

ANTHEM MEDICARE ADVANTAGE CERTIFICATION PRACTICE EXAM (SAMPLE) STUDY GUIDE



Prepare with structure. Pass with confidence



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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. Which of the following scenarios is most likely to lead to corrective action?**
 - A. Prompt reporting of events
 - B. Repeated late event reporting
 - C. Successful enrollment drives
 - D. High attendance at events
- 2. 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
- 3. Catastrophic Coverage in Part D begins once the member reaches which threshold?**
 - A. Deductible threshold
 - B. Co-payment threshold
 - C. TrOOP threshold
 - D. Maximum out-of-pocket threshold
- 4. 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
- 5. What additional benefits do Medicare Advantage plans often include beyond medical coverage?**
 - A. Travel discounts
 - B. Extra benefits like dental, vision, hearing, and wellness programs
 - C. Only emergency coverage
 - D. Free gym membership

- 6. Which option best describes the flexibility of using preferred vs. non-preferred providers in a PPO plan?**
- A. More flexibility with non-preferred providers
 - B. Less flexibility overall
 - C. Equal flexibility as any service
 - D. More restrictions for preferred providers
- 7. In the context of Medicare Advantage plans, what does the term "network" refer to?**
- A. A geographic area where services are provided
 - B. A group of healthcare providers agreed to provide services
 - C. The total number of enrolled members in a plan
 - D. An online portal for managing healthcare
- 8. Prior to making an enrollment decision, what must beneficiaries do?**
- A. Sign the final enrollment forms
 - B. Review the pre-enrollment checklist
 - C. Contact a Medicare representative
 - D. Wait for a confirmation letter
- 9. Do enrollees need a referral to see an out-of-network provider under Medicare Advantage?**
- A. Yes, always
 - B. No, but they should verify the provider's acceptance
 - C. Only for PPO plans
 - D. Only for HMO plans
- 10. What is the primary reason for needing express written consent from beneficiaries under TPMOs?**
- A. It protects the beneficiary's privacy
 - B. It simplifies the data sharing process
 - C. It allows for faster service delivery
 - D. It enhances marketing strategies

Answers

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

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Explanations

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1. Which of the following scenarios is most likely to lead to corrective action?

- A. Prompt reporting of events
- B. Repeated late event reporting**
- C. Successful enrollment drives
- D. High attendance at events

The scenario that is most likely to lead to corrective action is the one involving repeated late event reporting. This situation indicates a persistent issue in the handling or management of events, suggesting that there may be systemic problems that need to be addressed. Timely reporting is crucial in maintaining compliance, ensuring accurate data management, and facilitating prompt responses to any issues that may arise during events. When event reporting is consistently late, it can lead to complications such as missed regulatory deadlines, misunderstandings among team members about event outcomes, and ultimately a potential decline in service quality. These issues can trigger a need for corrective action to ensure that procedures are improved, accountability is reinforced, and timelines are adhered to in the future. In contrast, prompt reporting of events demonstrates that the team is working efficiently and transparently, which reduces the likelihood of needing corrective action. Successful enrollment drives and high attendance at events are positive scenarios that typically reflect well on the organization, thus not necessitating corrective measures. Therefore, the focus on repeated late event reporting highlights an area of concern that requires immediate attention and improvement.

2. 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.

3. Catastrophic Coverage in Part D begins once the member reaches which threshold?

- A. Deductible threshold
- B. Co-payment threshold
- C. TrOOP threshold**
- D. Maximum out-of-pocket threshold

Catastrophic Coverage in Medicare Part D begins once a member reaches the TrOOP threshold, which stands for True Out-of-Pocket costs. This threshold consists of the amount the member has spent out of pocket for prescription drugs, including certain costs that count towards this threshold. Once the member's out-of-pocket expenses reach the specified TrOOP limit, they enter the catastrophic phase of the plan. During this phase, members are responsible for significantly lower co-payments or coinsurance for their covered medications, thereby providing substantial financial protection after high drug spending. Understanding the TrOOP threshold is crucial because it directly affects how and when beneficiaries receive coverage for their medications, making it a key component of the Medicare Part D program. Other thresholds, such as the deductible, co-payment, and maximum out-of-pocket thresholds, are related but serve different purposes within the structure of Medicare benefits. The deductible is the initial amount that must be paid before the plan begins to pay, while the co-payment threshold refers to the tiered payment system for medications prior to reaching the catastrophic stage. The maximum out-of-pocket threshold typically pertains to other parts of Medicare, such as Medicare Advantage plans, rather than specifically to Part D. Therefore, recognizing the role of the TrO

4. 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.

5. What additional benefits do Medicare Advantage plans often include beyond medical coverage?

- A. Travel discounts
- B. Extra benefits like dental, vision, hearing, and wellness programs**
- C. Only emergency coverage
- D. Free gym membership

Medicare Advantage plans typically offer a range of additional benefits that extend beyond standard medical coverage, which is why the correct choice emphasizes the inclusion of services such as dental, vision, hearing, and wellness programs. These enhancements are designed to provide more comprehensive care and support for enrollees' overall health, addressing needs that Original Medicare does not cover. Many Medicare Advantage plans recognize the importance of preventive care and overall well-being, leading to the inclusion of wellness programs that can promote healthier lifestyles. Additionally, dental and vision care can significantly impact a person's quality of life, making these benefits vital to many enrollees. Hearing aids and related services are also commonly included due to their importance in maintaining communication and connectivity as individuals age. The other options, while they may reflect benefits that some plans offer individually, do not encapsulate the broader scope of additional benefits provided by Medicare Advantage plans effectively. Travel discounts and free gym memberships might be part of some plans, but they are not universally applicable and do not represent the core additional benefits that most plans include. Emergency coverage is essential but does not encompass the varied supplementary services that provide more holistic care.

6. Which option best describes the flexibility of using preferred vs. non-preferred providers in a PPO plan?

- A. More flexibility with non-preferred providers**
- B. Less flexibility overall
- C. Equal flexibility as any service
- D. More restrictions for preferred providers

In a Preferred Provider Organization (PPO) plan, members enjoy a higher level of flexibility when choosing their healthcare providers, especially when it comes to using non-preferred providers. By design, PPO plans allow beneficiaries to seek care from both preferred and non-preferred providers. While using preferred providers typically results in lower out-of-pocket costs and more covered services, members are not limited to these networks—they can also receive care from non-preferred providers. The appeal of this structure is that it empowers enrollees to make choices that best fit their individual healthcare needs, even if it means incurring higher out-of-pocket costs for services rendered by non-preferred providers. This aspect of PPO plans provides members with significant flexibility to access a wider range of specialists and facilities as necessary, without needing referrals, which is a common limitation in other types of health plans. While preferred providers offer certain financial incentives, the inherent nature of the PPO plan enables members to have more autonomy in their health care decisions, illustrating why the option describing more flexibility with non-preferred providers is the right choice.

7. In the context of Medicare Advantage plans, what does the term "network" refer to?

- A. A geographic area where services are provided
- B. A group of healthcare providers agreed to provide services**
- C. The total number of enrolled members in a plan
- D. An online portal for managing healthcare

In the context of Medicare Advantage plans, the term "network" specifically refers to a group of healthcare providers who have contracted with the insurance plan to deliver services to its members. This network typically includes a variety of providers such as primary care physicians, specialists, hospitals, and other healthcare facilities that accept the plan's terms and agreed-upon rates. Members of Medicare Advantage plans often receive the most substantial benefits when they utilize providers within this network. In-network providers generally have negotiated rates with the plan, which can lead to lower out-of-pocket costs for members compared to out-of-network providers. Understanding this aspect of Medicare Advantage plans is crucial as it influences both the accessibility of care and the financial implications for beneficiaries. The other options, while related to healthcare, do not align with the specific definition of "network" in this context. The geographic area mentioned does relate to service delivery areas, but it does not capture the essence of a "network." The total number of enrolled members relates to the scale of the plan rather than its provider component, and an online portal pertains to technology and management rather than the relationships between providers and the plan.

8. Prior to making an enrollment decision, what must beneficiaries do?

- A. Sign the final enrollment forms
- B. Review the pre-enrollment checklist**
- C. Contact a Medicare representative
- D. Wait for a confirmation letter

Beneficiaries must review the pre-enrollment checklist before making an enrollment decision to ensure they fully understand their options and the requirements of enrolling in a Medicare Advantage plan. This checklist typically includes vital information about eligibility, covered services, costs, and deadlines, which are crucial for beneficiaries to consider in order to make an informed choice. By reviewing the checklist, beneficiaries can avoid common pitfalls, assess their healthcare needs, and determine if the plan aligns with their expectations and budget. This preparatory step can help beneficiaries navigate the complexities of Medicare Advantage options and make selections that best suit their individual preferences and healthcare requirements. It is an essential step to maximize the benefits they can receive and ensure a smoother enrollment process.

9. Do enrollees need a referral to see an out-of-network provider under Medicare Advantage?

- A. Yes, always
- B. No, but they should verify the provider's acceptance**
- C. Only for PPO plans
- D. Only for HMO plans

Enrollees in a Medicare Advantage plan do not generally need a referral to see an out-of-network provider, but it is crucial for them to verify whether that provider accepts their specific Medicare Advantage plan. This verification is important because coverage for out-of-network services can vary based on the plan type, and some may cover them only at a higher out-of-pocket cost or not at all. Selecting an out-of-network provider without ensuring their acceptance of the plan could lead to unexpected expenses. This flexibility is particularly significant for enrollees who may wish to seek care from a specialist or provider outside their established network, allowing for broader choices while still enabling them to get necessary medical services with an understanding of potential costs involved.

10. What is the primary reason for needing express written consent from beneficiaries under TPMOs?

- A. It protects the beneficiary's privacy**
- B. It simplifies the data sharing process
- C. It allows for faster service delivery
- D. It enhances marketing strategies

The primary reason for needing express written consent from beneficiaries under Third Party Marketing Organizations (TPMOs) is to protect the beneficiary's privacy. This requirement is fundamentally rooted in ensuring that beneficiaries understand and agree to the collection and sharing of their personal information. By obtaining express consent, organizations make it clear that they are respecting the individual's right to privacy and autonomy over their own personal data. This is especially important in healthcare, where sensitive information can significantly impact a person's life. While aspects such as simplifying data sharing, faster service delivery, and enhancing marketing strategies can be important in the context of TPMO operations, they do not take precedence over the necessity to protect patient confidentiality and personal information. The emphasis on express written consent ensures that beneficiaries are fully informed about how their data will be used, which aligns with regulatory standards and ethical obligations in healthcare. This approach fosters trust between the beneficiaries and organizations, maintaining compliance with privacy laws and regulations.

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!

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