CVS Health – Aetna One Advocate (A1A) Training Practice Test (Sample)

Study Guide

Everything you need from our exam experts!

Questions

1. What is the main benefit of using a PPO plan compared to an HMO plan?

A. No need for a primary care provider

B. Higher premiums

C. Strict network restrictions

D. Lower co-payments

2. What do you call the amount of money paid monthly or yearly by an individual or employer for an insurance plan?

A. Co-pay

B. Deductible

C. Out of pocket max

D. Premium

3. What does OA EC refer to in health plans?

A. Open Access Elect Choice

B. Opportunity Access Enhanced Coverage

C. Open Area Emergency Care

D. Obligated Access Elect Care

4. What does Medicare Part B primarily cover?

A. Inpatient hospital stays

B. Outpatient procedures and supplies

C. Long-term care services

D. Prescription drugs

5. For how long does an occurrence remain on an employee's record?

A. 180 days

B. 365 days

C. 1 year and 6 months

D. 2 years

6. What is an example of a private health insurance company?

A. Aetna

B. Cigna

C. Blue Cross Blue Shield

D. Humana

7. What event might allow an individual to enroll in health insurance outside of the standard enrollment period?

A. Co-Pay

B. Qualifying Life Event

C. PPO

D. Premium

8. What type of insurance provides coverage for those with low income and limited resources?

A. Medicare

B. Medicaid

C. Private Insurance

D. Long-Term Care Insurance

9. What does OA MC represent in Aetna's terminology?

A. Open Access Managed Choice

B. Official Account Managed Care

C. Optimal Access Medical Care

D. Outside Agency Managed Care

10. What term describes a healthcare provider that has a contract with an insurance company to provide discounted services?

A. Primary Care Physician

B. Preferred Provider

C. PPO

D. HSA

Answers

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

Explanations

1. What is the main benefit of using a PPO plan compared to an HMO plan?

A. No need for a primary care provider

B. Higher premiums

C. Strict network restrictions

D. Lower co-payments

The primary advantage of utilizing a PPO (Preferred Provider Organization) plan compared to an HMO (Health Maintenance Organization) plan lies in the flexibility it offers regarding healthcare provider choices. In a PPO plan, members are not required to select a primary care provider (PCP) and do not need a referral to see specialists, allowing for greater autonomy in managing their healthcare. This flexibility is particularly beneficial for individuals who prefer to have direct access to specialists and other healthcare services without going through a PCP. HMO plans, on the other hand, typically require members to choose a primary care provider who coordinates all healthcare services and provides referrals to specialists. This structured approach can limit immediate access to certain healthcare providers and services, making PPOs appealing to those who value the ability to make independent healthcare decisions. Higher premiums, strict network restrictions, and lower co-payments do not represent the main benefit of PPO plans; instead, these characteristics often define how PPOs contrast with HMOs in terms of costs and network management, focusing on the flexibility that PPOs provide in choosing healthcare providers without the constraints imposed by a primary care provider.

2. What do you call the amount of money paid monthly or yearly by an individual or employer for an insurance plan?

A. Co-pay

B. Deductible

C. Out of pocket max

D. Premium

The term for the amount of money paid monthly or yearly by an individual or employer for an insurance plan is referred to as a premium. This payment is typically necessary to maintain coverage under the insurance policy. The premium is distinct from other insurance terms, as it represents the regular investment made to ensure access to healthcare services, benefits, and protections outlined in the policy. In contrast, a co-pay is a fixed amount that policyholders pay for specific services or medications at the time of receiving care. A deductible is the amount that must be paid out-of-pocket by the insured before the insurance company begins to cover costs. The out-of-pocket maximum is the highest amount a policyholder would pay in total for covered services within a policy period, after which the insurance company covers 100% of the costs. These distinctions highlight the role of the premium as the foundational financial commitment to securing an insurance policy.

3. What does OA EC refer to in health plans?

A. Open Access Elect Choice

B. Opportunity Access Enhanced Coverage

C. Open Area Emergency Care

D. Obligated Access Elect Care

Open Access Elect Choice refers to a type of health plan that allows members the flexibility to seek care from a wide network of providers without the need for a referral. This model is beneficial for members who wish to have more control over their healthcare decisions, including their choice of healthcare providers and specialists. The term "Open Access" implies that patients have greater freedom to access services, whereas "Elect Choice" indicates an emphasis on making personal choices regarding care options. In the context of health plans, this model can encourage utilization of preventive services and potentially lead to better health outcomes as members are not restricted by referral requirements. This approach is particularly attractive to individuals who value convenience and flexibility in their healthcare arrangements.

4. What does Medicare Part B primarily cover?

A. Inpatient hospital stays

B. Outpatient procedures and supplies

C. Long-term care services

D. Prescription drugs

Medicare Part B is designed to provide coverage primarily for outpatient services, which includes a variety of medical procedures and supplies used in a non-hospital setting. This can encompass office visits to physicians, preventive services, diagnostic tests, and necessary outpatient surgeries. Additionally, it covers certain durable medical equipment (DME) that patients may need outside of a hospital. The primary focus of Medicare Part B is to ensure beneficiaries have access to essential healthcare services without requiring an inpatient hospital stay, which differentiates it from other parts of Medicare. This allows individuals to maintain their health and manage chronic conditions effectively while avoiding hospital admissions, which can carry significant costs and risks. In contrast, other options fall outside the scope of Medicare Part B. For instance, inpatient hospital stays are primarily covered under Medicare Part A, while long-term care services typically fall outside of Medicare's coverage and are not included in Part B. Finally, prescription drugs are generally covered under Medicare Part D, rather than Part B, although some specific medications administered in a clinical setting may fall under Part B's umbrella.

5. For how long does an occurrence remain on an employee's record?

A. 180 days

B. 365 days

C. 1 year and 6 months

D. 2 years

The duration for which an occurrence remains on an employee's record is crucial in understanding the performance management and disciplinary processes within an organization. In this instance, the correct answer indicates that an occurrence remains on record for 365 days, which aligns with standard practices in many organizations for performance tracking and accountability. This time frame allows for a reasonable period during which an employee can receive feedback and work towards improvement. After 365 days, the occurrence may no longer have an impact on decisions such as promotions, raises, or employment evaluations. This policy is designed to encourage employees to learn from mistakes without being permanently penalized, supporting personal and professional development. Such a practice fosters an environment where employees can make amends and enhance their performance over time, ultimately benefiting the organization as a whole.

6. What is an example of a private health insurance company?

A. Aetna

B. Cigna

C. Blue Cross Blue Shield

D. Humana

Humana is indeed an example of a private health insurance company. It operates within the private sector, providing a variety of health plans and services. Humana focuses on offering health insurance for individuals, families, and employers, engaging in areas such as Medicare Advantage and other managed care plans. Understanding why Humana qualifies as a private health insurance company is essential for recognizing the landscape of private insurance options available to consumers. These companies operate independently of the government and typically work to provide competitive health insurance products. The other options, Aetna, Cigna, and Blue Cross Blue Shield, also represent private health insurance companies; however, choosing Humana demonstrates familiarity with one of the major players in the health insurance market.

7. What event might allow an individual to enroll in health insurance outside of the standard enrollment period?

A. Co-Pay

B. Qualifying Life Event

C. PPO

D. Premium

The correct choice revolves around the concept of a "Qualifying Life Event." This term refers to significant changes in an individual's life circumstances that provide eligibility for a special enrollment period in a health insurance plan, despite the standard enrollment window having passed. Typical examples of qualifying life events include marriage, divorce, the birth or adoption of a child, and loss of other health coverage. During a qualifying life event, individuals are granted a specific timeframe in which they can enroll in a health insurance plan or make changes to their existing coverage. This flexibility is crucial as it ensures that individuals can secure necessary health care coverage at pivotal moments in their lives, contributing to the overall stability of their health care access. The other choices relate to different aspects of health insurance but do not encompass the enrollment process. Co-pays refer to out-of-pocket expenses for medical services; PPO is a type of health insurance plan that provides more flexibility when choosing healthcare providers; and premiums are the payments made to maintain health insurance coverage. None of these terms indicate a mechanism for enrolling outside of the standard enrollment period, making "Qualifying Life Event" the only option that accurately addresses the situation.

8. What type of insurance provides coverage for those with low income and limited resources?

A. Medicare

B. Medicaid

C. Private Insurance

D. Long-Term Care Insurance

Medicaid is a government program specifically designed to provide health coverage for individuals and families with low income and limited resources. It is essential for helping vulnerable populations, including low-income adults, children, pregnant women, elderly individuals, and those with disabilities, access necessary healthcare services. Medicaid offers a range of services, including hospital and doctor visits, preventive care, and other essential health services that might otherwise be unaffordable for these individuals. In contrast, Medicare primarily serves the elderly and some younger individuals with disabilities, focusing on different eligibility criteria centered around age and specific health conditions, rather than income levels. Private insurance is typically purchased by individuals or provided by employers and is not specifically targeted at low-income populations. Long-term care insurance is designed to cover services such as nursing home care or in-home care, but it is not aimed at providing health coverage for those with low income. Thus, Medicaid is unique in its focus on supporting those who face financial challenges in accessing healthcare.

9. What does OA MC represent in Aetna's terminology?

A. Open Access Managed Choice

B. Official Account Managed Care

C. Optimal Access Medical Care

D. Outside Agency Managed Care

The term OA MC in Aetna's terminology stands for Open Access Managed Choice. This designation indicates a type of health plan that allows members greater flexibility in selecting their healthcare providers and accessing services without a primary care physician's referral. Members typically can see specialists and other providers directly, contributing to a more streamlined and patient-friendly approach in managing healthcare needs. Open Access Managed Choice is particularly beneficial for those who may require specialist care or services frequently, as it removes the barriers that can sometimes exist in more traditional managed care plans. This aligns with Aetna's focus on providing a range of care options that prioritize member preferences and convenience, promoting better health outcomes and satisfaction. In contrast, the other options presented do not reflect Aetna's established terms or would not resonate with the principles of the Open Access model described. Hence, recognizing OA MC as Open Access Managed Choice helps in understanding how Aetna structures its health plan offerings to accommodate member needs.

10. What term describes a healthcare provider that has a contract with an insurance company to provide discounted services?

A. Primary Care Physician

B. Preferred Provider

C. PPO

D. HSA

The term that describes a healthcare provider with a contract to provide discounted services to an insurance company is "Preferred Provider." This designation signifies that the provider agrees to offer services at lower rates for the members of that insurance plan, which helps keep costs down for both the insurer and the insured. This arrangement is beneficial for patients, as they typically receive care from these providers at reduced out-of-pocket expenses. A primary care physician is a type of healthcare provider who serves as a patient's main point of contact for health care, but this role does not inherently imply a financial agreement with an insurance company. PPO stands for Preferred Provider Organization, which is a type of health insurance plan that allows members to see any healthcare provider but encourages the use of preferred providers by offering better coverage for those services. While connected to the concept of preferred providers, it is not the term that specifically identifies the provider itself. HSA refers to a Health Savings Account, which is a savings account for healthcare expenses that can provide tax advantages, rather than a description of a healthcare provider's contractual relationship with insurers. Understanding the concept of preferred providers helps clarify how healthcare costs and patient access intersect within insurance networks.