

ANTHEM MEDICARE ADVANTAGE CERTIFICATION 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. How does telehealth fit into the services offered by Anthem Medicare Advantage plans?**
 - A. It is an optional service requiring additional fees
 - B. It is only available for mental health services
 - C. It typically includes telehealth services as part of their coverage for convenient access to care
 - D. It is available exclusively through affiliated hospitals
- 2. What is required for a member to receive preventive care without costs in an HMO plan?**
 - A. Using any provider
 - B. Choosing an in-network provider
 - C. Obtaining a referral
 - D. Paying the full premium
- 3. How does a cancellation differ from a disenrollment?**
 - A. A cancellation occurs after the effective date
 - B. A cancellation can only be initiated in writing
 - C. A cancellation applies before the effective date
 - D. A cancellation requires a doctor's request
- 4. How often must Chronic SNPs (CSNPs) reconfirm a beneficiary's eligibility?**
 - A. Every 6 months
 - B. Annually
 - C. Every two years
 - D. Only at enrollment
- 5. Which Part D benefit phase was eliminated starting with Calendar Year 2025?**
 - A. Initial Coverage phase
 - B. Deductible phase
 - C. Coverage Gap phase
 - D. Catastrophic Coverage phase

- 6. What does it mean when a plan is “Medicare-certified”?**
- A. It has met all federal regulations and requirements set forth by CMS
 - B. It offers exclusive coverage to a select number of individuals
 - C. It is authorized to operate only in certain states
 - D. It is a plan that charges extra premiums for additional benefits
- 7. 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
- 8. What is the purpose of the Evidence of Coverage document?**
- A. To outline the plan's annual premium changes
 - B. To provide detailed information about the plan's rights, benefits, and responsibilities
 - C. To list all participating healthcare providers in the network
 - D. To summarize the plan's customer service policies
- 9. What does the term “inpatient services” generally imply within the scope of Medicare?**
- A. Care provided without a hospital stay
 - B. Services that require a formal admission to a hospital
 - C. Services provided at home only
 - D. Care that is only focused on emergency situations
- 10. What action is required if a beneficiary wants to change their plan during the SEP?**
- A. Notify the previous provider only
 - B. Reapply for a new plan only
 - C. Change must be documented
 - D. Submit a disenrollment request

Answers

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

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Explanations

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1. How does telehealth fit into the services offered by Anthem Medicare Advantage plans?

- A. It is an optional service requiring additional fees
- B. It is only available for mental health services
- C. It typically includes telehealth services as part of their coverage for convenient access to care**
- D. It is available exclusively through affiliated hospitals

Telehealth services are an integral part of the care delivery model in Anthem Medicare Advantage plans, emphasizing convenient and accessible healthcare for members. Integrating telehealth into their offerings allows beneficiaries to consult with healthcare providers remotely, thus improving access to care, especially for those who may face barriers in visiting physical locations due to distance, mobility issues, or time constraints. This approach aligns with the overall aim of Anthem Medicare Advantage plans to provide comprehensive and patient-centered care. Telehealth services often encompass a wide range of medical consultations beyond just mental health, supporting various specialties and primary care visits. By including telehealth as part of their standard coverage, Anthem enables members to efficiently manage their health needs while also promoting the use of technology in healthcare delivery. The inclusion of telehealth as a standard benefit ensures that the plans remain relevant and responsive to the needs of modern healthcare consumers, allowing for a more flexible response to patient requirements.

2. What is required for a member to receive preventive care without costs in an HMO plan?

- A. Using any provider
- B. Choosing an in-network provider**
- C. Obtaining a referral
- D. Paying the full premium

For a member to receive preventive care without any costs in a Health Maintenance Organization (HMO) plan, it is essential for the member to choose an in-network provider. HMO plans typically emphasize a network of healthcare providers to manage costs and ensure coordinated care. When members utilize providers who are within this network, they can take advantage of the benefits structured around preventive services at no additional cost, in line with the Affordable Care Act (ACA) mandates. Choosing an in-network provider guarantees that the services are covered in full by the plan, thereby eliminating any out-of-pocket expenses for preventive care. This approach not only incentivizes members to seek preventive services but also aligns with the HMO's focus on managing healthcare spending and maintaining health through early detection and prevention.

3. How does a cancellation differ from a disenrollment?

- A. A cancellation occurs after the effective date
- B. A cancellation can only be initiated in writing
- C. A cancellation applies before the effective date**
- D. A cancellation requires a doctor's request

A cancellation specifically refers to the termination of a Medicare Advantage plan before it officially takes effect. This means that when a cancellation is processed, the individual has not yet begun to receive benefits or coverage under that plan. It allows the enrollee to back out of the plan before any services or benefits have been put into place, thereby not incurring any costs or commitments associated with that particular plan. In contrast, disenrollment occurs after the effective date of coverage; it signifies that an individual has decided to leave the plan after they have commenced receiving benefits. Consequently, understanding the timing surrounding cancellations and disenrollment is crucial for enrollees to manage their plans effectively. The other options do not accurately represent the nature of cancellations. For instance, cancellations do not require a written initiation, nor do they require a doctor's request, which are stipulations that are more typically related to the disenrollment process or specific conditions under certain plans. Therefore, identifying the distinction based on timing clarifies the difference between a cancellation and a disenrollment.

4. How often must Chronic SNPs (CSNPs) reconfirm a beneficiary's eligibility?

- A. Every 6 months
- B. Annually**
- C. Every two years
- D. Only at enrollment

Chronic Special Needs Plans (CSNPs) are designed to serve individuals with specific chronic conditions, and maintaining accurate eligibility for these beneficiaries is crucial for ensuring they receive appropriate care and services. CSNPs are required to reconfirm a beneficiary's eligibility on an annual basis. This annual verification helps ensure that the needs of beneficiaries remain aligned with the criteria for enrollment in CSNPs, as their health status may change over time. Conducting this eligibility confirmation annually allows CSNPs to accurately assess whether beneficiaries still fit within the designated chronic population targeted by the plan. It ensures that those still qualifying can continue to receive the tailored benefits and specialized care that CSNPs offer, which are vital in managing chronic conditions effectively. Other potential time frames such as every 6 months, every two years, or only at enrollment do not align with Medicare's requirements, which emphasize the significance of an annual check-in for maintaining the integrity of the special needs programs.

5. Which Part D benefit phase was eliminated starting with Calendar Year 2025?

- A. Initial Coverage phase
- B. Deductible phase
- C. Coverage Gap phase**
- D. Catastrophic Coverage phase

The Coverage Gap phase, often referred to as the "donut hole," is the correct choice because starting in Calendar Year 2025, significant changes were made to Medicare Part D to provide more financial relief to beneficiaries. The goal of these changes is to reduce out-of-pocket costs for prescription drugs as a part of the broader effort to make healthcare more affordable. Prior to 2025, beneficiaries would enter the Coverage Gap after they had spent a certain amount on medications, leading to increased costs until they reached the next phase of Catastrophic Coverage. However, with the adjustments in 2025, this phase is being eliminated, allowing for a more straightforward and economical approach to accessing medications. This is part of changes initiated by legislation aimed at making prescription drugs more accessible by ensuring that beneficiaries do not experience a gap in coverage that results in higher out-of-pocket costs. The other phases of Medicare Part D – such as the Initial Coverage phase, Deductible phase, and Catastrophic Coverage phase – will remain; thus, the elimination of the Coverage Gap phase represents a significant shift in how Medicare Part D functions, aimed at benefiting enrollees directly.

6. What does it mean when a plan is "Medicare-certified"?

- A. It has met all federal regulations and requirements set forth by CMS**
- B. It offers exclusive coverage to a select number of individuals
- C. It is authorized to operate only in certain states
- D. It is a plan that charges extra premiums for additional benefits

When a plan is labeled as "Medicare-certified," it signifies that it has fulfilled all the necessary federal regulations and requirements set forth by the Centers for Medicare & Medicaid Services (CMS). This certification process ensures that the plan adheres to specific standards related to benefits, quality, pricing, and other operational aspects that protect the interests of Medicare beneficiaries. The certification indicates to beneficiaries that the plan meets rigorous guidelines designed to ensure that they receive a consistent level of care and service. In addition, Medicare-certified plans are regularly monitored to ensure ongoing compliance with CMS standards, which helps maintain the integrity and quality of health care provided to enrollees. This certification is essential for plans wishing to offer Medicare Advantage products, allowing them to participate in the Medicare program and obtain funding to offer services to eligible individuals. The other choices reflect characteristics that do not align with the meaning of "Medicare-certified." For instance, exclusive coverage to a select group of individuals or operating only in certain states does not pertain to the certification process. Similarly, charging extra premiums for additional benefits does not determine whether a plan is certified by Medicare; rather, all certified plans must comply with standard Medicare coverage requirements regardless of their pricing strategies.

7. 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.

8. What is the purpose of the Evidence of Coverage document?

- A. To outline the plan's annual premium changes
- B. To provide detailed information about the plan's rights, benefits, and responsibilities**
- C. To list all participating healthcare providers in the network
- D. To summarize the plan's customer service policies

The Evidence of Coverage (EOC) document serves as a comprehensive resource that outlines the rights, benefits, and responsibilities of both the member and the health plan. It is designed to ensure that members have a clear understanding of what their Medicare Advantage plan offers, including the services covered, limitations, member obligations, and the procedures for obtaining care. This transparency is crucial for facilitating informed decision-making and enhancing member satisfaction. The EOC is an essential tool for members to navigate their healthcare options, understand their coverage details, and know what to expect from their plan throughout the coverage year. This document typically includes information on costs, covered services, and how to appeal decisions regarding coverage. By clearly delineating these elements, the EOC empowers members to maximize their healthcare benefits effectively and reinforces their rights as beneficiaries of the plan.

9. What does the term "inpatient services" generally imply within the scope of Medicare?

- A. Care provided without a hospital stay
- B. Services that require a formal admission to a hospital**
- C. Services provided at home only
- D. Care that is only focused on emergency situations

The term "inpatient services" within the scope of Medicare specifically refers to services that necessitate a formal admission to a hospital. This includes a range of medical treatments and procedures that require patients to be formally admitted to a healthcare facility for observation, treatment, or surgical procedures, where they usually stay overnight or longer. Medicare covers these inpatient services, providing insurance coverage for patients during their hospital stay. The focus on a formal admission is crucial, as it differentiates inpatient care from outpatient services, where patients receive care without being admitted to the hospital. Inpatient services often involve more intensive medical supervision and resources due to the severity of the patient's condition or the complexity of the treatment being provided.

10. What action is required if a beneficiary wants to change their plan during the SEP?

- A. Notify the previous provider only
- B. Reapply for a new plan only
- C. Change must be documented**
- D. Submit a disenrollment request

When a beneficiary wishes to change their plan during a Special Enrollment Period (SEP), it is essential for the change to be documented properly. Documentation serves multiple purposes: it provides verification of the changes made, ensures that the beneficiary's new coverage starts without issues, and maintains a clear record of the beneficiary's plan modifications. Proper documentation is critical in the healthcare system to prevent any lapses in coverage and ensure that the changes align with the regulations governing Medicare Advantage plans. Other options may involve steps in the process but do not address the fundamental requirement of having the change documented. Merely notifying a previous provider or reapplying for a new plan may not suffice without the necessary documentation in place. Submitting a disenrollment request can be part of the process but again highlights the need to have a documented record of the beneficiary's actions to ensure a smooth transition to the new plan. Therefore, documenting the change is the most crucial action required when a beneficiary decides to modify their healthcare coverage during an SEP.

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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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