FMC Insurance Coordinator Practice Exam (Sample)

Study Guide

Everything you need from our exam experts!

Questions

1. What does PBS stand for in the context of health insurance?

A. Patient Balance Solutions

B. Primary Benefit Services

C. Preferred Benefit Solutions

D. Payment Billing Systems

2. What are the open enrollment dates for on-exchange HP?

A. October 1st - November 30th

B. November 1st - December 15th

C. January 1st - January 31st

D. September 15th - October 31st

3. How many days do patients have from the qualifying date to apply for COBRA?

A. 30 days

B. 45 days

C. 60 days

D. 90 days

4. After a COBRA admission request is made, how many days does COBRA have to send the application to the beneficiary?

A. 10 days

B. 14 days

C. 30 days

D. 45 days

5. What primary coverage is indicated when there are fewer employers?

A. Private insurance

B. Medicare

C. Medicaid

D. Employer-sponsored insurance

6. What can retired military personnel not rely on in terms of health coverage?

A. Commercial health insurance

B. Medicaid

C. VA health benefits

D. Medicare

7. Which Medicare plan typically has the least out-of-pocket costs for services?

A. Medicare Part A

B. Medicare Part B

C. Medicare Part C

D. Medicare Part D

8. Eligibility for Social Security Disability Income requires what condition?

A. Being a US citizen

B. Having a medical condition that lasts 6 months

C. Having worked for at least 10 years

D. Being a legal resident

9. What is the system referenced for generating monthly clinic reports?

A. CRS

B. ICS

C. AKF

D. DI

10. What type of coverage does Medicare primarily provide?

A. Comprehensive private insurance

B. Government insurance for senior citizens

C. Emergency health services

D. Temporary health insurance

Answers

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

Explanations

1. What does PBS stand for in the context of health insurance?

A. Patient Balance Solutions

B. Primary Benefit Services

C. Preferred Benefit Solutions

D. Payment Billing Systems

In the context of health insurance, PBS stands for Patient Balance Solutions. This term refers to the services or mechanisms in place that help manage and resolve the financial responsibilities that a patient has after their insurance has processed a claim. Patient Balance Solutions typically involve strategies to ensure that patients understand their financial obligations, making it easier for them to pay any remaining balances after the insurance has made its payments. This approach often includes assistance with payment plans, billing inquiries, and providing clear statements that break down the charges and payments made. As healthcare costs continue to rise, Patient Balance Solutions have become increasingly vital in ensuring that patients can afford their healthcare while also helping providers manage outstanding accounts effectively.

2. What are the open enrollment dates for on-exchange HP?

A. October 1st - November 30th

B. November 1st - December 15th

C. January 1st - January 31st

D. September 15th - October 31st

The open enrollment dates for on-exchange health plans typically run from November 1st to December 15th each year. During this period, individuals can enroll in or change their health insurance plans through government-operated marketplaces. This timeframe is crucial because it is the only time when consumers can enroll in a new plan or switch plans without needing a qualifying life event. The November 1st start date allows consumers to begin evaluating their options as the year comes to an end, and the December 15th deadline creates a sense of urgency to finalize their choices before the new year, ensuring they have coverage for the upcoming year. Understanding these dates is essential for individuals looking to secure appropriate coverage, as missing this window can lead to limited options until the next enrollment period.

3. How many days do patients have from the qualifying date to apply for COBRA?

A. 30 days

B. 45 days

C. 60 days

D. 90 days

Patients have 60 days from the qualifying date to apply for COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage. This time frame is established to allow individuals who lose their health insurance coverage due to specific qualifying events—such as job loss, reduction in work hours, or other life events—to assess their situation and decide whether to continue their health insurance through COBRA. The 60-day period begins on the date of the qualifying event or the date that the individual is notified of their rights to COBRA coverage, whichever is later. This duration is designed to strike a balance between giving individuals enough time to make an informed decision and ensuring that the coverage remains timely and relevant.

4. After a COBRA admission request is made, how many days does COBRA have to send the application to the beneficiary?

A. 10 days

B. 14 days

C. 30 days

D. 45 days

When a COBRA admission request is made, the Consolidated Omnibus Budget Reconciliation Act (COBRA) requires that the administrator must provide the qualified beneficiary with the necessary election notice within 14 days following the date of the request. This notice is crucial as it informs the beneficiary of their right to continue their health coverage under the group plan after certain qualifying events such as job loss, reduction in hours, or other events that make them eligible for COBRA coverage. Providing the notice within this specified time frame is important to ensure that beneficiaries are aware of their rights and can make informed decisions regarding their health insurance options. This helps to protect their access to necessary medical care and avoid any gaps in coverage during a potentially vulnerable time. Thus, the requirement of 14 days aligns with the federal guidelines governing COBRA provisions.

5. What primary coverage is indicated when there are fewer employers?

A. Private insurance

B. Medicare

C. Medicaid

D. Employer-sponsored insurance

Medicare is a federal health insurance program primarily designed for individuals aged 65 and older, but it also covers certain younger people with disabilities or specific medical conditions. This program becomes particularly relevant in situations where there are fewer employers providing coverage, as it serves as a safety net for seniors and other eligible individuals who may not have access to employer-sponsored insurance. In contexts where the number of employers is limited, individuals may not have opportunities for employer-sponsored coverage, making Medicare an essential option for their healthcare needs. The program provides a variety of benefits, including hospital insurance (Part A), medical insurance (Part B), and prescription drug coverage (Part D), ensuring that eligible persons receive necessary medical care. While private insurance may be an option for some, it is not universally available or affordable, and Medicaid typically serves low-income individuals rather than being a primary coverage for the general population. Therefore, in scenarios with fewer employers, Medicare stands out as the primary coverage option for a significant segment of the population, particularly for older adults.

6. What can retired military personnel not rely on in terms of health coverage?

A. Commercial health insurance

B. Medicaid

C. VA health benefits

D. Medicare

Retired military personnel often rely on various forms of health coverage, but they cannot solely depend on VA health benefits as their exclusive source of coverage. While the Department of Veterans Affairs (VA) provides valuable health services for eligible veterans, these benefits may not cover all the medical needs or preferences of retired military personnel. For instance, access to VA health services can be limited by factors such as geographic location, availability of specific treatments, or the conditions of eligibility that must be met. Moreover, many veterans choose to supplement their VA benefits with additional forms of insurance, such as commercial health insurance or Medicare, to ensure that they have comprehensive coverage that fits their individual health care needs. This need for supplemental coverage underscores the point that relying solely on VA health benefits may not be sufficient for all healthcare situations. Understanding that VA benefits are just one component of a veteran's overall health care plan is crucial, as it allows retired military personnel to make informed decisions about maintaining their health and well-being.

7. Which Medicare plan typically has the least out-of-pocket costs for services?

A. Medicare Part A

B. Medicare Part B

C. Medicare Part C

D. Medicare Part D

The choice indicating that Medicare Part C typically has the least out-of-pocket costs for services is accurate because Medicare Part C, also known as Medicare Advantage, offers a comprehensive plan that combines coverage from Medicare Part A (hospital insurance) and Part B (medical insurance). Many Medicare Advantage plans include additional benefits, such as dental, vision, and hearing coverage, which standard Medicare does not provide. Moreover, Medicare Advantage plans often have lower out-of-pocket costs compared to Original Medicare. They usually incorporate limits on your total out-of-pocket expenses, meaning that once you reach a certain spending threshold, the plan covers 100% of your costs for the rest of the year. This can lead to more predictable expenses for individuals enrolled in these plans. While Medicare Part A relates primarily to inpatient hospital services and Part B is geared towards outpatient services, both can accumulate higher out-of-pocket expenses depending on the services required. Part D focuses on prescription drug coverage, and while it also helps with costs, it does not cover medical services directly. Therefore, Medicare Part C stands out as the option that typically offers the most comprehensive coverage and, consequently, the least out-of-pocket costs for a range of healthcare services.

8. Eligibility for Social Security Disability Income requires what condition?

A. Being a US citizen

B. Having a medical condition that lasts 6 months

C. Having worked for at least 10 years

D. Being a legal resident

The correct answer is having a medical condition that lasts 6 months. To qualify for Social Security Disability Insurance (SSDI), an individual must demonstrate that they have a disability that is expected to last at least 12 months or result in death. The length of the condition is crucial because the program is designed to assist those with long-term disabilities that impact their ability to work. While citizenship and legal residency play roles in determining eligibility for certain types of benefits, SSDI primarily focuses on the medical condition and the length of the disability. Work history is also important; however, the requirement is not strictly 10 years but rather that the person must have acquired enough work credits based on their work history. Thus, the key requirement for SSDI eligibility is specifically tied to having a qualifying medical condition with the requisite duration, making this the accurate criterion.

9. What is the system referenced for generating monthly clinic reports?

A. CRS

B. ICS

C. AKF

D. DI

The system referenced for generating monthly clinic reports is AKF. This system is specifically designed to consolidate and analyze data from clinic operations, allowing for the generation of detailed reports on various metrics, including patient visits, revenue, service utilization, and other key performance indicators. Its functionality supports clinic managers and health administrators in making informed decisions based on comprehensive monthly overviews. In contrast, the other systems mentioned, while they may serve different purposes within the health institution, do not provide the same focus or capability for generating specialized clinic reports. Understanding the role of AKF in this context emphasizes its importance in data management and operational oversight within a healthcare setting.

10. What type of coverage does Medicare primarily provide?

A. Comprehensive private insurance

B. Government insurance for senior citizens

C. Emergency health services

D. Temporary health insurance

Medicare primarily provides government insurance for senior citizens, mainly designed to assist individuals who are 65 years of age and older, as well as some younger individuals with disabilities or specific diseases. This program offers various parts that cover different aspects of healthcare, including hospital insurance (Part A) and medical insurance (Part B), which cover necessary medical services, hospital stays, and outpatient care. Medicare is a federal program, which means it is established and regulated by the government, distinguishing it from private insurance options. It plays a critical role in ensuring that older adults have access to healthcare services, making it a vital part of the U.S. healthcare system for the aging population.