

WELLCARE ACT MASTERY – BROKER AND EMPLOYEE PRACTICE EXAM (SAMPLE) STUDY GUIDE



Prepare with structure. Pass with confidence



Copyright © 2026 by Examzify - A Kaluba Technologies Inc. product.

ALL RIGHTS RESERVED.

No part of this book may be reproduced or transferred in any form or by any means, graphic, electronic, or mechanical, including photocopying, recording, web distribution, taping, or by any information storage retrieval system, without the written permission of the author.

Notice: Examzify makes every reasonable effort to obtain accurate, complete, and timely information about this product from reliable sources.

SAMPLE

Table of Contents

Copyright	1
Table of Contents	2
Introduction	3
How to Use This Guide	4
Questions	5
Answers	8
Explanations	10
Next Steps	15

SAMPLE

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

SAMPLE

1. How do WellCare and CMS marketing guidelines affect broker activities?

- A. Marketing and advertising must be compliant; materials require pre-approval and truthful representation.
- B. Brokers can use any marketing content with no pre-approval.
- C. Brokers must only use digital marketing.
- D. Marketing guidelines do not apply to brokers.

2. How does a Medicare Part D plan determine drug costs and coverage?

- A. Based on a flat per-prescription price decided by CMS.
- B. Through its formulary with tiers, copays/coinsurance, and potential utilization controls like prior authorization.
- C. By the consumer's location alone.
- D. Only by the annual premium.

3. What is ERISA and how does it relate to most employer-sponsored health plans?

- A. ERISA is a federal law governing private-sector employee benefit plans, including many group health plans.
- B. ERISA is a state tax code.
- C. ERISA is a patient privacy rule.
- D. ERISA is a medical treatment guideline.

4. Which action helps ensure enrollment accuracy during a sales interaction?

- A. Confirm personal data
- B. Verify plan selection aligns with needs
- C. Collect all required signatures and documents
- D. Provide side-by-side comparisons

5. Which statement about SEP eligibility best describes when it applies?

- A. SEP eligibility is limited to annual open enrollment.
- B. Eligibility to enroll outside standard enrollment periods due to qualifying life events.
- C. SEP applies only to drug plans.
- D. SEP requires employer sponsorship.

- 6. In what system is the Health Risk Assessment (HRA) completed after the enrollment application?**
- A. Value-Based Enrollment (VBE) portal
 - B. Health Care Management System
 - C. Insurance Claim Database
 - D. Member Services Platform
- 7. Enrollment records retention is typically governed by policy and jurisdiction; what range is commonly cited?**
- A. 2-3 years
 - B. 4-6 years
 - C. 8-10 years
 - D. 12-15 years
- 8. What is a formulary in the context of health plans?**
- A. The plan's approved list of drugs; brokers verify medications against it
 - B. A list of preferred hospitals in the network
 - C. A schedule of premium payments
 - D. A guide to non-drug services coverage
- 9. How long are enrollment records typically retained for compliance?**
- A. Usually several years (commonly 4–6 years, depending on policy and jurisdiction).
 - B. Until the member's plan is terminated.
 - C. Forever, in all cases.
 - D. Only 1 year.
- 10. Is final 2025 plan and benefit information allowed to be discussed with beneficiaries before September 30, 2024?**
- A. Yes
 - B. No
 - C. Only in private meetings
 - D. Only after official release

Answers

SAMPLE

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

SAMPLE

Explanations

SAMPLE

1. How do WellCare and CMS marketing guidelines affect broker activities?

- A. Marketing and advertising must be compliant; materials require pre-approval and truthful representation.**
- B. Brokers can use any marketing content with no pre-approval.
- C. Brokers must only use digital marketing.
- D. Marketing guidelines do not apply to brokers.

Marketing guidelines require all broker marketing to be compliant and pre-approved before use. This ensures that any materials or representations about WellCare plans and CMS programs are accurate, non-deceptive, and fully aligned with what the plans can offer and what Medicare allows. In practice, brokers can't simply create or share content on their own; instead, marketing pieces—whether flyers, emails, social posts, or presentations—must go through the plan's compliance review and CMS-aligned approval process before they're used. This protects consumers from incorrect benefits, costs, or network details and ensures disclosures and required messages are included, such as plan type and eligibility notes. Additionally, brokers often undergo CMS-based certification and WellCare training to stay current with rules on truthful advertising, allowed claims, and appropriate outreach. The emphasis is on accurate portrayals and proper disclosures, rather than unilateral or unverifiable claims. Materials approved by the plan help maintain consistency with CMS marketing standards and reduce regulatory risk for the broker and the plan. The other options would bypass this essential review, confine or misstate where marketing can occur, or ignore the applicability of these guidelines, which is not how WellCare and CMS expect broker activities to be conducted.

2. How does a Medicare Part D plan determine drug costs and coverage?

- A. Based on a flat per-prescription price decided by CMS.
- B. Through its formulary with tiers, copays/coinsurance, and potential utilization controls like prior authorization.**
- C. By the consumer's location alone.
- D. Only by the annual premium.

Medicare Part D costs and coverage come from the plan's own design, not a single CMS price. Each Part D plan publishes a formulary, which is a list of covered drugs organized into tiers. The tier a drug sits in determines the member's cost sharing—copays or coinsurance that vary by tier. Higher tiers generally mean higher out-of-pocket costs. Plans also use utilization controls, such as prior authorization, step therapy, and quantity limits, to manage which drugs are approved and in what amounts. These elements together—the formulary with its tiered cost sharing and any utilization management—set how much you'll pay for a given drug and whether the drug will be covered at all. While premiums and where you live can affect plan choice and overall affordability, the actual drug costs and coverage come from the plan's formulary design and its cost-sharing structure.

3. What is ERISA and how does it relate to most employer-sponsored health plans?

- A. ERISA is a federal law governing private-sector employee benefit plans, including many group health plans.**
- B. ERISA is a state tax code.
- C. ERISA is a patient privacy rule.
- D. ERISA is a medical treatment guideline.

ERISA is a federal law that governs private-sector employee benefit plans, including many group health plans. It doesn't dictate which benefits must be offered, but it sets the framework for how those plans are run: plan fiduciaries must manage assets prudently and in participants' best interests, there are rules about eligibility and vesting, funding, and required disclosures, and there are formal procedures for filing and appealing benefit claims. Because of ERISA, participants often have the right to sue for plan benefits or fiduciary breaches in federal court, and many state laws that would otherwise regulate these plans are preempted to keep protections uniform across states. It does not usually apply to government or church plans and is not a medical treatment or privacy rule.

4. Which action helps ensure enrollment accuracy during a sales interaction?

- A. Confirm personal data**
- B. Verify plan selection aligns with needs
- C. Collect all required signatures and documents
- D. Provide side-by-side comparisons

Getting the member's information right is essential because enrollment hinges on accurate data as the foundation for eligibility, billing, and the correct coverage. By confirming personal data—like full name, date of birth, Social Security number or member ID, current address, and contact details—you catch typos, mismatches, or outdated information before it flows into the system. This reduces errors such as enrolling the wrong person, delays caused by mismatched records, incorrect premium amounts, or misissued ID cards. Verifying these details with the member during the interaction helps ensure the enrollment record truly reflects who is enrolling and what they want. While other steps matter for a good experience—checking that the plan fits the member's needs, ensuring all signatures and documents are collected, and offering clear plan comparisons—they don't directly guarantee the accuracy of the enrollment data itself. Verifying plan alignment supports suitability, collecting documents supports completeness and compliance, and side-by-side comparisons aid understanding; none directly ensures the recorded information is correct in the system.

5. Which statement about SEP eligibility best describes when it applies?

- A. SEP eligibility is limited to annual open enrollment.
- B. Eligibility to enroll outside standard enrollment periods due to qualifying life events.**
- C. SEP applies only to drug plans.
- D. SEP requires employer sponsorship.

A Special Enrollment Period is an enrollment window that's opened when a qualifying life event occurs, allowing someone to enroll in or change coverage outside the usual annual open enrollment. This matters because it shows that eligibility for SEP is tied to these life events and provides a limited time to enroll or adjust plans so coverage can start promptly. Examples of qualifying life events include things like gaining or losing other coverage, marriage or the birth/adoption of a child, moving to a new area with different plan options, or changes in citizenship status. SEPs are not limited to drug plans, nor do they require employer sponsorship; they exist to accommodate these life changes within a defined time frame.

6. In what system is the Health Risk Assessment (HRA) completed after the enrollment application?

- A. Value-Based Enrollment (VBE) portal**
- B. Health Care Management System
- C. Insurance Claim Database
- D. Member Services Platform

The Health Risk Assessment (HRA) is completed after the enrollment application primarily within the Value-Based Enrollment (VBE) portal. This system is designed specifically to facilitate the collection and processing of health data from new enrollees, enabling healthcare providers to better understand the needs and potential risks associated with their members' health. Utilizing the VBE portal allows for a streamlined approach to health assessments that align with value-based care principles, which focus on improving health outcomes while managing costs effectively. By completing HRAs in this portal immediately after enrollment, healthcare providers can swiftly identify areas where additional support or intervention may be necessary, leading to more personalized and effective care planning for members. In contrast, other systems mentioned, such as the Health Care Management System, Insurance Claim Database, and Member Services Platform, serve different functions. The Health Care Management System focuses on ongoing care coordination and management rather than the specific intake of HRA data immediately post-enrollment. The Insurance Claim Database is centered around processing claims and doesn't engage in collecting health assessments. The Member Services Platform is geared towards member inquiries and support but is not primarily designed for the completion of health risk assessments. Thus, the VBE portal is the most appropriate system for this process.

7. Enrollment records retention is typically governed by policy and jurisdiction; what range is commonly cited?

- A. 2-3 years
- B. 4-6 years**
- C. 8-10 years
- D. 12-15 years

Enrollment records retention is guided by policy and jurisdiction, and four to six years is the range most often cited. This window lines up with the period in which enrollment-related disputes, corrections, and regulatory inquiries commonly arise, so keeping records for that span helps ensure evidence is available when needed. It also matches typical expectations for plan administration and audit cycles, providing a practical balance between compliance needs and storage costs. Longer time frames—eight to ten years or more—tend to be more than needed for routine enrollment activity and add unnecessary burden, while shorter spans like two to three years risk not covering later claims or inquiries that emerge after the shorter window.

8. What is a formulary in the context of health plans?

- A. The plan's approved list of drugs; brokers verify medications against it
- B. A list of preferred hospitals in the network
- C. A schedule of premium payments
- D. A guide to non-drug services coverage

A formulary is the health plan's approved list of prescription drugs that are covered under the plan, often organized into tiers that determine your out-of-pocket costs. This list guides which medications the plan will pay for and at what level of cost sharing, helping to manage costs while aiming to ensure safe and effective therapy. Brokers verify medications against the formulary to confirm coverage and estimate what a member will pay; if a prescribed drug isn't on the formulary, alternatives or prior authorization may be needed. The other options describe different concepts—network/provider directories for hospitals, a billing schedule for premiums, and coverage of non-drug services—none of which define a formulary.

9. How long are enrollment records typically retained for compliance?

- A. Usually several years (commonly 4–6 years, depending on policy and jurisdiction).
- B. Until the member's plan is terminated.
- C. Forever, in all cases.
- D. Only 1 year.

Retention of enrollment records for compliance hinges on regulatory expectations that require keeping records long enough to support audits, inquiries, and claims processing under the plan. Enrollment data—who was enrolled, when coverage started or changed, and when it ended—needs to be available for a period that covers potential disputes and regulator requests. Because investigations and claims can arise years after enrollment, the standard practice is to retain these records for several years, typically around four to six years, with the exact duration depending on the policy and the jurisdiction. This window also aligns with common statutes of limitations and regulatory audit timelines, ensuring documentation is available if issues come up. Keeping records for only one year would leave gaps for late-emerging questions or audits, while retaining them forever is usually longer than many regulatory requirements require. Even after a plan ends, the mandated retention period still applies to satisfy regulatory obligations and potential inquiries.

10. Is final 2025 plan and benefit information allowed to be discussed with beneficiaries before September 30, 2024?

- A. Yes
- B. No
- C. Only in private meetings
- D. Only after official release

The correct response highlights that discussing final 2025 plan and benefit information with beneficiaries is restricted before September 30, 2024. This is crucial because it ensures compliance with regulations that govern the release of Medicare plan information. The aim is to prevent misinformation and confusion among beneficiaries, allowing them to make informed decisions based on officially released and complete information. Once the official plan details are available, beneficiaries can receive accurate and comprehensive information, which is vital for their understanding of the options available to them. This timing also helps to ensure that all educational efforts and marketing strategies are based on consistent and thoroughly vetted information. By adhering to this guideline, brokers and employees maintain the integrity of the enrollment process and help ensure that beneficiaries are adequately informed at the right time, reducing the potential for misunderstandings that might arise from premature discussions.

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://wellcareactmasterybrokeremployee.examzify.com>

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

SAMPLE