

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



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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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 must a Third-Party Marketing Organization (TPMO) include in their marketing materials?**
 - A. A detailed description of the plans offered
 - B. The disclaimer for selling more than one Medicare Advantage plan
 - C. All promotional discounts available
 - D. Information about competitor plans
- 2. What is the ANOC and why is it significant for members?**
 - A. Administrative Notice of Change; informs members of plan changes for the next year.
 - B. Annual Network of Care; lists providers.
 - C. Annual Notice of Change; informs members of plan changes for the next year.
 - D. Annual Notification of Coverage; informs about benefits.
- 3. Which Prescription Drug Plan (PDP) is recommended for a dual-eligible chooser?**
 - A. Value Plus
 - B. Classic
 - C. Standard Choice
 - D. Essential Care
- 4. Which item is listed as a member support resource?**
 - A. Care management
 - B. Digital marketing
 - C. Digital tools
 - D. Legal advice
- 5. What should brokers avoid stating beyond policy terms?**
 - A. Guarantees or statements beyond policy terms
 - B. Side-by-side comparisons
 - C. Clear language
 - D. Verified plan summaries

- 6. Which statement is true about a Special Enrollment Period (SEP)?**
- A. It is a time outside AEP when enrollment or switching is allowed; example: moving to a new area
 - B. SEP occurs automatically during the AEP
 - C. SEP only applies to Medicare Advantage plans
 - D. SEP cannot be used to enroll in a PDP
- 7. Which form is used to reconcile Premium Tax Credits on taxes?**
- A. A form used to reconcile Premium Tax Credits.
 - B. A form that shows proof of health coverage.
 - C. A form that lists prescription drug coverage.
 - D. A form that reports employer contributions.
- 8. What is the purpose of prior authorization in drug coverage?**
- A. A process requiring plan approval before coverage; the plan or its designee approves or denies
 - B. A guarantee of coverage for any prescribed drug
 - C. A method to determine drug price after dispensing
 - D. A patient-only approval process without plan involvement
- 9. What is prior authorization and which party makes the decision?**
- A. A process requiring plan approval before coverage; the plan or its designee approves or denies
 - B. A patient self-approves a drug for coverage
 - C. A pharmacist approves every prescription
 - D. A state agency approves all medications before dispensing
- 10. What populations does a Dual-Eligible Special Needs Plan (D-SNP) serve?**
- A. People eligible for both Medicare and Medicaid
 - B. People eligible for Medicare only
 - C. People with private employer plans
 - D. People under 65 without Medicare

Answers

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

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Explanations

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1. What must a Third-Party Marketing Organization (TPMO) include in their marketing materials?

- A. A detailed description of the plans offered
- B. The disclaimer for selling more than one Medicare Advantage plan**
- C. All promotional discounts available
- D. Information about competitor plans

A Third-Party Marketing Organization (TPMO) must ensure that their marketing materials are compliant with regulations, particularly when it comes to representing Medicare Advantage plans. Including the disclaimer for selling more than one Medicare Advantage plan is crucial because it informs potential beneficiaries that the TPMO operates with more than one carrier and emphasizes the importance of transparency. This helps consumers understand that they might encounter varied options and that their decisions should be made based on thorough comparisons of plans, which might be influenced by the representation provided. Transparency in marketing is essential for ensuring that beneficiaries are equipped with the knowledge to make informed decisions about their healthcare choices. This value aligns with the overarching goal of maintaining integrity in the healthcare marketplace, giving consumers a clearer understanding of their options without any misleading impressions. While details about plans, promotional discounts, or competitor information can be relevant, they do not hold the same regulatory emphasis on disclosure and transparency as the requirement for disclaimers when it comes to marketing multiple Medicare Advantage plans.

2. What is the ANOC and why is it significant for members?

- A. Administrative Notice of Change; informs members of plan changes for the next year.
- B. Annual Network of Care; lists providers.
- C. Annual Notice of Change; informs members of plan changes for the next year.**
- D. Annual Notification of Coverage; informs about benefits.

ANOC stands for Annual Notice of Change. It's the document plans send to members each year that lays out what will change in the coming year—things like benefits, costs (premiums, deductibles, copays), the provider network, formulary changes, and service areas. Its significance is that it gives members clear, advance information so they can see how the next year's plan will differ from this year and decide whether to stay with the plan, switch, or take other actions during open enrollment. It's also how plans meet regulatory requirements by ensuring members are informed before the new year begins. The notice is usually mailed or made available online before the next plan year starts, so members have time to review and plan.

3. Which Prescription Drug Plan (PDP) is recommended for a dual-eligible chooser?

- A. Value Plus
- B. Classic**
- C. Standard Choice
- D. Essential Care

The recommended Prescription Drug Plan (PDP) for a dual-eligible chooser is the Classic plan. This plan is designed to provide comprehensive coverage for individuals who qualify for both Medicare and Medicaid. These beneficiaries often have unique healthcare needs, and the Classic plan typically offers a balance of cost and coverage that is particularly suited to those needs. The Classic plan generally includes a broad formulary, which allows access to a wide range of prescription medications that dual-eligible individuals often require. Additionally, this option usually features lower copayments and premiums compared to some other plans, making it a cost-effective choice for those who might be managing multiple medical conditions or prescriptions. This combination of accessibility to necessary medications, affordability, and coverage comprehensiveness makes the Classic plan a strong recommendation for dual-eligible individuals looking for a Prescription Drug Plan. Other plans may not provide the same level of support or financial benefits tailored to the needs of these beneficiaries.

4. Which item is listed as a member support resource?

- A. Care management
- B. Digital marketing
- C. Digital tools**
- D. Legal advice

Member support resources are the tools and services that help members access benefits, navigate care, and manage their health. Digital tools fit this role because they provide direct, on-demand assistance that members can use anytime—think portals, mobile apps, online chat, telehealth, and interactive educational modules to find providers, view benefits, check claims, or schedule visits. Care management is a structured service aimed at coordinating care for people with complex needs, rather than a general resource; digital marketing is about promoting services, not directly helping members, and legal advice is specialized guidance not typically listed as a standard member support resource.

5. What should brokers avoid stating beyond policy terms?

- A. Guarantees or statements beyond policy terms**
- B. Side-by-side comparisons
- C. Clear language
- D. Verified plan summaries

Brokers should stick to what the policy actually covers and avoid making guarantees or promises beyond those terms. Policy language defines exactly what is covered, excluded, and under what conditions; any statement that goes beyond that can mislead clients, create false expectations, and raise ethical or regulatory concerns. You can explain the coverage in clear, plain language and discuss riders or endorsements that the policy includes, but you shouldn't imply coverage or outcomes that aren't stated in the policy. That's why avoiding statements beyond policy terms is the best approach. Other practices like presenting side-by-side comparisons, using clear language, and providing verified plan summaries are useful for understanding and transparency—they help clients see differences and know exactly what the policy says.

6. Which statement is true about a Special Enrollment Period (SEP)?

- A. It is a time outside AEP when enrollment or switching is allowed; example: moving to a new area
- B. SEP occurs automatically during the AEP
- C. SEP only applies to Medicare Advantage plans
- D. SEP cannot be used to enroll in a PDP

Special Enrollment Periods let you enroll in or switch Medicare plans outside the regular enrollment window when you have a qualifying life event. Moving to a new area is a classic example, because a change in location can affect plan availability, networks, and costs, making it appropriate to adjust your coverage outside the usual period. This is why the described statement is the true one: SEP is a time outside the annual election period during which enrollment or switching is allowed due to a qualifying life event. It's not automatic during the annual enrollment period, and it isn't limited to Medicare Advantage—SEP applies to MA, MA-PD, and stand-alone prescription drug plans (PDP), so you can use an SEP to enroll in a PDP as well.

7. Which form is used to reconcile Premium Tax Credits on taxes?

- A. A form used to reconcile Premium Tax Credits.
- B. A form that shows proof of health coverage.
- C. A form that lists prescription drug coverage.
- D. A form that reports employer contributions.

The main idea is that Premium Tax Credit reconciliation happens on a dedicated tax form that calculates your actual credit and compares it to what you were advanced throughout the year. This form is the Premium Tax Credit reconciliation form (Form 8962). It uses the Marketplace information you received on Form 1095-A to know how much PTC was paid in advance and combines it with your reported income and family size to figure the true PTC you qualify for. Then it compares the advanced payments to the calculated PTC: if more was paid than you're entitled, you repay the difference; if less was paid than you're entitled, you can claim the remaining amount as a credit on your tax return. This form is filed with your federal return (1040 series) and ensures your tax outcome reflects your actual eligibility. Other forms shown in the choices serve different purposes—proof of health coverage, prescription drug coverage details, or employer contributions—so they aren't used to reconcile the Premium Tax Credit.

8. What is the purpose of prior authorization in drug coverage?

- A. A process requiring plan approval before coverage; the plan or its designee approves or denies
- B. A guarantee of coverage for any prescribed drug
- C. A method to determine drug price after dispensing
- D. A patient-only approval process without plan involvement

Prior authorization is a plan-driven step in drug coverage that requires the plan or its designee to review a prescription before the drug is covered. This review checks whether the medication is medically necessary, appropriate for the condition, and aligns with the plan's formulary and utilization-management rules. If approved, the drug is covered under the member's benefits; if not, coverage may be denied or an alternative covered option or an exception process may be pursued. It isn't a guarantee that any drug will be covered, it doesn't set or reveal the drug's price after dispensing, and it always involves the plan rather than being a patient-only approval.

9. What is prior authorization and which party makes the decision?

- A. A process requiring plan approval before coverage; the plan or its designee approves or denies**
- B. A patient self-approves a drug for coverage
- C. A pharmacist approves every prescription
- D. A state agency approves all medications before dispensing

Prior authorization is a process where approval for coverage is obtained from the payer before a drug or service will be covered. The decision is made by the plan or its designee (such as a pharmacy benefits manager or medical director), who reviews clinical information to determine medical necessity and appropriateness. This upfront step helps control costs and ensures that high-cost or specialized treatments are used appropriately. It's not something a patient self-approves, nor does a pharmacist approve every prescription, and it isn't a state agency approving all medications before dispensing. The plan or its designee holds the authority to approve or deny coverage.

10. What populations does a Dual-Eligible Special Needs Plan (D-SNP) serve?

- A. People eligible for both Medicare and Medicaid**
- B. People eligible for Medicare only
- C. People with private employer plans
- D. People under 65 without Medicare

A Dual-Eligible Special Needs Plan is built for people who qualify for both Medicare and Medicaid. These plans coordinate benefits and services across both programs for individuals who are enrolled in both, often offering enhanced care coordination and added Medicaid-covered supports. That's why the population served is those who are eligible for Medicare and Medicaid simultaneously. People who have Medicare only aren't dual-eligible and wouldn't enroll in a D-SNP, those with private employer plans aren't in Medicare Advantage through Medicaid, and those under 65 without Medicare don't meet the Medicare eligibility requirement to participate in a D-SNP.

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!

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