FMC Insurance Coordinator Practice Exam (Sample)

Study Guide

Everything you need from our exam experts!

Table of Contents

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

1. If a transplant patient returns after 36 months, when does the new COB take effect?

A. 1st day of the following month

B. 1st day of the 3rd month

C. 1st day of the 1st month

D. Immediately upon return

2. What is usually required for Medicare Part D beneficiaries before coverage resumes during the coverage gap?

A. Annual income assessment

B. Filing a claim with their provider

C. Reaching their deductible

D. Obtaining a referral

3. Which form is necessary to apply for Medicare via mail?

A. Form 2728

B. Form 1040

C. Form W-2

D. Form 1099

4. How long is the period for which Medicare will pay secondary to an Employer Group Health Plan (EGHP)?

A. 18 months

B. 24 months

C. 30 months

D. 36 months

5. What does the "donut hole" refer to in Medicare Part D?

A. A subsidy for low-income seniors

B. A coverage gap where patients pay out-of-pocket

C. A penalty for late enrollment

D. A limit on the number of prescriptions covered

6. What occurs if a patient restarts COB within 12 months?

A. A new COB is established

B. The same COB remains

C. The previous plan is reinstated

D. No COB is necessary

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. What does MCD stand for in healthcare?

A. Medicare Development

B. Medicaid

C. Medicare Coverage Document

D. Medical Care Division

9. If a person applies for on-exchange HP before December 15th, when does the plan become effective?

A. February 1st

B. December 15th

C. January 1st

D. Immediate effect

10. 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

Answers

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

Explanations

1. If a transplant patient returns after 36 months, when does the new COB take effect?

A. 1st day of the following month

B. 1st day of the 3rd month

C. 1st day of the 1st month

D. Immediately upon return

When a transplant patient returns after 36 months, the new Coordination of Benefits (COB) takes effect on the 1st day of the 1st month following the return. This is based on the policies governing COB, where a patient usually needs to reestablish their coverage under the new circumstances, especially after a significant period has elapsed since their last treatment or service related to their transplant. In this case, the 1st day of the 1st month indicates that the coverage will activate from the beginning of the month immediately after the patient's return, allowing for a clean administrative cutoff. This ensures that any claims start being processed under the newly coordinated benefits right away, avoiding any confusion or billing issues that could arise from overlapping or confusing coverage periods. Such clear timing facilitates a smoother transition for patients as they resume care, while also aligning with standard insurance procedures regarding the starting points of coverage after extended absences.

2. What is usually required for Medicare Part D beneficiaries before coverage resumes during the coverage gap?

A. Annual income assessment

B. Filing a claim with their provider

C. Reaching their deductible

D. Obtaining a referral

Medicare Part D beneficiaries typically experience a coverage gap, often referred to as the "donut hole," where they must pay a higher percentage of their drug costs. Before their coverage resumes, beneficiaries are generally required to reach their deductible amount. This deductible is a predetermined amount that enrollees must pay out-of-pocket for their medications before their Medicare Part D plan begins to cover costs again. Once beneficiaries have spent enough to meet this deductible during the coverage gap, their insurance will once again contribute towards their drug costs. The other choices do not align with the requirements for resuming coverage. For instance, an annual income assessment is more relevant to determining eligibility for certain programs or subsidies but does not directly affect the resumption of coverage in the context of the coverage gap. Filing a claim with a provider is part of the claims process, but it is not specifically linked to the conditions under which coverage resumes in the coverage gap. Similarly, obtaining a referral is not a requirement for Medicare Part D, as it primarily applies to Medicare Part B and is associated with accessing certain types of healthcare services rather than prescription drug coverage. Therefore, reaching the deductible is the correct requirement before coverage resumes during this period.

3. Which form is necessary to apply for Medicare via mail?

A. Form 2728

B. Form 1040

C. Form W-2

D. Form 1099

The necessary form to apply for Medicare via mail is Form 2728. This form is specifically designed for individuals to initiate their application for Medicare benefits, particularly for those who are eligible based on age or disability. It collects essential information needed for enrollment, ensuring that the application process follows regulatory requirements. The other forms listed serve different purposes. Form 1040 is an individual income tax return form used mainly for reporting personal income to the IRS. Form W-2 is related to wage and tax reporting, provided by employers to employees, summarizing income and withholdings. Form 1099 is utilized to report various types of income other than wages, salaries, and tips. Therefore, these forms are not suitable for Medicare applications and do not fulfill the requirements necessary for enrollment in the Medicare program.

4. How long is the period for which Medicare will pay secondary to an Employer Group Health Plan (EGHP)?

A. 18 months

B. 24 months

C. 30 months

D. 36 months

Medicare pays secondary to an Employer Group Health Plan (EGHP) for 30 months when the individual is considered to have end-stage renal disease (ESRD) and is covered under a group health plan. This coordination of benefits is particularly designed to allow those with ESRD to receive coverage from their employer's plan for a substantial period before Medicare coverage begins. After the 30-month period, Medicare becomes the primary payer. In contrast, the other durations mentioned do not relate to the correct coordination of benefits under Medicare for individuals with EGHP. The 18, 24, and 36 month options do not accurately reflect the specific provisions concerning Medicare and EGHP relationships, particularly in the context of individuals with renal issues. Thus, the 30-month time frame is tailored to meet the needs of these patients while aligning with federal guidelines on healthcare coverage.

5. What does the "donut hole" refer to in Medicare Part D?

A. A subsidy for low-income seniors

B. A coverage gap where patients pay out-of-pocket

C. A penalty for late enrollment

D. A limit on the number of prescriptions covered

The "donut hole" in Medicare Part D refers specifically to a coverage gap in prescription drug coverage where beneficiaries find themselves having to pay out-of-pocket expenses after they reach a certain threshold in their total drug costs. In simpler terms, after participants and their drug plan spend a combined amount of money on covered drugs, the beneficiary enters into the donut hole phase. During this period, the amount that individuals pay for their medications increases significantly until they reach another threshold that qualifies them for catastrophic coverage, which drastically reduces their drug costs. This gap can present a financial challenge for seniors, as they are responsible for a larger portion of their drug expenses during this period. Understanding this aspect of Medicare Part D is crucial for anyone involved in managing or coordinating insurance for individuals who rely on these benefits, as it directly affects their out-of-pocket costs and budget planning for healthcare expenses.

6. What occurs if a patient restarts COB within 12 months?

A. A new COB is established

B. The same COB remains

C. The previous plan is reinstated

D. No COB is necessary

When a patient restarts Coordination of Benefits (COB) within 12 months, the same COB remains because the patient's circumstances and the relationships among the different insurance policies have not changed significantly since the initial determination. This means that the original coordination rules established remain applicable without requiring a reevaluation or adjustment. In many insurance scenarios, COB rules are designed to streamline the process and ensure that benefits are paid efficiently without overlaps or duplications. Therefore, if the COB was already established and the patient is returning within a year, there is continuity in the benefits coordination process, thus maintaining the same established arrangement.

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. What does MCD stand for in healthcare?

A. Medicare Development

B. Medicaid

C. Medicare Coverage Document

D. Medical Care Division

The acronym MCD in healthcare stands for Medicaid. Medicaid is a joint federal and state program that provides health coverage to low-income individuals and families, including children, pregnant women, elderly individuals, and people with disabilities. It plays a critical role in ensuring access to medical services for those who may not be able to afford care otherwise. Understanding the importance of Medicaid is crucial in the context of healthcare as it directly impacts millions of Americans, providing not only essential medical services but also helping to alleviate financial burdens associated with healthcare costs. It is a vital program that supports public health initiatives and promotes better health outcomes for vulnerable populations.

9. If a person applies for on-exchange HP before December 15th, when does the plan become effective?

A. February 1st

B. December 15th

C. January 1st

D. Immediate effect

When an individual applies for an on-exchange Health Plan (HP) before December 15th, the plan becomes effective on January 1st of the following year. This timing aligns with the open enrollment period for health insurance plans, which typically allows individuals to enroll or make changes to their health coverage effective at the start of the new year, assuming they apply by the deadline. Applying before December 15th is crucial because it ensures that coverage starts on January 1st, allowing individuals to avoid any gaps in their health insurance and ensuring they are covered for any medical needs that arise at the beginning of the year. The choice of February 1st would imply a later starting date, which does not reflect the typical timeline for on-exchange plans starting on the first of the year if enrolled by mid-December. The other options either suggest immediate coverage or a starting date that does not align with the enrollment deadlines for on-exchange plans, reinforcing that January 1st is the correct choice for applications made prior to December 15th.

10. 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.

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://fmcinsurancecoord.examzify.com

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