

North Carolina Medicare Supplement & Long-Term Care Insurance Licensing Practice Exam (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. What is an essential factor to consider when selecting a Long-Term Care policy?**
 - A. The insurer's reputation**
 - B. The range of covered services vs. personal care needs**
 - C. The location of the nursing facility**
 - D. The policy's promotional discounts**

- 2. What does the term "which pays first" refer to in insurance?**
 - A. Determining who pays for the least expensive treatment**
 - B. Determining the order of coverage when multiple policies are available**
 - C. Determining which policy has the highest limit**
 - D. Determining the eligibility for coverage**

- 3. How long is the typical waiting period for long-term care benefits to begin in a policy?**
 - A. 15 days**
 - B. 30, 60, or 90 days depending on the plan**
 - C. 6 months**
 - D. 1 year**

- 4. What is the penalty for not enrolling in Medicare Part B when first eligible?**
 - A. A 5% increase in premiums**
 - B. A 10% increase in premiums for each 12-month period**
 - C. A flat fee for late enrollment**
 - D. An extension of the enrollment period**

- 5. What does the Quality Improvement Organization (QIO) do?**
 - A. Provides funding for hospitals**
 - B. Reviews care provided to Medicare beneficiaries**
 - C. Handles billing disputes for patients**
 - D. Offers medical training to healthcare professionals**

- 6. In which situation does Medicare pay as the secondary payer?**
- A. For all injuries related to Workers' Compensation**
 - B. Only for injuries not covered by any other insurance**
 - C. When liability insurance is the primary payer**
 - D. For preventive services only**
- 7. What is a requirement for an individual to qualify for Medicare's Home Health Care benefit?**
- A. They must have been hospitalized prior.**
 - B. They must be confined to home and under a physician's care.**
 - C. They must be able to leave the house unassisted**
 - D. They must have a private insurance plan.**
- 8. Which type of income must be considered when determining eligibility for QMB?**
- A. Only investment income**
 - B. Low-income and low-assets**
 - C. High-income**
 - D. Fixed incomes only**
- 9. What is the minimum loss ratio mandated for individual Long-Term Care insurance policies?**
- A. 50%**
 - B. 60%**
 - C. 70%**
 - D. 75%**
- 10. What happens if you dis-enroll from Medicare Advantage within 12 months?**
- A. You cannot get Med Supp**
 - B. You are guaranteed acceptance into Med Supp**
 - C. You may face penalties**
 - D. You must wait for the next enrollment period**

Answers

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

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Explanations

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1. What is an essential factor to consider when selecting a Long-Term Care policy?

- A. The insurer's reputation**
- B. The range of covered services vs. personal care needs**
- C. The location of the nursing facility**
- D. The policy's promotional discounts**

When selecting a Long-Term Care policy, evaluating the range of covered services compared to personal care needs is crucial. This factor is central to ensuring that the policy aligns with the specific care requirements of the individual. Long-Term Care policies can vary significantly in terms of what services are covered—such as in-home care, assisted living, nursing home care, and memory care. Understanding these details allows individuals to determine whether the policy will adequately meet their health care and personal needs as they age or if they face chronic illnesses that necessitate long-term care. Considering one's personal care needs also means taking into account the potential changes in health over time. A policy that does not provide sufficient coverage for the necessary services could lead to significant out-of-pocket expenses or insufficient care later on. While factors like the insurer's reputation, the location of facilities, and discounts on premiums may also be important, they do not have the same direct impact on whether the policy will provide appropriate care when it is needed. The primary goal is to ensure that the chosen Long-Term Care policy meets the various requirements for care that one anticipates facing.

2. What does the term "which pays first" refer to in insurance?

- A. Determining who pays for the least expensive treatment**
- B. Determining the order of coverage when multiple policies are available**
- C. Determining which policy has the highest limit**
- D. Determining the eligibility for coverage**

The term "which pays first" in insurance specifically addresses the situation when an individual holds multiple insurance policies that could potentially cover the same claim. In such cases, it's essential to establish the order in which these policies will respond to a claim. This is known as coordinating benefits. When determining which policy pays first, the rules set out by the insurers will dictate the order of payment. For example, if someone has both a primary health insurance policy and a secondary policy, the primary policy will be responsible for paying claims up to its limits before the secondary policy steps in to cover any remaining expenses. This process ensures that the insured receives the maximum benefits available without exceeding the total claim costs. The other options do not accurately describe the "which pays first" concept. The process of deciding who pays for the least expensive treatment, determining which policy has the highest limit, or assessing eligibility for coverage do not directly relate to the sequence of payments among multiple insurance policies. Hence, the correct understanding of "which pays first" is vital for effective claims management and maximization of covered benefits.

3. How long is the typical waiting period for long-term care benefits to begin in a policy?

- A. 15 days
- B. 30, 60, or 90 days depending on the plan**
- C. 6 months
- D. 1 year

The typical waiting period for long-term care benefits to begin in a policy is often 30, 60, or 90 days, depending on the specific plan chosen by the policyholder. This waiting period, also referred to as the elimination period, is the time that must pass after the onset of a qualifying event before the insurance company starts paying for long-term care services. Different insurance plans offer flexibility in choosing the waiting period length, allowing individuals to select a timeframe that aligns with their personal needs and financial situation. A shorter waiting period may lead to higher premium costs, while a longer waiting period may lower the premium but require the insured to cover out-of-pocket expenses longer before benefits kick in. Understanding this aspect of long-term care insurance is crucial for consumers as it helps them make informed choices based on their unique circumstances and financial planning for potential long-term care needs.

4. What is the penalty for not enrolling in Medicare Part B when first eligible?

- A. A 5% increase in premiums
- B. A 10% increase in premiums for each 12-month period**
- C. A flat fee for late enrollment
- D. An extension of the enrollment period

The penalty for not enrolling in Medicare Part B when first eligible is indeed a 10% increase in premiums for each 12-month period that enrollment is delayed. This penalty is designed to encourage timely enrollment in Medicare Part B, which covers essential medical services, such as doctor visits and outpatient care. If an individual does not sign up for Part B during their Initial Enrollment Period, they will have to wait until the General Enrollment Period to enroll, which runs from January 1 to March 31 each year. As a result of this delay, the 10% penalty applies to the standard premium for every 12-month period that they were eligible but did not enroll. This can lead to significantly higher costs over time as the penalties accumulate. Understanding this penalty is crucial for beneficiaries, as it emphasizes the importance of taking timely action to enroll in Medicare Part B to avoid ongoing premium increases that can impact their health care budget.

5. What does the Quality Improvement Organization (QIO) do?

- A. Provides funding for hospitals**
- B. Reviews care provided to Medicare beneficiaries**
- C. Handles billing disputes for patients**
- D. Offers medical training to healthcare professionals**

The Quality Improvement Organization (QIO) primarily focuses on reviewing the care provided to Medicare beneficiaries to ensure it meets established quality standards. QIOs are tasked with monitoring and improving the quality of care for these individuals by conducting evaluations, analyzing healthcare outcomes, and providing recommendations for improvements. Their role is crucial in maintaining high standards of care and enhancing the overall healthcare experience for Medicare recipients. While some organizations may handle aspects of funding, billing disputes, or training healthcare professionals, these functions do not align with the primary mission of a QIO. Instead, the key responsibility of QIOs is the oversight and improvement of quality in healthcare services received by Medicare beneficiaries, making option B the most accurate representation of their work.

6. In which situation does Medicare pay as the secondary payer?

- A. For all injuries related to Workers' Compensation**
- B. Only for injuries not covered by any other insurance**
- C. When liability insurance is the primary payer**
- D. For preventive services only**

Medicare pays as the secondary payer when liability insurance is the primary payer. This situation occurs because Medicare generally serves as a secondary insurance when there is another primary source liable for the payment of the medical expenses. In cases where liability insurance (for instance, in an accident or injury scenario) is responsible for covering the incurred costs, Medicare will step in to cover additional eligible expenses once the primary payer has fulfilled its obligations. Understanding the distinctions among various insurance roles is crucial. For instance, workers' compensation typically holds primary responsibility in cases of work-related injuries, so Medicare would not be secondary in those scenarios. Furthermore, preventive services do not affect the order of payment, as Medicare does not limit its secondary payer role solely to preventive services or limit it based on whether other insurances cover non-injuries. This highlights the broader context of how Medicare interacts with other forms of insurance in diverse circumstances. Thus, the correct answer reflects the established protocol that designates liability insurance as the primary payer, allowing Medicare to assume its secondary role.

7. What is a requirement for an individual to qualify for Medicare's Home Health Care benefit?

- A. They must have been hospitalized prior.
- B. They must be confined to home and under a physician's care.**
- C. They must be able to leave the house unassisted
- D. They must have a private insurance plan.

To qualify for Medicare's Home Health Care benefit, an individual must be confined to their home and under the care of a physician. This criterion ensures that services are provided to those who have a legitimate need for home health assistance due to their medical condition, which limits their ability to leave their home safely. The requirement of being under a physician's care guarantees that the individual receives proper medical oversight and that home health services are part of a structured plan of care aimed at improving or maintaining their health. Being confined to home signifies that the individual's condition makes it unrealistic or unsafe for them to engage in regular daily activities outside their residence without significant assistance. This aspect is vital, as Medicare aims to provide support where it is most needed, allowing individuals to recover or manage their health conditions in a familiar, comfortable setting. Other options involve conditions that do not align with the requirements under Medicare. For instance, prior hospitalization is not a prerequisite, nor is being able to leave the house unassisted, as those who qualify may have mobility challenges. Additionally, having a private insurance plan does not affect eligibility for Medicare's Home Health Care benefit, as this program is specifically under Medicare provisions.

8. Which type of income must be considered when determining eligibility for QMB?

- A. Only investment income
- B. Low-income and low-assets**
- C. High-income
- D. Fixed incomes only

The correct answer focuses on the combination of income levels and asset limitations that are used to assess eligibility for the Qualified Medicare Beneficiary (QMB) program. The QMB program helps individuals with limited financial resources by covering their Medicare premiums, deductibles, and coinsurance. To determine eligibility for QMB, both income and asset criteria are evaluated. This means that low-income individuals with financial resources below a certain threshold can qualify for assistance. It's essential to consider the totality of one's financial situation, which includes not only income but also assets. Therefore, acknowledging the importance of both low-income status and low-asset levels is crucial. Investment income, high-income levels, or fixed income considerations alone do not encompass the necessary criteria for eligibility. Rather, the overall financial context highlighted by the combined assessment of low income and low assets reflects the actual guidelines set forth by the QMB program, ensuring assistance is directed to those in significant financial need.

9. What is the minimum loss ratio mandated for individual Long-Term Care insurance policies?

- A. 50%
- B. 60%**
- C. 70%
- D. 75%

The minimum loss ratio mandated for individual Long-Term Care insurance policies is defined as the percentage of premium dollars that must be spent on claims rather than on administrative costs, marketing, or profit. A loss ratio of 60% means that at least 60% of the premiums collected must be used to pay for the benefits provided to policyholders. This requirement is intended to ensure that a significant portion of the premiums is utilized for the intended purpose of covering long-term care expenses, rather than being absorbed by the insurance company's overhead or profit margins. Establishing a minimum loss ratio helps protect consumers by ensuring that they receive a fair value in terms of benefits in relation to the premiums they pay. By mandating that at least 60% of the premium must go towards claims, regulators create a standard that promotes the financial integrity of the long-term care insurance market and encourages insurers to design their products responsibly. Understanding this criterion is crucial for both consumers and insurance professionals, as it fosters confidence in the long-term care insurance marketplace by ensuring that policies are not only financial instruments but also vehicles for delivering necessary care to policyholders.

10. What happens if you dis-enroll from Medicare Advantage within 12 months?

- A. You cannot get Med Supp
- B. You are guaranteed acceptance into Med Supp**
- C. You may face penalties
- D. You must wait for the next enrollment period

When an individual dis-enrolls from a Medicare Advantage plan within the first 12 months, they are typically given a guaranteed issue right to obtain a Medicare Supplement (Medigap) policy. This means that insurance companies selling Medigap policies must accept the applicant regardless of any pre-existing conditions and cannot charge higher premiums based on health status. This provision is designed to ensure that individuals have access to supplemental insurance coverage shortly after leaving a Medicare Advantage plan. In this context, individuals benefit from having this guaranteed acceptance option, therefore facilitating a smoother transition to obtaining necessary healthcare coverage without the worry of denials or increased costs associated with their health history. This feature is particularly important for those who may not have had the option to enroll in Medigap at other times due to health concerns.

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://ncmedicaresuppltcinsurance.examzify.com>

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

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