

CVS Health - Aetna One Advocate (A1A) Training 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 type of health insurance plan offers the least restrictions but is generally more costly?**
 - A. EPO**
 - B. PPO**
 - C. HMO**
 - D. POS**

- 2. Which of the following describes a PPO insurance plan?**
 - A. Requires members to use network providers exclusively**
 - B. Provides no financial incentive for using network providers**
 - C. Offers higher co-insurance for using network providers**
 - D. Is limited to one specific health care provider**

- 3. What is necessary for patients prior to receiving any elective procedure in terms of financial obligations?**
 - A. Prior authorization**
 - B. Deductible payment**
 - C. Full payment**
 - D. Verification of benefits**

- 4. What classification is given to a hospital room that contains two beds?**
 - A. Private Room**
 - B. Semi-private Room**
 - C. Shared Room**
 - D. Multiple Occupancy Room**

- 5. What type of document is required for proving a child's dependency in case of disability?**
 - A. Insurance Policy**
 - B. Birth Certificate**
 - C. Medical Carrier Proof**
 - D. Government ID**

- 6. What is the written order from a physician that allows a patient to see a specialist?**
- A. Prescription**
 - B. Referral**
 - C. Authorization**
 - D. Consultation**
- 7. What is the name of the process by which a provider contacts the insurance provider to verify coverage for a procedure?**
- A. Preauthorization**
 - B. Credentialing**
 - C. Verification of Benefits**
 - D. Claim Submission**
- 8. Which of the following best describes the cost-sharing aspect of health insurance where a patient pays a percentage of the covered service?**
- A. Copayment**
 - B. Coinsurance**
 - C. Deductible**
 - D. Premium**
- 9. Who is classified as a part-time employee?**
- A. An employee working at least 40 hours per week**
 - B. An employee working an average of less than 30 hours per week**
 - C. An employee working at least 20 hours per week**
 - D. An employee only working weekends**
- 10. In most health insurance plans, what is required before certain treatments can begin?**
- A. Claim Submission**
 - B. Preauthorization**
 - C. Deductible Payment**
 - D. Initial Consultation**

Answers

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

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Explanations

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1. What type of health insurance plan offers the least restrictions but is generally more costly?

- A. EPO**
- B. PPO**
- C. HMO**
- D. POS**

A Preferred Provider Organization (PPO) plan is characterized by its flexibility and fewer restrictions compared to other types of health insurance plans. Members in a PPO can seek care from any healthcare provider, and they do not need a primary care physician or a referral to see specialists. This offers significant convenience for patients who prefer to have more control over their healthcare choices. However, this added flexibility comes at a higher cost. Premiums for PPO plans are typically more expensive than those for Health Maintenance Organization (HMO) plans, which require members to choose a network of doctors and get referrals for specialty care. The higher out-of-pocket costs associated with PPOs can also include higher deductibles and co-pays, especially when choosing out-of-network providers. In contrast, EPO (Exclusive Provider Organization) plans typically do not cover any out-of-network services at all, unless it's an emergency, thus having restrictions similar to HMOs but without requiring referrals. Similarly, POS (Point of Service) plans offer some flexibility but still enforce a primary care physician network and require referrals to specialists, adding a layer of restriction. Thus, identifying a PPO as providing the least restrictions but generally being more costly aligns perfectly with the understanding of these plan types and how they operate within the

2. Which of the following describes a PPO insurance plan?

- A. Requires members to use network providers exclusively**
- B. Provides no financial incentive for using network providers**
- C. Offers higher co-insurance for using network providers**
- D. Is limited to one specific health care provider**

The correct response indicates that a PPO (Preferred Provider Organization) insurance plan typically offers higher co-insurance when members choose to use network providers. This structure is a hallmark of PPO plans, as they provide greater flexibility in choosing healthcare providers. Under a PPO plan, members often have the option to see any healthcare provider, but there are financial benefits and incentives to use the providers within the network. When members opt for a network provider, they usually encounter lower co-payments or co-insurance. This makes it financially advantageous to choose in-network services, encouraging members to utilize the providers that have agreed to negotiated rates with the insurance company. This flexibility and incentive create a balance between member choice and cost management for both the provider and the insurer. Thus, the answer accurately reflects one of the key features of PPO plans, emphasizing how they structure costs to promote the use of network providers.

3. What is necessary for patients prior to receiving any elective procedure in terms of financial obligations?

- A. Prior authorization**
- B. Deductible payment**
- C. Full payment**
- D. Verification of benefits**

Prior authorization is a critical step that ensures the planned elective procedure is deemed medically necessary and that coverage is pre-approved by the insurance provider. This process involves the healthcare provider obtaining consent from the insurance company before the procedure can take place. It serves as a safeguard for both the patient and the provider, confirming that the procedure will be covered under the patient's health plan, thereby preventing unexpected financial liabilities after the fact. This process also enables the patient to understand their financial obligations ahead of time, as the insurer will outline what costs, if any, will be the patient's responsibility. By securing prior authorization, patients can move forward with their elective procedures with greater confidence regarding their financial responsibilities.

4. What classification is given to a hospital room that contains two beds?

- A. Private Room**
- B. Semi-private Room**
- C. Shared Room**
- D. Multiple Occupancy Room**

A hospital room with two beds is classified as a semi-private room. This classification reflects the arrangement where two patients share the space, allowing for some level of privacy while also being in the company of another patient. Semi-private rooms are commonly used in hospitals to accommodate more patients while still providing a manageable level of comfort and privacy. On the other hand, a private room is intended for one patient only, ensuring maximum privacy and personal space. A shared room implies a less formal designation and can be seen as encompassing any arrangement where space is shared but is not specific to the level of privacy; it doesn't follow the established healthcare terminology. Multiple occupancy room also indicates a room that houses more than one patient but is typically used in a broader context without specifying the number of beds or patients. Thus, semi-private maintains the most precise definition for a room with two beds.

5. What type of document is required for proving a child's dependency in case of disability?

- A. Insurance Policy**
- B. Birth Certificate**
- C. Medical Carrier Proof**
- D. Government ID**

The requirement for proving a child's dependency in the context of disability is most accurately fulfilled through medical carrier proof. This type of documentation typically includes medical records, proof of the child's disability status, or letters from medical professionals, which affirm that the child is dependent due to a qualifying disability. Such proof is essential for organizations and insurers to assess eligibility for various benefits and coverage options related to the child's care and support. While a birth certificate may establish the relationship between the child and the parent, it does not indicate the child's disability status. An insurance policy and a government ID, while they may serve other purposes, do not provide the necessary medical validation to prove dependency due to a disability. Therefore, medical carrier proof is the most relevant and essential document in this scenario.

6. What is the written order from a physician that allows a patient to see a specialist?

- A. Prescription**
- B. Referral**
- C. Authorization**
- D. Consultation**

The correct answer, which is a referral, represents a document or order from a primary care physician that designates a patient to receive specialized medical services from another provider or specialist. The referral typically contains necessary information about the patient's condition and the specific reasons for the consultation, helping to ensure that the specialist is well-informed regarding the patient's needs. This process is essential as it streamlines care by coordinating healthcare providers, facilitating effective communication and ensuring the patient receives appropriate services. In many health insurance plans, a referral from a primary care physician is required for coverage of specialist services, making it an important aspect of patient care management. The other terms, while related to healthcare, do not accurately describe this specific process. A prescription is a written order for medication rather than a directive to see a specialist. Authorization typically relates to obtaining approval from an insurance company for specific treatments or procedures and is not synonymous with the act of referring a patient. Consultation generally refers to the process of discussing a case or seeking advice, but it does not describe the formal order that initiates a patient's visit to a specialist.

7. What is the name of the process by which a provider contacts the insurance provider to verify coverage for a procedure?

- A. Preauthorization**
- B. Credentialing**
- C. Verification of Benefits**
- D. Claim Submission**

The suitable term for the process in which a healthcare provider reaches out to an insurance company to confirm that a patient's health plan covers a specific procedure is known as preauthorization. This step is essential for ensuring that the procedure is eligible for coverage before it is performed. Typically, preauthorization helps both the provider and the patient understand the extent of the insurance coverage, potentially avoiding surprises regarding out-of-pocket costs later on. In the context of healthcare, preauthorization serves as a proactive measure where approval is sought before services are rendered. This is critical for procedures that may be costly or require special consideration based on the health plan's guidelines. It helps in managing healthcare costs and ensuring that the patient's care aligns with the insurance company's policies. Verification of Benefits, while related, specifically refers to confirming the details of what is covered under a patient's plan, rather than gaining prior approval to perform a procedure. Credentialing involves the process of verifying the qualifications of a healthcare provider to ensure they are licensed and capable of offering specific services but does not pertain to the patient's procedure approvals. Claim Submission refers to the process of billing the insurance company after a service has been provided, further highlighting the distinct steps involved in the healthcare insurance process.

8. Which of the following best describes the cost-sharing aspect of health insurance where a patient pays a percentage of the covered service?

- A. Copayment**
- B. Coinsurance**
- C. Deductible**
- D. Premium**

The correct choice is coinsurance, which is the term that accurately describes the cost-sharing model where a patient is required to pay a percentage of the costs for covered healthcare services. In this arrangement, after the patient has satisfied their deductible, they share in the costs of their care by paying a set percentage of the expenses, while the insurance company covers the rest. This system encourages individuals to be more mindful about their healthcare usage, as they have a direct financial stake in the services they receive. In contrast, other options like copayments, deductibles, and premiums do not represent this specific percentage-sharing structure. A copayment is a fixed amount the patient pays for a specific service, a deductible is the total amount that must be paid out-of-pocket before insurance starts to share in the cost, and a premium is the regular payment made to maintain health insurance coverage. Coinsurance is distinct because it involves a proportional sharing of costs, making it the best descriptor for the scenario provided.

9. Who is classified as a part-time employee?

- A. An employee working at least 40 hours per week
- B. An employee working an average of less than 30 hours per week**
- C. An employee working at least 20 hours per week
- D. An employee only working weekends

A part-time employee is classified as one who works an average of less than 30 hours per week. This classification aligns with common labor standards and guidelines that differentiate between full-time and part-time work. Typically, full-time employees work a minimum of 30 hours per week, with many organizations considering those who work 40 hours or more as full-time. Therefore, the threshold of less than 30 hours per week is critical in establishing part-time status. This classification helps employers in managing employee benefits, payroll, and work expectations, as part-time employees may not receive the same benefits or responsibilities as full-time counterparts. Understanding this distinction is essential for adhering to labor regulations and for accurately assessing workforce needs.

10. In most health insurance plans, what is required before certain treatments can begin?

- A. Claim Submission
- B. Preauthorization**
- C. Deductible Payment
- D. Initial Consultation

Preauthorization is a critical step in most health insurance plans that ensures certain treatments or procedures are approved by the insurance provider before they are carried out. This process helps the insurer determine whether the proposed treatment is medically necessary and covered under the policy terms. Preauthorization serves to manage costs and ensure that patients receive appropriate care. By requiring preauthorization, health plans can prevent unnecessary or inappropriate interventions and keep healthcare expenses in check. Providers typically submit a request that includes relevant clinical information to support the need for the treatment, and a decision is communicated back to the provider and the patient. While other options like claim submission, deductible payment, and initial consultation may be components of the insurance process, they do not specifically serve the same purpose as preauthorization. Claim submission relates to the process of billing the insurer after services have been provided, deductible payment refers to the amount a patient must pay out of pocket before insurance begins to cover costs, and an initial consultation is the first meeting between a patient and provider to discuss care, irrespective of whether treatment requires prior approval.

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://cvshealtha1atraining.examzify.com>

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

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