

# United Healthcare 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**

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- 1. When is a thorough needs assessment required?**
  - A. After making plan recommendations**
  - B. Before making any plan recommendations**
  - C. Only when a consumer asks for additional information**
  - D. Before conducting annual reviews**
  
- 2. Who benefits from the non-profit nature of the Medical Information Bureau (MIB)?**
  - A. Insurance companies and consumers**
  - B. Only insurance agents**
  - C. Only policyholders**
  - D. Insurance regulators only**
  
- 3. Which of the following is true about a PFFS plan regarding referrals?**
  - A. Referrals are always required**
  - B. Referrals are optional depending on the situation**
  - C. Referrals are only necessary for specialty care**
  - D. No referrals are needed at all**
  
- 4. What must happen if an agent learns about a change in their scheduled event?**
  - A. They must inform all attendees immediately.**
  - B. They can change the time at their discretion.**
  - C. They should report it to their manager and find a replacement if needed.**
  - D. They are not allowed to change the schedule.**
  
- 5. What does holding Power of Attorney allow John to do for his mother regarding Medicare Advantage enrollment?**
  - A. Sign the Enrollment Application with no documentation**
  - B. Sign the Enrollment Application but not provide documentation**
  - C. Sign the Enrollment Application and provide documentation upon request**
  - D. Attend marketing appointments without signing**

**6. During the Open Enrollment Period (OEP), is it possible to make changes to a PDP?**

- A. Yes, changes can be made**
- B. No, changes cannot be made**
- C. Only minor adjustments are allowed**
- D. Changes can be made only for certain customers**

**7. Who is authorized to sign an Enrollment Application?**

- A. The consumer only**
- B. The consumer or authorized legal representative**
- C. The consumer or anyone the consumer authorizes**
- D. The consumer, spouse, or adult child only**

**8. If a DSNP member loses Medicaid eligibility, what is their next step regarding enrollment?**

- A. They will be automatically enrolled in a new plan.**
- B. They enter a grace period and may be disenrolled if eligibility isn't reestablished.**
- C. They immediately lose coverage.**
- D. They can retain their plan without any changes.**

**9. Which statement is true regarding AARP Medicare Supplement Insurance?**

- A. It is only required to meet state requirements**
- B. It fulfills federal requirements for Medicare Part D**
- C. It meets and exceeds federal and state requirements**
- D. It does not provide coverage during open enrollment**

**10. What is a Scope of Appointment (SOA)?**

- A. A document for consumer complaints**
- B. Permission to discuss certain products with consumers**
- C. Requirements for billing inquiries**
- D. Generic marketing authorization**

## **Answers**

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

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## **Explanations**

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## 1. When is a thorough needs assessment required?

- A. After making plan recommendations
- B. Before making any plan recommendations**
- C. Only when a consumer asks for additional information
- D. Before conducting annual reviews

A thorough needs assessment is a critical step in the planning process that occurs before making any plan recommendations. This assessment involves gathering detailed information about the individual's or group's specific needs, preferences, circumstances, and health status. By conducting this assessment first, a provider can ensure that the recommendations are tailored to effectively meet the unique needs of the individual. This process also helps in identifying any underlying issues that may not be immediately visible, ensuring that the proposed plans are relevant and beneficial. Engaging in a needs assessment before making recommendations leads to a more informed decision-making process, ultimately enhancing the quality of care and support provided. It allows for a comprehensive understanding of what services or support may be required and ensures that the subsequent recommendations are aligned with the actual needs of the consumer.

## 2. Who benefits from the non-profit nature of the Medical Information Bureau (MIB)?

- A. Insurance companies and consumers**
- B. Only insurance agents
- C. Only policyholders
- D. Insurance regulators only

The non-profit nature of the Medical Information Bureau (MIB) primarily benefits both insurance companies and consumers. Insurance companies gain access to a centralized database that helps them evaluate risk more accurately, aiding in the underwriting process. This access allows them to make informed decisions regarding coverage options and premiums, ultimately contributing to their ability to offer competitive rates. At the same time, consumers benefit from the MIB's non-profit structure because it promotes a level playing field among insurers. Since the information is standardized and accessible to various insurance companies, policyholders can obtain fairer evaluations based on consistent criteria. Additionally, the MIB helps reduce instances of insurance fraud, which can lead to overall lower costs for consumers as the risk of fraudulent claims is minimized. The other choices focus on narrower groups; insurance agents, policyholders, or regulators alone do not capture the broad advantages offered by the MIB's non-profit nature, which is designed to enhance the insurance process for a wider audience. Therefore, the most accurate representation of who benefits is that both insurance companies and consumers gain from this structure.

**3. Which of the following is true about a PFFS plan regarding referrals?**

- A. Referrals are always required**
- B. Referrals are optional depending on the situation**
- C. Referrals are only necessary for specialty care**
- D. No referrals are needed at all**

A PFFS (Private Fee-for-Service) plan does not require referrals for services. This feature is a distinct aspect of how PFFS plans operate compared to other types of managed care plans. Beneficiaries enrolled in a PFFS plan have the flexibility to seek care from any provider that accepts the plan's terms and conditions, without the need for a referral from a primary care physician or any other gatekeeper. This flexibility allows enrollees to access healthcare services more freely, facilitating immediate care without the extra step of obtaining a referral, which can be a barrier in other health plan structures. PFFS plans emphasize patient choice and access, which makes the absence of a referral requirement particularly valuable for beneficiaries who may need more direct access to various healthcare services.

**4. What must happen if an agent learns about a change in their scheduled event?**

- A. They must inform all attendees immediately.**
- B. They can change the time at their discretion.**
- C. They should report it to their manager and find a replacement if needed.**
- D. They are not allowed to change the schedule.**

The requirement for an agent who learns about a change in their scheduled event is to report it to their manager and find a replacement if needed. This approach ensures that the change is communicated through the proper channels, maintaining a professional and organized structure within the agency. This process allows the management team to assess the situation, make necessary adjustments, and ensure that all attendees and stakeholders are informed and that there is an adequate replacement to cover the responsibilities of the agent if needed. It emphasizes accountability and teamwork, aligning with best practices in professional settings where communication and problem-solving are key. Other options present different perspectives on handling a scheduling change but do not follow the established protocol of reporting to a manager. While immediate communication with attendees might seem urgent, it is often more effective and necessary to first engage management to determine the best course of action. Changing the time at one's discretion can lead to miscommunications and conflicts without proper notice to all parties involved. Lastly, the option suggesting that agents cannot change the schedule entirely undermines their ability to respond to unexpected situations effectively, as adjustments are often necessary in dynamic environments.

**5. What does holding Power of Attorney allow John to do for his mother regarding Medicare Advantage enrollment?**

- A. Sign the Enrollment Application with no documentation**
- B. Sign the Enrollment Application but not provide documentation**
- C. Sign the Enrollment Application and provide documentation upon request**
- D. Attend marketing appointments without signing**

Holding Power of Attorney (POA) enables John to act on behalf of his mother in various legal and financial matters, including healthcare-related decisions such as Medicare Advantage enrollment. When John has POA, he is authorized to sign documents related to his mother's healthcare and benefits, which includes the Enrollment Application for a Medicare Advantage plan. The reason signing the Enrollment Application and providing documentation upon request is correct relates to the legal authority granted by the Power of Attorney. With this authority, John can not only fill out the Enrollment Application but must also ensure that any required documentation that supports the application can be provided when necessary. This might include verification of eligibility, proof of identity, or similar documents. In contrast, simply signing the Enrollment Application without documentation does not align with the expectations set in such legal arrangements, as there could be instances where supporting information is needed to process the application properly. Similarly, not being able to provide documentation when required would undermine the purpose of having Power of Attorney, which is to facilitate complete and informed decision-making on behalf of his mother.

**6. During the Open Enrollment Period (OEP), is it possible to make changes to a PDP?**

- A. Yes, changes can be made**
- B. No, changes cannot be made**
- C. Only minor adjustments are allowed**
- D. Changes can be made only for certain customers**

The designated time frame of the Open Enrollment Period (OEP) typically allows beneficiaries to make changes to their healthcare plans, but this varies based on the type of plan and the specific rules governing it. In the context of a Prescription Drug Plan (PDP), the OEP does not permit any changes to an existing plan. Individuals must wait for the Annual Enrollment Period (AEP) to make modifications such as switching from one PDP to another or adjusting their current plan. This rigidity is established to maintain stability within the plan choices available to beneficiaries during a defined period. Therefore, stating that changes cannot be made during OEP accurately reflects the regulations surrounding PDPs and their respective enrollment windows.

## 7. Who is authorized to sign an Enrollment Application?

- A. The consumer only
- B. The consumer or authorized legal representative**
- C. The consumer or anyone the consumer authorizes
- D. The consumer, spouse, or adult child only

The consumer or an authorized legal representative is the correct answer for who is authorized to sign an Enrollment Application. This aligns with standard practices in healthcare enrollment processes, where individuals may have legal representatives—such as guardians or power of attorney—who are permitted to act on their behalf in legal matters, including signing documents related to healthcare enrollment. This ensures that the rights and interests of those who may be incapacitated or otherwise unable to make decisions are protected. The presence of an authorized legal representative helps to verify that the application is signed by someone with the legal authority to do so, thereby safeguarding the integrity of the enrollment process. Other options do not capture the necessary legal nuance. For instance, while the consumer alone could sign the application, it doesn't take into account scenarios involving those who are unable to sign due to health conditions or incapacity. Similarly, though a consumer may choose to authorize someone else to sign on their behalf, that authorization must meet legal requirements to be valid, and not just any person can be considered authorized without proper legal authority. The option that limits to immediate family members might not encompass all legal representatives available to the consumer, thus narrowing the scope unfairly.

## 8. If a DSNP member loses Medicaid eligibility, what is their next step regarding enrollment?

- A. They will be automatically enrolled in a new plan.
- B. They enter a grace period and may be disenrolled if eligibility isn't reestablished.**
- C. They immediately lose coverage.
- D. They can retain their plan without any changes.

When a Dual Special Needs Plan (DSNP) member loses their Medicaid eligibility, the appropriate next step is that they enter a grace period. This allows them time to work on reestablishing their Medicaid eligibility without losing their coverage immediately. During this grace period, the member may continue to receive the benefits of their current plan, however, they may be at risk of being disenrolled if they are unable to reestablish their eligibility before the stipulated timeframe ends. This process is crucial because DSNPs are specifically designed to serve individuals who are eligible for both Medicare and Medicaid, and the loss of Medicaid impacts the member's eligibility to remain in the DSNP after the grace period. Therefore, this step emphasizes the importance of Medicaid eligibility in maintaining the member's enrollment in their plan. It's worth noting that immediately losing coverage or being automatically enrolled in a new plan does not accurately reflect the safeguards provided to members who are facing potential disenrollment.

## 9. Which statement is true regarding AARP Medicare Supplement Insurance?

- A. It is only required to meet state requirements**
- B. It fulfills federal requirements for Medicare Part D**
- C. It meets and exceeds federal and state requirements**
- D. It does not provide coverage during open enrollment**

The statement regarding AARP Medicare Supplement Insurance that is accurate is that it meets and exceeds both federal and state requirements. Medicare Supplement Insurance, commonly known as Medigap, is designed to help cover costs that original Medicare does not, such as copayments, coinsurance, and deductibles. In order to ensure consumers have substantial protection and benefits, AARP Medicare Supplement Insurance adheres to the regulatory standards established at both the federal and state levels. By exceeding these requirements, AARP aims to offer enhanced benefits and support for individuals who choose their plans, providing additional peace of mind for members. This quality of meeting and surpassing existing regulations helps consumers feel confident that they are getting robust coverage that caters to their healthcare needs, especially considering that Medicare can have significant out-of-pocket costs. The other statements do not hold true; for example, while AARP Medicare Supplement Insurance does meet state requirements, indicating that it is compliant is not sufficient for the coverage expectations. Additionally, it does not have a direct relationship with federal Medicare Part D requirements, which pertain specifically to prescription drug plans. Lastly, AARP Medicare Supplement Insurance does offer coverage during open enrollment, which is typically a critical period for individuals transitioning into Medicare or making necessary changes to

## 10. What is a Scope of Appointment (SOA)?

- A. A document for consumer complaints**
- B. Permission to discuss certain products with consumers**
- C. Requirements for billing inquiries**
- D. Generic marketing authorization**

A Scope of Appointment (SOA) is fundamentally a permission granted by a consumer that allows an agent or representative to discuss specific products with them. This is an essential part of maintaining compliance in healthcare discussions because it ensures that consumers are fully aware of the topics being addressed during an appointment or consultation. The importance of the SOA lies in its role as a protective measure for both consumers and agents. It establishes a clear boundary regarding the topics to be covered, which helps avoid any potential misunderstandings about the conversation's purpose. This practice aligns with regulations and ethical standards in healthcare marketing and communication, reinforcing the importance of informed consent. In contrast, the other options do not correctly define a Scope of Appointment. For instance, while consumer complaints are a valid concern in healthcare contexts, they relate to issue resolution rather than the permission for discussing services or products. Billing inquiries are specific to financial aspects and do not pertain to the scope of discussions about healthcare products. Lastly, generic marketing authorization refers to permissions related to marketing practices but does not address the personalized consent required for discussing specific services with consumers.

# 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](mailto:hello@examzify.com).**

**Or visit your dedicated course page for more study tools and resources:**

**<https://unitedhealthcarecertification.examzify.com>**

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

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