

MCBC Medicare Practice Test (Sample)

Study Guide



Everything you need from our exam experts!

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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. 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

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- 1. Who are the Medical Advantage plans designed for?**
 - A. Mature adults seeking alternative coverage**
 - B. Individuals with low income**
 - C. All Medicare beneficiaries**
 - D. Only those enrolled in Part A**

- 2. What does a premium refer to in the context of Medicare?**
 - A. The initial enrollment fee for Medicare**
 - B. The monthly payment for Medicare coverage**
 - C. The yearly deductible amount**
 - D. A penalty charge for late enrollment**

- 3. What section of the ABN includes Boxes I-J?**
 - A. Body**
 - B. Signature Box**
 - C. Header**
 - D. Options Box**

- 4. The MPFS was developed from the _____ system.**
 - A. RBRVS**
 - B. RCVS**
 - C. ERS**
 - D. MBF**

- 5. Which of the following services is usually covered under Medicare?**
 - A. Cosmetic surgery**
 - B. Routine vision exams**
 - C. Home health care**
 - D. Self-help group sessions**

- 6. What type of benefits do supplemental insurance plans typically provide?**
 - A. Emergency services only**
 - B. Benefits similar to a standard group health plan**
 - C. Only prescription drug coverage**
 - D. Emergency and inpatient care only**

- 7. How can beneficiaries receive assistance with Medicare questions?**
- A. Only through private insurance advisors**
 - B. Via the State Health Insurance Assistance Program (SHIP) and Medicare's customer service**
 - C. Through online forums and social media platforms**
 - D. By contacting healthcare providers directly**
- 8. What happens to services not clearly documented according to Medicare guidelines in claims?**
- A. They are approved without issue.**
 - B. They are returned for further documentation.**
 - C. They incur additional fees.**
 - D. They are held for review indefinitely.**
- 9. Which of the following best describes the cost-sharing structure in original Medicare?**
- A. Only monthly premiums are required**
 - B. Requires only copayments for physician visits**
 - C. Includes premiums, deductibles, and coinsurance**
 - D. No out-of-pocket expenses are necessary**
- 10. If a patient has both Medicare and a Medigap plan, what action does Medicare automatically take concerning claims?**
- A. Medicare will send the claim to the primary payer only**
 - B. Medicare will manually review all claims**
 - C. Medicare will automatically send claims to Medigap for secondary payment**
 - D. Medicare will not process claims**

Answers

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

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Explanations

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1. Who are the Medical Advantage plans designed for?

- A. Mature adults seeking alternative coverage
- B. Individuals with low income
- C. All Medicare beneficiaries**
- D. Only those enrolled in Part A

Medical Advantage plans, also known as Medicare Advantage (MA) plans, are designed to provide an alternative to traditional Medicare for all beneficiaries who qualify. These plans integrate coverage from Medicare Part A (hospital insurance) and Part B (medical insurance) into one plan, often including additional benefits such as vision, dental, and wellness programs. All Medicare beneficiaries are eligible to enroll in these plans during designated enrollment periods, regardless of their income or health status. This broad eligibility is what makes the plans accessible to a wide range of individuals, allowing them to select coverage that best meets their personal health needs and financial situations. While some individuals might see these plans as an option for mature adults or those with lower incomes, the key point is that they can be tailored to fit the needs of any individual who is already enrolled in Medicare. Thus, they serve a comprehensive audience and reflect the objective of enhancing accessibility to essential healthcare services.

2. What does a premium refer to in the context of Medicare?

- A. The initial enrollment fee for Medicare
- B. The monthly payment for Medicare coverage**
- C. The yearly deductible amount
- D. A penalty charge for late enrollment

In the context of Medicare, a premium refers specifically to the monthly payment required to maintain coverage under various Medicare plans. This payment is made regardless of whether the beneficiary utilizes Medicare services during that month. For example, individuals enrolled in Medicare Part B are required to pay a monthly premium, which covers outpatient services, preventive care, and some home health care. Understanding that the premium is a recurring charge that individuals must budget for is essential for managing healthcare costs in retirement. It is notable that while there may be an initial enrollment period or other fees related to Medicare services, the premium is distinctly about the ongoing monthly payments for the coverage provided. The other options, such as initial enrollment fees or penalties, while relevant to Medicare, do not accurately describe the concept of a premium.

3. What section of the ABN includes Boxes I-J?

- A. Body
- B. Signature Box**
- C. Header
- D. Options Box

The section of the Advance Beneficiary Notice of Noncoverage (ABN) that includes Boxes I-J is the Signature Box. This area is crucial as it is where the patient or their representative sign to indicate that they understand that Medicare may not pay for the services received. The signature confirms that the beneficiary is aware of their financial responsibility should Medicare not cover the costs. Proper completion of this section ensures compliance with Medicare guidelines and protects both the provider and the beneficiary from misunderstandings regarding payment obligations. Other sections such as the Body, Header, and Options Box have specific roles. The Body provides a clear explanation of why Medicare may deny coverage, while the Header contains important identification information about the notice and the provider. The Options Box typically outlines the choices available to the patient regarding their care and the potential financial implications of each choice. The focus on the Signature Box highlights the importance of informed consent and acknowledgement in the context of Medicare billing.

4. The MPFS was developed from the ____ system.

- A. RBRVS**
- B. RCVS
- C. ERS
- D. MBF

The correct answer is derived from the Resource-Based Relative Value Scale (RBRVS) system. The Medicare Physician Fee Schedule (MPFS) uses the RBRVS as its foundational framework for determining payment rates for physicians and other healthcare providers. RBRVS was designed to create a more equitable system for compensating healthcare providers by assigning a relative value to each service based on the resources required to provide it, including the provider's work, practice expenses, and malpractice costs. This approach allows for a standardized payment mechanism that considers the complexity and effort involved in delivering various healthcare services. By establishing the MPFS on the RBRVS, Medicare ensures that payment rates reflect the relative cost of services, promoting fairness across different specialties and patient needs. This foundation is crucial for maintaining consistency in payment methods and effectively managing healthcare costs. Understanding the connection to RBRVS helps clarify how the MPFS operates within the broader Medicare framework, emphasizing the importance of resource allocation in healthcare reimbursement.

5. Which of the following services is usually covered under Medicare?

- A. Cosmetic surgery**
- B. Routine vision exams**
- C. Home health care**
- D. Self-help group sessions**

Home health care is typically covered under Medicare, which provides essential support for beneficiaries who are homebound and require skilled nursing care, physical therapy, or other necessary services in a home setting. This coverage can include assistance with activities of daily living, medical supplies, and health care services under the supervision of a healthcare provider. The focus of Medicare is primarily on medical needs and rehabilitation services; therefore, services that are not medically necessary, such as cosmetic surgery, or those that are considered preventive or routine, like routine vision exams, generally do not qualify for coverage. Additionally, self-help group sessions are not deemed to be part of the covered mental health services under Medicare, as they typically do not involve licensed healthcare providers or are not structured as clinical therapy provided to individuals.

6. What type of benefits do supplemental insurance plans typically provide?

- A. Emergency services only**
- B. Benefits similar to a standard group health plan**
- C. Only prescription drug coverage**
- D. Emergency and inpatient care only**

Supplemental insurance plans are designed to enhance the coverage provided by primary health plans, such as Medicare. These plans typically offer benefits that are similar to those found in standard group health and can include a variety of services not fully covered by the primary plan. For instance, they may provide assistance with co-pays, co-insurance, and deductibles, as well as additional benefits like vision and dental care, which are often excluded from original Medicare plans. This feature allows individuals to have broader access to healthcare services while minimizing out-of-pocket expenses. The goal of supplemental insurance is to fill the gaps in coverage, ensuring that members have adequate financial protection and access to necessary healthcare services. In contrast, the other options focus on restrictions or specific areas of coverage, which do not capture the comprehensive nature of benefits provided by supplemental insurance. Hence, the characterization of the benefits as being similar to a standard group health plan accurately reflects the extensive coverage these supplemental plans typically offer.

7. How can beneficiaries receive assistance with Medicare questions?

- A. Only through private insurance advisors
- B. Via the State Health Insurance Assistance Program (SHIP) and Medicare's customer service**
- C. Through online forums and social media platforms
- D. By contacting healthcare providers directly

Beneficiaries can receive assistance with Medicare questions through the State Health Insurance Assistance Program (SHIP) and Medicare's customer service. SHIP is a national program that offers free, unbiased information to individuals needing help with Medicare and related issues, providing personalized counseling and support tailored to the specific needs of beneficiaries. Additionally, Medicare's customer service is a valuable resource. Beneficiaries can directly contact the Medicare helpline for inquiries about coverage, benefits, and specific situations regarding their Medicare plans. The presence of these two resources emphasizes the structured support system established to help individuals navigate Medicare, ensuring they have access to authoritative and reliable information. This increases their ability to make informed decisions about their healthcare coverage. While private insurance advisors could potentially provide assistance, their services might not be unbiased or free. Online forums and social media can offer community support, but they may lack credibility and professionalism in dealing with specific Medicare-related queries. Contacting healthcare providers directly may yield some information, but these professionals typically focus on medical services rather than detailed Medicare plan questions. Thus, option B presents the most reliable and comprehensive means for beneficiaries to receive assistance with their Medicare-related questions.

8. What happens to services not clearly documented according to Medicare guidelines in claims?

- A. They are approved without issue.
- B. They are returned for further documentation.**
- C. They incur additional fees.
- D. They are held for review indefinitely.

When services are not clearly documented in accordance with Medicare guidelines, they are typically returned for further documentation. This process is in place to ensure that all services billed are adequately supported by the necessary paperwork, catering to the requirements for appropriate billing and compliance. The purpose of this protocol is to protect both the provider and the Medicare system from fraudulent claims and to ensure that beneficiaries receive the services they are entitled to based on accurate and complete records. Proper documentation is essential for validating the medical necessity and appropriateness of the services provided. If the documentation falls short, it reflects on the clarity and comprehensiveness of the records, prompting a request for additional information before any decisions regarding payment or denial are made.

9. Which of the following best describes the cost-sharing structure in original Medicare?

- A. Only monthly premiums are required**
- B. Requires only copayments for physician visits**
- C. Includes premiums, deductibles, and coinsurance**
- D. No out-of-pocket expenses are necessary**

The cost-sharing structure in original Medicare encompasses several components, which is why the correct choice is that it includes premiums, deductibles, and coinsurance. In original Medicare, beneficiaries are required to pay a monthly premium for Part B (medical insurance), as well as a deductible before Medicare starts to pay its share for services. After reaching the deductible, beneficiaries typically pay coinsurance, which is a percentage of the cost of services, such as an inpatient hospital stay or other medical services. This multi-faceted approach to cost-sharing means beneficiaries often encounter various out-of-pocket expenses depending on the services they receive. The other options do not capture the comprehensive nature of the cost structure in original Medicare. There is more to cost-sharing than just monthly premiums or copayments, and suggesting that there are no out-of-pocket expenses disregards the reality of deductibles and coinsurance. Thus, recognizing the integral components of premiums, deductibles, and coinsurance is essential for understanding how costs work within original Medicare.

10. If a patient has both Medicare and a Medigap plan, what action does Medicare automatically take concerning claims?

- A. Medicare will send the claim to the primary payer only**
- B. Medicare will manually review all claims**
- C. Medicare will automatically send claims to Medigap for secondary payment**
- D. Medicare will not process claims**

When a patient has both Medicare and a Medigap plan, Medicare automatically plays a crucial role in the claims process. Medicare is considered the primary payer, meaning that it will first process the claim submitted for medical services or treatment. Once Medicare has evaluated the claim and determined the eligible benefits, it will then automatically forward the remaining balance — that is, any costs that aren't covered by Medicare — to the Medigap plan. This automated process allows for seamless handling of claims and ensures that patients can easily receive the benefits that their supplemental coverage offers. Since Medigap is designed to cover costs not fully paid by Medicare, such as deductibles and coinsurance, the automatic transmission of the claim supports timely payment and reduces the burden on the patient to manage these payments themselves. Thus, the correct answer reflects this efficient process whereby Medicare acts as the primary payer and automatically sends the claims to Medigap for any secondary payment, ensuring that beneficiaries can leverage the full benefits of both Medicare and their Medigap plans.

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://mcbcmedicare.examzify.com>

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

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