

United Health Coverage (UHC) Medicare Basics 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. What does Medicare Part A primarily cover?**
 - A. Outpatient care and preventive services**
 - B. Hospital insurance and inpatient stays**
 - C. Prescription drug coverage**
 - D. Medically necessary outpatient services**
- 2. Which of the following services is usually covered by Medicare Part A?**
 - A. Routine vision check-ups**
 - B. Emergency room visits**
 - C. Acupuncture treatments**
 - D. Long-term care in a nursing home**
- 3. When does Medicare supplement open enrollment take place?**
 - A. During the first six months when a consumer is 65 or older and enrolled in Medicare Part B**
 - B. From January 1 to March 31 each year**
 - C. Annually from October 15 to December 7**
 - D. Whenever the consumer chooses**
- 4. For an individual who is 65 or older and enrolled in Medicare Part B, when does open enrollment for Medicare supplements begin?**
 - A. Immediately upon enrollment in any Medicare program**
 - B. On their birthday month only**
 - C. During the first six months of being 65 or older and enrolled in Medicare Part B**
 - D. Every October during the annual enrollment period**
- 5. What typically happens if Doug sees an out-of-network provider?**
 - A. He pays a copayment at the time of service**
 - B. He may receive partial reimbursement**
 - C. He pays the entire cost of the service**
 - D. He is referred back to an in-network provider**

6. What are "extra help" programs in Medicare Part D?

- A. Programs that provide free drugs**
- B. Financial assistance to lower-income beneficiaries**
- C. Programs with no eligibility requirements**
- D. Support groups for Medicare beneficiaries**

7. What is the purpose of the Medicare Annual Election Period?

- A. To enroll in a new health insurance program**
- B. To review and make changes to Medicare plans**
- C. To choose a primary care physician**
- D. To receive additional funds for health services**

8. What are "Extras" in Medicare Advantage plans?

- A. Additional costs for outpatient services**
- B. Extra premiums for preventive services**
- C. Additional benefits such as vision and dental services**
- D. Non-covered services that require out-of-pocket payments**

9. What is a primary care provider's responsibility in Medicare?

- A. To perform surgery on specialized patients**
- B. To coordinate a patient's overall care**
- C. To provide only emergency care services**
- D. To manage billing and insurance claims**

10. How can beneficiaries enroll in a Medicare Advantage plan?

- A. Only during the Initial Enrollment Period**
- B. Any time during the year**
- C. During designated Enrollment Periods**
- D. Through private brokers only**

Answers

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

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Explanations

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1. What does Medicare Part A primarily cover?

- A. Outpatient care and preventive services
- B. Hospital insurance and inpatient stays**
- C. Prescription drug coverage
- D. Medically necessary outpatient services

Medicare Part A primarily covers hospital insurance and inpatient stays, making it essential for individuals who require hospital care. This includes costs associated with inpatient hospital stays, skilled nursing facility care, hospice care, and some home health services. The focus of Part A is on providing coverage for services that require admission to a facility, which is critical for those who need extensive medical care or procedures that cannot be done in an outpatient setting. The other options, while important aspects of healthcare coverage, do not fall under the purview of Medicare Part A. Outpatient care and preventive services are mainly covered by Medicare Part B. Prescription drug coverage is provided under Medicare Part D, which specifically addresses medications that patients receive at pharmacies. Medically necessary outpatient services are also covered by Part B. Thus, understanding the specific coverages of each part of Medicare is essential for navigating healthcare options effectively.

2. Which of the following services is usually covered by Medicare Part A?

- A. Routine vision check-ups
- B. Emergency room visits**
- C. Acupuncture treatments
- D. Long-term care in a nursing home

Medicare Part A primarily covers services related to hospital stays and inpatient care. This includes emergency room visits that result in inpatient admission, which is why the choice indicating emergency room visits is correct. When a patient requires immediate medical attention and is subsequently admitted to a hospital, the costs associated with that emergency visit fall under Medicare Part A coverage. In contrast, routine vision check-ups are typically not included in Medicare Part A, as they are considered preventive services usually covered under other programs. Acupuncture treatments also fall outside of Part A coverage since they are generally not regarded as a standard medical treatment necessary for inpatient care. Long-term care in a nursing home may be covered partially by Medicare, but only in specific circumstances, such as following a hospital stay and for a limited duration; otherwise, it may not fall under Part A. Thus, emergency room visits are the only choice that aligns directly with the coverage provided by Medicare Part A for immediate, necessary medical care.

3. When does Medicare supplement open enrollment take place?

- A. During the first six months when a consumer is 65 or older and enrolled in Medicare Part B**
- B. From January 1 to March 31 each year**
- C. Annually from October 15 to December 7**
- D. Whenever the consumer chooses**

The correct answer highlights that Medicare supplement open enrollment occurs during the first six months when a person is 65 years or older and enrolled in Medicare Part B. This period is significant because it is when individuals have the right to purchase a Medicare supplement plan (also known as Medigap) without undergoing medical underwriting. This means that the insurance company cannot deny you coverage or charge you more based on pre-existing conditions, making it a critical time for beneficiaries to secure their supplemental coverage. Understanding this timeframe is essential, as it allows beneficiaries to take advantage of guaranteed issue rights, which can significantly affect their future options and costs for supplemental health coverage. Since health status and age often lead to higher premiums or denial of coverage later on, the initial enrollment period presents a unique and valuable opportunity for individuals to ensure comprehensive coverage alongside their Medicare benefits.

4. For an individual who is 65 or older and enrolled in Medicare Part B, when does open enrollment for Medicare supplements begin?

- A. Immediately upon enrollment in any Medicare program**
- B. On their birthday month only**
- C. During the first six months of being 65 or older and enrolled in Medicare Part B**
- D. Every October during the annual enrollment period**

The correct answer is focused on understanding the Medicare supplement enrollment rules. When an individual turns 65 or older and enrolls in Medicare Part B, they benefit from a guaranteed issue period for Medicare supplement plans that begins during the first six months after they turn 65. This is a crucial time because during this six-month period, individuals have the right to enroll in any Medicare supplement plan available in their area without being subject to medical underwriting, which means they can't be denied coverage based on health status. Understanding this timing is essential for beneficiaries, as it gives them flexibility and protection in choosing a supplement plan that best suits their needs without the risk of higher premiums or denied applications due to pre-existing conditions. This initial enrollment period allows seniors to secure coverage that can help with out-of-pocket costs associated with Medicare services. The other options don't align with the specific rules governing Medicare supplement enrollment. Immediate enrollment does not provide the same protections, being strictly limited to the six-month window. Birthday month enrollment is not a standard guideline for Medicare supplements and does not secure the guaranteed issue rights. Lastly, the annual enrollment period in October pertains primarily to Medicare Advantage and Part D plans, not Medicare supplements, making it irrelevant in the context of this question.

5. What typically happens if Doug sees an out-of-network provider?

- A. He pays a copayment at the time of service**
- B. He may receive partial reimbursement**
- C. He pays the entire cost of the service**
- D. He is referred back to an in-network provider**

If Doug sees an out-of-network provider, he usually pays the entire cost of the service. This situation arises because many Medicare Advantage plans have specific networks of providers with whom they have negotiated rates, and visiting a provider outside of this network often means the plan does not cover any expenses incurred. When a beneficiary chooses to go out of network, the insurance typically does not provide any reimbursement, leaving the individual responsible for the full bill. This structure is designed to encourage enrollees to utilize the in-network services, which are typically more cost-effective and may come with lower out-of-pocket costs. In many cases, beneficiaries who are enrolled in Medicare Advantage plans have few options for coverage when opting to go outside their network. Therefore, the potential for partial reimbursement or reduced copayments generally does not apply in out-of-network situations, affirming that the significant out-of-pocket expense would indeed be the entire cost for services rendered.

6. What are "extra help" programs in Medicare Part D?

- A. Programs that provide free drugs**
- B. Financial assistance to lower-income beneficiaries**
- C. Programs with no eligibility requirements**
- D. Support groups for Medicare beneficiaries**

"Extra help" programs in Medicare Part D refer to financial assistance provided to lower-income beneficiaries to help them afford prescription drug costs. These programs are designed to alleviate the financial burden on individuals who may struggle with premiums, deductibles, and co-payments associated with Medicare prescription drug plans. Eligibility for these programs considers various factors, including income and resources, and aims to make prescription medications more accessible to those who need them most. This is particularly critical for beneficiaries who may have chronic health conditions requiring ongoing medication treatment. The other choices do not accurately capture the essence of "extra help" programs. While some programs may include free drugs, they do not encompass the broad financial assistance aspect or the specific criteria for eligibility that characterize the "extra help" programs. Furthermore, not all programs are without eligibility requirements, as determining qualification is paramount to ensuring that aid is directed toward those in genuine need. Lastly, support groups, while valuable, do not pertain to the financial assistance element of the Medicare Part D framework.

7. What is the purpose of the Medicare Annual Election Period?

- A. To enroll in a new health insurance program**
- B. To review and make changes to Medicare plans**
- C. To choose a primary care physician**
- D. To receive additional funds for health services**

The Medicare Annual Election Period serves as an essential opportunity for beneficiaries to review their current Medicare plans and make changes as needed. This period typically runs from October 15 to December 7 each year, during which individuals can switch from Original Medicare to a Medicare Advantage plan, change from one Medicare Advantage plan to another, or enroll in a standalone Medicare prescription drug plan. By allowing beneficiaries to assess their healthcare needs, compare coverage options, and select a plan that best meets their requirements, this period ensures that individuals have the ability to make informed decisions regarding their healthcare coverage. It's a crucial time for beneficiaries to analyze their existing plans, considering factors such as costs, coverage changes, and network providers, to ensure they are receiving the best possible care for the upcoming year.

8. What are "Extras" in Medicare Advantage plans?

- A. Additional costs for outpatient services**
- B. Extra premiums for preventive services**
- C. Additional benefits such as vision and dental services**
- D. Non-covered services that require out-of-pocket payments**

"Extras" in Medicare Advantage plans refer to additional benefits that go beyond the standard coverage offered by Medicare. These can include services such as vision, dental, hearing, and wellness programs, which are not typically covered under Original Medicare (Part A and Part B). Medicare Advantage plans are required to cover all the services that Original Medicare provides, but they often include additional perks to attract enrollees and enhance their overall healthcare experience. The inclusion of these extra benefits can significantly improve access to important healthcare services and help maintain overall well-being. For many beneficiaries, these additional services can lead to better health outcomes and increased satisfaction with their Medicare coverage, making Medicare Advantage plans an attractive option for those looking for comprehensive coverage with added benefits.

9. What is a primary care provider's responsibility in Medicare?

- A. To perform surgery on specialized patients**
- B. To coordinate a patient's overall care**
- C. To provide only emergency care services**
- D. To manage billing and insurance claims**

A primary care provider's responsibility in Medicare is to coordinate a patient's overall care. This involves acting as the main point of contact for patients and ensuring they receive comprehensive and continuous healthcare services. They help manage preventive services, diagnose and treat a variety of health issues, and coordinate referrals to specialists when necessary. This comprehensive approach is crucial in helping patients navigate the complexities of the healthcare system, especially in the context of Medicare, where patients may have multiple healthcare needs and services spread across various providers. While performing surgery, providing emergency services, and managing billing are important aspects of healthcare, these are not the primary responsibilities of a primary care provider within the Medicare framework. Instead, their primary focus is on the ongoing management of a patient's health and the coordination of care, which can include preventive measures, routine check-ups, and the management of chronic conditions.

10. How can beneficiaries enroll in a Medicare Advantage plan?

- A. Only during the Initial Enrollment Period**
- B. Any time during the year**
- C. During designated Enrollment Periods**
- D. Through private brokers only**

Beneficiaries can enroll in a Medicare Advantage plan during designated Enrollment Periods, which include several specific time frames throughout the year. The Initial Enrollment Period occurs when individuals first become eligible for Medicare, typically starting three months before their 65th birthday and lasting for seven months. In addition to this initial enrollment opportunity, there are also other designated periods like the Annual Enrollment Period, where beneficiaries can switch from Original Medicare to a Medicare Advantage plan or vice versa, and the Special Enrollment Periods, which allow for enrollment under certain circumstances, such as moving to a new area or losing other health coverage. This structured approach to enrollment ensures that beneficiaries have specific times to make their healthcare choices while providing flexibility based on their circumstances. The other options do not accurately represent the regulations surrounding Medicare Advantage plan enrollment, as they either suggest limited enrollment opportunities or restrict the methods of enrollment.

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://unitedhealthcoveragemedicarebasics.examzify.com>

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

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