

NORTH CAROLINA MEDICARE SUPPLEMENT & LONG-TERM CARE INSURANCE LICENSING PRACTICE EXAM (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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THE FULL VERSION STUDY GUIDE**

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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 happens if a non-participating doctor accepts Medicare assignment?**
 - A. They must charge the maximum allowable fee.
 - B. They are completely free from any billing regulations.
 - C. They may charge excess fees instead of Medicare rates.
 - D. They follow all participating doctor guidelines.
- 2. Which of the following is commonly covered by Long-Term Care Insurance?**
 - A. Cosmetic surgery
 - B. Emergency room visits
 - C. Assisted living services
 - D. Routine doctor check-ups
- 3. When should a beneficiary apply for Medicare at age 65 if not already retired?**
 - A. 2 months before turning 65
 - B. 3 months before turning 65
 - C. 6 weeks before turning 65
 - D. The month they turn 65
- 4. What office must be contacted to apply for Medicaid benefits?**
 - A. Department of Revenue
 - B. Department of Social Services (DSS)
 - C. Health and Human Services
 - D. Department of Insurance
- 5. Which of the following is NOT covered by Medicare?**
 - A. Intermediate care
 - B. Skilled nursing care
 - C. Custodial care
 - D. Home health care
- 6. Which service is NOT covered under Home Health Care?**
 - A. Intermittent skilled nursing
 - B. Occupational therapy
 - C. Homemaker services
 - D. Medical social services

- 7. What type of care does long-term care primarily provide?**
- A. Emergency medical assistance
 - B. Non-medical support for daily living activities
 - C. Comprehensive medical treatment
 - D. Subacute care
- 8. What is required to be provided upon delivery of a Long-Term Care Insurance policy?**
- A. A premium summary
 - B. Outline of Coverage
 - C. A claims guide
 - D. Policy cancellation terms
- 9. What is the defining benefit of a Medigap Plan F?**
- A. It covers only outpatient services
 - B. It covers all Medicare Part A and B deductibles and copayments
 - C. It provides long-term care benefits
 - D. It includes coverage for dental and vision care
- 10. What does "permanent insurance" refer to in the context of healthcare coverage?**
- A. Insurance that has a fixed premium
 - B. Insurance that covers short-term illnesses
 - C. Insurance that remains in force as long as premiums are paid
 - D. Insurance only for chronic illnesses

Answers

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

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Explanations

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1. What happens if a non-participating doctor accepts Medicare assignment?

- A. They must charge the maximum allowable fee.**
- B. They are completely free from any billing regulations.
- C. They may charge excess fees instead of Medicare rates.
- D. They follow all participating doctor guidelines.

When a non-participating doctor accepts Medicare assignment, they are agreeing to accept the Medicare-approved amount for their services as full payment, which is why charging the maximum allowable fee is the correct understanding. By accepting this assignment, the doctor is required to bill Medicare directly for services rendered, rather than billing the patient. This means the physician cannot charge the patient more than the Medicare-approved amount, thus ensuring that patients are not billed excessive fees. Therefore, when a non-participating doctor accepts assignment, they must adhere to the same rate restrictions applied to participating providers, which includes only charging the maximum allowable fee set by Medicare. The other options reflect misconceptions about billing practices. Non-participating providers do not have the freedom to charge whatever they wish (as implied in one choice). Additionally, there are specific guidelines and regulations they must still follow, such as those relating to billing and reimbursement, which distinguishes them from participating doctors who may have different obligations and a different set of guidelines to follow.

2. Which of the following is commonly covered by Long-Term Care Insurance?

- A. Cosmetic surgery
- B. Emergency room visits
- C. Assisted living services**
- D. Routine doctor check-ups

Long-Term Care Insurance is designed to assist individuals with the costs associated with long-term care services, which are primarily needed when individuals are unable to perform basic activities of daily living due to illness, injury, or other health conditions. Assisted living services are a significant component of long-term care, as they provide support with daily activities while allowing individuals to maintain a degree of independence in a community setting. This type of coverage is intended to help pay for the care received in assisted living facilities, which can include personal care services, supervision, and other support tailored to individual needs. In contrast, services like cosmetic surgery do not fall under the typical scope of long-term care insurance, as they are considered elective and not necessary for day-to-day living. Emergency room visits are generally covered by health insurance rather than long-term care insurance, as they pertain to immediate medical care rather than ongoing support. Similarly, routine doctor check-ups are also typically covered by general health insurance policies instead of long-term care insurance, as these visits do not directly relate to the extended support or assistance that long-term care insurance aims to provide.

3. When should a beneficiary apply for Medicare at age 65 if not already retired?

- A. 2 months before turning 65
- B. 3 months before turning 65**
- C. 6 weeks before turning 65
- D. The month they turn 65

A beneficiary should apply for Medicare three months before turning 65 to ensure that their coverage begins on time. This is a crucial window, as Medicare offers a seven-month initial enrollment period that begins three months before the beneficiary's 65th birthday, includes the birthday month, and extends three months after the birthday month. Applying three months in advance allows for potential processing time and ensures that the beneficiary does not experience any gaps in coverage when they reach 65. Furthermore, this period aligns with Medicare guidelines, ensuring that the necessary steps are taken to avoid unnecessary delays or issues with coverage that might arise if the application is made too close to the birthday. While applying two months before or during the birthday month may seem helpful, it could lead to delays in coverage starting at the appropriate time. It's crucial to adhere to the three-month guideline to avoid any complications in receiving the benefits that Medicare provides.

4. What office must be contacted to apply for Medicaid benefits?

- A. Department of Revenue
- B. Department of Social Services (DSS)**
- C. Health and Human Services
- D. Department of Insurance

To apply for Medicaid benefits, the appropriate office to contact is the Department of Social Services (DSS). This agency is specifically responsible for administering social service programs, which include Medicaid in North Carolina. Medicaid is a joint federal and state program that provides health coverage for certain individuals and families, particularly those with low income or specific health needs. The Department of Social Services plays a critical role in determining eligibility, processing applications, and providing assistance with the program. Therefore, individuals needing to apply for Medicaid or seeking information about their eligibility or benefits should reach out to the DSS. Other options, such as the Department of Revenue, primarily deal with state taxation and related functions, while the Department of Insurance oversees insurance regulation and protections but does not administer Medicaid. The Department of Health and Human Services has a broader scope that includes health programs but does not specifically handle Medicaid applications at the local level, which is managed by DSS.

5. Which of the following is NOT covered by Medicare?

- A. Intermediate care
- B. Skilled nursing care
- C. Custodial care**
- D. Home health care

Medicare provides limited coverage for various types of medical and health services, focusing primarily on medically necessary care. Among the types of care mentioned, custodial care is the one not covered by Medicare. Custodial care refers to assistance with activities of daily living (ADLs) such as bathing, dressing, and eating, primarily provided when someone is unable to care for themselves due to chronic illness or disability. This type of care is considered non-medical and does not include skilled nursing services or medical supervision. In contrast, Medicare does provide coverage for skilled nursing care, which is a level of care that requires the skills of a licensed nurse for procedures such as administering medications or monitoring medical conditions. Intermediate care, which often includes some nursing care but does not rise to the level of skilled nursing, may also be partially covered, particularly in the context of skilled nursing facilities after a qualifying hospital stay. Home health care is covered under Medicare if it involves skilled nursing or therapy services to aid in recovery or management of a health condition. Understanding the nuances of these different levels of care is essential for navigating Medicare coverage effectively, particularly for beneficiaries seeking support for aging or chronic health issues.

6. Which service is NOT covered under Home Health Care?

- A. Intermittent skilled nursing
- B. Occupational therapy
- C. Homemaker services**
- D. Medical social services

Home health care generally includes a range of medical and therapeutic services provided in the home setting, designed to assist patients who require specific health care services but do not need to be hospitalized. The services that are typically covered under home health care include intermittent skilled nursing, occupational therapy, and medical social services. Homemaker services, while they may be beneficial for individuals who require support with activities of daily living (ADLs), are generally considered custodial care rather than skilled care. This type of service focuses on assisting with non-medical tasks such as cooking, cleaning, and personal shopping, which do not necessitate a licensed health care provider. In summary, homemaker services are distinct from the skilled nursing and therapy services covered under home health care because they do not provide medical treatment or rehabilitation, which is a core requirement for coverage in this context. Therefore, this makes the option referring to homemaker services the correct answer in identifying what is not covered under home health care services.

7. What type of care does long-term care primarily provide?

- A. Emergency medical assistance
- B. Non-medical support for daily living activities**
- C. Comprehensive medical treatment
- D. Subacute care

Long-term care primarily provides non-medical support for daily living activities. This type of care is focused on helping individuals who may have chronic illnesses, disabilities, or cognitive impairments carry out everyday tasks that they may struggle with independently. These tasks can include bathing, dressing, meal preparation, and assistance with mobility, among others. While emergency medical assistance is crucial in acute situations, long-term care is not intended for such conditions. Similarly, comprehensive medical treatment and subacute care involve more intensive medical interventions, which are not the primary focus of long-term care services. Instead, long-term care emphasizes enhancing the quality of life and maintaining independence for individuals who require continuous assistance over an extended period. Thus, option B is the most accurate representation of what long-term care primarily provides.

8. What is required to be provided upon delivery of a Long-Term Care Insurance policy?

- A. A premium summary
- B. Outline of Coverage**
- C. A claims guide
- D. Policy cancellation terms

Providing an Outline of Coverage upon delivery of a Long-Term Care Insurance policy is essential as it serves to inform and educate the policyholder about the key features and benefits of the insurance plan. This document outlines what the coverage entails, including the services and settings in which benefits are paid, waiting periods, and exclusions. The goal of providing this summary is to ensure that policyholders have a clear understanding of how their policy works and what to expect, thereby facilitating informed decision-making. While a premium summary, claims guide, and policy cancellation terms may also be relevant documents, they are not specifically mandated to be delivered at the time the Long-Term Care Insurance policy is issued. The Outline of Coverage is a critical component to ensure that consumers are aware of their coverage details right from the start, helping them to maximize their benefits and understand their rights as policyholders.

9. What is the defining benefit of a Medigap Plan F?

- A. It covers only outpatient services
- B. It covers all Medicare Part A and B deductibles and copayments**
- C. It provides long-term care benefits
- D. It includes coverage for dental and vision care

A Medigap Plan F is known for its comprehensive coverage, which includes all deductibles, copayments, and coinsurance expenses associated with Medicare Part A and Part B. This means it provides financial protection against out-of-pocket costs for services that Medicare typically covers. Individuals enrolled in Plan F are not responsible for most costs that may arise from hospital stays, outpatient care, or other Medicare-covered treatments, allowing them to have greater peace of mind regarding their healthcare expenses. Medigap Plan F is particularly valuable because it essentially acts as a secondary insurance plan to Medicare, filling in the gaps that Medicare leaves behind. This is why it has been a popular choice for those looking for exhaustive coverage. In contrast, the other options imply limitations or coverage that Medigap Plan F does not provide, such as being confined to outpatient services, offering long-term care benefits, or including dental and vision care. These services are typically not covered under standard Medigap plans and must be obtained through separate policies.

10. What does "permanent insurance" refer to in the context of healthcare coverage?

- A. Insurance that has a fixed premium
- B. Insurance that covers short-term illnesses
- C. Insurance that remains in force as long as premiums are paid**
- D. Insurance only for chronic illnesses

In the context of healthcare coverage, "permanent insurance" refers to a type of insurance that remains in force as long as premiums are paid. This means that as long as the policyholder continues to make the required premium payments, the coverage will not lapse or expire. This is particularly important for individuals seeking long-term health coverage, as they want assurance that their insurance will be available when they need it, regardless of how long they live or how their health may change over time. Permanent insurance typically includes features such as cash value accumulation, which can grow over time, providing a potential source of funds for the policyholder. It contrasts with temporary insurance, which usually provides coverage for a specific period and may not offer the same long-term financial security. Other options do not accurately capture the essence of permanent insurance. For instance, insurance that has a fixed premium might describe certain policies, but it does not encompass the idea of permanence regarding coverage. Coverage for short-term illnesses or chronic illnesses specifically is also not synonymous with permanence. The important characteristic of permanent insurance is its ongoing nature as long as premiums are kept up to date.

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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