

Anthem Medicare Advantage Certification 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

- 1. Are agents eligible for commission payments on plans sold before completing necessary licensing and certification?**
 - A. Yes**
 - B. No**
 - C. Only if the plan is approved by Medicare**
 - D. It varies by state**
- 2. Beneficiaries can opt out of their Medicare Supplement plan without consequences. True or False?**
 - A. True**
 - B. False**
 - C. Only if done during Open Enrollment**
 - D. Only if they switch to another plan**
- 3. How does prescription drug coverage function in most Anthem Medicare Advantage plans?**
 - A. It is completely separate from medical coverage**
 - B. It is included as a Part D plan for medications**
 - C. It requires an additional monthly fee**
 - D. It's only available for certain illnesses**
- 4. If reviewing an existing member's plan needs, what document should you consider?**
 - A. Annual Enrollment Notice**
 - B. Annual Changes Overview**
 - C. Member Satisfaction Survey**
 - D. Annual Notice of Changes**
- 5. What does "ANOC" stand for in the context of Medicare?**
 - A. Annual Notice of Changes**
 - B. Annual Network of Coverage**
 - C. Annual Notification of Coverage**
 - D. Annual Notice of Options**

- 6. What are events designed to steer potential enrollees toward a specific plan called?**
- A. Informational events**
 - B. Sales and Marketing events**
 - C. Educational events**
 - D. Community outreach events**
- 7. What does Medicare Advantage typically require for specialist visits?**
- A. No referral is needed**
 - B. Referral from a primary care physician**
 - C. Special approval by Medicare**
 - D. Payment of an additional fee**
- 8. What is the role of the Centers for Medicare and Medicaid Services (CMS) in relation to Medicare Advantage plans?**
- A. To provide additional funding for beneficiaries**
 - B. To regulate and oversee compliance with federal guidelines**
 - C. To offer training for healthcare providers**
 - D. To set premium rates for plans**
- 9. What does an HMO plan typically require regarding healthcare providers?**
- A. Members can choose any provider**
 - B. Members must use network providers**
 - C. Members can switch providers anytime**
 - D. Members can only see a specified number of specialists**
- 10. Which type of plan requires members to have a primary care physician?**
- A. Preferred Provider Organization (PPO)**
 - B. Health Maintenance Organization (HMO)**
 - C. Medicare Cost Plan**
 - D. Private Fee-for-Service Plan**

Answers

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

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Explanations

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1. Are agents eligible for commission payments on plans sold before completing necessary licensing and certification?

A. Yes

B. No

C. Only if the plan is approved by Medicare

D. It varies by state

Agents must complete the necessary licensing and certification before they are eligible for commission payments on the plans they sell. This requirement ensures that agents have the required knowledge and understanding of Medicare Advantage plans, federal regulations, and the rules governing their sale. This process is critical not only for compliance with legal standards but also for ensuring that consumers receive accurate information and appropriate advice regarding their health insurance options. In addition, completing certification helps maintain the integrity of the Medicare program, as agents must be equipped to guide beneficiaries effectively. Hence, agents who sell plans before obtaining the necessary qualifications risk not only losing commission payments but also potentially facing repercussions from regulatory bodies. The focus on licensing and certification aims to protect consumers and ensure a standard of quality in the sales process.

2. Beneficiaries can opt out of their Medicare Supplement plan without consequences. True or False?

A. True

B. False

C. Only if done during Open Enrollment

D. Only if they switch to another plan

The statement is false because opting out of a Medicare Supplement plan can have consequences, particularly regarding coverage and potential penalties. Medicare Supplement plans are designed to cover costs that Original Medicare does not, and cancelling a plan may leave a beneficiary without necessary supplemental coverage. Additionally, if a beneficiary decides to opt out of their Medicare Supplement plan and later wishes to re-enroll, they might face difficulties. Insurance companies may require medical underwriting, and beneficiaries could be denied coverage or charged higher premiums based on their health status. Furthermore, certain enrollment periods exist, and if a beneficiary opts out outside of these periods, they may not have guaranteed issue rights when seeking to obtain a new plan. Thus, understanding the implications of opting out is crucial for beneficiaries to ensure they do not inadvertently negate important health coverage.

3. How does prescription drug coverage function in most Anthem Medicare Advantage plans?

- A. It is completely separate from medical coverage**
- B. It is included as a Part D plan for medications**
- C. It requires an additional monthly fee**
- D. It's only available for certain illnesses**

In most Anthem Medicare Advantage plans, prescription drug coverage is included as a Part D plan for medications, which is essential for comprehensive healthcare coverage. Medicare Advantage plans are required to provide at least the same level of coverage as Original Medicare (Parts A and B), and many of these plans enhance their offerings by bundling prescription drug coverage directly within their services. This integration means that beneficiaries can manage their medical and prescription needs under one plan, simplifying the process and often resulting in cost savings. Having this drug coverage included helps members access medications more conveniently and is part of the overall preventative care strategy that these plans encompass. The alignment between medical and prescription drug coverage allows for better coordination of care, as healthcare providers can have access to a patient's medications, ensuring appropriate treatment plans.

4. If reviewing an existing member's plan needs, what document should you consider?

- A. Annual Enrollment Notice**
- B. Annual Changes Overview**
- C. Member Satisfaction Survey**
- D. Annual Notice of Changes**

The Annual Notice of Changes (ANOC) is a crucial document when reviewing an existing member's plan needs because it outlines any modifications to the member's benefits, coverage, costs, and any other pertinent changes for the upcoming plan year. This document is provided to members annually and serves as a detailed guide for understanding how their plan may evolve, enabling both members and advisors to make informed decisions about their healthcare coverage. In the context of evaluating a member's plan, the ANOC highlights changes that could impact their health care decisions, such as new benefits available, any increased premiums, adjusted co-pays, or network changes. This information is essential for determining whether the current plan still meets the member's needs or if it might be time to explore different options. While the other documents mentioned can contribute to understanding a member's overall situation, they do not provide the same level of detail regarding specific changes to the member's plan. The Annual Enrollment Notice typically gives information about enrollment periods rather than specific plan adjustments. The Annual Changes Overview may summarize key changes but lacks the comprehensive detail found in the ANOC. The Member Satisfaction Survey, while valuable for insights into overall satisfaction, does not offer data about the actual specifics of a plan's benefits or changes.

5. What does "ANOC" stand for in the context of Medicare?

- A. Annual Notice of Changes**
- B. Annual Network of Coverage**
- C. Annual Notification of Coverage**
- D. Annual Notice of Options**

The term "ANOC" stands for "Annual Notice of Changes," which is a crucial document provided to Medicare beneficiaries. This notice is issued annually by Medicare Advantage plans and outlines any changes to the plan's coverage, costs, and service area that will take effect in the upcoming plan year. It assists beneficiaries in understanding how their benefits may be adjusted, which is essential for making informed decisions during the annual enrollment period. Receiving the ANOC allows beneficiaries to review how changes might affect their healthcare needs and financial responsibilities, giving them the opportunity to compare their current plan with others to ensure they have the best coverage for their situation. It plays an essential role in promoting transparency and informed decision-making within the Medicare program. The other options do not accurately define the acronym or do not reflect the specific purpose of the document within the Medicare system.

6. What are events designed to steer potential enrollees toward a specific plan called?

- A. Informational events**
- B. Sales and Marketing events**
- C. Educational events**
- D. Community outreach events**

The term used to describe events designed specifically to steer potential enrollees toward a particular plan is "Sales and Marketing events." These events are strategically organized to promote a specific Medicare Advantage plan, highlighting its benefits, features, and any associated offerings that may appeal to potential enrollees. During these events, representatives provide detailed information that encourages attendees to consider enrolling in the plan being promoted, helping to drive enrollment efforts. In contrast, informational events tend to focus on providing general information about Medicare options without a specific agenda to direct attendees toward a single choice. Educational events often have a similar aim, educating attendees about Medicare in a broader context without the intent to promote a particular plan. Community outreach events are typically aimed at building relationships and awareness within the community rather than pushing for enrollment in a specific plan. Therefore, the primary focus of Sales and Marketing events aligns with the goal of guiding potential enrollees toward a specific offering, setting them apart from the other types of events mentioned.

7. What does Medicare Advantage typically require for specialist visits?

- A. No referral is needed**
- B. Referral from a primary care physician**
- C. Special approval by Medicare**
- D. Payment of an additional fee**

Medicare Advantage plans commonly require a referral from a primary care physician for specialist visits. This requirement is in place to promote coordinated care and ensure that patients receive appropriate treatment within the context of their overall health management. By obtaining a referral, the primary care physician can help guide patients to the right specialist and provide relevant medical information to facilitate effective care. This approach not only helps in managing costs but also enhances the continuity of care, as the primary physician typically oversees the patient's health journey. It's important to note that some Medicare Advantage plans may have different rules, and certain plans could allow direct access to specialists without a referral. However, as a general rule, the referral practice is a common feature of many Medicare Advantage plans.

8. What is the role of the Centers for Medicare and Medicaid Services (CMS) in relation to Medicare Advantage plans?

- A. To provide additional funding for beneficiaries**
- B. To regulate and oversee compliance with federal guidelines**
- C. To offer training for healthcare providers**
- D. To set premium rates for plans**

The role of the Centers for Medicare and Medicaid Services (CMS) in relation to Medicare Advantage plans is primarily to regulate and oversee compliance with federal guidelines. CMS ensures that these plans meet specific standards set by the federal government with regard to quality, access, and cost. This oversight is critical to maintaining the integrity and effectiveness of Medicare Advantage plans, ensuring that beneficiaries receive the appropriate level of care and coverage. By enforcing regulations, CMS protects beneficiaries from potential abuses and ensures a level playing field among different Medicare Advantage plans, which helps foster competition and innovation while safeguarding consumer interests. This regulatory role includes monitoring the performance of the plans, approving plan benefits, and enforcing compliance with federal regulations, which collectively contributes to the overall stability and reliability of the Medicare Advantage program.

9. What does an HMO plan typically require regarding healthcare providers?

- A. Members can choose any provider**
- B. Members must use network providers**
- C. Members can switch providers anytime**
- D. Members can only see a specified number of specialists**

An HMO (Health Maintenance Organization) plan typically requires members to use network providers for their healthcare services. This network consists of a group of doctors, hospitals, and other healthcare providers that have agreed to provide services at reduced rates for the members of the HMO. By using network providers, members benefit from lower out-of-pocket costs and more coordinated care, as these providers communicate and collaborate to manage the member's health. When members seek care outside of this network, they often face higher costs or may not be covered at all, which incentivizes them to stick to the designated network. This structure helps HMOs manage healthcare costs effectively and ensures that members receive care that is aligned with the plan's guidelines and networks. In contrast, allowing members to choose any provider or switch providers freely would undermine the cost control and care coordination benefits HMOs are designed to offer. The limitations on seeing specialists without referral are also characteristic of HMO plans, but the primary requirement centers around the use of network providers.

10. Which type of plan requires members to have a primary care physician?

- A. Preferred Provider Organization (PPO)**
- B. Health Maintenance Organization (HMO)**
- C. Medicare Cost Plan**
- D. Private Fee-for-Service Plan**

A Health Maintenance Organization (HMO) plan is structured to emphasize preventive care while requiring members to select a primary care physician (PCP). This designation is essential because the PCP acts as the coordinator of care, managing and directing the member's healthcare services, including referrals to specialists. Utilizing a primary care physician helps streamline the process of receiving care and ensures that all aspects of a member's health are monitored and managed effectively. This model is designed to encourage regular check-ups and preventative measures, which ultimately benefits the overall health of the members and helps control costs within the plan by limiting unnecessary specialists or services outside the network, which may not be covered without a referral. In contrast, other types of plans like Preferred Provider Organizations (PPOs) allow greater flexibility, enabling members to see any doctor without needing a referral, while Medicare Cost Plans and Private Fee-for-Service Plans also provide different structures regarding the management of care, but do not necessitate members to have a primary care physician in the same manner as an HMO.

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://anthemmedicareadvantage.examzify.com>

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