

NORTH CAROLINA MEDICARE SUPPLEMENT AND LONG-TERM CARE AGENT PRACTICE TEST (SAMPLE)

STUDY GUIDE



**SAMPLE STUDY GUIDE
WITH LIMITED QUESTIONS**

**VISIT US ONLINE FOR
THE FULL VERSION STUDY GUIDE**

<https://ncmedicarelongtermcareagent.examzify.com>



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Table of Contents

Copyright	1
Table of Contents	2
Introduction	3
How to Use This Guide	4
Questions	5
Answers	8
Explanations	10
Next Steps	15

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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. What type of care does custodial care provide?**
 - A. Medical assistance with chronic illnesses
 - B. Emergency medical care
 - C. Non-medical assistance with activities of daily living
 - D. Physical therapy services

- 2. What does a Medicare Summary Notice (MSN) provide?**
 - A. A summary of monthly payments made to Medicare
 - B. A summary of healthcare services and items billed to Medicare
 - C. A detailed statement of your medical history
 - D. A list of covered medications under Medicare Part D

- 3. What is a characteristic of Medicare Part A premiums?**
 - A. Always free for everyone
 - B. Varies based on income for some individuals
 - C. Fixed rate for all users
 - D. Only applies to hospital stays

- 4. What should an insurer do if a long-term care policy loses its qualified status?**
 - A. Notify the policyholder in writing immediately
 - B. Notify the policyholder in writing within 30 days
 - C. No notification is necessary
 - D. Provide a financial report within 30 days

- 5. What additional coverage do Medigap Plans B, C, D, F, G, M, and N provide beyond Plan A?**
 - A. Coverage for dental services
 - B. Basic coverage plus help with costs not covered by Medicare
 - C. Long-term care benefits
 - D. Prescription drug coverage

- 6. Which of the following services is covered under Part B of Medicare?**
- A. Inpatient hospital care
 - B. Doctor services and outpatient care
 - C. Home health care only
 - D. Long-term care
- 7. Under which Part of Medicare is inpatient blood transfusion covered?**
- A. Part A
 - B. Part B
 - C. Part C
 - D. Part D
- 8. What determines the amount Medicare pays for a service under PPS?**
- A. The patient's income
 - B. A fixed, predetermined payment
 - C. The number of procedures performed
 - D. The length of hospital stay
- 9. What type of care is Medicare primarily designed to cover?**
- A. Long-term care
 - B. Custodial care
 - C. Acute care and some skilled nursing care
 - D. Preventative care
- 10. What is the primary role of the Utilization Review Committee (URC) in Medicare service provider hospitals?**
- A. Establishing new healthcare laws
 - B. Providing marketing support for hospitals
 - C. Overseeing admissions, cost of care, and quality for Medicare beneficiaries
 - D. Regulating insurance premiums

Answers

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

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Explanations

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1. What type of care does custodial care provide?

- A. Medical assistance with chronic illnesses
- B. Emergency medical care
- C. Non-medical assistance with activities of daily living**
- D. Physical therapy services

Custodial care primarily focuses on providing non-medical assistance with daily living activities for individuals who may not be able to fully care for themselves due to aging, illness, or disability. This type of care typically encompasses help with basic activities such as bathing, dressing, eating, and mobility. The essence of custodial care is its non-medical nature, which distinguishes it from services that require medical expertise or skilled providers. For instance, even though it plays a crucial role in supporting individuals' overall well-being, custodial care does not involve treatment for chronic illnesses, emergency medical interventions, or specialized medical services like physical therapy. The importance of custodial care lies in maintaining a person's comfort and dignity while helping them manage daily life challenges, which is essential for many who need ongoing support.

2. What does a Medicare Summary Notice (MSN) provide?

- A. A summary of monthly payments made to Medicare
- B. A summary of healthcare services and items billed to Medicare**
- C. A detailed statement of your medical history
- D. A list of covered medications under Medicare Part D

A Medicare Summary Notice (MSN) serves as an important document for Medicare beneficiaries, providing a comprehensive summary of healthcare services and items that have been billed to Medicare. It explains the medical services received, the amount billed by healthcare providers, what Medicare has paid, and which charges are the responsibility of the beneficiary. This makes it an essential tool for understanding healthcare expenditures and monitoring billing for accuracy, helping beneficiaries keep track of their medical care and expenses. The other options do not accurately represent the primary function of the MSN. While monthly payments made to Medicare, medical history details, and lists of covered medications under Medicare Part D are important, they are not included in the summary provided by the MSN. Instead, the MSN focuses specifically on the services and items related to medical claims, making option B the correct choice.

3. What is a characteristic of Medicare Part A premiums?

- A. Always free for everyone
- B. Varies based on income for some individuals**
- C. Fixed rate for all users
- D. Only applies to hospital stays

Medicare Part A is designed to cover hospital insurance, which includes inpatient hospital stays, certain skilled nursing facility care, hospice care, and some home health care. A key characteristic of Medicare Part A is that most individuals do not pay a premium for it if they or their spouse have worked and paid Medicare taxes for a sufficient number of quarters (typically 40 quarters or 10 years). For those who do not meet this requirement, Medicare Part A premiums can vary based on how long they or their spouse worked and paid Medicare taxes. This means that while many individuals receive Part A without a premium, others may have to pay a premium if they don't meet the work requirement, making the premium variable for those individuals. The other options misrepresent the nature of Part A premiums. Claiming that premiums are "always free for everyone" overlooks the exceptions for individuals who haven't worked long enough; stating that premiums are "fixed for all users" fails to acknowledge the variability for non-qualifying individuals; and suggesting the premium "only applies to hospital stays" incorrectly implies that there is no charge associated with the premium itself irrespective of the services provided.

4. What should an insurer do if a long-term care policy loses its qualified status?

- A. Notify the policyholder in writing immediately
- B. Notify the policyholder in writing within 30 days**
- C. No notification is necessary
- D. Provide a financial report within 30 days

If a long-term care policy loses its qualified status, the insurer is required to notify the policyholder in writing within 30 days. This requirement is crucial because losing qualified status can have significant tax implications and affect the benefits associated with the policy. By informing the policyholder within a set period, they can make informed decisions regarding their coverage and understand the changes that may affect their financial responsibilities and eligibility for certain tax benefits. The other options do not align with regulatory requirements. Immediate notification may not be practical or required by law, and no notification being necessary would leave policyholders uninformed about significant changes to their policy. Providing a financial report within 30 days does not address the critical need to inform the policyholder about the loss of qualified status, which is essential for their understanding of the policy's implications.

5. What additional coverage do Medigap Plans B, C, D, F, G, M, and N provide beyond Plan A?

- A. Coverage for dental services
- B. Basic coverage plus help with costs not covered by Medicare**
- C. Long-term care benefits
- D. Prescription drug coverage

Medigap Plans B, C, D, F, G, M, and N build upon the foundational coverage provided by Plan A, which typically includes basic hospital and medical benefits. These additional plans enhance the level of protection by covering various out-of-pocket costs that Medicare doesn't fully pay. Specifically, they address several critical aspects such as co-insurance for hospital stays, co-payments for doctor visits, and additional benefits like the first three pints of blood per year. By providing this additional coverage for costs not covered by Medicare, these plans help alleviate the financial burden that beneficiaries might face when utilizing healthcare services. This means that enrollees in these plans can expect to have improved financial security and reduced out-of-pocket expenses related to their healthcare. Therefore, the correct answer is that these plans offer basic coverage along with essential assistance for costs not covered by Medicare, enhancing overall health coverage for beneficiaries.

6. Which of the following services is covered under Part B of Medicare?

- A. Inpatient hospital care
- B. Doctor services and outpatient care**
- C. Home health care only
- D. Long-term care

Part B of Medicare is designed to cover a range of outpatient services and medical care that is essential for beneficiaries. This includes doctor services — such as visits to your primary care physician or specialists — as well as outpatient care, which can involve a variety of services provided outside of a hospital setting. Additionally, Part B covers certain preventive services aimed at preventing illnesses or detecting them at an early stage. In contrast, inpatient hospital care falls under Part A, which focuses on hospital and skilled nursing facility care. Home health care, while partially covered by Medicare, does not exclusively fall under Part B; it can also involve various services that require specific conditions to be met. Finally, long-term care, which includes assistance with daily living activities over an extended period, is generally not covered by Medicare at all. Thus, Part B is primarily focused on a variety of outpatient services, making it the correct choice in this context.

7. Under which Part of Medicare is inpatient blood transfusion covered?

A. Part A

B. Part B

C. Part C

D. Part D

Inpatient blood transfusions are covered under Part A of Medicare. This coverage applies when a patient is hospitalized and requires a blood transfusion as part of their treatment while staying in a covered facility, such as a hospital. Part A of Medicare primarily focuses on hospital insurance, which includes coverage for inpatient care in hospitals, skilled nursing facilities, hospice care, and some home health care services. When an individual is admitted to a hospital and receives blood, the costs associated with the transfusion are part of the overall hospital stay charges that Medicare Part A covers. In contrast, Part B covers outpatient services, including doctor visits and preventive services, but not inpatient hospital services. Part C refers to Medicare Advantage plans, which are offered by private companies and combine the coverage of Parts A and B, while Part D specifically addresses prescription drug coverage. Therefore, the nature of inpatient blood transfusions aligns directly with the benefits provided by Part A.

8. What determines the amount Medicare pays for a service under PPS?

A. The patient's income

B. A fixed, predetermined payment

C. The number of procedures performed

D. The length of hospital stay

Medicare uses the Prospective Payment System (PPS) to determine how much it will reimburse healthcare providers for certain services. Under this system, the payment amount is based on a fixed, predetermined rate that is established in advance for specific services, rather than being influenced by the individual patient's income or other factors related to the patient (like A). This predetermined payment is typically based on various factors such as the diagnosis-related groups (DRGs) for inpatient services, or case-mix categories for outpatient services. Therefore, once a service is classified, the payment amount is set and does not change regardless of the actual costs incurred by the healthcare provider in delivering that service. The options concerning the number of procedures performed or the length of the hospital stay may have some relevance in the broader context of healthcare delivery, but they do not directly influence the fixed payment amount under the PPS. Thus, the correct answer reflects the fundamental principle of how PPS operates within the Medicare system.

9. What type of care is Medicare primarily designed to cover?

- A. Long-term care
- B. Custodial care
- C. Acute care and some skilled nursing care**
- D. Preventative care

Medicare is primarily designed to cover acute care and certain types of skilled nursing care because its main purpose is to provide health insurance for individuals aged 65 and older, as well as some younger individuals with disabilities. Acute care refers to medical care provided for a short-term illness or a severe injury that requires immediate attention. This includes hospital stays, surgeries, and treatments for acute health issues. Skilled nursing care, which Medicare may cover, typically involves services that require the expertise of licensed health professionals, such as nurses or therapists, for conditions that need specific medical intervention rather than ongoing custodial support. While Medicare does offer preventive services, its predominant focus remains on treating acute medical conditions and providing necessary skilled nursing care for patients recovering from such incidents. In contrast, long-term care and custodial care generally focus on assistance with daily living activities and are not usually covered by Medicare. Preventative care, while essential, is only a part of Medicare's broader scope, not its primary functionality. Thus, understanding the nuances of what Medicare covers helps clarify why acute care and certain skilled nursing services are the foundation of Medicare's offerings.

10. What is the primary role of the Utilization Review Committee (URC) in Medicare service provider hospitals?

- A. Establishing new healthcare laws
- B. Providing marketing support for hospitals
- C. Overseeing admissions, cost of care, and quality for Medicare beneficiaries**
- D. Regulating insurance premiums

The primary role of the Utilization Review Committee (URC) in Medicare service provider hospitals centers around overseeing admissions, costs of care, and quality specifically for Medicare beneficiaries. This responsibility is essential because it ensures that patients receive appropriate and necessary medical services while also evaluating whether the services provided align with Medicare guidelines and standards. By focusing on admissions, the URC examines whether the reasons for hospitalizations meet medical necessity criteria. This helps to prevent unnecessary admissions and ensures that patients are allocated to the right level of care. When it comes to cost of care, the URC reviews treatment expenses to ascertain that they are justified and compliant with Medicare reimbursement policies, which is vital for the hospital's financial health and sustainability. Additionally, quality oversight ensures that the care provided meets accepted standards, thereby enhancing patient outcomes and safety. This systematic review helps to maintain high standards of care while also controlling healthcare costs within the Medicare program, ultimately benefiting both patients and healthcare providers. The other options involve functions that the URC does not typically handle. Establishing new healthcare laws is a function of legislative bodies and regulatory agencies, not hospital committees. Providing marketing support for hospitals is related to the hospital's administrative function and marketing teams, rather than the URC's role. Regulating insurance

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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