

North Carolina Medicare Supplement and Long-Term Care Agent Practice Test (Sample)

Study Guide



Everything you need from our exam experts!

This is a sample study guide. To access the full version with hundreds of 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.

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. Don't worry about getting everything right, 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, and take breaks to retain information better.

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.

7. Use Other Tools

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. At what stage in the Medicare Part D coverage do insureds face a 25% cost for medications?**
 - A. Initial coverage period**
 - B. Coverage gap**
 - C. Catastrophic coverage**
 - D. Annual deductible phase**
- 2. What requirements must be met for Long-Term Care (LTC) approval for someone on Medicaid?**
 - A. Physical and occupational therapy requirements**
 - B. Financial and medical/functional eligibility requirements**
 - C. Age and income restrictions**
 - D. Prior hospital stay requirements**
- 3. Which Medigap plans were introduced effective June 1, 2010?**
 - A. Plans E and H**
 - B. Plans M and N**
 - C. Plans I and J**
 - D. Plans A and C**
- 4. When are rebates required to be issued to customers if MLR standards are not met?**
 - A. January 1**
 - B. June 30**
 - C. September 30**
 - D. December 31**
- 5. What is the primary purpose of Medicare Part A?**
 - A. To provide monthly income**
 - B. To cover outpatient services**
 - C. To cover inpatient hospital stays and related services**
 - D. To provide long-term care services**

6. How does a provider receive payment if they do not accept assignment on a \$480 bill with Medicare approving \$400?

- A. Medicare pays the provider directly**
- B. Provider receives a full payment from the patient**
- C. The patient receives the payment from Medicare**
- D. The provider receives payment plus limiting charge**

7. What type of plans are Medicare Advantage plans considered?

- A. Preferred Provider Organization plans**
- B. Government-funded programs**
- C. Managed care plans**
- D. Supplemental insurance plans**

8. When does coverage start for Medicare?

- A. First day in month of 65th birthday**
- B. First day of the year**
- C. The day after enrollment**
- D. Last day of the enrollment month**

9. After Medicare covers the first 20 days in a skilled nursing facility, what is the coverage for days 21-100?

- A. No coverage**
- B. Full coverage**
- C. Coinsurance coverage**
- D. Only partial coverage**

10. Which of the following services is NOT covered under Medicare Part A?

- A. Home Health Care**
- B. Inpatient Hospital Care**
- C. Prescription Drugs**
- D. Skilled Nursing Facility Care**

Answers

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

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Explanations

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1. At what stage in the Medicare Part D coverage do insureds face a 25% cost for medications?

- A. Initial coverage period**
- B. Coverage gap**
- C. Catastrophic coverage**
- D. Annual deductible phase**

The phase in which insureds face a 25% cost for medications is actually during the coverage gap in the Medicare Part D plan. This stage is also commonly known as the "donut hole." During the coverage gap, beneficiaries are responsible for a higher percentage of their prescription drug costs compared to the initial coverage period. In the initial coverage period, beneficiaries pay a fixed copayment or coinsurance until they reach a certain limit on their covered prescription drug costs. After reaching this limit, they enter the coverage gap, where they are required to pay a percentage of the cost of their prescriptions—25% of the cost for both brand-name and generic drugs as of the latest policies. Once their out-of-pocket costs reach a specific threshold, beneficiaries then move into catastrophic coverage, where they'll only pay a small copayment or coinsurance for medications for the rest of the year. Understanding this structure helps clarify the financial responsibilities at different stages of Medicare Part D coverage and emphasizes the significance of the coverage gap in the overall plan.

2. What requirements must be met for Long-Term Care (LTC) approval for someone on Medicaid?

- A. Physical and occupational therapy requirements**
- B. Financial and medical/functional eligibility requirements**
- C. Age and income restrictions**
- D. Prior hospital stay requirements**

For Long-Term Care (LTC) approval for someone on Medicaid, it is essential to meet financial and medical/functional eligibility requirements. Financial eligibility typically involves ensuring that the individual's income and assets fall below certain thresholds set by Medicaid. This ensures that assistance is provided to those who need it the most based on their financial situation. Medical/functional eligibility requires a comprehensive assessment to determine if the individual needs the level of care that LTC provides. This evaluation often considers factors such as the individual's ability to perform daily activities (such as bathing, dressing, or eating) and the presence of any medical conditions that necessitate supervision or assistance. These two main categories of eligibility—financial and medical/functional—are fundamental in assessing whether an individual qualifies for LTC services under Medicaid. This approach ensures that support is directed to individuals who have genuine needs for long-term care services due to their health conditions while also maintaining a safety net for those with limited financial resources.

3. Which Medigap plans were introduced effective June 1, 2010?

- A. Plans E and H**
- B. Plans M and N**
- C. Plans I and J**
- D. Plans A and C**

Plans M and N were the new Medigap plans introduced on June 1, 2010. These plans were designed to provide more options for Medicare beneficiaries by offering different cost-sharing arrangements. Plan M has a lower premium than some other plans but requires the beneficiary to cover some cost-sharing, specifically, a portion of the Medicare Part A deductible. This can make it appealing for those who are willing to take on some out-of-pocket expenses in exchange for a lower monthly premium. Plan N introduces a similar concept by offering a lower premium in exchange for increased cost-sharing responsibilities, such as copayments for certain types of services. By offering these plans, the Medicare program aims to enhance consumer choice and allow beneficiaries to tailor their coverage based on their individual needs and preferences. The other options listed represent plans that were in existence before June 2010 or were not introduced at that time, making them irrelevant to the question about new plans introduced on that specific date.

4. When are rebates required to be issued to customers if MLR standards are not met?

- A. January 1**
- B. June 30**
- C. September 30**
- D. December 31**

Rebates must be issued to customers if the Medical Loss Ratio (MLR) standards are not met by September 30. The MLR regulations are designed to ensure that a minimum percentage of premium dollars collected by health insurers is spent on medical care and improving health care quality rather than on administrative costs and profit. If an insurer does not meet these standards, they are required to provide rebates to policyholders. The deadline for issuing these rebates is at the end of September following the calendar year in which the standards were evaluated. This allows sufficient time for insurers to calculate their expenditures and determine if they fall short of the MLR requirements. The other choices do not align with the regulations governing MLR rebate issuance, as they fall outside the designated time frame established for compliance.

5. What is the primary purpose of Medicare Part A?

- A. To provide monthly income
- B. To cover outpatient services
- C. To cover inpatient hospital stays and related services**
- D. To provide long-term care services

The primary purpose of Medicare Part A is to cover inpatient hospital stays and related services. This part of Medicare is designed to help beneficiaries with the costs associated with being hospitalized, including semi-private rooms, meals, nursing care, and other related hospital services. It plays a crucial role in ensuring that individuals have access to necessary medical care when they are admitted to a hospital, which is a significant aspect of healthcare coverage for older adults and certain disabled individuals. Other options address different components or types of services not covered by Medicare Part A. For instance, providing monthly income relates more closely to Social Security benefits rather than Medicare. Outpatient services, like doctor visits and preventive care, are typically covered under Medicare Part B. Long-term care services, such as nursing home care, are not predominantly covered by Medicare Part A, as it primarily focuses on acute care and short-term stays in hospitals rather than ongoing long-term care.

6. How does a provider receive payment if they do not accept assignment on a \$480 bill with Medicare approving \$400?

- A. Medicare pays the provider directly
- B. Provider receives a full payment from the patient
- C. The patient receives the payment from Medicare
- D. The provider receives payment plus limiting charge**

When a provider does not accept assignment for Medicare services, they retain the right to charge their patient a higher fee than what Medicare approves. In this scenario, since Medicare has approved \$400 of the \$480 bill, the provider can still bill the patient for the difference. The "limiting charge" is the maximum amount that a non-participating provider can charge a beneficiary for a service after Medicare has approved a lower amount. In this case, the provider can charge the patient the approved amount (\$400) plus any additional amount up to the limiting charge on that approved service. This means that while the provider will receive payment from Medicare, the total payment they receive will also include what the patient pays to meet the limiting charged amount. Therefore, the provider receives payment from Medicare for the approved amount and can charge the patient for any additional amount permissible under the limiting charge, ensuring they are compensated appropriately for their services while also complying with Medicare regulations.

7. What type of plans are Medicare Advantage plans considered?

- A. Preferred Provider Organization plans**
- B. Government-funded programs**
- C. Managed care plans**
- D. Supplemental insurance plans**

Medicare Advantage plans are classified as managed care plans because they are designed to provide a more coordinated, comprehensive approach to healthcare compared to traditional Medicare. These plans are offered by private insurance companies that contract with Medicare to provide all the benefits covered under Medicare Parts A and B, often including additional services. Managed care plans typically involve a network of providers and facilities that beneficiaries are encouraged to use, which brings greater cost efficiency and potentially improved patient outcomes. This structure aims to manage costs and deliver preventive care, as well as streamline treatments. While it's true that some Medicare Advantage plans can function similarly to Preferred Provider Organization (PPO) plans by offering a network of doctors and hospitals, their overarching characteristic is that they fall under the managed care umbrella, which emphasizes coordinated care and cost control. Other options, like being government-funded programs or supplemental insurance, do not accurately describe the overall operational framework and intent of Medicare Advantage plans.

8. When does coverage start for Medicare?

- A. First day in month of 65th birthday**
- B. First day of the year**
- C. The day after enrollment**
- D. Last day of the enrollment month**

Coverage for Medicare typically begins on the first day of the month in which an individual turns 65 years old. This is an important aspect of Medicare enrollment, as it allows individuals to access healthcare services as soon as they reach the eligibility age. Medicare coverage extends to various services, including hospital care (Part A) and medical services (Part B), and understanding the specific start dates can help beneficiaries plan for their healthcare needs effectively. The other options do not align with Medicare's coverage start dates. Coverage does not begin on the first day of the year, nor does it start the day after enrollment or on the last day of the enrollment month. This understanding of the timing of Medicare coverage is crucial for those approaching eligibility age or helping clients navigate their Medicare options.

9. After Medicare covers the first 20 days in a skilled nursing facility, what is the coverage for days 21-100?

- A. No coverage**
- B. Full coverage**
- C. Coinsurance coverage**
- D. Only partial coverage**

For days 21 through 100 in a skilled nursing facility after the initial 20 days covered by Medicare, there is a coinsurance requirement. Medicare Part A covers the first 20 days fully without any cost to the beneficiary, but from day 21 onward, the beneficiary is responsible for a coinsurance payment. This coinsurance amount is established by Medicare guidelines and typically is a set daily fee that varies each year. This structure is designed to encourage patients to transition out of skilled nursing care as soon as medically feasible, while still offering a substantial benefit during the critical period of rehabilitation or recovery. Understanding this coinsurance aspect is important for both beneficiaries and agents, as it impacts financial planning and expectations regarding out-of-pocket costs for extended care. In contrast to the other possible answers, there are specific payment obligations during this period, and it's crucial to recognize that coverage does not drop to zero, nor is it fully covered like the first 20 days, which is why the other options do not accurately reflect the terms of Medicare coverage after day 20.

10. Which of the following services is NOT covered under Medicare Part A?

- A. Home Health Care**
- B. Inpatient Hospital Care**
- C. Prescription Drugs**
- D. Skilled Nursing Facility Care**

Medicare Part A primarily covers inpatient services, which include care received in hospitals, skilled nursing facilities, hospice, and some home health care, but it does not cover outpatient services or prescription drugs. The absence of coverage for prescription drugs under Part A is an important distinction, as prescription drug coverage is instead offered through Medicare Part D or Medicare Advantage plans that include drug coverage. Understanding this separation is crucial for navigating Medicare benefits effectively, as it helps beneficiaries identify where they need to seek additional coverage when it comes to medication costs. Thus, prescription drugs are not considered a service provided by Medicare Part A, making that selection the correct answer.

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://ncmedicarelongtermcareagent.examzify.com>

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

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