

Medicare Ethics and Compliance 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. Which statement about a stand-alone Prescription Drug Plan (PDP) is true?**
 - A. It provides prescription drug coverage and can be paired with plans that do not include drug coverage.**
 - B. It provides medical services.**
 - C. It is the same as Original Medicare.**
 - D. It includes hospital coverage only.**

- 2. Which document identifies the scope of products that can be discussed at a personal marketing appointment?**
 - A. The Enrollment Application**
 - B. The Plan Summary**
 - C. The Scope of Appointment**
 - D. The Statement of Understanding**

- 3. To complete an Enrollment Application on behalf of a consumer, what authority must the individual have?**
 - A. The individual must be a licensed attorney**
 - B. The individual must be legally authorized in the state to act on behalf of the consumer (Power of Attorney)**
 - C. The individual must be the consumer's guardian**
 - D. The individual must be a medical professional**

- 4. Which guideline should you follow before recommending a plan change?**
 - A. Only recommend a plan that is the consumer's current plan**
 - B. Do not rely only on and become biased by the consumer's stated reason for calling**
 - C. Conduct a thorough needs assessment**
 - D. Next quarter is a better time**

- 5. Which action demonstrates compliant interaction with a consumer about plan options?**
 - A. Compare plan benefits, costs, network, and drug coverage with current plan**
 - B. Push a plan with extra price padding**
 - C. Misrepresent the plan's network**
 - D. Force enrollment without consent**

- 6. Why is an agent prohibited from entering their own email address in LEAN?**
- A. The consumer would not receive plan related correspondence intended for him/her**
 - B. It speeds processing**
 - C. It prevents duplicate records**
 - D. It is beyond policy**
- 7. Aries is considering enrolling in a Medicare Advantage plan with prescription drug coverage after leaving a stand-alone PDP. Which option is available to Aries?**
- A. Stay in the PDP and add a separate MA plan.**
 - B. Enroll in a Medicare Advantage plan with prescription drug coverage, which will disenroll him from his PDP.**
 - C. Enroll in a plan that only covers dental.**
 - D. Wait until the next open enrollment period to decide.**
- 8. Why should a person who assists the consumer with decisions be present on the enrollment call?**
- A. To participate in decisions and confirm understanding**
 - B. To sign enrollment forms**
 - C. To provide medical advice**
 - D. To help the agent sell more plans**
- 9. What should you verify about drug coverage when proposing a new plan?**
- A. The medications used are on the plan's formulary and their tier and any utilization management**
 - B. The plan's toll-free number**
 - C. The distance to the pharmacy**
 - D. The plan's logo font**
- 10. If a member assumes their new plan has everything their old plan had and more, what is a likely outcome?**
- A. Dissatisfied complaints**
 - B. Higher satisfaction**
 - C. No change**
 - D. Immediate premium reduction**

Answers

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

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Explanations

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1. Which statement about a stand-alone Prescription Drug Plan (PDP) is true?

- A. It provides prescription drug coverage and can be paired with plans that do not include drug coverage.**
- B. It provides medical services.**
- C. It is the same as Original Medicare.**
- D. It includes hospital coverage only.**

Stand-alone Prescription Drug Plans provide coverage for prescription medications only and are designed to pair with Medicare medical coverage that doesn't include drugs. Original Medicare doesn't pay for most prescription drugs, so enrolling in a PDP adds the drug coverage you need, while the medical benefits come from Part A and Part B (or from a Medicare Advantage plan that may or may not include drugs). A PDP does not cover medical services or hospital care, which are handled by other parts of Medicare. This is why the statement that best describes a stand-alone PDP is that it offers prescription drug coverage and can be paired with plans that do not include drug coverage.

2. Which document identifies the scope of products that can be discussed at a personal marketing appointment?

- A. The Enrollment Application**
- B. The Plan Summary**
- C. The Scope of Appointment**
- D. The Statement of Understanding**

The scope of appointment is the document that defines what products and topics may be discussed during a personal marketing appointment. It serves as the written authorization that keeps the conversation within approved categories—typically Medicare Advantage, Part D prescription drug plans, or related products—so the agent and beneficiary are aligned on what can be covered in that meeting. This helps protect the beneficiary from discussions about plans outside the agreed scope and ensures compliance with CMS marketing rules. The form is signed before the discussion, and it should be updated if new topics or products are added. By contrast, an enrollment application is used to enroll in a plan, a plan summary describes plan features and costs, and a statement of understanding is an acknowledgment related to marketing processes rather than defining the discussion scope.

- 3. To complete an Enrollment Application on behalf of a consumer, what authority must the individual have?**
- A. The individual must be a licensed attorney**
 - B. The individual must be legally authorized in the state to act on behalf of the consumer (Power of Attorney)**
 - C. The individual must be the consumer's guardian**
 - D. The individual must be a medical professional**

The key idea is that someone can complete an enrollment on another person's behalf only if they have valid legal authority recognized by state law. This is typically provided by a Power of Attorney, which grants a designated individual the legal permission to act for the consumer in enrollment matters. Because enrollment involves sensitive personal information, the plan and CMS need verifiable proof that the representative is authorized to act for the consumer, ensuring the consumer's consent and the accuracy of the information submitted. Being a licensed attorney isn't required; the representative can be a non-attorney with proper authorization. A guardian can have authority, but that's a separate legal arrangement and not the general requirement. A medical professional isn't needed for this role.

- 4. Which guideline should you follow before recommending a plan change?**
- A. Only recommend a plan that is the consumer's current plan**
 - B. Do not rely only on and become biased by the consumer's stated reason for calling**
 - C. Conduct a thorough needs assessment**
 - D. Next quarter is a better time**

Before recommending a plan change, you must gather a complete picture of the consumer's needs so the suggestion truly fits their situation. A thorough needs assessment digs into what medications they take (dosages, formulations, refill frequency), their current and anticipated health needs, preferred providers and pharmacies, plan features that matter (formulary coverage, prior authorization requirements, network restrictions), and the real impact on premiums, deductibles, copays, and out-of-pocket costs. It also captures personal preferences and any anticipated changes in health status or budget. When you have this full picture, you can compare plans to find one that covers the medications at the lowest reasonable cost, provides the necessary provider access, and aligns with the consumer's preferences, ensuring the recommendation is in their best interest and compliant with suitability standards. Limiting the recommendation to the consumer's current plan would miss opportunities to improve coverage and cost, and focusing only on the timing (next quarter) doesn't address whether the plan itself actually fits the consumer's needs. While it's wise not to rely solely on the caller's stated reason for the call, a thorough needs assessment naturally covers that concern by evaluating all relevant factors and ensuring the chosen plan truly matches the consumer's situation.

5. Which action demonstrates compliant interaction with a consumer about plan options?

A. Compare plan benefits, costs, network, and drug coverage with current plan

B. Push a plan with extra price padding

C. Misrepresent the plan's network

D. Force enrollment without consent

Providing a compliant interaction means helping the consumer understand plan options by clearly comparing benefits, costs, network, and drug coverage with what they currently have. This transparent, objective approach supports informed decision-making, respects the consumer's autonomy, and avoids misrepresentation or pressure. It aligns with Medicare expectations for accurate, complete information and voluntary consent. The other actions—pushing a plan with inflated prices, misrepresenting the network, or enrolling someone without consent—are deceptive or coercive and do not meet compliant standards.

6. Why is an agent prohibited from entering their own email address in LEAN?

A. The consumer would not receive plan related correspondence intended for him/her

B. It speeds processing

C. It prevents duplicate records

D. It is beyond policy

The main principle here is that plan communications must go to the consumer, not the agent. If an agent's email is entered, all plan-related notices and messages would be delivered to that address, which can mean the consumer misses important information, questions about benefits can be answered by the wrong party, and privacy or confidentiality could be compromised. Keeping the recipient as the consumer ensures timely delivery, proper record-keeping, and that the consumer receives information intended for them. Why the other options don't fit: entering the agent's email doesn't speed processing; in fact, it can delay the consumer getting notices or create confusion about who is responsible for handling the communication. It doesn't prevent duplicate records; it can instead introduce misattribution or gaps in the consumer's record. And it's not beyond policy—the policy requires correct, consumer-directed contact information to protect privacy and ensure proper communication.

7. Aries is considering enrolling in a Medicare Advantage plan with prescription drug coverage after leaving a stand-alone PDP. Which option is available to Aries?
- A. Stay in the PDP and add a separate MA plan.
 - B. Enroll in a Medicare Advantage plan with prescription drug coverage, which will disenroll him from his PDP.**
 - C. Enroll in a plan that only covers dental.
 - D. Wait until the next open enrollment period to decide.

Enrolling in a Medicare Advantage plan that includes prescription drug coverage creates single, integrated coverage and ends any involvement with a standalone PDP. When Aries joins an MA plan with drug coverage, the PDP enrollment is automatically terminated because the MA-PD replaces the separate drug plan. So the available path after leaving the PDP is to switch to a Medicare Advantage plan with prescription drug coverage, which disenrolls him from the PDP. Staying in a PDP and adding a separate MA plan isn't possible because you can't hold a standalone drug plan and a Medicare Advantage plan with drug coverage at the same time. A plan that only covers dental isn't aligned with replacing a PDP with an MA-PD, and waiting for the next open enrollment period wouldn't address the immediate need to enroll in integrated MA-PD coverage.

8. Why should a person who assists the consumer with decisions be present on the enrollment call?
- A. To participate in decisions and confirm understanding**
 - B. To sign enrollment forms
 - C. To provide medical advice
 - D. To help the agent sell more plans

Having a decision-support person present on the enrollment call helps ensure the consumer makes an informed, voluntary choice. This helper can ask clarifying questions, restate the consumer's needs and preferences, and verify that the consumer understands key plan details such as coverage, costs, networks, and drug benefits. Their presence supports autonomy and helps prevent confusion or miscommunication, so the consumer can enroll in a plan that truly fits their situation. The helper's role is to support understanding, not to provide medical advice or to sign forms unless they are an authorized representative. They should not be involved in pressuring the consumer or in sales; the focus is on informed decision-making and appropriate consent.

9. What should you verify about drug coverage when proposing a new plan?

- A. The medications used are on the plan's formulary and their tier and any utilization management**
- B. The plan's toll-free number**
- C. The distance to the pharmacy**
- D. The plan's logo font**

The main idea is to verify how a plan covers the medications the member uses. In Medicare plans, coverage for drugs is defined by a formulary—the list of drugs the plan covers. Within that formulary, drugs are placed in tiers that determine the member's cost share, so knowing the tier helps estimate out-of-pocket costs. There may also be utilization-management requirements, such as prior authorization, step therapy, or quantity limits, which can affect whether a drug is approved or how long it takes to get coverage. When proposing a new plan, confirming that the member's medications are on the formulary, understanding their tier, and checking for any utilization-management hurdles ensures you're presenting a plan that actually covers the needed drugs and shows realistic costs and access. The other factors—toll-free number, pharmacy distance, or the logo font—don't determine drug coverage or access, so they're not the focus when assessing coverage.

10. If a member assumes their new plan has everything their old plan had and more, what is a likely outcome?

- A. Dissatisfied complaints**
- B. Higher satisfaction**
- C. No change**
- D. Immediate premium reduction**

When someone assumes a new plan will match or exceed what their old plan offered, the key idea at play is expectation versus reality of benefits. In Medicare plans, coverage can differ in several important ways: what services are covered, which doctors and pharmacies are in-network, the formulary for medications, and what you must pay out-of-pocket or obtain prior authorization for. If the new plan doesn't actually provide the same access or lower costs as the old one, that initial assumption will feel like a mismatch, leading to frustration and complaints. So the most likely outcome is dissatisfaction and more complaints because the reality falls short of the belief that "everything old had and more." Higher satisfaction would require the new plan to truly deliver equivalent or better coverage without introducing new hurdles; no change would imply there's no impact from switching, which isn't what typically happens when differences exist. A rapid premium reduction could occur in some cases, but it isn't the direct or most predictable result of assuming comprehensive equivalence in benefits.

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://medicareethicscompliance.examzify.com>

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

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