CVS HEALTH – AETNA ONE ADVOCATE (A1A) TRAINING PRACTICE TEST (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.

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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!

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Questions

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1. 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

2. In which scenario is a Federal Tax Return needed for dependent eligibility?

A. For Children Under 18

B. For Legal Spouses

C. For Grandchild Dependents

D. For Domestic Partners

3. Which aspect of insurance involves the cost-sharing mechanism where the insured pays a portion of the bill after the deductible is met?

A. Premium

B. Co-insurance

C. Copayment

D. Deductible

4. 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

5. What is the agreement between an insurance company and the policyholder called?

A. Policy document

B. Contract

C. Insurance binder

D. Underwriting agreement

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6. Which document is necessary for a grandchild dependent's eligibility?

A. Proof of Joint Ownership

B. Grandchild Affidavit

C. Marriage Certificate

D. Child's Social Security Card

7. Which document is required for a legal spouse dependency eligibility?

A. Government Issued Marriage Certificate

B. Health Insurance Policy

C. Spousal Affidavit

D. Birth Certificate

8. What term describes a healthcare provider that has a contract with an insurance company to provide discounted services?

A. Primary Care Physician

B. Preferred Provider

C. PPO

D. HSA

9. What does meeting the out-of-pocket max amount signify for an insured individual?

A. All future expenses will be covered by the insurer

B. Ongoing payment of premiums is required

C. Reduced rates for prescription medications

D. Higher deductible payments

10. What is the primary purpose of a referral within the healthcare system?

A. To obtain medication

B. To coordinate specialty care

C. To manage insurance claims

D. To schedule lab tests

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Answers

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

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Explanations

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1. 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.

2. In which scenario is a Federal Tax Return needed for dependent eligibility?

A. For Children Under 18

B. For Legal Spouses

C. For Grandchild Dependents

D. For Domestic Partners

A Federal Tax Return is required for dependent eligibility when determining the status of grandchild dependents. This is because the IRS has specific guidelines regarding who qualifies as a dependent, particularly for grandchildren. In scenarios where a grandparent claims their grandchild as a dependent, providing a Federal Tax Return helps establish that the grandchild resides with the grandparent and meets the criteria set by the IRS. For children under 18, legal spouses, and domestic partners, other types of documentation or forms are typically sufficient to establish eligibility for benefits. For example, children are generally covered under age-based eligibility without needing tax return documentation, and legal spouses are accounted for through marriage certificates. Similarly, domestic partners might require different forms of verification that do not include a federal tax return.

3. Which aspect of insurance involves the cost-sharing mechanism where the insured pays a portion of the bill after the deductible is met?

A. Premium

B. Co-insurance

C. Copayment

D. Deductible

The correct answer reflects the concept of co-insurance, which is a specific cost-sharing arrangement in health insurance. Once a policyholder meets their deductible—a predetermined amount that must be paid out-of-pocket before insurance starts to cover costs—they are then responsible for a percentage of any further expenses incurred. This percentage is known as co-insurance. For example, if a health insurance plan has a co-insurance rate of 20%, the insured will pay 20% of the covered medical expenses after the deductible is satisfied, while the insurance company pays the remaining 80%. This mechanism is designed to share the financial burden between the insurer and the insured, encouraging mindful use of healthcare services. In contrast, premiums are regular payments made to maintain the insurance policy, copayments are fixed amounts paid for specific services (like a doctor's visit), and deductibles are the amounts that need to be paid before any insurance benefits are triggered. Understanding co-insurance is crucial in calculating out-of-pocket expenses for healthcare services post-deductible.

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4. 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.

5. What is the agreement between an insurance company and the policyholder called?

A. Policy document

B. Contract

C. Insurance binder

D. Underwriting agreement

The agreement between an insurance company and the policyholder is referred to as a contract. This contract outlines the specific terms and conditions of the insurance coverage, including the rights and responsibilities of both parties. It details the coverage provided, any limitations or exclusions, the premium amounts, and the duration of the insurance coverage. In the context of insurance, the contract is a fundamental document that binds the insurer to provide specified benefits in exchange for payment of premiums by the policyholder. It is legally enforceable, providing a clear framework for what to expect from the insurance relationship. Other terms, such as "policy document," refer specifically to the document that includes the details of the contract but do not encompass the legal agreement itself. An "insurance binder" is a temporary agreement that provides coverage until a formal policy is issued, and an "underwriting agreement" generally refers to the process of evaluating risk and setting premium rates, rather than the agreement between the insurer and policyholder.

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6. Which document is necessary for a grandchild dependent's eligibility?

A. Proof of Joint Ownership

B. Grandchild Affidavit

C. Marriage Certificate

D. Child's Social Security Card

The Grandchild Affidavit is the necessary document for establishing a grandchild dependent's eligibility. This affidavit serves as a formal declaration that specifies the relationship between the grandchild and the primary insured, affirming the grandchild's status as a dependent. It often includes relevant details, such as residency and financial dependency, which are critical for eligibility determination under the health plan. In the context of dependent eligibility for insurance, it's essential to have documentation that clearly outlines the relationship and circumstances. While proof of joint ownership, marriage certificates, and social security cards may be relevant in other contexts, they do not specifically establish the eligibility of a grandchild as a dependent under the policy. The Grandchild Affidavit uniquely fulfills the requirement by providing the necessary confirmation of the dependent relationship as per the plan's stipulations.

7. Which document is required for a legal spouse dependency eligibility?

A. Government Issued Marriage Certificate

B. Health Insurance Policy

C. Spousal Affidavit

D. Birth Certificate

The correct answer, a government-issued marriage certificate, serves as the official proof of marriage between two individuals. This document is essential for establishing legal spouse dependency eligibility because it provides legal validation of the marital relationship. Employers, insurance companies, and other institutions require this document to confirm that the spouse is a legitimate dependent of the employee for benefits purposes. In contrast, a health insurance policy, while it may mention covered dependents, does not serve as proof of the marriage itself. A spousal affidavit is a document in which one spouse attests to certain facts regarding the marriage; however, it is not universally recognized as legal proof compared to a marriage certificate. Lastly, a birth certificate pertains to an individual's birth and relationship to parents but does not provide any information regarding marriage status. Therefore, the government-issued marriage certificate is the primary document required to verify the legal status of a spouse for dependency eligibility.

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8. What term describes a healthcare provider that has a contract with an insurance company to provide discounted services?

A. Primary Care Physician

B. Preferred Provider

C. PPO

D. HSA

The term that describes a healthcare provider with a contract to provide discounted services to an insurance company is "Preferred Provider." This designation signifies that the provider agrees to offer services at lower rates for the members of that insurance plan, which helps keep costs down for both the insurer and the insured. This arrangement is beneficial for patients, as they typically receive care from these providers at reduced out-of-pocket expenses. A primary care physician is a type of healthcare provider who serves as a patient's main point of contact for health care, but this role does not inherently imply a financial agreement with an insurance company. PPO stands for Preferred Provider Organization, which is a type of health insurance plan that allows members to see any healthcare provider but encourages the use of preferred providers by offering better coverage for those services. While connected to the concept of preferred providers, it is not the term that specifically identifies the provider itself. HSA refers to a Health Savings Account, which is a savings account for healthcare expenses that can provide tax advantages, rather than a description of a healthcare provider's contractual relationship with insurers. Understanding the concept of preferred providers helps clarify how healthcare costs and patient access intersect within insurance networks.

9. What does meeting the out-of-pocket max amount signify for an insured individual?

A. All future expenses will be covered by the insurer

B. Ongoing payment of premiums is required

C. Reduced rates for prescription medications

D. Higher deductible payments

Meeting the out-of-pocket maximum signifies that the insured individual has reached the limit of what they must pay in a given policy period, usually a calendar year, for covered healthcare services. Once this threshold is met, the insurance plan covers 100% of the costs for covered services, meaning that the individual doesn't have to pay any further costs out-of-pocket for those services for the remainder of the policy period. This is a significant benefit as it provides financial protection against high medical expenses, ensuring that individuals are not faced with overwhelming costs after reaching their out-of-pocket maximum. In contrast, ongoing premium payments (the second choice) are a standard requirement regardless of whether or not the out-of-pocket maximum is met. While reduced rates for prescription medications (the third choice) may apply depending on the plan, they are not directly tied to reaching the out-of-pocket limit. Lastly, the concept of higher deductible payments (the fourth choice) relates to the initial amount an insured must pay before the insurance starts covering costs, which is separate from the implications of meeting an out-of-pocket maximum.

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10. What is the primary purpose of a referral within the healthcare system?

A. To obtain medication

B. To coordinate specialty care

C. To manage insurance claims

D. To schedule lab tests

The primary purpose of a referral within the healthcare system is to coordinate specialty care. Referrals are essential in ensuring that patients receive appropriate and timely care from specialized providers who have the expertise to address specific health issues. When a primary care physician identifies a patient's need for specialty services—such as consultations, diagnostic evaluations, or advanced treatment—they will provide a referral to connect the patient with the right specialist. This process helps streamline the patient's care by ensuring that all healthcare providers involved are informed about the patient's medical history, current health status, and treatment plans. Coordinating care in this manner is vital for continuity, as it allows specialists to work together with primary care providers to create a comprehensive approach to managing a patient's health, ultimately leading to better health outcomes. Other options, while related to different aspects of healthcare, do not capture the primary function of a referral specifically as it pertains to directing patients to specialty care providers for advanced evaluation or treatment.

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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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