC) MEDICARE BASICS 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. Can a beneficiary change their Medicare plan outside of the Open Enrollment Period?

A. No, changes can only happen during Open Enrollment

B. Yes, under certain circumstances

C. Only if they have a serious health condition

D. Changes are not allowed after the initial enrollment

2. Which statement does not correctly define prescription drug stages?

A. All users pay the exact same deductible

B. Stage costs can vary depending on medication type

C. There is a cap on what members pay in each stage

D. Stages can impact the overall cost of medications

3. What is a "network" in the context of Medicare Advantage plans?

A. A facility where all Medicare claims are processed

B. A group of doctors, hospitals, and providers contracted with a Medicare Advantage plan

C. Any healthcare provider that accepts Medicare patients

D. A national database of Medicare providers

4. Which of the following is NOT one of the four parts of Medicare?

A. Part A

B. Part B

C. Part C

D. Part E

5. What is one eligibility requirement for Original Medicare?

A. Being 70 years of age or older

B. Being under 65 years of age with certain disabilities for more than 24 months

C. Having a low income

D. All of the above

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6. Which type of Medicare plan generally requires referrals to see specialists?

A. Medicare Fee-for-Service

B. Health Maintenance Organization (HMO)

C. Preferred Provider Organization (PPO)

D. Stand-alone Prescription Drug Plan

7. What does the Medicare Card indicate?

A. That an individual is eligible for Medicaid

B. That an individual is enrolled in Medicare

C. That an individual has private health insurance

D. That an individual has reached retirement age

8. Can spouses apply for Medicare based on their partner's work history?

A. No, only individuals can apply independently

B. Yes, if they are aged 65 or older and have been married for at least a year

C. Yes, regardless of age or marriage duration

D. Only if the primary breadwinner is deceased

9. Which statement accurately describes the difference between Original Medicare and Medicare Advantage?

A. Both are run by private companies

B. Original Medicare is managed by the federal government, while Medicare Advantage is offered by private insurers

C. Original Medicare covers outpatient services only

D. Medicare Advantage does not include hospital coverage

10. Which group primarily benefits from Medigap insurance?

A. Individuals with employer-provided insurance

B. Those who need coverage for out-of-pocket costs related to Original Medicare

C. People under 30

D. Individuals eligible for Medicaid

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Answers

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

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Explanations

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1. Can a beneficiary change their Medicare plan outside of the Open Enrollment Period?

A. No, changes can only happen during Open Enrollment

B. Yes, under certain circumstances

C. Only if they have a serious health condition

D. Changes are not allowed after the initial enrollment

Beneficiaries can change their Medicare plan outside of the Open Enrollment Period under certain circumstances, which makes this the correct choice. These circumstances may include situations such as moving to a new area, losing current coverage, or experiencing a change in financial status that qualifies them for extra assistance. Additionally, beneficiaries may also be eligible for special enrollment periods due to specific life events, such as getting married or divorced, or when they qualify for Medicaid. While there are designated enrollment periods for making changes to Medicare plans, the existence of special enrollment periods allows for flexibility to ensure that beneficiaries can maintain appropriate coverage in response to life's changes and unexpected situations. This policy is designed to ensure beneficiaries aren't locked into their plans and have options to adjust their coverage when their needs change.

2. Which statement does not correctly define prescription drug stages?

A. All users pay the exact same deductible

B. Stage costs can vary depending on medication type

C. There is a cap on what members pay in each stage

D. Stages can impact the overall cost of medications

The statement regarding all users paying the exact same deductible is incorrect because deductibles for prescription drug plans can differ based on the specific plan a member has enrolled in. Each Medicare Part D plan may set its own deductible amount, which members must meet before their coverage starts. This variability means that not all users are subject to the same deductible, as it can change from one plan to another depending on factors such as plan design and regional availability. In contrast, the other statements accurately reflect how prescription drug coverage works. Costs can vary based on the medication type, as some drugs may have different price tiers in the formulary. There is indeed a cap on what members pay in each stage, which is a protective measure to prevent excessive out-of-pocket spending. Lastly, the stages of cost-sharing (deductible, initial coverage, coverage gap, and catastrophic coverage) can significantly impact the overall cost of medications for beneficiaries, influencing how much they spend throughout the coverage year depending on their drug usage and plan structure.

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3. What is a "network" in the context of Medicare Advantage plans?

A. A facility where all Medicare claims are processed

B. A group of doctors, hospitals, and providers contracted with a Medicare Advantage plan

C. Any healthcare provider that accepts Medicare patients

D. A national database of Medicare providers

In the context of Medicare Advantage plans, a "network" refers to a group of doctors, hospitals, and providers that have contracted with a Medicare Advantage plan to provide services to its members. This network is an essential aspect of how these plans operate, as they typically offer lower costs and coordinated care for services rendered by in-network providers. Members of a Medicare Advantage plan are encouraged to use these contracted providers to ensure they receive covered services at the lowest cost possible, as out-of-pocket expenses can be significantly higher when utilizing out-of-network providers. This arrangement helps manage healthcare costs and ensures that the plan can provide comprehensive care while maintaining quality and efficiency. The other choices do not accurately represent the concept of a network within the framework of Medicare Advantage plans. For instance, a facility where claims are processed is not directly related to the healthcare providers available to members, while the description of healthcare providers that accept Medicare patients does not pertain to the structure of provider networks specifically associated with Medicare Advantage plans. Lastly, a national database of Medicare providers refers to a broader compilation of providers, rather than a specific group contracted to a particular plan.

4. Which of the following is NOT one of the four parts of Medicare?

A. Part A

B. Part B

C. Part C

D. Part E

Medicare is structured into four defined parts: Part A, Part B, Part C, and Part D. Each part addresses different aspects of healthcare coverage for eligible individuals, primarily those aged 65 and older or those with specific disabilities. Part A covers inpatient hospital stays, skilled nursing facility care, hospice care, and some home health care. Part B focuses on outpatient care, including doctor visits, preventive services, and outpatient hospital services. Part C, or Medicare Advantage, allows beneficiaries to receive their Medicare benefits through private insurance plans that may incorporate coverage from multiple parts. Finally, Part D offers prescription drug coverage. Since D is not part of this established framework, it is the correct choice as the option that is not a part of Medicare. The existence of only four parts—A, B, C, and D—clarifies that while the first three are essential components of the Medicare program, E does not exist within this system.

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5. What is one eligibility requirement for Original Medicare?

A. Being 70 years of age or older

B. Being under 65 years of age with certain disabilities for more than 24 months

C. Having a low income

D. All of the above

One eligibility requirement for Original Medicare is being under 65 years of age with certain disabilities for more than 24 months. This provision is part of the Social Security Administration's regulations, allowing individuals who qualify due to a disability to access Medicare coverage earlier than the traditional age threshold of 65. Individuals who have received Social Security Disability Insurance (SSDI) for 24 months automatically become eligible for Medicare, regardless of their age. This option is critical as it extends health care coverage to younger individuals who may not otherwise qualify based solely on age. The other potential options in the question do not align with the primary eligibility criteria for Original Medicare. For instance, while age 70 and older represents an age group often covered by Medicare, simply reaching that age without the requisite other qualifications does not guarantee coverage. Similarly, having a low income is relevant for some Medicare programs, such as Medicare Savings Programs or Medicaid, but it does not directly qualify someone for Original Medicare itself. Thus, the specific requirement concerning individuals under age 65 with disabilities is the correct criteria representing eligibility for Original Medicare.

6. Which type of Medicare plan generally requires referrals to see specialists?

A. Medicare Fee-for-Service

B. Health Maintenance Organization (HMO)

C. Preferred Provider Organization (PPO)

D. Stand-alone Prescription Drug Plan

Health Maintenance Organization (HMO) plans are designed to manage healthcare costs and ensure coordinated care among providers. In an HMO structure, members typically need to select a primary care physician (PCP) who serves as the main point of contact for their healthcare needs. This PCP is responsible for overseeing the patient's care and referring them to specialists when necessary. The referral requirement is a key feature of HMO plans, as it helps to create a controlled environment in which necessary services are reviewed and approved by the primary care provider. This system encourages preventive care and can help streamline the process of accessing healthcare services, but it also means that members may need to go through their PCP to seek specialized treatment or diagnostics. In contrast, other plans like Medicare Fee-for-Service allow beneficiaries to see any doctor that accepts Medicare without needing a referral, providing more flexibility. Preferred Provider Organizations (PPO) offer a broader range of choices as well, allowing members to see specialists without referrals, albeit often at a higher cost if they go out of network. Stand-alone Prescription Drug Plans focus solely on providing prescription medication coverage, and do not involve referrals or specialist visits at all.

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7. What does the Medicare Card indicate?

A. That an individual is eligible for Medicaid

B. That an individual is enrolled in Medicare

C. That an individual has private health insurance

D. That an individual has reached retirement age

The Medicare Card is a key indicator that an individual is enrolled in Medicare. This card is issued to beneficiaries who have met the eligibility requirements, which typically include being 65 years of age or older, or having specific disabilities or medical conditions. It serves as proof of enrollment in the Medicare program, allowing individuals to access the benefits provided under Medicare, including Part A (Hospital Insurance) and Part B (Medical Insurance). The card displays the individual's name, Medicare number, and the coverage type, which confirms their enrollment status and benefits. Understanding this is crucial for beneficiaries, as the card is necessary for receiving health care services and for providers to bill Medicare accurately.

8. Can spouses apply for Medicare based on their partner's work history?

A. No, only individuals can apply independently

B. Yes, if they are aged 65 or older and have been married for at least a year

C. Yes, regardless of age or marriage duration

D. Only if the primary breadwinner is deceased

Spouses can indeed apply for Medicare based on their partner's work history, provided that specific conditions are met. The correct answer indicates that spouses aged 65 or older who have been married for at least one year are eligible to apply for Medicare using their partner's work history. This is essential because Medicare often requires beneficiaries to have a qualifying work record, which typically means they must have contributed to Social Security for a certain number of quarters. Eligibility for Medicare benefits based on a spouse's work record highlights the collaborative support built into the program, which recognizes the importance of familial roles in financial planning for healthcare during retirement. Additionally, by allowing spousal access to Medicare, it ensures that couples can maintain healthcare continuity, even if only one partner has the requisite work history. Understanding the nuances of eligibility not only reflects the intentions behind the Medicare program but also aids couples in making informed decisions regarding their healthcare coverage as they age. Spouses can leverage this option as a significant benefit, assuming the outlined conditions—age and duration of marriage—are fulfilled.

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9. Which statement accurately describes the difference between Original Medicare and Medicare Advantage?

A. Both are run by private companies

B. Original Medicare is managed by the federal government, while Medicare Advantage is offered by private insurers

C. Original Medicare covers outpatient services only

D. Medicare Advantage does not include hospital coverage

The distinction that Original Medicare is managed by the federal government while Medicare Advantage is offered by private insurers is pivotal in understanding how these two programs operate. Original Medicare consists of two parts: Part A, which covers hospital insurance, and Part B, which covers medical insurance. This program is administered directly by the Centers for Medicare & Medicaid Services (CMS) and is uniformly available across the United States. On the other hand, Medicare Advantage plans, also known as Medicare Part C, are an alternative way to receive Medicare benefits. These plans are offered by private insurance companies that contract with Medicare to provide all the benefits of Original Medicare, and often include additional coverage like vision, dental, and sometimes prescription drugs. This clear division of responsibility highlights the structural differences between the two options. While both programs aim to provide health coverage to seniors and certain younger individuals with disabilities, they do so under different management and organizational frameworks. The option indicating that Original Medicare is managed by the government aligns perfectly with this understanding, making it the correct statement.

10. Which group primarily benefits from Medigap insurance?

A. Individuals with employer-provided insurance

B. Those who need coverage for out-of-pocket costs related to Original Medicare

C. People under 30

D. Individuals eligible for Medicaid

Medigap insurance, also known as Medicare Supplement Insurance, is designed to help pay for certain out-of-pocket costs that Original Medicare does not cover. This includes deductibles, copayments, and coinsurance, which can add up significantly for beneficiaries. As Original Medicare typically only covers about 80% of approved medical expenses, many individuals find that the remaining costs can be burdensome. Therefore, those who enroll in Medigap plans primarily do so to gain financial protection against these additional costs, enhancing their overall healthcare coverage. Doing so allows them to manage their healthcare expenses more effectively, ensuring they receive necessary medical services without a heavy financial burden. The other groups mentioned do not align with the primary purpose of Medigap. Individuals with employer-provided insurance often have coverage that can work alongside Medicare or even replace the need for Medigap. People under 30 typically do not meet the eligibility requirements for Medicare in general, and individuals eligible for Medicaid have state-sponsored insurance that often provides broader coverage without the need for Medigap.

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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://unitedhealthcoveragemedicarebasics.examzify.com

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

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