

Wellcare ACT Mastery - TeleAgent Practice Exam (Sample)

Study Guide



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SAMPLE

Questions

- 1. How must the TPMO disclaimer be communicated during a sales call?**
 - A. Only at the end of the call**
 - B. Verbally within the first minute**
 - C. Via email after the call**
 - D. Through printed materials sent later**
- 2. What must lead-generating activities facilitated by a TPMO include?**
 - A. Consent for third-party contact**
 - B. A warning about the risks of sharing information**
 - C. A notice that the beneficiary's information may be shared with a licensed agent**
 - D. An option to opt out of any future communication**
- 3. How can TeleAgents boost their confidence while speaking with members?**
 - A. Through adequate preparation and practice**
 - B. By winging the conversation**
 - C. Through extensive technical jargon**
 - D. By avoiding member inquiries**
- 4. What is an effective method for managing a member's complaint?**
 - A. Ignore the complaint unless it becomes severe**
 - B. Listen actively, acknowledge the issue, and provide a solution**
 - C. Immediately escalate all complaints to a supervisor**
 - D. Dismiss the member's feelings and move on**
- 5. What two pieces of information are essential to collect during enrollments for a better onboarding experience?**
 - A. Social Security Number and Mailing Address**
 - B. Email Address and Mobile Phone Number**
 - C. Health History and Current Medications**
 - D. Date of Birth and Emergency Contact**

- 6. By how many calendar days must a grievance request be filed from the event date or when the member is aware of the issue?**
- A. 30 days**
 - B. 45 days**
 - C. 60 days**
 - D. 90 days**
- 7. What percentage of all eligible Medicare beneficiaries will Wellcare account for in its 32 states by 2025?**
- A. 70%**
 - B. 77%**
 - C. 80%**
 - D. 85%**
- 8. True or False: Grievance procedures are distinct from initial and appeal procedures.**
- A. True**
 - B. False**
 - C. Only sometimes true**
 - D. Depends on the plan**
- 9. Why is follow-up communication important post-enrollment?**
- A. It reassures members about their benefits**
 - B. It leads to more sales opportunities**
 - C. It reduces staff workloads**
 - D. It allows for quicker enrollment processes**
- 10. What is a requirement regarding applications for Wellcare products?**
- A. Must be completed without assistance**
 - B. Must be reviewed by a supervisor only**
 - C. Should include specialist provider ID**
 - D. Can be completed by a family member**

Answers

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

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Explanations

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1. How must the TPMO disclaimer be communicated during a sales call?

- A. Only at the end of the call**
- B. Verbally within the first minute**
- C. Via email after the call**
- D. Through printed materials sent later**

The TPMO disclaimer must be communicated verbally within the first minute of a sales call to ensure compliance with regulations set by the Centers for Medicare & Medicaid Services (CMS) and to promote transparency during the interaction. This ensures that prospective customers are made aware of the nature of the third-party marketing organization (TPMO) and its role in the sales process right from the beginning. By disclosing this information early, it helps build trust and allows the potential client to make informed decisions about the services being offered. Timing is crucial in this context, as waiting until the end of the call or communicating the disclaimer through email or printed materials would not meet the regulatory guidelines. Immediate verbal communication allows for any questions or clarifications the consumer may have to be addressed promptly, ensuring a clearer understanding of the situation.

2. What must lead-generating activities facilitated by a TPMO include?

- A. Consent for third-party contact**
- B. A warning about the risks of sharing information**
- C. A notice that the beneficiary's information may be shared with a licensed agent**
- D. An option to opt out of any future communication**

Lead-generating activities facilitated by a Third-Party Marketing Organization (TPMO) must include a notice that the beneficiary's information may be shared with a licensed agent. This is crucial because transparency is a key requirement in the marketing of healthcare plans. Beneficiaries need to be fully aware of how their data may be utilized, particularly if this sharing could lead to them being contacted by a licensed agent for further discussions about potential healthcare options. This notice ensures that beneficiaries can make informed decisions regarding their personal information and helps maintain trust in the marketing process. Facilitating such activities while providing clear communication about the sharing of information aligns with the regulatory requirements that protect beneficiary rights and promote ethical marketing practices in the healthcare sector.

3. How can TeleAgents boost their confidence while speaking with members?

A. Through adequate preparation and practice

B. By winging the conversation

C. Through extensive technical jargon

D. By avoiding member inquiries

TeleAgents can significantly boost their confidence while speaking with members through adequate preparation and practice. When TeleAgents thoroughly prepare, they familiarize themselves with the products, services, and potential questions or concerns members might have. This preparation includes understanding the company's policies, being aware of common issues, and crafting responses to typical queries. As a result, when TeleAgents engage with members, they are more informed and capable of addressing inquiries effectively, which contributes to a more confident interaction. Furthermore, practice allows TeleAgents to refine their communication skills and become comfortable in delivering information. Rehearsing conversations or role-playing different scenarios can help them anticipate questions and learn how to articulate their responses clearly. This level of preparedness not only instills confidence but also enhances the overall member experience, as members feel heard and valued. In contrast, winging the conversation, relying on extensive technical jargon, or avoiding member inquiries can lead to confusion, miscommunication, and a negative experience for both the TeleAgent and the member. Lack of preparation often results in uncertainty, while the use of jargon can alienate members who may not understand technical terms. Avoiding inquiries can leave members feeling undervalued or ignored, further diminishing the trust and rapport essential in these interactions.

4. What is an effective method for managing a member's complaint?

A. Ignore the complaint unless it becomes severe

B. Listen actively, acknowledge the issue, and provide a solution

C. Immediately escalate all complaints to a supervisor

D. Dismiss the member's feelings and move on

Listening actively, acknowledging the issue, and providing a solution is an effective method for managing a member's complaint because it demonstrates empathy and respect for the member's concerns. Active listening involves fully concentrating on what the member is saying, which not only helps in understanding the root of their complaint but also makes them feel valued and heard. Acknowledging the issue shows that you recognize the importance of their feelings and experiences, fostering trust and rapport between you and the member. Providing a solution is crucial in complaint management, as it addresses the member's needs and helps to resolve the issue at hand. A well-structured response can turn a negative experience into a positive one, often leading to increased member satisfaction and loyalty. This approach not only assists in resolving the current complaint but also sets a precedent for effective communication and conflict resolution in the future, promoting a culture of excellence in member relations.

5. What two pieces of information are essential to collect during enrollments for a better onboarding experience?

- A. Social Security Number and Mailing Address**
- B. Email Address and Mobile Phone Number**
- C. Health History and Current Medications**
- D. Date of Birth and Emergency Contact**

Collecting the email address and mobile phone number is essential during enrollments for a better onboarding experience because these two pieces of information facilitate effective communication between the service provider and the enrollee. With an email address, the organization can send important updates, confirmation of enrollment, reminders, and other essential information that the enrollee may need during their time with the service. Mobile phone numbers enhance this communication further by allowing for quick outreach via text messages or calls, which can be particularly important for reminders or urgent updates. Engaging with enrollees promptly and through their preferred channels significantly improves satisfaction and retention. In an environment where timely communication is crucial for providing support, having accurate contact information is a cornerstone of efficient onboarding and helps ensure that new members feel informed and valued from the start.

6. By how many calendar days must a grievance request be filed from the event date or when the member is aware of the issue?

- A. 30 days**
- B. 45 days**
- C. 60 days**
- D. 90 days**

A grievance request must be filed within 60 calendar days from the date of the event or when the member becomes aware of the issue. This timeframe is established to ensure that grievances are addressed in a timely manner, allowing members to voice their concerns and seek resolution. The 60-day period allows enough time for members to organize their thoughts and gather any necessary documentation about their grievances, while also promoting prompt action by the organization in handling complaints. Members need to be aware of this timeline to ensure that their grievances are considered, as any requests submitted after this deadline may not be accepted, potentially leaving issues unresolved.

7. What percentage of all eligible Medicare beneficiaries will Wellcare account for in its 32 states by 2025?

- A. 70%**
- B. 77%**
- C. 80%**
- D. 85%**

The correct answer is based on Wellcare's strategic goal of expanding its market share within the Medicare beneficiary population. By 2025, Wellcare is projected to account for 77% of all eligible Medicare beneficiaries across its operational states. This figure underscores Wellcare's commitment to increasing its presence and services for Medicare beneficiaries, reflecting its business objectives and growth strategies within the healthcare sector. This important percentage indicates a significant market penetration that aligns with Wellcare's focus on providing tailored healthcare solutions for seniors. Therefore, understanding this figure provides insight into Wellcare's strategic positioning within the Medicare landscape and its plans to reach a larger demographic to ensure that they are adequately meeting the needs of Medicare beneficiaries in those 32 states by the specified year.

8. True or False: Grievance procedures are distinct from initial and appeal procedures.

- A. True**
- B. False**
- C. Only sometimes true**
- D. Depends on the plan**

Grievance procedures are indeed distinct from initial and appeal procedures, making the statement true. Grievance procedures specifically pertain to the process through which members can express dissatisfaction and formally complain about issues related to their health plan, services, or treatment. This could involve anything from dissatisfaction with customer service to issues with access to care. In contrast, initial procedures refer to the initial steps taken when a member requests a service or claims a benefit, while appeal procedures are the steps taken when a member disputes a denied service or claim. Each of these processes serves a different purpose within the framework of patient rights and operational protocols of health plans. By recognizing that grievance procedures serve as a mechanism for addressing complaints, separate from the more transactional nature of initial requests and appeals, it becomes clear why this statement is true. Understanding the distinct roles these processes play is crucial for effectively navigating a health plan's policies and ensuring that member concerns are appropriately addressed.

9. Why is follow-up communication important post-enrollment?

- A. It reassures members about their benefits**
- B. It leads to more sales opportunities**
- C. It reduces staff workloads**
- D. It allows for quicker enrollment processes**

Follow-up communication post-enrollment is essential because it reassures members about their benefits. This step is crucial for ensuring that members feel secure and informed about their coverage after making a significant decision, such as enrolling in a plan. It helps to clarify any questions they might have about their benefits, contributing to a positive member experience and increasing satisfaction. By reinforcing their decision through communication, members are more likely to engage with the services available to them and utilize their benefits effectively. This reassurance can help reduce anxiety or confusion regarding their plan, leading to better retention rates and an improved overall relationship with the organization. Other options have their merits, but they do not fully capture the primary purpose and impact of follow-up communication post-enrollment as effectively as reassurance about benefits does.

10. What is a requirement regarding applications for Wellcare products?

- A. Must be completed without assistance**
- B. Must be reviewed by a supervisor only**
- C. Should include specialist provider ID**
- D. Can be completed by a family member**

The requirement that applications for Wellcare products should include a specialist provider ID is significant because it ensures that the application process is accurate and comprehensive. Including the specialist provider ID helps in verifying the credentials and qualifications of the medical professionals who will be involved in the patient's care or services. This addition enhances the integrity of the application, allowing for proper alignment with the healthcare services that Wellcare offers, ultimately benefiting both the provider and the member by ensuring the appropriateness of care. Having all necessary information, such as the specialist provider ID, streamlines the handling of the application by enabling a quicker review process, which can lead to timely access to care and services. Moreover, this requirement aligns with best practices in healthcare by fostering transparency and accountability in the provider network.