AHIP & NABIP 2027

700 ORIGINAL PRACTICE QUESTIONS

8 topic sets • 4 full mock exams • bonus drill
Separate answer section with explanations, distractor rationales, source, and verified date

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How to use this book

Work the questions in Part I without looking ahead. Each item has a stable number and ID. Part II repeats those exact markers and adds the correct letter, explanation, a reason each distractor is wrong, the AHIP/NABIP scope label, source, and verified date.

Contents

• Topic Set - Parts A/B/C/D, eligibility, plan types (90)
• Topic Set - MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs (75)
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• Mock Exam 1 - 50 questions (50)
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Both certification finals are closed-book. These original practice items are for recall and application practice; a score here does not guarantee a certification result.

PART I - PRACTICE QUESTIONS

Mark one answer per question. The answer section begins after all question sets.

Topic Set - Parts A/B/C/D, eligibility, plan types

90 questions. Choose one answer per item; answers and full rationales are in Part II.

QUESTION 1 | T-001

After an outpatient visit, Lena sees separate charges for her physician's services and assumes Part A is the primary source of coverage. Which Medicare part generally addresses the professional services in this setting?

A. Part B generally covers the physician's outpatient services.

B. Part A generally covers every service delivered on a hospital campus.

C. Part C pays the claim even when Lena has not joined Medicare Advantage.

D. Part D generally covers the physician's evaluation and treatment.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 2 | T-002

A new plan member disputes a denial and wants the document containing the plan's full benefits, exclusions, costs, and appeal rights. Which document should the agent identify?

A. The member should rely on the Provider Directory as the complete plan contract.

B. The member should consult the Evidence of Coverage for the detailed plan terms.

C. The member should use the formulary as the source for every medical benefit rule.

D. The member should treat the Summary of Benefits as the exhaustive governing document.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 3 | T-003

Marcus wants to keep Original Medicare for hospital and medical coverage while adding outpatient prescription coverage. Which arrangement fits that stated preference?

A. He should join an MA-only plan and assume it includes Part D.

B. He should keep only Parts A and B because Original Medicare automatically includes retail drug coverage.

C. He may retain Original Medicare and enroll in a stand-alone prescription drug plan.

D. He must replace Original Medicare with an MA-PD plan to obtain any Part D coverage.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 4 | T-004

Noah has Part A, has not enrolled in Part B, and lives inside an MA plan's service area. He asks the agent to submit an MA enrollment today. How should the eligibility issue be handled?

A. Residence in the service area is enough even without Part B.

B. Part A alone permits MA enrollment whenever an agent recommends the plan.

C. A stand-alone PDP election automatically supplies the missing Part B eligibility.

D. He generally must have both Part A and Part B before he can enroll in Medicare Advantage.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 5 | T-005

Priya is comparing Original Medicare alone with Medicare Advantage and wants protection from unlimited annual cost sharing for covered Part A and Part B services. Which distinction is accurate?

A. Medicare Advantage plans include a medical out-of-pocket maximum, while Original Medicare alone has no single annual cap.

B. Original Medicare and every MA plan use the same universal annual medical spending limit.

C. Only Part D drug spending is subject to any out-of-pocket accounting under Medicare.

D. Original Medicare supplies an annual medical cap only when the beneficiary declines supplemental coverage.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 6 | T-006

A community resident needs nursing-home-level care but can live safely at home with coordinated medical and supportive services. Which Medicare program should be explored if local eligibility requirements are met?

A. A Medigap policy that replaces Medicare's covered services.

B. A Program of All-Inclusive Care for the Elderly arrangement.

C. A stand-alone PDP that coordinates all medical and long-term care.

D. An Employer Group Waiver Plan available to every community resident.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 7 | T-007

A zero-premium MA plan appeals to Glenn, who says enrollment means Medicare will stop charging him the Part B premium. What is the accurate response?

A. The MA plan always refunds the entire Part B premium after enrollment.

B. A zero plan premium converts Part B into a premium-free benefit for every member.

C. He generally continues paying the Part B premium despite a zero-dollar MA plan premium.

D. The Part B premium is replaced by a mandatory stand-alone drug-plan premium.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 8 | T-008

An agent proposes that Elise remain in Medicare Advantage and buy Medigap to pay her MA copayments. Which assessment follows Medicare's coverage structure?

A. The arrangement is required whenever an MA plan uses coinsurance.

B. Medigap can reimburse MA cost sharing if the policies have the same insurer.

C. The sale is appropriate as long as Elise signs a disclosure before enrollment.

D. Medigap is designed to supplement Original Medicare, not to cover Medicare Advantage cost sharing.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 9 | T-009

Which fact should be confirmed before advising a working beneficiary that delaying Part B will preserve a future Special Enrollment Period?

A. The coverage is based on current employment, with payer-order facts also reviewed.

B. The beneficiary can elect COBRA after employment ends.

C. The retiree plan uses the former employer's name.

D. The beneficiary has enough savings to pay a future premium.

Parts A/B/C/D, eligibility, plan types | Direct Knowledge

QUESTION 10 | T-010

Before recommending a plan to someone who will not change doctors and takes several ongoing prescriptions, what review is most responsive to those needs?

A. Compare only the plans' headline premiums and assume access is identical.

B. Check current provider participation, the formulary, utilization rules, and pharmacy network.

C. Confirm that the plan advertises supplemental benefits, then skip medical access details.

D. Use last year's directory and drug list because plan networks and formularies remain fixed.

Parts A/B/C/D, eligibility, plan types | Direct Knowledge

QUESTION 11 | T-011

Under Original Medicare, which pairing correctly identifies the benefit generally associated with covered durable medical equipment for home use?

A. Part A, because every item used after a hospital stay is an inpatient benefit.

B. Part D, because equipment is dispensed by a supplier.

C. Part B, when medical necessity, documentation, and supplier requirements are satisfied.

D. Part C, even when the beneficiary has never enrolled in an MA plan.

Parts A/B/C/D, eligibility, plan types | Direct Knowledge

QUESTION 12 | T-012

A Part D enrollee asks the drug plan to cover a non-formulary medication supported by the prescriber. What initial plan action is being requested?

A. A grievance about the plan's courtesy and customer service.

B. An organization determination for a Part A hospital claim.

C. An automatic independent review without a plan-level decision.

D. A coverage determination on the drug and exception request.

Parts A/B/C/D, eligibility, plan types | Direct Knowledge

QUESTION 13 | T-013

What is the soundest way to confirm whether a younger applicant qualifies for Medicare through disability rather than age?

A. Verify the official entitlement record and its effective date.

B. Assume any long-term health condition creates immediate Medicare entitlement.

C. Use the applicant's preferred MA plan as proof of underlying eligibility.

D. Wait for the applicant to reach the standard age and ignore the disability pathway.

Parts A/B/C/D, eligibility, plan types | Direct Knowledge

QUESTION 14 | T-014

During a recommendation, an agent describes an MA plan as a small dental add-on and never addresses the client's retiree coverage. What correction is required before enrollment?

A. Submit first because other coverage can be reviewed after the effective date.

B. Explain that MA is the health-coverage route and review how the election may affect existing coverage.

C. Discuss only dental benefits because the client asked about dental care.

D. Treat retiree coverage as automatically unchanged by every MA election.

Parts A/B/C/D, eligibility, plan types | Compliance Judgment

QUESTION 15 | T-015

A script states that every enrollee in a zero-premium MA plan will pay nothing for Medicare coverage. Which revision is compliant?

A. Keep the statement because zero premium means no medical cost sharing.

B. Add that all beneficiaries receive the same Part B premium reduction.

C. Distinguish the plan premium from Part B premiums and plan cost sharing.

D. Replace the statement with a promise that supplemental benefits erase all costs.

Parts A/B/C/D, eligibility, plan types | Compliance Judgment

QUESTION 16 | T-016

Quality review finds an application from a beneficiary with Part A but no Part B, submitted to an MA plan solely because the agent believed the plan was a good fit. What should happen?

A. Approve it because suitability overrides technical eligibility.

B. Convert it automatically into a Part B enrollment request.

C. Hold it until the agent signs an eligibility waiver.

D. Do not represent the person as MA-eligible without the required Part B enrollment and election facts.

Parts A/B/C/D, eligibility, plan types | Compliance Judgment

QUESTION 17 | T-017

Evaluate this statement: A beneficiary can keep Original Medicare for medical coverage and add a stand-alone Part D plan for outpatient prescriptions. Which response is correct?

A. True; this is a permitted way to combine Parts A and B with separate drug coverage.

B. False; Part D is available only inside Medicare Advantage.

C. False; a PDP automatically replaces Original Medicare with Part C.

D. True; but the PDP also becomes the beneficiary's Medigap policy.

Parts A/B/C/D, eligibility, plan types | Alt Format / True False

QUESTION 18 | T-018

Match each need with the most appropriate source: a complete plan contract, confirmation of a doctor's network status, and review of a drug's tier. Which sequence is accurate?

A. Summary of Benefits; formulary; Evidence of Coverage.

B. Evidence of Coverage; Provider Directory; formulary.

C. Provider Directory; Evidence of Coverage; Summary of Benefits.

D. Formulary; Summary of Benefits; Provider Directory.

Parts A/B/C/D, eligibility, plan types | Alt Format / Matching

QUESTION 19 | T-101

Rosa is billed for a home health nurse visit ordered after her hip surgery and assumes Part D must be the payer because a nurse, not a doctor, delivered the care.

A. Part B or, when tied to a covered inpatient stay's home health eligibility, Part A generally addresses this skilled home health service.

B. Part D generally covers skilled home health nursing because it is delivered outside a facility.

C. Part C is the payer whenever a home health agency bills electronically.

D. The clinician's job title alone determines which Medicare part pays the claim.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 20 | T-102

Anwar reads that his upcoming knee procedure will happen at a hospital-owned surgery center and concludes the entire bill must fall under Part A because of the hospital ownership.

A. Any procedure performed at a hospital-owned facility is automatically inpatient and billed under Part A.

B. The setting and formal patient status determine the applicable part, so an outpatient procedure at that facility is generally handled under Part B.

C. Part C pays the claim because Anwar has Original Medicare.

D. Part D is responsible because supplies are dispensed during the procedure.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 21 | T-103

Which description most accurately distinguishes Part C from Parts A, B, and D as they are generally presented to a new beneficiary?

A. Part C is a supplemental benefit that beneficiaries add on top of Parts A, B, and D.

B. Part C exists only for beneficiaries who are not eligible for Part A.

C. Part C is a private-plan pathway, Medicare Advantage, through which a beneficiary can receive Part A and Part B benefits and often Part D as well.

D. Part C automatically replaces a beneficiary's Part B premium obligation with a flat plan fee.

Parts A/B/C/D, eligibility, plan types | Direct Knowledge

QUESTION 22 | T-104

Keiko takes three maintenance medications and wants to confirm which coverage handles them once she fills prescriptions at a retail pharmacy rather than during a hospital stay.

A. Part A covers retail prescriptions whenever the drugs were originally prescribed during a hospital stay.

B. Part B is the standard source of coverage for all maintenance medications filled at a pharmacy.

C. Coverage depends on the pharmacy chain rather than on the type of drug benefit involved.

D. Outpatient prescription drugs filled at a retail pharmacy are generally the domain of Part D, whether through a stand-alone plan or an MA-PD.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 23 | T-105

An intake note for Boone lists his coverage only as 'Medicare' without recording which parts he holds, then an agent proceeds to recommend a Medicare Advantage plan. What must happen first?

A. The agent must confirm Boone's actual Part A and Part B status before treating him as MA-eligible.

B. The recommendation may proceed because most people with any Medicare coverage qualify for MA.

C. The agent should submit the MA application and let the carrier verify eligibility after the fact.

D. A signed intake form removes any need to check Boone's specific Part A and Part B status.

Parts A/B/C/D, eligibility, plan types | Compliance Judgment

QUESTION 24 | T-106

Yusuf turns sixty-five next month and has never worked in Medicare-taxed employment, though his spouse has a long qualifying work history. He asks whether he can get Part A without paying a premium.

A. He cannot receive premium-free Part A unless he personally accumulated the qualifying work quarters.

B. He may still qualify for premium-free Part A based on his spouse's qualifying work record even without his own.

C. He must wait until his spouse begins collecting Social Security before any Part A eligibility exists.

D. He automatically owes the standard Part A premium regardless of any spousal work record.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 25 | T-107

What is the general work-history benchmark commonly used to determine whether someone qualifies for premium-free Part A?

A. Only twenty years of qualifying work will avoid any Part A premium obligation.

B. Any amount of part-time work automatically qualifies a person for premium-free Part A.

C. Roughly ten years, about forty quarters, of Medicare-taxed work is generally the benchmark for premium-free Part A.

D. Part A premiums are unrelated to work history and depend solely on current income.

Parts A/B/C/D, eligibility, plan types | Direct Knowledge

QUESTION 26 | T-108

Trent, age fifty-two, has received Social Security Disability Insurance for exactly two years and asks his agent whether Medicare eligibility has begun.

A. Medicare eligibility through disability never begins before age sixty-five under any circumstance.

B. SSDI alone never leads to Medicare entitlement without a separate Medicare application years later.

C. Only a diagnosis of a listed condition, not an SSDI qualifying period, can trigger disability-based Medicare.

D. Reaching roughly twenty-four months of SSDI generally establishes Medicare entitlement regardless of age.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 27 | T-109

Simone was recently diagnosed with amyotrophic lateral sclerosis and asks whether she must wait through a standard disability qualifying period before Medicare begins.

A. A diagnosis of ALS generally establishes Medicare entitlement without waiting through the standard disability qualifying period.

B. She must complete the same lengthy SSDI qualifying period required for other disabling conditions.

C. Only beneficiaries who are already sixty-five can use a disability-based diagnosis for entitlement.

D. Medicare entitlement for ALS depends on enrolling in a specific Medicare Advantage plan first.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 28 | T-110

Which statement correctly describes how End-Stage Renal Disease fits into Medicare's eligibility framework?

A. A person with ESRD only becomes Medicare-eligible after turning sixty-five like every other beneficiary.

B. ESRD is its own qualifying pathway to Medicare that can apply regardless of age when the applicable requirements are met.

C. ESRD entitlement is granted automatically the moment dialysis is first discussed with a physician.

D. ESRD only affects which Part D formulary a beneficiary may use, not overall Medicare eligibility.

Parts A/B/C/D, eligibility, plan types | Direct Knowledge

QUESTION 29 | T-111

A file for Faridah shows she qualifies for Medicare at age fifty-eight but the enrollment worksheet only checks the age-65 box, leaving the actual pathway blank. What must the agent correct?

A. Nothing needs correction because every Medicare beneficiary is treated as age-eligible for paperwork purposes.

B. The worksheet is acceptable as long as Faridah eventually turns sixty-five.

C. The agent must document the actual disability, ALS, or ESRD basis for her entitlement rather than leaving an inaccurate age-based box checked.

D. The agent should simply guess which pathway is more common and select it.

Parts A/B/C/D, eligibility, plan types | Compliance Judgment

QUESTION 30 | T-112

Callum is discharged from the hospital, readmitted eleven days later for the same condition, and assumes a brand-new Part A deductible now applies because it is a separate admission.

A. Every new hospital admission automatically creates a new benefit period and a new deductible.

B. Benefit periods are measured strictly by calendar year rather than by gaps in inpatient care.

C. Only a discharge to hospice can end a Part A benefit period.

D. Because fewer than sixty days passed without inpatient or skilled nursing care, this readmission generally falls within the same benefit period rather than starting a new one.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 31 | T-113

Ingrid remains hospitalized well beyond the days generally covered before daily coinsurance begins and asks what protects her if the stay runs even longer within the same benefit period.

A. Lifetime reserve days can generally be used, at a higher daily coinsurance, once the earlier extended-stay days in that benefit period are exhausted.

B. Once the extended-stay days are used, Medicare covers all further inpatient days automatically at no cost.

C. Lifetime reserve days renew every benefit period so they can be used repeatedly without limit.

D. Lifetime reserve days apply only to skilled nursing facility stays, never to hospital stays.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 32 | T-114

How is a Medicare Part A benefit period generally best described to a beneficiary planning for a possible hospitalization?

A. It is a fixed twelve-month period identical to a calendar year.

B. It begins with inpatient admission and continues until the beneficiary has been out of inpatient and skilled nursing care for a set number of consecutive days, after which a new period can begin.

C. It ends automatically on the day of hospital discharge no matter what care follows.

D. It is the same concept as the annual out-of-pocket maximum used in Medicare Advantage.

Parts A/B/C/D, eligibility, plan types | Direct Knowledge

QUESTION 33 | T-115

A summary prepared for Desmond states that Part A coinsurance never increases no matter how long an inpatient stay lasts. What correction does accuracy require?

A. The statement can stand because Part A coinsurance is always a single flat amount.

B. The summary should instead claim there is never any coinsurance for inpatient stays.

C. The summary should reflect that Part A cost sharing generally rises in tiers as a stay lengthens, including a higher rate once lifetime reserve days are used.

D. The summary is fine as long as it also mentions the deductible once.

Parts A/B/C/D, eligibility, plan types | Compliance Judgment

QUESTION 34 | T-116

Petra delayed Part B for several years without other coverage and now learns her premium will be permanently higher. She asks how that increase is generally structured.

A. The increase is a single one-time fee charged only in the first year of enrollment.

B. The increase depends on income level rather than how long enrollment was delayed.

C. The increase disappears automatically after five years of paying it.

D. The Part B late-enrollment premium increase is generally added as roughly ten percent for each full twelve-month period of the delay, and it lasts as long as she keeps Part B.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 35 | T-117

Aiden wants to know whether choosing a zero-premium Medicare Advantage plan will end his separate obligation to pay the Part B premium.

A. He generally continues to owe the Part B premium even after enrolling in a zero-premium MA plan.

B. A zero-premium MA plan automatically eliminates the separate Part B premium.

C. Part B premiums are only owed by beneficiaries who remain in Original Medicare.

D. The MA plan will refund his Part B premium each month as a standard feature of every zero-premium plan.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 36 | T-118

What general principle explains why a Medicare Advantage plan's advertised zero premium does not mean a beneficiary's total Medicare costs are zero?

A. Zero-premium plans are required to waive all deductibles and copayments as well.

B. The plan premium is only one component of cost; the Part B premium and applicable cost sharing continue to apply separately.

C. The Part B premium is suspended automatically whenever a plan charges no premium.

D. Total costs are zero because CMS caps every beneficiary's annual spending at the plan premium.

Parts A/B/C/D, eligibility, plan types | Direct Knowledge

QUESTION 37 | T-119

A recorded pitch tells Nadia that switching to a zero-premium plan means Medicare will 'basically be free from now on.' What must the corrected version state?

A. The statement is acceptable because 'basically free' is understood to be a sales expression, not a fact.

B. The correction should simply remove the word 'basically' and keep the rest of the claim.

C. The corrected statement must clarify that Part B premiums and applicable plan cost sharing continue despite the plan carrying no separate premium.

D. No correction is needed if the plan happens to have a five-star rating.

Parts A/B/C/D, eligibility, plan types | Compliance Judgment

QUESTION 38 | T-120

Felix went eighteen months without creditable prescription coverage before enrolling in a Part D plan and wants to understand how his penalty is generally calculated.

A. The penalty is a flat one-time dollar fee unrelated to how many months elapsed.

B. The penalty applies only if the beneficiary is enrolled in a stand-alone PDP rather than an MA-PD.

C. The penalty resets to zero automatically once the beneficiary switches plans.

D. The Part D late-enrollment penalty is generally based on roughly one percent of the national base premium for each full month without creditable coverage.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 39 | T-121

Corinne's employer says her retiree drug plan is 'just as good' as Medicare's, but she has no documentation confirming that comparison. She asks the agent what to rely on.

A. She should rely on the employer's official creditable-coverage disclosure notice rather than an undocumented verbal assurance.

B. A verbal assurance from HR is sufficient documentation on its own.

C. Creditable coverage status is determined by the size of the employer, not by the plan's own drug benefit design.

D. Because the plan is employer-sponsored, no comparison to the Part D standard is ever required.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 40 | T-122

Which statement most accurately reflects how the Part D coverage gap, often called the donut hole, currently functions?

A. The coverage gap still exists and requires enrollees to pay the full negotiated price for drugs.

B. The coverage gap has been eliminated, and Part D now relies on an annual out-of-pocket threshold that leads into a catastrophic phase.

C. The coverage gap was replaced by a rule that suspends drug coverage entirely once it is reached.

D. The coverage gap applies only to enrollees who use a stand-alone PDP rather than an MA-PD.

Parts A/B/C/D, eligibility, plan types | Direct Knowledge

QUESTION 41 | T-123

Junko crosses the current annual out-of-pocket threshold in the middle of the plan year and asks what happens to her cost sharing on covered drugs for the rest of that year.

A. She must keep paying the same coinsurance percentage for the rest of the year regardless of the threshold.

B. Crossing the threshold means her plan drops her coverage until the next plan year.

C. Once she reaches the annual out-of-pocket threshold, she generally enters the catastrophic phase and owes no further cost sharing on covered Part D drugs for the remainder of that plan year.

D. The threshold only affects her deductible, not any coinsurance for the remainder of the year.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 42 | T-124

A marketing draft tells prospects the Part D 'donut hole' still applies exactly as it did years ago. What edit brings this into line with current facts?

A. No edit is needed since the coverage gap concept is timeless and never changes.

B. The fix is to delete all mention of Part D costs rather than describe the current structure.

C. The draft only needs a disclaimer added at the bottom without changing the outdated claim itself.

D. The draft must be revised to reflect that the coverage gap has been eliminated and describe the current annual out-of-pocket threshold structure instead.

Parts A/B/C/D, eligibility, plan types | Compliance Judgment

QUESTION 43 | T-125

Reviewing his options at renewal, Idris specifically asks whether picking up a stand-alone Part D plan would force him off Original Medicare and into a network-based arrangement for his medical care.

A. Adding a stand-alone PDP does not change his underlying medical coverage; he can remain on Original Medicare's non-network structure while the PDP handles only drug benefits.

B. Picking up a PDP shifts his medical benefits into whatever pharmacy network the drug plan uses.

C. A stand-alone PDP can only be added by someone who first drops Original Medicare entirely.

D. Adding any Part D coverage automatically enrolls him in a Medicare Advantage network plan as well.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 44 | T-126

Which requirement generally applies to every Medicare Advantage plan regarding a beneficiary's yearly spending on covered Part A and Part B services?

A. MA plans may choose whether to include any annual out-of-pocket limit at all.

B. Each MA plan must include an annual out-of-pocket maximum for those covered services.

C. The requirement applies only to HMO plans and not to PPO or other MA plan types.

D. The requirement covers Part D drug spending rather than Part A and B medical services.

Parts A/B/C/D, eligibility, plan types | Direct Knowledge

QUESTION 45 | T-127

Which coverage protection generally applies across every Medicare Advantage plan type when a member needs emergency or urgently needed care while outside the plan's network?

A. The plan can decline to cover the visit entirely because the hospital is out of network.

B. Only HMO plans are required to cover out-of-network emergencies; PPO plans are exempt from this rule.

C. Emergency and urgently needed care is generally covered by every MA plan type nationwide regardless of network status.

D. Coverage depends on whether the member obtained prior authorization before the emergency occurred.

Parts A/B/C/D, eligibility, plan types | Direct Knowledge

QUESTION 46 | T-128

Which combination of benefits is Medicare Advantage generally understood to bundle for a beneficiary who selects an MA-PD plan?

A. Only Part A benefits, with Part B and Part D purchased through entirely separate policies.

B. Only Medigap-style supplemental benefits without any underlying Part A or Part B coverage.

C. Only Part D coverage, leaving medical benefits to be obtained separately through Original Medicare.

D. Part A and Part B coverage together with Part D drug coverage, delivered through one private plan.

Parts A/B/C/D, eligibility, plan types | Direct Knowledge

QUESTION 47 | T-129

Ramon compares staying in Original Medicare without supplemental coverage against joining an MA plan and specifically wants to know which route currently caps his annual medical cost exposure.

A. The MA plan generally includes a required annual out-of-pocket cap for covered medical services, while Original Medicare alone does not have one overall cap.

B. Both routes include an identical federally set annual medical spending cap.

C. Neither route includes any annual limit on medical cost sharing.

D. Only Part D spending is subject to any annual limit under either route.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 48 | T-130

Marketing copy for an MA plan states it 'covers everything Original Medicare does, plus more, with zero exceptions.' What revision does accuracy require?

A. The claim is fine because every MA plan is legally required to have no exceptions of any kind.

B. The claim should be revised to reflect that MA plans cover Medicare-required benefits subject to the plan's specific rules, networks, and any supplemental extras, rather than promising zero exceptions.

C. The fix is to delete the word 'everything' but keep 'zero exceptions' as written.

D. No revision is needed as long as the plan has a high star rating.

Parts A/B/C/D, eligibility, plan types | Compliance Judgment

QUESTION 49 | T-131

Beatriz asks whether choosing a plan with coinsurance instead of flat copayments changes her financial risk if she needs an expensive inpatient surgery later in the year.

A. Coinsurance and flat copayments produce identical financial exposure for any procedure.

B. Flat copayments always cost more than coinsurance regardless of the service's price.

C. A coinsurance structure generally exposes her to more cost variability, since the percentage-based share can rise sharply with an expensive procedure, unlike a flat copay.

D. Cost-sharing structure has no bearing on her financial risk once she has Medicare Advantage.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 50 | T-132

Solomon needs nursing-home-level care but his family strongly prefers he continue living at home with coordinated services, and he lives inside a program's defined service area.

A. A stand-alone PDP would coordinate both his medical and long-term care needs.

B. A Medigap policy would replace the need for any Medicare-covered services he currently uses.

C. Every community resident automatically qualifies for this program regardless of care needs or location.

D. A Program of All-Inclusive Care for the Elderly arrangement should be explored if the local age, service-area, and care-level requirements are met.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 51 | T-133

What distinguishes an Employer Group Waiver Plan from a plan a beneficiary would enroll in directly on the individual market?

A. An EGWP is sponsored through an employer or union group arrangement rather than purchased individually by the beneficiary.

B. An EGWP is available only to beneficiaries who have never held employer coverage.

C. An EGWP and an individual-market MA plan always have identical enrollment procedures.

D. An EGWP refers to any plan that waives the Part B premium for all enrollees.

Parts A/B/C/D, eligibility, plan types | Direct Knowledge

QUESTION 52 | T-134

Stellan is drawn to a Medicare Medical Savings Account plan because he wants prescription coverage included automatically alongside the account-funded medical benefit.

A. MSA plans automatically bundle Part D coverage into the account-funded design.

B. MSA plans generally include no drug coverage at all, so he would need to separately enroll in a stand-alone Part D plan to get that benefit.

C. He cannot obtain any Part D coverage while enrolled in an MSA plan under any circumstance.

D. MSA plans replace Part D entirely with unlimited account withdrawals for any prescription cost.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 53 | T-135

How should an agent generally characterize the provider network associated with a Medicare MSA plan?

A. MSA plans use the same defined network structure as a typical HMO plan.

B. MSA plans require every provider to sign a specific plan contract before treating a member.

C. MSA plans generally have no defined provider network, and the member may use any Medicare-approved provider who agrees to treat them.

D. MSA plans restrict members to providers located within the plan's home state only.

Parts A/B/C/D, eligibility, plan types | Direct Knowledge

QUESTION 54 | T-136

Perpetua lives in a rural county with few participating providers and is considering a longtime non-network Private Fee-for-Service plan there. She asks about the practical risk of that choice.

A. PFFS plans guarantee the same continuity-of-care protections as an HMO network contract.

B. Provider participation in a non-network PFFS plan is locked in for the full plan year once agreed to.

C. Rural location has no bearing on the practical access risk of a non-network PFFS plan.

D. Because non-network PFFS relies on individual providers agreeing to the plan's terms visit by visit, a scarce-provider county could see several providers stop accepting the plan at once.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 55 | T-137

A brochure calls a Medicare MSA plan 'total freedom, use any doctor with no restrictions whatsoever.' What correction keeps this accurate?

A. The brochure should state that a member may use any Medicare-approved provider willing to treat them, rather than promising unrestricted access with no conditions.

B. The brochure is accurate because MSA plans truly have no conditions on which provider can be used.

C. The fix is to say the plan works only with providers under exclusive plan contracts.

D. No correction is needed since 'total freedom' is understood as ordinary marketing language.

Parts A/B/C/D, eligibility, plan types | Compliance Judgment

QUESTION 56 | T-138

Wren remains enrolled in a Medicare Advantage plan but is considering buying a Medigap policy specifically to help cover the MA plan's copayments.

A. Medigap can reimburse MA copayments as long as the same insurer sells both products.

B. Medigap is designed to supplement Original Medicare's cost sharing, not to pay a Medicare Advantage plan's copayments.

C. The purchase is appropriate as long as Wren signs an acknowledgment before buying the policy.

D. Every Medigap policy automatically converts to MA-compatible coverage once purchased.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 57 | T-139

How are Medigap plans generally structured across different insurance companies within the same state?

A. Each insurer designs its own unique benefit package for every Medigap letter.

B. Medigap plans vary in benefits based on the beneficiary's income level.

C. Medigap plans are standardized by letter, so a given letter's benefits are generally identical across companies within that state.

D. Medigap letters describe drug coverage tiers rather than medical supplement benefits.

Parts A/B/C/D, eligibility, plan types | Direct Knowledge

QUESTION 58 | T-140

Ezra just turned sixty-five, enrolled in Part B for the first time this month, and asks when his strongest federal Medigap purchase protection window opens.

A. It opens only after he has been enrolled in a Medicare Advantage plan for a full year.

B. It recurs every year during the fall Annual Election Period.

C. It depends entirely on the insurer's discretion to waive medical underwriting.

D. It generally opens with the first month he is both sixty-five or older and enrolled in Part B, running for about six months.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 59 | T-141

Duncan joined Medicare Advantage the first time he became eligible for Part A at sixty-five, dropped it eight months later, and asks whether he now has guaranteed-issue rights for a Medigap policy.

A. A trial-right protection can generally apply because he is returning to Original Medicare within one year of that first-time Medicare Advantage enrollment.

B. No guaranteed-issue protection exists for anyone who has ever enrolled in Medicare Advantage.

C. Guaranteed issue only applies to beneficiaries who have been enrolled in MA for at least five years.

D. His guaranteed-issue rights depend solely on which state he lives in and nothing else.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 60 | T-142

A worksheet recommends Medigap to Farah, who plans to remain in her current Medicare Advantage plan, describing the Medigap policy as a way to lower her MA copayments. What must be corrected?

A. The worksheet is accurate because Medigap can be used to offset any plan's cost sharing.

B. The recommendation must be corrected to reflect that Medigap does not pay Medicare Advantage cost sharing while she remains enrolled in that MA plan.

C. The fix is simply to lower the recommended Medigap plan letter without changing the underlying claim.

D. No correction is needed as long as Farah is told the premium amount in advance.

Parts A/B/C/D, eligibility, plan types | Compliance Judgment

QUESTION 61 | T-143

Otis dropped Original Medicare in favor of a Medigap-eligible route years ago, has now been in a Medicare Advantage plan for several years, and wants to know if switching back today gives him the same guaranteed-issue protection Duncan received.

A. He automatically receives the same guaranteed-issue protection regardless of how long he stayed in MA.

B. Guaranteed-issue rights end completely for anyone who has ever enrolled in Medicare Advantage.

C. Unlike a first-time enrollee returning within a year, Otis generally faces medical underwriting unless a state law extends broader guaranteed-issue rights.

D. His only option is to remain in Medicare Advantage permanently with no path back to Original Medicare.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 62 | T-144

Miriam qualifies as a Qualified Medicare Beneficiary and is billed directly by a provider for her Part B coinsurance. She asks whether that bill is proper.

A. The bill is proper as long as the provider does not participate in Medicaid.

B. QMB only prevents billing for the Part B premium, not for coinsurance or copays.

C. The bill is proper because QMB status only applies to Part A hospital charges.

D. It generally is not proper; QMB status protects her from being billed for Medicare Part A and B deductibles, coinsurance, and copays.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 63 | T-145

Tobias hears that his QMB status means Medicaid 'pays for everything' and wants to know whether that description is accurate.

A. It is generally not accurate; QMB specifically covers Medicare Part A and B premiums and cost sharing rather than providing full Medicaid benefits.

B. QMB and full Medicaid coverage are simply two names for the identical benefit.

C. QMB automatically includes long-term care benefits on top of Medicare cost sharing.

D. QMB only pays for prescription drug costs and nothing related to Parts A or B.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 64 | T-146

What distinguishes a full-benefit dual eligible from someone who only qualifies for a Medicare Savings Program like QMB?

A. There is no meaningful difference; both terms describe identical Medicaid benefits.

B. A full-benefit dual eligible qualifies for complete state Medicaid benefits, not just premium or cost-sharing assistance.

C. A Medicare Savings Program participant automatically receives every full Medicaid benefit as well.

D. Full-benefit dual eligibility depends on Medicare Advantage enrollment rather than Medicaid qualification.

Parts A/B/C/D, eligibility, plan types | Direct Knowledge

QUESTION 65 | T-147

Selin, a military retiree, tells the agent that having TRICARE for Life means she does not need to bother with Part B. She asks whether that is accurate.

A. TRICARE for Life replaces the need for Part B entirely for military retirees.

B. Dropping Part B has no effect on TRICARE for Life eligibility for a retiree who already has TFL.

C. It generally is not accurate; TRICARE for Life requires active enrollment in both Medicare Part A and Part B, and dropping Part B can end that TFL eligibility.

D. TRICARE for Life only coordinates with Part D, not with Parts A and B.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 66 | T-148

Gustavo is sixty-eight, still working at a company with more than twenty employees, and has coverage through that employer's group health plan. He asks who generally pays first for his medical claims.

A. Medicare always pays first for any beneficiary who has reached age sixty-five.

B. Payer order depends only on which plan Gustavo enrolled in first, regardless of employer size.

C. The employer plan can never be primary while Gustavo is eligible for Medicare.

D. The employer group health plan generally pays first, with Medicare paying secondary, because the employer has more than the applicable size threshold and his coverage is based on current employment.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 67 | T-149

For Medicare Secondary Payer purposes tied to disability-based Medicare eligibility rather than age, which detail should an agent confirm about a beneficiary's employer coverage?

A. Whether the employer meets the applicable large-employer size threshold used for the disability-based coordination rule, which differs from the age-based threshold.

B. The disability-based threshold is identical to the age-based employer-size threshold in every case.

C. Employer size is irrelevant to Medicare Secondary Payer rules once eligibility is disability-based.

D. Only the beneficiary's income determines payer order under Medicare Secondary Payer rules.

Parts A/B/C/D, eligibility, plan types | Direct Knowledge

QUESTION 68 | T-150

An enrollment file for Naledi lists her as dual-eligible for a D-SNP based only on a self-reported statement that she 'thinks' she has Medicaid. What must the agent do before finalizing the enrollment?

A. A self-reported belief is sufficient evidence to finalize a D-SNP enrollment.

B. The agent must obtain acceptable documented evidence of her Medicaid or MSP eligibility before treating her as D-SNP eligible.

C. The agent may finalize enrollment now and gather documentation only if the plan later asks for it.

D. D-SNP eligibility does not require any Medicaid or MSP verification at all.

Parts A/B/C/D, eligibility, plan types | Compliance Judgment

QUESTION 69 | T-151

Hollis wants to confirm his cardiologist is in-network before enrolling and is unsure which plan document actually answers that question.

A. He should rely on the Evidence of Coverage as the primary network-status source.

B. He should use the formulary since it lists every provider along with covered drugs.

C. He should check the plan's Provider Directory to confirm network participation.

D. He should treat the Summary of Benefits as a complete listing of network providers.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 70 | T-152

Which specific plan document is designed to show a covered drug's cost-tier placement and any related coverage rules?

A. The Evidence of Coverage lists individual drug tiers for every covered medication.

B. The Provider Directory shows the tier placement of a covered medication.

C. The Summary of Benefits lists every covered drug along with its exact tier.

D. The plan's formulary is the document that shows a drug's tier placement and any related coverage rules.

Parts A/B/C/D, eligibility, plan types | Direct Knowledge

QUESTION 71 | T-153

When a Part D enrollee formally requests that the plan cover a non-formulary drug supported by the prescriber, what is that initial plan-level request generally called?

A. It is generally treated as a coverage determination, including any requested exception to the formulary.

B. It is generally treated as a grievance about the plan's customer service.

C. It is generally treated as an organization determination limited to Part A hospital claims.

D. It is generally treated as an automatic independent review bypassing any plan-level decision.

Parts A/B/C/D, eligibility, plan types | Direct Knowledge

QUESTION 72 | T-154

A file shows an MA medical benefit denial being processed under Part D coverage-determination rules by mistake. What must the file be corrected to reflect?

A. No correction is needed since the two processes are functionally interchangeable.

B. The file should be corrected to process the medical benefit denial as an organization determination rather than under Part D coverage-determination procedures.

C. The fix is to reclassify the request as a grievance instead of either determination type.

D. The file should instead be closed with no formal determination recorded at all.

Parts A/B/C/D, eligibility, plan types | Compliance Judgment

QUESTION 73 | T-155

Chinelo submits an MA enrollment application listing Part A entitlement but leaves the Part B effective date blank, and the agent wants to know what must happen before submission.

A. The application can be submitted as-is since the carrier will fill in any missing dates later.

B. A blank Part B field can be treated as proof that Chinelo has no Part B at all.

C. The agent must confirm and document Chinelo's actual Part B effective date before submitting the MA application.

D. The agent should estimate a plausible effective date rather than confirm the actual one.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 74 | T-156

Amara's neighbor tells her that once she joins Medicare Advantage, returning to Original Medicare later happens automatically if she simply stops using her MA card.

A. The neighbor is correct that no action is needed to return to Original Medicare.

B. Returning to Original Medicare is possible only by canceling Part B entirely first.

C. MA plans automatically disenroll a member after any month of unused benefits.

D. That is generally inaccurate; returning to Original Medicare from Medicare Advantage generally requires an affirmative disenrollment request during an applicable period.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 75 | T-157

When a beneficiary enrolls in a new stand-alone Part D plan during a valid election period, what generally happens to enrollment in the prior Part D plan?

A. Enrolling in the new Part D plan generally triggers automatic disenrollment from the prior plan, so a separate cancellation is generally not required.

B. A separate cancellation form must be submitted to the old plan or the beneficiary remains enrolled in both.

C. Both plans continue billing the beneficiary until the next Annual Election Period regardless of the new enrollment.

D. Switching plans this way is not permitted outside a specific written waiver from both carriers.

Parts A/B/C/D, eligibility, plan types | Direct Knowledge

QUESTION 76 | T-158

Which statement best reflects the general relationship between Original Medicare and routine dental, vision, and hearing services?

A. Original Medicare fully covers routine dental, vision, and hearing care for every beneficiary.

B. Original Medicare generally does not cover routine dental, vision, or hearing services, which is part of why some beneficiaries consider Medicare Advantage.

C. Original Medicare covers these services only after a beneficiary turns seventy.

D. These services are covered under Part D rather than being excluded from Original Medicare.

Parts A/B/C/D, eligibility, plan types | Direct Knowledge

QUESTION 77 | T-159

A recommendation for Priyanka never mentions that her Medicare Advantage plan is her full replacement for Original Medicare, describing it only as an add-on with extra perks. What must be corrected?

A. No correction is needed as long as the extra perks are accurately described.

B. The fix is to describe MA as a type of Medigap policy instead.

C. The recommendation must be corrected to clearly explain that MA is a replacement route for Part A and Part B benefits, not merely a supplemental add-on.

D. The recommendation only needs a footnote listing the plan's star rating.

Parts A/B/C/D, eligibility, plan types | Compliance Judgment

QUESTION 78 | T-160

Marguerite has Part A only, has never enrolled in Part B, and asks the agent to enroll her in a Medicare Advantage plan this week because she likes its advertised benefits.

A. The agent may enroll her now since Part A alone is generally sufficient for MA eligibility.

B. The agent can substitute a stand-alone PDP enrollment to satisfy the missing Part B requirement.

C. The advertised benefits create an exception that overrides the usual Part B requirement.

D. The agent generally cannot treat her as MA-eligible until she also has Part B, regardless of how appealing the advertised benefits are.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 79 | T-161

Solomon's card shows his name, Medicare Beneficiary Identifier, and effective dates, and the agent wants to know what specifically to verify from it before submitting an enrollment.

A. The agent should verify that the name, MBI, and current Part A and/or Part B effective dates on the card match the application before submitting it.

B. Only the beneficiary's name needs to be checked against the application.

C. The card's issue date is the only detail relevant to enrollment accuracy.

D. Card details do not need to be checked once the beneficiary verbally confirms them.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 80 | T-162

What does Medigap's 'guaranteed renewable' protection generally mean for a policyholder who pays premiums on time?

A. The insurer can cancel the policy at any time if the policyholder's health declines.

B. The insurer generally cannot cancel the policy for health reasons as long as premiums are paid on time and the application was truthful, though it may still raise premiums for the entire class.

C. The insurer must freeze the policyholder's premium permanently once the policy is guaranteed renewable.

D. Guaranteed renewable applies only if the application contained inaccurate information.

Parts A/B/C/D, eligibility, plan types | Direct Knowledge

QUESTION 81 | T-163

How are a PACE program's benefits generally structured relative to Medicare and Medicaid for a qualifying participant?

A. PACE benefits are limited strictly to Medicare with no role for Medicaid under any circumstance.

B. PACE replaces Medicare and Medicaid entirely with a separate state-only benefit package.

C. PACE generally coordinates comprehensive Medicare benefits and, when applicable, Medicaid benefits for its participants.

D. PACE benefits depend on the participant first purchasing a Medigap policy.

Parts A/B/C/D, eligibility, plan types | Direct Knowledge

QUESTION 82 | T-164

Which statement correctly distinguishes the QMB and SLMB Medicare Savings Programs?

A. SLMB generally pays more categories of cost than QMB does.

B. QMB and SLMB provide identical benefits under different program names.

C. Both programs generally pay Part A and Part B premiums but never cost sharing.

D. QMB generally pays Part A and Part B premiums plus cost sharing, while SLMB generally pays only the Part B premium.

Parts A/B/C/D, eligibility, plan types | Direct Knowledge

QUESTION 83 | T-165

Which statement accurately describes the general payer relationship between Medicare and TRICARE for Life for an eligible military retiree enrolled in both?

A. Medicare generally pays first and TRICARE for Life generally pays most of the remaining Medicare-allowed cost.

B. TRICARE for Life generally pays first, with Medicare paying whatever remains.

C. TRICARE for Life eliminates the retiree's need to maintain Medicare coverage at all.

D. TRICARE for Life generally pays only toward Part D drug costs and nothing else.

Parts A/B/C/D, eligibility, plan types | Direct Knowledge

QUESTION 84 | T-166

Evaluate this statement: A beneficiary generally needs both Part A and Part B to be eligible for Medicare Advantage. Which response is correct?

A. False; Part A alone is generally sufficient for Medicare Advantage eligibility.

B. True; MA eligibility generally requires both Part A entitlement and Part B enrollment.

C. False; Medicare Advantage eligibility depends only on residing in the plan's service area.

D. True; but only for HMO-type Medicare Advantage plans specifically.

Parts A/B/C/D, eligibility, plan types | Alt Format / True False

QUESTION 85 | T-167

Evaluate this statement: Medigap policies are designed to supplement Medicare Advantage cost sharing in the same way they supplement Original Medicare. Which response is correct?

A. True; Medigap pays MA copayments whenever the same company sells both products.

B. True; Medigap can be used interchangeably with either Original Medicare or Medicare Advantage.

C. False; Medigap is designed to supplement Original Medicare, not Medicare Advantage cost sharing.

D. False; Medigap does not supplement any part of Medicare at all.

Parts A/B/C/D, eligibility, plan types | Alt Format / True False

QUESTION 86 | T-168

Evaluate this statement: The Medicare Part D coverage gap, formerly called the donut hole, has been eliminated in favor of an annual out-of-pocket threshold. Which response is correct?

A. False; the coverage gap still requires enrollees to pay full price once reached.

B. False; the coverage gap was replaced by a rule suspending all drug coverage.

C. True; but only for enrollees in a stand-alone PDP, not an MA-PD.

D. True; the former coverage-gap phase has been eliminated and replaced by a structure built around an annual out-of-pocket threshold.

Parts A/B/C/D, eligibility, plan types | Alt Format / True False

QUESTION 87 | T-169

Match each situation with the coverage route most consistent with it: keeping Original Medicare while adding drug coverage, obtaining medical and drug coverage from one private plan, and needing nursing-home-level care while living safely at home. Which sequence is accurate?

A. Stand-alone PDP; MA-PD; PACE.

B. MA-PD; PACE; stand-alone PDP.

C. PACE; stand-alone PDP; MA-PD.

D. Stand-alone PDP; PACE; MA-PD.

Parts A/B/C/D, eligibility, plan types | Alt Format / Matching

QUESTION 88 | T-170

Match each document with its purpose: confirming a drug's cost tier, confirming a clinician's network status, and reviewing the complete plan contract. Which sequence is accurate?

A. Evidence of Coverage; formulary; Provider Directory.

B. Formulary; Provider Directory; Evidence of Coverage.

C. Provider Directory; Evidence of Coverage; formulary.

D. Formulary; Evidence of Coverage; Provider Directory.

Parts A/B/C/D, eligibility, plan types | Alt Format / Matching

QUESTION 89 | T-171

Select all statements that generally apply to Medicare Advantage plan eligibility: it generally requires Part A entitlement; it generally requires Part B enrollment; it generally requires residence in the plan's service area; it generally requires proof of a Medigap policy. Which option correctly identifies the true statements?

A. All four listed conditions, including proof of a Medigap policy, are generally required.

B. Only Part A entitlement and service-area residence are generally required, with Part B enrollment optional.

C. Part A entitlement, Part B enrollment, and service-area residence are generally required; a Medigap policy is not.

D. Only proof of a Medigap policy and Part B enrollment are generally required.

Parts A/B/C/D, eligibility, plan types | Alt Format / Select All

QUESTION 90 | T-172

Select all statements that accurately describe a Medicare MSA plan: it generally has no built-in drug coverage; it generally has no defined provider network; it funds a savings account annually; it generally requires a signed exclusive provider contract. Which option correctly identifies the true statements?

A. All four listed statements, including a signed exclusive provider contract, are generally accurate.

B. Only the annually funded savings account statement is generally accurate.

C. Only the no-defined-network and exclusive-contract statements are generally accurate.

D. No built-in drug coverage, no defined provider network, and an annually funded savings account are all generally accurate; a signed exclusive provider contract is not.

Parts A/B/C/D, eligibility, plan types | Alt Format / Select All

Topic Set - MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs

75 questions. Choose one answer per item; answers and full rationales are in Part II.

QUESTION 91 | T-019

Tanya wants some coverage when she chooses physicians outside a plan's preferred network and accepts higher cost sharing for that flexibility. Which plan type most directly matches her priority?

A. An HMO that excludes routine non-network care except under limited protections.

B. An MSA chosen solely because it deposits funds into an account.

C. A PPO with an out-of-network benefit subject to the plan's terms.

D. A D-SNP for which no Medicaid eligibility has been established.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 92 | T-020

A PFFS member schedules a routine visit with a clinician who accepted the plan's terms last month but will not confirm acceptance for the new visit. What should the member understand?

A. The clinician must accept the PFFS plan forever after treating the member once.

B. Any provider accepting Original Medicare must accept every PFFS payment arrangement.

C. The plan must treat the visit as an emergency because acceptance is uncertain.

D. Prior treatment may not guarantee acceptance of the plan's terms for this encounter.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 93 | T-021

Omar selects a Medicare MSA and later realizes that he needs outpatient drug coverage. Which additional enrollment is generally compatible with that plan type?

A. A stand-alone Part D plan may be added because the MSA does not include drug coverage.

B. A second MA-PD must be added so both health plans remain active.

C. A Medigap policy must provide the Part D benefit for the MSA.

D. No Part D option is available to anyone enrolled in an MSA.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 94 | T-022

Evelyn has Medicare and a current Medicaid category accepted by a plan designed for dual-eligible beneficiaries. Which special-needs plan is tailored to that qualification?

A. A C-SNP based solely on the existence of Medicaid coverage.

B. A D-SNP serving beneficiaries with the plan's qualifying dual status.

C. An I-SNP requiring no institutional or level-of-care facts.

D. A non-SNP plan whose enrollment is restricted to dual eligibility.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 95 | T-023

A client reports having diabetes and asks an agent to mark the C-SNP eligibility field as confirmed before the plan completes its required verification. What is the proper handling?

A. The agent may approve any C-SNP because a self-report is always final.

B. The agent may substitute a general MA eligibility check for the chronic-condition review.

C. The qualifying condition must be confirmed through the plan's required C-SNP process.

D. The client must instead qualify for an I-SNP because diabetes is never relevant to a C-SNP.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 96 | T-024

Nora lives at home but requires an institutional level of care expected to continue under the plan's assessment standard. Is home residence alone enough to rule out I-SNP eligibility?

A. Yes, because every I-SNP enrollee must occupy a nursing-home bed on the application date.

B. Yes, unless the applicant also has the Medicaid category required by every D-SNP.

C. No, because an agent may waive the assessment whenever home care is expensive.

D. No; a qualifying institutional-equivalent pathway may apply when the required assessment is satisfied.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 97 | T-025

Caleb is enrolled in an HMO that already includes Part D. He wants to add a stand-alone PDP while keeping the HMO unchanged. What risk must the agent explain?

A. An incompatible PDP election can cause disenrollment from the MA-PD arrangement.

B. The PDP will automatically become secondary drug coverage without affecting the HMO.

C. CMS requires every MA-PD member to maintain two separate drug plans.

D. The HMO must convert into an MSA whenever a PDP application is submitted.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 98 | T-026

How does an HMO point-of-service feature differ from a full PPO out-of-network benefit?

A. It removes every network and referral rule from the HMO contract.

B. It covers specified non-network services under defined HMO plan terms.

C. It turns the HMO into Original Medicare for services outside the network.

D. It guarantees the same cost sharing for every in-network and out-of-network service.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Direct Knowledge

QUESTION 99 | T-027

Which feature identifies a regional PPO rather than a local PPO?

A. It excludes every out-of-network benefit.

B. It may enroll people who do not have Part B.

C. Its service area is a CMS-defined region governed by regional-plan requirements.

D. It must operate as a special-needs plan for dual-eligible beneficiaries.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Direct Knowledge

QUESTION 100 | T-028

What does the FIDE designation communicate about a dual-eligible special-needs plan?

A. The plan has no responsibility to coordinate Medicaid information.

B. The plan is simply any D-SNP that uses an HMO network.

C. The plan serves only beneficiaries with a qualifying chronic condition.

D. The plan meets CMS requirements for a fully integrated Medicare-Medicaid structure.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Direct Knowledge

QUESTION 101 | T-029

Who makes the plan-level decision that a member meets approved eligibility criteria for a chronically ill supplemental benefit?

A. The plan applies its published criteria and administration process.

B. The selling agent makes a binding determination during the appointment.

C. The beneficiary becomes eligible merely by requesting the benefit.

D. The debit-card vendor decides without reference to plan coverage rules.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Direct Knowledge

QUESTION 102 | T-030

Which statement accurately describes a supplemental-benefit debit card under the CY2027 rules?

A. The card is unrestricted cash that can be used after the plan year ends.

B. Its use must be tied to plan-covered items and services for the applicable plan year.

C. The card makes every enrollee eligible for all conditional supplemental benefits.

D. Its advertised face value is payable to the member even when no covered purchase occurs.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Direct Knowledge

QUESTION 103 | T-031

An agent recommends the lowest-premium plan without asking whether the client's specialist accepts the PFFS terms or participates in the selected network. What is the compliance correction?

A. Treat premium as conclusive because provider-use rules are the member's concern after enrollment.

B. Submit the application and let the first claim reveal whether the provider is usable.

C. Review the specific network, referral, out-of-network, or acceptance rules before recommending the plan.

D. Assume all Medicare-participating clinicians accept all MA plan arrangements.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Compliance Judgment

QUESTION 104 | T-032

A flyer describes a conditional grocery benefit as guaranteed cash available to every plan member. How should quality control respond?

A. Approve it because all supplemental benefits are automatically available as cash.

B. Approve it if the dollar figure is printed in large type.

C. Replace the plan name but keep the universal eligibility claim.

D. Reject the wording and disclose the benefit's eligibility, covered-use, and plan limits accurately.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Compliance Judgment

QUESTION 105 | T-033

Consider four statements about Medicare plan types. I. A PPO can cover out-of-network care at higher cost. II. An MSA may be paired with a stand-alone PDP. III. Every PFFS provider must accept the plan for all future visits after one encounter. IV. A D-SNP requires no qualifying Medicaid status. Which answer includes all and only the accurate statements?

A. I and II only.

B. I and III only.

C. II and IV only.

D. III and IV only.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Alt Format / Select All

QUESTION 106 | T-173

Priya belongs to an HMO requiring a written PCP referral before specialist care and wants to see an out-of-network cardiologist a friend recommended. What should she confirm before scheduling?

A. Whether the referral rule applies only to specialists inside the plan's network.

B. Whether the cardiologist accepts Original Medicare assignment nationwide.

C. Whether the visit will automatically qualify as emergency care.

D. Whether a friend's recommendation waives the plan's referral requirement.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 107 | T-174

Marcus enrolls in a local PPO and later takes a new job that keeps him inside the same county but near its outer boundary. Does his move affect plan eligibility?

A. Yes, any change of employer automatically ends MA plan eligibility.

B. No, staying within the plan's approved service area preserves his enrollment.

C. Yes, a local PPO requires a fixed home address at the county's center.

D. No, because PPOs have no service area restriction at all.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 108 | T-175

Which requirement distinguishes a regional Medicare Advantage PPO's benefit design from a local PPO's?

A. It may charge a different premium in each county of its region.

B. It never offers an out-of-network benefit.

C. It must offer the same premium and benefit package across its CMS-defined region.

D. It is restricted to a single state regardless of region size.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Direct Knowledge

QUESTION 109 | T-176

Dolores enrolls in a PFFS plan operating in an area where CMS requires network-based competition standards, and the plan maintains a contracted provider network. What does this mean for her?

A. The plan can no longer be classified as a PFFS plan.

B. She loses her right to see any non-network provider entirely.

C. Her plan automatically becomes a regional PPO.

D. Her PFFS plan may still operate with contracted providers under applicable network requirements.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 110 | T-177

A brochure tells prospects that a Medicare MSA plan lets them see literally any doctor with no restriction whatsoever. What correction does quality control require?

A. State that the provider must accept Medicare and not have opted out of the program.

B. Leave the claim unchanged because MSA plans truly have no provider limits.

C. Replace 'any doctor' with 'any hospital' and approve the brochure.

D. Add a footnote listing the plan's premium instead of correcting the access claim.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Compliance Judgment

QUESTION 111 | T-178

Under what circumstance must an HMO cover care from a non-network provider without requiring the usual referral or prior authorization?

A. None; HMO enrollees must return to the service area before treatment is covered.

B. Urgently needed and emergency services remain covered outside the network under applicable protections.

C. The enrollee must first switch to a PPO to receive any coverage.

D. Coverage applies only if the enrollee notifies the plan within 24 hours of travel.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Direct Knowledge

QUESTION 112 | T-179

Hector is comparing an HMO and a PPO and wants to know which plan type generally lets him see a specialist without first getting a referral. Which plan structure fits that need?

A. An HMO, because referrals are optional in every plan.

B. An MSA, because it has no network at all.

C. A PPO, because it typically does not require a referral for specialist care.

D. A PFFS plan, because Medicare participation always guarantees referral-free access.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 113 | T-180

Evaluate this statement: A regional PPO must offer identical premiums and benefits across every part of its CMS-defined region. Which response is correct?

A. False; regional PPOs may set a different premium in each county.

B. False; only local PPOs must maintain a uniform benefit design.

C. True; but the benefit package may still vary from county to county.

D. True; the uniform premium and benefit requirement applies across the region.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Alt Format / True False

QUESTION 114 | T-181

Which fact accurately describes how Medicare MSA plan funds may be used before the plan's deductible is met?

A. Deposited account funds may pay qualified medical expenses before the deductible is satisfied.

B. Account funds may only be used after the annual deductible is fully met.

C. Account funds may be used for any personal expense without restriction.

D. Account funds automatically convert into Part D premium payments.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Direct Knowledge

QUESTION 115 | T-182

Naomi is comparing an HMO with embedded Part D against a Medicare MSA and is confused about why the MSA quote never lists a drug benefit. What should she be told?

A. The MSA quote is incomplete, and Part D will be added automatically before enrollment.

B. Medicare MSA plans do not include Part D, so drug coverage must come from a separate stand-alone PDP if wanted.

C. MSA plans include Part D only for enrollees who also have Medicaid.

D. The absence of a drug benefit means Naomi cannot select an MSA at all.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 116 | T-183

An agent tells a dual-eligible client that every D-SNP automatically provides the same fully integrated Medicaid coordination as a FIDE-designated plan. How should this be corrected?

A. No correction is needed because all D-SNPs meet the FIDE standard.

B. Replace 'FIDE' with 'HMO' and leave the claim otherwise unchanged.

C. Clarify that only plans meeting CMS's fully integrated criteria carry the FIDE designation.

D. Tell the client that Medicaid coordination is never available outside a FIDE plan.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Compliance Judgment

QUESTION 117 | T-184

Desmond currently has Original Medicare and a stand-alone PDP, and he is considering an HMO that already includes Part D. What must he understand about keeping his current PDP?

A. The PDP will merge automatically with the HMO's drug benefit.

B. He must keep both plans active to remain compliant with CMS rules.

C. The HMO cannot include Part D if he already owns a PDP.

D. Enrolling in the MA-PD generally ends the need for, and compatibility with, his separate PDP.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 118 | T-185

What structural feature must every Medicare Advantage plan include regardless of whether it is an HMO, PPO, PFFS, or MSA?

A. An annual out-of-pocket maximum limiting a member's Part A and B cost sharing.

B. A requirement that every plan include embedded Part D coverage.

C. A guarantee that every provider in the country participates.

D. A ban on any referral requirement for specialist care.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Direct Knowledge

QUESTION 119 | T-186

Ingrid's non-SNP Medicare Advantage plan has grown to serve an overwhelmingly dual-eligible membership over several years. Why might this matter to CMS?

A. CMS treats high dual-eligible enrollment in a non-SNP plan as irrelevant to plan renewal.

B. CMS may treat the plan as a D-SNP look-alike once dual enrollment crosses the applicable threshold.

C. Ingrid's plan must immediately convert to an I-SNP regardless of her own status.

D. The plan automatically gains FIDE status once dual enrollment is high enough.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 120 | T-187

Match each plan-type feature to the structure it describes: a fixed high deductible paired with a plan-funded account, a payment-terms-based arrangement with individual providers, and a uniform premium and benefit design across a CMS-defined multi-county area. Which sequence is correct?

A. PFFS; Regional PPO; MSA.

B. Regional PPO; MSA; PFFS.

C. MSA; PFFS; Regional PPO.

D. MSA; Regional PPO; PFFS.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Alt Format / Matching

QUESTION 121 | T-188

Under CMS's institutional-equivalent pathway, what duration of expected care is generally required for community-dwelling I-SNP eligibility?

A. There is no minimum expected duration under this pathway.

B. A duration of at least 30 days is generally required.

C. A duration of at least 12 months is generally required.

D. A duration generally expected to last at least 90 days is required.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Direct Knowledge

QUESTION 122 | T-189

Rosalind lives at home, has no nursing-facility stay, and undergoes a state-based level-of-care assessment showing she needs institutional-level services for an extended period. Can she still pursue I-SNP enrollment?

A. Yes, through the institutional-equivalent pathway once the required assessment is satisfied.

B. No, because I-SNP enrollment always requires a current nursing-facility resident status.

C. Yes, but only if she also has a qualifying Medicaid category.

D. No, because home-based assessments are not accepted for any SNP category.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 123 | T-190

An agent enrolls a client in a D-SNP using a Medicaid card issued three years earlier without checking whether the eligibility is still current. What is the compliance issue?

A. There is no issue because Medicaid cards never expire in CMS's view.

B. Current dual-eligible status must be confirmed through acceptable evidence before relying on it for D-SNP enrollment.

C. The agent should have used the client's Social Security number instead of any Medicaid documentation.

D. The enrollment is valid as long as the card lists the correct state.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Compliance Judgment

QUESTION 124 | T-191

How does a coordination-only D-SNP differ from an integrated FIDE-SNP or HIDE-SNP?

A. A coordination-only D-SNP has no obligation regarding Medicaid benefits at all.

B. An integrated SNP is defined solely by using an HMO network.

C. A coordination-only D-SNP aligns benefit information, while integrated SNPs combine Medicare and Medicaid financing and care management.

D. There is no meaningful structural difference between the two designations.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Direct Knowledge

QUESTION 125 | T-192

Tobias is denied a covered service by his highly integrated FIDE-SNP and wants to know which appeals process governs his situation.

A. He must file two entirely separate Medicare and Medicaid appeals with different plans.

B. No appeal is available because FIDE-SNPs are exempt from grievance procedures.

C. He should appeal to Original Medicare because FIDE-SNPs are not part of Medicare Advantage.

D. A highly integrated D-SNP generally uses one unified Medicare-Medicaid appeals and grievance process.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 126 | T-193

Camila wants a plan that pays claims based on the provider's willingness to accept its payment terms for each service rather than a fixed network list. Which plan type fits her description?

A. A PFFS plan, whose payment terms a provider may accept for a given encounter.

B. An HMO, because HMOs never rely on a network at all.

C. A regional PPO, because premiums vary automatically with provider terms.

D. An MSA, because its funding structure replaces provider payment terms.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 127 | T-194

Elias is choosing between a local PPO and a regional PPO and cares most about a consistent benefit design if he later moves within the same multi-county service footprint. Which plan type better matches that priority?

A. A local PPO, because its benefits change by county to match local needs.

B. A regional PPO, because it must offer the same premium and benefits across its defined region.

C. An HMO, because HMOs always cover every U.S. region uniformly.

D. A PFFS plan, because PFFS plans replace regional benefit design entirely.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 128 | T-195

Which statement accurately describes how a beneficiary's chronic condition qualifies for a C-SNP?

A. Any self-reported chronic illness automatically satisfies C-SNP eligibility.

B. An agent may select any condition believed to be serious enough to qualify.

C. The condition must appear on CMS's approved list and be confirmed through the plan's verification process.

D. Eligibility depends solely on the beneficiary's age rather than any diagnosis.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Direct Knowledge

QUESTION 129 | T-196

Farah's C-SNP plan asks her physician to confirm a specific chronic condition from CMS's approved list before her enrollment is finalized. Why does the plan require this step rather than accepting her own statement?

A. Because physician confirmation replaces the need for any Medicare Advantage eligibility.

B. Because CMS prohibits any self-reported information from ever being collected.

C. Because physician confirmation converts the plan into an I-SNP.

D. Because C-SNP eligibility requires verification of the qualifying condition beyond a self-report.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 130 | T-197

A prospect asks whether the plan's over-the-counter debit card balance can simply be handed to them as cash at year-end. What is the compliant response?

A. Explain that the card funds must be used for covered items and services within the applicable plan year, not paid out as cash.

B. Confirm that unused balances are automatically mailed as a check each December.

C. Tell the prospect that any leftover balance carries over indefinitely.

D. Promise that the full advertised balance will be paid regardless of purchases made.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Compliance Judgment

QUESTION 131 | T-198

Which coverage carve-out lets an HMO enrollee obtain routine dialysis treatment while temporarily away from the plan's service area?

A. The plan's point-of-service feature, which every HMO must include for dialysis.

B. The out-of-area dialysis exception recognized for enrollees who travel temporarily.

C. A rule converting the enrollee's HMO into a PPO for the trip's duration.

D. A requirement that the enrollee first exhaust Original Medicare benefits.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Direct Knowledge

QUESTION 132 | T-199

Gustavo needs routine dialysis while visiting a different state for several weeks and worries his HMO will not cover it away from home. What should he be told about this situation?

A. Dialysis is never covered outside the enrollee's home service area.

B. He must switch to Original Medicare before any dialysis claim will be paid.

C. An out-of-area dialysis exception generally allows coverage for temporary travel situations like his.

D. His HMO automatically becomes a PFFS plan for the length of his trip.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 133 | T-200

Consider four statements about SNP structure. I. A C-SNP's qualifying condition must appear on CMS's approved list. II. A D-SNP may enroll any beneficiary regardless of Medicaid status. III. An I-SNP may serve a qualifying community resident through an institutional-equivalent pathway. IV. A FIDE-SNP reflects a lower level of Medicare-Medicaid integration than a coordination-only D-SNP. Which answer includes all and only the accurate statements?

A. I and II only.

B. II and III only.

C. I, III, and IV.

D. I and III only.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Alt Format / Select All

QUESTION 134 | T-201

How does the account portion of a Medicare MSA plan typically get funded?

A. The plan deposits funds into the account, generally on an annual basis.

B. The enrollee must personally contribute the entire deposit before coverage begins.

C. The federal government mails a separate check unrelated to the plan.

D. Funds are only added once the enrollee reaches the annual deductible.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Direct Knowledge

QUESTION 135 | T-202

Odette's Medicare MSA deposits an annual amount into her account, and she spends some of it early in the year on a covered service before meeting her deductible. What happens to any leftover balance at year-end?

A. It is forfeited entirely and cannot be used in any future year.

B. Unused MSA account funds may generally carry over for the enrollee's future use.

C. It converts automatically into a Part D premium credit.

D. It must be returned to CMS before the next plan year begins.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 136 | T-203

An agent describes a Medicare MSA plan to a prospect as having no deductible at all, only free coverage from day one. What must be corrected?

A. Nothing; MSA plans genuinely have no deductible under CMS rules.

B. Only the plan's premium figure needs correcting, not the deductible claim.

C. The description must be corrected because an MSA pairs a high deductible with the funded account.

D. The agent should instead describe the plan as a zero-premium PPO.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Compliance Judgment

QUESTION 137 | T-204

Ravi is enrolled in a PFFS plan without embedded drug coverage and asks whether he may still add a stand-alone Part D plan. What should he be told?

A. No PFFS enrollee may ever add a separate Part D plan.

B. He must first switch to an HMO before adding any drug coverage.

C. Adding a PDP will convert his plan into an MSA automatically.

D. He may generally add a stand-alone PDP because his PFFS plan has no embedded Part D.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 138 | T-205

Which general statement accurately describes an HMO's coverage of routine non-emergency care received outside its network?

A. It is generally not covered except under specific protections such as emergency or urgent care.

B. It is always covered at the same cost sharing as in-network care.

C. It is covered only if the enrollee first obtains a PPO rider.

D. It is covered automatically whenever the non-network provider accepts Medicare.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Direct Knowledge

QUESTION 139 | T-206

Selena, an HMO member, sees an out-of-network dermatologist for a routine skin check without an emergency, urgent, or dialysis-related reason. What is the likely coverage outcome?

A. The visit is automatically covered because Selena has Medicare Part B.

B. The visit is likely not covered because it falls outside the plan's network without a qualifying exception.

C. The visit converts her HMO into a PPO for that claim only.

D. The visit must be billed to Original Medicare instead of the HMO.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 140 | T-207

Judge the statement: A member who loses the qualifying status for their Special Needs Plan is disenrolled that same day in every case. Which evaluation is accurate?

A. True; CMS requires same-day disenrollment with no exceptions.

B. True; but only for C-SNP members, not D-SNP or I-SNP members.

C. False; a period of deemed continued eligibility may apply before disenrollment takes effect.

D. False; loss of SNP status has no effect on enrollment at all.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Alt Format / True False

QUESTION 141 | T-208

What limitation applies to how a plan-issued supplemental-benefit debit card balance may generally be used?

A. It may be transferred to a family member's separate Medicare account.

B. It may be used for any purchase once the calendar month begins.

C. It may be exchanged for cash once the enrollee requests it.

D. It must be used for covered items and services tied to the applicable plan year.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Direct Knowledge

QUESTION 142 | T-209

Woodrow receives a plan-issued debit card for a chronically ill supplemental benefit and asks whether he can spend it on anything he wants. What is the accurate answer?

A. Use is limited to the plan's covered items and services for the applicable plan year.

B. He may use it for any personal expense he chooses.

C. He may transfer the balance to a relative's bank account.

D. The balance never expires and may be spent whenever he likes.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 143 | T-210

A sales presentation tells dual-eligible prospects that every D-SNP nationwide automatically includes a grocery allowance as a guaranteed benefit. What correction is required?

A. None, because CMS mandates an identical grocery allowance in every D-SNP.

B. Clarify that supplemental benefits such as a grocery allowance vary by plan and are not guaranteed in every D-SNP.

C. Tell the prospect the benefit is only available through a C-SNP instead.

D. Advise the prospect to assume the benefit exists unless told otherwise in writing.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Compliance Judgment

QUESTION 144 | T-211

Which distinction accurately separates a full-benefit dual-eligible beneficiary from a partial-benefit dual-eligible beneficiary for SNP purposes?

A. A partial-benefit dual has complete state Medicaid benefits while a full-benefit dual does not.

B. There is no meaningful difference; both categories qualify for every D-SNP identically.

C. Full Medicaid coverage marks one category, while Medicare Savings Program assistance alone marks the other.

D. A full-benefit dual never qualifies for a D-SNP under any circumstance.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Direct Knowledge

QUESTION 145 | T-212

Bruno qualifies for a Medicare Savings Program that pays only his Part B premium, without full state Medicaid benefits, and wants to know whether he can still pursue a D-SNP. What should he be told?

A. No, because only full-benefit dual-eligible beneficiaries may ever enroll in a D-SNP.

B. No, because Medicare Savings Program status never counts toward SNP eligibility.

C. Yes, but only after his Medicaid benefits are upgraded to a full-benefit category.

D. Yes, partial-benefit dual-eligible status may still support SNP eligibility in most states.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 146 | T-213

Corinne is deciding between a PPO and an HMO because she frequently travels between two states and wants predictable access to specialists without a referral. Which plan-type feature best supports her situation?

A. A PPO's typical structure of referral-free specialist access, including an out-of-network option.

B. An HMO's gatekeeper referral requirement, because it guarantees nationwide access.

C. An MSA's high-deductible design, because it eliminates the need for any specialist visit.

D. A PFFS plan's per-encounter acceptance terms, because they replace referral requirements everywhere.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 147 | T-214

Dashiell's employer offers a PFFS plan, and he asks his agent whether every provider who has ever treated a PFFS member must keep accepting the plan going forward. How should the agent respond?

A. Yes, one accepted visit locks the provider into accepting the plan permanently.

B. No, provider acceptance of the plan's terms can be assessed on an encounter-by-encounter basis.

C. Yes, but only for providers who also participate in Original Medicare.

D. No, because PFFS plans never involve any provider acceptance process.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 148 | T-215

What does the term 'MA-PD' identify about a Medicare Advantage plan?

A. That the plan is restricted exclusively to dual-eligible beneficiaries.

B. That the plan has no annual out-of-pocket maximum.

C. That prescription drug benefits are built directly into the health plan itself.

D. That the plan operates only as a Medicare Savings Account.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Direct Knowledge

QUESTION 149 | T-216

Esperanza is enrolled in an HMO with embedded Part D and mistakenly submits an application for a stand-alone PDP thinking it will simply add extra drug coverage. What consequence should she be warned about?

A. The PDP will safely stack on top of her HMO's drug benefit with no effect.

B. Her HMO will automatically waive its Part D coverage while keeping medical benefits.

C. CMS will treat the extra PDP as a free upgrade to her existing plan.

D. The incompatible PDP election could cause her disenrollment from the MA-PD plan.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 150 | T-217

A presentation tells prospects that a PPO's out-of-network cost sharing is exactly the same as its in-network cost sharing. What must compliance require?

A. Correct the material to disclose that out-of-network cost sharing is generally higher under the plan's terms.

B. Approve the material because PPOs must charge identical cost sharing everywhere.

C. Remove only the word 'PPO' and leave the cost-sharing claim as written.

D. Add a disclaimer about premiums instead of correcting the cost-sharing claim.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Compliance Judgment

QUESTION 151 | T-218

What restriction generally applies to other insurance coverage held by an MSA plan enrollee?

A. There is no restriction; any other coverage may be combined freely.

B. Other coverage that would pay the MSA plan's deductible costs is generally incompatible with enrollment.

C. Only life insurance policies are restricted while all health coverage is permitted.

D. The restriction applies solely to enrollees who also have Part D.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Direct Knowledge

QUESTION 152 | T-219

Finnegan holds a separate policy that would pay his medical bills before his Medicare MSA deductible is met, and he wants to enroll in the MSA anyway. How should his agent respond?

A. The other policy has no bearing on MSA eligibility whatsoever.

B. He must cancel his MSA account, not the other policy, to fix the conflict.

C. That kind of coverage is generally incompatible with MSA enrollment because it would pay deductible costs the enrollee is meant to bear.

D. The other policy will simply become his plan's official provider network.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 153 | T-220

Match each SNP category to the basis for its eligibility: a qualifying severe or disabling chronic condition, a confirmed dual Medicare-Medicaid status, and an institutional or institutional-equivalent level of care. Which sequence is correct?

A. D-SNP; C-SNP; I-SNP.

B. I-SNP; D-SNP; C-SNP.

C. C-SNP; I-SNP; D-SNP.

D. C-SNP; D-SNP; I-SNP.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Alt Format / Matching

QUESTION 154 | T-221

Who establishes the geographic regions that a regional Medicare Advantage PPO must use for its service area?

A. CMS defines the regions that regional PPOs are required to use.

B. Each individual carrier freely draws its own regional boundaries.

C. State Medicaid agencies establish the regional boundaries.

D. The beneficiary selects the region at the time of enrollment.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Direct Knowledge

QUESTION 155 | T-222

Giselle enrolls in a regional PPO and later asks her agent whether the plan's premium could be higher in a neighboring county within the same region. What should the agent explain?

A. Yes, regional PPOs may set a different premium for each county in the region.

B. No, the same premium and benefit package apply throughout the plan's CMS-defined region.

C. Yes, but only during the plan's first year of operation.

D. No, because regional PPOs are not permitted to charge any premium at all.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 156 | T-223

An agent tells a local PPO prospect that the plan's benefit design is legally required to stay identical across the entire state, just like a regional PPO. What must be corrected?

A. Nothing, because all PPOs are legally identical statewide by CMS rule.

B. Only the word 'state' should be changed to 'nation' without further correction.

C. Clarify that a local PPO's service area and benefit design are not subject to the regional PPO's uniform-region requirement.

D. Tell the prospect the plan is actually a regional PPO to match the claim.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Compliance Judgment

QUESTION 157 | T-224

Harlan compares two PPOs, one local and one regional, and wants to know which one is more likely to have benefit variation between the different areas it covers. What should he understand?

A. Neither plan type may vary its benefits by area under any circumstance.

B. Both plan types are required to use identical, CMS-mandated statewide benefits.

C. Only the regional PPO may vary benefits by county within its footprint.

D. The local PPO is more likely to reflect area-based benefit variation, since the regional PPO must stay uniform across its region.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 158 | T-225

What is the defining feature of the 'gatekeeper' structure commonly associated with HMO plans?

A. A primary care provider generally coordinates and authorizes referrals for specialist care.

B. Every enrollee must pay the plan's full deductible before any visit is covered.

C. The enrollee selects a new insurer every time a referral is needed.

D. All out-of-network care is automatically covered at in-network rates.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Direct Knowledge

QUESTION 159 | T-226

Imani's HMO uses a primary care provider to coordinate her referrals, and she asks why her plan works this way instead of like her sister's PPO. How should the agent explain the difference?

A. Both plan types use the identical gatekeeper structure with no real difference.

B. Her HMO's gatekeeper structure coordinates referrals, while a PPO generally allows specialist access without one.

C. The gatekeeper structure only exists in PFFS plans, not HMOs.

D. Her sister's PPO must also use a primary care gatekeeper by law.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 160 | T-227

Consider four statements about plan-type cost sharing and access. I. A PPO's out-of-network benefit is typically available at higher member cost sharing. II. An HMO's point-of-service feature covers unlimited out-of-network care at in-network rates. III. A regional PPO must keep the same premium and benefits across its CMS-defined region. IV. A local PPO must match the regional PPO's statewide uniformity requirement. Which answer includes all and only the accurate statements?

A. I and IV only.

B. II and III only.

C. I and III only.

D. II and IV only.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Alt Format / Select All

QUESTION 161 | T-228

Which access feature generally distinguishes a PFFS plan from an HMO's gatekeeper structure?

A. A PFFS plan always requires a primary care referral before any specialist visit.

B. A PFFS plan bans out-of-network care entirely, unlike an HMO.

C. A PFFS plan converts into an HMO once a referral is requested.

D. A PFFS plan generally does not impose the HMO's primary care referral requirement.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Direct Knowledge

QUESTION 162 | T-229

Jasper grows frustrated that his PFFS plan's provider acceptance can vary visit to visit, so he wants a plan built around a stable contracted network instead. Which plan type more directly offers that structure?

A. An HMO or PPO, which are generally built around contracted provider networks.

B. Another PFFS plan, because all PFFS plans use identical acceptance rules.

C. An MSA, because its account replaces the need for any network.

D. Original Medicare, because it always includes a private contracted network.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 163 | T-230

An agent assures a client that any doctor who accepts Original Medicare will automatically accept every PFFS plan's payment terms. How should this statement be corrected?

A. No correction is needed since Medicare participation always equals PFFS acceptance.

B. Clarify that Medicare participation does not guarantee a provider's acceptance of a specific PFFS plan's terms.

C. Tell the client to disregard provider acceptance because PFFS plans have no rules at all.

D. Replace 'Original Medicare' with 'Medicaid' and leave the guarantee otherwise unchanged.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Compliance Judgment

QUESTION 164 | T-231

Which set correctly pairs each SNP abbreviation with the population it is designed to serve?

A. C-SNP for dual-eligible beneficiaries; D-SNP for chronic conditions; I-SNP for institutional care.

B. C-SNP for institutional care; D-SNP for dual-eligible beneficiaries; I-SNP for chronic conditions.

C. C-SNP for qualifying chronic conditions; D-SNP for dual-eligible beneficiaries; I-SNP for institutional or institutional-equivalent care.

D. C-SNP for chronic conditions; D-SNP for institutional care; I-SNP for dual-eligible beneficiaries.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Direct Knowledge

QUESTION 165 | T-232

Kendra has diabetes but no Medicaid or institutional care need, and she asks which SNP category, if any, might fit her situation. What should she be told?

A. She should pursue a D-SNP because diabetes is treated as a dual-eligible condition.

B. No SNP category can ever serve someone without Medicaid or institutional status.

C. She should pursue an I-SNP because chronic conditions default to institutional classification.

D. A C-SNP may fit if diabetes is on CMS's approved chronic-condition list and is verified through the plan's process.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

Topic Set - Enrollment periods, elections, SEPs, disenrollment

100 questions. Choose one answer per item; answers and full rationales are in Part II.

QUESTION 166 | T-034

In November, Rochelle wants to leave her current PDP and choose a different drug plan for the coming plan year. Which election period ordinarily supports that change?

A. The MA Open Enrollment Period, even though she is not enrolled in MA.

B. The Annual Election Period for a generally January 1 effective date.

C. The institutional SEP, even though she has never lived in a qualifying facility.

D. The 5-star SEP, regardless of the destination plan's rating.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 167 | T-035

Victor has Original Medicare on January 1 and decides in February that he wants to join an MA plan. Can he use the Medicare Advantage Open Enrollment Period for that first MA election?

A. Yes, because anyone with Part A may use the MA OEP to join MA.

B. Yes, as long as the plan has a higher Star Rating than Original Medicare.

C. No; the MA OEP does not let a person in Original Medicare enter MA.

D. No; no election period can ever permit him to join MA after January 1.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 168 | T-036

Harold lives in a qualifying nursing facility and wants to switch from one Medicare plan to another in May. Which enrollment rule is most relevant?

A. He must wait for AEP because institutional residence never creates an election right.

B. He may use the MA OEP even if he is not currently in Medicare Advantage.

C. He has an unlimited right to change plans forever after a single facility stay.

D. The institutional election opportunity is available while he resides there.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 169 | T-037

Denise permanently moves to a county outside her MA plan's service area. She gives the plan advance notice and asks about replacement coverage. What follows from the move?

A. A move SEP allows her to consider plans available at the new residence.

B. Her old plan must cover her indefinitely despite the permanent move.

C. She may enroll in any plan nationwide without regard to its service area.

D. Only a change in health status could create a midyear election.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 170 | T-038

Alicia's new address remains inside her current PDP's service area, but the move makes additional plans available. Does the relocation have enrollment significance?

A. No, because a move matters only when the old plan terminates immediately.

B. Yes; access to new plan options can create a move-related SEP.

C. No, because a beneficiary may never change PDPs outside AEP.

D. Yes; it allows enrollment in plans that do not serve the new address.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 171 | T-039

After several years abroad, Samuel reestablishes residence in the United States and wants an available Medicare health or drug plan. Which rule addresses his timing?

A. His return creates no plan-election opportunity until the next AEP.

B. He can keep a foreign address and select any U.S. plan without geographic eligibility.

C. Returning to the United States creates a time-limited SEP to join available coverage.

D. He automatically enters the highest-rated MA plan without making an election.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 172 | T-040

Mei receives Extra Help and wants to move from one stand-alone PDP to another outside AEP. She has no at-risk designation. What election opportunity may be available?

A. A one-time lifetime switch that can never be used again.

B. An unrestricted MA-to-MA election every week.

C. A permanent waiver of all service-area requirements.

D. The current monthly Part D SEP for qualifying Extra Help beneficiaries.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 173 | T-041

A full-benefit dual-eligible beneficiary wants coordinated Medicare and Medicaid coverage through an available integrated D-SNP. Which election rule should be examined?

A. The monthly integrated-care SEP for a qualifying aligned D-SNP election.

B. The MA OEP rule for people currently in Original Medicare.

C. The 5-star SEP even if the integrated plan has no 5-star rating.

D. The disaster SEP without any disaster-related missed election.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 174 | T-042

A PDP member with Medicaid receives notice that she is designated potentially at risk under a Part D drug-management program. She requests the ordinary monthly low-income PDP switch. How does the designation affect that request?

A. It guarantees immediate enrollment in any MA plan she chooses.

B. It bars use of the monthly Medicaid or Extra Help Part D SEP while the designation applies.

C. It permanently cancels the beneficiary's Medicare and Medicaid eligibility.

D. It creates a new right to submit multiple PDP elections in the same month.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 175 | T-043

What should an agent evaluate when employer or union health coverage ends and the beneficiary needs MA or Part D coverage?

A. Whether the beneficiary can invent an AEP date for the application.

B. Whether nonpayment of the employer premium will automatically create MA enrollment.

C. The applicable loss-of-employer-coverage SEP and its specific timing.

D. Whether the new plan will ignore ordinary eligibility because coverage was lost.

Enrollment periods, elections, SEPs, disenrollment | Direct Knowledge

QUESTION 176 | T-044

When employer drug coverage is involuntarily lost or newly declared non-creditable, which Medicare enrollment issue becomes central?

A. A permanent prohibition on joining Part D.

B. An automatic conversion of the employer plan into an MA-PD.

C. A requirement to wait eight months under the Part B framework.

D. A time-limited Part D SEP measured under the loss-of-creditable-coverage rules.

Enrollment periods, elections, SEPs, disenrollment | Direct Knowledge

QUESTION 177 | T-045

A plan tells members that its Medicare contract will not be renewed for the next year. What enrollment protection generally follows?

A. A special election window for affected members to choose replacement coverage.

B. A requirement that every member remain without coverage for the next plan year.

C. Automatic lifetime enrollment in the sponsor's nearest commercial product.

D. A right to keep the nonrenewing Medicare plan active indefinitely.

Enrollment periods, elections, SEPs, disenrollment | Direct Knowledge

QUESTION 178 | T-046

Which condition is necessary for a disaster or emergency SEP to remedy a missed plan election?

A. The beneficiary merely prefers a plan after its premium decreases.

B. A qualifying emergency prevented use of another election period for which the person was eligible.

C. The agent forgot to submit an application and labels the error a disaster.

D. Any weather event occurred somewhere in the country during the plan year.

Enrollment periods, elections, SEPs, disenrollment | Direct Knowledge

QUESTION 179 | T-047

What should be preserved when materially inaccurate plan information caused a beneficiary to enroll?

A. Only the agent's later recollection, with all original materials destroyed.

B. A new application falsely dated inside AEP.

C. Records of the representation and its effect for case-specific relief review.

D. A promise that CMS will approve an SEP before reviewing the facts.

Enrollment periods, elections, SEPs, disenrollment | Direct Knowledge

QUESTION 180 | T-048

When does a valid plan election submitted during the regular fall Annual Election Period generally take effect?

A. On the date the beneficiary first discusses the plan with an agent.

B. Retroactively to the first day of the prior calendar year.

C. Whenever the agent chooses after collecting the application.

D. January 1 of the next plan year.

Enrollment periods, elections, SEPs, disenrollment | Direct Knowledge

QUESTION 181 | T-049

An electronic enrollment form contains every demographic field, but the agent clicks the required acknowledgment boxes without the beneficiary's agreement. Is the request compliant?

A. No; the enrollment mechanism must capture the beneficiary's own acknowledgment and consent.

B. Yes; an agent may provide consent whenever the form is otherwise complete.

C. Yes; demographic accuracy eliminates the need for beneficiary authorization.

D. No; electronic enrollment is prohibited for every MA and Part D plan.

Enrollment periods, elections, SEPs, disenrollment | Compliance Judgment

QUESTION 182 | T-050

A client is ready to sign, but no one has discussed providers, prescriptions, pharmacies, costs, or the effect on other coverage. What must occur first?

A. The plan should activate coverage and conduct the review after the first claim.

B. The required Pre-Enrollment Checklist and needs discussion should be completed before enrollment.

C. The agent should ask only whether the client likes the plan's logo.

D. The omitted review can be replaced by a generic statement that every plan is suitable.

Enrollment periods, elections, SEPs, disenrollment | Compliance Judgment

QUESTION 183 | T-051

A complete MA application arrives in July, but the beneficiary has no current SEP or other election right. How should the agent treat the form?

A. Submit it as AEP because completeness changes the calendar.

B. Create an exceptional-circumstances SEP without CMS review.

C. Do not claim a valid election unless an applicable enrollment period is established.

D. Backdate the beneficiary's signature to the most recent AEP.

Enrollment periods, elections, SEPs, disenrollment | Compliance Judgment

QUESTION 184 | T-052

Judge the statement: During the MA Open Enrollment Period, a beneficiary already in MA may generally make one qualifying MA switch or return to Original Medicare. Which evaluation is accurate?

A. False; the MA OEP is available only to people in Original Medicare.

B. False; the period permits unlimited MA changes through March.

C. True; and it also lets any PDP enrollee enter MA without another election right.

D. True; the opportunity is limited to eligible current MA enrollees and permitted actions.

Enrollment periods, elections, SEPs, disenrollment | Alt Format / True False

QUESTION 185 | T-053

Match the circumstance to its election opportunity: a permanent move outside a plan's service area, current residence in a qualifying institution, and a fall plan change for next year. Which sequence is correct?

A. Move SEP; institutional SEP; Annual Election Period.

B. Annual Election Period; 5-star SEP; MA Open Enrollment Period.

C. Institutional SEP; disaster SEP; Initial Coverage Election Period.

D. MA Open Enrollment Period; move SEP; loss-of-coverage SEP.

Enrollment periods, elections, SEPs, disenrollment | Alt Format / Matching

QUESTION 186 | T-233

Priya turns 65 in October and files her Medicare Advantage election in July, three months before her birthday month. When does her MA coverage generally begin?

A. The first day of her birthday month, October 1.

B. The first day of the month after she files, August 1.

C. The first day of the following calendar year.

D. Coverage cannot start until the General Enrollment Period opens.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 187 | T-234

Desmond becomes entitled to Part A and Part B in June and submits his first MA election that same month, during his entitlement month. When should the coverage start?

A. The first day of the entitlement month, June 1.

B. The first day of the following month, July 1.

C. The first day of the prior month, May 1.

D. Whenever the plan's marketing department schedules new members.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 188 | T-235

Walter never enrolled during his Initial Enrollment Period and signs up for Part B in February through the General Enrollment Period. When does his coverage begin, and what should he expect?

A. Coverage starts immediately on the enrollment date, with no penalty ever possible.

B. Coverage is backdated a full year with no premium impact.

C. Coverage starts the month after enrollment, and a late penalty may apply.

D. Coverage cannot start until the next Annual Election Period.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 189 | T-236

Nadia's employment at a company that provided her group health coverage ends in March. She wants to enroll in Part B using the enrollment right tied to that employment. What should the agent confirm about her timing?

A. That she waits exactly one full year after her coverage ends before applying.

B. That she can only use this right during the fall Annual Election Period.

C. That the opportunity is available only to beneficiaries who never worked past age 65.

D. That she enrolls while covered by the group plan or within the period after the employment or coverage ends, whichever comes first.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 190 | T-237

Corinne leaves her job in April and elects COBRA continuation coverage. She tells her agent she believes the employment-based SEP clock will not start until her COBRA coverage runs out later in the year. How should the agent correct this?

A. Explain that electing or keeping COBRA does not extend or restart the SEP tied to active employment ending.

B. Confirm her understanding is accurate and file nothing until COBRA ends.

C. Tell her COBRA automatically extends her Initial Enrollment Period by a full year.

D. Advise her that COBRA converts her SEP into a permanent, ongoing enrollment right.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 191 | T-238

Julio, age 66, is still working with employer coverage and wants to delay only Part B for now while preserving his ability to take premium-free Part A whenever he chooses. Should he expect the same enrollment right to govern both parts?

A. Yes; both parts are locked to an identical eight-month deadline in every case.

B. No; premium-free Part A generally may be elected outside the same SEP window that governs Part B.

C. No; Part A can never be added after age 65 under any circumstance.

D. Yes; delaying Part B automatically cancels his eligibility for Part A permanently.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 192 | T-239

Roberta's employer sends an annual notice stating that her retiree drug coverage is no longer considered creditable. She wants to enroll in a Part D plan using the SEP tied to that change. What should the agent verify about timing?

A. That she must wait a full calendar year from the notice date before enrolling.

B. That the SEP for this event runs for the same eight months as the Part B employment SEP.

C. That the SEP window is tied to the loss of creditable status or the notice of that loss, whichever is later.

D. That losing creditable status has no bearing on any Part D enrollment right.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 193 | T-240

Theo voluntarily cancels his employer drug coverage even though it remained creditable, then asks his agent for a Part D special enrollment period based on that cancellation. How should the agent respond?

A. File the SEP request immediately because any loss of employer coverage automatically qualifies.

B. Tell him the cancellation creates an automatic right to enroll in any MA plan of his choosing.

C. Advise that voluntary cancellation extends his SEP window to a full year.

D. Explain that a voluntary drop of coverage that was still creditable does not by itself create this SEP.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 194 | T-241

Gwen enrolled in a plan after her agent described a benefit that the plan did not actually offer. Once she discovers the discrepancy, she asks whether she has any enrollment recourse. What should the agent identify?

A. A material misrepresentation at enrollment can itself qualify her for a special enrollment period.

B. No recourse exists once an enrollment application has been submitted.

C. She must wait until the next Annual Election Period with no other option.

D. Her only option is a formal grievance that does not affect her plan choice.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 195 | T-242

Following a FEMA-declared major disaster in his county, Nathaniel realizes he missed the deadline for an enrollment period he otherwise qualified for. What must be true for the disaster SEP to remedy the missed opportunity?

A. He only needs to live in the state where the disaster occurred, regardless of any missed window.

B. He must have missed another valid enrollment period as a result of being affected by the declared emergency.

C. The disaster SEP applies automatically to every Medicare beneficiary nationwide once declared.

D. He must first exhaust an appeal before the disaster SEP becomes available.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 196 | T-243

Adele is admitted to a skilled nursing facility that qualifies as an institution for enrollment purposes, and three months later she asks to switch her MA plan outside the fall election period. What enrollment right applies?

A. No election right exists until the following January.

B. Only the MA Open Enrollment Period, which is unrelated to her residence status.

C. The institutional SEP, which is available on an ongoing basis while she resides in a qualifying facility.

D. A one-time SEP available only in the calendar month she was admitted.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 197 | T-244

Continuing to live in the qualifying nursing facility from question above, Adele later wants to make a second plan change in a different month, still outside AEP. Should the agent expect this to be available?

A. No; only one lifetime use of the institutional SEP is ever permitted.

B. No; a facility resident loses all further election rights after the first change.

C. Yes, but only if she also qualifies for the disaster SEP in the same month.

D. Yes; the institutional SEP allows the beneficiary to make changes on an ongoing basis while residence continues.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 198 | T-245

Marcus permanently relocates to a new county outside his MA plan's service area and notifies the plan of the move in advance. What enrollment consequence follows from the permanent move itself?

A. A new election window opens tied directly to the relocation.

B. His existing plan automatically follows him regardless of service area.

C. He forfeits Medicare Advantage eligibility until the next Initial Enrollment Period.

D. He must return to his original address before any new election is possible.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 199 | T-246

Simone moves permanently in April but does not tell her plan until several weeks later. Does her delay in notifying the plan prevent the move-related SEP from applying to the April relocation?

A. Yes; failing to notify the plan on the exact day of the move voids the SEP entirely.

B. No; the SEP generally runs based on the move itself rather than solely on the date the plan happens to be notified.

C. Yes; only advance notice given before the move can ever create this SEP.

D. No; the delay instead converts her situation into a disaster SEP.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 200 | T-247

Estelle moves to a new address that remains within her current PDP's service area, and no additional plans become available at the new address. Does this relocation create an enrollment opportunity?

A. Yes; every change of address automatically creates a special enrollment period.

B. Yes; but only if she also changed her mailing address with Social Security.

C. No; a same-area move without new plan options does not by itself qualify for this SEP.

D. No; but it does immediately terminate her current PDP enrollment.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 201 | T-248

Felix relocates to a different neighborhood that stays within his MA plan's overall service area, but the move newly exposes several plans that were not available at his old address. What should the agent conclude about his enrollment rights?

A. No SEP applies because he technically remained inside the same broad service area.

B. He must wait for the next Annual Election Period regardless of the new options.

C. The new options only matter if he first disenrolls from his current plan.

D. A special enrollment period is available because new plan options opened up as a result of the move.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 202 | T-249

Winifred currently belongs to a plan rated below five stars and wants to switch into a nearby five-star-rated plan outside the fall election window. What must the agent confirm to use the 5-star SEP?

A. That the destination plan itself is the one carrying the five-star rating.

B. That her current plan also already carries a five-star rating.

C. That she has not used any other enrollment period earlier in the same year.

D. That the five-star SEP is available only during the fall Annual Election Period.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 203 | T-250

Having already used his one permitted MA Open Enrollment Period change back in February, Oscar later wants to use the 5-star SEP in September to move into a five-star plan. Does his earlier MA OEP use affect this later request?

A. Yes; using the MA OEP earlier in the year permanently forfeits any later special enrollment period.

B. No; the 5-star SEP is a separate, independent election that is not used up by an earlier MA OEP change.

C. Yes; he must first reverse his February change before the 5-star SEP becomes available.

D. No; but only because September falls inside the Annual Election Period.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 204 | T-251

Currently enrolled in an MA plan, Beatrix uses her MA Open Enrollment Period change to switch plans in January, then asks in March to make a second MA-to-MA switch under the same period. What should the agent explain?

A. The MA OEP allows unlimited changes as long as they occur before April.

B. A second change is permitted only if the first change is formally undone.

C. The MA OEP permits only one qualifying change per eligible beneficiary during the period.

D. The MA OEP resets monthly, allowing a new change every 30 days.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 205 | T-252

In April, after the MA Open Enrollment Period window has closed for the year, Terrance asks to use it to switch his MA plan. What should the agent tell him about timing?

A. The MA OEP remains open year-round for any current MA enrollee.

B. The MA OEP reopens automatically every calendar quarter.

C. The window closed, but it can be reopened by simply calling the plan's customer service line.

D. The window closed on March 31, so it cannot be used for this request.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 206 | T-253

During the fall Annual Election Period, Georgette submits an MA-PD election in mid-October, then submits a different election in late November before AEP closes. Which election should the agent expect to control her coverage?

A. The most recent valid election submitted before AEP closes generally governs.

B. Whichever election was submitted first is locked in and cannot be changed.

C. Both elections take effect simultaneously in different parts of the plan year.

D. Neither election is valid because only one submission per beneficiary is allowed during AEP.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 207 | T-254

Hollis takes no action during the fall Annual Election Period, and his current plan continues to be offered for the next year. What happens to his coverage on January 1?

A. His coverage automatically terminates because he did not submit a new election.

B. He is passively continued in the same plan without needing to take any action.

C. He is defaulted into Original Medicare with no drug coverage.

D. He must call the plan by January 1 or lose eligibility for Medicare altogether.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 208 | T-255

After several years in an MA plan, Ignatius decides he wants to return to Original Medicare. What must occur for that change to take effect?

A. The change happens automatically once he stops using his MA plan's network providers.

B. He must first exhaust his plan's internal grievance process.

C. He must take an active step: file a disenrollment request in a window that permits it.

D. No request is needed; Original Medicare resumes the moment his MA premium is unpaid.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 209 | T-256

Rosalind enrolls in a new stand-alone PDP through her agent. She asks whether she also needs to separately cancel her prior PDP so the two enrollments do not overlap. What should the agent tell her?

A. She must mail a written cancellation letter to the old plan before the new enrollment can process.

B. Both plans will remain active simultaneously unless she calls both companies.

C. She must wait for the old plan's contract year to end before the new enrollment can start.

D. Nothing further; the new enrollment itself handles the switch.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 210 | T-257

Consuela has full Medicaid benefits and wants to change from one stand-alone PDP to another in the middle of the year, outside AEP. How often can she generally use the SEP built for her circumstance?

A. Monthly, unlike the once-a-year limit most beneficiaries face.

B. Only once per calendar year, identical to most other beneficiaries.

C. As often as she wants, with no monthly limitation at all.

D. Never, because full Medicaid eligibility removes all Part D election rights.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 211 | T-258

Bartholomew, who has Extra Help, receives notice that he has been identified as potentially at risk under a Part D drug-management program. He then asks to use his usual monthly SEP to switch PDPs. What should the agent explain?

A. The designation has no bearing on his ability to use the monthly SEP.

B. That particular SEP is off the table for as long as the designation stands.

C. The designation instead grants him an unlimited number of additional SEPs.

D. The designation automatically disenrolls him from Medicare entirely.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 212 | T-259

Yusuf's plan notifies him that he no longer meets the special needs category that originally qualified him for his SNP. When does the SEP tied to that loss of status generally begin?

A. It begins only after a full year has passed since the change.

B. It begins the day his plan's contract renews the following January.

C. It begins in the month his qualifying status changes.

D. It never begins because loss of SNP status eliminates all election rights.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 213 | T-260

Yusuf's plan believes he may regain his qualifying status soon and instead of disenrolling him immediately, keeps him enrolled for a period first. What is this temporary continuation generally called, and how long can it run?

A. A grievance extension, which always lasts exactly one year.

B. A hardship waiver, which has no defined time limit.

C. An appeal stay, which only applies after a final adverse decision.

D. Deemed continued eligibility, which can run from 30 days up to six months.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 214 | T-261

CMS terminates a plan's contract effective December 31. Karim is enrolled in that plan and wants to know how his special enrollment period is generally timed relative to that termination date.

A. It generally runs from the month before the termination date through two months after it.

B. It is limited to the single calendar day the contract ends.

C. It does not open until the following year's Annual Election Period.

D. It requires Karim to file a formal grievance before it becomes available.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 215 | T-262

A plan issues a nonrenewal effective January 1 of the coming year. Priscilla, one of its members, asks when her related enrollment window generally opens relative to that nonrenewal date.

A. It opens only on January 1 itself, with no earlier access.

B. It generally opens weeks before January 1, well ahead of the nonrenewal date itself.

C. It opens a full calendar year before the nonrenewal takes effect.

D. It never opens because nonrenewal automatically defaults members to Original Medicare with no election needed.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 216 | T-263

A plan sponsor and CMS mutually agree to end a contract effective December 31. Fernanda, enrolled in that plan, asks how this SEP compares in timing to one created by a CMS-initiated termination.

A. Both termination types always produce an identical SEP window with no differences.

B. A mutual-consent termination eliminates any SEP entirely, unlike a CMS termination.

C. The two are not identical; her sponsor-driven window tends to start sooner.

D. Only a CMS-initiated termination can ever create a related SEP.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 217 | T-264

Right after submitting a new MA election, Fatima changes her mind and wants to stop the pending enrollment before its effective date arrives. How should the agent respond to her request?

A. Tell her cancellation is never possible once an application is submitted.

B. Wait until the plan year begins before any cancellation request can be filed.

C. Advise her that canceling now will retroactively cancel her current coverage as well.

D. Submit the cancellation promptly, since a pending enrollment may generally be canceled before its effective date.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 218 | T-265

In August, outside any Annual Election Period or known SEP, Dwayne submits a complete MA application with no documented qualifying event. How should the agent treat the submission?

A. Recognize that a complete application alone does not establish a valid election right if no qualifying period applies.

B. Process it immediately because a complete application is always sufficient on its own.

C. Backdate the effective date to the most recent AEP automatically.

D. Treat the application as automatically converting into a valid SEP request.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 219 | T-266

Leland loses his job-based coverage in November while the fall Annual Election Period is also open, and each period would set a different effective date for his new plan. What should the agent do?

A. Automatically apply whichever period the agent personally prefers.

B. Let Leland choose which available period and effective date he wants to use.

C. Ignore the job-loss SEP entirely since AEP is already open.

D. Delay any enrollment until only one of the two periods remains available.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 220 | T-267

New to Medicare, Odalys files her ICEP election in June, the same month her Part A and Part B entitlement both begin. Based on that timing, when should her MA coverage start?

A. The first day of June, her entitlement month itself.

B. The first day of the prior month, May.

C. The first day of July, the month after her entitlement month.

D. Whenever she happens to first use her plan's benefits.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 221 | T-268

Still new to Medicare, Reuben files his ICEP election in March, three months before his June entitlement month begins. Based on that earlier filing, when should his MA coverage start?

A. The first day of the month after he files, April 1.

B. The first day of the month after his entitlement month, July 1.

C. Coverage starts only once he submits a second confirming application.

D. The first day of his entitlement month, June 1.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 222 | T-269

What must an agent confirm about a client's group health coverage before relying on the employment-based Part B special enrollment period?

A. Whether the coverage is currently active through employment or ended within the qualifying window.

B. Whether the client has ever traveled outside the United States.

C. Whether the client's Part A premium has ever been late.

D. Whether the client belongs to a Medicare Savings Program.

Enrollment periods, elections, SEPs, disenrollment | Direct Knowledge

QUESTION 223 | T-270

Which fact most directly determines whether a beneficiary's change of address creates a service-area-related special enrollment period?

A. Whether the beneficiary changed banks around the same time.

B. Whether the move is outside the plan's service area or newly exposes different plan options.

C. Whether the move occurred during a leap year.

D. Whether the beneficiary's new address has a different area code.

Enrollment periods, elections, SEPs, disenrollment | Direct Knowledge

QUESTION 224 | T-271

What condition is generally required for the involuntary loss of creditable drug coverage to open a Part D special enrollment period?

A. The beneficiary must have already used the Annual Election Period earlier the same year.

B. The beneficiary must be under age 65 at the time of the loss.

C. The loss of creditable coverage was involuntary rather than a voluntary cancellation.

D. The prior coverage must have been provided by a government employer specifically.

Enrollment periods, elections, SEPs, disenrollment | Direct Knowledge

QUESTION 225 | T-272

What distinguishes a qualifying involuntary loss of drug coverage from a situation that does not support this particular SEP?

A. Whether the beneficiary's former employer was a large or small business.

B. Whether the coverage was ever reviewed by a state insurance department.

C. Whether the beneficiary kept paper copies of every plan document.

D. Whether the beneficiary's own voluntary choice, rather than an outside event, ended the creditable coverage.

Enrollment periods, elections, SEPs, disenrollment | Direct Knowledge

QUESTION 226 | T-273

What must be true of an inaccurate statement for it to support a material-misrepresentation special enrollment period?

A. Reliance: the beneficiary must have acted on it when making the enrollment decision.

B. The statement must have been made after the beneficiary already disenrolled.

C. The statement must involve the plan's corporate address rather than benefits.

D. The statement must have been made by a family member unrelated to the plan or agent.

Enrollment periods, elections, SEPs, disenrollment | Direct Knowledge

QUESTION 227 | T-274

What condition generally must be satisfied for a disaster or emergency special enrollment period to remedy a missed election?

A. The beneficiary must have filed a police report about property damage.

B. The beneficiary missed another valid enrollment opportunity because of a FEMA-declared emergency or major disaster.

C. The beneficiary must show the emergency lasted longer than six months.

D. The beneficiary must live within one mile of a declared disaster site.

Enrollment periods, elections, SEPs, disenrollment | Direct Knowledge

QUESTION 228 | T-275

What must be verified about a beneficiary's living situation before applying the institutional special enrollment period?

A. That the beneficiary has lived at the same address for at least ten years.

B. That the beneficiary owns rather than rents their residence.

C. Current or recent residence in a facility that qualifies as an institution for this purpose.

D. That the beneficiary's facility is located in the same state as their prior address.

Enrollment periods, elections, SEPs, disenrollment | Direct Knowledge

QUESTION 229 | T-276

When evaluating eligibility for the 5-star special enrollment period, which fact about the beneficiary's current plan is generally irrelevant to the analysis?

A. Whether the destination plan carries a qualifying five-star rating.

B. Whether the destination plan is actually available in the beneficiary's service area.

C. Whether the destination plan is the type of plan this SEP can be used to join.

D. The star rating of the plan the beneficiary is currently enrolled in.

Enrollment periods, elections, SEPs, disenrollment | Direct Knowledge

QUESTION 230 | T-277

What is the outer limit on the number of qualifying changes the MA Open Enrollment Period permits an eligible enrollee to make?

A. One qualifying change during the period.

B. Unlimited changes as long as each occurs in a different month.

C. Two changes, one in each half of the window.

D. Three changes, matching the number of months in the window.

Enrollment periods, elections, SEPs, disenrollment | Direct Knowledge

QUESTION 231 | T-278

Which group of beneficiaries is generally eligible to use the Medicare Advantage Open Enrollment Period?

A. Beneficiaries currently enrolled only in Original Medicare with no MA history.

B. Those who are current MA members when the window opens.

C. Beneficiaries who have never had any form of Medicare coverage.

D. Beneficiaries enrolled exclusively in a stand-alone Medigap policy.

Enrollment periods, elections, SEPs, disenrollment | Direct Knowledge

QUESTION 232 | T-279

Which date range defines the fall Annual Election Period each year, before any change takes effect the following January?

A. November 1 through December 31.

B. September 15 through November 7.

C. October 15 through December 7.

D. October 1 through November 30.

Enrollment periods, elections, SEPs, disenrollment | Direct Knowledge

QUESTION 233 | T-280

What generally happens to a beneficiary's Medicare Advantage or Part D coverage when no action is taken during AEP and the current plan continues to be offered?

A. Coverage is suspended until the beneficiary affirmatively re-enrolls.

B. Coverage automatically converts to Original Medicare with no drug benefit.

C. Coverage lapses entirely at the end of the current plan year.

D. Nothing changes; the same plan simply carries forward on its own.

Enrollment periods, elections, SEPs, disenrollment | Direct Knowledge

QUESTION 234 | T-281

What must a Medicare Advantage enrollee do to return to Original Medicare rather than remaining in MA?

A. Take a deliberate, timed action rather than relying on inaction.

B. Simply stop paying the MA plan's premium and wait for coverage to lapse.

C. Notify only their primary care physician of the intended change.

D. Wait for the plan to initiate the disenrollment automatically each year.

Enrollment periods, elections, SEPs, disenrollment | Direct Knowledge

QUESTION 235 | T-282

What administrative step is generally unnecessary when a beneficiary enrolls in a new MA or Part D plan that will replace an existing one?

A. Providing accurate personal information on the new enrollment request.

B. A separate cancellation request to the beneficiary's prior plan.

C. Confirming the new plan's service area covers the beneficiary's residence.

D. Confirming the new election is submitted during a valid enrollment period.

Enrollment periods, elections, SEPs, disenrollment | Direct Knowledge

QUESTION 236 | T-283

How frequently may a full-benefit dual-eligible beneficiary generally use the SEP that allows switching stand-alone Part D drug plans?

A. Once per calendar quarter.

B. Only once during the entire plan year.

C. Once per calendar month.

D. As often as daily, with no monthly limitation.

Enrollment periods, elections, SEPs, disenrollment | Direct Knowledge

QUESTION 237 | T-284

What effect does an active Part D at-risk or potentially-at-risk drug-management designation generally have on SEP eligibility?

A. It has no effect on any Medicare enrollment right whatsoever.

B. It automatically grants the beneficiary an additional annual SEP.

C. It converts the beneficiary's Part D coverage into Original Medicare only.

D. It blocks use of one specific recurring monthly election right.

Enrollment periods, elections, SEPs, disenrollment | Direct Knowledge

QUESTION 238 | T-285

When does the SEP tied to a member's loss of the special needs status that qualified them for a SNP generally begin?

A. In the month the qualifying status change occurs.

B. Only after the plan's next contract renewal date.

C. Exactly one calendar year after the status changes.

D. Only once a formal appeal of the status change is denied.

Enrollment periods, elections, SEPs, disenrollment | Direct Knowledge

QUESTION 239 | T-286

What purpose does a period of deemed continued eligibility generally serve for a SNP member who may be regaining qualifying status?

A. It permanently exempts the member from ever losing SNP eligibility again.

B. It bridges a gap so the member is not disenrolled the instant status is lost.

C. It automatically enrolls the member in a different, non-SNP MA plan.

D. It converts the member's SNP enrollment into a Medigap policy.

Enrollment periods, elections, SEPs, disenrollment | Direct Knowledge

QUESTION 240 | T-287

How does a CMS-initiated contract termination generally affect an enrolled member's enrollment timeline?

A. It has no effect on the member's coverage until the following AEP.

B. It immediately and permanently ends the member's Medicare eligibility.

C. It creates a bounded window for the member to pick a replacement plan.

D. It requires the member to file a lawsuit before any new plan can be selected.

Enrollment periods, elections, SEPs, disenrollment | Direct Knowledge

QUESTION 241 | T-288

What generally distinguishes a plan's voluntary nonrenewal from a CMS-initiated contract termination for SEP-timing purposes?

A. Only a CMS-initiated termination can ever create a related SEP.

B. Only a voluntary nonrenewal can ever create a related SEP.

C. Neither event creates any enrollment opportunity for affected members.

D. Each type of contract-ending event can open a related SEP, though the two are not always timed identically.

Enrollment periods, elections, SEPs, disenrollment | Direct Knowledge

QUESTION 242 | T-289

What can a beneficiary generally do with a pending Medicare Advantage enrollment before its effective date arrives?

A. Cancel the pending enrollment before it takes effect.

B. Nothing; a submitted election can never be undone at any point.

C. Only change the effective date, never cancel the request outright.

D. Cancel it only after the effective date has already passed.

Enrollment periods, elections, SEPs, disenrollment | Direct Knowledge

QUESTION 243 | T-290

What generally determines whether an MA or Part D application submitted outside AEP and the MA OEP is valid?

A. Whether the application form happens to be filled out completely.

B. Whether the beneficiary has a current qualifying special enrollment period.

C. Whether the beneficiary's agent has been licensed for more than five years.

D. Whether the application is submitted using a specific brand of pen or software.

Enrollment periods, elections, SEPs, disenrollment | Direct Knowledge

QUESTION 244 | T-291

What must occur when more than one valid election period is open at the same time and each would produce a different effective date?

A. The agent must automatically apply whichever period is administratively easiest.

B. The earliest-opening period always controls regardless of the beneficiary's preference.

C. The beneficiary must be allowed to choose which available period and effective date to use.

D. The application must be rejected until only one period remains open.

Enrollment periods, elections, SEPs, disenrollment | Direct Knowledge

QUESTION 245 | T-292

What effective-date rule generally applies to an ICEP election depending on whether it is filed before or during the month of Part A and Part B entitlement?

A. Both timings always produce the identical first-of-entitlement-month effective date.

B. Both timings always produce the identical first-of-following-month effective date.

C. Filing before the entitlement month delays coverage by a full year in every case.

D. Filing before the entitlement month starts coverage that month; filing during it starts coverage the next month.

Enrollment periods, elections, SEPs, disenrollment | Direct Knowledge

QUESTION 246 | T-293

An agent marks a July application as tied to an SEP the beneficiary never actually experienced, just to avoid holding it until AEP. Is that handling acceptable?

A. No; an application must reflect the beneficiary's actual, documented qualifying event.

B. Yes; any reasonable-sounding SEP label keeps the application moving.

C. Yes; the effective date can be corrected later without consequence.

D. No; but only because July applications are always automatically rejected.

Enrollment periods, elections, SEPs, disenrollment | Compliance Judgment

QUESTION 247 | T-294

Before a beneficiary signs an enrollment application, the agent has not yet discussed which providers, pharmacies, and costs are relevant to the choice. What must happen before the signature is collected?

A. Nothing further; a signature alone satisfies all enrollment obligations.

B. The required plan-relevant discussion must occur before the beneficiary is asked to sign.

C. The discussion can be completed at any later date after enrollment is processed.

D. The requirement applies only to telephonic applications, not in-person ones.

Enrollment periods, elections, SEPs, disenrollment | Compliance Judgment

QUESTION 248 | T-295

An agent submits an enrollment application citing a qualifying life event as the SEP basis but never actually confirms with the beneficiary that the event occurred. Is this acceptable practice?

A. Yes; agents may assume a plausible SEP basis whenever convenient.

B. Yes; confirmation is required only if the beneficiary is under age 65.

C. No; that basis needs to be verified first, not simply assumed.

D. No; but only because SEP-based applications can never be submitted by an agent.

Enrollment periods, elections, SEPs, disenrollment | Compliance Judgment

QUESTION 249 | T-296

During a paper application, a beneficiary tells the agent to simply sign every required acknowledgment box so the process moves faster. What is the correct next step?

A. Sign the boxes as requested since the beneficiary gave verbal permission.

B. Leave the boxes blank and submit the incomplete form anyway.

C. Have a family member sign the boxes instead, regardless of authority to do so.

D. Decline to sign on the beneficiary's behalf and ensure the beneficiary personally provides each required acknowledgment.

Enrollment periods, elections, SEPs, disenrollment | Compliance Judgment

QUESTION 250 | T-297

A caller asks the agent to disenroll a relative's Medicare plan on the relative's behalf, without providing any documentation of authority to act for that person. How should the agent proceed?

A. Decline to process the request until documented authority, such as a valid power of attorney, is provided.

B. Process the disenrollment immediately since the caller identified the relative by name.

C. Process it, but only if the caller is a spouse rather than another relative.

D. Ask the relative's physician to authorize the disenrollment instead.

Enrollment periods, elections, SEPs, disenrollment | Compliance Judgment

QUESTION 251 | T-298

An agent receives a complete application in a month when the beneficiary has no documented SEP and AEP has not yet opened. What is the compliant way to handle the submission?

A. Submit it immediately and let the carrier sort out the effective date later.

B. Set it aside until a genuine election opportunity actually opens.

C. Alter the application date to make it appear submitted during the prior AEP.

D. Process it as a General Enrollment Period request regardless of the beneficiary's actual situation.

Enrollment periods, elections, SEPs, disenrollment | Compliance Judgment

QUESTION 252 | T-299

A beneficiary calls to cancel a pending MA enrollment before its effective date, but the agent processes it anyway, reasoning that it was already submitted to the carrier. Was that the compliant response?

A. Yes; once submitted to the carrier, an application can never be stopped.

B. Yes; only the carrier, never the agent, may act on a cancellation request.

C. No; a beneficiary's request to cancel a still-pending enrollment before its effective date should be honored.

D. No; but only because the beneficiary must submit the cancellation in writing before any phone request counts.

Enrollment periods, elections, SEPs, disenrollment | Compliance Judgment

QUESTION 253 | T-300

A member flagged as potentially at risk under a Part D drug-management program asks to use the monthly Dual or Extra Help SEP, and the agent processes the switch without checking the flag. What compliance problem does this create?

A. There is no compliance problem, since the SEP is always available regardless of any designation.

B. The problem is that the SEP should have been processed as a 5-star SEP instead.

C. The problem is that only a supervisor, never a frontline agent, may ever process this SEP.

D. The agent processed an SEP the member could not currently use because of the active at-risk designation.

Enrollment periods, elections, SEPs, disenrollment | Compliance Judgment

QUESTION 254 | T-301

A member insists on keeping both a prior PDP and a newly enrolled PDP active at the same time. What should the agent explain about how the system will actually handle this?

A. The prior plan drops off on its own; the two cannot run side by side.

B. Both plans can remain active together indefinitely if the member simply requests it.

C. The member must pay two separate premiums to keep both plans active.

D. The carrier will merge the two PDPs into a single combined plan.

Enrollment periods, elections, SEPs, disenrollment | Compliance Judgment

QUESTION 255 | T-302

An agent tells a client that the 5-star SEP is only usable if the client's current plan is rated below three stars. Is that guidance accurate?

A. Yes; a below-three-star current plan is a documented precondition for this SEP.

B. No; the current plan's rating is not a condition of this SEP, which instead depends on the destination plan's rating.

C. Yes; but only during the fall Annual Election Period.

D. No; but only because the SEP requires the current plan to be rated above four stars instead.

Enrollment periods, elections, SEPs, disenrollment | Compliance Judgment

QUESTION 256 | T-303

An agent enrolls a beneficiary using the institutional SEP based solely on the beneficiary's verbal claim of living in a qualifying facility, without any documentation of that residency. What compliance concern does this raise?

A. There is no concern, since verbal statements alone always establish SEP eligibility.

B. The concern only applies if the beneficiary is also enrolled in a D-SNP.

C. The enrollment basis was not verified, risking reliance on an SEP that may not actually apply.

D. The concern is limited to whether the facility accepts the beneficiary's insurance.

Enrollment periods, elections, SEPs, disenrollment | Compliance Judgment

QUESTION 257 | T-304

A caller states she is affected by a FEMA-declared disaster and wants to use the disaster SEP, but the agent processes the request without confirming she actually missed another valid enrollment period as a result. What is missing from the agent's review?

A. Nothing; residency in a declared disaster area is sufficient by itself.

B. A requirement that she first file a claim with her homeowner's insurance.

C. A requirement that the disaster have lasted at least a full calendar year.

D. Confirmation that the declared emergency actually caused her to miss another valid enrollment opportunity.

Enrollment periods, elections, SEPs, disenrollment | Compliance Judgment

QUESTION 258 | T-305

Judge the statement: A beneficiary already enrolled in Medicare Advantage may use the MA Open Enrollment Period to make exactly one qualifying MA-to-MA switch or a return to Original Medicare. Which evaluation is correct?

A. True; the period is limited to eligible current MA enrollees and a single permitted change.

B. False; the period is open to anyone regardless of current enrollment.

C. True; but only for beneficiaries who have never used any other SEP.

D. False; the period actually permits unlimited changes throughout the year.

Enrollment periods, elections, SEPs, disenrollment | Alt Format / True False

QUESTION 259 | T-306

Evaluate the claim: missing the Initial Enrollment Period and later signing up for Part B during the General Enrollment Period still means coverage begins immediately with no possibility of a late penalty. Which evaluation is correct?

A. True; GEP always eliminates any late-enrollment penalty automatically.

B. False; coverage generally starts the month after enrollment and a penalty may apply.

C. True; but only because GEP coverage starts on the exact enrollment date.

D. False; but only because GEP is unavailable to anyone who missed their IEP.

Enrollment periods, elections, SEPs, disenrollment | Alt Format / True False

QUESTION 260 | T-307

Judge the statement: Enrolling in a new Medicare Advantage or Part D plan automatically disenrolls the beneficiary from the prior plan, so no separate cancellation form is required. Which evaluation is correct?

A. False; a written cancellation to the prior plan is always required first.

B. True; but only if the beneficiary also calls the prior plan to confirm.

C. True; the new enrollment itself triggers disenrollment from the prior plan.

D. False; both plans generally remain active until the next AEP.

Enrollment periods, elections, SEPs, disenrollment | Alt Format / True False

QUESTION 261 | T-308

Match each circumstance to its enrollment opportunity: an involuntary end to employer group health coverage, a beneficiary who missed AEP due to a FEMA-declared disaster, and a member who loses the special needs status that qualified them for a SNP. Which sequence is correct?

A. Disaster SEP; loss-of-special-needs-status SEP; employer-coverage SEP.

B. 5-star SEP; employer-coverage SEP; disaster SEP.

C. Loss-of-special-needs-status SEP; 5-star SEP; disaster SEP.

D. Employer-coverage SEP; disaster SEP; loss-of-special-needs-status SEP.

Enrollment periods, elections, SEPs, disenrollment | Alt Format / Matching

QUESTION 262 | T-309

Match each event to its associated enrollment window: a materially inaccurate plan description relied on at enrollment, a member becoming eligible to switch into a qualifying five-star plan, and a member notified that Medicaid or Extra Help now qualifies them for a monthly PDP switch. Which sequence is correct?

A. Material-misrepresentation SEP; 5-star SEP; Dual or Extra Help monthly SEP.

B. 5-star SEP; Dual or Extra Help monthly SEP; material-misrepresentation SEP.

C. Institutional SEP; disaster SEP; 5-star SEP.

D. Dual or Extra Help monthly SEP; material-misrepresentation SEP; institutional SEP.

Enrollment periods, elections, SEPs, disenrollment | Alt Format / Matching

QUESTION 263 | T-310

Match each contract-ending scenario to how its related enrollment window is generally timed: a CMS-initiated termination effective December 31, a sponsor or mutual-consent termination effective December 31, and a plan nonrenewal effective January 1. Which sequence best reflects that each opens a related SEP window, though not all at an identical starting point?

A. Only the CMS-initiated termination opens any related SEP window at all.

B. Each ending event opens a related SEP window, with the sponsor or mutual-consent case generally opening earliest.

C. None of the three events opens a related SEP window for affected members.

D. Only the January 1 nonrenewal opens a related SEP window.

Enrollment periods, elections, SEPs, disenrollment | Alt Format / Matching

QUESTION 264 | T-311

Consider four statements about enrollment periods. I. The MA Open Enrollment Period permits one qualifying change for an eligible current MA enrollee. II. General Enrollment Period coverage generally starts the same day as enrollment. III. The institutional SEP remains available on an ongoing basis while qualifying residence continues. IV. A voluntary cancellation of coverage that remained creditable creates the involuntary-loss Part D SEP. Which answer includes all and only the accurate statements?

A. Statements I and II only.

B. Statements II and IV only.

C. Statements I and III only.

D. Statements III and IV only.

Enrollment periods, elections, SEPs, disenrollment | Alt Format / Select All

QUESTION 265 | T-312

Review four statements about SEP eligibility limits. I. An active Part D at-risk designation suspends use of the monthly Dual or Extra Help SEP. II. Automatic disenrollment from a prior plan still requires a separate written cancellation form. III. Deemed continued eligibility for a SNP member can run from 30 days up to six months. IV. The 5-star SEP depends on the beneficiary's current plan carrying a five-star rating. Which response contains every accurate statement?

A. Statements I, II, and III.

B. Statements II and IV only.

C. Statements III and IV only.

D. Statements I and III only.

Enrollment periods, elections, SEPs, disenrollment | Alt Format / Select All

Topic Set - Part D, formularies, tiers, Extra Help, TrOOP

60 questions. Choose one answer per item; answers and full rationales are in Part II.

QUESTION 266 | T-054

A prescription appears on the plan's formulary, yet the price differs sharply between the beneficiary's neighborhood pharmacy and a preferred pharmacy. What explains the possible difference?

A. Formulary inclusion makes the price identical at every pharmacy.

B. Network and preferred-pharmacy status can affect access and cost sharing.

C. The drug becomes non-covered whenever a pharmacy charges more.

D. Part B sets one retail price for all Part D prescriptions.

Part D, formularies, tiers, Extra Help, TrOOP | Scenario

QUESTION 267 | T-055

The pharmacy rejects a formulary drug because the plan has not confirmed that the patient meets its clinical coverage criteria. Which utilization rule is being applied?

A. A quantity limit that concerns only the amount dispensed in a period.

B. A tiering exception that has already lowered the member's cost sharing.

C. Prior authorization requiring plan approval before coverage.

D. A transition fill that permanently removes every plan restriction.

Part D, formularies, tiers, Extra Help, TrOOP | Scenario

QUESTION 268 | T-056

A plan requires Jorge to try a lower-cost formulary drug before it will cover the medication his prescriber selected. The prescriber says the required drug is medically inappropriate. What path addresses the issue?

A. Paying cash automatically forces the plan to count the drug as covered.

B. Changing pharmacies permanently cancels the utilization rule.

C. Filing a grievance substitutes for a decision on drug coverage.

D. Requesting an exception to the step-therapy requirement with prescriber support.

Part D, formularies, tiers, Extra Help, TrOOP | Scenario

QUESTION 269 | T-057

The plan pays most of a covered prescription's negotiated cost, and Ibrahim wants the entire drug price added to his personal TrOOP total. Which amount generally does not count as his TrOOP?

A. The Part D plan's own payment for the prescription.

B. His qualifying deductible payment for a covered drug.

C. His qualifying coinsurance for a covered Part D drug.

D. An allowable payment made on his behalf under TrOOP rules.

Part D, formularies, tiers, Extra Help, TrOOP | Scenario

QUESTION 270 | T-058

On the first day of new Part D coverage, Anita learns that a long-standing medication is non-formulary. Her prescriber needs time to choose an alternative or support an exception. What plan protection may provide temporary access?

A. A permanent formulary addition ordered by the dispensing pharmacy.

B. A transition supply under the plan's transition policy.

C. An automatic tiering exception for every non-formulary drug.

D. A conversion of the prescription into a Part A benefit.

Part D, formularies, tiers, Extra Help, TrOOP | Scenario

QUESTION 271 | T-059

What question does a Part D drug tier answer after formulary coverage has already been confirmed?

A. Whether the beneficiary is entitled to Medicare Part A.

B. Whether the prescriber participates in an MA medical network.

C. Which cost-sharing level the plan assigns to the covered drug.

D. Whether the beneficiary may use the MA Open Enrollment Period.

Part D, formularies, tiers, Extra Help, TrOOP | Direct Knowledge

QUESTION 272 | T-060

Which request is appropriate when a medically necessary drug is absent from the plan's formulary?

A. A provider-network appeal seeking admission of the prescriber to the plan.

B. A Medigap claim for the excluded prescription.

C. A complaint asking customer service to ignore the formulary informally.

D. A formulary exception supported through the Part D coverage-determination process.

Part D, formularies, tiers, Extra Help, TrOOP | Direct Knowledge

QUESTION 273 | T-061

Which status can cause a beneficiary to be deemed eligible for Extra Help without filing a separate subsidy application?

A. A qualifying Medicaid, Medicare Savings Program, or SSI category.

B. Enrollment in any zero-premium MA plan.

C. Ownership of a Medigap policy with a standardized letter.

D. Use of an out-of-network pharmacy for one prescription.

Part D, formularies, tiers, Extra Help, TrOOP | Direct Knowledge

QUESTION 274 | T-062

Why should a beneficiary retain annual notices showing that former employer prescription coverage was creditable?

A. The notices guarantee acceptance into every Medicare Advantage plan.

B. They can document continuous creditable coverage if a Part D penalty is questioned.

C. They replace the need to enroll during a valid Part D election period.

D. They prove that the employer coverage was a stand-alone Medicare PDP.

Part D, formularies, tiers, Extra Help, TrOOP | Direct Knowledge

QUESTION 275 | T-063

An agent advertises the Medicare Prescription Payment Plan as a discount that lowers the total price of every covered drug. What must be corrected?

A. Nothing, because enrollment erases all Part D cost sharing.

B. Only the plan name, because the discount claim is accurate.

C. Explain that the program spreads payments over time without reducing the total amount owed.

D. Promise that participation prevents TrOOP from accumulating.

Part D, formularies, tiers, Extra Help, TrOOP | Compliance Judgment

QUESTION 276 | T-064

A CY2027 benefit illustration inserts a separate coverage-gap phase between initial and catastrophic coverage. How should the reviewer revise it?

A. Keep the extra phase because every current Part D plan has four standard stages.

B. Move the gap before the deductible and label it mandatory.

C. Describe the gap as an optional election period for high-cost drugs.

D. Remove the obsolete gap and show deductible, initial coverage, and catastrophic phases.

Part D, formularies, tiers, Extra Help, TrOOP | Compliance Judgment

QUESTION 277 | T-065

Review these CY2027 defined-standard Part D statements. I. The deductible is $700. II. The annual out-of-pocket threshold is $2,400. III. A separate coverage-gap phase follows initial coverage. IV. Covered drugs in catastrophic coverage require enrollee cost sharing. Which answer contains every accurate statement?

A. Statements I and II.

B. Statements I and III.

C. Statements II and IV.

D. Statements III and IV.

Part D, formularies, tiers, Extra Help, TrOOP | Alt Format / Select All

QUESTION 278 | T-313

Renata's prescriber selects a covered drug that the plan places on its specialty tier, and she asks why a tiering exception cannot lower the cost sharing. What explains the plan's answer?

A. Many plans exclude the specialty tier from the tiering-exception process even though it is covered.

B. The drug must be non-formulary before any tiering rule can apply.

C. Specialty-tier placement means the plan refuses to cover the drug at all.

D. A grievance about tier fees automatically produces a lower copayment.

Part D, formularies, tiers, Extra Help, TrOOP | Scenario

QUESTION 279 | T-314

Walter's pharmacist says the prescriber already submitted a prior authorization request, but the claim still rejects at the counter days later. What should Walter do next?

A. Assume the rejection permanently excludes the drug from the formulary.

B. Contact the plan to confirm status or request a coverage determination on the pending request.

C. Pay full price and expect the payment to count as a formulary exception.

D. Switch pharmacies so the prior authorization requirement no longer applies.

Part D, formularies, tiers, Extra Help, TrOOP | Scenario

QUESTION 280 | T-315

Consuelo just moved into a long-term care facility and finds that her current Part D plan does not cover one of her existing prescriptions. Which protection may apply given her residential setting?

A. A permanent formulary rewrite issued by the facility's pharmacy.

B. An automatic tiering exception limited to nursing facility residents.

C. A transition supply, with rules that can differ for long-term care residents.

D. A conversion of the drug into a Part A skilled nursing benefit.

Part D, formularies, tiers, Extra Help, TrOOP | Scenario

QUESTION 281 | T-316

Midway through the plan year, Otis learns his maintenance drug is being removed from the plan's formulary for the next plan year. When does the removal generally take effect for him?

A. Immediately, canceling his current prescription that same day.

B. Only if he requests a new Scope of Appointment first.

C. Never, because formularies cannot change once published.

D. At the start of the next plan year, following required advance notice to affected members.

Part D, formularies, tiers, Extra Help, TrOOP | Scenario

QUESTION 282 | T-317

Naomi's plan requires her ongoing maintenance medication to be filled through its mail-order pharmacy to receive standard cost sharing. What does this describe?

A. A pharmacy network rule tied to how and where the drug is dispensed.

B. A formulary exclusion that removes the drug from coverage entirely.

C. A step-therapy requirement demanding a different medication first.

D. A quantity limit restricting the amount dispensed each fill.

Part D, formularies, tiers, Extra Help, TrOOP | Scenario

QUESTION 283 | T-318

Devon uses a manufacturer discount card to lower what he pays at the pharmacy counter for a covered Part D drug. Does that discounted amount count toward his TrOOP?

A. Yes, because any amount taken off the counter price always counts.

B. Generally no, because amounts paid through many manufacturer discount arrangements are not qualifying TrOOP payments.

C. Yes, but only if the pharmacy is out-of-network.

D. No, because using a discount card removes the drug from the formulary.

Part D, formularies, tiers, Extra Help, TrOOP | Scenario

QUESTION 284 | T-319

Amara's Extra Help subsidy changes from full to partial part-way through the year, and her prescription costs rise. What most likely explains the change?

A. A billing error that the pharmacy must correct without any plan involvement.

B. A permanent loss of all Part D coverage rights.

C. A redetermination of her income or resources that moved her past the full-subsidy threshold.

D. An automatic downgrade triggered whenever a beneficiary changes plans.

Part D, formularies, tiers, Extra Help, TrOOP | Scenario

QUESTION 285 | T-320

Felix has modest income and resources but has no Medicaid, Medicare Savings Program, or SSI status on file. What step allows him to be considered for Extra Help?

A. Waiting for automatic deeming, since every low-income beneficiary is deemed eventually.

B. Enrolling in a zero-premium Medicare Advantage plan.

C. Asking his pharmacy to self-certify his income level.

D. Filing an Extra Help application for CMS to make a subsidy-eligibility determination.

Part D, formularies, tiers, Extra Help, TrOOP | Scenario

QUESTION 286 | T-321

Grace wants to understand how her Part D late-enrollment penalty amount was calculated after a documented gap in creditable coverage. What is the general basis for the calculation?

A. Roughly one percent of the national base beneficiary premium for each full month without creditable coverage.

B. A flat one-time fee charged only in the first month of enrollment.

C. A percentage of her specific plan's highest drug copayment.

D. An amount set solely by her pharmacy based on drugs filled.

Part D, formularies, tiers, Extra Help, TrOOP | Scenario

QUESTION 287 | T-322

Hector receives Extra Help and later learns he had a gap in creditable drug coverage before he enrolled. Does he still face a Part D late-enrollment penalty?

A. Yes, and it will always exceed the penalty a non-subsidized beneficiary owes.

B. Generally no, because full Extra Help eligibility relieves the beneficiary of the late-enrollment penalty.

C. Yes, but only until he changes to a different PDP.

D. No, because Extra Help removes any gap in creditable coverage retroactively.

Part D, formularies, tiers, Extra Help, TrOOP | Scenario

QUESTION 288 | T-323

Ingrid's employer retiree plan ended, and she cannot locate the annual notice that stated whether it was creditable. She worries this alone means she owed a penalty. Which reply is accurate?

A. Yes, because Medicare treats a missing notice as an automatic non-creditable finding.

B. No, because retiree drug coverage is always creditable regardless of design.

C. A missing notice does not itself prove the coverage was non-creditable; the plan can request other evidence of creditable status.

D. No, because creditable-coverage rules apply only to active-employer plans, never retiree plans.

Part D, formularies, tiers, Extra Help, TrOOP | Scenario

QUESTION 289 | T-324

Nadia wants to join the Medicare Prescription Payment Plan after she has already paid several prescriptions out of pocket this year. Can she still participate for the remainder of the plan year?

A. No, participation is only available during the plan year's final month.

B. No, once any drug cost sharing has been paid the option is permanently closed.

C. Yes, but only if she also files a new Extra Help application first.

D. Yes, generally she may opt in during the plan year, and it applies to her remaining eligible cost sharing going forward.

Part D, formularies, tiers, Extra Help, TrOOP | Scenario

QUESTION 290 | T-325

Owen assumes he can enroll the Medicare Prescription Payment Plan for just one expensive prescription while paying for his other drugs the usual way. Is that assumption accurate?

A. No, the program spreads eligible Part D cost sharing across the covered drugs under the plan rather than a single selected drug.

B. Yes, because the program is designed as a per-drug election.

C. No, because the program only ever applies to over-the-counter items.

D. Yes, provided the drug is on the plan's specialty tier.

Part D, formularies, tiers, Extra Help, TrOOP | Scenario

QUESTION 291 | T-326

Priya's Part D plan denies a requested exception, and her prescriber states that waiting for the standard review could seriously jeopardize her health. What review right may apply?

A. A routine grievance addressing only customer-service conduct.

B. An expedited coverage determination supported by the prescriber's statement.

C. A permanent formulary rewrite ordered by the pharmacy.

D. An automatic switch into a different Part D plan.

Part D, formularies, tiers, Extra Help, TrOOP | Scenario

QUESTION 292 | T-327

Samuel reached the catastrophic phase of his Part D benefit in November. What happens to his cost-sharing obligation when the new plan year begins in January?

A. His catastrophic-phase protection carries over permanently across all future years.

B. He owes a lump-sum repayment before any new coverage begins.

C. His deductible and cost-sharing phases reset, and TrOOP accumulation starts again for the new plan year.

D. He is automatically disenrolled once catastrophic coverage is reached.

Part D, formularies, tiers, Extra Help, TrOOP | Scenario

QUESTION 293 | T-328

During the Annual Enrollment Period, Rafael compares two Part D plans and notices his regular pharmacy is preferred under one plan but only standard network under the other. Why might this matter for his decision?

A. Only formulary drug lists differ between preferred and standard pharmacies.

B. Preferred pharmacy status changes which drugs are covered, not the cost.

C. Standard network pharmacies always charge the plan's full retail price with no coverage.

D. Preferred-pharmacy cost sharing can be lower than standard-network cost sharing for the same covered drug.

Part D, formularies, tiers, Extra Help, TrOOP | Scenario

QUESTION 294 | T-329

Delia's prescriber wants to request a formulary exception for a brand-name drug because no generic or therapeutic equivalent is appropriate for her condition. What must accompany the request?

A. A supporting statement from the prescriber addressing medical necessity for that specific drug.

B. Nothing, because the absence of a generic automatically adds the drug to the formulary.

C. A separate Scope of Appointment signed by the beneficiary.

D. Proof that the beneficiary has already paid full retail price twice.

Part D, formularies, tiers, Extra Help, TrOOP | Scenario

QUESTION 295 | T-330

Yuki's prescriber believes a higher quantity than the plan's standard limit is medically appropriate for a safety-monitored medication. What is the correct path to request the larger amount?

A. Filling the prescription at two different pharmacies to bypass the limit.

B. Requesting a quantity-limit exception with the prescriber's supporting clinical information.

C. Filing a grievance about the pharmacy's dispensing software.

D. Waiting until the next plan year, when quantity limits automatically expire.

Part D, formularies, tiers, Extra Help, TrOOP | Scenario

QUESTION 296 | T-331

Mei is traveling out of state when she runs out of a maintenance medication and cannot reach an in-network pharmacy before a health emergency worsens. What Part D protection may apply?

A. A permanent transfer of her plan enrollment to the new state.

B. An automatic formulary addition for every pharmacy she visits nationwide.

C. Out-of-network access rules that can apply in specified emergency circumstances.

D. A requirement that she pay full price with no possible reimbursement.

Part D, formularies, tiers, Extra Help, TrOOP | Scenario

QUESTION 297 | T-332

Corazon's plan wants to move her current maintenance drug to a higher cost-sharing tier before the next plan year. What must generally happen before that change affects her?

A. Nothing, because tier placement can change for current users without any notice.

B. The change takes effect immediately once the plan's board approves it internally.

C. She must first file a grievance to delay the change.

D. Affected enrollees generally receive advance notice before such formulary changes take effect.

Part D, formularies, tiers, Extra Help, TrOOP | Scenario

QUESTION 298 | T-333

Btissam wonders whether switching from a stand-alone PDP into an MA-PD plan will change her existing Extra Help subsidy eligibility. What is generally true?

A. Her Extra Help eligibility is a separate federal determination that does not depend on which type of Part D plan she picks.

B. Extra Help ends automatically whenever a beneficiary leaves a stand-alone PDP.

C. MA-PD enrollment always upgrades a partial subsidy to a full subsidy.

D. Extra Help only applies to beneficiaries enrolled in stand-alone PDPs.

Part D, formularies, tiers, Extra Help, TrOOP | Scenario

QUESTION 299 | T-334

Soo-jin's pharmacist fills her prescription with the generic version of a brand-name drug on the formulary, and her copay is noticeably lower. What explains the lower amount?

A. The generic automatically became a specialty-tier drug requiring prior authorization.

B. Generic drugs are commonly placed on a lower cost-sharing tier than their brand-name counterparts.

C. The pharmacy discounted the price on its own without any plan tier rule.

D. Generic substitution removes the drug from TrOOP tracking entirely.

Part D, formularies, tiers, Extra Help, TrOOP | Scenario

QUESTION 300 | T-335

How does a Part D step-therapy rule typically operate for an affected drug class?

A. It bars the beneficiary from ever receiving the requested drug.

B. It sets the maximum dollar amount a pharmacy may charge.

C. It requires trying one or more specified drugs before the plan covers the requested medication.

D. It cancels the beneficiary's TrOOP accumulation for that class.

Part D, formularies, tiers, Extra Help, TrOOP | Direct Knowledge

QUESTION 301 | T-336

Which entity issues the initial decision on a Part D beneficiary's formulary exception request?

A. The federal Medicare agency handles every exception request directly.

B. The prescribing physician issues the binding coverage decision alone.

C. The state insurance department reviews and approves all Part D exceptions.

D. The Part D plan sponsor issues the initial coverage determination on the request.

Part D, formularies, tiers, Extra Help, TrOOP | Direct Knowledge

QUESTION 302 | T-337

What does a Part D plan's TrOOP accounting generally track for a beneficiary?

A. Qualifying out-of-pocket payments applied toward the annual out-of-pocket threshold.

B. The plan's total administrative overhead for the year.

C. The number of pharmacies in the plan's network.

D. The beneficiary's Part B premium payments for the year.

Part D, formularies, tiers, Extra Help, TrOOP | Direct Knowledge

QUESTION 303 | T-338

In Part D program terms, what does a plan's formulary represent?

A. The plan's list of network hospitals and surgical centers.

B. The plan's list of covered prescription drugs, including any tier or utilization rules.

C. The federal schedule of Original Medicare Part B premiums.

D. A list of every pharmacy nationwide that accepts Medicare.

Part D, formularies, tiers, Extra Help, TrOOP | Direct Knowledge

QUESTION 304 | T-339

What must generally support a request for a Part D tiering exception on a covered drug?

A. Confirmation that the drug already sits on the plan's lowest tier.

B. A signed Scope of Appointment listing every product type.

C. Medical support from the prescriber showing lower-tier alternatives are not appropriate.

D. Proof that the beneficiary changed pharmacies during the plan year.

Part D, formularies, tiers, Extra Help, TrOOP | Direct Knowledge

QUESTION 305 | T-340

Once a Part D late-enrollment penalty applies to a beneficiary, how long does it generally continue?

A. It ends automatically after twelve months regardless of coverage history.

B. It applies only during the first plan year of enrollment.

C. It is waived the first time the beneficiary changes plans.

D. It generally continues for as long as the beneficiary maintains Part D coverage, absent an applicable exception.

Part D, formularies, tiers, Extra Help, TrOOP | Direct Knowledge

QUESTION 306 | T-341

Which set of Part D costs can Extra Help reduce for an eligible beneficiary?

A. Premiums, deductibles, and prescription cost sharing, depending on subsidy level.

B. Only the Part B premium and nothing related to Part D.

C. Only pharmacy delivery fees for mail-order prescriptions.

D. Only the beneficiary's Medigap premium.

Part D, formularies, tiers, Extra Help, TrOOP | Direct Knowledge

QUESTION 307 | T-342

What is a Part D coverage determination, in general program terms?

A. A plan's marketing disclosure delivered before a sales appointment.

B. The plan's initial decision on a drug coverage, payment, or exception request.

C. A federal audit of the plan's formulary design.

D. A pharmacy's internal log of dispensed prescriptions.

Part D, formularies, tiers, Extra Help, TrOOP | Direct Knowledge

QUESTION 308 | T-343

What purpose does a Part D transition supply generally serve for an affected enrollee?

A. It permanently replaces the need for any future formulary exception.

B. It converts a retail prescription into inpatient hospital coverage.

C. It provides temporary access to a needed drug while a longer-term option is pursued.

D. It eliminates the beneficiary's obligation to pay any cost sharing that year.

Part D, formularies, tiers, Extra Help, TrOOP | Direct Knowledge

QUESTION 309 | T-344

Once a beneficiary reaches the CY2027 catastrophic phase, what does the beneficiary generally owe for covered Part D drugs for the rest of the plan year?

A. The same coinsurance percentage that applied in the initial coverage phase.

B. A reduced flat copay set at half the standard-tier amount.

C. The full negotiated price with no plan contribution.

D. No cost sharing for covered Part D drugs.

Part D, formularies, tiers, Extra Help, TrOOP | Direct Knowledge

QUESTION 310 | T-345

What is the CY2027 defined standard Part D deductible amount?

A. $700, the figure CMS finalized for the CY2027 Part D deductible.

B. $2,400, the figure tied to the CY2027 catastrophic-coverage trigger.

C. $615, last year's defined standard deductible figure.

D. $2,100, last year's catastrophic-coverage trigger figure.

Part D, formularies, tiers, Extra Help, TrOOP | Direct Knowledge

QUESTION 311 | T-346

What is the CY2027 annual out-of-pocket threshold that triggers Part D catastrophic coverage?

A. $700, the figure tied to the CY2027 Part D deductible.

B. $2,400, the figure CMS finalized for the CY2027 catastrophic-coverage threshold.

C. $615, last year's defined standard deductible figure.

D. $2,100, last year's catastrophic-coverage threshold figure.

Part D, formularies, tiers, Extra Help, TrOOP | Direct Knowledge

QUESTION 312 | T-347

What does the Medicare Prescription Payment Plan generally do for a participating Part D enrollee?

A. It lowers the enrollee's total annual drug cost liability.

B. It replaces the need for a formulary or tiering exception.

C. It spreads eligible Part D cost sharing into monthly payments across the remaining plan year.

D. It automatically qualifies the enrollee for Extra Help.

Part D, formularies, tiers, Extra Help, TrOOP | Direct Knowledge

QUESTION 313 | T-348

Which category of beneficiary is generally deemed eligible for Extra Help without submitting a separate subsidy application?

A. Any beneficiary enrolled in a Medicare Advantage plan.

B. Any beneficiary who recently changed Part D plans during AEP.

C. Any beneficiary who requests a formulary exception.

D. One who is automatically deemed through full Medicaid, an MSP, or SSI-based eligibility.

Part D, formularies, tiers, Extra Help, TrOOP | Direct Knowledge

QUESTION 314 | T-349

An agent tells a prospect that any drug placed on a plan's specialty tier is automatically excluded from coverage. What correction is needed?

A. Clarify that specialty-tier placement reflects a cost-sharing level for a covered drug, not automatic exclusion.

B. Nothing, because specialty-tier drugs are always non-formulary.

C. Tell the prospect that specialty tiers only exist for over-the-counter items.

D. Confirm the statement, since specialty tiers guarantee a coverage denial.

Part D, formularies, tiers, Extra Help, TrOOP | Compliance Judgment

QUESTION 315 | T-350

An agent tells every prospect that Extra Help never requires an application because eligibility is always automatic. What must be corrected?

A. Nothing, because CMS eliminated the Extra Help application entirely.

B. Explain that only specific deemed categories skip the application, while others must apply for a subsidy determination.

C. Tell prospects that Extra Help applications are handled exclusively by pharmacies.

D. Confirm the claim, since every Part D enrollee is deemed eligible.

Part D, formularies, tiers, Extra Help, TrOOP | Compliance Judgment

QUESTION 316 | T-351

An agent assures a beneficiary that opting into the Medicare Prescription Payment Plan automatically enrolls them in Extra Help as well. What must the agent correct?

A. Confirm the statement, since both programs share one combined application.

B. Say that Extra Help no longer exists now that the payment plan is available.

C. Clarify that the payment plan and Extra Help are separate programs, and one does not automatically enroll the beneficiary in the other.

D. Tell the beneficiary that only agents may enroll someone in Extra Help.

Part D, formularies, tiers, Extra Help, TrOOP | Compliance Judgment

QUESTION 317 | T-352

An agent tells a beneficiary that reaching the Part D catastrophic phase means she will never owe drug cost sharing again in any future year. What correction is required?

A. Nothing, because catastrophic status is permanent once reached.

B. Tell her the catastrophic phase only applies to Part B services.

C. Explain that catastrophic status transfers automatically to any new plan she joins later.

D. Clarify that catastrophic-phase protection applies for the remainder of that plan year, and cost-sharing phases reset each new plan year.

Part D, formularies, tiers, Extra Help, TrOOP | Compliance Judgment

QUESTION 318 | T-353

An agent tells a client that requesting a formulary exception is a waste of time and simply advises switching plans instead without discussing the option fully. What is the concern?

A. The agent should fairly present available options, including the exception process, rather than steering the client away from it.

B. Nothing, because formulary exceptions are never granted.

C. Only pharmacists may discuss formulary exceptions with beneficiaries.

D. Switching plans is legally required before any exception request may be filed.

Part D, formularies, tiers, Extra Help, TrOOP | Compliance Judgment

QUESTION 319 | T-354

During a plan comparison, an agent tells a beneficiary that TrOOP simply equals the full retail price of every drug purchased that year. What must be corrected?

A. Nothing, because TrOOP and total drug spending are identical figures.

B. Explain that TrOOP reflects specific qualifying out-of-pocket payments, not the drug's full retail price.

C. Tell the beneficiary that TrOOP only applies to Part B drugs.

D. Say that TrOOP resets every time the beneficiary changes pharmacies.

Part D, formularies, tiers, Extra Help, TrOOP | Compliance Judgment

QUESTION 320 | T-355

An agent describes a plan's prior authorization requirement and its quantity limit as the exact same utilization rule with identical effects. What should the agent correct?

A. Nothing, because both rules always apply to the same drugs simultaneously.

B. State that neither rule can ever be appealed by the beneficiary.

C. Explain that prior authorization requires advance plan approval, while a quantity limit restricts the amount covered in a period.

D. Say that both rules were eliminated under the current defined standard benefit.

Part D, formularies, tiers, Extra Help, TrOOP | Compliance Judgment

QUESTION 321 | T-356

Review these Part D utilization-management statements. I. A quantity limit caps the amount of a covered drug paid for in a period. II. Step therapy always permanently bars the originally requested drug. III. Prior authorization requires plan approval based on specified criteria before coverage. IV. A tiering exception can lower cost sharing for many covered higher-tier drugs. Which answer contains every accurate statement?

A. Statements I and II.

B. Statements II and III.

C. Statements I, II, and IV.

D. Statements I, III, and IV.

Part D, formularies, tiers, Extra Help, TrOOP | Alt Format / Select All

QUESTION 322 | T-357

Evaluate this statement: Under the CY2027 defined standard Part D benefit, an enrollee owes no cost sharing for covered drugs after reaching the annual out-of-pocket threshold. Which response is correct?

A. True; catastrophic coverage removes cost sharing on covered Part D drugs for the remainder of that plan year.

B. False; the enrollee still owes the same coinsurance rate as the initial coverage phase.

C. True; but only for beneficiaries who also receive Extra Help.

D. False; catastrophic coverage was eliminated for CY2027.

Part D, formularies, tiers, Extra Help, TrOOP | Alt Format / True False

QUESTION 323 | T-358

Evaluate this statement: A beneficiary who is deemed eligible for full Extra Help and then loses qualifying Medicaid status mid-year immediately loses the subsidy that same month. Which response is correct?

A. True; deemed status ends the instant the underlying Medicaid eligibility ends.

B. False; deemed Extra Help generally continues at least through the end of that calendar year despite the mid-year Medicaid change.

C. True; but only for beneficiaries enrolled in a D-SNP.

D. False; deemed status can never end for any reason once granted.

Part D, formularies, tiers, Extra Help, TrOOP | Alt Format / True False

QUESTION 324 | T-359

Match each Part D term to its correct description: 1. Formulary 2. TrOOP 3. Transition supply 4. Tiering exception. I. Temporary access to a drug while a longer-term solution is pursued. II. A request to lower cost sharing for an eligible higher-tier covered drug. III. The plan's list of covered drugs. IV. Qualifying out-of-pocket payments counted toward the annual threshold. Which pairing is entirely correct?

A. 1-I, 2-II, 3-III, 4-IV.

B. 1-II, 2-IV, 3-I, 4-III.

C. 1-III, 2-IV, 3-I, 4-II.

D. 1-IV, 2-III, 3-II, 4-I.

Part D, formularies, tiers, Extra Help, TrOOP | Alt Format / Matching

QUESTION 325 | T-360

Review these Extra Help and late-enrollment statements. I. A qualifying Medicaid, Medicare Savings Program, or SSI status can deem a beneficiary eligible for Extra Help. II. Full Extra Help eligibility generally relieves a beneficiary of the Part D late-enrollment penalty. III. Every Extra Help recipient must file a separate subsidy application. IV. The late-enrollment penalty calculation generally uses the national base beneficiary premium. Which answer contains every accurate statement?

A. Statements I and III only.

B. Statements III and IV only.

C. Statements I, III, and IV.

D. Statements I, II, and IV.

Part D, formularies, tiers, Extra Help, TrOOP | Alt Format / Select All

Topic Set - Marketing, communications, SOA, events

85 questions. Choose one answer per item; answers and full rationales are in Part II.

QUESTION 326 | T-066

A plan sends members a neutral notice listing new customer-service hours and contact information, with no benefits, costs, ratings, comparisons, or enrollment appeal. How should the piece be classified?

A. Marketing, because every message from a plan tries to retain members.

B. A communication that does not satisfy both marketing prongs.

C. An enrollment mechanism because it contains a telephone number.

D. A sales event invitation because it describes service hours.

Marketing, communications, SOA, events | Scenario

QUESTION 327 | T-067

A seminar advertised as educational begins comparing named plans' copayments and distributes carrier enrollment forms during the presentation. What has happened?

A. The event remains educational because the speaker first explained Parts A through D.

B. The enrollment forms are permitted as long as attendees do not sign immediately.

C. Plan-specific sales content has changed the activity into marketing.

D. Any event held in a library is exempt from Medicare marketing rules.

Marketing, communications, SOA, events | Scenario

QUESTION 328 | T-068

An educational program is followed immediately by a sales presentation in the same room. The host announces the transition but blocks the exits and begins the pitch at once. Which requirement is still unmet?

A. The host must restore a mandatory twelve-hour delay in every case.

B. The host must collect applications during the educational portion first.

C. The host must keep the transition secret to avoid confusing attendees.

D. Attendees must receive a meaningful opportunity to leave before marketing begins.

Marketing, communications, SOA, events | Scenario

QUESTION 329 | T-069

A hospital offers an agent a table in its public cafeteria and another table beside patients receiving infusions. Where may compliant marketing potentially occur?

A. In the permitted public common area, subject to facility and CMS rules.

B. Only beside the infusion chairs because patients are easier to reach there.

C. In both locations if the agent avoids discussing premiums.

D. In neither location because all health-care settings ban common-area marketing.

Marketing, communications, SOA, events | Scenario

QUESTION 330 | T-070

At a scheduled one-on-one video meeting, the agent begins comparing MA plans before documenting which product categories the beneficiary agreed to discuss. What should the agent have done?

A. Wait until an enrollment is submitted before documenting any scope.

B. Obtain and document the Scope of Appointment before the personal marketing discussion.

C. Use a Permission to Contact record as unlimited authority to discuss every product.

D. Skip the scope because video meetings are not personal marketing appointments.

Marketing, communications, SOA, events | Scenario

QUESTION 331 | T-071

On October 2, 2026, a beneficiary completes a valid written SOA and requests an in-person plan comparison later that day. Must the agent impose the former two-day waiting period?

A. Yes, because every SOA must age for two full days before any discussion.

B. Yes, unless the beneficiary signs a waiver created by the agent.

C. No; the PY2027 rule removed the waiting period, but the SOA still must precede the meeting.

D. No; the rule also eliminated the SOA requirement for in-person appointments.

Marketing, communications, SOA, events | Scenario

QUESTION 332 | T-072

A written SOA lists only Medicare Advantage. During the appointment, the beneficiary spontaneously asks to compare a stand-alone PDP as well. How should the added topic be handled?

A. The agent must ignore every beneficiary question outside the original scope forever.

B. The original MA entry automatically authorizes all health and non-health products.

C. The agent may add any lucrative product without telling the beneficiary.

D. The beneficiary-initiated expansion should be documented through an updated scope as required.

Marketing, communications, SOA, events | Scenario

QUESTION 333 | T-073

An agency buys a list of older adults' mobile numbers and sends plan sales texts without any beneficiary request or authorization. Which rule governs the outreach?

A. The texts are prohibited unsolicited direct contact; purchasing data is not consent.

B. The texts are beneficiary-initiated because the vendor chose the recipients.

C. The list gives automatic Permission to Contact for all represented plans.

D. The messages are educational as long as they contain no application link.

Marketing, communications, SOA, events | Scenario

QUESTION 334 | T-074

Which event giveaway is most consistent with Medicare's nominal-gift rules?

A. Cash offered only to people who complete an enrollment.

B. A modest noncash item offered to attendees regardless of enrollment.

C. A general-purpose payment card provided in exchange for a referral's phone number.

D. A monetary rebate that increases when the beneficiary selects the promoted plan.

Marketing, communications, SOA, events | Direct Knowledge

QUESTION 335 | T-075

Which outreach method may be used when its content and channel safeguards comply with CMS rules?

A. An unrequested sales text to every number on a purchased list.

B. A door-to-door visit to homes whose residents never invited the agent.

C. A marketing email with a working opt-out that the sender honors.

D. A ringless sales voicemail sent without permission to a prospect.

Marketing, communications, SOA, events | Direct Knowledge

QUESTION 336 | T-076

What food may a sponsor generally provide at a Medicare marketing or sales event?

A. A full catered dinner advertised as the reason to attend.

B. A restaurant voucher redeemable after an enrollment form is signed.

C. An unrestricted grocery card for each prospect who supplies contact data.

D. Light snacks and refreshments that do not amount to a meal.

Marketing, communications, SOA, events | Direct Knowledge

QUESTION 337 | T-077

What makes a side-by-side comparison of two MA plans supportable?

A. It uses current plan documents, identifies the relevant year, and states the comparison accurately.

B. It labels one plan best for everyone without identifying a measure.

C. It omits benefit conditions so both columns appear simpler.

D. It relies on the agent's memory of benefits from an earlier year.

Marketing, communications, SOA, events | Direct Knowledge

QUESTION 338 | T-078

Which cost information belongs in a beneficiary-needs review before enrollment?

A. Only the advertised plan premium, even when expected services have cost sharing.

B. Applicable premiums, deductibles, copayments, coinsurance, and costs for relevant care.

C. Only costs for benefits the agent personally uses.

D. No cost information if the plan includes a supplemental allowance.

Marketing, communications, SOA, events | Direct Knowledge

QUESTION 339 | T-079

On October 5, an agent asks prospects to complete and hand over AEP applications dated October 15 so the office can hold them. What is the correct response?

A. Accept the forms because future dating creates an early election right.

B. Accept them if the agent promises not to review the answers.

C. Do not solicit or take possession of completed AEP requests before the period opens.

D. Submit them immediately and let the plan change every signature date.

Marketing, communications, SOA, events | Compliance Judgment

QUESTION 340 | T-080

During an MA appointment, the agent introduces an annuity that the beneficiary did not request and asks for a signature before returning to Medicare coverage. Is that appropriate?

A. Yes, because an MA SOA authorizes every insurance and financial product.

B. Yes, if the annuity pays the agent no commission in the first year.

C. No, but only because annuities must be sold at educational events.

D. No; agent-initiated non-health cross-selling does not belong in the Medicare marketing appointment.

Marketing, communications, SOA, events | Compliance Judgment

QUESTION 341 | T-081

Assess this PY2027 statement: An educational-event attendee may voluntarily complete an SOA for a later personal appointment, but plan-specific marketing may not begin during the educational session. Which option is correct?

A. True; collecting the future scope does not convert the event into a plan sales presentation.

B. False; merely displaying an SOA always requires immediate plan marketing.

C. False; educational events must collect completed enrollment forms instead.

D. True; and the agent may begin comparing named plan copays before the event ends.

Marketing, communications, SOA, events | Alt Format / True False

QUESTION 342 | T-082

Pair each setting with its proper description: a general Medicare lesson with no plan promotion, a seminar comparing one carrier's benefits, and a scheduled one-on-one plan discussion. Which sequence is accurate?

A. Sales event; educational event; informal contact.

B. Educational event; marketing or sales event; personal marketing appointment.

C. Personal appointment; communication; educational event.

D. Educational event; personal appointment; public common area.

Marketing, communications, SOA, events | Alt Format / Matching

QUESTION 343 | T-361

Lena's personal insurance-agent website has carried general Medicare information for a year with no plan-specific content. She then adds a chart comparing two named MA plans' premiums and copays. What changes about the page's classification?

A. The added comparison chart now satisfies the marketing content prong for that page.

B. Nothing changes, because only a brand-new URL can become marketing.

C. The whole website becomes marketing only if Lena also submits an enrollment form.

D. The page stays a communication as long as Lena wrote the chart herself.

Marketing, communications, SOA, events | Scenario

QUESTION 344 | T-362

Marcus's agency mails current enrollees a letter praising their plan and stating its exact specialist copay to encourage them to stay enrolled. Marcus assumes the letter is exempt because it targets only existing members. Is he correct?

A. Yes; only new-enrollee mail can ever satisfy the intent prong.

B. No; naming a specific copay to influence a stay-enrolled decision meets both marketing prongs.

C. Yes; retention mail is automatically excluded from the marketing definition.

D. No; but only because the letter also should have included a Star Rating.

Marketing, communications, SOA, events | Scenario

QUESTION 345 | T-363

A flyer for Dolores's agency states only a plan's Star Rating, with no premium, copay, or benefit language anywhere on the page. Does the flyer meet the marketing definition's content prong?

A. No; only premium or benefit language can satisfy the content prong.

B. No; a Star Rating is treated as neutral operational information.

C. Yes; a performance measure like a Star Rating satisfies the content prong on its own.

D. Yes; but only if the flyer also lists a phone number.

Marketing, communications, SOA, events | Scenario

QUESTION 346 | T-364

Priya's agency airs a radio spot saying 'Priya's Insurance can help you understand Medicare,' without naming any plan, premium, or benefit. How should the spot be classified?

A. As marketing, because any agency advertisement is inherently plan-specific.

B. As marketing, because radio is a regulated broadcast channel.

C. As an enrollment mechanism, because listeners might call the agency.

D. As a communication, because no plan-specific content satisfies the content prong.

Marketing, communications, SOA, events | Scenario

QUESTION 347 | T-365

Yusuf sends a compliant marketing email with a working opt-out. A beneficiary replies asking for more details rather than opting out. May Yusuf now call her to continue the conversation?

A. Yes, once she has replied, but he still needs a signed SOA before discussing specific plan details.

B. No, because the original email was already an unsolicited contact.

C. Yes, and her reply also serves as a valid Scope of Appointment.

D. No, unless he waits 48 hours from the date of the original email.

Marketing, communications, SOA, events | Scenario

QUESTION 348 | T-366

A prospect signs a Permission to Contact card at Carmen's booth so she can follow up later. Does the signed card let Carmen enroll the prospect in a plan that day?

A. Yes; a signed PTC satisfies every requirement of a Scope of Appointment.

B. No; the card authorizes contact but not a discussion of specific products or enrollment.

C. Yes; because both forms require the same product-type checklist.

D. No; because PTC cards may only be used at educational events.

Marketing, communications, SOA, events | Scenario

QUESTION 349 | T-367

Walter's office assistant checks every product-type box on a blank SOA before Walter's appointments to save time, and beneficiaries sign without discussing which boxes apply. What is wrong with this practice?

A. Nothing; pre-checking every box maximizes compliance coverage.

B. Nothing; the assistant's signature authority covers the beneficiary's choices.

C. The SOA no longer reflects the beneficiary's own agreement about which products to discuss.

D. The problem is only that Walter did not use a printed form.

Marketing, communications, SOA, events | Scenario

QUESTION 350 | T-368

Beatriz has a client sign an SOA on September 24, 2026, for an in-person appointment scheduled September 25, 2026. Does this timing comply with the rule in effect that week?

A. Yes; the waiting period was already eliminated by September 2026.

B. Yes; a one-day gap has always satisfied the waiting rule.

C. No; but only because a written SOA cannot be used for in-person appointments.

D. No; the 48-hour SOA waiting period is still in force until October 1, 2026.

Marketing, communications, SOA, events | Scenario

QUESTION 351 | T-369

Ingrid's adult daughter attends her Medicare appointment in her place with documented power of attorney. Whose name should anchor the Scope of Appointment record?

A. Ingrid's, as the beneficiary, with the daughter signing under her documented authority.

B. The daughter's, because she is the one physically present and signing.

C. Neither; POA attendance removes the requirement for any SOA at all.

D. The agent's, since the agent is the one collecting the document.

Marketing, communications, SOA, events | Scenario

QUESTION 352 | T-370

Desmond takes a beneficiary's Scope of Appointment verbally on a recorded phone call instead of in writing. What must that recording actually capture for the SOA to be valid?

A. Only a general 'yes' to being contacted again in the future.

B. The beneficiary's identity, the specific products to be discussed, the date, and clear agreement.

C. A recording of the entire subsequent sales conversation, not the scope itself.

D. Nothing beyond Desmond's own verbal summary read back at the end of the call.

Marketing, communications, SOA, events | Scenario

QUESTION 353 | T-371

Noor calls her senior-center session 'educational' on the flyer, but she seats one carrier's MA benefit brochure at every chair before attendees arrive. Does the label control how the event is classified?

A. Yes; CMS classifies events solely by the wording printed on the flyer.

B. No; but only because chairs must be arranged in rows for a sales event.

C. No; distributing plan-specific marketing material reclassifies the gathering as a sales event.

D. Yes; because the brochures were placed before the presentation began.

Marketing, communications, SOA, events | Scenario

QUESTION 354 | T-372

At a community health fair on September 15, 2026, Teresa collects signed SOA cards from attendees for later appointments. Is this action compliant with the rule in effect that day?

A. Yes; SOA collection at educational events has always been permitted.

B. Yes; because the fair was open to the general public.

C. No; but only because health fairs can never host educational content.

D. No; SOA collection at educational events remains banned until October 1, 2026.

Marketing, communications, SOA, events | Scenario

QUESTION 355 | T-373

At a Medicare sales event, Soren's team sets up a free hearing-test station and plans to prioritize follow-up calls to attendees whose results suggest hearing loss. What is the compliance problem?

A. Health screening at a marketing event can be used to target beneficiaries by health status.

B. There is no problem as long as the results stay confidential from Soren personally.

C. The only defect is that hearing tests must be performed by a licensed audiologist.

D. The only defect is that the station should have been placed farther from the entrance.

Marketing, communications, SOA, events | Scenario

QUESTION 356 | T-374

A caller who is actually a carrier's secret shopper asks Aisha detailed benefit questions. Aisha skips the SOA and answers in full because 'it's just a phone question.' What risk has Aisha created?

A. None, because secret-shopper calls are not treated as real compliance tests.

B. A compliance flag for discussing plan benefits before a valid SOA was documented.

C. None, because phone conversations are exempt from the SOA requirement.

D. A flag only if Aisha also failed to read the TPMO disclaimer.

Marketing, communications, SOA, events | Scenario

QUESTION 357 | T-375

Roland learns that a plan he sold is exiting the market next year. He wants to proactively call his affected clients about their options. Is this contact allowed?

A. No; a plan exit permanently bars the agent from contacting those clients.

B. Yes, and the exit lets Roland skip the SOA and steer everyone to one replacement plan.

C. Yes, but it remains a compliant contact governed by the normal marketing and SOA rules.

D. No; only the plan sponsor, never the agent, may contact exiting members.

Marketing, communications, SOA, events | Scenario

QUESTION 358 | T-376

A carrier notifies Mabel that a beneficiary filed a complaint alleging she misrepresented a plan's benefits. Mabel believes the complaint is inaccurate. What should she do before the carrier's response deadline?

A. Ignore the notice, since unresolved complaints are automatically dismissed after 30 days.

B. Ask the beneficiary directly to withdraw the complaint before responding to the carrier.

C. Wait for CMS to contact her directly rather than responding to the carrier's investigation.

D. Respond with her documentation, such as call recordings and SOA timestamps, before the deadline.

Marketing, communications, SOA, events | Scenario

QUESTION 359 | T-377

Felix's TPMO wants to share its full list of beneficiary leads with a partner TPMO to expand outreach. What must happen before that data can be shared for MA or Part D marketing purposes?

A. The beneficiary must give prior express written consent naming each receiving TPMO.

B. Nothing further, because one-to-one consent requirements no longer apply to TPMOs.

C. The partner TPMO must simply agree to follow the same disclaimer language.

D. The data may be shared freely once both TPMOs are licensed in the same state.

Marketing, communications, SOA, events | Scenario

QUESTION 360 | T-378

Junko's marketing emails include an opt-out link that has been broken for weeks without her noticing. Do the emails remain permitted unsolicited contact during that time?

A. Yes; the presence of any opt-out link satisfies the requirement regardless of function.

B. No; the email exception applies only when the opt-out mechanism actually works.

C. Yes; broken links only matter if a recipient formally complains.

D. No; but only because emails require a physical mailing address instead.

Marketing, communications, SOA, events | Scenario

QUESTION 361 | T-379

Otis buys a 2027 lead list and has a vendor drop ringless sales voicemails onto every number without any prior request from those consumers. Is this outreach compliant?

A. Yes; ringless delivery avoids the unsolicited-contact restriction because the phone never rings.

B. Yes; purchasing the list creates the consent needed for direct outreach.

C. No; ringless voicemail remains a prohibited unsolicited-contact method regardless of delivery technique.

D. No; but only because the vendor, not Otis, placed the calls.

Marketing, communications, SOA, events | Scenario

QUESTION 362 | T-380

Selma sends compliant Medicare direct mail to a beneficiary who is on a general do-not-contact list maintained for phone and text outreach. Is the mailing permitted?

A. No; a do-not-contact listing blocks every channel, including postal mail.

B. No; only beneficiaries who never joined a do-not-contact list may receive mail.

C. Yes; but only if Selma first obtains a signed SOA from the recipient.

D. Yes; direct mail carries no opt-out requirement under the unsolicited-contact rules.

Marketing, communications, SOA, events | Scenario

QUESTION 363 | T-381

Bruno's CRM is configured to automatically block contact for 48 hours after any SOA is signed, even for appointments scheduled after October 1, 2026. Does CMS require this waiting period?

A. No; the waiting period was eliminated, and nothing requires a new minimum delay instead.

B. Yes; the 48-hour wait continues to apply to every SOA regardless of date.

C. Yes; eliminating the old wait created a mandatory same-day contact rule instead.

D. No; and Bruno's CRM setting is itself a violation that must be removed immediately.

Marketing, communications, SOA, events | Scenario

QUESTION 364 | T-382

After learning CMS dropped the requirement to keep documentation on file for superlative claims, Ada plans to discard her substantiation records for 'top-rated plan' language she used last quarter. Is discarding them a good idea?

A. Yes; once documentation is not required, keeping it serves no purpose at all.

B. Not necessarily; the underlying ban on misleading or unsubstantiated claims still applies.

C. No; discarding records now would itself violate a CMS retention requirement.

D. Yes; superlative claims are entirely unregulated once the filing requirement is dropped.

Marketing, communications, SOA, events | Scenario

QUESTION 365 | T-383

A vendor tells Pilar that CMS finalized a rule banning marketing the dollar value of a plan's supplemental debit-card benefit. Should Pilar rely on that claim?

A. Yes; the dollar-value marketing ban took effect along with the rest of CY2027.

B. Yes; but only debit cards issued after October 1, 2026 are covered.

C. No; that specific proposal was not finalized, though other debit-card administration guardrails were.

D. No; because CMS never proposed any rule addressing debit-card benefits at all.

Marketing, communications, SOA, events | Scenario

QUESTION 366 | T-384

One of Corwin's recorded calls covers both the sales pitch and the beneficiary's enrollment. How should the retention period for that single recording be handled?

A. The entire recording follows the shorter marketing-call retention period.

B. The call must be deleted once either portion reaches its retention limit.

C. Retention no longer applies once a call includes both a pitch and an enrollment.

D. The enrollment-evidence portion stays on the longer clock even though the marketing-only portion can roll off sooner.

Marketing, communications, SOA, events | Scenario

QUESTION 367 | T-385

A beneficiary signs an SOA with Delphine but ultimately decides not to enroll in any plan. Does that SOA still need to be retained for the same period as one that led to enrollment?

A. Yes; retention attaches to the SOA as a marketing-contact record regardless of the outcome.

B. No; SOAs from beneficiaries who decline may be discarded immediately.

C. No; only SOAs tied to a completed enrollment carry any retention duty.

D. Yes; but only if Delphine personally chooses to keep the file.

Marketing, communications, SOA, events | Scenario

QUESTION 368 | T-386

At the end of his educational talk, Griffin mumbles a quick transition and immediately begins handing out enrollment forms before anyone can leave the room. What safeguard has Griffin failed to provide?

A. A restored twelve-hour separation between the two sessions.

B. A clear transition notice and a meaningful opportunity to leave before marketing activity begins.

C. A second SOA collected specifically for the enrollment-form portion.

D. A written waiver signed by each attendee agreeing to stay for the pitch.

Marketing, communications, SOA, events | Scenario

QUESTION 369 | T-387

A prospect returns Petra's generic business reply card requesting general information. Petra emails back with the plan's specific deductible and copay amounts. Is the follow-up email classified the same way as the original card?

A. Yes; a follow-up automatically inherits the classification of the piece it answers.

B. Yes; because responding to a request can never itself become marketing.

C. No; the follow-up is evaluated separately and meets the content prong on its own.

D. No; but only because email is a different channel than the original card.

Marketing, communications, SOA, events | Scenario

QUESTION 370 | T-388

Cassius enters every attendee who completes an enrollment application on-site into a raffle for a large television. Attendees who do not enroll are not eligible for the drawing. What is the problem with this raffle?

A. Raffles of any kind are banned at every Medicare marketing event.

B. The television is too small a prize to raise any inducement concern.

C. The problem is only that Cassius failed to announce the odds of winning.

D. Entry is conditioned on enrolling, making the raffle a prohibited inducement.

Marketing, communications, SOA, events | Scenario

QUESTION 371 | T-389

A user publicly comments on Winona's social media post asking what Medicare plans she sells. Winona replies with a direct message answering the question. Has Winona engaged in a prohibited unsolicited contact?

A. No; replying to the user's own public question is a response to beneficiary-initiated contact.

B. Yes; any direct message sent by an agent is treated as unsolicited outreach.

C. Yes; social media replies are banned regardless of who spoke first.

D. No; but only because the platform is not covered by the unsolicited-contact rule.

Marketing, communications, SOA, events | Scenario

QUESTION 372 | T-390

Vikram's agency installs a website chatbot that automatically generates specific plan premium comparisons for any visitor who types in a plan name. How should this chatbot content be treated?

A. As a communication, because a chatbot is automated rather than written by a person.

B. As marketing, because it produces plan-specific comparative content designed to influence enrollment.

C. As exempt from CMS review because no human agent typed the response.

D. As marketing only for visitors who ultimately request an application.

Marketing, communications, SOA, events | Scenario

QUESTION 373 | T-391

Last year an agent cold-called Odalys without her consent, which was itself a violation. Today Odalys calls that same agent on her own to ask about plans. May the agent discuss plans with her now?

A. No; last year's violation permanently bars any future contact with Odalys.

B. Yes, and today's call also erases the record of last year's violation.

C. Yes, with a proper SOA; today's call is beneficiary-initiated and stands on its own.

D. No; the agent must first report last year's call to CMS before responding.

Marketing, communications, SOA, events | Scenario

QUESTION 374 | T-392

When may an agent discuss specific Medicare plan options with a beneficiary without first obtaining a signed Scope of Appointment?

A. Whenever the appointment takes place over video instead of in person.

B. Whenever the beneficiary is already enrolled in one of the agent's plans.

C. Whenever the discussion happens at an approved educational event.

D. When the beneficiary unexpectedly walks in or calls the agent on their own initiative.

Marketing, communications, SOA, events | Direct Knowledge

QUESTION 375 | T-393

What must occur before an agent discusses specific plan benefits, whether or not a Scope of Appointment already exists for that conversation?

A. Reading the required TPMO disclaimer to the beneficiary.

B. Offering the beneficiary a printed comparison of every available plan.

C. Waiting the full 48 hours previously required after the SOA was signed.

D. Confirming the beneficiary's Medicare number and Social Security number.

Marketing, communications, SOA, events | Direct Knowledge

QUESTION 376 | T-394

Which element was removed from the standardized TPMO disclaimer effective October 1, 2026, while the rest of the disclaimer stayed in place?

A. The statement that the agent may not represent every available plan.

B. The sentence referring beneficiaries to their State Health Insurance Assistance Program.

C. The reference directing beneficiaries to Medicare.gov.

D. The reference directing beneficiaries to 1-800-MEDICARE.

Marketing, communications, SOA, events | Direct Knowledge

QUESTION 377 | T-395

Under the current recordkeeping rule for recorded sales calls, which portion of the recording keeps the longer, ten-year retention period?

A. The portion covering only the agent's initial greeting and disclaimer.

B. The entire call, once any part of it discusses enrollment.

C. The portion of the call that evidences the beneficiary's enrollment.

D. No portion; the whole recording now follows a single six-year period.

Marketing, communications, SOA, events | Direct Knowledge

QUESTION 378 | T-396

What happened to the requirement to wait 48 hours between a signed Scope of Appointment and the marketing discussion it covers, effective October 1, 2026?

A. The waiting period was extended from 48 hours to 72 hours.

B. The waiting period was eliminated along with the SOA requirement itself.

C. The waiting period now applies only to appointments scheduled by phone.

D. The waiting period was eliminated, though the SOA itself is still required.

Marketing, communications, SOA, events | Direct Knowledge

QUESTION 379 | T-397

What replaced the former mandatory twelve-hour separation between an educational event and a sales event held at the same location?

A. A required clear transition notice and a meaningful opportunity for attendees to leave.

B. No requirement at all; the two events may now run together without any notice.

C. A shortened but still-mandatory two-hour separation between the sessions.

D. A requirement that attendees sign a waiver agreeing to stay for both sessions.

Marketing, communications, SOA, events | Direct Knowledge

QUESTION 380 | T-398

What did CMS change about superlative marketing claims, such as calling a plan the 'best' option, for CY2027?

A. It banned all superlative language from Medicare marketing materials entirely.

B. It dropped the requirement to keep supporting documentation on file, while still banning misleading claims.

C. It required superlative claims to be pre-approved by CMS before each use.

D. It made superlative claims subject only to state-level insurance review.

Marketing, communications, SOA, events | Direct Knowledge

QUESTION 381 | T-399

How does a Permission to Contact form differ from a Scope of Appointment in what it authorizes?

A. A PTC and an SOA authorize exactly the same set of activities.

B. A PTC requires a product-type checklist, while an SOA does not.

C. A PTC authorizes future outreach, while only an SOA documents which product types may be discussed.

D. A PTC replaces the need for any SOA once it is signed.

Marketing, communications, SOA, events | Direct Knowledge

QUESTION 382 | T-400

Which locations inside a health-care facility remain available for compliant Medicare plan marketing, subject to facility and CMS rules?

A. Any examination room, as long as the patient consents in advance.

B. The pharmacy counter, because prescriptions are picked up there.

C. Any treatment area, provided the agent wears a visible identification badge.

D. Appropriate public common areas, such as a lobby or cafeteria.

Marketing, communications, SOA, events | Direct Knowledge

QUESTION 383 | T-401

What became newly allowed at educational events effective October 1, 2026, that had previously been prohibited since 2023?

A. Making Scope of Appointment forms available and collecting them from attendees.

B. Distributing plan-specific benefit comparisons during the educational session.

C. Accepting completed enrollment applications during the educational session.

D. Discussing a named plan's premium during the educational session.

Marketing, communications, SOA, events | Direct Knowledge

QUESTION 384 | T-402

Can a piece satisfy the marketing definition's content prong by naming a specific plan alone, without any premium, benefit, or comparison language?

A. No; the content prong always requires at least premium or benefit detail.

B. Yes; plan identification by itself can satisfy the content prong.

C. No; naming a plan only matters if a comparison to another plan is also present.

D. Yes; but only when the piece is distributed at a marketing event.

Marketing, communications, SOA, events | Direct Knowledge

QUESTION 385 | T-403

Which requirement applies to compliant unsolicited marketing email but has no equivalent for compliant unsolicited direct mail?

A. A signed Scope of Appointment attached to each message.

B. Prior approval from CMS before the message is sent.

C. A working opt-out mechanism that the sender honors.

D. A requirement that the recipient already be an enrolled member.

Marketing, communications, SOA, events | Direct Knowledge

QUESTION 386 | T-404

Which type of information, on its own, can independently satisfy the content prong of the marketing definition?

A. A general statement that the agency helps people understand Medicare.

B. A description of the agent's years of industry experience.

C. An invitation to call the office for more information.

D. A plan-specific performance measure, such as a Star Rating.

Marketing, communications, SOA, events | Direct Knowledge

QUESTION 387 | T-405

Besides meeting the content standard, what else must a piece meet before it is regulated as marketing rather than a plain communication?

A. An intent standard, showing it is designed to influence an enrollment or retention decision.

B. Approval from the beneficiary's physician confirming the content is accurate.

C. Distribution through a licensed insurance agent rather than any other employee.

D. A minimum print run large enough to reach a defined number of households.

Marketing, communications, SOA, events | Direct Knowledge

QUESTION 388 | T-406

What must a sponsor generally do before holding a formal Medicare marketing or sales event, that is not required for an informal educational gathering?

A. Obtain a signed SOA from every attendee before the doors open.

B. Report the event to CMS in advance.

C. Secure a separate marketing license for the specific venue.

D. Publish the event only through printed newspaper advertising.

Marketing, communications, SOA, events | Direct Knowledge

QUESTION 389 | T-407

For how long must a signed Scope of Appointment generally be retained, regardless of whether the beneficiary went on to enroll?

A. Six years, the same shortened period as the marketing-only portion of a recorded call.

B. Three years, matching the first phase of the call-recording retention schedule.

C. Ten years, the same period as other enrollment-related compliance records.

D. No fixed period; retention is left to each agent's own discretion.

Marketing, communications, SOA, events | Direct Knowledge

QUESTION 390 | T-408

What must a beneficiary's consent specify before a TPMO may share the beneficiary's personal data with another TPMO for MA or Part D marketing purposes?

A. Only that the beneficiary agrees to be contacted about Medicare in general.

B. Only the general category of insurance products the data may support.

C. The state where the receiving TPMO is licensed to do business.

D. Each specific receiving entity, so the beneficiary can accept or reject each one.

Marketing, communications, SOA, events | Direct Knowledge

QUESTION 391 | T-409

Which CY2027 marketing proposal involving supplemental-benefit debit cards did CMS ultimately decline to finalize?

A. A cap on marketing the dollar value of the debit-card benefit.

B. A requirement that debit cards display the plan's Star Rating.

C. A ban on issuing debit cards to newly enrolled members.

D. A requirement that debit-card marketing be pre-approved by the beneficiary's physician.

Marketing, communications, SOA, events | Direct Knowledge

QUESTION 392 | T-410

Under the intent standard of the marketing definition, what kind of enrollment-related decision can bring a communication within the definition of marketing?

A. Only a decision to newly enroll in a plan for the first time.

B. A decision to remain enrolled in a plan, not only a decision to newly enroll.

C. Only a decision to disenroll from a plan during an election period.

D. Only a decision to switch from one plan sponsor to a competing one.

Marketing, communications, SOA, events | Direct Knowledge

QUESTION 393 | T-411

How does CMS determine whether an organization is a TPMO for purposes of Medicare marketing rules?

A. By whether the organization's own materials use the word 'TPMO' to describe itself.

B. By whether the organization is a plan sponsor rather than an independent vendor.

C. By the lead-generation, marketing, sales, or enrollment functions it actually performs.

D. By the number of states in which the organization is licensed.

Marketing, communications, SOA, events | Direct Knowledge

QUESTION 394 | T-412

A new agent proposes cold-calling beneficiaries from a purchased list 'just to introduce myself, not to sell anything.' Should a compliance reviewer approve this plan?

A. Yes; introductory calls are exempt as long as no plan is mentioned.

B. Yes; purchasing the list establishes the needed permission to call.

C. No; but only because the agent has not yet completed annual certification.

D. No; an unsolicited outbound call is prohibited regardless of the agent's stated purpose.

Marketing, communications, SOA, events | Compliance Judgment

QUESTION 395 | T-413

A field manager tells new agents they can skip the TPMO disclaimer 'as long as the call never gets to plan specifics.' Should compliance approve this guidance?

A. No; the safe practice is to read the disclaimer before any call that could turn into a benefits discussion.

B. Yes; the disclaimer is only required once an enrollment form is signed.

C. Yes; skipping the disclaimer is fine on any purely introductory call.

D. No; but only because the manager lacks authority to issue any compliance guidance.

Marketing, communications, SOA, events | Compliance Judgment

QUESTION 396 | T-414

To reduce storage costs, an office manager proposes retaining all signed SOA and enrollment records for only six years instead of the current schedule. Should compliance approve this change?

A. Yes; six years applies uniformly to every marketing and enrollment record.

B. No; SOA and enrollment-evidence records must be retained for the longer, ten-year period.

C. Yes; storage cost is an accepted basis for shortening any retention period.

D. No; but only because paper records require longer retention than digital ones.

Marketing, communications, SOA, events | Compliance Judgment

QUESTION 397 | T-415

A supervisor proposes giving every attendee who completes an on-site enrollment application a gas gift card. Should compliance approve this incentive?

A. Yes; gift cards are always treated as nominal items regardless of value or condition.

B. Yes; as long as the card cannot be used to purchase gasoline for resale.

C. No; conditioning a spendable card on enrollment is a prohibited inducement.

D. No; but only because gas prices fluctuate and the value cannot be fixed.

Marketing, communications, SOA, events | Compliance Judgment

QUESTION 398 | T-416

An agent plans a senior-center 'resource fair,' labeled educational, where invited carrier representatives will hand out branded MA rate sheets to attendees. What should compliance require?

A. Approve the event as educational because the invitation used the word 'resource.'

B. Approve the event as educational as long as no application forms are present.

C. Require carrier representatives to leave, but keep the rate sheets on the tables.

D. Reclassify the gathering as a marketing or sales event because of the branded rate sheets.

Marketing, communications, SOA, events | Compliance Judgment

QUESTION 399 | T-417

A TPMO's intake form asks beneficiaries to consent generally to being contacted, then the TPMO wants to treat that single signature as consent to share data with any future partner TPMO. Is this sufficient?

A. No; consent must identify each specific receiving TPMO for the beneficiary to accept or reject.

B. Yes; one signed consent to future contact covers any later data-sharing partner.

C. Yes; as long as the intake form is updated once a year.

D. No; but only because the beneficiary must re-sign for every new plan year.

Marketing, communications, SOA, events | Compliance Judgment

QUESTION 400 | T-418

Running short on time, an agent begins comparing plan benefits and plans to read the TPMO disclaimer 'at the end' of the call. What should compliance direct?

A. Allow the deferral as long as the disclaimer is eventually read before the call ends.

B. Require the disclaimer before any benefits discussion, not deferred to the end of the call.

C. Allow the deferral only for calls under a set number of minutes.

D. Require the disclaimer only if the beneficiary asks about compensation.

Marketing, communications, SOA, events | Compliance Judgment

QUESTION 401 | T-419

A marketing coordinator wants to send a text blast to current enrollees warning of an upcoming rate increase, reasoning that 'current members don't count as unsolicited contact.' Is that reasoning correct?

A. Yes; existing enrollment status removes any beneficiary from unsolicited-contact protection.

B. Yes; rate-increase notices are treated as neutral communications exempt from the rule.

C. No; an unrequested text to enrollees who have not initiated contact is still prohibited.

D. No; but only because rate-increase content always requires prior CMS approval.

Marketing, communications, SOA, events | Compliance Judgment

QUESTION 402 | T-420

A manager tells an agent to keep offering clients a voluntary 48-hour wait after signing an SOA dated October 3, 2026, 'just to be extra safe.' Is CMS requiring that wait?

A. Yes; the 48-hour wait still applies to every SOA regardless of date.

B. No; and offering any voluntary delay is itself now a compliance violation.

C. Yes; but only for appointments scheduled during the AEP period.

D. No; the requirement was eliminated, though choosing to wait voluntarily is not itself a violation.

Marketing, communications, SOA, events | Compliance Judgment

QUESTION 403 | T-421

Compliance reviews an educational-event slide deck dated August 2026 that invites attendees to sign SOA forms on the spot during the session. Is this content acceptable for that date?

A. No; SOA collection at educational events was still banned before the October 1, 2026 change.

B. Yes; SOA collection has always been permitted at educational events.

C. Yes; the slide is acceptable as long as no plan benefits are also discussed.

D. No; but only because slide decks require CMS pre-approval regardless of content.

Marketing, communications, SOA, events | Compliance Judgment

QUESTION 404 | T-422

Assess this statement: 'The walk-in/call-in exception to the SOA requirement applies even when a beneficiary approaches an agent's table inside an organized, CMS-reportable sales event.' Which option is correct?

A. True; any unscheduled approach anywhere qualifies for the exception.

B. False; inside an organized sales event, standard SOA-before-discussion rules apply to every attendee.

C. False; the exception was eliminated entirely along with the 48-hour wait.

D. True; but only if the beneficiary approaches during the first hour of the event.

Marketing, communications, SOA, events | Alt Format / True False

QUESTION 405 | T-423

Assess this statement: 'The CY2027 rule eliminated both the twelve-hour educational-to-sales gap and the underlying requirement to obtain a Scope of Appointment.' Which option is correct?

A. True; both requirements were eliminated on the same effective date.

B. False; neither requirement changed under the CY2027 rule.

C. False; the twelve-hour gap was eliminated, but the SOA requirement itself remains.

D. True; only the SOA requirement was eliminated, while the twelve-hour gap remains.

Marketing, communications, SOA, events | Alt Format / True False

QUESTION 406 | T-424

Assess this statement: 'A plan-neutral notice announcing new customer-service hours, with no benefit, cost, or comparison language, remains a communication because it fails the content prong.' Which option is correct?

A. False; any notice sent by a plan automatically becomes marketing.

B. False; customer-service hours are treated as comparative content.

C. True; but only because the notice also fails the intent standard entirely.

D. True; without benefit, cost, or comparison content, the piece does not meet the content prong.

Marketing, communications, SOA, events | Alt Format / True False

QUESTION 407 | T-425

Match each item to its correct description: a mail-in card requesting more information, the statement read before discussing plan benefits, and the form authorizing future contact without a product checklist. Which sequence is accurate?

A. Business reply card; TPMO disclaimer; Permission to Contact.

B. TPMO disclaimer; Permission to Contact; business reply card.

C. Permission to Contact; business reply card; TPMO disclaimer.

D. Business reply card; Permission to Contact; TPMO disclaimer.

Marketing, communications, SOA, events | Alt Format / Matching

QUESTION 408 | T-426

Match each record type to its retention period: the marketing-only portion of a recorded call, the enrollment-evidence portion of that same call, and a signed Scope of Appointment. Which sequence is accurate?

A. Ten years; six years; six years.

B. Six years; ten years; ten years.

C. Six years; six years; ten years.

D. Ten years; ten years; six years.

Marketing, communications, SOA, events | Alt Format / Matching

QUESTION 409 | T-427

Select the group of outreach channels that may be used compliantly without the beneficiary having contacted the agent first: which combination is correct?

A. Unrequested sales texts and ringless voicemail drops to a purchased list.

B. Uninvited door-to-door visits and unsolicited social-media direct messages.

C. Compliant postal direct mail and marketing email with a working, honored opt-out.

D. Cold outbound calls and ringless voicemail drops to a purchased list.

Marketing, communications, SOA, events | Alt Format / Select All

QUESTION 410 | T-428

Select the group of activities that must not occur during an educational event even after the CY2027 changes: which combination is correct?

A. Making SOA forms available and collecting signed SOA forms.

B. General Parts A through D instruction and answering attendee questions.

C. Distributing a printed schedule and providing light refreshments.

D. Plan-specific benefit comparisons and collecting completed enrollment applications.

Marketing, communications, SOA, events | Alt Format / Select All

Topic Set - TPMOs, call recording, permission to contact

40 questions. Choose one answer per item; answers and full rationales are in Part II.

QUESTION 411 | T-083

A TPMO agent discusses two plans' premiums and networks during a web meeting with audio enabled. The agent proposes recording only the enrollment portion if the beneficiary applies. What is required?

A. Only the final signature screen must be retained.

B. Recording is optional because the call used a web platform.

C. The marketing and sales audio must be recorded in its entirety.

D. The call may be reconstructed later from the agent's notes.

TPMOs, call recording, permission to contact | Scenario

QUESTION 412 | T-084

A customer-service employee calls a member only to confirm the mailing address for a replacement ID card. No plan choice, benefits, sales, or enrollment is discussed. Does the specific TPMO marketing-call mandate apply?

A. Yes, because every call with a Medicare beneficiary is a sales call.

B. Yes, but only the employee's side of the call must be captured.

C. No, and the organization may ignore every other recordkeeping rule.

D. No; this purely administrative interaction falls outside that particular recording mandate.

TPMOs, call recording, permission to contact | Scenario

QUESTION 413 | T-085

A TPMO wants to delete a sales-call audio file after eighteen months and retain only an automated transcript for the rest of its marketing-record period. How should the archive policy be corrected?

A. Keep the audio for the first three years and retain the marketing or sales record for at least six years.

B. Keep only the transcript from the day of the call because format never matters.

C. Delete every non-enrollment call as soon as the beneficiary declines the plan.

D. Retain the audio for one month and rely on agent memory afterward.

TPMOs, call recording, permission to contact | Scenario

QUESTION 414 | T-086

A lead form says personal data may be shared with trusted partners and provides one checkbox approving an unnamed network of TPMOs. What defect must be fixed before sharing?

A. The form must promise that every recipient offers the same plans.

B. Each receiving TPMO must be named and separately accepted or rejected through prior written consent.

C. The data must be shared first so the beneficiary can decide after receiving calls.

D. The form must remove all beneficiary choices and make sharing mandatory.

TPMOs, call recording, permission to contact | Scenario

QUESTION 415 | T-087

When must a TPMO agent deliver the current standardized disclaimer during a sales call?

A. After the enrollment is complete and the beneficiary can no longer compare plans.

B. Only if the beneficiary asks whether the agent represents every plan.

C. Before discussing plan benefits, using the current required content.

D. At the end of the call after all benefit and cost claims.

TPMOs, call recording, permission to contact | Direct Knowledge

QUESTION 416 | T-088

How does Permission to Contact differ from a Scope of Appointment?

A. Permission to Contact lists every product that may be sold, while an SOA authorizes cold calling.

B. They are interchangeable names for the same enrollment signature.

C. An SOA allows data sharing among unnamed TPMOs, while contact permission records a sale.

D. Permission allows outreach; the SOA documents product categories for a personal marketing appointment.

TPMOs, call recording, permission to contact | Direct Knowledge

QUESTION 417 | T-089

A vendor plans to telephone people from a purchased lead list and disclose during the call that their information will be sent to an agent. What should compliance require instead?

A. Obtain a valid beneficiary basis for contact and present required lead disclosures before the relevant data use or transfer.

B. Treat ownership of the list as prior express consent from every person named.

C. Allow the calls if each agent deletes the numbers after enrollment.

D. Use a generic partner label so no receiving entity can be identified.

TPMOs, call recording, permission to contact | Compliance Judgment

QUESTION 418 | T-090

Examine four sponsor-oversight statements. I. Agents must complete annual Medicare training and testing. II. Sponsors must monitor applicable licensing and appointment. III. TPMO arrangements must support monthly reporting of specified disciplinary actions. IV. Delegating sales ends the sponsor's oversight responsibility. Which response identifies all accurate statements?

A. Statements I and IV.

B. Statements I, II, and III.

C. Statements II and IV only.

D. Statements III and IV only.

TPMOs, call recording, permission to contact | Alt Format / Select All

QUESTION 419 | T-429

A TPMO's web-meeting platform records video and audio together, and the agent asks whether muting the beneficiary's microphone during the plan-comparison segment is acceptable if the enrollment portion stays fully recorded. What must the agent do instead?

A. Keep the beneficiary's audio active throughout the entire marketing, sales, and enrollment portion of the call.

B. Mute only the beneficiary's side because agent-only audio satisfies the requirement.

C. Record video without capturing any audio at all.

D. Skip recording until the beneficiary formally applies for a plan.

TPMOs, call recording, permission to contact | Scenario

QUESTION 420 | T-430

During a recorded phone call, Marcus obtains a beneficiary's verbal Scope of Appointment but only asks, 'Is it okay if we talk today?' before moving into a benefits comparison. What is missing from this verbal SOA?

A. A written signature witnessed by a notary.

B. Confirmation of the beneficiary's identity and the specific product types to be discussed.

C. A promise that the beneficiary will enroll before the call ends.

D. A separate Permission to Contact form filled out afterward.

TPMOs, call recording, permission to contact | Scenario

QUESTION 421 | T-431

Dolores declines to sign a paper Scope of Appointment but clearly states her agreement on a call the agency records and retains. Does her verbal confirmation satisfy the SOA requirement?

A. No, because only a handwritten signature can ever satisfy an SOA.

B. No, because a phone-based SOA requires a notarized transcript.

C. Yes, a properly captured recorded verbal confirmation can satisfy the requirement.

D. Yes, but only if the beneficiary later signs the same form in person.

TPMOs, call recording, permission to contact | Scenario

QUESTION 422 | T-432

A lead-generation vendor plans an automated pre-recorded voice-message campaign to a purchased list of Medicare beneficiaries who never requested contact. Is this campaign permitted under the current unsolicited-contact rules?

A. Yes, because purchased lists always establish a beneficiary relationship.

B. Yes, as long as the recording discloses the sponsor's name.

C. No, because all forms of marketing contact are now banned.

D. No, prerecorded voice messages remain outside the permitted unsolicited-contact channels.

TPMOs, call recording, permission to contact | Scenario

QUESTION 423 | T-433

An agency wants to send an email newsletter describing three plans' premiums to prospects who never opted in, and the email includes a working unsubscribe link. Does this satisfy the permitted unsolicited-contact channel for marketing email?

A. Yes, marketing email is permitted when a functioning opt-out mechanism is included.

B. No, marketing email is banned regardless of any opt-out link.

C. Yes, but only if the recipient already purchased a plan.

D. No, because email requires the same consent standard as text messages.

TPMOs, call recording, permission to contact | Scenario

QUESTION 424 | T-434

A brokerage instructs canvassers to knock on doors in a senior housing complex without any resident having requested a visit or scheduled an appointment. Is this door-to-door approach compliant?

A. Yes, because in-person contact is always exempt from unsolicited-contact rules.

B. No, unsolicited in-person outreach without an invitation is not a permitted channel.

C. Yes, provided the canvasser carries a printed brochure instead of speaking.

D. No, because senior housing complexes require a special waiver to visit at all.

TPMOs, call recording, permission to contact | Scenario

QUESTION 425 | T-435

Lena's agency runs an educational seminar and, once the presentation ends, immediately begins one-on-one enrollment pitches in the same room without telling attendees the event has changed purpose. What compliance step did the agency skip?

A. Obtaining a written Scope of Appointment from every seminar attendee before the seminar begins.

B. Waiting a fixed number of hours between the seminar and any sales contact.

C. Providing a notice of transition and a genuine opportunity for attendees to leave.

D. Filing the educational event with the state insurance department in advance.

TPMOs, call recording, permission to contact | Scenario

QUESTION 426 | T-436

At an educational event held after October 1, 2026, an attendee approaches Marcus and asks to complete a Scope of Appointment on the spot before any sales discussion begins. May Marcus collect it at that event?

A. No, an SOA can never be collected at any educational event.

B. No, an SOA may only be mailed to the beneficiary's home afterward.

C. Yes, but only if the beneficiary waits a fixed number of hours first.

D. Yes, current rules permit SOA collection at the educational event itself.

TPMOs, call recording, permission to contact | Scenario

QUESTION 427 | T-437

An agency offers every attendee at a marketing event a small tote bag regardless of whether they enroll, while a separate raffle prize is a gift card that can be redeemed for cash at any retailer. Which part of this plan is not compliant?

A. The cash-redeemable gift card, because gifts may never function as cash equivalents.

B. The tote bag, because gifts must never be offered to non-enrollees.

C. The tote bag, because gifts require a written waiver signed in advance.

D. The raffle format itself, because prize drawings are entirely prohibited at marketing events.

TPMOs, call recording, permission to contact | Scenario

QUESTION 428 | T-438

A TPMO obtains a beneficiary's written consent naming a specific partner organization before sharing her contact information, then that partner later forwards her data to a third TPMO she never approved. What compliance defect occurred?

A. No defect occurred because the original consent covers any future recipient automatically.

B. The third TPMO received data without its own separately identified prior written consent.

C. No defect occurred because the beneficiary can object only after enrollment.

D. The defect is that the original consent should have been given orally instead of in writing.

TPMOs, call recording, permission to contact | Scenario

QUESTION 429 | T-439

A regional FMO delegates lead intake, appointment setting, and enrollment support to a subcontracted call center, and the FMO's leadership later argues the call center's compliance failures are not the FMO's problem. Is that position accurate?

A. Yes, once a function is subcontracted the delegating entity has no further duty.

B. Yes, but only because the call center calls itself an independent business.

C. No, oversight responsibility continues throughout the delegated first-tier, downstream, and TPMO chain.

D. No, but only if the FMO signed no written contract with the call center.

TPMOs, call recording, permission to contact | Scenario

QUESTION 430 | T-440

A carrier's mystery-shopper program places a call posing as a prospective enrollee, and the agent skips the required disclaimer because the call sounded informal. What should the agent have assumed about every prospect call?

A. That informal-sounding callers are exempt from standard disclosure requirements.

B. That disclaimers are only required once a caller confirms genuine interest.

C. That monitoring only happens at in-person events, never by phone.

D. That any prospect call could be monitored or recorded and later reviewed.

TPMOs, call recording, permission to contact | Scenario

QUESTION 431 | T-441

A compliance auditor pulls a marketing call from month four after it occurred and finds only a written transcript on file, with no audio available for months one through three. What does this gap violate?

A. The audio-retention requirement covering the first three years after the call.

B. Nothing, because a transcript alone is always sufficient for the full retention period.

C. The requirement that recordings be destroyed within thirty days of the call.

D. A rule that bars retaining any sales call beyond the calendar year it occurred.

TPMOs, call recording, permission to contact | Scenario

QUESTION 432 | T-442

An agent's supervisor tells her that a follow-up voicemail confirming a scheduled appointment does not need to be recorded because it happens after the sales conversation already occurred. Is the supervisor correct?

A. Yes, because only the very first call in a sequence must ever be recorded.

B. No, if the voicemail still involves marketing, sales, or enrollment content it remains covered.

C. Yes, because voicemail messages are never considered part of a sales call.

D. No, but only because appointment confirmations must always be handwritten instead.

TPMOs, call recording, permission to contact | Scenario

QUESTION 433 | T-443

Which unsolicited-contact channel is included on the current permitted list?

A. Prerecorded robocall voice drops.

B. Unsolicited text messages without prior consent.

C. Direct mail and print advertising.

D. Unscheduled door-to-door visits.

TPMOs, call recording, permission to contact | Direct Knowledge

QUESTION 434 | T-444

What happened to the 48-hour waiting period between a signed Scope of Appointment and the related sales contact under the current rules?

A. It was extended to a mandatory 72-hour window.

B. It was replaced with a same-day contact requirement.

C. It now applies only to in-person appointments.

D. It was eliminated, though the SOA itself is still required.

TPMOs, call recording, permission to contact | Direct Knowledge

QUESTION 435 | T-445

Which statement accurately describes the CY2027 change to superlative claims such as 'top-rated plan'?

A. Supporting documentation no longer must be kept on file, but misleading claims remain prohibited.

B. Superlative claims are now completely banned in any marketing material.

C. Superlative claims require notarized substantiation before each use.

D. Superlative claims may now be used only during the Annual Election Period.

TPMOs, call recording, permission to contact | Direct Knowledge

QUESTION 436 | T-446

What best distinguishes a marketing communication from a general communication under the applicable two-part test?

A. Whether the piece is printed rather than delivered electronically.

B. Whether the piece meets both an intent prong and a content prong.

C. Whether the piece names a beneficiary's current physician.

D. Whether the piece is produced by the plan sponsor rather than an agent.

TPMOs, call recording, permission to contact | Direct Knowledge

QUESTION 437 | T-447

Under the applicable framework, what generally distinguishes a first-tier entity from a downstream entity in the FDR chain?

A. Whether the entity has ever sold a Medicare Advantage plan.

B. Whether the entity is a corporation rather than an individual.

C. The entity's position in the contract chain relative to the plan sponsor.

D. Whether the entity charges a commission for its services.

TPMOs, call recording, permission to contact | Direct Knowledge

QUESTION 438 | T-448

Which condition must a compliant prospect gift always satisfy regardless of its form?

A. It must be redeemable for cash at the recipient's discretion.

B. It must be reserved only for people who ultimately enroll.

C. It must exceed a substantial dollar value to attract attention.

D. It must never function as cash or a cash equivalent.

TPMOs, call recording, permission to contact | Direct Knowledge

QUESTION 439 | T-449

What must the current standardized TPMO disclaimer still direct consumers toward, even after the CY2027 content change?

A. Medicare.gov and 1-800-MEDICARE as independent information resources.

B. The agent's personal client-satisfaction ratings.

C. A specific competitor's published premium list.

D. The agency's internal complaint-resolution hotline only.

TPMOs, call recording, permission to contact | Direct Knowledge

QUESTION 440 | T-450

Which method is NOT an accepted way to document a valid Scope of Appointment under current guidance?

A. A paper form signed by the beneficiary.

B. An unrecorded verbal exchange with no documentation retained afterward.

C. An electronic or e-signature capture.

D. A recorded verbal confirmation capturing the required elements.

TPMOs, call recording, permission to contact | Direct Knowledge

QUESTION 441 | T-451

What is the general purpose of the annual TPMO and agent training-and-testing requirement?

A. To replace the need for any state insurance license.

B. To certify agents for a single carrier only, regardless of other appointments.

C. To confirm agents and TPMO personnel understand current Medicare marketing and compliance rules before selling.

D. To satisfy a one-time requirement that never needs repeating.

TPMOs, call recording, permission to contact | Direct Knowledge

QUESTION 442 | T-452

What is the general effect of a plan sponsor delegating enrollment functions to a downstream TPMO?

A. The sponsor's Medicare contract responsibilities transfer entirely to the TPMO.

B. The delegation automatically expires after each contract year without renewal.

C. The beneficiary must separately approve the delegation before any call occurs.

D. The sponsor retains monitoring and oversight duties over the delegated functions.

TPMOs, call recording, permission to contact | Direct Knowledge

QUESTION 443 | T-453

A field manager tells new agents to fill in the Scope of Appointment date as the day of the sales meeting even when it was actually signed two days earlier, calling it a harmless cleanup. How should an agent respond?

A. Refuse, because the SOA must reflect the date it was actually executed.

B. Comply, since backdating is allowed as long as the beneficiary later confirms it.

C. Comply, but only note the correction in a private file.

D. Refuse only if the beneficiary complains about the date first.

TPMOs, call recording, permission to contact | Compliance Judgment

QUESTION 444 | T-454

A compliance officer learns that a lead vendor has been transferring beneficiary contact data to a second TPMO using a single generic consent checkbox that never names the recipient. What must the officer require before sharing continues?

A. Continuing the current process because the checkbox already exists on the form.

B. Halting further sharing until consent separately identifies and is obtained for each specific recipient.

C. Allowing the sharing to continue if the recipient promises not to contact the beneficiary by phone.

D. Requiring the beneficiary to opt out after the data has already been shared.

TPMOs, call recording, permission to contact | Compliance Judgment

QUESTION 445 | T-455

An agency's script tells representatives to skip the required disclaimer at the start of a call and instead 'add it later if the caller sounds like a serious buyer.' What should compliance direct the team to do?

A. Keep the script because most callers never reach the sales portion anyway.

B. Deliver the disclaimer only when a caller specifically asks about representation.

C. Deliver the required disclaimer before any plan-benefit discussion, on every qualifying call.

D. Add the disclaimer to marketing emails instead of phone calls.

TPMOs, call recording, permission to contact | Compliance Judgment

QUESTION 446 | T-456

A sponsor discovers that a subcontracted TPMO has been actively selling plans for two months without completing the required annual training and testing for its staff. What must the sponsor do?

A. Allow the TPMO to continue selling while training is completed on its own schedule.

B. Excuse the gap because the subcontractor is not directly appointed by the sponsor.

C. Wait until the next audit cycle to address the missed requirement.

D. Suspend the TPMO's covered sales activity until training and testing are completed and confirmed.

TPMOs, call recording, permission to contact | Compliance Judgment

QUESTION 447 | T-457

A reviewer wants to discard the agency's saved backup files supporting a 'top-rated plan in the region' claim, noting that CMS no longer requires the documentation to be kept on file. Should the backup files be discarded?

A. No, keeping the substantiation still helps manage misleading-claims and audit risk.

B. Yes, because the claim itself is now automatically presumed accurate.

C. Yes, because superlative claims are banned and the file is irrelevant.

D. No, but only because state law separately requires notarized copies.

TPMOs, call recording, permission to contact | Compliance Judgment

QUESTION 448 | T-458

Evaluate the statement: Once a marketing or sales call's audio has been recorded, an agency may permanently delete that audio after one year and keep nothing further. Which response is accurate?

A. True, because one year of audio fully satisfies the retention obligation.

B. False; audio must be kept for the first three years within a longer overall retention period.

C. True, but only for calls that did not result in an enrollment.

D. False, but only because video, not audio, is the actual required format.

TPMOs, call recording, permission to contact | Alt Format / True False

QUESTION 449 | T-459

Match each compliance document to its correct function, then identify the pairing that is entirely correct. 1) Permission to Contact. 2) Scope of Appointment. A) Documents the product types a beneficiary agrees to discuss at a personal sales appointment. B) Authorizes future outreach to the beneficiary without describing specific plans.

A. 1-A and 2-B.

B. 1-A and 2-A.

C. 1-B and 2-A.

D. 1-B and 2-B.

TPMOs, call recording, permission to contact | Alt Format / Matching

QUESTION 450 | T-460

Review four statements about TPMO compliance obligations. I. A subcontracted TPMO's disciplinary actions must be reportable to the sponsor on a recurring basis. II. Sponsors must monitor licensing and appointment status across the delegated chain. III. A signed contract with a subcontractor permanently satisfies all future oversight duties. IV. Agents and TPMO personnel must complete required training and testing before selling. Which response identifies every accurate statement?

A. Statements I and III only.

B. Statements II and III only.

C. Statements I, III, and IV.

D. Statements I, II, and IV.

TPMOs, call recording, permission to contact | Alt Format / Select All

Topic Set - Fraud, waste and abuse; privacy; reporting

25 questions. Choose one answer per item; answers and full rationales are in Part II.

QUESTION 451 | T-091

An employee accidentally transposes two digits on one enrollment record, promptly reports the mistake, and corrects it. There is no evidence of deception or a pattern. How should the conduct be characterized?

A. Fraud because every inaccurate field proves intent to deceive.

B. Abuse because an isolated typo always violates accepted medical standards.

C. An error that requires correction but lacks the intent element of fraud.

D. Waste because a data-entry mistake is automatically inefficient utilization.

Fraud, waste and abuse; privacy; reporting | Scenario

QUESTION 452 | T-092

A laptop containing beneficiary records disappears from an agent's car. The agent cannot yet tell whether anyone opened the files. What should happen first under the organization's privacy procedures?

A. Wait for proof of identity theft before telling anyone.

B. Delete the device from the inventory and recreate the files silently.

C. Ask beneficiaries to investigate the loss on their own.

D. Report the potential incident promptly through the designated privacy or security channel.

Fraud, waste and abuse; privacy; reporting | Scenario

QUESTION 453 | T-093

What does the HIPAA minimum-necessary principle require when it applies to an enrollment-support task?

A. Limit access, use, or disclosure to information reasonably needed for the stated purpose.

B. Open the beneficiary's complete clinical record in case any detail becomes interesting.

C. Send the full file to every employee who might work on a future issue.

D. Avoid all access even when the authorized task cannot be completed without relevant data.

Fraud, waste and abuse; privacy; reporting | Direct Knowledge

QUESTION 454 | T-094

Why should a Medicare organization screen prospective and current workers against the OIG List of Excluded Individuals and Entities?

A. The list shows every person who has ever made a billing error.

B. Federal health-program payment generally cannot be made for items or services furnished, ordered, or prescribed by excluded parties.

C. The list replaces all state licensing and background-review requirements.

D. A person appears on the list whenever a beneficiary files a grievance.

Fraud, waste and abuse; privacy; reporting | Direct Knowledge

QUESTION 455 | T-095

An agent sees a recurring pattern of suspicious enrollment signatures but cannot determine whether a crime occurred. A manager says nothing should be reported without conclusive proof. Which response follows compliance practice?

A. Alter the files to make the signatures look consistent before any review.

B. Contact the suspected person privately and promise that no records will be preserved.

C. Preserve the facts and report the concern through the designated compliance channel.

D. Publish beneficiary details so outside observers can decide whether fraud occurred.

Fraud, waste and abuse; privacy; reporting | Compliance Judgment

QUESTION 456 | T-461

An agent tells a prospect the plan has 'no monthly cost at all' to close the sale, despite knowing the plan carries a modest premium disclosed elsewhere in the materials. How should this statement be classified?

A. Fraud, because it is a knowing, material misrepresentation made to obtain the enrollment.

B. Waste, because it merely reflects an inefficient sales process.

C. Abuse, but only if the agent later apologizes for the statement.

D. An honest mistake, because premiums can be confusing to summarize verbally.

Fraud, waste and abuse; privacy; reporting | Scenario

QUESTION 457 | T-462

An agency owner wants to appoint a new agent immediately after contracting is signed, planning to run the OIG exclusion screen sometime during the first month of active selling. What is wrong with this plan?

A. Nothing, because exclusion screening is only required once a complaint is filed.

B. Screening should occur before the person is hired or contracted, not afterward.

C. Nothing, because exclusion status can never change after initial hire.

D. Screening only applies to licensed agents, not to appointed but unlicensed staff.

Fraud, waste and abuse; privacy; reporting | Scenario

QUESTION 458 | T-463

A monthly exclusion-list screen returns a partial name match on a contracted downline agent, and a reviewer wants to immediately clear the file since the address on record does not match. What is the correct next step?

A. Clear the agent instantly because any address mismatch proves the match is wrong.

B. Exclude the agent instantly because any partial match must be treated as confirmed.

C. Document further verification using identifiers such as date of birth before deciding.

D. Ignore the match entirely because monthly screening is optional after initial hire.

Fraud, waste and abuse; privacy; reporting | Scenario

QUESTION 459 | T-464

An office assistant emails a spreadsheet containing every client's Social Security number to her personal account so she can finish paperwork over the weekend. What compliance concern does this raise?

A. None, because working from home is always an approved business practice.

B. None, as long as she deletes the email from her personal inbox eventually.

C. A concern only if a client later files a formal complaint.

D. A minimum-necessary and data-security concern requiring prompt reporting.

Fraud, waste and abuse; privacy; reporting | Scenario

QUESTION 460 | T-465

An agency adopts a new CRM platform that stores client health and enrollment details in the cloud, but no signed agreement addresses how the vendor must safeguard that data. What is missing?

A. A business associate agreement binding the vendor to appropriate safeguards for the data it handles.

B. A separate state insurance license issued specifically to the CRM vendor.

C. A notarized letter from each client approving the software purchase.

D. An annual AHIP certification completed by the vendor's engineering staff.

Fraud, waste and abuse; privacy; reporting | Scenario

QUESTION 461 | T-466

A carrier's internal audit finds that a batch of claims was systematically overpaid due to a configuration error, and leadership debates whether to wait for CMS to discover it or report it first. Which approach better reflects sound compliance practice?

A. Wait silently, since voluntary disclosure could draw unwanted attention.

B. Report the overpayment proactively through the applicable self-disclosure process.

C. Quietly correct future claims without addressing the past overpayment.

D. Delay any action until a formal audit notice arrives.

Fraud, waste and abuse; privacy; reporting | Scenario

QUESTION 462 | T-467

A hospital system offers an agent a private payment tied to each Medicare enrollment the agent directs to one of its affiliated providers, separate from any normal carrier commission. What federal concern does this arrangement raise?

A. A Family and Medical Leave Act concern, since it involves employee compensation.

B. A concern only under state consumer-protection advertising rules.

C. An Anti-Kickback Statute concern, because it rewards referrals connected to federal health-program business.

D. No concern, because any private payment outside a carrier's system is presumptively lawful.

Fraud, waste and abuse; privacy; reporting | Scenario

QUESTION 463 | T-468

A lead-generation company argues it owes no downstream compliance duties because it never signed a contract directly with the plan sponsor, only with an agency in the middle. Is that argument correct?

A. Yes, only entities with a direct sponsor contract carry any compliance duties.

B. Yes, provided the lead company never touches enrollment paperwork itself.

C. No, but only because lead companies must always be independently licensed.

D. No, obligations flow down the contract chain to entities handling data on the sponsor's behalf.

Fraud, waste and abuse; privacy; reporting | Scenario

QUESTION 464 | T-469

Files past their approved retention period sit in a locked cabinet with no litigation hold in place, and an office manager wants to place them in the regular recycling bin after tearing each page in half. What is wrong with this disposal method?

A. Torn paper in regular recycling can still leave protected information readable with secure safeguards absent.

B. Nothing is wrong, because the retention period has already expired.

C. Nothing is wrong, because tearing a page always renders it fully unreadable.

D. The problem is only that recycling bins must be emptied by an approved vendor.

Fraud, waste and abuse; privacy; reporting | Scenario

QUESTION 465 | T-470

What element most distinguishes fraud from waste in a Medicare compliance context?

A. Whether any dollar amount at all was involved in the conduct.

B. Whether the conduct involved knowing and willful deception for an unauthorized benefit.

C. Whether a supervisor was aware the conduct occurred.

D. Whether the affected beneficiary later filed a written complaint.

Fraud, waste and abuse; privacy; reporting | Direct Knowledge

QUESTION 466 | T-471

What is the core prohibition of the Anti-Kickback Statute?

A. It bars any communication between an agent and a treating physician.

B. It requires all Medicare commissions to be publicly disclosed online.

C. It bars knowingly offering, paying, soliciting, or receiving remuneration to induce federal health-program referrals.

D. It bars agents from working with more than one carrier at a time.

Fraud, waste and abuse; privacy; reporting | Direct Knowledge

QUESTION 467 | T-472

What is the general liability standard under the False Claims Act?

A. Liability requires proof that a beneficiary suffered a physical injury.

B. Liability applies only to conduct occurring inside a hospital setting.

C. Liability requires a signed confession from the person involved.

D. Liability attaches to knowingly submitting or causing false claims material to federal payment.

Fraud, waste and abuse; privacy; reporting | Direct Knowledge

QUESTION 468 | T-473

What does exclusion from federal health-care programs generally prevent an excluded individual or entity from doing?

A. Having items or services they furnish, order, or prescribe paid for by federal health programs.

B. Ever obtaining any professional license again in any state.

C. Voting in any federal or state election.

D. Filing a personal grievance about their own exclusion determination.

Fraud, waste and abuse; privacy; reporting | Direct Knowledge

QUESTION 469 | T-474

What does the HIPAA minimum-necessary standard require when it applies to a workplace task?

A. Full, unrestricted access to a client's entire medical history for every task.

B. Limiting the protected information accessed, used, or disclosed to what the specific task reasonably requires.

C. Sharing protected information with any coworker who might need it someday.

D. Avoiding all use of protected information even when the task cannot otherwise be completed.

Fraud, waste and abuse; privacy; reporting | Direct Knowledge

QUESTION 470 | T-475

Why does a business associate agreement matter when a vendor handles protected health information?

A. It replaces the need for any employee confidentiality training.

B. It certifies a vendor's financial solvency to carriers.

C. It obligates a vendor handling protected information to appropriate safeguards.

D. It authorizes a vendor to resell client data to marketing firms.

Fraud, waste and abuse; privacy; reporting | Direct Knowledge

QUESTION 471 | T-476

An agent notices a recurring pattern of duplicate claims submissions tied to the same provider but has no proof of intentional wrongdoing, and a manager insists nothing should be reported without a completed investigation first. What is the correct response?

A. Wait for the manager's informal investigation to finish before saying anything.

B. Confront the provider directly and demand an explanation before reporting anything.

C. Say nothing, since the agent's role does not include monitoring claims patterns.

D. Report the observed pattern promptly through the designated compliance channel.

Fraud, waste and abuse; privacy; reporting | Compliance Judgment

QUESTION 472 | T-477

A newly contracted vendor handles beneficiary PII to generate leads but has no direct agreement with the plan sponsor, and its manager argues it therefore owes no compliance obligations at all. How should this be corrected?

A. Clarify that flow-down obligations still apply because the vendor is a downstream or related entity in the chain.

B. Agree, since only entities under direct sponsor contract carry compliance duties.

C. Require the vendor to sign a sponsor contract before any obligations apply.

D. Apply the obligations only after the vendor's first reported compliance failure.

Fraud, waste and abuse; privacy; reporting | Compliance Judgment

QUESTION 473 | T-478

A supervisor discovers an unintentional billing overpayment affecting several members and tells the team to quietly correct future bills without disclosing the past error to anyone. What should staff do instead?

A. Follow the supervisor's instruction because silent correction avoids unnecessary attention.

B. Escalate the matter for consideration through an applicable self-disclosure process.

C. Wait for an external audit to identify the same issue independently.

D. Correct only the members who happen to complain about their bill.

Fraud, waste and abuse; privacy; reporting | Compliance Judgment

QUESTION 474 | T-479

Evaluate the statement: An organization satisfies its HIPAA obligations once it signs a business associate agreement, regardless of whether it also applies the minimum-necessary standard internally. Which response is accurate?

A. True, because a signed agreement covers every applicable privacy obligation.

B. True, but only for vendors located outside the organization's home state.

C. False; a business associate agreement and the minimum-necessary standard address separate, ongoing obligations.

D. False, but only because business associate agreements are optional in every case.

Fraud, waste and abuse; privacy; reporting | Alt Format / True False

QUESTION 475 | T-480

Review four statements about fraud, waste, and abuse concepts. I. Fraud requires knowing and willful deception for an unauthorized benefit. II. Abuse always requires the same intent element as fraud. III. Waste can occur without any deceptive intent. IV. A promptly corrected clerical error is not automatically labeled fraud. Which response identifies every accurate statement?

A. Statements I and II only.

B. Statements II and III only.

C. Statements I, II, and IV.

D. Statements I, III, and IV.

Fraud, waste and abuse; privacy; reporting | Alt Format / Select All

Topic Set - Beneficiary protections, appeals, grievances

25 questions. Choose one answer per item; answers and full rationales are in Part II.

QUESTION 476 | T-096

A member is upset about repeated long hold times and a rude customer-service representative, but no benefit or payment decision is disputed. Which process fits the complaint?

A. A Part D formulary exception for a non-covered drug.

B. An expedited appeal based on urgent medical jeopardy.

C. An organization determination on a requested MA service.

D. A grievance addressing dissatisfaction with plan service and operations.

Beneficiary protections, appeals, grievances | Scenario

QUESTION 477 | T-097

An MA plan denies a requested service, and the treating physician says waiting for the standard appeal timeframe could seriously jeopardize the member's health and ability to regain function. What review should be requested?

A. An expedited appeal supported by the urgent health facts.

B. A routine grievance with no review of the coverage denial.

C. A sales complaint that cancels every plan decision automatically.

D. A future AEP election instead of using the current appeal rights.

Beneficiary protections, appeals, grievances | Scenario

QUESTION 478 | T-098

What is the MA plan's initial decision on coverage or payment for a requested medical service called?

A. A Part D coverage determination.

B. An organization determination.

C. A customer-service grievance.

D. An independent review entity decision.

Beneficiary protections, appeals, grievances | Direct Knowledge

QUESTION 479 | T-099

A plan instructs agents to discourage eligible applicants who report expensive chronic conditions because they may use more services. How should the instruction be treated?

A. Accept it because expected claims determine whether an eligible person may enroll.

B. Use it only for applicants who ask about supplemental benefits.

C. Reject it as discriminatory enrollment conduct based on expected health costs.

D. Apply it only when the applicant lives inside the service area.

Beneficiary protections, appeals, grievances | Compliance Judgment

QUESTION 480 | T-100

Evaluate the statement: An MA member who experiences a genuine emergency outside the routine network may be denied solely because no ordinary referral was obtained first. Which response is accurate?

A. True; all network and referral rules apply before emergency treatment.

B. True; unless the member had scheduled the emergency with the plan.

C. False; but only a Medigap policy can provide the emergency protection.

D. False; emergency coverage protections are not conditioned on ordinary pre-service referral rules.

Beneficiary protections, appeals, grievances | Alt Format / True False

QUESTION 481 | T-481

A Part D member is charged a higher tier copay than expected for a maintenance medication and wants the plan to apply a lower cost-sharing tier, without disputing that the drug itself is covered. What request should be filed?

A. A tiering exception request through the Part D coverage-determination process.

B. A grievance about the pharmacy staff's customer service.

C. An MA organization determination on a medical service.

D. A quality-of-care complaint to the applicable Quality Improvement Organization.

Beneficiary protections, appeals, grievances | Scenario

QUESTION 482 | T-482

A member calls to complain that no Spanish-speaking interpreter was available during a benefits call, though the plan later processed the request correctly once an interpreter joined. No coverage decision is being challenged. What is the proper channel for this complaint?

A. An expedited appeal based on urgent medical jeopardy.

B. A grievance addressing dissatisfaction with plan service and access.

C. A Part D coverage determination on interpreter services.

D. An organization determination on a requested MA benefit.

Beneficiary protections, appeals, grievances | Scenario

QUESTION 483 | T-483

An MA plan denies a requested home health service, and the member's physician documents that delaying the standard appeal timeframe could seriously jeopardize the member's ability to regain normal function. Which review pathway fits these facts?

A. A routine grievance addressing dissatisfaction with the denial letter's tone.

B. A Quality Improvement Organization complaint about the treating physician.

C. An expedited appeal supported by the physician's urgent-risk documentation.

D. A future election-period plan change instead of appealing now.

Beneficiary protections, appeals, grievances | Scenario

QUESTION 484 | T-484

Weeks after discharge from a skilled nursing facility, a member believes the facility's Medicare-covered care fell dangerously short of accepted standards, but is not disputing whether the stay itself was covered. Which process can address the quality concern?

A. A Part D tiering exception request.

B. An MA organization determination on the nursing-facility stay.

C. A change to the facility's published Star Rating by the member directly.

D. A quality-of-care complaint filed with the applicable Quality Improvement Organization.

Beneficiary protections, appeals, grievances | Scenario

QUESTION 485 | T-485

While reviewing a new applicant's health history, an agent privately decides not to present an otherwise suitable MA plan to her because her dialysis treatment suggests she will likely use more services than average. What compliance problem does this decision create?

A. It discriminates against an eligible applicant based on anticipated health-related utilization.

B. None, because agents may freely select which eligible clients to serve.

C. None, as long as the agent documents the reason in a private file.

D. It only becomes a problem if the applicant later files a formal grievance.

Beneficiary protections, appeals, grievances | Scenario

QUESTION 486 | T-486

A plan's online portal shows a coverage denial message that says only 'request not approved' with no explanation of how to seek further review. A member asks how to challenge the decision but finds no guidance anywhere on the portal. What must the plan correct?

A. Nothing, because portal messages are not required to describe appeal rights.

B. The portal must provide accurate notice explaining the applicable appeal path and review rights.

C. The plan should direct the member to file a grievance instead of an appeal.

D. The plan should tell the member to wait until the next Annual Election Period.

Beneficiary protections, appeals, grievances | Scenario

QUESTION 487 | T-487

During an out-of-network emergency room visit while traveling, an MA member's plan later denies the claim solely because no prior authorization was obtained before treatment began. Is denying solely on that basis consistent with emergency-care protections?

A. Yes, because prior authorization applies equally to emergency and routine services.

B. Yes, provided the member was traveling more than a set distance from home.

C. No, emergency-care coverage is not conditioned on obtaining prior authorization beforehand.

D. No, but only because travel-related emergencies fall under a separate Medigap benefit.

Beneficiary protections, appeals, grievances | Scenario

QUESTION 488 | T-488

After an MA plan issues an initial organization determination denying a requested service, the member wants the plan itself to take a fresh look at the same decision before pursuing outside review. What is this next step generally called?

A. A quality-of-care complaint to the Quality Improvement Organization.

B. A brand-new organization determination on an unrelated service.

C. A grievance about the denial letter's readability.

D. A reconsideration of the plan's initial organization determination.

Beneficiary protections, appeals, grievances | Scenario

QUESTION 489 | T-489

A member's adult child, acting as an authorized representative, submits an appeal on the member's behalf after the plan denied a requested item. The plan's staff hesitate because the member did not personally sign the request. What should staff do?

A. Accept the appeal once the representative's proper authorization is confirmed.

B. Reject the appeal because only the member may ever submit one.

C. Convert the request into a grievance instead of processing it as an appeal.

D. Require the member to resubmit in person before any review begins.

Beneficiary protections, appeals, grievances | Scenario

QUESTION 490 | T-490

What is the general function of a grievance in the MA and Part D beneficiary protection framework?

A. It reverses an adverse coverage or payment decision automatically.

B. It addresses a member's dissatisfaction with plan service or operations, apart from a coverage decision.

C. It replaces the need for any coverage-determination process.

D. It is available only during the Annual Election Period.

Beneficiary protections, appeals, grievances | Direct Knowledge

QUESTION 491 | T-491

How is a Part D coverage determination generally defined?

A. A plan's decision about a member's satisfaction with call-center service.

B. An MA plan's decision on a requested medical service.

C. The Part D plan's initial decision on drug coverage or payment, including exception requests.

D. A hospital's internal decision about discharge planning.

Beneficiary protections, appeals, grievances | Direct Knowledge

QUESTION 492 | T-492

What must a plan generally provide when it issues an adverse organization determination?

A. A referral to a state insurance department for review.

B. An automatic enrollment into a different plan.

C. A private apology letter with no further detail.

D. Notice explaining the decision and the applicable appeal rights.

Beneficiary protections, appeals, grievances | Direct Knowledge

QUESTION 493 | T-493

What general standard supports a request for an expedited appeal?

A. Applying the standard review timeframe could seriously jeopardize life, health, or the ability to regain function.

B. The member simply prefers a faster answer than usual.

C. The request involves a routine annual wellness visit.

D. The member has previously filed more than one grievance.

Beneficiary protections, appeals, grievances | Direct Knowledge

QUESTION 494 | T-494

What does MA and Part D nondiscrimination in enrollment generally require regarding an applicant's health status?

A. Agents may prioritize applicants expected to generate lower plan costs.

B. Eligible applicants may not be discouraged from enrolling because of their health status or expected utilization.

C. Health status may be used to set a higher premium for a specific eligible applicant.

D. Health status questions are required before any eligible applicant may enroll.

Beneficiary protections, appeals, grievances | Direct Knowledge

QUESTION 495 | T-495

What is the general role of the applicable Quality Improvement Organization regarding a Medicare beneficiary's care?

A. It decides whether an MA plan must pay a specific claim.

B. It replaces the plan's grievance process entirely.

C. It reviews quality-of-care complaints about Medicare-covered services.

D. It sets each plan's official Star Rating unilaterally.

Beneficiary protections, appeals, grievances | Direct Knowledge

QUESTION 496 | T-496

A call-center director instructs representatives to log every dissatisfied caller as 'general feedback' rather than as a formal grievance, so the team's grievance count stays low for a monthly report. What should compliance require instead?

A. Keep the practice because feedback logs are simpler to manage than grievance files.

B. Apply it only to callers who do not ask for a supervisor.

C. Allow it during high call-volume periods only.

D. Require complaints meeting the grievance definition to be logged and processed as grievances.

Beneficiary protections, appeals, grievances | Compliance Judgment

QUESTION 497 | T-497

A reviewer wants to deny a member's request for expedited appeal review solely because the member's letter never used the word 'expedited,' even though the attached physician note describes a serious risk from delay. How should compliance direct the review?

A. Evaluate the substance of the request against the urgency standard, regardless of the specific wording used.

B. Deny the request because the required term was not used.

C. Convert the request into a routine grievance instead.

D. Ask the member to resubmit using the exact required phrase before any review begins.

Beneficiary protections, appeals, grievances | Compliance Judgment

QUESTION 498 | T-498

A supervisor tells appeal staff to hold expedited requests for the standard review period whenever the team is short-staffed, reasoning that the urgent timeframe is only a guideline. What should staff do?

A. Follow the supervisor's approach since staffing constraints are a valid reason to slow reviews.

B. Apply the required expedited timeframe regardless of staffing and escalate the instruction if needed.

C. Apply the expedited timeframe only to requests received before noon each day.

D. Convert overflow expedited requests into grievances to reduce the backlog.

Beneficiary protections, appeals, grievances | Compliance Judgment

QUESTION 499 | T-499

Match each review type to its correct description, then identify the pairing that is entirely correct. 1) Grievance. 2) Organization determination. 3) Expedited appeal. A) An MA plan's initial coverage or payment decision. B) A shortened-timeframe review used when delay could seriously jeopardize health. C) A complaint about plan service or conduct, apart from a coverage decision.

A. 1-A, 2-C, 3-B.

B. 1-B, 2-A, 3-C.

C. 1-C, 2-A, 3-B.

D. 1-C, 2-B, 3-A.

Beneficiary protections, appeals, grievances | Alt Format / Matching

QUESTION 500 | T-500

Evaluate the statement: A member must first file and complete a grievance before becoming eligible to request an appeal of a coverage denial. Which response is accurate?

A. True, because grievances and appeals always occur in a fixed sequence.

B. True, but only when the denial involves a Part D drug.

C. False, but only because appeals are reserved for MA benefits alone.

D. False; a grievance and an appeal address different issues and neither is a prerequisite for the other.

Beneficiary protections, appeals, grievances | Alt Format / True False

Mock Exam 1 - 50 questions

50 questions. Choose one answer per item; answers and full rationales are in Part II.

QUESTION 501 | M1-001

Nina spends the night at a hospital under outpatient observation status and assumes the stay must be billed as a Part A inpatient admission. Which statement is most accurate?

A. Formal patient status matters, and outpatient hospital services are generally handled under Part B.

B. Any overnight hospital stay is automatically a Part A inpatient admission.

C. Part D determines whether observation services are medically necessary.

D. Part C is the payer even though Nina uses Original Medicare.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 502 | M1-002

A member in a standard HMO arranges a routine visit with a non-network specialist without checking whether a referral is required. What should the member expect?

A. The HMO must treat every routine specialist visit as emergency care.

B. Network and referral requirements may control whether the routine service is covered.

C. The visit automatically receives PPO out-of-network benefits.

D. The specialist's acceptance of Original Medicare overrides the HMO contract.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 503 | M1-003

A newly eligible beneficiary's Part A starts before Part B. She wants to make her first MA election when both parts become active. Which enrollment opportunity should be reviewed?

A. The 5-star SEP, whether or not the destination plan has five stars.

B. The MA OEP, even though she has never been enrolled in MA.

C. Her Initial Coverage Election Period tied to entitlement to both Part A and Part B.

D. An institutional SEP based solely on delayed Part B enrollment.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 504 | M1-004

A Part D plan covers a medication but pays for no more than a stated number of tablets during a thirty-day period. Which plan rule is illustrated?

A. A pharmacy-network exclusion based only on the store's address.

B. A step-therapy rule requiring a different medicine first.

C. A formulary exception that adds a non-covered drug.

D. A quantity limit restricting the covered amount in a defined period.

Part D, formularies, tiers, Extra Help, TrOOP | Scenario

QUESTION 505 | M1-005

At an in-person PY2027 sales appointment, an agent relies on a verbal understanding of topics and has no written Scope of Appointment. What is the defect?

A. The product scope should have been documented in writing before the in-person discussion.

B. The agent should have waited until after enrollment to ask what products were discussed.

C. A Permission to Contact card automatically serves as a written SOA for all products.

D. In-person appointments are exempt from scope requirements once the waiting period is removed.

Marketing, communications, SOA, events | Scenario

QUESTION 506 | M1-006

Which telephonic interaction is expressly included in the current recording requirement described by CMS training guidance?

A. A call limited to confirming office holiday hours.

B. A call capturing the beneficiary's enrollment acknowledgments and election.

C. An internal staff meeting with no beneficiary participation.

D. A pharmacy's automated refill reminder with no plan discussion.

TPMOs, call recording, permission to contact | Direct Knowledge

QUESTION 507 | M1-007

Which description best fits waste in a Medicare program context?

A. Knowing deception used to obtain an unauthorized payment.

B. A practice violating accepted standards and causing improper cost.

C. Inefficient or excessive use of resources that creates unnecessary expense without clear fraudulent intent.

D. A single corrected typographical error with no resource impact.

Fraud, waste and abuse; privacy; reporting | Direct Knowledge

QUESTION 508 | M1-008

A Part D member asks the plan to waive prior authorization for a covered medication. What initial decision must the plan issue?

A. An MA organization determination on an inpatient benefit.

B. A grievance decision about staff courtesy.

C. A Quality Improvement Organization ruling on care quality.

D. A Part D coverage determination on the exception request.

Beneficiary protections, appeals, grievances | Direct Knowledge

QUESTION 509 | M1-009

To draw prospects to a plan presentation, an agent offers free blood-pressure screenings and plans to tailor sales recommendations to the readings. What should compliance direct?

A. Remove the health screening because it is inappropriate at a Medicare marketing event.

B. Keep the screening if only people with high readings receive plan information.

C. Require attendees to enroll before learning their results.

D. Move the screening beside the pharmacy counter and continue the event.

Marketing, communications, SOA, events | Compliance Judgment

QUESTION 510 | M1-010

Match each service with the Medicare part principally associated with it under Original Medicare: inpatient hospital care, physician office services, and outpatient prescription-drug coverage. Which sequence is correct?

A. Part B; Part A; Part C.

B. Part A; Part B; Part D.

C. Part D; Part C; Part A.

D. Part C; Part D; Part B.

Parts A/B/C/D, eligibility, plan types | Alt Format / Matching

QUESTION 511 | M1-011

Leon's move keeps him inside his MA plan's service area but opens access to plans not offered at his former address. What should an agent determine?

A. Whether the MA OEP allows unlimited changes after any move.

B. Whether the old plan must be terminated before the address changes.

C. Whether the new plan availability gives Leon a move-related SEP.

D. Whether geographic eligibility can be ignored for the destination plan.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 512 | M1-012

A beneficiary receives Extra Help but has no verified Medicaid eligibility. An agent says the subsidy automatically proves full Medicaid status and D-SNP eligibility. Which correction is needed?

A. Extra Help always includes full state Medicaid and institutional eligibility.

B. Every Part D subsidy recipient must enroll in a D-SNP.

C. The subsidy is a Medigap protection rather than a Part D program.

D. Extra Help reduces qualifying Part D costs but does not by itself establish full Medicaid or D-SNP eligibility.

Part D, formularies, tiers, Extra Help, TrOOP | Scenario

QUESTION 513 | M1-013

Before an MSA member meets the plan's medical deductible, she pays a qualified expense using money deposited in the medical savings account. Which description is correct?

A. The account can help pay qualified expenses while the high-deductible plan has not begun paying covered medical claims.

B. The account deposit is embedded Part D coverage for her prescriptions.

C. Using the account immediately converts the MSA into a PPO.

D. Every account withdrawal counts toward the medical deductible even when it is not a qualifying Medicare-covered expense.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 514 | M1-014

A satisfied enrollee wants to help an agent find new clients. Which request avoids taking a friend's personal information from the enrollee?

A. Ask for a spreadsheet of neighbors' telephone numbers.

B. Invite the enrollee to share the agent's business card so interested friends can initiate contact.

C. Pay the enrollee for each unconsented email address provided.

D. Ask the enrollee to sign Permission to Contact on each friend's behalf.

Marketing, communications, SOA, events | Scenario

QUESTION 515 | M1-015

After discharge, a beneficiary believes the hospital's Medicare-covered care was dangerously poor but is not challenging whether a plan benefit was covered. Which channel may address the quality concern?

A. A Part D formulary exception.

B. A request to change the plan's Star Rating.

C. A quality-of-care complaint to the applicable Quality Improvement Organization.

D. An agent compensation appeal.

Beneficiary protections, appeals, grievances | Scenario

QUESTION 516 | M1-016

Which plan document is designed as a concise pre-enrollment overview rather than the complete contract?

A. The Evidence of Coverage.

B. The Provider Directory.

C. The plan formulary.

D. The Summary of Benefits.

Parts A/B/C/D, eligibility, plan types | Direct Knowledge

QUESTION 517 | M1-017

What destination-plan fact is essential before using the 5-star Special Enrollment Period?

A. The destination has Medicare's qualifying overall 5-star rating for the applicable year.

B. The beneficiary's current plan has exactly four stars.

C. The selling agent represents only one carrier.

D. The destination has the lowest premium in the service area.

Enrollment periods, elections, SEPs, disenrollment | Direct Knowledge

QUESTION 518 | M1-018

Where may an approved Medicare sales table generally be placed inside a health-care facility?

A. Inside an occupied examination room.

B. In a permitted public lobby or cafeteria away from patient care.

C. At the pharmacy counter where prescriptions are dispensed.

D. Beside a treatment chair during a clinical procedure.

Marketing, communications, SOA, events | Direct Knowledge

QUESTION 519 | M1-019

A lead vendor transfers a beneficiary's personal data to another TPMO, then emails a consent form after the recipient has already made a sales call. Can the later signature cure the original transfer?

A. Yes, if both TPMOs sell Medicare plans.

B. Yes, if the beneficiary eventually enrolls.

C. No; the required express written consent must precede the inter-TPMO sharing.

D. No, because beneficiary data may never be shared under any circumstances.

TPMOs, call recording, permission to contact | Compliance Judgment

QUESTION 520 | M1-020

Consider these Part D statements. I. A formulary identifies the plan's covered drugs. II. Step therapy may require trying a specified drug first. III. A transition supply can provide temporary access while an exception is pursued. IV. The plan-paid share of every drug automatically counts as the beneficiary's TrOOP. Which option contains all accurate statements?

A. Statements I and III only.

B. Statements I, II, and IV.

C. Statements II and IV only.

D. Statements I, II, and III.

Part D, formularies, tiers, Extra Help, TrOOP | Alt Format / Select All

QUESTION 521 | M1-021

While traveling, an HMO member develops symptoms requiring immediate emergency treatment at the nearest hospital outside the network. Which plan-type principle applies?

A. Emergency coverage protections apply without the HMO's ordinary routine-care network process.

B. The member must return home before receiving any covered evaluation.

C. Out-of-area care is covered only after changing the HMO into a PPO.

D. The hospital visit becomes Part D because it occurs outside the service area.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 522 | M1-022

Martin's active employment ended, but he kept COBRA and delayed Part B because he believed the job-based SEP clock would not begin until COBRA ended. What is the key correction?

A. COBRA creates a new eight-year Part B enrollment period.

B. COBRA is not current-employment coverage and generally does not extend the Part B SEP clock.

C. Part B can be added automatically through any MA application.

D. A retiree may delay Part B indefinitely whenever continuation coverage remains available.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 523 | M1-023

A covered non-specialty drug is placed on a high cost-sharing tier, and the prescriber explains why lower-tier alternatives are unsuitable. What request focuses on reducing the drug's cost sharing?

A. A transition fill that removes the drug from the formulary.

B. A grievance about the pharmacy's store hours.

C. A tiering exception, subject to the plan's eligibility limits.

D. An MA organization determination for medical equipment.

Part D, formularies, tiers, Extra Help, TrOOP | Scenario

QUESTION 524 | M1-024

A community center schedules objective Medicare education immediately before a carrier sales event. Which transition preserves beneficiary choice under the current rule?

A. Begin the carrier presentation silently while the education slides remain visible.

B. Lock the room so attendees cannot leave between sessions.

C. Collect enrollment forms before announcing that the event type is changing.

D. State clearly that education is ending and allow enough time for attendees to exit.

Marketing, communications, SOA, events | Scenario

QUESTION 525 | M1-025

Beneficiary paper files have reached the approved end of their retention period, no legal hold applies, and destruction is authorized. Which disposal method is appropriate?

A. Use a secure process that makes the protected information unreadable and unrecoverable.

B. Place intact files in an unlocked public recycling bin.

C. Photograph every page on a personal phone before discarding it.

D. Give the records to an unapproved vendor without a privacy agreement.

Fraud, waste and abuse; privacy; reporting | Scenario

QUESTION 526 | M1-026

What should an agent verify before describing a particular PFFS plan as having no provider network?

A. Whether the beneficiary has owned Medigap in the past.

B. Whether that PFFS plan actually uses contracted providers and how its payment terms operate.

C. Whether all local HMOs require the same referrals.

D. Whether the plan includes an MSA deposit.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Direct Knowledge

QUESTION 527 | M1-027

Which event can require a plan to involuntarily disenroll a member using prescribed notice and timing rules?

A. The member asks a difficult question about cost sharing.

B. The agent prefers a competitor's plan.

C. The member permanently moves outside the plan's service area.

D. A provider leaves the network while the member still resides locally.

Enrollment periods, elections, SEPs, disenrollment | Direct Knowledge

QUESTION 528 | M1-028

Which outreach channel is generally permissible when the material is accurate and does not mimic official government correspondence?

A. An uninvited home visit.

B. An unrequested ringless sales voicemail.

C. A cold sales text to a purchased number.

D. A compliant piece of postal direct mail.

Marketing, communications, SOA, events | Direct Knowledge

QUESTION 529 | M1-029

A sales manager tells agents to steer people with costly medical histories away from an eligible MA plan, even when the plan meets their stated needs. What should the agents do?

A. Refuse the direction because enrollment may not discriminate based on expected health costs.

B. Follow it whenever the applicant takes more than one prescription.

C. Use the instruction only during AEP so it is not discriminatory.

D. Tell applicants that service-area eligibility depends on projected claims.

Beneficiary protections, appeals, grievances | Compliance Judgment

QUESTION 530 | M1-030

Evaluate this statement: A complaint about discourteous plan service, when no benefit denial is challenged, is generally handled as a grievance. Which response is correct?

A. False; every complaint must begin as an expedited appeal.

B. True; the issue concerns service rather than an adverse coverage determination.

C. False; the only remedy is to wait for AEP and change plans.

D. True; and filing it automatically reverses every unrelated benefit denial.

Beneficiary protections, appeals, grievances | Alt Format / True False

QUESTION 531 | M1-031

Darius is sixty-five, enrolls in Part B for the first time, and asks when his broad federal Medigap purchase protection begins. Which timing rule should the agent explain?

A. It begins only after Darius has spent one year in Medicare Advantage.

B. It starts whenever an insurer decides to stop medical underwriting.

C. The six-month federal open-enrollment period begins with the first month he is both sixty-five or older and enrolled in Part B.

D. It begins during every Annual Election Period and renews each fall.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 532 | M1-032

A prospect asks whether an agent can promise that the plan will approve a food benefit for chronically ill members. How should the agent respond?

A. The benefit is guaranteed whenever the prospect has any diagnosis.

B. The agent may approve eligibility if the plan appears affordable.

C. Every debit-card holder automatically receives the benefit in cash.

D. The plan must apply its published SSBCI criteria, so the agent should explain the process without promising approval.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 533 | M1-033

Before her new MA election becomes effective, Fatima changes her mind and promptly asks to stop the pending enrollment within the permitted cancellation window. What should the agent do?

A. Route the cancellation through the plan's approved process and document the request.

B. Ignore the request because every signed election is immediately irrevocable.

C. Advise Fatima to stop paying all Medicare premiums instead.

D. Submit a second incompatible plan election without checking another enrollment right.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 534 | M1-034

A carrier promotes a Medicare sales seminar by offering every attendee a full restaurant meal during the presentation. Which adjustment is necessary?

A. Keep the meal but require an application before dessert.

B. Replace the meal with permissible light refreshments that are not tied to enrollment.

C. Move the meal to a patient treatment room.

D. Issue cash equal to the meal's value instead.

Marketing, communications, SOA, events | Scenario

QUESTION 535 | M1-035

When may a Part D late-enrollment penalty become a concern after a beneficiary's initial period has ended?

A. Whenever the beneficiary changes PDPs while maintaining continuous coverage.

B. Whenever a formulary moves a drug to another tier.

C. After a continuous gap of at least sixty-three days without Part D or other creditable drug coverage, absent an exception.

D. After one prescription is filled at a nonpreferred pharmacy.

Part D, formularies, tiers, Extra Help, TrOOP | Direct Knowledge

QUESTION 536 | M1-036

Which element belongs in the current standardized TPMO disclaimer before plan benefits are discussed?

A. A promise that the agent represents every plan in the nation.

B. A list of all beneficiaries previously enrolled by the agency.

C. A statement that Medicare.gov is unavailable to consumers.

D. The required organization and product counts plus Medicare's independent information resources.

TPMOs, call recording, permission to contact | Direct Knowledge

QUESTION 537 | M1-037

Which arrangement presents a federal Anti-Kickback Statute concern?

A. A secret payment offered to induce referrals of federally reimbursed health-care business.

B. A documented salary for legitimate work at fair market value under a compliant arrangement.

C. A beneficiary's good-faith grievance about customer service.

D. A plan's routine correction of an accidental data-entry error.

Fraud, waste and abuse; privacy; reporting | Direct Knowledge

QUESTION 538 | M1-038

During a telephonic application, a beneficiary asks the agent to skip all required acknowledgments and simply choose the answers. What should the agent do?

A. Complete the acknowledgments personally because speed is more important than consent.

B. Pause and ensure the beneficiary provides the required acknowledgment and consent through the approved mechanism.

C. Sign the beneficiary's name and disclose it only if the plan audits the call.

D. Submit a blank form and add consent after coverage begins.

Enrollment periods, elections, SEPs, disenrollment | Compliance Judgment

QUESTION 539 | M1-039

An advertisement calls a three-star plan the highest-rated option in the state without naming a measure, geography, or source. What should the reviewer require?

A. Keep the claim because superlatives never need factual support.

B. Add a government seal so the statement appears official.

C. Remove or substantiate the comparison with accurate current data and clear context.

D. Replace the Star Rating with the agent's personal ranking and omit the year.

Marketing, communications, SOA, events | Compliance Judgment

QUESTION 540 | M1-040

Match each beneficiary with the applicable opportunity: a current MA member seeking one February switch, a nursing-home resident seeking a May plan change, and a beneficiary choosing next year's plan in November. Which sequence is correct?

A. Annual Election Period; move SEP; ICEP.

B. Institutional SEP; MA OEP; 5-star SEP.

C. ICEP; Annual Election Period; institutional SEP.

D. MA Open Enrollment Period; institutional SEP; Annual Election Period.

Enrollment periods, elections, SEPs, disenrollment | Alt Format / Matching

QUESTION 541 | M1-041

A retiree receives a Medicare plan offered only through the former employer's group benefits program. Which coverage category should the agent recognize?

A. An Employer Group Waiver Plan sponsored through the employer or union arrangement.

B. A Medigap policy sold to every Medicare beneficiary in the state.

C. An individual-market MSA created by the retiree's former physician.

D. A PACE program available without service-area or care-level requirements.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 542 | M1-042

A beneficiary has a chronic condition served by a local C-SNP but does not have Medicaid. The agent rejects the applicant because every SNP supposedly requires dual eligibility. Is the reasoning correct?

A. Yes, because D-SNP, C-SNP, and I-SNP all use the same Medicaid test.

B. No; C-SNP eligibility rests on a qualifying condition confirmed through the plan's process.

C. Yes, unless the beneficiary also joins an MSA.

D. No; C-SNP enrollment requires no Medicare Advantage eligibility at all.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 543 | M1-043

A member's plan displays Medicare's consistently low-performing icon after remaining below the specified star threshold for the required years. What option should be reviewed?

A. A guaranteed move to any plan nationwide regardless of service area.

B. An unlimited number of elections while the low rating continues.

C. The SEP for members of consistently low-performing plans.

D. A Medigap open-enrollment period created by the plan's rating.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 544 | M1-044

A low-income beneficiary struggles with a large early-year prescription bill and may qualify for Extra Help. The agent offers only the Medicare Prescription Payment Plan. What broader distinction should be explained?

A. The payment plan and Extra Help both merely change the due date without affecting cost.

B. The payment plan replaces every Part D subsidy determination.

C. Extra Help spreads the same liability while the payment plan reduces it.

D. The payment plan smooths timing, while Extra Help may actually reduce qualifying Part D costs.

Part D, formularies, tiers, Extra Help, TrOOP | Scenario

QUESTION 545 | M1-045

Which activity belongs at an educational event rather than a Medicare sales event?

A. Teaching general Parts A through D concepts without naming plan benefits or collecting enrollment requests.

B. Comparing one carrier's copayments and distributing its applications.

C. Offering a cash reward to anyone who selects the featured plan.

D. Collecting completed AEP applications before the election period opens.

Marketing, communications, SOA, events | Direct Knowledge

QUESTION 546 | M1-046

What happens to a plan sponsor's compliance responsibility when lead generation and enrollment functions are delegated to TPMOs and subcontractors?

A. It ends as soon as the first vendor signs a contract.

B. The sponsor retains oversight duties throughout the delegated chain.

C. It transfers permanently to the beneficiary whose data was collected.

D. It applies only if the subcontractor calls itself a TPMO.

TPMOs, call recording, permission to contact | Direct Knowledge

QUESTION 547 | M1-047

Which conduct most directly raises a False Claims Act concern?

A. Correcting a harmless transposed digit and documenting the change.

B. Filing a grievance about a representative's rude behavior.

C. Knowingly causing false records to support claims for federal payment.

D. Comparing two current plan formularies before enrollment.

Fraud, waste and abuse; privacy; reporting | Direct Knowledge

QUESTION 548 | M1-048

A plan notice tells members that coverage denials are final and supplies no explanation of reconsideration rights. What must be corrected?

A. Add a statement that only agents may challenge plan decisions.

B. Tell members to wait until the next AEP instead of seeking review.

C. Replace the notice with a grievance form that cannot address coverage.

D. Provide accurate notice of the applicable appeal path and review rights.

Beneficiary protections, appeals, grievances | Compliance Judgment

QUESTION 549 | M1-049

An agent schedules a Medicare plan appointment, then inserts an unrequested life-insurance pitch between the benefit comparison and enrollment form. What should the supervisor require?

A. Remove the agent-initiated non-health cross-sale from the Medicare appointment.

B. Keep it because any Medicare SOA covers all insurance products.

C. Keep it if the beneficiary is not allowed to ask questions.

D. Move the life policy onto the MA enrollment form.

Marketing, communications, SOA, events | Compliance Judgment

QUESTION 550 | M1-050

Review these certification-topic statements. I. Part A is principally associated with covered inpatient hospital care. II. HMOs generally use networks for routine services. III. Valid fall AEP elections generally begin January 1. IV. Permission to Contact replaces the product-specific Scope of Appointment. Which response contains every accurate statement?

A. Only I and IV are accurate.

B. I, II, and III are accurate.

C. II and IV are accurate.

D. I, III, and IV are accurate.

TPMOs, call recording, permission to contact | Alt Format / Select All

Mock Exam 2 - 50 questions

50 questions. Choose one answer per item; answers and full rationales are in Part II.

QUESTION 551 | M2-001

Wendell has a lengthy record of Medicare-covered employment and asks whether he must pay a monthly premium for Part A. What should the agent confirm first?

A. Whether his work history meets the threshold for premium-free Part A.

B. Whether he has ever purchased a Medigap policy.

C. Whether he already enrolled in a stand-alone PDP.

D. Whether his local MA plan charges a zero premium.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 552 | M2-002

Bridget receives outpatient lab testing ordered by her physician and assumes Part A pays for it because a hospital drew the sample. Which part generally applies?

A. Part A generally covers the lab service because a hospital collected the sample.

B. Part B generally covers medically necessary outpatient laboratory services.

C. Part C pays the claim even though Bridget has not joined Medicare Advantage.

D. Part D generally covers the ordering physician's laboratory request.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 553 | M2-003

Simone is admitted as a hospital inpatient after a scheduled surgery and wants to know which part generally pays for the covered facility stay.

A. Part B generally covers every inpatient facility charge.

B. Part D covers the inpatient stay whenever drugs are administered.

C. Part A generally covers the covered inpatient hospital stay.

D. Part C is the payer even without a Medicare Advantage election.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 554 | M2-004

Oscar enrolled in Original Medicare decades ago and now asks whether a Medicare Advantage election would end his statutory entitlement to Parts A and B.

A. Joining Medicare Advantage ends his underlying entitlement to Parts A and B.

B. Joining Medicare Advantage requires him to reapply for Social Security retirement benefits.

C. Joining Medicare Advantage cancels Part A but not Part B.

D. Joining Medicare Advantage keeps his underlying Part A and Part B entitlement while changing how benefits are delivered.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 555 | M2-005

Which document should an agent consult to confirm whether a specific specialist currently participates in a plan's network?

A. The plan's Evidence of Coverage.

B. The plan's Provider Directory.

C. The plan's formulary.

D. The plan's Summary of Benefits.

Parts A/B/C/D, eligibility, plan types | Direct Knowledge

QUESTION 556 | M2-006

What is the defining feature that separates Part C from Parts A, B, and D as a coverage category?

A. Part C is a supplemental policy sold only to Original Medicare enrollees.

B. Part C is a stand-alone drug benefit administered by a plan sponsor.

C. Part C is a private-plan alternative through which a beneficiary can receive Medicare benefits.

D. Part C is a federal cash subsidy paid directly to low-income beneficiaries.

Parts A/B/C/D, eligibility, plan types | Direct Knowledge

QUESTION 557 | M2-007

Who determines the official effective date recorded for a beneficiary's Medicare entitlement?

A. The entitlement record maintained under the official Medicare enrollment process.

B. The selling agent, based on the appointment date.

C. The employer's human-resources office, based on retirement paperwork.

D. The pharmacy, based on the first filled prescription.

Parts A/B/C/D, eligibility, plan types | Direct Knowledge

QUESTION 558 | M2-008

A checklist review finds that an application listing Part A only was submitted to an MA plan on the assumption that Part B would be added automatically. What must the agent correct?

A. Submit the application and let the plan resolve any missing Part B enrollment later.

B. Treat the assumption as sufficient because Part B is optional for MA.

C. Add a note asking Social Security to enroll the applicant automatically in Part B.

D. Confirm actual Part B enrollment before representing the application as eligible for Medicare Advantage.

Parts A/B/C/D, eligibility, plan types | Compliance Judgment

QUESTION 559 | M2-009

Match each situation to the Medicare part it principally involves: a scheduled inpatient surgery, a routine physician office visit, and a retail prescription refill. Which sequence is correct?

A. Part A; Part B; Part D.

B. Part B; Part A; Part C.

C. Part D; Part C; Part A.

D. Part C; Part D; Part B.

Parts A/B/C/D, eligibility, plan types | Alt Format / Matching

QUESTION 560 | M2-010

Fiona enrolls in an HMO and later needs a routine referral to see a cardiologist who does not participate in the plan's network. What should she expect?

A. The HMO must always treat the visit as an emergency regardless of urgency.

B. Routine access to a non-network cardiologist may be limited absent an applicable referral or exception.

C. The visit automatically converts her plan into a PPO for that specialty.

D. Original Medicare rules replace the HMO's network requirements for any specialist visit.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 561 | M2-011

Callum owns a PFFS plan and learns that his preferred urgent-care clinic will not accept the plan's payment terms for a scheduled follow-up. What should he do?

A. Assume every Medicare-participating clinic must accept his PFFS plan's terms.

B. File a grievance that automatically compels the clinic's participation.

C. Confirm whether an alternative provider willing to accept the plan's terms is available.

D. Treat the refusal as proof that the plan has no valid Medicare contract.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 562 | M2-012

Renata is enrolled in a D-SNP and later loses the Medicaid category the plan required for enrollment. What consequence should be reviewed?

A. Losing Medicaid has no bearing on eligibility for a plan tailored to dual-eligible beneficiaries.

B. The plan automatically reclassifies itself as a C-SNP once Medicaid ends.

C. Renata immediately loses all Medicare Part A and Part B entitlement.

D. Continued D-SNP eligibility depends on maintaining the plan's required dual-eligibility status, subject to any applicable grace period.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 563 | M2-013

Desmond wants a plan that lets him see any provider accepting the plan's terms without selecting a primary care physician for routine referrals. Which plan type most directly matches that description?

A. A PFFS plan structured without a primary care referral requirement.

B. A standard HMO requiring primary care coordination for routine referrals.

C. A D-SNP limited to a qualifying dual-eligibility category.

D. An I-SNP limited to an institutional level of care.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 564 | M2-014

What is the practical difference between an MA-PD and a stand-alone PDP?

A. An MA-PD covers only Part D, while a PDP covers only Part A and Part B.

B. An MA-PD combines Medicare Advantage medical benefits with embedded Part D coverage, while a stand-alone PDP provides only drug coverage.

C. An MA-PD is available solely to dual-eligible beneficiaries, while a PDP is not.

D. An MA-PD and a stand-alone PDP are two names for the identical plan type.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Direct Knowledge

QUESTION 565 | M2-015

Which factor distinguishes a local PPO from a regional PPO in Medicare Advantage?

A. Whether the plan offers any out-of-network benefit at all.

B. Whether the plan can enroll a beneficiary without Part B.

C. Whether the plan's approved service area is a local configuration or a CMS-defined region.

D. Whether the plan is automatically a special-needs plan.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Direct Knowledge

QUESTION 566 | M2-016

An enrollment file shows a beneficiary marked eligible for a C-SNP based only on the agent's personal impression that she appeared chronically ill. What correction is required?

A. Accept the agent's impression because visible symptoms are sufficient evidence.

B. Convert the file into a D-SNP application without new evidence.

C. Approve the file only if the agent adds a signed personal guarantee.

D. Confirm the qualifying condition through the plan's required verification process before treating the enrollment as valid.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Compliance Judgment

QUESTION 567 | M2-017

Evaluate this statement: Every Medicare Advantage HMO automatically includes an out-of-network benefit equal to a PPO's. Which response is accurate?

A. False; an HMO's non-network coverage is generally more limited than a PPO's out-of-network benefit.

B. True; CMS requires identical out-of-network benefits for every plan type.

C. False; but only because HMOs never cover emergency care.

D. True; because every HMO includes a point-of-service rider by default.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Alt Format / True False

QUESTION 568 | M2-018

Theo currently belongs to a three-star MA plan and asks whether he may switch mid-year into a plan carrying Medicare's full 5-star rating. What must be confirmed before advising him?

A. Whether his current plan's rating disqualifies every future election for the rest of the year.

B. Whether the destination plan currently holds Medicare's qualifying overall 5-star rating and the SEP remains available.

C. Whether he must first wait for the next Annual Election Period regardless of rating.

D. Whether a 5-star election requires him to drop Part B entirely.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 569 | M2-019

Paulina's group health coverage through her spouse's employer ends unexpectedly on a Friday, and she wants Part D coverage in place without a lapse. What should the agent verify?

A. Whether she must wait until the next fall Annual Election Period regardless of the loss.

B. Whether Medicaid eligibility is required before any Part D election can occur.

C. Whether the loss of that group coverage creates a time-limited Part D Special Enrollment Period.

D. Whether her spouse's employer must enroll her directly in a PDP.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 570 | M2-020

Nadia signs a written Scope of Appointment and then submits a complete MA application in June with no SEP, AEP, or initial election right documented. How should the agent treat the submission?

A. It should not be represented as a valid election unless an applicable enrollment period is established.

B. It should be processed as an AEP request because the paperwork is complete.

C. It should be approved automatically because the SOA was properly documented.

D. It should be converted into an institutional SEP without confirming residence.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 571 | M2-021

Gideon relocates permanently to a new state and, before the move, notifies his MA plan in advance of the exact date. When might his election window begin under that advance notice?

A. Only after the move is complete, with no earlier starting point permitted.

B. It may begin before the move month when advance notice is properly provided.

C. It never applies because moves only support Part D elections.

D. It begins automatically on the date of his original Initial Coverage Election Period.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 572 | M2-022

Corinne's MA plan sends written notice that its Medicare contract will not continue past the current year. She asks whether she must wait for the next fall election to choose new coverage. What should the agent explain?

A. She must wait for AEP because nonrenewal creates no separate opportunity.

B. She automatically defaults into whichever plan has the lowest premium in her county.

C. A nonrenewal generally creates a special election window for choosing replacement coverage sooner.

D. She may keep the nonrenewing plan active indefinitely by contacting the plan directly.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 573 | M2-023

Which fact is central to determining whether a beneficiary may use the Medicare Advantage Open Enrollment Period this year?

A. Whether the beneficiary has ever purchased a Medigap policy.

B. Whether the beneficiary's income qualifies for Extra Help.

C. Whether the beneficiary's prescriber participates in the plan's network.

D. Whether the beneficiary is currently enrolled in Medicare Advantage.

Enrollment periods, elections, SEPs, disenrollment | Direct Knowledge

QUESTION 574 | M2-024

What distinguishes the Initial Coverage Election Period from the Annual Election Period?

A. The ICEP is tied to a beneficiary's first entitlement to both Part A and Part B, while AEP recurs each fall for all eligible beneficiaries.

B. The ICEP occurs every fall, while AEP occurs only once in a lifetime.

C. The ICEP applies only to beneficiaries already enrolled in an MA plan.

D. The ICEP and AEP are two names describing the identical enrollment period.

Enrollment periods, elections, SEPs, disenrollment | Direct Knowledge

QUESTION 575 | M2-025

Which situation is most likely to support a disaster or emergency Special Enrollment Period?

A. A beneficiary simply prefers a plan with a newly reduced premium.

B. A qualifying declared emergency prevented use of another valid election opportunity.

C. An agent forgot to submit a completed application on time.

D. A weather event affected a region where the beneficiary does not reside.

Enrollment periods, elections, SEPs, disenrollment | Direct Knowledge

QUESTION 576 | M2-026

A submitted enrollment form shows a signature date that was altered to fall within the AEP window after the beneficiary actually signed it in July. What must compliance do?

A. Accept the corrected date because the beneficiary eventually wanted AEP coverage.

B. Forward the file for processing without noting the discrepancy.

C. Treat the altered date as a documentation integrity violation and investigate the actual election timing.

D. Ask the beneficiary to resign using the same false date to match the file.

Enrollment periods, elections, SEPs, disenrollment | Compliance Judgment

QUESTION 577 | M2-027

Review these enrollment-timing statements. I. The MA OEP is limited to people already enrolled in Medicare Advantage. II. A permanent move outside a plan's service area can create a Special Enrollment Period. III. A completed application always creates a valid election regardless of timing. IV. AEP elections generally take effect January 1. Which answer identifies all and only the accurate statements?

A. Statements I and III only.

B. Statements II and III only.

C. Statements I, III, and IV.

D. Statements I, II, and IV.

Enrollment periods, elections, SEPs, disenrollment | Alt Format / Select All

QUESTION 578 | M2-028

Emil's plan requires him to try two lower-cost formulary alternatives before it will cover the brand-name drug his prescriber originally selected. His prescriber says both alternatives are medically unsuitable for him. What request addresses the situation?

A. A step-therapy exception request supported by the prescriber's medical statement.

B. A grievance about the pharmacy's posted business hours.

C. An organization determination for a Part A hospital claim.

D. A permanent formulary rewrite issued directly by the dispensing pharmacy.

Part D, formularies, tiers, Extra Help, TrOOP | Scenario

QUESTION 579 | M2-029

Rosalind fills a covered prescription and later reviews her statement, wanting to understand which amounts actually count toward her personal true out-of-pocket total. What should she be told?

A. The full negotiated price of the drug always becomes her TrOOP regardless of who pays it.

B. Her qualifying deductible and coinsurance payments generally count, while the plan's own payment generally does not.

C. TrOOP applies only to Part B services and never to Part D drugs.

D. TrOOP resets to zero every time she changes pharmacies.

Part D, formularies, tiers, Extra Help, TrOOP | Scenario

QUESTION 580 | M2-030

Hector's long-standing medication is not on his new Part D plan's formulary, and his prescriber needs time to review alternatives. What temporary protection may apply during that review?

A. A permanent tier reassignment ordered automatically by the pharmacy.

B. An immediate formulary exception with no supporting request required.

C. A transition supply under the plan's required transition policy.

D. A conversion of the prescription into a Part B medical benefit.

Part D, formularies, tiers, Extra Help, TrOOP | Scenario

QUESTION 581 | M2-031

Under the current CY2027 defined-standard Part D benefit, what happens to a beneficiary's cost sharing for covered drugs once catastrophic coverage begins?

A. Cost sharing increases sharply for every covered drug at that stage.

B. A separate coverage-gap payment is required before catastrophic coverage applies.

C. The beneficiary must pay the plan's full negotiated price during this phase.

D. The beneficiary owes no cost sharing for covered Part D drugs in catastrophic coverage.

Part D, formularies, tiers, Extra Help, TrOOP | Direct Knowledge

QUESTION 582 | M2-032

How does a formulary exception differ from a tiering exception in Part D?

A. A formulary exception requests coverage of a drug not on the list, while a tiering exception requests lower cost sharing for an eligible covered drug on a higher tier.

B. A formulary exception lowers cost sharing, while a tiering exception adds a new drug to the list.

C. The two terms describe the identical Part D request in every case.

D. A formulary exception applies only to Part B services.

Part D, formularies, tiers, Extra Help, TrOOP | Direct Knowledge

QUESTION 583 | M2-033

A printed rate sheet tells prospects that the Medicare Prescription Payment Plan will reduce their total annual drug spending. What must be corrected before distribution?

A. Nothing, because the payment plan always lowers the amount owed.

B. State accurately that the program spreads cost-sharing payments over the year without reducing the total amount owed.

C. Add a promise that enrollees will never reach the deductible phase.

D. Replace the phrase with a claim that TrOOP no longer applies to participants.

Part D, formularies, tiers, Extra Help, TrOOP | Compliance Judgment

QUESTION 584 | M2-034

Vivian's plan mails a notice reminding members to schedule an annual wellness visit, without discussing benefits, costs, comparisons, or any enrollment step. How should the piece be classified for marketing purposes?

A. Marketing, because the plan authored and sent the notice.

B. An enrollment mechanism, because it references a scheduled visit.

C. A communication that does not meet both required marketing elements.

D. A sales event invitation tied to the wellness visit.

Marketing, communications, SOA, events | Scenario

QUESTION 585 | M2-035

A seminar billed as general Medicare education begins highlighting one carrier's specific premium and starts handing attendees that carrier's enrollment forms. What has the event become?

A. It remains educational because the flyer used the word education.

B. It becomes a grievance proceeding once forms are distributed.

C. It becomes an organization determination requiring formal appeal rights.

D. It becomes a marketing or sales event because of the plan-specific content and form distribution.

Marketing, communications, SOA, events | Scenario

QUESTION 586 | M2-036

Bruno's agency wants to hand out branded pens and notepads at a sales event without conditioning the items on enrollment or completing a form. Is that generally consistent with the nominal-gift approach?

A. Yes, when the modest noncash items are offered to attendees regardless of whether they enroll.

B. No, because any item bearing a company logo is automatically prohibited.

C. Yes, but only if attendees first agree to complete an application.

D. No, because nominal items may be offered only at educational events.

Marketing, communications, SOA, events | Scenario

QUESTION 587 | M2-037

Alina's team plans a joint session where a general Medicare lesson is followed by a separate carrier's sales pitch in the same conference room. What must the transition include to preserve attendee choice under the current rule?

A. A private signal understood only by staff so attendees do not notice the change.

B. A clear announcement that the educational portion has ended, with real time to leave before marketing begins.

C. Locked doors until the carrier's presentation concludes.

D. Collection of every attendee's completed enrollment form during the educational segment.

Marketing, communications, SOA, events | Scenario

QUESTION 588 | M2-038

Which factual basis is required to support a claim that one MA plan's benefit is superior to another's?

A. A general impression formed by the agent without checking current materials.

B. An unqualified superlative applied to every category of benefit.

C. Current, traceable plan documents identifying the specific measure and plan year being compared.

D. The agent's recollection of the plans from an earlier enrollment period.

Marketing, communications, SOA, events | Direct Knowledge

QUESTION 589 | M2-039

Which practice is consistent with CMS's health-care-setting marketing location rules?

A. Approaching patients while they wait in an examination room.

B. Setting up a table beside chairs used for ongoing treatment.

C. Soliciting enrollment at the pharmacy's dispensing counter.

D. Setting up in an approved public common area such as a lobby or cafeteria.

Marketing, communications, SOA, events | Direct Knowledge

QUESTION 590 | M2-040

A quality review finds a lead form offering a modest thank-you item explicitly for anyone who signs an MA application on the spot. What correction is required?

A. Remove the enrollment condition, since tying any item to completing an application creates an inducement problem.

B. Keep the offer because the item's value is small.

C. Approve it only for attendees over a certain age.

D. Replace the item with cash of an equivalent value.

Marketing, communications, SOA, events | Compliance Judgment

QUESTION 591 | M2-041

An agent's script claims that comparing plans always takes less than five minutes and skips any discussion of the beneficiary's current providers or prescriptions. What must be added before the meeting proceeds?

A. Nothing, since a fast comparison satisfies the beneficiary-needs requirement.

B. A genuine review of the beneficiary's providers, drugs, pharmacies, and costs before any recommendation.

C. A requirement that the beneficiary sign first and ask questions afterward.

D. A statement that every plan is equally suitable regardless of individual circumstances.

Marketing, communications, SOA, events | Compliance Judgment

QUESTION 592 | M2-042

Assess this statement: A Scope of Appointment listing only Medicare Advantage automatically authorizes an agent to discuss a stand-alone PDP without any further documentation. Which evaluation is accurate?

A. True; an MA entry always includes stand-alone drug plans.

B. True; but only during the fall Annual Election Period.

C. False; discussing an additional product category requires appropriate scope documentation for that category.

D. False; but only because SOAs are never required for stand-alone PDPs.

Marketing, communications, SOA, events | Alt Format / True False

QUESTION 593 | M2-043

Warren's TPMO records only the portion of a sales call after the beneficiary agrees to enroll, deleting the earlier benefit-comparison audio. Is that consistent with the recording requirement?

A. Yes, because only the enrollment portion legally matters.

B. Yes, if the agent summarizes the deleted portion in writing.

C. Yes, because web-based calls are exempt from the requirement.

D. No; the marketing and sales portion of the call must be recorded in its entirety.

TPMOs, call recording, permission to contact | Scenario

QUESTION 594 | M2-044

Celeste's agency wants to share a caller's contact details with a second, unnamed marketing partner listed only as an affiliate network. What must the consent process include?

A. Identification of each specific receiving TPMO with a separate opportunity to accept or decline sharing.

B. A single blanket checkbox covering every possible future partner.

C. Verbal agreement obtained after the data has already been transferred.

D. An assumption of consent whenever the caller does not object.

TPMOs, call recording, permission to contact | Scenario

QUESTION 595 | M2-045

What is the primary function of a Scope of Appointment in a personal marketing appointment?

A. It authorizes an agent to make unsolicited outbound calls to any beneficiary.

B. It documents the specific product categories the beneficiary has agreed to discuss.

C. It replaces the plan's required enrollment mechanism entirely.

D. It serves as the beneficiary's formal grievance filing.

TPMOs, call recording, permission to contact | Direct Knowledge

QUESTION 596 | M2-046

A monitoring report shows that a downstream vendor performing enrollment support for a sponsor has never been checked against licensing or appointment records. What must the sponsor do?

A. Nothing, because delegation to a vendor removes the sponsor's oversight duty.

B. Wait until a complaint arrives before reviewing the vendor's credentials.

C. Establish and maintain oversight of the vendor's licensing and appointment status as part of its ongoing compliance program.

D. Instruct the vendor to self-certify without any independent verification.

TPMOs, call recording, permission to contact | Compliance Judgment

QUESTION 597 | M2-047

Dario notices that a colleague has been billing for a specific test in a pattern that never varies and always reaches the exact same reimbursement ceiling. He is unsure whether this reflects a documented policy or a deliberate scheme. What should he do?

A. Assume it is authorized and take no further action.

B. Confront the colleague directly and demand a private explanation before telling anyone else.

C. Wait until he personally reviews every past claim before mentioning the pattern.

D. Report the observed pattern promptly through the designated compliance channel and preserve the supporting facts.

Fraud, waste and abuse; privacy; reporting | Scenario

QUESTION 598 | M2-048

Which description most accurately distinguishes abuse from fraud in a Medicare compliance context?

A. Abuse involves practices inconsistent with accepted standards that create unnecessary cost, without the knowing deception required for fraud.

B. Abuse and fraud both require identical proof of knowing intent to deceive.

C. Abuse applies only to clerical data-entry mistakes.

D. Abuse is a synonym for a beneficiary's dissatisfaction with customer service.

Fraud, waste and abuse; privacy; reporting | Direct Knowledge

QUESTION 599 | M2-049

Miriam's MA plan denies coverage for a requested procedure, and her physician states that following the standard appeal timeline could seriously jeopardize her ability to regain function. Which review should be requested?

A. A routine grievance addressing customer-service dissatisfaction.

B. An expedited appeal supported by the physician's statement about the health risk of delay.

C. A Special Enrollment Period to change plans immediately.

D. A quality-of-care complaint filed with an unrelated state agency.

Beneficiary protections, appeals, grievances | Scenario

QUESTION 600 | M2-050

Which description accurately fits an MA plan's reconsideration of its own initial adverse organization determination?

A. It is the same process as a Part D coverage determination.

B. It is a final decision that cannot involve any further review.

C. It is an internal appeal level where the plan reexamines its initial coverage or payment decision.

D. It is limited to complaints about representative courtesy.

Beneficiary protections, appeals, grievances | Direct Knowledge

Mock Exam 3 - 50 questions

50 questions. Choose one answer per item; answers and full rationales are in Part II.

QUESTION 601 | M3-001

Rosa receives chemotherapy at a hospital-owned outpatient clinic and assumes any charge tied to a hospital building falls under Part A. Which part generally covers the outpatient drug administration itself?

A. Part B generally covers medically necessary outpatient drug administration in this clinic setting.

B. Part A covers the administration because the clinic is owned by a hospital.

C. Part D covers the administration whenever the medication is injected rather than swallowed.

D. Part C pays automatically even though Rosa has not enrolled in Medicare Advantage.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 602 | M3-002

Ivan's kidney specialist mentions that permanent kidney failure requiring dialysis can create Medicare entitlement well before the usual retirement age. What should the agent verify before treating Ivan as Medicare-eligible?

A. Whether dialysis patients automatically forfeit Medicare eligibility until age sixty-five.

B. Ivan's official entitlement record and its effective date, since this pathway differs from standard age-based entitlement.

C. Whether a nephrologist referral alone satisfies Medicare's entitlement requirement.

D. Whether Ivan must first enroll in Medicare Advantage before this entitlement pathway can begin.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 603 | M3-003

Naomi is sixty-five, has fewer than the typical quarters of qualifying work history, and worries she cannot get Part A at all. What should the agent clarify about her options?

A. Insufficient work history disqualifies her from Part A under every circumstance.

B. She must join a Medicare Advantage plan first to unlock Part A eligibility.

C. She may still be able to enroll in Part A by paying a monthly premium instead of receiving it premium-free.

D. Only Part B is available to anyone without the standard work history.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 604 | M3-004

Felix assumes his MA plan's benefits, premium, and cost sharing will remain identical every year without any notice. Which document should the agent point him to for confirming annual changes?

A. The Provider Directory, since it lists which benefits never change.

B. A prior year's Summary of Benefits, since it remains the governing document.

C. The formulary alone, because it covers every plan benefit category.

D. The Annual Notice of Change, which describes plan modifications for the coming year.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 605 | M3-005

Which fact distinguishes Part A hospital coverage from Part B medical coverage in Original Medicare?

A. Part A principally addresses inpatient and certain institutional care, while Part B principally addresses outpatient and professional services.

B. Part A covers only prescription drugs dispensed at a hospital pharmacy.

C. Part B applies solely to beneficiaries enrolled in a Medicare Advantage plan.

D. Part A and Part B cover identical services with no meaningful distinction.

Parts A/B/C/D, eligibility, plan types | Direct Knowledge

QUESTION 606 | M3-006

What should an agent confirm before telling a beneficiary that Original Medicare alone will pay for long-term custodial nursing-home stays?

A. Original Medicare covers unlimited custodial nursing-home stays for any beneficiary.

B. Original Medicare generally does not cover long-term custodial care, so the limited skilled-care benefits it does provide should be clarified.

C. A Medicare Advantage debit card always converts into custodial-care coverage.

D. Part D pays for custodial nursing-home room and board.

Parts A/B/C/D, eligibility, plan types | Direct Knowledge

QUESTION 607 | M3-007

Why might two beneficiaries with the same diagnosis receive different Medicare cost-sharing amounts for the same outpatient service?

A. Medicare cost sharing is identical for every beneficiary regardless of plan.

B. Only the treating physician's personal fee schedule determines the amount owed.

C. Their coverage route, such as Original Medicare versus a specific Medicare Advantage plan, can set different cost-sharing structures for the same service.

D. Cost sharing depends exclusively on the beneficiary's zip code and nothing else.

Parts A/B/C/D, eligibility, plan types | Direct Knowledge

QUESTION 608 | M3-008

An agent tells a prospect that Original Medicare Part A and Part B alone provide unlimited annual protection against high medical costs. What correction does compliance require?

A. Approve the statement because Part A and Part B always cap total costs.

B. Approve it only if the prospect signs an acknowledgment form.

C. Replace the claim with a promise that Medigap eliminates all future costs.

D. Clarify that Original Medicare generally has no single overall annual cap on Part A and Part B cost sharing.

Parts A/B/C/D, eligibility, plan types | Compliance Judgment

QUESTION 609 | M3-009

Evaluate this statement: A beneficiary who lacks enough qualifying work history for premium-free Part A may still be able to obtain Part A by paying a monthly premium. Which response is correct?

A. True; this is a permitted pathway to Part A coverage separate from the premium-free route.

B. False; insufficient work history bars Part A under every circumstance.

C. False; only Part B may ever be purchased without sufficient work history.

D. True; but the premium is waived automatically for everyone who asks.

Parts A/B/C/D, eligibility, plan types | Alt Format / True False

QUESTION 610 | M3-010

Greta enrolls in a standard HMO and wants to see a specialist without visiting her primary care physician first. What should she generally expect?

A. Every HMO automatically waives referral rules for specialist care.

B. The HMO may require a referral or primary-care coordination before the specialist visit is covered.

C. The specialist visit converts her HMO into a PFFS plan for that encounter.

D. PPO out-of-network rules automatically apply to her HMO visit.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 611 | M3-011

Dmitri's PFFS plan explains that some providers are deemed to accept the plan's terms while others are not. What determines whether a given provider's care is covered?

A. Every provider nationwide is automatically deemed to accept every PFFS plan.

B. PFFS coverage depends only on whether Dmitri has Part D.

C. Coverage can depend on whether that specific provider has agreed to the plan's terms for the service provided.

D. The plan converts into Original Medicare whenever a provider declines the terms.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 612 | M3-012

Yolanda has full Medicaid benefits and Medicare and wants a plan that coordinates both programs closely. Which plan category is designed for her situation?

A. A C-SNP based only on her age rather than any chronic condition.

B. An MSA chosen because it includes an integrated Medicaid deposit.

C. A regional PPO available to any beneficiary regardless of Medicaid status.

D. A D-SNP serving beneficiaries with her qualifying dual-eligible category.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 613 | M3-013

Simone is covered by her former employer's EGWP and wants to independently switch to a different individual-market MA plan during the fall election period. What should the agent confirm?

A. Whether her employer-sponsored coverage or plan terms affect her ability to make an independent individual election.

B. Whether the EGWP automatically forbids her from ever using any election period.

C. Whether Original Medicare must first be cancelled before the EGWP can exist.

D. Whether her Part D coverage disqualifies her from Medicare entirely.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 614 | M3-014

Which description accurately distinguishes a Medicare MSA from other Medicare Advantage plan types?

A. It always includes an embedded Part D benefit like an MA-PD.

B. It combines a high-deductible health plan with a medical savings account and does not include embedded Part D coverage.

C. It requires a referral from a primary care physician for every service.

D. It is available only to beneficiaries who qualify for a D-SNP.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Direct Knowledge

QUESTION 615 | M3-015

What is the defining structural feature that separates a regional PPO from a local PPO?

A. Only regional PPOs may enroll beneficiaries who lack Part B.

B. Only local PPOs may offer any out-of-network benefit.

C. The regional PPO's service area is a CMS-defined region rather than a locally configured area.

D. Regional PPOs are automatically special-needs plans for chronic conditions.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Direct Knowledge

QUESTION 616 | M3-016

A flyer calls a plan's supplemental grocery allowance guaranteed spending money for every enrollee regardless of eligibility criteria. How should the reviewer correct the claim?

A. Approve the flyer because every supplemental benefit functions as unrestricted spending money.

B. Approve it if a disclaimer is added in a smaller font at the bottom.

C. Replace only the plan's logo while keeping the guaranteed-money claim.

D. Require the flyer to disclose the benefit's actual eligibility and covered-use limits accurately.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Compliance Judgment

QUESTION 617 | M3-017

Match each plan feature with its plan type: a defined CMS region rather than a local service area, a high-deductible account-based structure with no embedded Part D, and enrollment tied to a qualifying dual-eligible category. Which sequence is accurate?

A. Regional PPO; Medicare MSA; D-SNP.

B. D-SNP; Regional PPO; Medicare MSA.

C. Medicare MSA; D-SNP; Regional PPO.

D. Regional PPO; D-SNP; Medicare MSA.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Alt Format / Matching

QUESTION 618 | M3-018

Aaron, currently enrolled in an MA plan, already used his one permitted MA Open Enrollment Period switch in January. In March he wants to switch again using the same period. What should the agent explain?

A. The MA OEP allows unlimited switches through the end of March.

B. The MA OEP generally allows only one qualifying change, so a second switch under that same period is not available.

C. He must use the 5-star SEP even though no 5-star plan is involved.

D. He should backdate the new request to January to reuse the same period.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 619 | M3-019

Priscilla's employer eliminates her retiree health plan mid-year without her requesting the change. She wants to enroll in a Part D plan right away. Which timing issue should the agent verify?

A. Whether she must wait until the next AEP regardless of the coverage loss.

B. Whether the loss automatically enrolls her in a stand-alone PDP without an election.

C. Whether the loss of creditable employer coverage opens a time-limited Part D Special Enrollment Period.

D. Whether her former employer must first approve her Part D enrollment.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 620 | M3-020

Winston missed his valid AEP election because a declared regional emergency closed his usual community assistance office during the entire election period. What relief should be reviewed?

A. An automatic extension of AEP for every beneficiary nationwide.

B. A permanent right to enroll in MA at any time going forward.

C. A requirement that the community office reopen before any relief is possible.

D. A disaster or emergency SEP addressing his inability to use the AEP opportunity for which he was otherwise eligible.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 621 | M3-021

Carmen newly qualifies for Extra Help in June and wants to switch stand-alone PDPs that same month without waiting for AEP. She has no drug-management restriction. What election opportunity applies?

A. The monthly low-income Part D SEP available to qualifying Extra Help beneficiaries.

B. The MA Open Enrollment Period, even though she has no MA enrollment.

C. The institutional SEP, even though she does not live in a qualifying facility.

D. The 5-star SEP, regardless of the destination plan's rating.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 622 | M3-022

Which fact should be verified before assuming a beneficiary's move creates a Special Enrollment Period?

A. Whether the beneficiary merely visited the new area for a short vacation.

B. Whether the move is permanent and results in different plan availability at the new address.

C. Whether the beneficiary's favorite plan has the same name in both locations.

D. Whether the move occurred during the same week as an AEP election.

Enrollment periods, elections, SEPs, disenrollment | Direct Knowledge

QUESTION 623 | M3-023

Why is a beneficiary's return to the United States after living abroad treated as a distinct enrollment circumstance?

A. It automatically enrolls the beneficiary in the highest-rated plan nationwide.

B. It requires the beneficiary to keep a foreign mailing address indefinitely.

C. It is a recognized Special Enrollment Period circumstance for joining available Medicare coverage after the return.

D. It has no bearing on any Medicare election opportunity.

Enrollment periods, elections, SEPs, disenrollment | Direct Knowledge

QUESTION 624 | M3-024

What generally happens to a beneficiary's coverage options when a Medicare plan's contract is not renewed for the coming year?

A. The member is required to remain uninsured until the following AEP.

B. The plan continues indefinitely despite the nonrenewal decision.

C. The member is automatically transferred into the sponsor's commercial insurance product.

D. A special election window and required notices support the member's move to replacement coverage.

Enrollment periods, elections, SEPs, disenrollment | Direct Knowledge

QUESTION 625 | M3-025

A completed MA enrollment form arrives in early August with no documented SEP, AEP, or MA OEP eligibility, yet the agent wants to submit it immediately. What is the correct handling?

A. Do not treat the form as a valid election until an applicable enrollment period is documented.

B. Submit the form and let the plan invent a qualifying SEP later.

C. Change the signature date to the most recent AEP to resolve the gap.

D. Treat the form as automatically valid because it is fully completed.

Enrollment periods, elections, SEPs, disenrollment | Compliance Judgment

QUESTION 626 | M3-026

During telephonic enrollment, the beneficiary's spouse answers the required acknowledgment questions on the beneficiary's behalf without the beneficiary present. What must the agent do?

A. Continue because a spouse's answers are always an acceptable substitute.

B. Stop and obtain the beneficiary's own acknowledgment and consent through the approved mechanism.

C. Complete the enrollment and note the discrepancy only if it is later questioned.

D. Ask the spouse to sign the beneficiary's name on the recorded call.

Enrollment periods, elections, SEPs, disenrollment | Compliance Judgment

QUESTION 627 | M3-027

Consider four statements about Medicare election periods. I. The MA OEP permits eligible current MA enrollees one qualifying change. II. A permanent move outside the service area can create a Special Enrollment Period. III. The Annual Election Period lets a person in Original Medicare join Medicare Advantage for the next plan year. IV. Institutional election rights require the beneficiary to have never left the facility. Which answer includes all and only the accurate statements?

A. I and IV only.

B. II and IV only.

C. I, II, and III only.

D. I, II, III, and IV.

Enrollment periods, elections, SEPs, disenrollment | Alt Format / Select All

QUESTION 628 | M3-028

Otis has taken the same maintenance drug for years, but his plan adds a new prior-authorization rule mid-year before he has time to get approval. What temporary protection might apply while he pursues approval?

A. A permanent formulary rewrite ordered by the dispensing pharmacy.

B. An automatic waiver that cancels the new prior-authorization rule for everyone.

C. A tiering exception that addresses only cost-sharing placement, not authorization.

D. A transition supply that can provide temporary access while the required approval or exception is pursued.

Part D, formularies, tiers, Extra Help, TrOOP | Scenario

QUESTION 629 | M3-029

Beatriz uses a manufacturer coupon to reduce her out-of-pocket cost on a covered brand-name drug and assumes the coupon amount still counts fully toward her TrOOP. What should the agent clarify?

A. Certain manufacturer discounts may not count toward TrOOP in the same way as her own qualifying payments, so the specific rule should be checked.

B. Every dollar of any coupon or discount always counts as her personal TrOOP.

C. Coupons automatically disqualify the drug from the plan's formulary.

D. TrOOP tracking stops entirely once any coupon is used on a prescription.

Part D, formularies, tiers, Extra Help, TrOOP | Scenario

QUESTION 630 | M3-030

Hassan qualifies for a partial Extra Help subsidy rather than the full-subsidy level. He assumes this means no reduction in his Part D costs at all. What should the agent explain?

A. A partial subsidy provides no reduction whatsoever in Part D costs.

B. A partial subsidy can still reduce his qualifying premium, deductible, or cost sharing, even though it is less generous than the full-subsidy level.

C. Partial subsidy status automatically converts him to full Medicaid benefits.

D. Partial subsidy eligibility requires him to enroll in a D-SNP.

Part D, formularies, tiers, Extra Help, TrOOP | Scenario

QUESTION 631 | M3-031

Which two Part D concepts should be checked separately before concluding that a covered drug is fully accessible to a beneficiary?

A. Only the drug's tier number, since tier alone determines access.

B. Only the beneficiary's zip code, since location alone determines coverage.

C. Formulary coverage and any applicable utilization-management rule, such as prior authorization or step therapy.

D. Only the pharmacy's business hours, since timing alone determines access.

Part D, formularies, tiers, Extra Help, TrOOP | Direct Knowledge

QUESTION 632 | M3-032

A longtime client asks whether she will hit the “donut hole” her neighbor remembers from years past. Under the current CY2027 defined-standard Part D benefit design, which phase structure applies?

A. Four phases, including a separate coverage-gap phase between initial and catastrophic coverage.

B. A single flat-coinsurance phase that runs for the entire plan year.

C. A deductible phase followed by full negotiated price until the out-of-pocket threshold is met.

D. Three phases — deductible, initial coverage, and catastrophic — with no separate coverage-gap phase.

Part D, formularies, tiers, Extra Help, TrOOP | Direct Knowledge

QUESTION 633 | M3-033

Marketing copy claims that every Part D enrollee automatically receives Extra Help once enrolled. What must the reviewer require?

A. Remove the claim and describe Extra Help as a separate subsidy requiring its own qualifying status.

B. Keep the claim because Part D enrollment and Extra Help are the same program.

C. Approve the claim if it appears only in the fine print.

D. Replace Extra Help with a description of the Medicare Prescription Payment Plan instead.

Part D, formularies, tiers, Extra Help, TrOOP | Compliance Judgment

QUESTION 634 | M3-034

Josephine calls an agent to compare MA plans by phone, and the agent begins discussing specific plan benefits before confirming which product categories she wants to cover. What should have occurred first?

A. Nothing, because telephone appointments do not require any Scope of Appointment.

B. The agent should have obtained and documented a Scope of Appointment before the plan-specific discussion.

C. The agent should have waited until enrollment was complete to document scope.

D. The agent should have relied on a prior Permission to Contact as sufficient scope.

Marketing, communications, SOA, events | Scenario

QUESTION 635 | M3-035

Malik's agency wants to give every event attendee a general-purpose prepaid gift card whether or not they enroll. Is that consistent with Medicare's marketing rules?

A. Yes, because the card is offered regardless of enrollment, so it is automatically compliant.

B. Yes, because any general-purpose card is automatically treated as a modest noncash item.

C. A broadly spendable gift card functions as a cash equivalent and is not treated the same as a modest noncash item.

D. No, because attendees may never receive anything of value at any Medicare event.

Marketing, communications, SOA, events | Scenario

QUESTION 636 | M3-036

Renata's agency sends unsolicited direct messages through a social media platform promoting a specific MA plan to people who never requested contact. How should this outreach be classified?

A. As a permitted communication because social media is not covered by CMS marketing rules.

B. As an educational message because it mentions general Medicare information.

C. As beneficiary-initiated contact because the recipients follow the agency's public page.

D. As prohibited unsolicited direct contact, similar to other restricted outbound channels.

Marketing, communications, SOA, events | Scenario

QUESTION 637 | M3-037

Curtis prepares a plan comparison chart for a prospect but reuses figures from an old plan year without noting the source or date. What correction is needed before use?

A. The chart should be updated to current plan-year figures with the source and applicable year clearly identified.

B. The chart is acceptable as long as the numbers were once accurate for some year.

C. The chart should be relabeled as an official CMS publication.

D. The chart should remove all dates so it never appears outdated.

Marketing, communications, SOA, events | Scenario

QUESTION 638 | M3-038

Which factor determines whether a beneficiary interaction qualifies as a personal marketing appointment requiring a Scope of Appointment?

A. Whether the meeting happens inside an office building rather than by phone.

B. Whether it is an individualized, scheduled discussion of specific plan products with the beneficiary.

C. Whether the beneficiary brings a family member along.

D. Whether the agent personally prefers to document a scope.

Marketing, communications, SOA, events | Direct Knowledge

QUESTION 639 | M3-039

Which description accurately reflects the current rule on transitioning from an educational event to a sales presentation in the same room?

A. A mandatory forty-eight hour delay must separate the two sessions at all times.

B. No transition of any kind is ever permitted at the same location.

C. A clear notice and a genuine opportunity to leave may permit the transition without the former waiting period.

D. The transition may occur silently as long as the agenda mentions both sessions.

Marketing, communications, SOA, events | Direct Knowledge

QUESTION 640 | M3-040

An agent collects completed AEP applications on October 12 and plans to hold them until the period legally opens. What must compliance direct?

A. Approve the practice because the applications will not be submitted until October 15.

B. Approve it only if the agent promises not to read the answers.

C. Allow it if the beneficiary initials a note acknowledging the early collection.

D. Do not solicit or take possession of completed AEP requests before the period opens, regardless of any planned holding period.

Marketing, communications, SOA, events | Compliance Judgment

QUESTION 641 | M3-041

A recruitment script instructs new agents to promise every prospect that a specific MA plan will approve their preferred grocery benefit application. What must be corrected?

A. Remove the guarantee and explain that the plan applies its own published eligibility criteria.

B. Keep the promise if the agent personally believes the prospect will qualify.

C. Keep the promise only for prospects who mention a chronic illness.

D. Replace the promise with a claim that all enrollees automatically receive cash instead.

Marketing, communications, SOA, events | Compliance Judgment

QUESTION 642 | M3-042

Assess this statement: A neutral plan notice listing only updated customer-service phone numbers, with no benefit, cost, or comparison content, automatically qualifies as marketing because a plan sponsor sent it. Which response is correct?

A. True; any notice sent by a plan sponsor is automatically marketing.

B. False; sponsor authorship alone does not satisfy both required marketing prongs.

C. True; but only if the notice also contains an enrollment form.

D. False; but only because phone numbers are always considered educational content.

Marketing, communications, SOA, events | Alt Format / True False

QUESTION 643 | M3-043

Cyrus conducts a plan comparison entirely through a live web chat with no audio, and the beneficiary later enrolls through that chat. Does the TPMO audio-recording mandate apply to this interaction?

A. Yes, because every enrollment of any kind must always be captured on an audio recording.

B. No, and no other recordkeeping obligation applies to a chat-based enrollment.

C. The specific audio-recording mandate targets telephonic calls, so a text-only chat is analyzed under the rules that actually apply to that channel.

D. Yes, but only if the beneficiary specifically requests that a recording be made.

TPMOs, call recording, permission to contact | Scenario

QUESTION 644 | M3-044

Odalys gave permission to be contacted about Medicare Advantage plans only. An agent later calls her about a separate dental discount product using that same permission. What is the problem?

A. There is no problem because any permission to contact covers every future product.

B. There is no problem because dental products are automatically included in every MA discussion.

C. The problem is solved as long as the agent apologizes at the start of the call.

D. The outreach exceeds the scope of the permission Odalys actually gave for contact.

TPMOs, call recording, permission to contact | Scenario

QUESTION 645 | M3-045

Why does a TPMO's marketing and sales call retention duty distinguish the first three years from years four through six?

A. Audio must be kept during the initial three years, while a complete and accurate transcript may substitute during the remaining retention years.

B. No records of any kind need to be kept after the first year.

C. Only the beneficiary's name must be retained after year one.

D. The distinction applies only to calls that resulted in an enrollment.

TPMOs, call recording, permission to contact | Direct Knowledge

QUESTION 646 | M3-046

A lead-sharing agreement lets one TPMO forward beneficiary data to five other named companies through a single combined checkbox with no way to decline any one of them individually. What must be fixed?

A. Nothing, because naming all five companies together satisfies the consent requirement.

B. Give the beneficiary the ability to accept or reject each named recipient separately through prior express written consent.

C. Add a sixth unnamed company to the same combined checkbox.

D. Remove all company names so the form appears simpler.

TPMOs, call recording, permission to contact | Compliance Judgment

QUESTION 647 | M3-047

Perla accidentally faxes an enrollment record to the wrong office and immediately notices the error. What should she do first under standard privacy procedures?

A. Wait to see whether the receiving office calls to complain.

B. Resend the same fax to the correct office and consider the matter closed.

C. Report the potential disclosure promptly through the designated privacy or security channel.

D. Ask a coworker informally rather than alerting the compliance team.

Fraud, waste and abuse; privacy; reporting | Scenario

QUESTION 648 | M3-048

During annual compliance training, an agent asks how “waste” differs from fraud and abuse in CMS program-integrity terms. Which statement best characterizes waste?

A. Waste requires the same proof of knowing, willful deception that fraud requires.

B. Waste refers only to billing mistakes made by beneficiaries themselves.

C. Waste is any practice that automatically results in criminal prosecution.

D. Waste is overutilization or careless use of resources that squanders program dollars, generally without criminal intent.

Fraud, waste and abuse; privacy; reporting | Direct Knowledge

QUESTION 649 | M3-049

Which timeframe consideration is central to deciding whether an appeal should be handled on an expedited basis?

A. Whether the standard appeal timeframe could seriously jeopardize the member's life, health, or ability to regain maximum function.

B. Whether the beneficiary simply prefers a faster answer for convenience.

C. Whether the agent believes the appeal is likely to succeed.

D. Whether the beneficiary has already filed a separate grievance.

Beneficiary protections, appeals, grievances | Direct Knowledge

QUESTION 650 | M3-050

Match each situation with its proper review channel: dissatisfaction with a representative's tone, an MA plan's initial decision on a requested service, and an urgent situation where delay could seriously jeopardize health. Which sequence is accurate?

A. Organization determination; grievance; expedited appeal.

B. Grievance; organization determination; expedited appeal.

C. Expedited appeal; grievance; organization determination.

D. Grievance; expedited appeal; organization determination.

Beneficiary protections, appeals, grievances | Alt Format / Matching

Mock Exam 4 - 45 questions

45 questions. Choose one answer per item; answers and full rationales are in Part II.

QUESTION 651 | M4-001

Renata is scheduled for a same-day procedure at an outpatient surgical clinic and wonders which Medicare part usually pays the facility fee. What should she be told?

A. Part D covers the facility fee whenever anesthesia is billed separately.

B. Part A covers every charge billed by an outpatient clinic.

C. Part B generally covers the outpatient facility fee when Medicare's coverage rules are met.

D. Part C pays the claim even though Renata has never joined Medicare Advantage.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 652 | M4-002

Marcus keeps hearing that his new MA plan replaces Medicare entirely and stops his obligation to the federal program. How should an agent correct that impression?

A. The MA plan delivers his Medicare Part A and Part B benefits through a private contract with CMS.

B. The MA plan is an optional add-on that leaves Original Medicare as his primary payer.

C. The MA plan converts his coverage into an employer-sponsored group product.

D. The MA plan exists only to supplement a Medigap policy he already owns.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 653 | M4-003

Which pairing correctly matches a covered service with the Medicare part principally responsible for it under Original Medicare?

A. A short inpatient rehabilitation stay is generally a Part D matter.

B. An outpatient prescription filled at a retail pharmacy is generally a Part A matter.

C. A physician's office evaluation is generally a Part B matter.

D. A hospice election is generally handled entirely under Part C.

Parts A/B/C/D, eligibility, plan types | Direct Knowledge

QUESTION 654 | M4-004

Dolores wants a plan that lets her see any doctor accepting the plan's payment terms without a primary-care referral, and she is comparing an HMO with a PFFS option. Which observation is accurate?

A. An HMO ordinarily provides the same non-network access as the PFFS plan she is comparing.

B. Both plan types require an identical prior-authorization process for every specialist visit.

C. Neither plan type can ever include an out-of-network benefit for emergencies.

D. A PFFS plan may allow her to see providers who accept the plan's terms without the HMO's routine referral structure.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 655 | M4-005

A recommendation letter tells Tobias that Part A alone will pay for his ongoing outpatient physical therapy sessions. What must be corrected before he relies on it?

A. Nothing, because Part A pays for any therapy connected to a past hospital stay.

B. The letter should clarify that Part A and Part B are separate parts and outpatient therapy is generally addressed under Part B.

C. The letter should tell him that Part D pays for outpatient therapy services instead.

D. The letter should state that Part C automatically applies even without an MA enrollment.

Parts A/B/C/D, eligibility, plan types | Compliance Judgment

QUESTION 656 | M4-006

Odalys enrolls in an MSA and later worries that the plan's account deposit is her only source of coverage before she meets the deductible. What should she understand about the deposit?

A. It can help pay qualified medical expenses while the high-deductible plan has not yet begun paying claims.

B. It functions as Part D coverage that pays her outpatient prescriptions directly.

C. It automatically becomes a PPO out-of-network benefit once the deductible resets.

D. It converts the MSA into a zero-premium HMO for the remainder of the year.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 657 | M4-007

Wendell has Part A only and hopes an agent can enroll him directly in a Medicare Advantage plan today because he likes its extra benefits. What is the correct response?

A. Submit the MA application because Part A alone satisfies eligibility whenever the agent believes the plan is a good fit.

B. Explain that MA eligibility generally requires both Part A and Part B, along with service-area residence and a valid election opportunity.

C. Tell him the plan will automatically enroll him in Part B once the MA form is filed.

D. Enroll him in a stand-alone PDP instead, since that plan type never requires Part B.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 658 | M4-008

Ines currently has Medicare and a Medicaid category her state confirms is accepted by a nearby plan built for beneficiaries in her situation. Which plan type is designed around that dual status?

A. An I-SNP based only on her home address.

B. A C-SNP admitting members without regard to Medicaid status.

C. A D-SNP limited to beneficiaries meeting the plan's approved dual-eligibility categories.

D. A PFFS plan that ignores Medicaid eligibility altogether.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 659 | M4-009

A home dialysis patient asks whether kidney failure alone can create Medicare eligibility apart from turning sixty-five or qualifying by disability. What should the agent confirm?

A. Dialysis alone always creates instant enrollment without any application process.

B. Only the standard age-based pathway can ever establish Medicare entitlement.

C. A disability-based determination is the sole alternative Medicare offers to age-based eligibility.

D. End-Stage Renal Disease is a recognized basis for Medicare eligibility separate from the age-65 pathway, subject to its own rules.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 660 | M4-010

What generally happens when a beneficiary already enrolled in an HMO or PPO that includes embedded Part D coverage separately joins a stand-alone PDP?

A. The stand-alone PDP simply layers on as secondary drug coverage with no other effect on the MA-PD.

B. CMS treats the two elections as duplicates and automatically cancels the newer one only.

C. The new election can cause disenrollment from the MA-PD arrangement unless an exception applies.

D. The MA-PD converts into a Medicare Supplement policy once the second election is processed.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Direct Knowledge

QUESTION 661 | M4-011

What is the most reliable source for confirming a prospect's actual Part A and Part B effective dates rather than relying on a verbal estimate?

A. The beneficiary's official Medicare enrollment record, such as through the Social Security Administration or the beneficiary's Medicare account.

B. The agent's general assumption based on the prospect's stated age.

C. The plan's marketing brochure, which lists standard effective dates for every beneficiary.

D. A social media post the prospect made about turning sixty-five.

Parts A/B/C/D, eligibility, plan types | Direct Knowledge

QUESTION 662 | M4-012

Desmond has a qualifying institutional-equivalent level of care documented under his plan's required assessment, even though he still lives at home. Does home residence alone disqualify him from I-SNP eligibility?

A. Yes, because every I-SNP enrollee must physically reside in a nursing facility on the application date.

B. Yes, unless he also carries the specific Medicaid category required for every D-SNP.

C. No, because an agent may waive the required assessment when home care becomes costly.

D. No, because a qualifying institutional-equivalent pathway may apply once the required assessment is satisfied.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Scenario

QUESTION 663 | M4-013

Evaluate this statement: A beneficiary who has Part A but has not enrolled in Part B cannot elect Medicare Advantage on the strength of Part A entitlement alone. Which evaluation is correct?

A. True; the missing Part B enrollment leaves the eligibility picture incomplete for an MA election.

B. False; Part A alone has always been sufficient for enrollment in any Medicare Advantage plan.

C. True; but only because the beneficiary must also already own a Medigap policy.

D. False; Part B enrollment becomes optional whenever an agent recommends the plan.

Parts A/B/C/D, eligibility, plan types | Alt Format / True False

QUESTION 664 | M4-014

Priscilla has been paying the Part B premium for years and now assumes her new zero-premium MA plan will erase that ongoing charge entirely. What should the agent clarify?

A. Her Part B premium generally continues even though the MA plan itself carries no additional premium.

B. The MA plan automatically refunds every dollar of her Part B premium after enrollment.

C. A zero-dollar plan premium converts Part B into a premium-free benefit for all enrollees.

D. The Part B premium is replaced entirely by a mandatory drug-plan premium.

Parts A/B/C/D, eligibility, plan types | Scenario

QUESTION 665 | M4-015

Under a Medicare MSA, what should a member understand about using account funds for a purchase that is not a qualified medical expense?

A. Every withdrawal automatically counts toward the plan deductible regardless of its purpose.

B. Non-qualified withdrawals are returned to CMS automatically at the end of the plan year.

C. The plan converts to an HMO the first time a non-qualified withdrawal occurs.

D. A non-qualified withdrawal can carry different tax and deductible consequences than a qualified one.

MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs | Direct Knowledge

QUESTION 666 | M4-016

Anwar's plan announces it will not renew its Medicare contract for next year, and he receives a notice about his options. What enrollment protection generally follows a nonrenewal?

A. A requirement that he remain without any coverage until the following AEP.

B. Automatic lifetime enrollment in the sponsor's nearest commercial insurance product.

C. A right to keep the nonrenewing plan active indefinitely by simply not responding.

D. A special election opportunity for affected members to choose replacement Medicare coverage.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 667 | M4-017

Sable's prescriber wants a specific brand medication, but the plan requires her to try a lower-cost formulary drug first, and her prescriber says that drug is medically inappropriate for her. What path addresses the conflict?

A. Paying cash for the brand drug automatically forces the plan to count it as covered.

B. Switching pharmacies permanently cancels the plan's step-therapy requirement.

C. Requesting a step-therapy exception supported by the prescriber's medical statement.

D. Filing a grievance in place of a decision on the drug coverage question.

Part D, formularies, tiers, Extra Help, TrOOP | Scenario

QUESTION 668 | M4-018

Apart from disaster relief, under what general condition might CMS grant case-specific relief based on a plan sponsor's or federal employee's own error?

A. Whenever a beneficiary simply changes their mind sometime after enrolling.

B. When a documented plan or federal error affected the individual's timely, informed election and relief is otherwise warranted.

C. Only when the beneficiary raises it through an unrelated customer-service grievance.

D. Automatically, without any review of the specific facts involved.

Enrollment periods, elections, SEPs, disenrollment | Direct Knowledge

QUESTION 669 | M4-019

Yusuf's plan denies a formulary drug because it has not yet confirmed that he meets the plan's clinical criteria for coverage. Which utilization tool is being applied?

A. A quantity limit restricting only the amount dispensed in a period.

B. A tiering exception that has already lowered his cost sharing.

C. Prior authorization requiring plan approval before the drug is covered.

D. A permanent transition fill that removes every future plan restriction.

Part D, formularies, tiers, Extra Help, TrOOP | Scenario

QUESTION 670 | M4-020

An agent tells a supervisor that a client's Medicare card arriving late in the mail creates a special 'mail-delay SEP,' and submits an MA application in August on that basis. How should compliance respond?

A. Approve the application because any mail delay automatically creates an enrollment period.

B. Instruct the agent to enter the fabricated SEP designation into the system without further review.

C. Approve it only after the agent obtains a written apology letter from the postal service.

D. Reject the claimed basis because no such SEP exists, and separately confirm whether an actual qualifying election period applies.

Enrollment periods, elections, SEPs, disenrollment | Compliance Judgment

QUESTION 671 | M4-021

Under the CY2027 defined-standard Part D benefit, what happens to a covered drug's cost sharing once a beneficiary reaches catastrophic coverage?

A. The beneficiary continues to owe the same coinsurance percentage as in the initial coverage phase.

B. The beneficiary re-enters a separate coverage-gap phase before catastrophic coverage applies.

C. The plan bills the beneficiary a flat annual fee unrelated to drug cost.

D. The beneficiary owes no cost sharing for covered Part D drugs during catastrophic coverage.

Part D, formularies, tiers, Extra Help, TrOOP | Direct Knowledge

QUESTION 672 | M4-022

Corinne permanently relocates to a state where her current MA plan does not operate, and she gives the plan advance notice of the move. What follows from these facts?

A. A move-related SEP lets her consider plans available at her new address.

B. Her existing plan must continue covering her indefinitely despite the permanent move.

C. She may enroll in any plan nationwide regardless of that plan's own service area.

D. Only a change in health status, not a move, could create a midyear election.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 673 | M4-023

Once a Part D coverage determination on a requested drug is denied, what is generally the next step available to the beneficiary or prescriber?

A. Filing a grievance in place of pursuing the coverage-determination appeal path.

B. Requesting redetermination at the applicable next appeal level within the drug-plan process.

C. Waiting for the following AEP before any further review can occur.

D. Asking a pharmacist to override the denial at the point of sale.

Part D, formularies, tiers, Extra Help, TrOOP | Direct Knowledge

QUESTION 674 | M4-024

How long does the institutional Special Enrollment Period generally continue once a qualifying resident leaves the facility?

A. It ends the instant the resident is discharged, with no continuing window.

B. It continues for a defined limited period after departure rather than ending immediately or lasting indefinitely.

C. It continues indefinitely for as long as the person remains a Medicare beneficiary.

D. It converts automatically into the 5-star Special Enrollment Period upon discharge.

Enrollment periods, elections, SEPs, disenrollment | Direct Knowledge

QUESTION 675 | M4-025

Roman's MA plan denies a requested procedure, and his physician states that waiting for the standard appeal timeframe could seriously jeopardize his health and ability to regain function. What review should be requested?

A. An expedited appeal supported by the documented urgent health facts.

B. A routine grievance that does not reconsider the coverage denial.

C. A marketing complaint that automatically cancels the plan's decision.

D. A future AEP election used instead of the current appeal rights.

Beneficiary protections, appeals, grievances | Scenario

QUESTION 676 | M4-026

What should an agent evaluate when a beneficiary's employer or union group health coverage ends and Medicare Advantage or Part D coverage is needed?

A. Whether the beneficiary can select any convenient date and call it an AEP submission.

B. Whether nonpayment of the old employer premium automatically creates MA enrollment.

C. The applicable loss-of-group-coverage SEP and its specific timing requirements.

D. Whether the new plan can ignore ordinary eligibility because coverage was lost.

Enrollment periods, elections, SEPs, disenrollment | Direct Knowledge

QUESTION 677 | M4-027

What must be true of both the beneficiary and the destination plan for the monthly integrated-care election opportunity to apply?

A. The plan need not be aligned with Medicaid as long as the beneficiary has any Medicare Advantage coverage.

B. The beneficiary must hold a qualifying full-benefit dual status and the destination must be a qualifying aligned integrated D-SNP.

C. The beneficiary must first complete a full year in Original Medicare before using this opportunity.

D. The destination plan must carry Medicare's overall 5-star rating for the applicable year.

Enrollment periods, elections, SEPs, disenrollment | Direct Knowledge

QUESTION 678 | M4-028

Josephine's plan requires prior authorization before it will pay for a specialty medication, and she asks the agent whether paying out of pocket avoids the requirement altogether. What is the accurate answer?

A. Paying cash does not satisfy the plan's coverage rule or make the drug a covered claim.

B. Paying cash automatically converts the drug into a formulary exception approval.

C. Paying cash removes the requirement permanently for every future refill.

D. Paying cash transfers the utilization rule to Original Medicare instead.

Part D, formularies, tiers, Extra Help, TrOOP | Scenario

QUESTION 679 | M4-029

An office manager instructs staff to hold completed AEP applications collected on October 3 and submit them as soon as the election period opens on October 15. Is this handling compliant?

A. Yes, because holding forms until the correct submission date cures any early solicitation.

B. Yes, provided the beneficiary's signature date is later changed to October 15.

C. No; agents may not solicit or take possession of completed AEP requests before the period opens.

D. No, but only because October 15 is itself an invalid AEP start date.

Enrollment periods, elections, SEPs, disenrollment | Compliance Judgment

QUESTION 680 | M4-030

Pair each need with its correct process: a member disputing an MA plan's initial coverage decision, a member requesting a Part D drug exception, and a member complaining about rude customer service with no coverage dispute. Which sequence is accurate?

A. Organization determination appeal; Part D coverage determination; grievance.

B. Grievance; organization determination appeal; Part D coverage determination.

C. Part D coverage determination; grievance; organization determination appeal.

D. Organization determination appeal; grievance; Part D coverage determination.

Beneficiary protections, appeals, grievances | Alt Format / Matching

QUESTION 681 | M4-031

Silas hosts a session billed as educational, but midway through he begins comparing two named carriers' copayments and hands out enrollment forms. What has occurred?

A. Plan-specific sales content has changed the activity into a marketing or sales event.

B. The event remains educational because it opened with general Parts A through D content.

C. Distributing forms is acceptable as long as no attendee signs one immediately.

D. The venue determines the classification, so a community room keeps it educational.

Marketing, communications, SOA, events | Scenario

QUESTION 682 | M4-032

Petra's agency wants to stop recording sales calls once a caller says they are not interested in enrolling, on the theory that only completed enrollments require audio. Is that approach correct?

A. Yes, because the recording duty applies only after a beneficiary agrees to enroll.

B. Yes, because declined calls are automatically reclassified as administrative service calls.

C. No, but only because every phone call of any kind must be recorded without exception.

D. No; the marketing and sales portion of the call must be recorded regardless of the outcome.

TPMOs, call recording, permission to contact | Scenario

QUESTION 683 | M4-033

Anders' office prints a flyer calling a three-star plan the best-rated option in the region without naming a measure, year, or source. What must a reviewer require?

A. Keep the claim because superlative language never needs factual support.

B. Add a government-style seal so the flyer looks officially endorsed.

C. Replace the Star Rating with the agent's personal opinion and no date.

D. Remove or substantiate the comparison with accurate, current data and clear context.

Marketing, communications, SOA, events | Compliance Judgment

QUESTION 684 | M4-034

Camille notices a recurring pattern of oddly similar enrollment signatures but cannot yet tell whether misconduct occurred, and her supervisor says nothing should be reported without conclusive proof. What is the correct response?

A. Alter the signature files so they appear consistent before anyone reviews them.

B. Contact the suspected agent privately and promise the records will be destroyed.

C. Publish the beneficiary signature data publicly so outsiders can judge for themselves.

D. Preserve the observed facts and report the concern through the designated compliance channel.

Fraud, waste and abuse; privacy; reporting | Scenario

QUESTION 685 | M4-035

Besides current sourcing and a clearly stated plan year, what additional element must a supportable named-plan comparison include?

A. A prediction of next year's premium so readers can plan ahead financially.

B. A stated basis or measure for the comparison, so the claim is not left unqualified.

C. The selling agent's personal opinion about which plan pays the highest commission.

D. A guarantee that the compared plans will never change their listed benefits.

Marketing, communications, SOA, events | Direct Knowledge

QUESTION 686 | M4-036

What distinguishes a communication that must satisfy both prongs of the marketing definition from a piece that remains a general communication?

A. Whether the piece was authored by the plan sponsor rather than an outside vendor.

B. Whether the piece meets both an intent standard and the specified marketing-content standard.

C. Whether the piece was mailed instead of emailed to the recipient.

D. Whether the piece uses the plan's official logo anywhere on the page.

Marketing, communications, SOA, events | Direct Knowledge

QUESTION 687 | M4-037

A regional sales director tells new agents that any statement is acceptable at a marketing event as long as it is not literally false. What correction does compliance need to make?

A. Confirm the instruction because only outright falsehoods are ever restricted.

B. Narrow the instruction to statements about premiums only, leaving other claims unrestricted.

C. Explain that misleading or unsubstantiated statements are also prohibited, not just outright falsehoods.

D. Apply the instruction only to written materials and exempt spoken remarks.

Marketing, communications, SOA, events | Compliance Judgment

QUESTION 688 | M4-038

Review these four fraud, waste, and abuse statements. I. Fraud requires knowing and willful deception for an unauthorized benefit. II. Waste can occur without the intent element required for fraud. III. Abuse describes practices inconsistent with accepted business or medical standards. IV. Every isolated data-entry typo automatically qualifies as fraud. Which answer includes all and only the accurate statements?

A. Statements I, II, and III.

B. Statements I and IV only.

C. Statements II, III, and IV.

D. Statements I, III, and IV.

Fraud, waste and abuse; privacy; reporting | Alt Format / Select All

QUESTION 689 | M4-039

Rosalind's team sets up a table in a hospital's public lobby, well away from any treatment area, to answer general Medicare plan questions during visiting hours. Is this location generally permissible for marketing?

A. No, because every part of a health-care facility is off-limits to Medicare marketing.

B. No, unless the agent also avoids discussing any plan's premium.

C. Yes, because CMS permits marketing in appropriate common areas subject to facility and CMS rules.

D. Yes, but only if the table is placed beside patients receiving treatment.

Marketing, communications, SOA, events | Scenario

QUESTION 690 | M4-040

Under the current retention framework described in CMS training guidance, how must a TPMO handle a marketing and sales call's audio during the required retention period?

A. Delete the audio after thirty days and keep only handwritten notes.

B. Retain the audio for the first three years, with audio or a complete transcript acceptable for the remaining years of the required period.

C. Keep only a same-day transcript because audio format is never required.

D. Discard every call that does not result in an enrollment.

TPMOs, call recording, permission to contact | Direct Knowledge

QUESTION 691 | M4-041

During a scheduled Medicare Advantage appointment, an agent pivots into promoting an unrelated identity-theft protection subscription right after covering plan benefits, without the beneficiary asking about it. What must the supervisor require?

A. Allow the pivot because any Medicare SOA authorizes discussing unrelated subscription products.

B. Allow it as long as the beneficiary is discouraged from asking follow-up questions.

C. Add the subscription terms directly onto the Medicare enrollment form.

D. Remove the agent-initiated unrelated cross-sale from the Medicare appointment.

Marketing, communications, SOA, events | Compliance Judgment

QUESTION 692 | M4-042

Evaluate this statement: An employee who discovers that beneficiary records may have been exposed should wait for confirmed proof of misuse before reporting the incident. Which evaluation is correct?

A. True; reporting before confirmed misuse wastes the organization's investigative resources.

B. True; the employee should instead ask affected beneficiaries to investigate first.

C. False; prompt reporting through the designated privacy or security channel is expected even before misuse is confirmed.

D. False; but only because the employee should notify beneficiaries directly instead of the organization.

Fraud, waste and abuse; privacy; reporting | Alt Format / True False

QUESTION 693 | M4-043

Beatrix's agency plans to email a consent form to a beneficiary after another TPMO has already received and called about her data transferred from a lead list. Does the later email fix the transfer?

A. Yes, if both TPMOs are licensed to sell Medicare plans.

B. Yes, if the beneficiary eventually enrolls in a plan.

C. No; the required prior express written consent must precede the inter-TPMO data sharing.

D. No, because beneficiary data can never be shared between TPMOs under any circumstance.

TPMOs, call recording, permission to contact | Scenario

QUESTION 694 | M4-044

Which giveaway at a Medicare marketing event is most consistent with the nominal-gift limitations described in CMS guidance?

A. Cash paid only to attendees who complete an enrollment application.

B. A modest noncash item offered to attendees regardless of whether they enroll.

C. A general-purpose gift card issued in exchange for a referral's phone number.

D. A rebate that grows larger when the attendee selects the promoted plan.

Marketing, communications, SOA, events | Direct Knowledge

QUESTION 695 | M4-045

Match each item with its function: the document required before an in-person personal marketing appointment, the authorization needed before unsolicited outreach, and the disclosure delivered before discussing plan benefits on a sales call. Which sequence is correct?

A. Permission to Contact; Scope of Appointment; TPMO disclaimer.

B. Scope of Appointment; Permission to Contact; TPMO disclaimer.

C. TPMO disclaimer; Scope of Appointment; Permission to Contact.

D. Scope of Appointment; TPMO disclaimer; Permission to Contact.

TPMOs, call recording, permission to contact | Alt Format / Matching

Bonus Drill - 5 questions

5 questions. Choose one answer per item; answers and full rationales are in Part II.

QUESTION 696 | B-001

Otis's Initial Coverage Election Period spans several months because his Part A and Part B effective dates do not align on the same calendar date. He wants his MA coverage to begin as early as the rules allow. What determines the earliest possible effective date?

A. The date he first spoke informally with an agent about MA plans.

B. The date listed on his Medigap application, if he owns one.

C. The date his employer's group plan originally began.

D. The alignment of his ICEP timing with the applicable MA enrollment effective-date rules.

Enrollment periods, elections, SEPs, disenrollment | Scenario

QUESTION 697 | B-002

Which date generally controls whether a beneficiary's Annual Election Period request produces January 1 coverage rather than a later effective date?

A. Whether the request was validly submitted within the AEP window itself.

B. Whether the beneficiary's birthday falls before or after October 15.

C. Whether the agent personally prefers an earlier start date.

D. Whether the plan's marketing materials were printed before September.

Enrollment periods, elections, SEPs, disenrollment | Direct Knowledge

QUESTION 698 | B-003

A file shows an SEP claimed for a permanent move, but the only supporting document is a hotel receipt from a two-night stay in another state. What must be resolved before the election is treated as valid?

A. Nothing, because any out-of-state document satisfies the move requirement.

B. Whether the facts actually establish a qualifying permanent change of residence rather than temporary travel.

C. Whether the hotel offered a senior discount during the stay.

D. Whether the beneficiary enjoyed the trip enough to consider relocating.

Enrollment periods, elections, SEPs, disenrollment | Compliance Judgment

QUESTION 699 | B-004

A draft flyer lists a plan's customer-service phone number alongside a comparison chart naming two competitors' premiums. Compliance must decide how to classify it. What is the correct classification?

A. A communication, because a phone number is present.

B. An educational piece, because it lists more than one company.

C. Marketing, because naming and comparing competing plans satisfies the required content standard.

D. A grievance notice, because it references customer service.

Marketing, communications, SOA, events | Compliance Judgment

QUESTION 700 | B-005

Consider four statements distinguishing marketing from communications. I. Marketing must satisfy both an intent standard and a content standard. II. A neutral operational notice with no comparative or benefit content can remain a communication. III. Any message a plan sends about its own services is automatically marketing. IV. A comparison of named plans' benefits is characteristic marketing content. Which answer identifies all and only the accurate statements?

A. Statements I and III only.

B. Statements II and III only.

C. Statements III and IV only.

D. Statements I, II, and IV.

Marketing, communications, SOA, events | Alt Format / Select All

PART II - ANSWERS & RATIONALES

Find the matching question number and ID. Every entry includes all three distractor rationales plus provenance and its verification date.

Topic Set - Parts A/B/C/D, eligibility, plan types

90 answer entries. Match each entry to the question number and ID printed in Part I.

ANSWER 1 | T-001

Correct answer: A. Part B generally covers the physician's outpatient services.

Explanation. Part B is Medical Insurance and is the usual starting point for medically necessary physician and outpatient services when Medicare's coverage requirements are met. The site name alone does not turn a professional outpatient service into a Part A benefit.

Why the other choices are wrong

B. Part A principally addresses inpatient hospital and certain other institutional benefits, not every service provided at a hospital location.

C. Part C applies only when a beneficiary receives Medicare benefits through a Medicare Advantage plan.

D. Part D concerns covered outpatient prescription drugs, not a physician's professional service.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 2 | T-002

Correct answer: B. The member should consult the Evidence of Coverage for the detailed plan terms.

Explanation. The Evidence of Coverage is the comprehensive member document describing covered benefits, cost sharing, exclusions, plan procedures, and appeal rights. A summary can orient a beneficiary, but a dispute over the full terms calls for the detailed coverage document.

Why the other choices are wrong

A. A Provider Directory addresses network participation and does not contain the complete benefit contract.

C. A formulary focuses on covered drugs, tiers, and related controls rather than all medical benefits.

D. The Summary of Benefits is intentionally concise and does not replace the detailed Evidence of Coverage.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 3 | T-003

Correct answer: C. He may retain Original Medicare and enroll in a stand-alone prescription drug plan.

Explanation. A beneficiary may keep Original Medicare as the health-coverage route and add Part D through a stand-alone PDP. This preserves federal Parts A and B while obtaining separate private prescription-drug coverage.

Why the other choices are wrong

A. An MA-only plan does not include Part D, and its rules may affect whether a separate PDP is compatible.

B. Original Medicare by itself does not supply the standard outpatient prescription-drug benefit.

D. An MA-PD can combine medical and drug benefits, but it is not the only way to obtain Part D coverage.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 4 | T-004

Correct answer: D. He generally must have both Part A and Part B before he can enroll in Medicare Advantage.

Explanation. Medicare Advantage eligibility generally requires entitlement to Part A, enrollment in Part B, residence in the plan's service area, and a valid election opportunity. Noah's Part A and residence facts do not cure the missing Part B enrollment.

Why the other choices are wrong

A. Service-area residence is necessary but does not replace the Part B requirement.

B. An agent's recommendation cannot create statutory plan eligibility.

C. A PDP supplies Part D drug coverage and does not enroll a person in Part B.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 5 | T-005

Correct answer: A. Medicare Advantage plans include a medical out-of-pocket maximum, while Original Medicare alone has no single annual cap.

Explanation. Medicare Advantage plans must set a maximum out-of-pocket limit for covered Part A and Part B services. Original Medicare by itself does not have one overall annual cap, so beneficiaries must separately assess their exposure and any supplemental coverage.

Why the other choices are wrong

B. The two coverage routes do not share one universal medical limit; MA plans have plan-specific limits within CMS rules.

C. Part D has separate out-of-pocket rules, but MA medical benefits also have a required maximum.

D. Declining supplemental coverage does not cause Original Medicare to create an annual medical cap.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-02

ANSWER 6 | T-006

Correct answer: B. A Program of All-Inclusive Care for the Elderly arrangement.

Explanation. PACE is an integrated program for people who meet its age, service-area, nursing-home-level-of-care, and safe-community-living requirements. It coordinates comprehensive Medicare and, when applicable, Medicaid services.

Why the other choices are wrong

A. Medigap supplements Original Medicare cost sharing and is not a comprehensive care-coordination program.

C. A PDP addresses prescription drugs rather than integrated medical and supportive services.

D. An EGWP is employer- or union-sponsored coverage and is not automatically available based on care needs.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 7 | T-007

Correct answer: C. He generally continues paying the Part B premium despite a zero-dollar MA plan premium.

Explanation. The premium charged by an MA plan is distinct from the beneficiary's Part B obligation. A plan may charge no additional premium, but MA enrollment generally does not remove the requirement to keep paying the Part B premium.

Why the other choices are wrong

A. Any plan-specific premium reduction benefit must be verified and is not an automatic full refund.

B. A zero-dollar plan premium does not change the general Part B premium rules.

D. MA enrollment does not create a universal requirement to buy a stand-alone PDP, and a PDP premium does not replace Part B.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 8 | T-008

Correct answer: D. Medigap is designed to supplement Original Medicare, not to cover Medicare Advantage cost sharing.

Explanation. Federal anti-duplication protections reflect that Medigap supplements Original Medicare. It is not a policy for paying an MA plan's deductibles, copayments, coinsurance, or premiums while the person remains in MA.

Why the other choices are wrong

A. Cost sharing in an MA plan does not create a requirement to purchase Medigap.

B. Common ownership or branding does not make Medigap coordinate with MA benefits.

C. A disclosure cannot turn an incompatible use of Medigap into an appropriate sale.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/medigap/ready-to-buy/change-policies/switch-drop
Verified: 2026-08-02

ANSWER 9 | T-009

Correct answer: A. The coverage is based on current employment, with payer-order facts also reviewed.

Explanation. The Part B current-employment protection depends on coverage tied to current work, and sound advice also examines employer size and Medicare Secondary Payer rules. COBRA and retiree coverage are not treated as active-employment coverage for this purpose.

Why the other choices are wrong

B. COBRA continuation does not extend the current-employment SEP clock after active work ends.

C. Employer branding does not make retiree coverage coverage based on current employment.

D. Personal savings do not establish enrollment rights or determine payer order.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start
Verified: 2026-08-02

ANSWER 10 | T-010

Correct answer: B. Check current provider participation, the formulary, utilization rules, and pharmacy network.

Explanation. A suitable pre-enrollment comparison tests the beneficiary's actual providers, drugs, utilization requirements, and pharmacies against current plan information. Premium alone cannot reveal whether established care and prescriptions fit the plan.

Why the other choices are wrong

A. Identical premiums do not imply identical networks, drug coverage, or restrictions.

C. Supplemental benefits do not replace review of core provider and prescription needs.

D. Network and formulary information can change, so stale plan-year materials are not reliable for a current choice.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 11 | T-011

Correct answer: C. Part B, when medical necessity, documentation, and supplier requirements are satisfied.

Explanation. Durable medical equipment is generally covered under Part B when Medicare's medical-necessity, documentation, and supplier conditions are satisfied. Coverage depends on the actual item and requirements, not simply on where the beneficiary previously received care.

Why the other choices are wrong

A. Part A does not automatically cover every item used after discharge.

B. Part D covers qualifying outpatient prescription drugs rather than durable medical equipment.

D. Part C applies only to beneficiaries enrolled in Medicare Advantage and is not an Original Medicare benefit label.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 12 | T-012

Correct answer: D. A coverage determination on the drug and exception request.

Explanation. A Part D coverage determination is the plan's initial decision about drug coverage, payment, or an exception to a formulary or utilization rule. An adverse decision can then activate the applicable appeal path.

Why the other choices are wrong

A. A grievance addresses dissatisfaction with service or operations rather than the merits of a drug-coverage request.

B. Organization determinations are MA decisions concerning Part C medical benefits, not Part D drug exceptions.

C. Review ordinarily begins with the plan's initial coverage determination before later appeal levels.

Applies to: Both
Source: https://www.cms.gov/medicare/appeals-grievances/managed-care
Verified: 2026-08-02

ANSWER 13 | T-013

Correct answer: A. Verify the official entitlement record and its effective date.

Explanation. Medicare can begin before the usual eligibility age under disability-based rules, but the official benefit and entitlement records control whether and when coverage starts. An agent should verify that record rather than infer eligibility from a diagnosis.

Why the other choices are wrong

B. A health condition alone is not proof that the statutory disability entitlement process has been satisfied.

C. Plan preference cannot establish entitlement to Medicare.

D. Disability is a distinct eligibility pathway, so an age-only analysis can overlook valid existing coverage.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 14 | T-014

Correct answer: B. Explain that MA is the health-coverage route and review how the election may affect existing coverage.

Explanation. The pre-enrollment discussion must accurately present the plan as full Medicare health coverage, not a benefit rider, and must address potential effects on other insurance. Those consequences can be material to an informed decision.

Why the other choices are wrong

A. Deferring a material coverage consequence until after enrollment defeats informed choice.

C. A narrow benefit question does not justify omitting the nature of the plan and its effect on existing coverage.

D. Retiree coverage terms vary and may be affected, so continuation cannot be assumed.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 15 | T-015

Correct answer: C. Distinguish the plan premium from Part B premiums and plan cost sharing.

Explanation. A truthful presentation separates a plan's premium from the continuing Part B obligation and from deductibles, copayments, or coinsurance. A zero plan premium does not mean that the beneficiary's total Medicare costs are zero.

Why the other choices are wrong

A. A zero plan premium says nothing by itself about point-of-service cost sharing.

B. A Part B premium reduction is plan-specific and must not be presented as universal.

D. Supplemental benefits have eligibility, coverage, and usage limits and cannot support a promise of no costs.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 16 | T-016

Correct answer: D. Do not represent the person as MA-eligible without the required Part B enrollment and election facts.

Explanation. Suitability does not substitute for Medicare Advantage eligibility. The file must establish both core Medicare parts, service-area residence, and a valid election period before an MA enrollment can be treated as valid.

Why the other choices are wrong

A. A favorable recommendation cannot override federal eligibility requirements.

B. An MA application is not a Social Security enrollment mechanism for Part B.

C. An agent has no authority to waive statutory eligibility conditions.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options
Verified: 2026-08-02

ANSWER 17 | T-017

Correct answer: A. True; this is a permitted way to combine Parts A and B with separate drug coverage.

Explanation. The statement is true. Original Medicare and a stand-alone PDP are compatible coverage choices, allowing Parts A and B to remain the medical route while the private PDP supplies Part D benefits.

Why the other choices are wrong

B. Stand-alone PDPs exist specifically to provide Part D outside an MA-PD.

C. Joining a stand-alone PDP does not by itself convert Original Medicare enrollment into Part C.

D. A PDP provides drug coverage and is not a Medicare supplement policy.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 18 | T-018

Correct answer: B. Evidence of Coverage; Provider Directory; formulary.

Explanation. The Evidence of Coverage contains the comprehensive plan terms, the Provider Directory addresses clinician and facility participation, and the formulary identifies covered drugs and tier placement.

Why the other choices are wrong

A. A benefit summary is not the full contract, and the formulary does not establish a physician's network status.

C. The Provider Directory is not the complete benefit contract, while the Summary of Benefits is not the drug-tier source.

D. A formulary does not contain all plan terms, and the Provider Directory does not list drug tiers.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 19 | T-101

Correct answer: A. Part B or, when tied to a covered inpatient stay's home health eligibility, Part A generally addresses this skilled home health service.

Explanation. Home health services are a medical benefit governed by Parts A and B coverage rules rather than by the outpatient drug benefit, regardless of which clinician performs the visit.

Why the other choices are wrong

B. Part D concerns covered outpatient prescription drugs, not skilled nursing services delivered in the home.

C. Part C applies only to beneficiaries who have actually enrolled in Medicare Advantage, not based on how a claim is submitted.

D. Coverage is determined by the type of service and applicable rules, not simply by whether a nurse or physician performed it.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 20 | T-102

Correct answer: B. The setting and formal patient status determine the applicable part, so an outpatient procedure at that facility is generally handled under Part B.

Explanation. Ownership of a facility by a hospital does not by itself convert an outpatient procedure into a Part A inpatient claim.

Why the other choices are wrong

A. Facility ownership does not establish inpatient status; formal admission determines it.

C. Part C applies only to beneficiaries actually enrolled in a Medicare Advantage plan.

D. Part D addresses outpatient prescription drugs, not surgical supplies used during a covered procedure.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 21 | T-103

Correct answer: C. Part C is a private-plan pathway, Medicare Advantage, through which a beneficiary can receive Part A and Part B benefits and often Part D as well.

Explanation. Part C is best understood as an alternative delivery route for the same federal benefits rather than a fifth kind of coverage.

Why the other choices are wrong

A. Part C is an alternative way to receive Part A and B benefits, not an add-on layered over them.

B. Medicare Advantage eligibility generally requires Part A entitlement, not the absence of it.

D. Enrolling in Part C does not eliminate the underlying Part B premium obligation.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 22 | T-104

Correct answer: D. Outpatient prescription drugs filled at a retail pharmacy are generally the domain of Part D, whether through a stand-alone plan or an MA-PD.

Explanation. Part D is specifically the outpatient prescription-drug benefit, which is the situation Keiko describes.

Why the other choices are wrong

A. Part A addresses inpatient hospital and related institutional benefits, not ongoing retail prescription fills.

B. Part B covers certain drugs administered in a clinical setting, but routine retail prescriptions are a Part D matter.

C. Which part applies depends on the nature of the drug and setting, not on which pharmacy brand fills it.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 23 | T-105

Correct answer: A. The agent must confirm Boone's actual Part A and Part B status before treating him as MA-eligible.

Explanation. Medicare Advantage eligibility depends on holding both Part A and Part B, so an undocumented generic 'Medicare' label cannot substitute for that verification.

Why the other choices are wrong

B. Eligibility is not a majority assumption; it depends on confirmed Part A and Part B status for this specific person.

C. Submitting first and verifying later does not satisfy the obligation to confirm eligibility facts before recommending or enrolling.

D. A form's existence does not substitute for actually confirming the underlying eligibility facts it is supposed to capture.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 24 | T-106

Correct answer: B. He may still qualify for premium-free Part A based on his spouse's qualifying work record even without his own.

Explanation. Premium-free Part A can be earned through a spouse's sufficient Medicare-taxed work history, not only through the beneficiary's own record.

Why the other choices are wrong

A. A spouse's qualifying work record can also establish premium-free Part A eligibility.

C. Spousal-based Part A eligibility is not conditioned on the spouse having already started benefits in every case reviewed here, and the claim overstates a fixed waiting rule.

D. A qualifying spousal work history can support premium-free Part A rather than an automatic premium obligation.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 25 | T-107

Correct answer: C. Roughly ten years, about forty quarters, of Medicare-taxed work is generally the benchmark for premium-free Part A.

Explanation. Reaching that quarter count typically means enough Medicare payroll tax was contributed over a working lifetime to earn the hospital-insurance benefit without an added monthly charge.

Why the other choices are wrong

A. The general benchmark is closer to ten years, not twenty.

B. Premium-free Part A depends on accumulating a sufficient quarter count, not merely having done some part-time work.

D. Premium-free Part A eligibility is tied to Medicare-taxed work history, not to current income level.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 26 | T-108

Correct answer: D. Reaching roughly twenty-four months of SSDI generally establishes Medicare entitlement regardless of age.

Explanation. Medicare eligibility through disability generally begins after an SSDI qualifying period of about two years, independent of reaching age sixty-five.

Why the other choices are wrong

A. Disability is a distinct pathway that can establish Medicare eligibility well before age sixty-five.

B. The disability pathway is designed to produce Medicare entitlement once its qualifying period is met, not to require an unrelated separate years-long process.

C. The general disability pathway runs on an SSDI qualifying period; only specific conditions like ALS or ESRD follow different rules.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 27 | T-109

Correct answer: A. A diagnosis of ALS generally establishes Medicare entitlement without waiting through the standard disability qualifying period.

Explanation. ALS is treated as an exception to the usual disability waiting period, so entitlement can begin immediately upon the qualifying diagnosis and disability determination.

Why the other choices are wrong

B. ALS is specifically excepted from the standard disability waiting period.

C. Disability-based entitlement, including the ALS exception, does not require having already reached age sixty-five.

D. Entitlement based on an ALS diagnosis arises under the disability pathway itself, not from any plan enrollment.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 28 | T-110

Correct answer: B. ESRD is its own qualifying pathway to Medicare that can apply regardless of age when the applicable requirements are met.

Explanation. ESRD-based entitlement is a distinct route into Medicare, separate from the age-65 and general disability pathways.

Why the other choices are wrong

A. ESRD is an independent eligibility pathway that does not require reaching age sixty-five.

C. ESRD-based entitlement depends on meeting the pathway's actual requirements, not merely on an initial conversation about dialysis.

D. ESRD is an entitlement pathway into Medicare itself, not a rule limited to drug-plan formularies.

Applies to: Both
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-13

ANSWER 29 | T-111

Correct answer: C. The agent must document the actual disability, ALS, or ESRD basis for her entitlement rather than leaving an inaccurate age-based box checked.

Explanation. An entitlement record that misstates the eligibility pathway can misrepresent the beneficiary's actual Medicare status and should be corrected to reflect the true basis.

Why the other choices are wrong

A. Treating a non-age pathway as an age-65 election misstates the actual entitlement basis and needs correction.

B. A future birthday does not fix an inaccurate record about her current entitlement basis.

D. Guessing rather than verifying the actual basis risks an inaccurate eligibility record.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 30 | T-112

Correct answer: D. Because fewer than sixty days passed without inpatient or skilled nursing care, this readmission generally falls within the same benefit period rather than starting a new one.

Explanation. A benefit period continues until the beneficiary has been out of inpatient and skilled nursing care for a defined stretch of consecutive days; an eleven-day gap does not reset it.

Why the other choices are wrong

A. A benefit period is defined by a gap in inpatient or skilled nursing care, not simply by the existence of a new admission.

B. Part A benefit periods reset based on a gap in care, not on the calendar year turning over.

C. A benefit period can end through an adequate gap in inpatient or skilled nursing care generally, not only through a hospice discharge.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 31 | T-113

Correct answer: A. Lifetime reserve days can generally be used, at a higher daily coinsurance, once the earlier extended-stay days in that benefit period are exhausted.

Explanation. Lifetime reserve days function as an additional pool available within a benefit period after the standard extended-stay coinsurance days run out, though each reserve day is usable only once over a lifetime.

Why the other choices are wrong

B. Further coverage generally depends on available lifetime reserve days rather than becoming automatically free.

C. Lifetime reserve days are a finite pool used across a beneficiary's lifetime, not a renewing per-period allowance.

D. Lifetime reserve days are associated with extended inpatient hospital stays, not limited to skilled nursing care.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 32 | T-114

Correct answer: B. It begins with inpatient admission and continues until the beneficiary has been out of inpatient and skilled nursing care for a set number of consecutive days, after which a new period can begin.

Explanation. This gap-based structure explains why a single illness with multiple admissions can still fall inside one benefit period.

Why the other choices are wrong

A. A benefit period is defined by care gaps, not by the calendar year.

C. The benefit period can continue after discharge if skilled care continues or the gap requirement is not yet met.

D. A benefit period concerns Part A inpatient cost-sharing structure, not the separate MA annual out-of-pocket maximum.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 33 | T-115

Correct answer: C. The summary should reflect that Part A cost sharing generally rises in tiers as a stay lengthens, including a higher rate once lifetime reserve days are used.

Explanation. Part A inpatient cost sharing is not flat; it is structured in tiers tied to how long the stay continues within a benefit period.

Why the other choices are wrong

A. Part A cost sharing is tiered by stay length rather than fixed at one flat amount.

B. Extended inpatient stays generally do involve coinsurance, so claiming none exists would also be inaccurate.

D. Mentioning the deductible does not correct the false claim that coinsurance never increases with a longer stay.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 34 | T-116

Correct answer: D. The Part B late-enrollment premium increase is generally added as roughly ten percent for each full twelve-month period of the delay, and it lasts as long as she keeps Part B.

Explanation. This penalty structure ties the surcharge to the number of full twelve-month periods of delay and continues for the duration of Part B enrollment, absent an exception.

Why the other choices are wrong

A. The Part B late-enrollment surcharge continues for as long as the beneficiary has Part B, not just the first year.

B. This late-enrollment surcharge is based on the length of the delay, separate from any income-related adjustment.

C. The surcharge generally persists for the duration of Part B enrollment rather than expiring after a set number of years.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 35 | T-117

Correct answer: A. He generally continues to owe the Part B premium even after enrolling in a zero-premium MA plan.

Explanation. An MA plan's own premium is distinct from the underlying Part B premium obligation, which generally continues regardless of the plan's advertised price.

Why the other choices are wrong

B. The MA plan's premium and the Part B premium are separate obligations; a zero plan premium does not remove the Part B charge.

C. Part B premium obligations generally continue for MA enrollees as well, not only for those who stay in Original Medicare.

D. A blanket monthly refund of the Part B premium is not a standard feature of every zero-premium plan and cannot be assumed.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 36 | T-118

Correct answer: B. The plan premium is only one component of cost; the Part B premium and applicable cost sharing continue to apply separately.

Explanation. Total cost exposure includes the continuing Part B premium along with any plan cost sharing, not just the plan's own premium line.

Why the other choices are wrong

A. A zero plan premium does not, by itself, waive deductibles or copayments.

C. The Part B premium obligation is not suspended based on a plan's own premium amount.

D. CMS does not cap total annual spending at the level of the plan's premium alone.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 37 | T-119

Correct answer: C. The corrected statement must clarify that Part B premiums and applicable plan cost sharing continue despite the plan carrying no separate premium.

Explanation. A compliant description must not blur the plan's zero premium with an implied end to all Medicare-related costs.

Why the other choices are wrong

A. A material cost claim cannot be excused as mere sales color; it must be corrected.

B. Removing one word does not fix the underlying false implication that Medicare becomes free.

D. A quality rating has no bearing on whether a false cost claim needs correction.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 38 | T-120

Correct answer: D. The Part D late-enrollment penalty is generally based on roughly one percent of the national base premium for each full month without creditable coverage.

Explanation. This penalty accrues on a monthly basis tied to the national base premium figure, which is why even a period under two years can still generate a meaningful surcharge.

Why the other choices are wrong

A. The Part D penalty is generally proportional to the number of uncovered months, not a flat one-time fee.

B. The Part D late-enrollment penalty can apply regardless of whether drug coverage comes through a PDP or an MA-PD.

C. Switching plans generally does not erase an already-accrued Part D late-enrollment penalty.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 39 | T-121

Correct answer: A. She should rely on the employer's official creditable-coverage disclosure notice rather than an undocumented verbal assurance.

Explanation. Only a documented creditable-coverage determination reliably establishes whether her employer drug plan meets the standard needed to avoid a future Part D penalty.

Why the other choices are wrong

B. An unwritten verbal assurance does not provide the documentation needed if creditable status is later questioned.

C. Creditable coverage status depends on how the plan's drug benefit compares to the standard, not on employer size.

D. Employer sponsorship alone does not exempt a plan from needing a documented creditable-coverage determination.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/plan-rules
Verified: 2026-08-13

ANSWER 40 | T-122

Correct answer: B. The coverage gap has been eliminated, and Part D now relies on an annual out-of-pocket threshold that leads into a catastrophic phase.

Explanation. Structural Part D changes removed the former coverage-gap phase in favor of a defined annual out-of-pocket cap.

Why the other choices are wrong

A. The former coverage-gap phase has been eliminated rather than continuing to require full-price payment.

C. Reaching the former gap threshold does not suspend coverage; the current structure moves toward a catastrophic phase instead.

D. The elimination of the former coverage gap applies to the Part D benefit generally, not to one plan type only.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/part-d/basics/costs
Verified: 2026-08-13

ANSWER 41 | T-123

Correct answer: C. Once she reaches the annual out-of-pocket threshold, she generally enters the catastrophic phase and owes no further cost sharing on covered Part D drugs for the remainder of that plan year.

Explanation. Once total spending crosses that line, the benefit design shifts so the plan absorbs the remaining covered drug costs through the end of the year.

Why the other choices are wrong

A. Reaching the annual threshold changes her cost-sharing obligation rather than leaving it unchanged.

B. Reaching the threshold moves her into a more favorable cost-sharing phase, not a loss of coverage.

D. The threshold governs when catastrophic-phase protection begins, which is broader than just the deductible.

Applies to: Both
Source: https://www.cms.gov/files/document/2027-announcement.pdf
Verified: 2026-08-13

ANSWER 42 | T-124

Correct answer: D. The draft must be revised to reflect that the coverage gap has been eliminated and describe the current annual out-of-pocket threshold structure instead.

Explanation. Presenting an outdated coverage-gap description as current would misstate how Part D cost sharing actually works today.

Why the other choices are wrong

A. The coverage-gap structure has changed, so describing it as unchanged would be inaccurate.

B. Omitting cost information entirely does not correct the outdated claim; it should be replaced with accurate current information.

C. A disclaimer does not cure a specific false statement that remains in the body of the material.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/part-d/basics/costs
Verified: 2026-08-13

ANSWER 43 | T-125

Correct answer: A. Adding a stand-alone PDP does not change his underlying medical coverage; he can remain on Original Medicare's non-network structure while the PDP handles only drug benefits.

Explanation. A stand-alone PDP is a separate drug-only product layered onto Original Medicare, so it has no effect on the non-network way his medical benefits are delivered.

Why the other choices are wrong

B. A PDP's pharmacy network governs where he fills prescriptions; it does not govern his medical benefit delivery under Original Medicare.

C. A stand-alone PDP is specifically designed to be added while a person keeps Original Medicare.

D. Electing a stand-alone PDP does not itself trigger separate enrollment in a Medicare Advantage plan.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/how-drug-plans-work
Verified: 2026-08-13

ANSWER 44 | T-126

Correct answer: B. Each MA plan must include an annual out-of-pocket maximum for those covered services.

Explanation. This annual cap is a built-in structural feature that limits how much a member can be charged over the course of the year for covered medical care.

Why the other choices are wrong

A. An annual out-of-pocket maximum for covered medical services is a general MA plan requirement, not an optional feature.

C. The out-of-pocket maximum requirement generally applies across Medicare Advantage plan types, not solely to HMOs.

D. This particular requirement concerns medical Part A and B cost sharing, while Part D has its own separate cost structure.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 45 | T-127

Correct answer: C. Emergency and urgently needed care is generally covered by every MA plan type nationwide regardless of network status.

Explanation. This nationwide emergency and urgent-care protection applies across MA plan designs regardless of the specific plan type involved.

Why the other choices are wrong

A. Out-of-network status does not remove MA coverage for genuine emergency or urgently needed care.

B. The emergency and urgent-care coverage requirement applies broadly across MA plan types, not to HMOs alone.

D. Genuine emergencies are not conditioned on obtaining prior authorization before receiving care.

Applies to: Both
Source: https://www.medicare.gov/publications/12026-Understanding-Medicare-Advantage-Plans.pdf
Verified: 2026-08-13

ANSWER 46 | T-128

Correct answer: D. Part A and Part B coverage together with Part D drug coverage, delivered through one private plan.

Explanation. An MA-PD is designed to combine medical and drug coverage into a single plan rather than requiring separate enrollments.

Why the other choices are wrong

A. An MA-PD is designed to bundle more than Part A alone; it also includes Part B and Part D.

B. An MA-PD replaces the Original Medicare delivery route for Parts A and B; it is not a supplement layered on top of it.

C. An MA-PD combines medical coverage with drug coverage rather than providing drug coverage alone.

Applies to: Both
Source: https://www.medicare.gov/publications/12026-Understanding-Medicare-Advantage-Plans.pdf
Verified: 2026-08-13

ANSWER 47 | T-129

Correct answer: A. The MA plan generally includes a required annual out-of-pocket cap for covered medical services, while Original Medicare alone does not have one overall cap.

Explanation. This is the core distinction Ramon is asking about: MA's built-in medical out-of-pocket maximum versus the absence of a single such cap under unsupplemented Original Medicare.

Why the other choices are wrong

B. Original Medicare alone does not include the same kind of universal annual medical cap that MA plans must build in.

C. MA plans are generally required to include an annual out-of-pocket maximum for covered medical services.

D. Part D has its own separate limit structure, but MA medical benefits also carry a required maximum.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 48 | T-130

Correct answer: B. The claim should be revised to reflect that MA plans cover Medicare-required benefits subject to the plan's specific rules, networks, and any supplemental extras, rather than promising zero exceptions.

Explanation. An unqualified 'zero exceptions' promise overstates how MA benefit design and utilization rules actually work.

Why the other choices are wrong

A. MA plans operate under specific rules, networks, and utilization requirements, which is inconsistent with a blanket 'zero exceptions' claim.

C. Retaining an absolute 'zero exceptions' claim still overstates how plan-specific rules actually work.

D. A quality rating does not make an absolute, unqualified benefit claim accurate.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 49 | T-131

Correct answer: C. A coinsurance structure generally exposes her to more cost variability, since the percentage-based share can rise sharply with an expensive procedure, unlike a flat copay.

Explanation. Because coinsurance scales with the price of the service, a costly surgery or extended stay can produce a materially larger bill than a flat-dollar copay would.

Why the other choices are wrong

A. A percentage-based coinsurance amount can scale much higher than a flat copay for an expensive service.

B. For high-cost services, coinsurance can exceed a flat copay rather than always costing less.

D. The choice between coinsurance and flat copayments materially affects her cost exposure within an MA plan.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 50 | T-132

Correct answer: D. A Program of All-Inclusive Care for the Elderly arrangement should be explored if the local age, service-area, and care-level requirements are met.

Explanation. PACE is specifically designed to let qualifying participants who need nursing-home-level care continue receiving coordinated services in the community rather than in an institution.

Why the other choices are wrong

A. A PDP addresses prescription drugs only and does not coordinate broader medical or long-term care.

B. Medigap supplements Original Medicare cost sharing; it does not coordinate or replace covered services.

C. PACE has specific eligibility requirements tied to care level and service area, not automatic universal access.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options
Verified: 2026-08-13

ANSWER 51 | T-133

Correct answer: A. An EGWP is sponsored through an employer or union group arrangement rather than purchased individually by the beneficiary.

Explanation. The defining feature of an EGWP is its employer- or union-sponsored group structure, which can affect both its benefit design and how it is administered.

Why the other choices are wrong

B. An EGWP specifically arises from an employer or union sponsorship, which is the opposite of never having held such coverage.

C. EGWP administration can differ from individual-market enrollment because it runs through the employer or union arrangement.

D. An EGWP is defined by its employer or union sponsorship structure, not by a universal Part B premium waiver.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options
Verified: 2026-08-13

ANSWER 52 | T-134

Correct answer: B. MSA plans generally include no drug coverage at all, so he would need to separately enroll in a stand-alone Part D plan to get that benefit.

Explanation. Because an MSA carries no built-in drug benefit, pairing it with a stand-alone PDP is the way to obtain Part D coverage alongside it.

Why the other choices are wrong

A. MSA plans do not include drug coverage as part of their design.

C. He can generally obtain Part D coverage by separately enrolling in a stand-alone PDP alongside the MSA.

D. MSA account funds are not a replacement for Part D drug coverage.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options
Verified: 2026-08-13

ANSWER 53 | T-135

Correct answer: C. MSA plans generally have no defined provider network, and the member may use any Medicare-approved provider who agrees to treat them.

Explanation. The absence of a conventional network is a structural feature of MSA plans, distinguishing them from HMO- or PPO-style network arrangements.

Why the other choices are wrong

A. MSA plans generally do not use a defined network the way an HMO does.

B. MSA coverage does not depend on a signed plan-specific contract; it depends on the provider being Medicare-approved and willing to treat the member.

D. MSA network flexibility is not limited to providers located within a single state.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options
Verified: 2026-08-13

ANSWER 54 | T-136

Correct answer: D. Because non-network PFFS relies on individual providers agreeing to the plan's terms visit by visit, a scarce-provider county could see several providers stop accepting the plan at once.

Explanation. This visit-by-visit participation model, rather than a signed continuing contract, is what creates the practical access risk Perpetua is asking about in a provider-scarce area.

Why the other choices are wrong

A. Non-network PFFS relies on per-visit provider agreement rather than the kind of signed continuing contract that supports HMO-style continuity.

B. Non-network PFFS provider participation is generally assessed visit by visit rather than locked in for the year.

C. A scarce-provider rural county increases the practical risk tied to per-visit PFFS provider participation.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options
Verified: 2026-08-13

ANSWER 55 | T-137

Correct answer: A. The brochure should state that a member may use any Medicare-approved provider willing to treat them, rather than promising unrestricted access with no conditions.

Explanation. This keeps the pitch honest: real access still depends on finding a clinician who accepts Medicare and consents to the visit, so the freedom is wide but never unconditional.

Why the other choices are wrong

B. Provider use is still tied to Medicare approval and provider willingness, which is a condition, not the absence of one.

C. That would misrepresent MSA plans in the opposite direction; they generally do not rely on such exclusive contracts.

D. A specific, factual-sounding access claim like this needs to be accurate rather than excused as generic marketing color.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 56 | T-138

Correct answer: B. Medigap is designed to supplement Original Medicare's cost sharing, not to pay a Medicare Advantage plan's copayments.

Explanation. Since a Medigap policy is built to work alongside the fee-for-service structure of traditional coverage, it has no mechanism for paying costs generated inside a private MA plan.

Why the other choices are wrong

A. Common ownership between insurers does not change the fact that Medigap coordinates with Original Medicare, not MA.

C. A signed acknowledgment does not change the underlying mismatch between Medigap's design and MA cost sharing.

D. Medigap policies remain structured to supplement Original Medicare and do not convert into MA-compatible coverage.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/medigap/basics/how-medigap-works
Verified: 2026-08-13

ANSWER 57 | T-139

Correct answer: C. Medigap plans are standardized by letter, so a given letter's benefits are generally identical across companies within that state.

Explanation. Because benefits are standardized letter by letter, comparing Medigap carriers usually comes down to price and service rather than differing benefit packages under the same letter.

Why the other choices are wrong

A. Medigap benefits under a given letter are generally standardized, not individually designed by each insurer.

B. Medigap benefit standardization is not based on the beneficiary's income; benefits attach to the plan letter.

D. Medigap letters describe standardized medical supplement benefit packages, not Part D drug tiers.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/medigap/basics/how-medigap-works
Verified: 2026-08-13

ANSWER 58 | T-140

Correct answer: D. It generally opens with the first month he is both sixty-five or older and enrolled in Part B, running for about six months.

Explanation. The federal Medigap open-enrollment protection is tied to this specific starting condition, age sixty-five or older together with new Part B enrollment.

Why the other choices are wrong

A. This federal Medigap protection is tied to age and Part B enrollment, not to prior time spent in Medicare Advantage.

B. The federal Medigap open-enrollment window is generally a one-time period, not a recurring annual event like AEP.

C. This federal protection window arises from Ezra's age and Part B enrollment timing, not from a company's discretionary choice.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/medigap/basics/how-medigap-works
Verified: 2026-08-13

ANSWER 59 | T-141

Correct answer: A. A trial-right protection can generally apply because he is returning to Original Medicare within one year of that first-time Medicare Advantage enrollment.

Explanation. This trial-right provision is specifically designed for someone in Duncan's situation, a first-time MA enrollee who returns to Original Medicare within the first year.

Why the other choices are wrong

B. A trial-right protection can specifically apply to a first-time MA enrollee who returns within the first year.

C. The trial-right protection is tied to a return within roughly the first year, not a five-year enrollment threshold.

D. State rules can add protections, but the trial-right provision itself is tied to the first-time, within-a-year MA situation described.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/medigap/ready-to-buy/change-policies/switch-drop
Verified: 2026-08-13

ANSWER 60 | T-142

Correct answer: B. The recommendation must be corrected to reflect that Medigap does not pay Medicare Advantage cost sharing while she remains enrolled in that MA plan.

Explanation. Recommending Medigap to reduce MA copayments misstates how Medigap coordinates only with Original Medicare, not with an MA plan the beneficiary keeps.

Why the other choices are wrong

A. Medigap is designed to supplement Original Medicare, not to offset a Medicare Advantage plan's cost sharing.

C. Changing the plan letter does not correct the fundamental error about what Medigap coordinates with.

D. Disclosing a premium amount does not correct a false claim about what the policy actually pays for.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/medigap/basics/how-medigap-works
Verified: 2026-08-13

ANSWER 61 | T-143

Correct answer: C. Unlike a first-time enrollee returning within a year, Otis generally faces medical underwriting unless a state law extends broader guaranteed-issue rights.

Explanation. The trial-right protection is tied to a first-time MA enrollment and a return within about a year, so a longtime MA member switching back later does not automatically receive the same protection.

Why the other choices are wrong

A. The trial-right protection specifically depends on a first-time enrollment and a prompt return, which does not describe Otis's longer tenure.

B. State law can still extend guaranteed-issue rights beyond the federal trial-right window in some cases.

D. He can generally return to Original Medicare; the issue is whether Medigap guaranteed issue applies, not whether the switch itself is possible.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/medigap/ready-to-buy/change-policies/switch-drop
Verified: 2026-08-13

ANSWER 62 | T-144

Correct answer: D. It generally is not proper; QMB status protects her from being billed for Medicare Part A and B deductibles, coinsurance, and copays.

Explanation. QMB is a federal cost-sharing protection, so a provider generally cannot bill her directly for these Medicare cost-sharing amounts.

Why the other choices are wrong

A. QMB protection against this kind of billing applies regardless of whether the specific provider participates in Medicaid.

B. QMB protection extends to deductibles, coinsurance, and copays, not just the Part B premium.

C. QMB protection covers Part A and Part B cost sharing generally, not Part A charges alone.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 63 | T-145

Correct answer: A. It is generally not accurate; QMB specifically covers Medicare Part A and B premiums and cost sharing rather than providing full Medicaid benefits.

Explanation. QMB is a narrower Medicare Savings Program benefit, distinct from full Medicaid coverage, so describing it as paying for everything overstates what it does.

Why the other choices are wrong

B. QMB is a more limited premium and cost-sharing benefit, distinct from comprehensive full Medicaid coverage.

C. QMB by itself does not include long-term care benefits unless Tobias is separately a full-benefit dual eligible.

D. QMB is specifically tied to Part A and Part B premiums and cost sharing, not to prescription drug costs alone.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 64 | T-146

Correct answer: B. A full-benefit dual eligible qualifies for complete state Medicaid benefits, not just premium or cost-sharing assistance.

Explanation. This distinction matters because a Medicare Savings Program alone provides more limited assistance than full state Medicaid coverage.

Why the other choices are wrong

A. Full-benefit dual eligibility and Medicare Savings Program-only status describe meaningfully different levels of Medicaid assistance.

C. A Medicare Savings Program alone, such as QMB, does not automatically confer complete Medicaid benefits.

D. Full-benefit dual eligibility is defined by qualifying for complete state Medicaid benefits, not by MA enrollment.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 65 | T-147

Correct answer: C. It generally is not accurate; TRICARE for Life requires active enrollment in both Medicare Part A and Part B, and dropping Part B can end that TFL eligibility.

Explanation. TFL is designed to wrap around Medicare rather than replace it, so Selin's continued Part B enrollment is generally necessary to keep her TFL eligibility intact.

Why the other choices are wrong

A. TFL generally requires continued Part B enrollment rather than replacing the need for it.

B. Dropping Part B can end TFL eligibility, so it is not consequence-free.

D. TFL coordination is generally tied to Parts A and B enrollment, which is the basis for the eligibility concern here.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 66 | T-148

Correct answer: D. The employer group health plan generally pays first, with Medicare paying secondary, because the employer has more than the applicable size threshold and his coverage is based on current employment.

Explanation. Medicare Secondary Payer rules generally make a sufficiently large employer's group plan the primary payer for an actively working beneficiary like Gustavo.

Why the other choices are wrong

A. Payer order can depend on employer size and current employment status, not solely on having reached age sixty-five.

B. Payer order for this situation depends on employer size and current-employment status, not simply on enrollment sequence.

C. A sufficiently large employer's group plan can be primary for an actively working, Medicare-eligible beneficiary.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 67 | T-149

Correct answer: A. Whether the employer meets the applicable large-employer size threshold used for the disability-based coordination rule, which differs from the age-based threshold.

Explanation. Mixing up the two thresholds is a common source of coordination errors, since the figure that controls payer order changes depending on which entitlement pathway applies.

Why the other choices are wrong

B. The disability-based threshold generally differs from the age-based one, so treating them as identical risks a coordination error.

C. Employer size remains relevant to payer-order coordination even when eligibility is disability-based.

D. Payer order coordination for this scenario turns on employer size and coverage basis, not on the beneficiary's income.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 68 | T-150

Correct answer: B. The agent must obtain acceptable documented evidence of her Medicaid or MSP eligibility before treating her as D-SNP eligible.

Explanation. D-SNP eligibility depends on confirmed dual status established through acceptable evidence, not on an uncertain self-report.

Why the other choices are wrong

A. An uncertain self-report does not satisfy the requirement to confirm dual eligibility with acceptable evidence.

C. Verification is expected before finalizing the enrollment, not deferred until a later request.

D. Confirmed Medicaid or MSP eligibility, supported by acceptable evidence, is required for D-SNP eligibility.

Applies to: Both
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-13

ANSWER 69 | T-151

Correct answer: C. He should check the plan's Provider Directory to confirm network participation.

Explanation. The Provider Directory is specifically the document that addresses which clinicians and facilities participate in a plan's network.

Why the other choices are wrong

A. The Evidence of Coverage addresses overall plan terms rather than being the primary source for individual provider network status.

B. A formulary lists covered drugs and their tiers, not participating providers.

D. The Summary of Benefits is a concise cost and benefit overview, not a provider network listing.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 70 | T-152

Correct answer: D. The plan's formulary is the document that shows a drug's tier placement and any related coverage rules.

Explanation. Tier placement and drug-specific coverage rules are specifically addressed in the formulary rather than in general plan-overview documents.

Why the other choices are wrong

A. The Evidence of Coverage addresses broader plan terms; the formulary is the document specifically organized by drug and tier.

B. The Provider Directory addresses network participation, not drug tier placement.

C. The Summary of Benefits is a concise overview and is not organized as a drug-by-drug tier listing.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 71 | T-153

Correct answer: A. It is generally treated as a coverage determination, including any requested exception to the formulary.

Explanation. A coverage determination is the plan's initial decision on drug coverage, payment, or a formulary exception, which matches the situation described.

Why the other choices are wrong

B. A grievance concerns dissatisfaction with service or operations, not the merits of a drug-coverage request.

C. Organization determinations concern Part C medical benefit decisions, not Part D drug-coverage requests.

D. Review ordinarily begins with the plan's own initial decision before any later independent review level.

Applies to: Both
Source: https://www.cms.gov/medicare/appeals-grievances/managed-care
Verified: 2026-08-13

ANSWER 72 | T-154

Correct answer: B. The file should be corrected to process the medical benefit denial as an organization determination rather than under Part D coverage-determination procedures.

Explanation. The two appeal tracks are not interchangeable: a decision touching medical benefits belongs to the Part C process, while the Part D track exists specifically for drug requests.

Why the other choices are wrong

A. Organization determinations and Part D coverage determinations follow distinct procedures and are not interchangeable.

C. A grievance addresses service complaints, not the substance of a medical benefit denial that needs a coverage decision.

D. A benefit denial requires a formal determination process, not closure without any recorded decision.

Applies to: Both
Source: https://www.cms.gov/medicare/appeals-grievances/managed-care
Verified: 2026-08-13

ANSWER 73 | T-155

Correct answer: C. The agent must confirm and document Chinelo's actual Part B effective date before submitting the MA application.

Explanation. Because MA eligibility generally depends on confirmed Part A and Part B status, an incomplete effective-date field should be resolved before the application goes forward.

Why the other choices are wrong

A. Leaving a required eligibility field unresolved before submission is not the same as confirming the underlying fact first.

B. A blank field is missing information, not proof of an actual eligibility status, and should be verified rather than assumed.

D. Estimating a date instead of confirming the actual effective date risks an inaccurate enrollment record.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 74 | T-156

Correct answer: D. That is generally inaccurate; returning to Original Medicare from Medicare Advantage generally requires an affirmative disenrollment request during an applicable period.

Explanation. Ceasing to use an MA card does not itself trigger a return to Original Medicare; an active election is generally required.

Why the other choices are wrong

A. An affirmative disenrollment request is generally required rather than the return happening automatically.

B. Returning to Original Medicare from MA does not generally require canceling Part B.

C. MA disenrollment is not generally triggered simply by a month passing without benefit use.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options
Verified: 2026-08-13

ANSWER 75 | T-157

Correct answer: A. Enrolling in the new Part D plan generally triggers automatic disenrollment from the prior plan, so a separate cancellation is generally not required.

Explanation. This automatic-disenrollment mechanism is the general rule that prevents someone from ending up enrolled in two Part D plans at once.

Why the other choices are wrong

B. A separate cancellation form is generally not required because the new enrollment triggers automatic disenrollment from the old plan.

C. The new valid enrollment generally ends the prior plan's enrollment rather than leaving both plans active.

D. A valid election period generally allows this kind of switch without requiring a special waiver from both carriers.

Applies to: Both
Source: https://www.medicare.gov/publications/11219-Understanding-Medicare-Advantage-Medicare-Drug-Plan-Enrollment-Periods.pdf
Verified: 2026-08-13

ANSWER 76 | T-158

Correct answer: B. Original Medicare generally does not cover routine dental, vision, or hearing services, which is part of why some beneficiaries consider Medicare Advantage.

Explanation. This coverage gap in Original Medicare is a commonly cited reason beneficiaries compare it against Medicare Advantage plans that may include such extras.

Why the other choices are wrong

A. Routine dental, vision, and hearing services are generally not covered benefits under Original Medicare.

C. Coverage of these routine services under Original Medicare is not generally tied to reaching a specific later age.

D. Part D addresses outpatient prescription drugs, not routine dental, vision, or hearing services.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 77 | T-159

Correct answer: C. The recommendation must be corrected to clearly explain that MA is a replacement route for Part A and Part B benefits, not merely a supplemental add-on.

Explanation. Presenting MA only as a perks add-on omits its fundamental nature as the delivery route for her core Medicare benefits, which is a material omission.

Why the other choices are wrong

A. Accurately describing perks does not cure the omission of MA's fundamental role as a Medicare benefit delivery route.

B. Recharacterizing MA as Medigap would introduce a separate inaccuracy rather than correct the omission.

D. A star-rating footnote does not address the missing explanation of what MA actually replaces.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 78 | T-160

Correct answer: D. The agent generally cannot treat her as MA-eligible until she also has Part B, regardless of how appealing the advertised benefits are.

Explanation. MA eligibility generally requires both Part A and Part B, so Marguerite's missing Part B enrollment is a barrier the advertised benefits do not remove.

Why the other choices are wrong

A. Part A alone is generally not sufficient; MA eligibility generally requires Part B as well.

B. A PDP provides drug coverage and does not establish Part B enrollment.

C. Attractive advertised benefits do not create an exception to the underlying Part B eligibility requirement.

Applies to: Both
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-13

ANSWER 79 | T-161

Correct answer: A. The agent should verify that the name, MBI, and current Part A and/or Part B effective dates on the card match the application before submitting it.

Explanation. Confirming these specific card details against the application is a basic accuracy check before an enrollment is submitted.

Why the other choices are wrong

B. Name alone is not sufficient; the MBI and effective dates also need to be checked.

C. The relevant details are the name, MBI, and current Part A/B effective dates, not simply an issue date.

D. A verbal confirmation does not substitute for actually checking the card details against the application.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 80 | T-162

Correct answer: B. The insurer generally cannot cancel the policy for health reasons as long as premiums are paid on time and the application was truthful, though it may still raise premiums for the entire class.

Explanation. Guaranteed renewable protects continued coverage against health-based cancellation while still allowing class-wide premium increases, which is the balance this protection strikes.

Why the other choices are wrong

A. Guaranteed renewable specifically prevents cancellation for health reasons when premiums are current and the application was truthful.

C. Guaranteed renewable protects against health-based cancellation, not against class-wide premium increases.

D. The protection depends on the application having been truthful, not on it containing inaccuracies.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/medigap/basics/how-medigap-works
Verified: 2026-08-13

ANSWER 81 | T-163

Correct answer: C. PACE generally coordinates comprehensive Medicare benefits and, when applicable, Medicaid benefits for its participants.

Explanation. This integrated structure is what allows PACE to coordinate a broad range of services rather than administering Medicare and Medicaid as separate, disconnected benefits.

Why the other choices are wrong

A. PACE can coordinate Medicaid benefits as well when a participant qualifies for them.

B. PACE coordinates existing Medicare and, when applicable, Medicaid benefits rather than replacing them with a separate package.

D. PACE participation does not depend on holding a separate Medigap policy.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options
Verified: 2026-08-13

ANSWER 82 | T-164

Correct answer: D. QMB generally pays Part A and Part B premiums plus cost sharing, while SLMB generally pays only the Part B premium.

Explanation. This is the general distinction between the two Medicare Savings Programs: QMB's broader premium-and-cost-sharing help versus SLMB's narrower Part B premium assistance.

Why the other choices are wrong

A. QMB generally provides the broader benefit, covering both premiums and cost sharing, while SLMB is narrower.

B. QMB and SLMB provide different scopes of assistance rather than being interchangeable names for the same benefit.

C. QMB generally covers cost sharing in addition to premiums, unlike a premium-only description of both programs.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 83 | T-165

Correct answer: A. Medicare generally pays first and TRICARE for Life generally pays most of the remaining Medicare-allowed cost.

Explanation. TFL is designed to wrap around Medicare as a secondary payer rather than to pay first or to substitute for Medicare coverage.

Why the other choices are wrong

B. The payer order generally runs the opposite way: Medicare pays first and TFL pays much of the remainder.

C. TFL is designed to wrap around continued Medicare enrollment rather than replace the need for it.

D. TFL generally coordinates with the broader Medicare benefit rather than being limited to Part D drug costs alone.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 84 | T-166

Correct answer: B. True; MA eligibility generally requires both Part A entitlement and Part B enrollment.

Explanation. This statement accurately reflects the general MA eligibility requirement.

Why the other choices are wrong

A. Part A alone is generally not sufficient; Part B is also generally required.

C. Service-area residence is one factor, but Part A and Part B status is also generally required.

D. The Part A and Part B eligibility requirement is not limited to one MA plan type.

Applies to: Both
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-13

ANSWER 85 | T-167

Correct answer: C. False; Medigap is designed to supplement Original Medicare, not Medicare Advantage cost sharing.

Explanation. This statement is false because Medigap coordinates specifically with Original Medicare's cost-sharing structure.

Why the other choices are wrong

A. Common company ownership does not change Medigap's design, which coordinates with Original Medicare rather than MA.

B. Medigap is not designed to be interchangeable with Medicare Advantage cost sharing.

D. Medigap does supplement Original Medicare cost sharing; the statement is false for a different reason than this option describes.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/medigap/basics/how-medigap-works
Verified: 2026-08-13

ANSWER 86 | T-168

Correct answer: D. True; the former coverage-gap phase has been eliminated and replaced by a structure built around an annual out-of-pocket threshold.

Explanation. This statement accurately reflects the current Part D benefit design.

Why the other choices are wrong

A. The former coverage-gap phase has been eliminated, so this description of it continuing is inaccurate.

B. Reaching the former gap threshold does not suspend coverage under the current structure.

C. The elimination of the former coverage gap applies to the Part D benefit generally, not to one plan type only.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/part-d/basics/costs
Verified: 2026-08-13

ANSWER 87 | T-169

Correct answer: A. Stand-alone PDP; MA-PD; PACE.

Explanation. A stand-alone PDP pairs with Original Medicare, an MA-PD bundles medical and drug coverage in one private plan, and PACE serves qualifying participants who need nursing-home-level care while remaining in the community.

Why the other choices are wrong

B. This ordering mismatches each coverage route with its situation; an MA-PD does not describe keeping Original Medicare separate from drug coverage.

C. PACE does not describe keeping Original Medicare while adding drug coverage, and the remaining pairings are also mismatched.

D. PACE does not describe a single private plan bundling medical and drug coverage, and MA-PD does not describe the nursing-home-level-care situation.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options
Verified: 2026-08-13

ANSWER 88 | T-170

Correct answer: B. Formulary; Provider Directory; Evidence of Coverage.

Explanation. The formulary addresses drug tier placement, the Provider Directory addresses network participation, and the Evidence of Coverage contains the comprehensive plan terms.

Why the other choices are wrong

A. The Evidence of Coverage is not organized as a drug-by-drug tier list, and the remaining pairings are also mismatched.

C. The Provider Directory does not show drug tiers, and the formulary is not the comprehensive plan contract.

D. The Evidence of Coverage is not the specific source for confirming a clinician's network status.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 89 | T-171

Correct answer: C. Part A entitlement, Part B enrollment, and service-area residence are generally required; a Medigap policy is not.

Explanation. Those three conditions form the core eligibility test, and owning a separate supplemental product plays no role in whether someone qualifies to join a Medicare Advantage plan.

Why the other choices are wrong

A. A Medigap policy is not a general MA eligibility requirement.

B. Part B enrollment is generally also required for MA eligibility, not merely optional.

D. Part A entitlement and service-area residence are also generally required, and a Medigap policy is not.

Applies to: Both
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-13

ANSWER 90 | T-172

Correct answer: D. No built-in drug coverage, no defined provider network, and an annually funded savings account are all generally accurate; a signed exclusive provider contract is not.

Explanation. MSA plans are generally structured around a high-deductible design with an annually funded account, no built-in drug benefit, and no conventional network, which rules out a signed exclusive provider contract requirement.

Why the other choices are wrong

A. MSA plans generally do not require a signed exclusive provider contract.

B. The no-drug-coverage and no-defined-network statements are also generally accurate for MSA plans.

C. An exclusive provider contract requirement is not generally accurate for MSA plans, while the no-drug-coverage and account-funding statements are also true.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options
Verified: 2026-08-13

Topic Set - MA, MA-PD, PDP, HMO, PPO, PFFS, MSA, SNPs

75 answer entries. Match each entry to the question number and ID printed in Part I.

ANSWER 91 | T-019

Correct answer: C. A PPO with an out-of-network benefit subject to the plan's terms.

Explanation. A PPO generally combines preferred in-network pricing with coverage for out-of-network services at a higher member cost. Provider willingness and the specific plan terms still matter, but the structure directly addresses Tanya's stated preference.

Why the other choices are wrong

A. An HMO generally relies on its network for routine care and does not provide the same broad non-network benefit.

B. An MSA's defining features are a high deductible and medical savings account, not a PPO-style preferred network.

D. D-SNP enrollment depends on qualifying Medicare-Medicaid status and is unrelated to a general desire for non-network access.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-02

ANSWER 92 | T-020

Correct answer: D. Prior treatment may not guarantee acceptance of the plan's terms for this encounter.

Explanation. Provider participation in a PFFS arrangement can depend on the particular plan's network status or on accepting its payment terms for an encounter. A previous visit is not necessarily a continuing promise for later routine care.

Why the other choices are wrong

A. One completed visit does not create permanent participation in every future encounter.

B. Medicare participation is not the same as acceptance of each PFFS plan's payment terms.

C. Uncertainty about routine provider acceptance does not transform a scheduled visit into emergency care.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-02

ANSWER 93 | T-021

Correct answer: A. A stand-alone Part D plan may be added because the MSA does not include drug coverage.

Explanation. Medicare MSA plans combine a high-deductible health plan with a medical savings account and do not include Part D. An MSA enrollee who wants prescription coverage may enroll separately in a stand-alone PDP.

Why the other choices are wrong

B. A beneficiary cannot ordinarily stack a second incompatible Medicare Advantage plan on the MSA.

C. Modern Medigap policies do not supply Part D, and Medigap is designed for Original Medicare rather than MA.

D. The absence of embedded drug coverage is precisely why a separate PDP is permitted with an MSA.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-02

ANSWER 94 | T-022

Correct answer: B. A D-SNP serving beneficiaries with the plan's qualifying dual status.

Explanation. A D-SNP limits enrollment to people whose Medicare and Medicaid status meets the plan's approved dual-eligibility categories. Current status must be confirmed through acceptable evidence rather than assumed from an old record.

Why the other choices are wrong

A. A C-SNP is organized around designated severe or disabling chronic conditions, not Medicaid status alone.

C. An I-SNP serves institutionalized people or qualifying institutional-equivalent residents.

D. A non-SNP MA plan does not impose a special-needs eligibility category.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 95 | T-023

Correct answer: C. The qualifying condition must be confirmed through the plan's required C-SNP process.

Explanation. C-SNP enrollment requires a condition served by that plan and verification under CMS and plan procedures. An agent can collect accurate information but cannot invent, waive, or personally finalize the clinical eligibility determination.

Why the other choices are wrong

A. A beneficiary statement alone does not universally complete the plan's required confirmation.

B. Ordinary MA eligibility does not establish the additional special-needs criterion.

D. C-SNPs are specifically designed for certain severe or disabling chronic conditions; I-SNP eligibility addresses institutional status or level of care.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 96 | T-024

Correct answer: D. No; a qualifying institutional-equivalent pathway may apply when the required assessment is satisfied.

Explanation. Some I-SNPs may serve community residents who meet the applicable institutional-equivalent level-of-care requirements for the required duration. Home residence does not decide the issue, but the plan's formal assessment remains essential.

Why the other choices are wrong

A. CMS permits qualifying institutional-equivalent pathways in addition to residence in an institution.

B. I-SNP qualification is distinct from D-SNP Medicaid categories.

C. The assessment cannot be waived by an agent or replaced by a cost judgment.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 97 | T-025

Correct answer: A. An incompatible PDP election can cause disenrollment from the MA-PD arrangement.

Explanation. When an HMO or PPO includes embedded Part D, it is an MA-PD. Joining a stand-alone PDP is ordinarily incompatible and may disenroll the beneficiary from the Medicare Advantage plan unless a specific exception applies.

Why the other choices are wrong

B. Medicare systems do not generally maintain an MA-PD and separate PDP as primary and secondary drug plans.

C. Dual Part D enrollment is not a standard requirement.

D. A drug-plan election does not convert the existing health plan into an MSA.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 98 | T-026

Correct answer: B. It covers specified non-network services under defined HMO plan terms.

Explanation. An HMO-POS feature is a limited plan-authorized exception for particular out-of-network services. It does not change the entire product into a PPO or erase the HMO's remaining network and coordination rules.

Why the other choices are wrong

A. The POS feature is limited and does not eliminate all HMO controls.

C. The beneficiary remains enrolled in Medicare Advantage rather than reverting to Original Medicare for selected services.

D. Cost sharing and covered categories follow the specific POS terms and need not match in-network amounts.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-02

ANSWER 99 | T-027

Correct answer: C. Its service area is a CMS-defined region governed by regional-plan requirements.

Explanation. A regional PPO is offered across a CMS-defined geographic region and follows the rules applicable to regional plans. A local PPO instead uses its approved local service-area configuration.

Why the other choices are wrong

A. PPOs characteristically provide an out-of-network option, generally at higher cost.

B. Medicare Advantage eligibility still generally requires Part A and Part B.

D. Regional status concerns geography and plan structure, not D-SNP eligibility.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 100 | T-028

Correct answer: D. The plan meets CMS requirements for a fully integrated Medicare-Medicaid structure.

Explanation. A FIDE SNP satisfies CMS's fully integrated dual-eligible standards, including specified alignment and risk arrangements. It represents a stronger defined integration level than a coordination-only D-SNP.

Why the other choices are wrong

A. D-SNPs have coordination duties, and full integration adds rather than removes them.

B. Network form alone does not establish FIDE status.

C. Chronic-condition restriction describes a C-SNP, not the defining feature of a FIDE SNP.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 101 | T-029

Correct answer: A. The plan applies its published criteria and administration process.

Explanation. The MA plan administers SSBCI eligibility under its approved criteria and process. An agent may accurately explain those criteria but should never promise that a prospect will qualify before the plan applies them.

Why the other choices are wrong

B. A sales representative does not have authority to issue the plan's binding eligibility decision.

C. A request does not by itself satisfy clinical or plan-developed criteria.

D. A payment vendor cannot replace the plan's coverage and eligibility process.

Applies to: Both
Source: https://www.cms.gov/newsroom/fact-sheets/contract-year-2027-medicare-advantage-part-d-final-rule
Verified: 2026-08-02

ANSWER 102 | T-030

Correct answer: B. Its use must be tied to plan-covered items and services for the applicable plan year.

Explanation. CMS strengthened controls so supplemental-benefit cards are linked to covered items and services and to the relevant plan year. The card is a method for administering benefits, not a general cash payment.

Why the other choices are wrong

A. Plan-year and covered-use limits contradict unrestricted, indefinite cash use.

C. A card does not override benefit-specific eligibility requirements.

D. A stated allowance is not automatically cash owed to the member without an eligible covered use.

Applies to: Both
Source: https://www.cms.gov/newsroom/fact-sheets/contract-year-2027-medicare-advantage-part-d-final-rule
Verified: 2026-08-02

ANSWER 103 | T-031

Correct answer: C. Review the specific network, referral, out-of-network, or acceptance rules before recommending the plan.

Explanation. A plan-type comparison must include how the beneficiary can actually use established providers. The relevant inquiry differs by HMO, PPO, PFFS, or other structure, so a premium-only recommendation is incomplete.

Why the other choices are wrong

A. Provider access is a material pre-enrollment suitability fact.

B. Waiting for a denied or expensive claim exposes the beneficiary to avoidable harm.

D. Participation in Medicare does not establish acceptance of every private plan's network or payment terms.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-02

ANSWER 104 | T-032

Correct answer: D. Reject the wording and disclose the benefit's eligibility, covered-use, and plan limits accurately.

Explanation. Conditional supplemental benefits must be marketed with their actual eligibility and covered-use restrictions. Presenting a plan-administered benefit as unrestricted money for every enrollee is materially misleading.

Why the other choices are wrong

A. Supplemental benefits can be conditional and are not automatically cash.

B. Typography does not cure a false description of eligibility or use.

C. Removing the plan name leaves the central misrepresentation unchanged.

Applies to: Both
Source: https://www.cms.gov/newsroom/fact-sheets/contract-year-2027-medicare-advantage-part-d-final-rule
Verified: 2026-08-02

ANSWER 105 | T-033

Correct answer: A. I and II only.

Explanation. Statements I and II are accurate. PPOs generally offer a higher-cost out-of-network benefit, and MSA enrollees may obtain Part D through a separate PDP because the MSA itself has no embedded drug coverage.

Why the other choices are wrong

B. Statement III is false because prior PFFS treatment does not necessarily guarantee acceptance for later encounters.

C. Statement IV is false because D-SNP enrollment depends on a qualifying dual-eligibility category.

D. Both III and IV misstate core eligibility and provider-acceptance rules.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-02

ANSWER 106 | T-173

Correct answer: A. Whether the referral rule applies only to specialists inside the plan's network.

Explanation. HMO referral requirements are generally tied to directing enrollees toward network providers; an out-of-network specialist typically falls outside that referral pathway and may not be covered the same way, so Priya needs to confirm how her plan's referral rule treats non-network care before scheduling.

Why the other choices are wrong

B. Accepting Original Medicare does not establish participation in Priya's private HMO network.

C. A planned specialist consultation is not converted into emergency care by asking about referrals.

D. A personal referral from a friend has no bearing on the plan's own referral procedure.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 107 | T-174

Correct answer: B. No, staying within the plan's approved service area preserves his enrollment.

Explanation. MA plan enrollment depends on residing within the plan's CMS-approved service area, not on employment status. As long as Marcus's residence remains inside the local PPO's approved county-based area, a job change alone does not affect his eligibility.

Why the other choices are wrong

A. Employment changes do not by themselves affect Medicare Advantage enrollment.

C. Service-area rules concern the approved boundary, not a fixed central address.

D. Local PPOs do have a defined service area even though they also offer an out-of-network benefit.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 108 | T-175

Correct answer: C. It must offer the same premium and benefit package across its CMS-defined region.

Explanation. A regional PPO operates under CMS rules requiring a uniform premium and benefit package throughout its defined region, distinguishing it from a local PPO's county-based service area design.

Why the other choices are wrong

A. Regional PPOs are required to maintain consistency across the region rather than vary by county.

B. Regional PPOs, like local PPOs, generally include an out-of-network benefit.

D. A CMS-defined region can span multiple states rather than being limited to one.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 109 | T-176

Correct answer: D. Her PFFS plan may still operate with contracted providers under applicable network requirements.

Explanation. Some PFFS plans are required to establish contracted provider networks depending on the competitive conditions in their service area, while still remaining a PFFS plan type. Dolores should review her plan's specific network status rather than assume all PFFS plans are network-free.

Why the other choices are wrong

A. Maintaining a network does not change the plan's underlying PFFS classification.

B. A contracted network does not eliminate the plan's other access terms unless the plan documents say so.

C. Building a network does not convert a PFFS plan into a different plan type.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 110 | T-177

Correct answer: A. State that the provider must accept Medicare and not have opted out of the program.

Explanation. Medicare MSA plans generally lack a contracted network, but coverage still depends on using a Medicare-approved provider who has not opted out of Medicare. The brochure must reflect that limitation instead of promising truly unrestricted access.

Why the other choices are wrong

B. The access claim overstates the plan's actual terms and needs correction.

C. Substituting one broad term for another does not fix the missing eligibility qualifier.

D. Adding premium information does not address the inaccurate access claim.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 111 | T-178

Correct answer: B. Urgently needed and emergency services remain covered outside the network under applicable protections.

Explanation. Medicare Advantage plans, including HMOs, must cover emergency and urgently needed services even outside the plan's network, recognizing that enrollees cannot always predict when unexpected care will be needed while away from the service area.

Why the other choices are wrong

A. Requiring a return home before treatment would defeat the purpose of the urgent/emergency protection.

C. An HMO enrollee does not need to change plan type to receive covered emergency or urgent care.

D. A general notice requirement of that kind is not what makes urgent or emergency coverage apply.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 112 | T-179

Correct answer: C. A PPO, because it typically does not require a referral for specialist care.

Explanation. PPOs are generally structured so that enrollees may see specialists, in-network or out, without a required referral, unlike the gatekeeper model many HMOs use. This directly matches Hector's stated priority.

Why the other choices are wrong

A. HMOs commonly do require a referral for specialist visits under their gatekeeper structure.

B. An MSA's defining feature is its savings-account and deductible design, not a referral-free promise.

D. Medicare participation by a clinician does not itself remove a PFFS plan's own terms of acceptance.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 113 | T-180

Correct answer: D. True; the uniform premium and benefit requirement applies across the region.

Explanation. The statement is true. CMS requires a regional PPO to maintain the same premium and benefit package throughout its defined region, which is a key structural difference from a local PPO's county-level design.

Why the other choices are wrong

A. The rule requires uniformity rather than county-by-county premium variation.

B. The uniform-design requirement applies to regional PPOs specifically, not local PPOs.

C. The requirement covers both premium and benefits together, not premium alone with benefit variation.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 114 | T-181

Correct answer: A. Deposited account funds may pay qualified medical expenses before the deductible is satisfied.

Explanation. A Medicare MSA pairs a high-deductible plan with an account the plan funds; enrollees may use that money toward qualified medical expenses even before the deductible is satisfied, though not every withdrawal is treated the same way for tax or deductible purposes.

Why the other choices are wrong

B. The account is specifically usable before the deductible is met, not only afterward.

C. MSA funds are intended for qualified medical expenses, not unrestricted personal spending.

D. The account does not automatically fund Part D premiums; the MSA has no embedded drug coverage.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 115 | T-182

Correct answer: B. Medicare MSA plans do not include Part D, so drug coverage must come from a separate stand-alone PDP if wanted.

Explanation. Medicare MSA plans do not include embedded Part D coverage by design, unlike an MA-PD such as many HMOs. An MSA enrollee who wants drug coverage may pursue a separate stand-alone PDP, but the absence in the MSA quote is not an oversight.

Why the other choices are wrong

A. The MSA's lack of Part D is a structural feature, not a missing item that gets added automatically.

C. MSA plans lack embedded Part D regardless of Medicaid status.

D. Absence of embedded Part D does not disqualify Naomi from choosing an MSA; it simply means drug coverage requires a separate election.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 116 | T-183

Correct answer: C. Clarify that only plans meeting CMS's fully integrated criteria carry the FIDE designation.

Explanation. Not every D-SNP meets CMS's fully integrated dual-eligible standard; a coordination-only D-SNP differs from a FIDE-designated plan in the depth of Medicare-Medicaid integration. The agent's blanket statement must be corrected to reflect that distinction.

Why the other choices are wrong

A. The claim inaccurately treats a specific integration designation as universal among D-SNPs.

B. Swapping network labels does not correct the underlying misstatement about integration level.

D. Coordination-only D-SNPs still provide some Medicaid coordination even without full FIDE integration.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 117 | T-184

Correct answer: D. Enrolling in the MA-PD generally ends the need for, and compatibility with, his separate PDP.

Explanation. Once Desmond enrolls in an HMO that includes Part D (an MA-PD), keeping a separate stand-alone PDP is ordinarily incompatible, since the MA-PD already provides the drug benefit and joining a stand-alone PDP could trigger disenrollment from the MA-PD.

Why the other choices are wrong

A. Medicare systems do not automatically merge a stand-alone PDP into an MA-PD's benefit.

B. CMS does not require maintaining two overlapping Part D sources.

C. An HMO can include Part D coverage regardless of a beneficiary's prior separate PDP enrollment.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 118 | T-185

Correct answer: A. An annual out-of-pocket maximum limiting a member's Part A and B cost sharing.

Explanation. Medicare Advantage plans, across plan types, are required to include an annual out-of-pocket maximum for original Medicare Part A and B services, protecting members from unlimited cost-sharing exposure once that limit is reached.

Why the other choices are wrong

B. Not every MA plan type embeds Part D; MSAs, for example, do not.

C. No MA plan type guarantees universal nationwide provider participation.

D. Referral requirements vary by plan type and are not banned across the board.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 119 | T-186

Correct answer: B. CMS may treat the plan as a D-SNP look-alike once dual enrollment crosses the applicable threshold.

Explanation. CMS monitors non-SNP MA plans whose enrollment becomes disproportionately dual-eligible and may treat such a plan as a D-SNP look-alike once the applicable enrollment threshold is met, which can affect whether CMS renews or contracts with the plan.

Why the other choices are wrong

A. This concentration is specifically relevant to CMS's look-alike policy and renewal decisions.

C. Plan conversion is not automatic or tied to any individual member's status.

D. FIDE status reflects a specific integration standard, not simply a high proportion of dual-eligible enrollees.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 120 | T-187

Correct answer: C. MSA; PFFS; Regional PPO.

Explanation. The high-deductible-plus-account design describes an MSA, the payment-terms-with-individual-providers arrangement describes a PFFS plan, and the uniform premium and benefit design across a defined multi-county region describes a regional PPO.

Why the other choices are wrong

A. The first and third labels are reversed relative to their descriptions.

B. All three labels are shifted out of order from their matching features.

D. The second and third labels are reversed relative to their descriptions.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 121 | T-188

Correct answer: D. A duration generally expected to last at least 90 days is required.

Explanation. The institutional-equivalent pathway lets a community-dwelling person qualify for I-SNP enrollment when an impartial state-based assessment shows a need for institutional-level care generally expected to last at least 90 days.

Why the other choices are wrong

A. The pathway does require an assessed minimum expected duration, not an open-ended standard.

B. Thirty days understates the generally required expected duration.

C. Twelve months overstates the standard actually applied.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 122 | T-189

Correct answer: A. Yes, through the institutional-equivalent pathway once the required assessment is satisfied.

Explanation. CMS permits a qualifying institutional-equivalent pathway for community residents whose assessed level-of-care need meets the applicable standard, so home residence alone does not rule Rosalind out of I-SNP eligibility.

Why the other choices are wrong

B. Nursing-facility residency is one basis for I-SNP eligibility, but it is not the only one.

C. I-SNP eligibility rests on institutional or institutional-equivalent status, not on a Medicaid category.

D. The institutional-equivalent pathway specifically relies on this type of state-based assessment.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 123 | T-190

Correct answer: B. Current dual-eligible status must be confirmed through acceptable evidence before relying on it for D-SNP enrollment.

Explanation. D-SNP enrollment requires confirming a beneficiary's current qualifying dual-eligible status through acceptable evidence, which may include a current Medicaid card, a state-agency letter, or a state eligibility system check; an outdated document does not establish present eligibility.

Why the other choices are wrong

A. Medicaid eligibility can change, so an old card does not confirm current status.

C. A Social Security number is not itself acceptable Medicaid eligibility evidence.

D. Listing the correct state does not establish that the eligibility shown is still current.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 124 | T-191

Correct answer: C. A coordination-only D-SNP aligns benefit information, while integrated SNPs combine Medicare and Medicaid financing and care management.

Explanation. A coordination-only D-SNP focuses on aligning Medicare and Medicaid benefit information for the member, while a more integrated FIDE-SNP or HIDE-SNP combines Medicare and Medicaid financing and care management under a single contracted structure.

Why the other choices are wrong

A. Coordination-only D-SNPs still have Medicaid-related coordination duties, even without full integration.

B. Network type alone does not define integration status.

D. The two designations reflect materially different levels of Medicare-Medicaid integration.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 125 | T-192

Correct answer: D. A highly integrated D-SNP generally uses one unified Medicare-Medicaid appeals and grievance process.

Explanation. Highly integrated D-SNPs, such as FIDE-SNPs, generally use a single unified appeals and grievance process that spans both the Medicare and Medicaid components of the member's coverage, rather than requiring two separate uncoordinated tracks.

Why the other choices are wrong

A. A unified process is the point of high integration, rather than two disconnected appeals.

B. FIDE-SNPs remain subject to grievance and appeals obligations.

C. A FIDE-SNP is a form of Medicare Advantage D-SNP, not a separate non-MA product.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 126 | T-193

Correct answer: A. A PFFS plan, whose payment terms a provider may accept for a given encounter.

Explanation. A PFFS plan's defining structure lets it pay providers based on the plan's payment terms, which a provider may accept for a given service, distinct from a fixed contracted network in the way Camila describes.

Why the other choices are wrong

B. HMOs are built around contracted network arrangements, not per-encounter provider acceptance.

C. Regional PPO premiums follow the region-wide uniform requirement, not individual provider terms.

D. An MSA's funding structure does not replace how providers are paid for services.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 127 | T-194

Correct answer: B. A regional PPO, because it must offer the same premium and benefits across its defined region.

Explanation. A regional PPO is required to maintain a uniform premium and benefit package across its entire CMS-defined region, which directly matches Elias's priority of consistent coverage if he relocates within that footprint.

Why the other choices are wrong

A. Local PPO benefit design does not carry the region-wide uniformity Elias wants.

C. HMOs use county- or area-based service areas rather than automatic nationwide uniformity.

D. PFFS plans are a distinct plan type and do not substitute for regional PPO benefit design rules.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 128 | T-195

Correct answer: C. The condition must appear on CMS's approved list and be confirmed through the plan's verification process.

Explanation. C-SNP eligibility depends on a condition that appears on CMS's approved chronic-condition list and must be confirmed through the plan's required verification process, not on an agent's own judgment or an unverified self-report.

Why the other choices are wrong

A. A self-report alone does not complete the plan's required condition verification.

B. Selecting a qualifying condition is not within an agent's discretion.

D. Age is not the basis for C-SNP condition-based eligibility.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 129 | T-196

Correct answer: D. Because C-SNP eligibility requires verification of the qualifying condition beyond a self-report.

Explanation. CMS requires C-SNP eligibility to be verified through the plan's process, which typically includes confirmation beyond the beneficiary's own statement, ensuring the qualifying chronic condition is properly documented before enrollment is finalized.

Why the other choices are wrong

A. Confirming the condition is an additional requirement, not a substitute for baseline MA eligibility.

B. Self-reported information may still be collected as part of the process; it simply is not sufficient alone.

C. Physician confirmation of a chronic condition does not change the plan into an I-SNP.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 130 | T-197

Correct answer: A. Explain that the card funds must be used for covered items and services within the applicable plan year, not paid out as cash.

Explanation. Under CY2027 rules, supplemental-benefit debit cards must be tied to covered items and services within the applicable plan year; the funds are not a cash payout, so the agent must correct the prospect's assumption rather than confirm it.

Why the other choices are wrong

B. There is no automatic year-end cash payout of unused card balances.

C. Indefinite carryover contradicts the plan-year-limited design of the benefit.

D. The card's value is tied to covered purchases, not an unconditional payment.

Applies to: Both
Source: https://www.cms.gov/newsroom/fact-sheets/contract-year-2027-medicare-advantage-part-d-final-rule
Verified: 2026-08-13

ANSWER 131 | T-198

Correct answer: B. The out-of-area dialysis exception recognized for enrollees who travel temporarily.

Explanation. Medicare Advantage plans, including HMOs, recognize an out-of-area dialysis exception allowing enrollees to obtain covered dialysis treatment while temporarily outside the plan's service area, alongside the emergency and urgently needed services protections.

Why the other choices are wrong

A. A POS feature is a separate, optional plan design element and is not the specific dialysis carve-out.

C. The plan type does not change because the member travels.

D. Exhausting Original Medicare is not a precondition for this exception.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 132 | T-199

Correct answer: C. An out-of-area dialysis exception generally allows coverage for temporary travel situations like his.

Explanation. CMS recognizes an out-of-area dialysis exception permitting Medicare Advantage enrollees, including those in HMOs, to receive covered dialysis treatment while temporarily traveling outside the plan's service area, addressing exactly the situation Gustavo describes.

Why the other choices are wrong

A. The exception specifically allows coverage in this kind of temporary-travel circumstance.

B. Switching plan types is not required to receive this coverage.

D. The underlying HMO does not change plan classification because the member is traveling.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 133 | T-200

Correct answer: D. I and III only.

Explanation. Statements I and III are accurate. A C-SNP's qualifying condition must be on CMS's approved list, and an I-SNP may serve a qualifying community resident under the institutional-equivalent pathway when the required assessment is satisfied.

Why the other choices are wrong

A. Statement II is false because D-SNP enrollment depends on a qualifying dual-eligibility category, not any beneficiary.

B. Statement II is inaccurate for the same reason, making this combination wrong.

C. Statement IV is false because FIDE-SNPs reflect a higher, not lower, level of integration than coordination-only D-SNPs.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 134 | T-201

Correct answer: A. The plan deposits funds into the account, generally on an annual basis.

Explanation. A Medicare MSA plan's account is funded by the plan itself, generally through an annual deposit, which the enrollee may then use toward qualified medical expenses before the plan's high deductible is met.

Why the other choices are wrong

B. The plan, not the enrollee, funds the account deposit under this structure.

C. The deposit comes from the MSA plan, not a separate unrelated government check.

D. Deposits are not conditioned on first reaching the deductible; the money can be used to help meet it.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 135 | T-202

Correct answer: B. Unused MSA account funds may generally carry over for the enrollee's future use.

Explanation. A Medicare MSA's account funds are a feature of the plan that generally allows unused amounts to carry over for the enrollee's future use, unlike a strict use-it-or-lose-it design, which is one reason MSA plans appeal to lower-utilizing members.

Why the other choices are wrong

A. Forfeiture at year-end is not how MSA account funds are treated.

C. Leftover MSA funds do not convert into Part D premium credits.

D. There is no requirement to return unused MSA account funds to CMS.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 136 | T-203

Correct answer: C. The description must be corrected because an MSA pairs a high deductible with the funded account.

Explanation. A Medicare MSA plan is specifically structured around a high deductible paired with a plan-funded account; describing it as having no deductible misrepresents the plan's core design and must be corrected before use.

Why the other choices are wrong

A. MSA plans are defined in part by their high-deductible structure, so the claim is inaccurate.

B. The deductible misstatement, not a premium figure, is the central problem here.

D. Recharacterizing the plan as a PPO does not correct the deductible misstatement and introduces a new inaccuracy.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 137 | T-204

Correct answer: D. He may generally add a stand-alone PDP because his PFFS plan has no embedded Part D.

Explanation. A PFFS plan without embedded Part D coverage generally allows the enrollee to add a compatible stand-alone PDP, since there is no existing MA-PD drug benefit that a new PDP election would conflict with.

Why the other choices are wrong

A. PFFS enrollees without embedded Part D are not universally barred from a separate PDP.

B. Switching to an HMO is not a prerequisite for adding compatible Part D coverage.

C. Adding a PDP does not change the underlying PFFS plan into an MSA.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 138 | T-205

Correct answer: A. It is generally not covered except under specific protections such as emergency or urgent care.

Explanation. An HMO generally does not cover routine non-emergency services obtained outside its network, apart from specific protections like emergency care, urgently needed services, and the out-of-area dialysis exception.

Why the other choices are wrong

B. Non-network cost sharing, when covered at all, is not the same as the in-network rate.

C. There is no 'PPO rider' mechanism that extends HMO coverage this way.

D. A provider's Medicare participation does not by itself create HMO network coverage.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 139 | T-206

Correct answer: B. The visit is likely not covered because it falls outside the plan's network without a qualifying exception.

Explanation. Because Selena's visit is routine and does not fall under the emergency, urgent, or out-of-area dialysis protections, her HMO is likely to treat the non-network service as not covered under its ordinary terms.

Why the other choices are wrong

A. Part B enrollment does not override the HMO's own network coverage terms.

C. A single claim does not change the plan's underlying type.

D. An HMO enrollee's care is generally billed through the MA plan, not routed back to Original Medicare.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 140 | T-207

Correct answer: C. False; a period of deemed continued eligibility may apply before disenrollment takes effect.

Explanation. The statement is false. A member who loses the qualifying status for their SNP may retain a period of deemed continued eligibility, generally 30 days to six months, before involuntary disenrollment actually takes effect, rather than being disenrolled the same day.

Why the other choices are wrong

A. Same-day disenrollment without exception misstates the deemed eligibility protection.

B. The deemed eligibility concept is not limited to C-SNP members alone.

D. Loss of qualifying status does have consequences for enrollment, just not necessarily an immediate one.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 141 | T-208

Correct answer: D. It must be used for covered items and services tied to the applicable plan year.

Explanation. CY2027 rules tie a supplemental-benefit debit card's use to covered items and services within the applicable plan year, rather than allowing unrestricted purchases, cash conversion, or transfer to another person's account.

Why the other choices are wrong

A. The benefit is tied to the enrolled member, not transferable to a separate account.

B. Use is tied to covered items and services, not simply the passage of a calendar month.

C. The card is not designed to be exchanged for cash on request.

Applies to: Both
Source: https://www.cms.gov/newsroom/fact-sheets/contract-year-2027-medicare-advantage-part-d-final-rule
Verified: 2026-08-13

ANSWER 142 | T-209

Correct answer: A. Use is limited to the plan's covered items and services for the applicable plan year.

Explanation. Supplemental-benefit debit cards under CY2027 rules are tied to covered items and services within the applicable plan year, so Woodrow's spending is limited to the plan's defined covered uses rather than open to any personal purchase.

Why the other choices are wrong

B. The card's use is restricted to plan-covered items and services, not unrestricted personal spending.

C. There is no provision for transferring the balance to another person's account.

D. The card's use is tied to the applicable plan year rather than being open-ended indefinitely.

Applies to: Both
Source: https://www.cms.gov/newsroom/fact-sheets/contract-year-2027-medicare-advantage-part-d-final-rule
Verified: 2026-08-13

ANSWER 143 | T-210

Correct answer: B. Clarify that supplemental benefits such as a grocery allowance vary by plan and are not guaranteed in every D-SNP.

Explanation. Supplemental benefits like a grocery allowance are plan-specific and administered under each plan's approved criteria; they are not a guaranteed, uniform feature of every D-SNP nationwide, so the presentation's blanket claim requires correction.

Why the other choices are wrong

A. CMS does not mandate an identical grocery benefit in every D-SNP.

C. Redirecting the claim to C-SNPs does not correct the inaccurate universal-benefit statement about D-SNPs.

D. Instructing a prospect to assume an unconfirmed benefit exists compounds rather than corrects the misrepresentation.

Applies to: Both
Source: https://www.cms.gov/newsroom/fact-sheets/contract-year-2027-medicare-advantage-part-d-final-rule
Verified: 2026-08-13

ANSWER 144 | T-211

Correct answer: C. Full Medicaid coverage marks one category, while Medicare Savings Program assistance alone marks the other.

Explanation. A full-benefit dual-eligible beneficiary has Medicare plus complete state Medicaid benefits, while a partial-benefit dual-eligible beneficiary has Medicare plus help from a Medicare Savings Program only, such as QMB, SLMB, or QI, without full Medicaid benefits.

Why the other choices are wrong

A. This reverses the actual definitions of the two categories.

B. D-SNP eligibility categories are not identical across all plans, and some plans have narrower dual-eligible criteria.

D. Full-benefit dual-eligible status is generally the core population most D-SNPs are designed to serve.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 145 | T-212

Correct answer: D. Yes, partial-benefit dual-eligible status may still support SNP eligibility in most states.

Explanation. A partial-benefit dual-eligible beneficiary, who receives Medicare Savings Program help without full state Medicaid benefits, generally remains SNP-eligible in most states, so Bruno's Medicare Savings Program status does not automatically exclude him from D-SNP enrollment.

Why the other choices are wrong

A. Full-benefit status is not the only category that can support D-SNP eligibility.

B. Medicare Savings Program status is directly relevant to partial-benefit SNP eligibility.

C. Bruno does not need to be upgraded to full-benefit Medicaid before pursuing SNP eligibility in most states.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 146 | T-213

Correct answer: A. A PPO's typical structure of referral-free specialist access, including an out-of-network option.

Explanation. A PPO's structure generally permits specialist visits without a referral and includes an out-of-network benefit at higher cost sharing, which fits Corinne's priority for flexible, predictable specialist access whether she travels or not.

Why the other choices are wrong

B. An HMO's gatekeeper model is the opposite of the referral-free flexibility Corinne wants.

C. An MSA's deductible design does not address referral requirements or specialist access.

D. PFFS payment terms concern how providers are paid, not a substitute for PPO-style specialist flexibility.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 147 | T-214

Correct answer: B. No, provider acceptance of the plan's terms can be assessed on an encounter-by-encounter basis.

Explanation. PFFS plan providers may generally decide whether to accept the plan's payment terms for a particular service, meaning a prior accepted visit does not guarantee acceptance for a future encounter, contrary to a permanent-acceptance assumption.

Why the other choices are wrong

A. A single accepted visit does not create an ongoing, permanent obligation for the provider.

C. Original Medicare participation does not change the encounter-by-encounter nature of PFFS acceptance.

D. PFFS plans do involve a provider acceptance process, even without a traditional contracted network.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 148 | T-215

Correct answer: C. That prescription drug benefits are built directly into the health plan itself.

Explanation. MA-PD identifies a Medicare Advantage plan, such as an HMO or PPO, that includes embedded Part D prescription drug coverage as part of its benefit package, distinguishing it from an MA-only plan or a stand-alone PDP.

Why the other choices are wrong

A. MA-PD status is unrelated to dual-eligible restriction; that describes D-SNPs.

B. MA-PD plans are still subject to the standard MA out-of-pocket maximum requirement.

D. MA-PD is a plan-type designation, not a description of an MSA.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 149 | T-216

Correct answer: D. The incompatible PDP election could cause her disenrollment from the MA-PD plan.

Explanation. Because Esperanza's HMO already includes embedded Part D, it is an MA-PD; enrolling in a separate stand-alone PDP is ordinarily incompatible and can result in disenrollment from the MA-PD rather than simply adding extra coverage.

Why the other choices are wrong

A. A second incompatible Part D source does not simply stack without consequence.

B. The HMO does not selectively waive only its drug benefit while keeping the medical portion intact.

C. CMS does not treat this combination as a routine free upgrade.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 150 | T-217

Correct answer: A. Correct the material to disclose that out-of-network cost sharing is generally higher under the plan's terms.

Explanation. PPOs generally apply higher cost sharing for out-of-network services than for in-network care; a presentation stating the two are identical misrepresents the plan's actual cost structure and must be corrected to disclose the real difference.

Why the other choices are wrong

B. PPOs are not required to charge identical in-network and out-of-network cost sharing.

C. Removing the plan-type label does not fix the underlying inaccurate cost-sharing claim.

D. A premium disclaimer does not address the false cost-sharing equivalence.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 151 | T-218

Correct answer: B. Other coverage that would pay the MSA plan's deductible costs is generally incompatible with enrollment.

Explanation. Medicare MSA plans are structured around the enrollee bearing the high deductible until it is met using the account or personal funds; other coverage that would pay those deductible costs on the enrollee's behalf is generally incompatible with MSA enrollment.

Why the other choices are wrong

A. A blanket 'no restriction' claim contradicts the MSA's core high-deductible design.

C. The restriction concerns coverage that would pay deductible costs, not specifically life insurance.

D. The restriction is not limited only to enrollees who separately have Part D.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 152 | T-219

Correct answer: C. That kind of coverage is generally incompatible with MSA enrollment because it would pay deductible costs the enrollee is meant to bear.

Explanation. Because an MSA is built around the enrollee bearing deductible costs before the plan pays, other coverage that would pay those same costs on the enrollee's behalf generally conflicts with MSA enrollment and must be addressed.

Why the other choices are wrong

A. The other coverage is directly relevant because of how it interacts with the deductible.

B. The MSA account is not what needs to be cancelled to resolve this kind of coverage conflict.

D. A separate insurance policy does not become the MSA plan's provider network.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 153 | T-220

Correct answer: D. C-SNP; D-SNP; I-SNP.

Explanation. A C-SNP's eligibility rests on a qualifying chronic condition, a D-SNP's eligibility rests on confirmed dual Medicare-Medicaid status, and an I-SNP's eligibility rests on institutional or institutional-equivalent level of care.

Why the other choices are wrong

A. The first two labels are reversed relative to their descriptions.

B. All three labels are shifted out of their correct order.

C. The last two labels are reversed relative to their descriptions.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 154 | T-221

Correct answer: A. CMS defines the regions that regional PPOs are required to use.

Explanation. CMS establishes the defined geographic regions that a regional Medicare Advantage PPO must use, and the plan must then offer uniform premiums and benefits throughout that CMS-defined region.

Why the other choices are wrong

B. Carriers do not independently set regional PPO boundaries; CMS defines them.

C. State Medicaid agencies are not the source of regional MA PPO boundaries.

D. A beneficiary chooses a plan to enroll in, not the underlying regional boundary itself.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 155 | T-222

Correct answer: B. No, the same premium and benefit package apply throughout the plan's CMS-defined region.

Explanation. A regional PPO is required to maintain a uniform premium and benefit package across its entire CMS-defined region, so Giselle's premium would not vary by county within that same region.

Why the other choices are wrong

A. County-by-county premium variation contradicts the regional PPO's uniform-design requirement.

C. The uniform requirement is not limited to a plan's first year of operation.

D. Regional PPOs may charge a premium; the rule concerns consistency, not a premium ban.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 156 | T-223

Correct answer: C. Clarify that a local PPO's service area and benefit design are not subject to the regional PPO's uniform-region requirement.

Explanation. The uniform premium and benefit requirement across a defined region applies specifically to regional PPOs; a local PPO is organized around its own county-based service area and is not bound by that regional-uniformity rule, so the statement must be corrected.

Why the other choices are wrong

A. PPOs are not uniformly required to be statewide-identical; that requirement is specific to regional PPOs.

B. Changing the geographic scope of the claim does not fix the underlying misapplication of the regional rule.

D. Mischaracterizing the plan as regional does not correct the compliance problem; it introduces a new inaccuracy.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 157 | T-224

Correct answer: D. The local PPO is more likely to reflect area-based benefit variation, since the regional PPO must stay uniform across its region.

Explanation. A local PPO's service area and benefit design are structured around its own approved local footprint and can reflect more localized variation, while a regional PPO must maintain the same premium and benefits across its entire CMS-defined region.

Why the other choices are wrong

A. Benefit variation by area is possible for a local PPO's design.

B. There is no requirement that both plan types use identical statewide benefits.

C. The uniform requirement applies to the regional PPO, not the local one; the relationship in this answer is reversed.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 158 | T-225

Correct answer: A. A primary care provider generally coordinates and authorizes referrals for specialist care.

Explanation. The gatekeeper structure commonly used by HMOs centers on a primary care provider who generally coordinates care and authorizes referrals to specialists, which is a defining organizational feature distinguishing many HMOs from PPOs.

Why the other choices are wrong

B. A gatekeeper referral structure is not the same as a plan-wide deductible requirement.

C. The gatekeeper model concerns referral coordination within one plan, not switching insurers.

D. The gatekeeper model does not equalize in-network and out-of-network cost sharing.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 159 | T-226

Correct answer: B. Her HMO's gatekeeper structure coordinates referrals, while a PPO generally allows specialist access without one.

Explanation. Imani's HMO uses a primary care provider to coordinate and authorize referrals, a structural feature that generally differs from a PPO, where enrollees typically may see specialists without a required referral.

Why the other choices are wrong

A. The two plan types are structured differently regarding referral coordination.

C. The gatekeeper model is commonly associated with HMOs, not PFFS plans.

D. PPOs are not legally required to use a primary care gatekeeper referral structure.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 160 | T-227

Correct answer: C. I and III only.

Explanation. Statements I and III are accurate. A PPO's out-of-network benefit generally comes with higher cost sharing, and a regional PPO must maintain the same premium and benefits throughout its CMS-defined region.

Why the other choices are wrong

A. Statement IV is false because a local PPO is not bound by the regional-uniformity rule.

B. Statement II is false because an HMO POS feature is a limited exception, not unlimited in-network-rate coverage.

D. Both II and IV misstate the actual rules governing these plan-type features.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 161 | T-228

Correct answer: D. A PFFS plan generally does not impose the HMO's primary care referral requirement.

Explanation. A PFFS plan generally does not use the HMO's primary care gatekeeper and referral structure, instead relying on provider acceptance of the plan's payment terms for each service, which is a key access-related distinction between the two plan types.

Why the other choices are wrong

A. Requiring a referral before every specialist visit describes the HMO gatekeeper model, not the typical PFFS structure.

B. A PFFS plan's access rules concern provider acceptance of terms, not a blanket ban on out-of-network care.

C. Provider acceptance questions do not convert a PFFS plan into an HMO.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 162 | T-229

Correct answer: A. An HMO or PPO, which are generally built around contracted provider networks.

Explanation. HMOs and PPOs are generally organized around contracted provider networks, offering more network stability than a PFFS plan's per-encounter provider acceptance approach, which matches Jasper's stated preference.

Why the other choices are wrong

B. Switching to another PFFS plan would not resolve the encounter-based acceptance approach Jasper wants to avoid.

C. An MSA's account and deductible design does not itself supply network stability.

D. Original Medicare is not built around a private contracted provider network in this sense.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 163 | T-230

Correct answer: B. Clarify that Medicare participation does not guarantee a provider's acceptance of a specific PFFS plan's terms.

Explanation. A provider's participation in Original Medicare is a separate fact from whether that provider accepts a particular PFFS plan's payment terms for a given service, so an agent cannot accurately promise automatic acceptance based on Medicare participation alone.

Why the other choices are wrong

A. The claim overstates what Medicare participation actually guarantees.

C. PFFS plans do have provider acceptance considerations, even without a traditional network.

D. Substituting 'Medicaid' does not correct the flawed guarantee and introduces an unrelated program.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 164 | T-231

Correct answer: C. C-SNP for qualifying chronic conditions; D-SNP for dual-eligible beneficiaries; I-SNP for institutional or institutional-equivalent care.

Explanation. A C-SNP serves beneficiaries with a qualifying severe or disabling chronic condition, a D-SNP serves beneficiaries with a qualifying dual Medicare-Medicaid status, and an I-SNP serves beneficiaries needing institutional or institutional-equivalent level of care.

Why the other choices are wrong

A. This option swaps the C-SNP and D-SNP populations.

B. This option shifts all three pairings out of their correct order.

D. This option swaps the D-SNP and I-SNP populations.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 165 | T-232

Correct answer: D. A C-SNP may fit if diabetes is on CMS's approved chronic-condition list and is verified through the plan's process.

Explanation. A C-SNP serves beneficiaries with a qualifying severe or disabling chronic condition drawn from CMS's approved list, so Kendra's diabetes could support C-SNP eligibility once verified through the plan's required process, independent of Medicaid or institutional status.

Why the other choices are wrong

A. Diabetes does not make Kendra dual-eligible; D-SNP eligibility depends on Medicaid status.

B. A C-SNP is specifically available to qualifying chronic-condition beneficiaries without Medicaid or institutional status.

C. A chronic condition does not default to institutional classification for I-SNP purposes.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

Topic Set - Enrollment periods, elections, SEPs, disenrollment

100 answer entries. Match each entry to the question number and ID printed in Part I.

ANSWER 166 | T-034

Correct answer: B. The Annual Election Period for a generally January 1 effective date.

Explanation. The Annual Election Period runs each fall and permits eligible beneficiaries to join, switch, or drop MA and Part D coverage for the next plan year. A valid AEP request ordinarily becomes effective January 1.

Why the other choices are wrong

A. The MA OEP is limited to eligible people already enrolled in Medicare Advantage.

C. Institutional election rights depend on residence in or recent departure from a qualifying institution.

D. The 5-star SEP requires a qualifying 5-star destination and is not a general substitute for AEP.

Applies to: Both
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-02

ANSWER 167 | T-035

Correct answer: C. No; the MA OEP does not let a person in Original Medicare enter MA.

Explanation. The MA OEP is an early-year opportunity for eligible beneficiaries already enrolled in MA to make one permitted change. A person in Original Medicare needs AEP, an initial opportunity, or a qualifying SEP to enter MA.

Why the other choices are wrong

A. Part A alone is insufficient for MA eligibility, and Original Medicare enrollees cannot use the MA OEP to enter MA.

B. Star Ratings do not convert the MA OEP into an initial MA election right.

D. Other election periods may permit a later MA enrollment when their requirements are met.

Applies to: Both
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-02

ANSWER 168 | T-036

Correct answer: D. The institutional election opportunity is available while he resides there.

Explanation. The institutional SEP generally permits qualifying residents to join, switch, or drop MA or Part D coverage while living in the institution. It also continues for a limited period after the person leaves.

Why the other choices are wrong

A. Qualifying institutional residence creates a specific midyear election opportunity.

B. The relevant right is the institutional SEP, not an expansion of the MA OEP.

C. The post-institution opportunity is time-limited and does not continue indefinitely.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-02

ANSWER 169 | T-037

Correct answer: A. A move SEP allows her to consider plans available at the new residence.

Explanation. A permanent move outside the current plan's service area creates a Special Enrollment Period. Advance notice can cause the opportunity to begin before the move month, and the beneficiary may choose coverage offered where she now resides.

Why the other choices are wrong

B. Permanent residence outside the service area can require disenrollment from the existing plan.

C. The replacement plan must still serve the beneficiary's new residence and all other eligibility rules apply.

D. CMS recognizes geographic moves as an enrollment event independent of a health change.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-02

ANSWER 170 | T-038

Correct answer: B. Yes; access to new plan options can create a move-related SEP.

Explanation. A move can trigger a Special Enrollment Period when the new address creates different plan choices, even if the beneficiary remains within the existing plan's service area. Eligibility remains limited to plans available at the new residence.

Why the other choices are wrong

A. New plan availability is itself a recognized move circumstance.

C. Multiple SEPs, including qualifying moves, permit Part D changes outside AEP.

D. The move does not waive the destination plan's service-area requirement.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-02

ANSWER 171 | T-039

Correct answer: C. Returning to the United States creates a time-limited SEP to join available coverage.

Explanation. Medicare.gov recognizes a Special Enrollment Period for beneficiaries who move back to the United States after living abroad. The person may join an available MA or drug plan during that defined opportunity.

Why the other choices are wrong

A. Return from living abroad is an express SEP circumstance.

B. Plan service-area residence still matters after the return.

D. The SEP permits a choice; it does not automatically assign a person to an MA plan.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-02

ANSWER 172 | T-040

Correct answer: D. The current monthly Part D SEP for qualifying Extra Help beneficiaries.

Explanation. A qualifying Extra Help or Medicaid beneficiary who is not restricted by Part D drug-management status may use the current low-income SEP once per calendar month to join or switch a stand-alone PDP.

Why the other choices are wrong

A. The current opportunity is recurring by calendar month while qualification continues, not once per lifetime.

B. The ordinary low-income SEP described here concerns PDP changes, not unlimited MA switches.

C. Every destination plan must still be available in the beneficiary's service area.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-02

ANSWER 173 | T-041

Correct answer: A. The monthly integrated-care SEP for a qualifying aligned D-SNP election.

Explanation. Eligible full-benefit duals may have a monthly opportunity to join or switch to a qualifying integrated D-SNP aligned with their Medicaid coverage. The destination plan and the beneficiary must meet the integrated-care requirements.

Why the other choices are wrong

B. Original Medicare beneficiaries cannot enter MA through the ordinary MA OEP.

C. A 5-star election depends on the destination's official rating and is not the basis for this integrated-care rule.

D. Disaster relief requires a qualifying emergency that prevented use of another election period.

Applies to: Both
Source: https://www.medicare.gov/publications/11219-Understanding-Medicare-Advantage-Medicare-Drug-Plan-Enrollment-Periods.pdf
Verified: 2026-08-02

ANSWER 174 | T-042

Correct answer: B. It bars use of the monthly Medicaid or Extra Help Part D SEP while the designation applies.

Explanation. The monthly Medicaid or Extra Help Part D SEP is unavailable while a beneficiary is identified as potentially at risk or at risk under a qualifying drug-management program. Other valid election opportunities must be assessed separately.

Why the other choices are wrong

A. The designation does not create a general MA enrollment right.

C. A drug-management status does not itself terminate underlying Medicare or Medicaid eligibility.

D. The rule restricts rather than expands use of the monthly PDP election opportunity.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-02

ANSWER 175 | T-043

Correct answer: C. The applicable loss-of-employer-coverage SEP and its specific timing.

Explanation. Loss of employer or union coverage can create a defined Special Enrollment Period for MA or Part D. The agent must distinguish that plan-election window from the separate Part B current-employment SEP and confirm the event dates.

Why the other choices are wrong

A. Election periods are based on law and facts, not an application label.

B. Nonpayment does not automatically enroll someone in replacement Medicare coverage.

D. A SEP supplies timing authority but does not waive Part A, Part B, service-area, or plan-specific eligibility.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-02

ANSWER 176 | T-044

Correct answer: D. A time-limited Part D SEP measured under the loss-of-creditable-coverage rules.

Explanation. Involuntary loss of creditable prescription coverage can create a Part D Special Enrollment Period. Its timing is governed by the drug-coverage rules and should not be confused with the longer Part B current-employment framework.

Why the other choices are wrong

A. The loss is a circumstance that may permit enrollment, not prohibit it.

B. Employer coverage does not transform into a Medicare Advantage product.

C. The Part B employment-based timing is a different enrollment rule from the Part D loss-of-creditable-coverage SEP.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-02

ANSWER 177 | T-045

Correct answer: A. A special election window for affected members to choose replacement coverage.

Explanation. Plan nonrenewal creates a special opportunity for affected members to select replacement Medicare coverage. CMS rules and the required member notice establish the precise window and transition consequences.

Why the other choices are wrong

B. The purpose of the SEP and notices is to support continuity, not force a coverage gap.

C. Commercial coverage cannot be assigned as a lifetime substitute for the Medicare plan.

D. A terminated contract cannot be kept in force indefinitely by an individual member.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-02

ANSWER 178 | T-046

Correct answer: B. A qualifying emergency prevented use of another election period for which the person was eligible.

Explanation. Disaster and emergency relief is designed for a beneficiary who had another valid election opportunity but could not use it because of the qualifying event. Official affected-area and timing criteria must be confirmed.

Why the other choices are wrong

A. Buyer preference after the fact is not a disaster-related inability to elect.

C. An agent's ordinary submission failure is not automatically an emergency event, though other remedies may be reviewed.

D. The event must apply to the beneficiary under CMS criteria; an unrelated event elsewhere is insufficient.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-02

ANSWER 179 | T-047

Correct answer: C. Records of the representation and its effect for case-specific relief review.

Explanation. CMS may grant relief when plan or agent misrepresentation affected an enrollment decision. The beneficiary should retain advertisements, notes, recordings, notices, and other evidence and contact the plan or Medicare for the proper review.

Why the other choices are wrong

A. Contemporaneous evidence is more useful than an unsupported memory, and records should not be destroyed.

B. Falsifying an election date creates a separate compliance problem.

D. The agent cannot guarantee a discretionary or fact-dependent CMS determination.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-02

ANSWER 180 | T-048

Correct answer: D. January 1 of the next plan year.

Explanation. A valid AEP election generally begins on January 1 following the fall election period. Submission must still be timely, complete, and supported by the beneficiary's valid request.

Why the other choices are wrong

A. A sales discussion is not the plan coverage effective date.

B. AEP elections are prospective and do not ordinarily create prior-year coverage.

C. Effective dates are set by CMS enrollment rules, not agent discretion.

Applies to: Both
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-02

ANSWER 181 | T-049

Correct answer: A. No; the enrollment mechanism must capture the beneficiary's own acknowledgment and consent.

Explanation. Approved enrollment mechanisms must document the beneficiary's acknowledgment and consent to required elements. An agent may assist with the process but cannot manufacture consent or accept the terms on the person's behalf.

Why the other choices are wrong

B. Agent completion of consent fields does not establish the beneficiary's agreement.

C. Correct personal data is separate from authorization to enroll.

D. Electronic mechanisms may be approved; the defect here is the absence of authentic beneficiary consent.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 182 | T-050

Correct answer: B. The required Pre-Enrollment Checklist and needs discussion should be completed before enrollment.

Explanation. CMS training requires review of the Pre-Enrollment Checklist and beneficiary-needs topics before completing the enrollment request. The purpose is to support an informed decision based on the person's actual care, drug, cost, and coverage circumstances.

Why the other choices are wrong

A. Post-enrollment review is too late to inform the election.

C. Branding preference does not address access, affordability, or coverage compatibility.

D. Medicare plans differ materially, so a universal suitability statement is neither accurate nor a substitute for the checklist.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 183 | T-051

Correct answer: C. Do not claim a valid election unless an applicable enrollment period is established.

Explanation. A technically complete form does not create authority to enroll. The beneficiary must make the election during AEP, an initial period, MA OEP when eligible, or a documented SEP that permits the requested action.

Why the other choices are wrong

A. Form completeness cannot convert July into the fall AEP.

B. Case-specific relief is determined through the proper CMS process, not invented by an agent.

D. Backdating is false documentation and does not establish a lawful election.

Applies to: Both
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-02

ANSWER 184 | T-052

Correct answer: D. True; the opportunity is limited to eligible current MA enrollees and permitted actions.

Explanation. The statement is true with the stated limitation. The MA OEP serves eligible people already enrolled in Medicare Advantage and permits one MA-to-MA change or a return to Original Medicare with the related Part D opportunity.

Why the other choices are wrong

A. The rule is the reverse; people in Original Medicare cannot use this period to enter MA.

B. Only one qualifying change is permitted under the MA OEP.

C. Stand-alone PDP enrollment alone does not make a person eligible to enter MA during this period.

Applies to: Both
Source: https://www.medicare.gov/publications/12026-Understanding-Medicare-Advantage-Plans.pdf
Verified: 2026-08-02

ANSWER 185 | T-053

Correct answer: A. Move SEP; institutional SEP; Annual Election Period.

Explanation. A permanent geographic move supports the move SEP, qualifying institutional residence supports the institutional opportunity, and the regular fall change for the next plan year uses AEP.

Why the other choices are wrong

B. AEP does not specifically classify a midyear move, and neither the 5-star nor MA OEP labels match the remaining facts.

C. The first two labels are reversed or unrelated, and ICEP concerns initial MA entitlement.

D. MA OEP does not arise from a move, and the final fact is the ordinary annual election rather than loss of coverage.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-02

ANSWER 186 | T-233

Correct answer: A. The first day of her birthday month, October 1.

Explanation. An election filed before the month of Medicare entitlement generally takes effect the first day of that entitlement month, so Priya's coverage is expected to begin on October 1.

Why the other choices are wrong

B. An August start would apply only to a request filed during or after her entitlement month, not three months ahead of it.

C. A January 1 start describes an Annual Election Period outcome, not an early Initial Coverage Election Period filing.

D. The General Enrollment Period applies to people who missed their Initial Enrollment Period, which is not Priya's circumstance.

Applies to: Both
Source: https://www.medicare.gov/publications/11219-Understanding-Medicare-Advantage-Medicare-Drug-Plan-Enrollment-Periods.pdf
Verified: 2026-08-13

ANSWER 187 | T-234

Correct answer: B. The first day of the following month, July 1.

Explanation. An election submitted during the month of entitlement to both Part A and Part B generally takes effect the first day of the following month, unlike an election filed before the entitlement month.

Why the other choices are wrong

A. A June 1 start applies only to elections made before the entitlement month, not during it.

C. Retroactive May start dates are not the standard rule for an election filed in the entitlement month.

D. Effective dates follow published enrollment rules, not a plan's internal scheduling choice.

Applies to: Both
Source: https://www.medicare.gov/publications/11219-Understanding-Medicare-Advantage-Medicare-Drug-Plan-Enrollment-Periods.pdf
Verified: 2026-08-13

ANSWER 188 | T-235

Correct answer: C. Coverage starts the month after enrollment, and a late penalty may apply.

Explanation. A General Enrollment Period sign-up generally starts coverage the month after enrollment, and because Walter missed his Initial Enrollment Period without another qualifying protection, a late-enrollment penalty may apply.

Why the other choices are wrong

A. An immediate start date with a penalty ruled out overstates the protection the GEP provides.

B. A full-year retroactive start with no premium effect is not how GEP enrollment works.

D. The GEP itself is the relevant window; Walter does not need to wait for the fall Annual Election Period for this Part B action.

Applies to: Both
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-13

ANSWER 189 | T-236

Correct answer: D. That she enrolls while covered by the group plan or within the period after the employment or coverage ends, whichever comes first.

Explanation. The employment-based Part B enrollment right runs while the person remains covered by the group health plan based on current employment, or during the period after that employment or coverage ends, whichever is earlier.

Why the other choices are wrong

A. A mandatory one-year wait misstates the timing and would let the right lapse.

B. This is a distinct enrollment right, not a use of the fall Annual Election Period.

C. The right is available to people who worked past 65 with qualifying group coverage, not the reverse.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-13

ANSWER 190 | T-237

Correct answer: A. Explain that electing or keeping COBRA does not extend or restart the SEP tied to active employment ending.

Explanation. The employment-based SEP is tied to when active employment or group coverage based on that employment ends; electing COBRA afterward does not extend or restart that window.

Why the other choices are wrong

B. Agreeing with the misunderstanding risks Corinne missing her enrollment window entirely.

C. COBRA does not extend the Initial Enrollment Period at all.

D. The SEP remains time-limited; COBRA does not convert it into an open-ended right.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start
Verified: 2026-08-13

ANSWER 191 | T-238

Correct answer: B. No; premium-free Part A generally may be elected outside the same SEP window that governs Part B.

Explanation. Because premium-free Part A generally carries no late penalty, a beneficiary like Julio can typically elect it outside the SEP window that specifically governs his employment-based Part B enrollment right.

Why the other choices are wrong

A. Treating both parts as bound to one identical deadline overstates the Part A flexibility most beneficiaries have.

C. Part A remains available after 65 for a person with qualifying work history.

D. Delaying Part B does not cancel Part A eligibility.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-13

ANSWER 192 | T-239

Correct answer: C. That the SEP window is tied to the loss of creditable status or the notice of that loss, whichever is later.

Explanation. The SEP connected to an involuntary loss of creditable prescription drug coverage begins at the loss of that coverage or the notice of the loss, whichever is later, and runs for a limited window rather than a full year.

Why the other choices are wrong

A. A mandatory one-year wait would let this limited window close entirely.

B. This SEP's duration is shorter than the eight-month employment-based Part B SEP; conflating the two risks a missed deadline.

D. A change from creditable to non-creditable status is exactly the kind of event this SEP addresses.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-13

ANSWER 193 | T-240

Correct answer: D. Explain that a voluntary drop of coverage that was still creditable does not by itself create this SEP.

Explanation. The SEP addresses an involuntary loss of creditable coverage; a beneficiary who voluntarily drops coverage that remained creditable has not experienced the qualifying event this SEP is built around.

Why the other choices are wrong

A. Not every loss of employer coverage is automatically qualifying; the involuntary and creditable-status elements matter.

B. This distinction affects Part D timing, not a general right to any MA plan.

C. There is no mechanism that extends this SEP to a full year based on a voluntary cancellation.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-13

ANSWER 194 | T-241

Correct answer: A. A material misrepresentation at enrollment can itself qualify her for a special enrollment period.

Explanation. When a carrier or its agent materially misrepresents a plan's provisions and the beneficiary relies on that misrepresentation to enroll, the misrepresentation itself can qualify as an event supporting a special enrollment period.

Why the other choices are wrong

B. A submitted application does not eliminate this specific enrollment protection.

C. Waiting for the next AEP is not required when this SEP applies.

D. A grievance addresses a different track and does not by itself fix a flawed enrollment.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-13

ANSWER 195 | T-242

Correct answer: B. He must have missed another valid enrollment period as a result of being affected by the declared emergency.

Explanation. The disaster or emergency SEP is designed to remedy a missed enrollment opportunity for a beneficiary affected by a FEMA-declared emergency or major disaster; it requires that another valid period was actually missed because of the event.

Why the other choices are wrong

A. Simple residence in the affected state, without a missed window connected to the emergency, does not establish the SEP.

C. The SEP is not a blanket nationwide entitlement unrelated to an individual's missed opportunity.

D. An appeal is not a prerequisite for this SEP.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-13

ANSWER 196 | T-243

Correct answer: C. The institutional SEP, which is available on an ongoing basis while she resides in a qualifying facility.

Explanation. Beneficiaries who reside in a qualifying institution have an ongoing special enrollment period that is not limited to a single month or tied to the fall Annual Election Period.

Why the other choices are wrong

A. Waiting until January is unnecessary because the institutional SEP is already available.

B. The MA OEP is a separate, narrower opportunity limited to current MA enrollees and a single change.

D. The institutional SEP is not restricted to only the admission month.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-13

ANSWER 197 | T-244

Correct answer: D. Yes; the institutional SEP allows the beneficiary to make changes on an ongoing basis while residence continues.

Explanation. Because the institutional SEP is available on an ongoing basis for qualifying residents, Adele can generally use it again for a later change while she continues to reside in the facility.

Why the other choices are wrong

A. The institutional SEP is not limited to a single lifetime use.

B. Continued residence does not extinguish further election rights.

C. The disaster SEP is a separate, unrelated opportunity and is not a precondition here.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-13

ANSWER 198 | T-245

Correct answer: A. A new election window opens tied directly to the relocation.

Explanation. A permanent move outside a plan's service area is a qualifying event that opens a special enrollment period so the beneficiary can choose from plans available in the new location.

Why the other choices are wrong

B. MA plans operate within defined service areas and do not simply follow an enrollee who moves permanently outside that area.

C. Moving does not eliminate MA eligibility altogether.

D. Returning to the old address is not a requirement of this SEP.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-13

ANSWER 199 | T-246

Correct answer: B. No; the SEP generally runs based on the move itself rather than solely on the date the plan happens to be notified.

Explanation. The move-related SEP is tied to the permanent relocation itself, with the enrollment window generally running from the move, so a later notification does not by itself erase the underlying qualifying event.

Why the other choices are wrong

A. There is no rule voiding the SEP simply because notice was not given on the exact day of the move.

C. Advance notice can start the SEP earlier, but it is not the only way the SEP becomes available.

D. A late notification does not transform an ordinary move into a disaster-related event.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-13

ANSWER 200 | T-247

Correct answer: C. No; a same-area move without new plan options does not by itself qualify for this SEP.

Explanation. The change-of-residence SEP generally requires either moving outside the plan's service area or a move that newly exposes different plan options; a same-area move without new options does not qualify on its own.

Why the other choices are wrong

A. Not every address change is a qualifying event under this SEP.

B. Updating a mailing address with Social Security is unrelated to whether this SEP applies.

D. A same-area move with no new options does not terminate her existing enrollment.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-13

ANSWER 201 | T-248

Correct answer: D. A special enrollment period is available because new plan options opened up as a result of the move.

Explanation. Even a move that keeps a beneficiary inside the same general service area can trigger a special enrollment period when it newly exposes plan options that were not previously available at the old address.

Why the other choices are wrong

A. Staying within the broad service area does not rule out the SEP when new options genuinely opened up.

B. Waiting for AEP is unnecessary once this SEP applies.

C. The SEP does not require disenrollment as a precondition; it is the mechanism for making the change itself.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-13

ANSWER 202 | T-249

Correct answer: A. That the destination plan itself is the one carrying the five-star rating.

Explanation. The 5-star SEP depends on the destination plan holding a qualifying five-star rating; it does not matter what rating the beneficiary's current or prior plan carries.

Why the other choices are wrong

B. Her current plan's rating is not the relevant fact; the destination plan's rating is what qualifies the SEP.

C. Using another enrollment period earlier in the year does not disqualify her from later using the 5-star SEP.

D. The 5-star SEP runs on its own separate annual window rather than only during AEP.

Applies to: Both
Source: https://www.medicare.gov/publications/11219-Understanding-Medicare-Advantage-Medicare-Drug-Plan-Enrollment-Periods.pdf
Verified: 2026-08-13

ANSWER 203 | T-250

Correct answer: B. No; the 5-star SEP is a separate, independent election that is not used up by an earlier MA OEP change.

Explanation. The 5-star SEP operates independently of the MA Open Enrollment Period, so an earlier MA OEP change does not block Oscar from later using the 5-star SEP when a qualifying five-star plan is available.

Why the other choices are wrong

A. There is no rule that an MA OEP change forfeits later, separate enrollment opportunities.

C. Reversing the February change is not a precondition for using the 5-star SEP.

D. The 5-star SEP is available across a set annual window and is not dependent on falling inside AEP.

Applies to: Both
Source: https://www.medicare.gov/publications/11219-Understanding-Medicare-Advantage-Medicare-Drug-Plan-Enrollment-Periods.pdf
Verified: 2026-08-13

ANSWER 204 | T-251

Correct answer: C. The MA OEP permits only one qualifying change per eligible beneficiary during the period.

Explanation. The Medicare Advantage Open Enrollment Period permits an eligible current MA enrollee to make one qualifying change; having already used that single change in January, Beatrix cannot make a second MA-to-MA switch under the same period.

Why the other choices are wrong

A. Unlimited changes before April misstates the single-change limit of this period.

B. Undoing the first change is not how the one-change limit works.

D. The MA OEP does not reset on a monthly cycle.

Applies to: Both
Source: https://www.medicare.gov/publications/12026-Understanding-Medicare-Advantage-Plans.pdf
Verified: 2026-08-13

ANSWER 205 | T-252

Correct answer: D. The window closed on March 31, so it cannot be used for this request.

Explanation. The Medicare Advantage Open Enrollment Period runs from January 1 through March 31 each year; once that window closes, it is no longer available until it opens again the following year.

Why the other choices are wrong

A. The MA OEP is a defined seasonal window, not a year-round opportunity.

B. There is no quarterly reopening of the MA OEP.

C. A customer service call does not reopen a closed enrollment period; a different qualifying event or period would be required instead.

Applies to: Both
Source: https://www.medicare.gov/publications/12026-Understanding-Medicare-Advantage-Plans.pdf
Verified: 2026-08-13

ANSWER 206 | T-253

Correct answer: A. The most recent valid election submitted before AEP closes generally governs.

Explanation. The Annual Election Period allows a beneficiary to submit more than one election; the most recent valid election made before the period closes is the one that generally takes effect.

Why the other choices are wrong

B. AEP does not lock in the first submission when a later valid election follows.

C. A beneficiary does not end up with two simultaneous elections from the same AEP.

D. Multiple submissions during AEP are permitted; the last one controls rather than invalidating the process.

Applies to: Both
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-13

ANSWER 207 | T-254

Correct answer: B. He is passively continued in the same plan without needing to take any action.

Explanation. When a beneficiary takes no action during AEP and the current plan continues to be offered, coverage generally continues into the next year without a new election being required.

Why the other choices are wrong

A. Inaction does not terminate coverage when the plan remains available.

C. There is no automatic default into Original Medicare from mere inaction.

D. A beneficiary's underlying Medicare eligibility does not depend on calling the plan during AEP.

Applies to: Both
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-13

ANSWER 208 | T-255

Correct answer: C. He must take an active step: file a disenrollment request in a window that permits it.

Explanation. Returning to Original Medicare from an MA plan is not automatic; the beneficiary must submit an affirmative disenrollment request during an available window such as the MA OEP, AEP, or a qualifying SEP.

Why the other choices are wrong

A. Simply not using network providers does not itself trigger disenrollment.

B. A grievance addresses a different type of complaint and is not a prerequisite for this election.

D. An unpaid premium may eventually lead to termination for nonpayment, but that is a distinct process from an affirmative return-to-Original-Medicare election.

Applies to: Both
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-13

ANSWER 209 | T-256

Correct answer: D. Nothing further; the new enrollment itself handles the switch.

Explanation. Enrolling in a new MA or Part D plan generally triggers automatic disenrollment from the prior plan, so a separate cancellation call or form is not required.

Why the other choices are wrong

A. A separate written cancellation letter is not the mechanism used; the new enrollment itself triggers the disenrollment.

B. The two plans do not remain simultaneously active once the new enrollment processes.

C. Waiting for the old contract year to end is unnecessary because the switch is handled automatically.

Applies to: Both
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-13

ANSWER 210 | T-257

Correct answer: A. Monthly, unlike the once-a-year limit most beneficiaries face.

Explanation. A beneficiary with Medicaid or Extra Help may generally use the applicable SEP once per calendar month to join or switch stand-alone Part D drug plans.

Why the other choices are wrong

B. This SEP is broader than a single annual use; it is available monthly.

C. The opportunity is monthly, not unlimited in frequency.

D. Full Medicaid eligibility does not eliminate Part D election rights; it instead supports this recurring monthly SEP.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-13

ANSWER 211 | T-258

Correct answer: B. That particular SEP is off the table for as long as the designation stands.

Explanation. A beneficiary identified as potentially at risk or at risk under a qualifying Part D drug-management program cannot use the monthly Dual or Extra Help SEP while that designation remains in effect.

Why the other choices are wrong

A. The designation directly restricts this specific monthly SEP.

C. The designation limits rather than expands his election opportunities.

D. A drug-management designation does not terminate underlying Medicare eligibility.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-423/subpart-V
Verified: 2026-08-13

ANSWER 212 | T-259

Correct answer: C. It begins in the month his qualifying status changes.

Explanation. The SEP tied to a loss of the special needs status that qualified a member for a SNP generally begins in the month the status change occurs.

Why the other choices are wrong

A. A one-year delay misstates when this SEP actually opens.

B. The SEP is not tied to the plan's contract renewal date.

D. Losing SNP-qualifying status opens an election right rather than eliminating one.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-13

ANSWER 213 | T-260

Correct answer: D. Deemed continued eligibility, which can run from 30 days up to six months.

Explanation. When a plan reasonably expects a member to regain qualifying status, it may use a period of deemed continued eligibility, generally ranging from 30 days up to six months, before proceeding with involuntary disenrollment.

Why the other choices are wrong

A. This mechanism is not a grievance extension and does not run for a fixed one-year term.

B. It is a defined, time-limited mechanism rather than an open-ended hardship waiver.

C. This continuation is separate from the appeals process and does not require a final adverse decision first.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-13

ANSWER 214 | T-261

Correct answer: A. It generally runs from the month before the termination date through two months after it.

Explanation. When CMS terminates a plan's contract, the related SEP generally opens the month before the termination date and continues for a period afterward, giving affected members time to select a new plan.

Why the other choices are wrong

B. The window extends well beyond a single day.

C. Karim does not need to wait for the next AEP because the termination-related SEP is already available.

D. A grievance is not a precondition for this SEP.

Applies to: Both
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-13

ANSWER 215 | T-262

Correct answer: B. It generally opens weeks before January 1, well ahead of the nonrenewal date itself.

Explanation. A plan nonrenewal effective January 1 generally opens a related SEP in early December, giving affected members time to choose a new plan before and after the nonrenewal date.

Why the other choices are wrong

A. The window opens earlier than the nonrenewal date itself.

C. A full year of advance access overstates the actual window.

D. Members generally still make an affirmative election among available options rather than being silently defaulted.

Applies to: Both
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-13

ANSWER 216 | T-263

Correct answer: C. The two are not identical; her sponsor-driven window tends to start sooner.

Explanation. A sponsor or mutual-consent termination generally opens its associated SEP earlier in the year than a CMS-initiated termination tied to the same year-end date, though both provide affected members a window to choose new coverage.

Why the other choices are wrong

A. The two termination types are not identical in when their related SEP windows open.

B. A mutual-consent termination still generally creates a related SEP rather than eliminating one.

D. Both a CMS-initiated termination and a sponsor or mutual-consent termination can create a related SEP.

Applies to: Both
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-13

ANSWER 217 | T-264

Correct answer: D. Submit the cancellation promptly, since a pending enrollment may generally be canceled before its effective date.

Explanation. A beneficiary may generally cancel a pending enrollment request before its effective date arrives, so the agent should act promptly to submit that cancellation on Fatima's behalf.

Why the other choices are wrong

A. Cancellation before the effective date is generally available, contrary to this claim.

B. Waiting until the plan year begins would defeat the purpose of stopping a still-pending enrollment.

C. Canceling a pending future enrollment does not retroactively disturb her existing, separate coverage.

Applies to: Both
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-13

ANSWER 218 | T-265

Correct answer: A. Recognize that a complete application alone does not establish a valid election right if no qualifying period applies.

Explanation. Completeness of an application does not substitute for an underlying valid election right; without a current Annual Election Period, MA OEP, or qualifying SEP, the August submission lacks the enrollment period needed to be valid.

Why the other choices are wrong

B. A complete form does not by itself create eligibility to enroll outside an applicable period.

C. Backdating to a prior AEP is not how an out-of-period application is handled.

D. Submitting an application does not automatically manufacture a qualifying event.

Applies to: Both
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-13

ANSWER 219 | T-266

Correct answer: B. Let Leland choose which available period and effective date he wants to use.

Explanation. When more than one election period is open and each would produce a different effective date, the beneficiary must be allowed to choose among the available options rather than having the agent select one unilaterally.

Why the other choices are wrong

A. The agent does not get to unilaterally pick the period on Leland's behalf.

C. An open AEP does not erase Leland's separate job-loss SEP rights.

D. Delaying is unnecessary since Leland can decide among the currently available periods now.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-13

ANSWER 220 | T-267

Correct answer: C. The first day of July, the month after her entitlement month.

Explanation. An ICEP election filed during the month of entitlement to both Part A and Part B generally takes effect the first day of the following month, so Odalys's coverage is expected to begin July 1.

Why the other choices are wrong

A. A June 1 start would only apply to an election filed before her entitlement month, not during it.

B. There is no rule producing a May retroactive start here.

D. The effective date follows the enrollment timing rule rather than her first use of benefits.

Applies to: Both
Source: https://www.medicare.gov/publications/11219-Understanding-Medicare-Advantage-Medicare-Drug-Plan-Enrollment-Periods.pdf
Verified: 2026-08-13

ANSWER 221 | T-268

Correct answer: D. The first day of his entitlement month, June 1.

Explanation. Because Reuben filed his election before the month of entitlement, his MA coverage is generally expected to begin the first day of that entitlement month, June 1.

Why the other choices are wrong

A. An April start would treat the filing as though it occurred during or after the entitlement month, which is not the case here.

B. A July start describes the rule for an election made during the entitlement month, not one filed early.

C. No second confirming application is required for the effective date to apply.

Applies to: Both
Source: https://www.medicare.gov/publications/11219-Understanding-Medicare-Advantage-Medicare-Drug-Plan-Enrollment-Periods.pdf
Verified: 2026-08-13

ANSWER 222 | T-269

Correct answer: A. Whether the coverage is currently active through employment or ended within the qualifying window.

Explanation. This SEP depends on whether the client remains covered under a group health plan based on current employment or is within the limited period after that employment or coverage ended.

Why the other choices are wrong

B. International travel history is not what determines this SEP's availability.

C. A late Part A premium is unrelated to eligibility for this particular SEP.

D. Medicare Savings Program membership does not govern this employment-based SEP.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-13

ANSWER 223 | T-270

Correct answer: B. Whether the move is outside the plan's service area or newly exposes different plan options.

Explanation. The relevant test is whether the move takes the beneficiary outside the plan's service area, or otherwise newly exposes plan options not previously available, not incidental facts about the move itself.

Why the other choices are wrong

A. A change of financial institution has no bearing on this enrollment rule.

C. The calendar year type is irrelevant to the SEP determination.

D. A different area code alone does not establish a qualifying move.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-13

ANSWER 224 | T-271

Correct answer: C. The loss of creditable coverage was involuntary rather than a voluntary cancellation.

Explanation. This SEP is built around an involuntary loss of creditable coverage; a beneficiary who voluntarily cancels coverage that remained creditable has not triggered the qualifying event.

Why the other choices are wrong

A. Prior use of AEP earlier in the year does not disqualify a beneficiary from this separate SEP.

B. This SEP is not limited to beneficiaries under age 65.

D. The SEP does not require that the prior employer specifically be a government entity.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-13

ANSWER 225 | T-272

Correct answer: D. Whether the beneficiary's own voluntary choice, rather than an outside event, ended the creditable coverage.

Explanation. The key distinction is whether the loss resulted from an involuntary event rather than the beneficiary's own voluntary decision to drop coverage that remained creditable.

Why the other choices are wrong

A. Employer size is not the deciding factor for this particular SEP.

B. State insurance department review is not a condition of this SEP.

C. Document retention by the beneficiary does not determine whether the SEP applies.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-13

ANSWER 226 | T-273

Correct answer: A. Reliance: the beneficiary must have acted on it when making the enrollment decision.

Explanation. A material misrepresentation SEP depends on the beneficiary relying on materially inaccurate information about the plan's provisions at the time of enrollment.

Why the other choices are wrong

B. A statement made after disenrollment does not describe the enrollment-time reliance this SEP requires.

C. A misstated corporate address is not the kind of material provision this SEP addresses.

D. The relevant misrepresentation generally comes from the carrier or its agent, not an unrelated family member.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-13

ANSWER 227 | T-274

Correct answer: B. The beneficiary missed another valid enrollment opportunity because of a FEMA-declared emergency or major disaster.

Explanation. This SEP requires that the beneficiary was affected by a FEMA-declared emergency or major disaster and, as a result, missed another valid enrollment opportunity.

Why the other choices are wrong

A. A police report about property damage is not a documented requirement for this SEP.

C. There is no fixed minimum emergency duration attached to this SEP.

D. Proximity of exactly one mile is not the standard used to define the affected area.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-13

ANSWER 228 | T-275

Correct answer: C. Current or recent residence in a facility that qualifies as an institution for this purpose.

Explanation. The institutional SEP depends on the beneficiary currently residing in, or having recently left, a facility that meets the qualifying institutional definition.

Why the other choices are wrong

A. Ten years at the same address is unrelated to whether the SEP applies.

B. Home ownership status does not determine eligibility for this SEP.

D. Being in the same state as a prior address is not a requirement of this SEP.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-13

ANSWER 229 | T-276

Correct answer: D. The star rating of the plan the beneficiary is currently enrolled in.

Explanation. The 5-star SEP turns on the destination plan's qualifying rating and availability, not on what star rating the beneficiary's current or prior plan happens to carry.

Why the other choices are wrong

A. The destination plan's five-star rating is the central, relevant fact for this SEP.

B. Availability of the destination plan in the service area is a relevant, necessary condition.

C. The type of plan being joined is relevant to whether this SEP can be used for it.

Applies to: Both
Source: https://www.medicare.gov/publications/11219-Understanding-Medicare-Advantage-Medicare-Drug-Plan-Enrollment-Periods.pdf
Verified: 2026-08-13

ANSWER 230 | T-277

Correct answer: A. One qualifying change during the period.

Explanation. The MA Open Enrollment Period permits an eligible current MA enrollee to make only one qualifying change during the window.

Why the other choices are wrong

B. Unlimited monthly changes overstates what this period allows.

C. Two changes is not the actual limit.

D. Three changes tied to the number of months in the window is not how this period works.

Applies to: Both
Source: https://www.medicare.gov/publications/12026-Understanding-Medicare-Advantage-Plans.pdf
Verified: 2026-08-13

ANSWER 231 | T-278

Correct answer: B. Those who are current MA members when the window opens.

Explanation. The MA OEP is limited to eligible beneficiaries who are already enrolled in a Medicare Advantage plan; it is not a pathway for people to newly enter MA.

Why the other choices are wrong

A. People in Original Medicare without current MA enrollment are not the intended users of this period.

C. A beneficiary with no Medicare coverage at all is not the intended population for this MA-specific window.

D. Medigap-only enrollment does not establish MA OEP eligibility.

Applies to: Both
Source: https://www.medicare.gov/publications/12026-Understanding-Medicare-Advantage-Plans.pdf
Verified: 2026-08-13

ANSWER 232 | T-279

Correct answer: C. October 15 through December 7.

Explanation. The Annual Election Period runs each fall from October 15 through December 7, giving beneficiaries a defined window to make changes for the coming plan year.

Why the other choices are wrong

A. A November 1 through December 31 window does not match the actual AEP dates.

B. The window does not begin as early as mid-September.

D. An October 1 through November 30 window misstates both the start and end dates.

Applies to: Both
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-13

ANSWER 233 | T-280

Correct answer: D. Nothing changes; the same plan simply carries forward on its own.

Explanation. Inaction during AEP, when the current plan remains available, generally results in the coverage passively continuing into the next plan year without requiring a new election.

Why the other choices are wrong

A. A suspension pending affirmative re-enrollment misstates how passive continuation works.

B. There is no automatic conversion to Original Medicare from mere inaction.

C. Coverage does not simply lapse when the current plan continues to be offered.

Applies to: Both
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-13

ANSWER 234 | T-281

Correct answer: A. Take a deliberate, timed action rather than relying on inaction.

Explanation. Returning to Original Medicare requires an affirmative disenrollment request submitted during an available window such as MA OEP, AEP, or a qualifying SEP; it does not happen on its own.

Why the other choices are wrong

B. Nonpayment may eventually lead to termination, but that is a distinct, less predictable process from a deliberate election.

C. Notifying a physician does not process a Medicare enrollment change.

D. Plans do not automatically initiate this kind of voluntary disenrollment each year.

Applies to: Both
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-13

ANSWER 235 | T-282

Correct answer: B. A separate cancellation request to the beneficiary's prior plan.

Explanation. Enrolling in a new MA or Part D plan generally triggers automatic disenrollment from the prior plan, so a separate cancellation request to that prior plan is not required.

Why the other choices are wrong

A. Accurate personal information remains a necessary part of any valid enrollment request.

C. Service-area coverage remains a necessary condition for the new enrollment to be valid.

D. The new election must still fall within a valid enrollment period to be effective.

Applies to: Both
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-13

ANSWER 236 | T-283

Correct answer: C. Once per calendar month.

Explanation. A beneficiary with Medicaid or Extra Help may generally use this SEP once per calendar month to join or switch stand-alone Part D plans.

Why the other choices are wrong

A. A quarterly limitation understates how often this SEP can actually be used.

B. A single annual use understates the recurring monthly nature of this SEP.

D. There is no daily-use frequency for this SEP; it operates on a monthly basis.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-13

ANSWER 237 | T-284

Correct answer: D. It blocks use of one specific recurring monthly election right.

Explanation. While an at-risk or potentially-at-risk drug-management designation remains in effect, it suspends the beneficiary's ability to use the monthly Dual or Extra Help SEP.

Why the other choices are wrong

A. The designation directly limits at least one specific enrollment right.

B. The designation restricts rather than grants an additional SEP.

C. The designation does not convert Part D coverage into Original Medicare.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-423/subpart-V
Verified: 2026-08-13

ANSWER 238 | T-285

Correct answer: A. In the month the qualifying status change occurs.

Explanation. This SEP generally begins in the month the member's qualifying special needs status changes, rather than being tied to a later renewal or appeal event.

Why the other choices are wrong

B. The SEP is not tied to the plan's contract renewal date.

C. A one-year delay misstates the actual start of this SEP.

D. A denied appeal is not a precondition for this SEP to begin.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-13

ANSWER 239 | T-286

Correct answer: B. It bridges a gap so the member is not disenrolled the instant status is lost.

Explanation. Deemed continued eligibility allows a SNP member to remain enrolled for a limited period, generally 30 days to six months, while the plan reasonably expects the member to regain qualifying status.

Why the other choices are wrong

A. The mechanism is time-limited and does not create a permanent exemption.

C. It does not automatically move the member into a different, non-SNP plan.

D. It does not convert SNP enrollment into a Medigap policy.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-13

ANSWER 240 | T-287

Correct answer: C. It creates a bounded window for the member to pick a replacement plan.

Explanation. A CMS-initiated contract termination generally opens a related special enrollment period around the termination date, giving the affected member time to choose new coverage.

Why the other choices are wrong

A. The member does not have to wait until the next AEP because the termination-related SEP is already available.

B. Losing a specific plan's contract does not end the member's underlying Medicare eligibility.

D. A lawsuit is not required before selecting new coverage under this SEP.

Applies to: Both
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-13

ANSWER 241 | T-288

Correct answer: D. Each type of contract-ending event can open a related SEP, though the two are not always timed identically.

Explanation. Both a plan's voluntary nonrenewal and a CMS-initiated contract termination can open a related SEP for affected members, though the specific timing windows are not necessarily identical between the two.

Why the other choices are wrong

A. A voluntary nonrenewal can also open a related SEP, not just a CMS-initiated termination.

B. A CMS-initiated termination likewise can open a related SEP.

C. Both events generally do create an enrollment opportunity for affected members.

Applies to: Both
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-13

ANSWER 242 | T-289

Correct answer: A. Cancel the pending enrollment before it takes effect.

Explanation. A beneficiary may generally cancel a pending enrollment request before its effective date arrives, giving them an opportunity to change course before coverage actually starts.

Why the other choices are wrong

B. Submitted elections are not permanently locked in before their effective date.

C. Outright cancellation, not just a date change, is generally available.

D. Waiting until after the effective date defeats the purpose of canceling a still-pending request.

Applies to: Both
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-13

ANSWER 243 | T-290

Correct answer: B. Whether the beneficiary has a current qualifying special enrollment period.

Explanation. Outside AEP and MA OEP, validity depends on whether the beneficiary has a current qualifying SEP; without one, the application lacks the underlying election right needed to be valid.

Why the other choices are wrong

A. Completeness of the form does not by itself establish a valid election right.

C. The agent's years of licensure do not determine the application's validity.

D. The tool used to complete the form has no bearing on validity.

Applies to: Both
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-13

ANSWER 244 | T-291

Correct answer: C. The beneficiary must be allowed to choose which available period and effective date to use.

Explanation. When multiple election periods with different effective dates are available at once, the beneficiary must be allowed to choose among them rather than having the agent or plan pick unilaterally.

Why the other choices are wrong

A. Administrative convenience for the agent does not override the beneficiary's right to choose.

B. There is no rule that the earliest-opening period automatically controls.

D. Rejecting the application is unnecessary when a valid choice can be made now.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-13

ANSWER 245 | T-292

Correct answer: D. Filing before the entitlement month starts coverage that month; filing during it starts coverage the next month.

Explanation. An ICEP election filed before the month of entitlement generally starts coverage on the first day of that entitlement month, while an election filed during the entitlement month generally starts coverage the following month.

Why the other choices are wrong

A. The two filing timings do not produce the same effective date.

B. Filing before the entitlement month does not push the start date to the following month; that describes filing during the entitlement month.

C. There is no rule delaying coverage a full year based on this timing distinction.

Applies to: Both
Source: https://www.medicare.gov/publications/11219-Understanding-Medicare-Advantage-Medicare-Drug-Plan-Enrollment-Periods.pdf
Verified: 2026-08-13

ANSWER 246 | T-293

Correct answer: A. No; an application must reflect the beneficiary's actual, documented qualifying event.

Explanation. An enrollment request must be tied to the beneficiary's real, documented qualifying event; fabricating an SEP basis to avoid holding an application for AEP misrepresents the application's basis.

Why the other choices are wrong

B. A plausible-sounding label does not substitute for an actual qualifying event.

C. A later correction does not undo the underlying misrepresentation involved in fabricating the basis.

D. July applications are not automatically rejected outright; the issue here is the false SEP claim, not the month itself.

Applies to: Both
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-13

ANSWER 247 | T-294

Correct answer: B. The required plan-relevant discussion must occur before the beneficiary is asked to sign.

Explanation. An agent must cover the plan-relevant details material to the beneficiary's decision, such as providers, pharmacies, costs, and the effect on other coverage, before collecting the beneficiary's signature.

Why the other choices are wrong

A. A signature by itself does not substitute for the substantive discussion that should precede it.

C. Completing the discussion only after enrollment defeats its purpose of informing the decision beforehand.

D. This expectation is not limited to telephonic applications only.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 248 | T-295

Correct answer: C. No; that basis needs to be verified first, not simply assumed.

Explanation. An agent must confirm that a qualifying event genuinely occurred before submitting an application on the basis of an SEP; assuming or guessing at a basis risks an invalid enrollment.

Why the other choices are wrong

A. Assuming a plausible basis without confirmation is not acceptable practice.

B. This confirmation duty is not limited to beneficiaries under age 65.

D. Agents can validly submit SEP-based applications when the underlying event is genuinely confirmed.

Applies to: Both
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-13

ANSWER 249 | T-296

Correct answer: D. Decline to sign on the beneficiary's behalf and ensure the beneficiary personally provides each required acknowledgment.

Explanation. An agent cannot substitute their own signature for the beneficiary's required acknowledgment and consent, even with verbal permission; the beneficiary must personally provide each required acknowledgment.

Why the other choices are wrong

A. Verbal permission does not authorize an agent to manufacture the beneficiary's own required consent.

B. Submitting an incomplete form is not the correct alternative.

C. A family member may sign only when they hold documented authority, such as a valid power of attorney, not simply because it is convenient.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 250 | T-297

Correct answer: A. Decline to process the request until documented authority, such as a valid power of attorney, is provided.

Explanation. Absent documented authority such as a valid power of attorney, an agent should not process a disenrollment on another person's behalf, regardless of the caller's stated relationship.

Why the other choices are wrong

B. Simply naming the relative does not establish legal authority to act for them.

C. Being a spouse does not automatically substitute for documented authority in every case.

D. A physician's authorization does not establish the legal authority needed for an enrollment action.

Applies to: Both
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-13

ANSWER 251 | T-298

Correct answer: B. Set it aside until a genuine election opportunity actually opens.

Explanation. Without a current SEP or an open AEP, the compliant approach is to hold or decline the application until a valid election opportunity actually exists rather than submitting it under a period that does not apply.

Why the other choices are wrong

A. Submitting it anyway and hoping the carrier corrects the date is not a compliant approach.

C. Altering the application date to falsely reflect an earlier AEP submission misrepresents the record.

D. The General Enrollment Period applies to a specific circumstance, missed Part A/B enrollment, and is not a catch-all substitute here.

Applies to: Both
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-13

ANSWER 252 | T-299

Correct answer: C. No; a beneficiary's request to cancel a still-pending enrollment before its effective date should be honored.

Explanation. A pending enrollment may generally be canceled before its effective date, so the agent should have acted on the beneficiary's request rather than allowing the enrollment to proceed unchanged.

Why the other choices are wrong

A. Submission to the carrier does not make a still-pending, not-yet-effective enrollment impossible to stop.

B. Agents can appropriately initiate a cancellation request on the beneficiary's behalf.

D. A verbal cancellation request from the beneficiary is a legitimate basis to act; a written-only rule is not the compliance issue here.

Applies to: Both
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-13

ANSWER 253 | T-300

Correct answer: D. The agent processed an SEP the member could not currently use because of the active at-risk designation.

Explanation. Because the monthly Dual or Extra Help SEP is unavailable to a member with an active at-risk designation, processing the switch without checking that status created an invalid enrollment.

Why the other choices are wrong

A. The at-risk designation does directly restrict this specific SEP.

B. The 5-star SEP is unrelated to this member's actual situation.

C. The core issue is the unchecked designation, not which staff role is authorized to process the SEP.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-423/subpart-V
Verified: 2026-08-13

ANSWER 254 | T-301

Correct answer: A. The prior plan drops off on its own; the two cannot run side by side.

Explanation. Enrolling in a new stand-alone PDP automatically disenrolls the member from the prior PDP, so the two cannot remain simultaneously active regardless of the member's preference.

Why the other choices are wrong

B. Requesting to keep both active does not override the automatic disenrollment that occurs.

C. The issue is not a billing question; the prior plan is disenrolled rather than continuing to be billed.

D. Carriers do not merge two separate PDP enrollments into one plan.

Applies to: Both
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-13

ANSWER 255 | T-302

Correct answer: B. No; the current plan's rating is not a condition of this SEP, which instead depends on the destination plan's rating.

Explanation. The 5-star SEP depends on the destination plan carrying a qualifying five-star rating; it does not require the beneficiary's current plan to fall below any particular star threshold.

Why the other choices are wrong

A. There is no such precondition tied to the current plan's rating.

C. This SEP operates on its own annual window and is not limited to the fall AEP.

D. The current plan's rating, high or low, is not the relevant condition for this SEP.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-423/subpart-V
Verified: 2026-08-13

ANSWER 256 | T-303

Correct answer: C. The enrollment basis was not verified, risking reliance on an SEP that may not actually apply.

Explanation. Relying solely on an unverified verbal claim risks enrolling the beneficiary under an SEP that does not actually apply, since the institutional SEP depends on documented qualifying residency.

Why the other choices are wrong

A. An unverified verbal claim does not, by itself, reliably establish SEP eligibility.

B. This verification concern is not limited to D-SNP enrollees.

D. Whether the facility accepts a particular insurance is a separate issue from confirming SEP eligibility.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-13

ANSWER 257 | T-304

Correct answer: D. Confirmation that the declared emergency actually caused her to miss another valid enrollment opportunity.

Explanation. The disaster SEP requires that the beneficiary actually missed another valid enrollment opportunity because of the declared emergency; simply residing in the affected area is not, by itself, sufficient.

Why the other choices are wrong

A. Residency alone does not establish the missed-opportunity element this SEP requires.

B. A homeowner's insurance claim is not part of the SEP eligibility review.

C. There is no minimum one-year duration requirement for the underlying disaster.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-13

ANSWER 258 | T-305

Correct answer: A. True; the period is limited to eligible current MA enrollees and a single permitted change.

Explanation. The statement is true as worded. The MA Open Enrollment Period serves eligible people already enrolled in Medicare Advantage and permits one qualifying change during the window.

Why the other choices are wrong

B. The MA OEP is not open to people outside current MA enrollment; that describes a different, incorrect scope.

C. There is no rule tying MA OEP use to never having used another SEP.

D. The period allows only one qualifying change, not unlimited changes.

Applies to: Both
Source: https://www.medicare.gov/publications/12026-Understanding-Medicare-Advantage-Plans.pdf
Verified: 2026-08-13

ANSWER 259 | T-306

Correct answer: B. False; coverage generally starts the month after enrollment and a penalty may apply.

Explanation. The statement is false. General Enrollment Period sign-ups generally start coverage the month after enrollment, and a late-enrollment penalty may apply because the Initial Enrollment Period was missed.

Why the other choices are wrong

A. GEP enrollment does not automatically eliminate a late penalty.

C. Coverage does not start on the exact enrollment date under GEP.

D. The GEP exists specifically for people who missed their IEP, so it remains available to them.

Applies to: Both
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-13

ANSWER 260 | T-307

Correct answer: C. True; the new enrollment itself triggers disenrollment from the prior plan.

Explanation. The statement is true. Enrolling in a new MA or Part D plan generally triggers automatic disenrollment from the prior plan, so a separate cancellation form is not required.

Why the other choices are wrong

A. A separate written cancellation is not the mechanism used; automatic disenrollment handles it.

B. A confirming call to the prior plan is not a requirement for the automatic disenrollment to occur.

D. The two plans do not remain simultaneously active until the next AEP.

Applies to: Both
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-13

ANSWER 261 | T-308

Correct answer: D. Employer-coverage SEP; disaster SEP; loss-of-special-needs-status SEP.

Explanation. The end of employer group coverage supports the employment-based SEP, a disaster-related missed election supports the disaster SEP, and losing SNP-qualifying status supports the loss-of-special-needs-status SEP.

Why the other choices are wrong

A. The first two labels are swapped relative to the described facts.

B. The 5-star SEP does not match any of the three described circumstances.

C. The sequence misassigns the disaster and status-loss facts to the wrong labels.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-13

ANSWER 262 | T-309

Correct answer: A. Material-misrepresentation SEP; 5-star SEP; Dual or Extra Help monthly SEP.

Explanation. A materially inaccurate plan description supports the material-misrepresentation SEP, a qualifying destination plan's five-star rating supports the 5-star SEP, and new Medicaid or Extra Help status supports the recurring monthly SEP.

Why the other choices are wrong

B. The first two labels are shifted out of order relative to the described facts.

C. Neither the institutional nor disaster SEP matches any of the three described events.

D. The labels are misaligned; none of the three facts describes institutional residency.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-13

ANSWER 263 | T-310

Correct answer: B. Each ending event opens a related SEP window, with the sponsor or mutual-consent case generally opening earliest.

Explanation. A CMS-initiated termination, a sponsor or mutual-consent termination, and a plan nonrenewal can each open a related SEP window for affected members, with the sponsor or mutual-consent scenario generally opening earliest among the three.

Why the other choices are wrong

A. The sponsor or mutual-consent termination and the nonrenewal also open related SEP windows, not just the CMS-initiated termination.

C. All three events generally provide an enrollment opportunity to affected members.

D. The CMS-initiated termination and the sponsor or mutual-consent termination also open related SEP windows.

Applies to: Both
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-13

ANSWER 264 | T-311

Correct answer: C. Statements I and III only.

Explanation. Statements I and III are accurate. The MA OEP permits one qualifying change for eligible current MA enrollees, and the institutional SEP continues to be available while qualifying residence continues.

Why the other choices are wrong

A. Statement II is false because GEP coverage generally starts the month after enrollment, not the same day.

B. Both II and IV are false; a voluntary cancellation of coverage that remained creditable does not create this particular SEP.

D. Statement IV is false, and this option omits the accurate institutional-SEP statement.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-13

ANSWER 265 | T-312

Correct answer: D. Statements I and III only.

Explanation. Statements I and III are accurate. An active at-risk designation suspends the monthly Dual or Extra Help SEP, and deemed continued eligibility for a SNP member can run from 30 days up to six months.

Why the other choices are wrong

A. Statement II is false because automatic disenrollment does not require a separate written cancellation form.

B. Both II and IV are false; the 5-star SEP depends on the destination plan's rating, not the current plan's rating.

C. Statement IV is false, and this option omits the accurate at-risk statement in I.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-423/subpart-V
Verified: 2026-08-13

Topic Set - Part D, formularies, tiers, Extra Help, TrOOP

60 answer entries. Match each entry to the question number and ID printed in Part I.

ANSWER 266 | T-054

Correct answer: B. Network and preferred-pharmacy status can affect access and cost sharing.

Explanation. Part D cost and access depend on more than whether a drug appears on the formulary. The pharmacy's network status and whether it has preferred cost-sharing arrangements can materially change what the member pays.

Why the other choices are wrong

A. Drug-list inclusion does not erase pharmacy-network pricing differences.

C. A higher charge at one location does not itself remove the drug from the formulary.

D. Part D plans establish their pharmacy arrangements; Part B does not set one universal retail price for Part D fills.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/how-drug-plans-work
Verified: 2026-08-02

ANSWER 267 | T-055

Correct answer: C. Prior authorization requiring plan approval before coverage.

Explanation. Prior authorization requires the plan to verify specified criteria before it will cover the prescription. The enrollee or prescriber may pursue the required approval or request an exception when supported.

Why the other choices are wrong

A. A quantity limit restricts the covered amount, not whether advance clinical approval was obtained.

B. A tiering exception concerns cost-sharing placement and is not the cause described.

D. A transition supply is temporary and does not permanently eliminate plan rules.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/plan-rules
Verified: 2026-08-02

ANSWER 268 | T-056

Correct answer: D. Requesting an exception to the step-therapy requirement with prescriber support.

Explanation. Step therapy generally requires use of one or more specified drugs first. When that sequence is medically unsuitable, the beneficiary or prescriber may seek a coverage-rule exception supported by the prescriber's medical statement.

Why the other choices are wrong

A. Cash payment does not automatically establish plan coverage or waive the rule.

B. Utilization management attaches to the plan's drug coverage and is not ordinarily erased by using another pharmacy.

C. A grievance addresses service dissatisfaction; a coverage determination is needed for the exception request.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/plan-rules
Verified: 2026-08-02

ANSWER 269 | T-057

Correct answer: A. The Part D plan's own payment for the prescription.

Explanation. TrOOP includes defined out-of-pocket payments by or on behalf of the beneficiary for covered Part D drugs. It does not simply equal the drug's total negotiated cost, and the plan-funded share generally is not personal TrOOP.

Why the other choices are wrong

B. A beneficiary's qualifying deductible payment for covered Part D drugs contributes to TrOOP.

C. Qualifying member coinsurance is out-of-pocket spending under the benefit rules.

D. Certain third-party payments on the beneficiary's behalf are included when they satisfy statutory requirements.

Applies to: Both
Source: https://www.cms.gov/files/document/2027-announcement.pdf
Verified: 2026-08-02

ANSWER 270 | T-058

Correct answer: B. A transition supply under the plan's transition policy.

Explanation. Part D transition policies can provide a temporary supply in specified situations when a new member takes a non-formulary drug or encounters a new utilization rule. The time supports a safe change or completion of an exception request.

Why the other choices are wrong

A. A pharmacy cannot permanently rewrite the plan's formulary.

C. Tiering exceptions address eligible covered drugs on higher tiers and do not automatically cover non-formulary products.

D. A retail prescription does not become a Part A service because of a formulary problem.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/plan-rules
Verified: 2026-08-02

ANSWER 271 | T-059

Correct answer: C. Which cost-sharing level the plan assigns to the covered drug.

Explanation. A formulary answers whether the plan covers the medication, while the tier indicates its cost-sharing placement. A complete review also considers utilization controls and pharmacy status.

Why the other choices are wrong

A. Medicare entitlement is determined outside the formulary tier structure.

B. A medical provider network is different from Part D drug-tier placement.

D. Election-period rights do not arise from a medication's tier.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/how-drug-plans-work
Verified: 2026-08-02

ANSWER 272 | T-060

Correct answer: D. A formulary exception supported through the Part D coverage-determination process.

Explanation. A formulary exception asks the Part D sponsor to cover a drug that is not on its list. The plan evaluates the request as a coverage determination using the prescriber's supporting medical statement.

Why the other choices are wrong

A. Prescriber network status does not add the drug to the formulary.

B. Medigap is not Part D drug coverage.

C. Informal complaints do not replace the formal coverage determination needed to establish coverage.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/plan-rules
Verified: 2026-08-02

ANSWER 273 | T-061

Correct answer: A. A qualifying Medicaid, Medicare Savings Program, or SSI category.

Explanation. CMS deems certain beneficiaries eligible for the Part D low-income subsidy based on qualifying Medicaid, Medicare Savings Program, or Supplemental Security Income status. Others who may qualify can apply for a formal determination.

Why the other choices are wrong

B. A plan's premium does not establish federal subsidy eligibility.

C. Medigap enrollment is not a deemed Extra Help category.

D. Pharmacy use has no bearing on income-based subsidy status.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 274 | T-062

Correct answer: B. They can document continuous creditable coverage if a Part D penalty is questioned.

Explanation. A Part D plan may need evidence of prior creditable drug coverage when determining whether a late-enrollment penalty applies. Keeping the employer's notices can demonstrate that the beneficiary did not have an uncovered non-creditable gap.

Why the other choices are wrong

A. The notice does not establish MA eligibility or service-area availability.

C. Creditable coverage history does not create a plan-election period.

D. Employer drug coverage can be creditable without being a Medicare PDP.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 275 | T-063

Correct answer: C. Explain that the program spreads payments over time without reducing the total amount owed.

Explanation. The Medicare Prescription Payment Plan is a cash-flow tool. It changes when the beneficiary pays covered Part D cost sharing across the remaining plan year, but it is not a subsidy or reduction in the underlying liability.

Why the other choices are wrong

A. The program does not eliminate deductibles, coinsurance, or other member liability.

B. The error concerns the substance of the discount claim, not branding.

D. Part D phase and TrOOP accounting continue under program rules despite the billing schedule.

Applies to: Both
Source: https://www.cms.gov/files/document/2027-announcement.pdf
Verified: 2026-08-02

ANSWER 276 | T-064

Correct answer: D. Remove the obsolete gap and show deductible, initial coverage, and catastrophic phases.

Explanation. The current redesigned Part D benefit no longer includes the former coverage-gap phase. For CY2027, the standard progression is the deductible phase, initial coverage, and catastrophic coverage after the annual out-of-pocket threshold is reached.

Why the other choices are wrong

A. The former four-phase structure is outdated.

B. The eliminated coverage gap cannot be restored by changing its position.

C. A coverage phase is not an enrollment opportunity and is not optional plan design in the manner described.

Applies to: Both
Source: https://www.cms.gov/files/document/2027-announcement.pdf
Verified: 2026-08-02

ANSWER 277 | T-065

Correct answer: A. Statements I and II.

Explanation. Statements I and II match CMS's final CY2027 parameters. The defined-standard deductible is $700, and catastrophic coverage begins when qualifying TrOOP reaches the $2,400 annual threshold.

Why the other choices are wrong

B. Statement III is false because the former coverage-gap phase has been eliminated.

C. Statement IV is false because the beneficiary owes no cost sharing for covered Part D drugs in catastrophic coverage.

D. Both III and IV describe obsolete or incorrect benefit features.

Applies to: Both
Source: https://www.cms.gov/files/document/2027-announcement.pdf
Verified: 2026-08-02

ANSWER 278 | T-313

Correct answer: A. Many plans exclude the specialty tier from the tiering-exception process even though it is covered.

Explanation. A Part D plan's exception process can allow a lower-tier cost share for many covered drugs, but plans commonly exclude the specialty tier from tiering exceptions given the tier's role. Renata's prescriber can still pursue other pathways if applicable.

Why the other choices are wrong

B. Tier placement concerns a covered drug's cost-sharing level, not whether it is on the formulary at all.

C. A specialty tier still reflects a covered benefit; it does not mean the plan denies coverage outright.

D. A grievance addresses service or operational dissatisfaction and does not itself decide a cost-sharing exception.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/plan-rules
Verified: 2026-08-13

ANSWER 279 | T-314

Correct answer: B. Contact the plan to confirm status or request a coverage determination on the pending request.

Explanation. A pending prior authorization is a plan-level review, so following up with the plan or asking for the coverage determination to be issued is the appropriate next step. This clarifies status and preserves appeal rights if the outcome is unfavorable.

Why the other choices are wrong

A. A rejected claim while a review is pending does not equal a final formulary decision.

C. Paying out of pocket does not substitute for the plan's coverage determination or automatically create an exception.

D. Prior authorization is a plan drug rule that follows the medication, not the dispensing pharmacy.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/plan-rules
Verified: 2026-08-13

ANSWER 280 | T-315

Correct answer: C. A transition supply, with rules that can differ for long-term care residents.

Explanation. Part D transition policies provide temporary coverage in specified circumstances, and long-term care residency is one setting where transition rules can differ from the general new-enrollee transition period. This supports continuity of care while a longer-term solution is pursued.

Why the other choices are wrong

A. A facility pharmacy cannot rewrite the plan's formulary.

B. Tiering exceptions concern cost-sharing placement for covered drugs and are not an automatic long-term-care rule.

D. A retail Part D prescription does not become a Part A skilled nursing benefit.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/plan-rules
Verified: 2026-08-13

ANSWER 281 | T-316

Correct answer: D. At the start of the next plan year, following required advance notice to affected members.

Explanation. Part D formularies can change between plan years, and plans generally must give affected enrollees advance notice before removing or restricting a drug they are using, with the change applying going forward rather than retroactively.

Why the other choices are wrong

A. A mid-year removal without proper notice and effective timing does not simply cancel a filled prescription that day.

B. A Scope of Appointment concerns marketing appointments and has no bearing on formulary-change notice.

C. CMS-approved formularies can and do change between plan years.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/plan-rules
Verified: 2026-08-13

ANSWER 282 | T-317

Correct answer: A. A pharmacy network rule tied to how and where the drug is dispensed.

Explanation. Part D plans can structure pharmacy networks so that certain maintenance drugs receive standard cost sharing only through specified channels, such as mail order or a preferred pharmacy. The drug itself remains a covered formulary item.

Why the other choices are wrong

B. The drug stays on the formulary; the rule concerns dispensing channel, not coverage.

C. Step therapy concerns the sequence of drugs tried, not where a drug is filled.

D. A quantity limit caps the amount covered in a period and is a separate rule from pharmacy channel.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/how-drug-plans-work
Verified: 2026-08-13

ANSWER 283 | T-318

Correct answer: B. Generally no, because amounts paid through many manufacturer discount arrangements are not qualifying TrOOP payments.

Explanation. TrOOP tracks specific qualifying payments made by or on behalf of the beneficiary under the program's rules. Amounts covered by many manufacturer discount arrangements are not treated as qualifying TrOOP contributions, so Devon's total may grow more slowly than the sticker discount suggests.

Why the other choices are wrong

A. Not every reduction in what is paid at the counter is a qualifying TrOOP payment.

C. Network status of the pharmacy does not change whether a manufacturer discount qualifies.

D. A discount card does not affect the drug's formulary status.

Applies to: Both
Source: https://www.cms.gov/files/document/2027-announcement.pdf
Verified: 2026-08-13

ANSWER 284 | T-319

Correct answer: C. A redetermination of her income or resources that moved her past the full-subsidy threshold.

Explanation. Extra Help subsidy levels can change following an income or resource redetermination, or after certain life events affecting deemed status. Confirming the new Extra Help notice, rather than assuming a system error, clarifies the reason for Amara's higher cost sharing.

Why the other choices are wrong

A. A subsidy-level shift is not ordinarily a pharmacy billing mistake.

B. A partial subsidy still provides Part D cost-sharing help; it is not a loss of all coverage rights.

D. Changing Part D plans does not by itself alter federal subsidy-level determinations.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 285 | T-320

Correct answer: D. Filing an Extra Help application for CMS to make a subsidy-eligibility determination.

Explanation. Beneficiaries who are not automatically deemed eligible can apply for Extra Help so that a formal income- and resource-based determination can be made. Filing the application is the path to a subsidy decision when deemed status does not already apply.

Why the other choices are wrong

A. Deeming applies to specific qualifying statuses; it is not automatic for every low-income beneficiary.

B. A plan's premium level does not create federal subsidy eligibility.

C. A pharmacy cannot certify income for Extra Help purposes.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 286 | T-321

Correct answer: A. Roughly one percent of the national base beneficiary premium for each full month without creditable coverage.

Explanation. The Part D late-enrollment penalty is generally calculated using a percentage of the national base beneficiary premium multiplied by the number of full months the person went without Part D or other creditable drug coverage after becoming eligible.

Why the other choices are wrong

B. The penalty is not a single flat one-time charge; it reflects the length of the uncovered gap.

C. The calculation uses the national base premium figure, not a specific plan's copayment.

D. A pharmacy does not determine the late-enrollment penalty amount.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/part-d/basics/costs
Verified: 2026-08-13

ANSWER 287 | T-322

Correct answer: B. Generally no, because full Extra Help eligibility relieves the beneficiary of the late-enrollment penalty.

Explanation. A beneficiary who qualifies for the full Part D low-income subsidy is generally not subject to the late-enrollment penalty even where a creditable-coverage gap exists. This is a subsidy-specific protection tied to Extra Help status.

Why the other choices are wrong

A. A relieved beneficiary does not simply owe a larger version of the penalty.

C. Switching PDPs does not restart or preserve a penalty that Extra Help already relieves.

D. Extra Help does not rewrite coverage history; it relieves the penalty consequence for the eligible beneficiary.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 288 | T-323

Correct answer: C. A missing notice does not itself prove the coverage was non-creditable; the plan can request other evidence of creditable status.

Explanation. The annual notice is useful documentation, but its absence does not automatically establish that prior coverage was non-creditable. A Part D plan reviewing a potential penalty can consider other available evidence of the coverage's creditable status.

Why the other choices are wrong

A. A missing document is not treated as conclusive proof against the beneficiary.

B. Not every retiree drug plan is automatically creditable; it depends on the plan's design.

D. Creditable-coverage rules are not limited to active-employment plans.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 289 | T-324

Correct answer: D. Yes, generally she may opt in during the plan year, and it applies to her remaining eligible cost sharing going forward.

Explanation. The Medicare Prescription Payment Plan is a payment-timing option a beneficiary can generally elect to join during the plan year, spreading eligible remaining Part D cost sharing across the rest of that year rather than requiring enrollment only at the start.

Why the other choices are wrong

A. The option is not restricted to only the final month of the year.

B. Earlier out-of-pocket payments do not permanently bar later participation.

C. Extra Help eligibility is a separate program and is not a prerequisite for this payment option.

Applies to: Both
Source: https://www.cms.gov/files/document/2027-announcement.pdf
Verified: 2026-08-13

ANSWER 290 | T-325

Correct answer: A. No, the program spreads eligible Part D cost sharing across the covered drugs under the plan rather than a single selected drug.

Explanation. The Medicare Prescription Payment Plan is structured around the beneficiary's overall Part D cost-sharing obligation for the plan year rather than allowing a beneficiary to select individual prescriptions for the program while excluding others.

Why the other choices are wrong

B. The program is not offered as a drug-by-drug election.

C. The program addresses Part D prescription cost sharing generally, not over-the-counter purchases.

D. Tier placement of a specific drug does not change how the payment program is structured.

Applies to: Both
Source: https://www.cms.gov/files/document/2027-announcement.pdf
Verified: 2026-08-13

ANSWER 291 | T-326

Correct answer: B. An expedited coverage determination supported by the prescriber's statement.

Explanation. When the standard timeframe for a Part D coverage decision could seriously jeopardize the beneficiary's life, health, or ability to regain maximum function, an expedited review may be requested, supported by the prescriber's statement of urgency.

Why the other choices are wrong

A. A grievance does not address the merits of a denied drug-coverage request.

C. A pharmacy cannot rewrite the plan's approved formulary.

D. An urgent review right does not require or produce an automatic plan change.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/plan-rules
Verified: 2026-08-13

ANSWER 292 | T-327

Correct answer: C. His deductible and cost-sharing phases reset, and TrOOP accumulation starts again for the new plan year.

Explanation. Part D benefit phases, including the deductible, initial coverage, and catastrophic coverage, are measured on an annual basis. A new plan year begins a fresh accounting of qualifying costs and TrOOP toward that year's threshold.

Why the other choices are wrong

A. Catastrophic-phase status from one year does not automatically continue into the next year's benefit structure.

B. Reaching catastrophic coverage does not create a lump-sum repayment obligation.

D. Benefit-phase status has no bearing on enrollment status.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/part-d/basics/costs
Verified: 2026-08-13

ANSWER 293 | T-328

Correct answer: D. Preferred-pharmacy cost sharing can be lower than standard-network cost sharing for the same covered drug.

Explanation. A plan's pharmacy network can include preferred and standard tiers with different member cost sharing for the same covered drug, so where a beneficiary fills prescriptions can affect what they pay even though the drug list itself may not change.

Why the other choices are wrong

A. The formulary list is generally the same; the network distinction affects cost sharing, not which drugs are covered.

B. The distinction is about cost sharing, not the covered drug list.

C. A standard network pharmacy still provides plan coverage; it is not equivalent to an uncovered, full-retail purchase.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/how-drug-plans-work
Verified: 2026-08-13

ANSWER 294 | T-329

Correct answer: A. A supporting statement from the prescriber addressing medical necessity for that specific drug.

Explanation. A formulary exception request generally requires the prescriber's supporting statement explaining why the formulary alternatives are not appropriate for the beneficiary, which the plan then evaluates as part of its coverage-determination process.

Why the other choices are wrong

B. Lack of a generic option does not automatically place a drug on the formulary; the plan still must evaluate the exception request.

C. A Scope of Appointment concerns marketing appointments and is unrelated to a drug-coverage exception.

D. Prior out-of-pocket payment is not a required element of the exception request.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/plan-rules
Verified: 2026-08-13

ANSWER 295 | T-330

Correct answer: B. Requesting a quantity-limit exception with the prescriber's supporting clinical information.

Explanation. When a standard quantity limit does not fit a beneficiary's medical needs, the prescriber can support a request for an exception through the plan's coverage-determination process, rather than working around the limit informally.

Why the other choices are wrong

A. Splitting fills across pharmacies does not create a valid exception and can raise its own safety concerns.

C. A grievance does not resolve a request to exceed a quantity limit.

D. Quantity limits do not automatically expire at the start of a new plan year.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/plan-rules
Verified: 2026-08-13

ANSWER 296 | T-331

Correct answer: C. Out-of-network access rules that can apply in specified emergency circumstances.

Explanation. Part D plans generally maintain rules allowing access at an out-of-network pharmacy in specified circumstances, such as certain travel or emergency situations, subject to the plan's terms.

Why the other choices are wrong

A. An out-of-state emergency fill does not change the beneficiary's plan enrollment.

B. The exception addresses the specific emergency circumstance, not a nationwide formulary change.

D. Plans can allow for reimbursement consideration in qualifying out-of-network situations rather than leaving the member with no recourse.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/how-drug-plans-work
Verified: 2026-08-13

ANSWER 297 | T-332

Correct answer: D. Affected enrollees generally receive advance notice before such formulary changes take effect.

Explanation. CMS rules generally require Part D plans to provide advance notice to affected enrollees before certain formulary changes, such as tier increases or removals, take effect, supporting continuity of care and informed decision-making.

Why the other choices are wrong

A. Advance notice requirements exist for enrollees currently using the affected drug.

B. Internal plan approval alone does not satisfy the beneficiary-notice requirement.

C. A grievance is not the mechanism that triggers or delays a required formulary-change notice.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/plan-rules
Verified: 2026-08-13

ANSWER 298 | T-333

Correct answer: A. Her Extra Help eligibility is a separate federal determination that does not depend on which type of Part D plan she picks.

Explanation. Extra Help eligibility is determined under separate federal income and resource rules and generally continues to apply toward the Part D benefit whether the beneficiary is enrolled in a stand-alone PDP or an MA-PD plan, subject to the usual redetermination process.

Why the other choices are wrong

B. Changing plan type does not itself terminate a subsidy determination.

C. A subsidy level is not automatically upgraded by choosing an MA-PD plan.

D. Extra Help can apply to Part D coverage obtained through either a stand-alone PDP or an MA-PD plan.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 299 | T-334

Correct answer: B. Generic drugs are commonly placed on a lower cost-sharing tier than their brand-name counterparts.

Explanation. Part D formularies commonly place generic drugs on lower cost-sharing tiers than equivalent brand-name products, so a generic fill can result in noticeably lower member cost sharing under the plan's tier structure.

Why the other choices are wrong

A. A generic substitution does not typically create a specialty-tier or prior-authorization requirement.

C. The lower amount reflects the plan's tier structure, not an independent pharmacy discount.

D. Qualifying cost sharing for a covered generic fill still counts toward TrOOP under the applicable rules.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/how-drug-plans-work
Verified: 2026-08-13

ANSWER 300 | T-335

Correct answer: C. It requires trying one or more specified drugs before the plan covers the requested medication.

Explanation. Step therapy is a utilization-management tool requiring that a beneficiary first try one or more specified, typically lower-cost drugs before the plan will cover the originally requested medication, subject to available exceptions.

Why the other choices are wrong

A. An exception process can still make the requested drug available; the rule does not bar it forever.

B. Step therapy concerns drug sequencing, not a dollar price cap.

D. Step therapy does not affect how TrOOP is tracked for qualifying payments.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/plan-rules
Verified: 2026-08-13

ANSWER 301 | T-336

Correct answer: D. The Part D plan sponsor issues the initial coverage determination on the request.

Explanation. The Part D plan sponsor is responsible for issuing the initial coverage determination on a formulary exception request, using the prescriber's supporting statement, before any later appeal levels apply.

Why the other choices are wrong

A. CMS oversees the program but does not issue each plan's individual coverage determinations.

B. A prescriber supports the request but does not issue the plan's binding coverage decision.

C. State insurance departments do not decide individual Part D coverage determinations.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/plan-rules
Verified: 2026-08-13

ANSWER 302 | T-337

Correct answer: A. Qualifying out-of-pocket payments applied toward the annual out-of-pocket threshold.

Explanation. TrOOP tracks qualifying out-of-pocket spending by or on behalf of a Part D beneficiary for covered drugs, which counts toward reaching the plan year's catastrophic-coverage threshold.

Why the other choices are wrong

B. Plan administrative costs are not part of a beneficiary's TrOOP accounting.

C. Network pharmacy count is unrelated to an individual's out-of-pocket tracking.

D. Part B premiums are a separate Medicare cost and are not part of Part D TrOOP.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/part-d/basics/costs
Verified: 2026-08-13

ANSWER 303 | T-338

Correct answer: B. The plan's list of covered prescription drugs, including any tier or utilization rules.

Explanation. A formulary is the Part D plan's list of covered prescription drugs, which is often organized into cost-sharing tiers and may include utilization-management rules such as prior authorization, step therapy, or quantity limits.

Why the other choices are wrong

A. Hospital and facility networks relate to medical benefits, not the Part D drug list.

C. Part B premiums are unrelated to a Part D formulary.

D. A formulary is a drug list, not a nationwide pharmacy directory.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/how-drug-plans-work
Verified: 2026-08-13

ANSWER 304 | T-339

Correct answer: C. Medical support from the prescriber showing lower-tier alternatives are not appropriate.

Explanation. A tiering exception request generally requires prescriber-supported medical information explaining why the formulary's lower-tier options are not appropriate for the beneficiary, subject to the plan's eligibility rules.

Why the other choices are wrong

A. A drug already on the lowest tier would not need a tiering exception.

B. A Scope of Appointment applies to marketing appointments, not clinical exception requests.

D. A pharmacy change does not itself support a tiering exception.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/plan-rules
Verified: 2026-08-13

ANSWER 305 | T-340

Correct answer: D. It generally continues for as long as the beneficiary maintains Part D coverage, absent an applicable exception.

Explanation. A Part D late-enrollment penalty, once established, is generally added to the beneficiary's premium for as long as they are enrolled in Part D, unless a recognized exception, such as qualifying for Extra Help, applies.

Why the other choices are wrong

A. The penalty is not limited to a fixed twelve-month period.

B. The penalty is not confined to only the first plan year.

C. Merely changing Part D plans does not itself remove an established penalty.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/part-d/basics/costs
Verified: 2026-08-13

ANSWER 306 | T-341

Correct answer: A. Premiums, deductibles, and prescription cost sharing, depending on subsidy level.

Explanation. Extra Help, the Part D low-income subsidy, can reduce a qualifying beneficiary's premium, deductible, and prescription cost sharing, with the exact amount of assistance depending on the beneficiary's subsidy level.

Why the other choices are wrong

B. Extra Help is specifically a Part D subsidy, not a Part B premium program.

C. The subsidy addresses core Part D costs, not merely delivery fees.

D. Medigap is a separate product and is not what Extra Help subsidizes.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 307 | T-342

Correct answer: B. The plan's initial decision on a drug coverage, payment, or exception request.

Explanation. A Part D coverage determination is the plan's initial decision addressing drug coverage, payment, or an exception request, and it establishes the record from which further appeal rights can be exercised if the decision is adverse.

Why the other choices are wrong

A. A coverage determination is a benefit decision, not a marketing disclosure.

C. A federal audit of a formulary is a separate oversight activity.

D. A pharmacy's dispensing log does not constitute the plan's coverage decision.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/plan-rules
Verified: 2026-08-13

ANSWER 308 | T-343

Correct answer: C. It provides temporary access to a needed drug while a longer-term option is pursued.

Explanation. A transition supply gives an affected enrollee temporary access to a non-formulary drug or one subject to a new utilization rule, allowing time for the prescriber and beneficiary to pursue an exception or switch to an appropriate alternative.

Why the other choices are wrong

A. A temporary supply does not eliminate the eventual need to pursue a formulary or utilization exception if the issue continues.

B. A transition supply concerns retail Part D dispensing, not inpatient hospital benefits.

D. The temporary supply does not remove ordinary Part D cost-sharing obligations.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/plan-rules
Verified: 2026-08-13

ANSWER 309 | T-344

Correct answer: D. No cost sharing for covered Part D drugs.

Explanation. Under the CY2027 defined standard benefit, once the beneficiary reaches the catastrophic phase after meeting the annual out-of-pocket threshold, the enrollee owes no cost sharing for covered Part D drugs for the remainder of that plan year.

Why the other choices are wrong

A. Catastrophic-phase cost sharing is not simply a continuation of the initial-phase coinsurance rate.

B. The catastrophic phase does not carry a reduced flat copay; the beneficiary owes no cost sharing.

C. The plan continues to pay in the catastrophic phase; the beneficiary is not billed the full price.

Applies to: Both
Source: https://www.cms.gov/files/document/2027-announcement.pdf
Verified: 2026-08-13

ANSWER 310 | T-345

Correct answer: A. $700, the figure CMS finalized for the CY2027 Part D deductible.

Explanation. CMS finalized the CY2027 defined standard Part D deductible at $700, an increase from the CY2026 defined standard deductible of $615.

Why the other choices are wrong

B. $2,400 marks the CY2027 out-of-pocket threshold, not the deductible.

C. $615 was last year's figure and does not reflect the CY2027 update.

D. $2,100 was last year's out-of-pocket threshold, not this year's deductible amount.

Applies to: Both
Source: https://www.cms.gov/files/document/2027-announcement.pdf
Verified: 2026-08-13

ANSWER 311 | T-346

Correct answer: B. $2,400, the figure CMS finalized for the CY2027 catastrophic-coverage threshold.

Explanation. CMS finalized the CY2027 annual out-of-pocket threshold for Part D catastrophic coverage at $2,400, an increase from the CY2026 threshold of $2,100.

Why the other choices are wrong

A. $700 marks the CY2027 deductible, not the catastrophic threshold.

C. $615 was last year's deductible figure, not this year's threshold.

D. $2,100 was last year's catastrophic threshold, not the CY2027 update.

Applies to: Both
Source: https://www.cms.gov/files/document/2027-announcement.pdf
Verified: 2026-08-13

ANSWER 312 | T-347

Correct answer: C. It spreads eligible Part D cost sharing into monthly payments across the remaining plan year.

Explanation. The Medicare Prescription Payment Plan is a cash-flow option that spreads a participating enrollee's eligible Part D cost sharing into payments across the remainder of the plan year, without reducing the total amount owed.

Why the other choices are wrong

A. The program changes payment timing, not the total liability owed.

B. The payment option is unrelated to formulary or tiering exception processes.

D. Participation in the payment plan does not itself establish Extra Help eligibility.

Applies to: Both
Source: https://www.cms.gov/files/document/2027-announcement.pdf
Verified: 2026-08-13

ANSWER 313 | T-348

Correct answer: D. One who is automatically deemed through full Medicaid, an MSP, or SSI-based eligibility.

Explanation. CMS deems beneficiaries with qualifying Medicaid, Medicare Savings Program, or Supplemental Security Income status automatically eligible for full Extra Help, without a separate subsidy application.

Why the other choices are wrong

A. Medicare Advantage enrollment alone does not establish deemed subsidy status.

B. Changing Part D plans during AEP does not create deemed Extra Help eligibility.

C. Requesting a formulary exception is unrelated to income-based subsidy deeming.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 314 | T-349

Correct answer: A. Clarify that specialty-tier placement reflects a cost-sharing level for a covered drug, not automatic exclusion.

Explanation. A specialty tier assigns a cost-sharing level to a covered drug; it does not mean the plan refuses to cover the medication. The agent's statement should be corrected to avoid discouraging a prospect from a plan that may still meet their needs.

Why the other choices are wrong

B. Specialty-tier drugs remain part of the covered formulary; they are not automatically non-formulary.

C. Specialty tiers apply to certain high-cost prescription drugs, not over-the-counter products.

D. The original statement is inaccurate and should not be confirmed.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/how-drug-plans-work
Verified: 2026-08-13

ANSWER 315 | T-350

Correct answer: B. Explain that only specific deemed categories skip the application, while others must apply for a subsidy determination.

Explanation. Only beneficiaries with specific qualifying Medicaid, Medicare Savings Program, or SSI status are automatically deemed eligible for Extra Help. Others who may qualify on income and resources must file an application for CMS to make a formal determination.

Why the other choices are wrong

A. CMS still maintains an Extra Help application process for beneficiaries who are not deemed.

C. Pharmacies do not process Extra Help subsidy applications.

D. Deemed status applies to specific qualifying categories, not to every Part D enrollee.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 316 | T-351

Correct answer: C. Clarify that the payment plan and Extra Help are separate programs, and one does not automatically enroll the beneficiary in the other.

Explanation. The Medicare Prescription Payment Plan and Extra Help are distinct programs serving different purposes: one manages payment timing, and the other is an income-based subsidy. Enrolling in one does not automatically enroll the beneficiary in the other.

Why the other choices are wrong

A. The two programs are not combined into one application.

B. Extra Help continues to operate as a separate subsidy program.

D. Beneficiaries themselves, not only agents, can pursue an Extra Help application.

Applies to: Both
Source: https://www.cms.gov/files/document/2027-announcement.pdf
Verified: 2026-08-13

ANSWER 317 | T-352

Correct answer: D. Clarify that catastrophic-phase protection applies for the remainder of that plan year, and cost-sharing phases reset each new plan year.

Explanation. Reaching the catastrophic phase eliminates cost sharing on covered Part D drugs for the rest of that specific plan year, but the deductible and coverage phases reset with each new plan year, so the agent's blanket statement is inaccurate.

Why the other choices are wrong

A. Catastrophic status is not a permanent, lifetime condition.

B. The catastrophic phase is a Part D drug-benefit concept, not a Part B medical-service rule.

C. Benefit-phase status does not automatically carry forward when a beneficiary changes plans.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/part-d/basics/costs
Verified: 2026-08-13

ANSWER 318 | T-353

Correct answer: A. The agent should fairly present available options, including the exception process, rather than steering the client away from it.

Explanation. A beneficiary has the right to request a formulary exception supported by the prescriber, and an agent should not discourage or omit that option without a fair discussion, even if a plan change is also a reasonable path to consider.

Why the other choices are wrong

B. Formulary exceptions can be granted when the plan's criteria and prescriber support are met.

C. Agents can appropriately discuss the exception process as part of informing a client's options.

D. A plan change is not a legal prerequisite to filing a formulary exception.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/plan-rules
Verified: 2026-08-13

ANSWER 319 | T-354

Correct answer: B. Explain that TrOOP reflects specific qualifying out-of-pocket payments, not the drug's full retail price.

Explanation. TrOOP is a defined accounting of qualifying out-of-pocket payments made by or on behalf of the beneficiary for covered Part D drugs, not simply the full retail cost of every purchase, so the agent's description should be corrected.

Why the other choices are wrong

A. TrOOP and total retail drug spending are not the same measure.

C. TrOOP is a Part D accounting concept, not a Part B measure.

D. Changing pharmacies does not reset the plan year's TrOOP accumulation.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/part-d/basics/costs
Verified: 2026-08-13

ANSWER 320 | T-355

Correct answer: C. Explain that prior authorization requires advance plan approval, while a quantity limit restricts the amount covered in a period.

Explanation. Prior authorization and quantity limits are distinct utilization-management tools. Prior authorization requires the plan to approve coverage based on specified criteria before dispensing, while a quantity limit caps how much of a covered drug the plan pays for in a defined period.

Why the other choices are wrong

A. The two rules can apply independently and are not always paired on the same drug.

B. Beneficiaries can pursue exceptions to utilization-management rules, including these two.

D. Utilization-management tools like prior authorization and quantity limits remain part of current Part D plan design.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/plan-rules
Verified: 2026-08-13

ANSWER 321 | T-356

Correct answer: D. Statements I, III, and IV.

Explanation. Statements I, III, and IV correctly describe quantity limits, prior authorization, and tiering exceptions. Statement II is inaccurate because step therapy can be addressed through an exception when the required sequence is medically inappropriate.

Why the other choices are wrong

A. Statement II is false, and this choice omits accurate statements III and IV.

B. Statement II is false, making this pairing inaccurate.

C. Statement II is false, so a choice including it cannot be fully accurate.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/plan-rules
Verified: 2026-08-13

ANSWER 322 | T-357

Correct answer: A. True; catastrophic coverage removes cost sharing on covered Part D drugs for the remainder of that plan year.

Explanation. The statement is true. Once a beneficiary reaches the CY2027 annual out-of-pocket threshold, the catastrophic phase applies and the enrollee owes no cost sharing for covered Part D drugs for the rest of that plan year, regardless of Extra Help status.

Why the other choices are wrong

B. The catastrophic phase does not simply continue the initial-phase coinsurance rate; cost sharing drops to zero for covered drugs.

C. The protection is not limited to Extra Help recipients; it applies broadly once the threshold is met.

D. Catastrophic coverage remains part of the CY2027 defined standard benefit.

Applies to: Both
Source: https://www.cms.gov/files/document/2027-announcement.pdf
Verified: 2026-08-13

ANSWER 323 | T-358

Correct answer: B. False; deemed Extra Help generally continues at least through the end of that calendar year despite the mid-year Medicaid change.

Explanation. The statement is false. A beneficiary deemed eligible for full Extra Help generally continues to receive that status at least through the end of the calendar year even if the underlying qualifying Medicaid eligibility ends mid-year, with CMS's annual redeeming process addressing eligibility going forward.

Why the other choices are wrong

A. Deemed status does not end the same month the underlying qualifying category changes.

C. The continuation is not limited to D-SNP enrollees; it follows the deemed-eligibility rule generally.

D. Deemed status is not permanent and is subject to CMS's periodic redetermination process.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 324 | T-359

Correct answer: C. 1-III, 2-IV, 3-I, 4-II.

Explanation. A formulary is the plan's covered-drug list (III), TrOOP tracks qualifying out-of-pocket payments toward the annual threshold (IV), a transition supply provides temporary access while a longer-term solution is pursued (I), and a tiering exception requests lower cost sharing for an eligible higher-tier drug (II).

Why the other choices are wrong

A. This pairing mismatches every term with the wrong description.

B. This pairing swaps formulary and tiering-exception descriptions incorrectly.

D. This pairing reverses all four terms against their correct descriptions.

Applies to: Both
Source: https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/how-drug-plans-work
Verified: 2026-08-13

ANSWER 325 | T-360

Correct answer: D. Statements I, II, and IV.

Explanation. Statements I, II, and IV are accurate: certain statuses deem Extra Help eligibility, full Extra Help generally relieves the late-enrollment penalty, and the penalty calculation generally uses the national base beneficiary premium. Statement III is false because deemed beneficiaries do not need to file a separate application.

Why the other choices are wrong

A. Statement III is false, and this choice omits accurate statements II and IV.

B. Statement III is false, and this choice omits accurate statements I and II.

C. Statement III is false, making this combination inaccurate.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

Topic Set - Marketing, communications, SOA, events

85 answer entries. Match each entry to the question number and ID printed in Part I.

ANSWER 326 | T-066

Correct answer: B. A communication that does not satisfy both marketing prongs.

Explanation. Marketing is a subset of communications that meets both an intent standard and a specified content standard. A neutral operational notice without plan-benefit or comparative content may remain a communication even though other CMS requirements still apply.

Why the other choices are wrong

A. Plan authorship alone does not establish both regulatory marketing prongs.

C. Contact information does not turn a notice into an enrollment request.

D. Listing service hours is not an invitation to a plan-specific sales presentation.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-02

ANSWER 327 | T-067

Correct answer: C. Plan-specific sales content has changed the activity into marketing.

Explanation. An educational event must provide objective Medicare information without plan-specific marketing or enrollment activity. Comparing named plan benefits and distributing applications crosses into sales-event conduct and requires the event to be treated accordingly.

Why the other choices are wrong

A. An educational opening does not preserve the classification once plan promotion begins.

B. Distribution of enrollment materials is inconsistent with an educational program even before signatures.

D. Venue does not override the content and purpose of the event.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 328 | T-068

Correct answer: D. Attendees must receive a meaningful opportunity to leave before marketing begins.

Explanation. Current rules allow a same-location transition without the former waiting interval only when attendees receive clear notice and sufficient practical time to leave. An announcement paired with blocked exits does not provide a genuine choice.

Why the other choices are wrong

A. The former waiting interval was removed under the current rule; notice and exit opportunity now control the transition.

B. Educational events may not be used to collect enrollment applications.

C. Transparency is required precisely so attendees understand that the event's character is changing.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 329 | T-069

Correct answer: A. In the permitted public common area, subject to facility and CMS rules.

Explanation. CMS permits marketing in appropriate common areas of health-care settings, such as a public cafeteria or lobby, while prohibiting it in treatment and patient-care areas. Facility policies and all other marketing rules still apply.

Why the other choices are wrong

B. An infusion space is a treatment area and cannot be used as a sales location.

C. Removing premium discussion does not make patient-care-area solicitation permissible.

D. The rules distinguish allowed common areas from prohibited care settings rather than imposing a total facility ban.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 330 | T-070

Correct answer: B. Obtain and document the Scope of Appointment before the personal marketing discussion.

Explanation. A personal marketing appointment requires a Scope of Appointment identifying the product types the beneficiary agreed to discuss. The documented scope must precede the plan discussion even when the meeting occurs by video.

Why the other choices are wrong

A. The SOA applies to the appointment, not only to appointments that produce enrollment.

C. Permission to Contact authorizes outreach but does not define the products for a sales meeting.

D. A scheduled individualized video comparison is still a personal marketing interaction.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 331 | T-071

Correct answer: C. No; the PY2027 rule removed the waiting period, but the SOA still must precede the meeting.

Explanation. For PY2027 marketing rules effective October 1, 2026, CMS removed the former 48-hour waiting period. It did not remove the requirement to obtain a written SOA before an in-person personal marketing appointment.

Why the other choices are wrong

A. The current rule no longer imposes the former universal waiting interval.

B. An agent-created waiver is unnecessary and cannot substitute for following CMS requirements.

D. The scope obligation remains, including written documentation for the in-person setting.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 332 | T-072

Correct answer: D. The beneficiary-initiated expansion should be documented through an updated scope as required.

Explanation. The SOA is not blanket permission. When a beneficiary initiates a request to discuss another product type, the agent may address it after documenting the expanded scope in the manner required for the appointment.

Why the other choices are wrong

A. Beneficiary-initiated questions may be addressed through a compliant scope update.

B. An MA-only SOA does not authorize unrelated product categories.

C. Agent-initiated expansion outside the agreed scope violates the purpose of the SOA.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 333 | T-073

Correct answer: A. The texts are prohibited unsolicited direct contact; purchasing data is not consent.

Explanation. CMS restricts unsolicited outbound calls, texts, voicemails, door-to-door visits, and social direct messages. Possession of contact information from a purchased list does not establish the beneficiary-specific permission needed for direct outreach.

Why the other choices are wrong

B. Vendor selection is not beneficiary initiation.

C. Permission must come through a compliant beneficiary authorization or request, not data ownership.

D. A sales text remains direct marketing outreach even if it omits an immediate enrollment link.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-02

ANSWER 334 | T-074

Correct answer: B. A modest noncash item offered to attendees regardless of enrollment.

Explanation. A modest noncash item may be permissible within CMS and sponsor limits when it is not conditioned on enrollment. Cash, cash equivalents, rebates, and incentives tied to an application raise beneficiary-inducement concerns.

Why the other choices are wrong

A. Cash cannot be used to induce Medicare plan enrollment.

C. A broadly spendable card is a cash equivalent, and rewarding the transfer of another person's data creates additional concerns.

D. A rebate tied to plan selection is a prohibited monetary inducement.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-02

ANSWER 335 | T-075

Correct answer: C. A marketing email with a working opt-out that the sender honors.

Explanation. CMS permits marketing email when it meets content, privacy, and opt-out requirements. Direct mail can also be permissible, while specified unrequested direct-contact methods remain restricted.

Why the other choices are wrong

A. Purchased data does not make unsolicited sales texts permissible.

B. Uninvited door-to-door marketing is a prohibited direct-contact method.

D. Ringless voicemail does not avoid the unsolicited-contact restriction simply because the telephone does not ring.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-02

ANSWER 336 | T-076

Correct answer: D. Light snacks and refreshments that do not amount to a meal.

Explanation. CMS permits light refreshments at marketing events when they do not constitute meals and no other inducement rule is violated. A full meal cannot be recast as a snack merely by separating it from the formal presentation.

Why the other choices are wrong

A. Meals may not be provided at Medicare sales events.

B. A voucher tied to enrollment is a cash-equivalent inducement.

C. An unrestricted card conditioned on lead information is neither a light refreshment nor an appropriate nominal gift.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 337 | T-077

Correct answer: A. It uses current plan documents, identifies the relevant year, and states the comparison accurately.

Explanation. A plan comparison should be traceable to current, authoritative plan information and should make its basis and plan year clear. It must not omit material qualifications or convert a limited metric into a universal superiority claim.

Why the other choices are wrong

B. An unqualified superlative lacks a supportable basis and ignores individual needs.

C. Removing material conditions can make the presentation misleading.

D. Stale recollection is not reliable evidence of current benefits or costs.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-02

ANSWER 338 | T-078

Correct answer: B. Applicable premiums, deductibles, copayments, coinsurance, and costs for relevant care.

Explanation. The pre-enrollment discussion must move beyond a headline premium and address the beneficiary's likely medical and drug costs. Relevant deductibles and point-of-service cost sharing can determine whether the plan actually fits the person's budget.

Why the other choices are wrong

A. A low or zero plan premium does not reveal the full member liability.

C. The beneficiary's needs, not the agent's experience, control the review.

D. A supplemental allowance does not eliminate the obligation to discuss core plan costs.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 339 | T-079

Correct answer: C. Do not solicit or take possession of completed AEP requests before the period opens.

Explanation. Agents may educate beneficiaries before AEP, but they may not solicit or possess completed AEP enrollment requests before October 15. Future dating does not cure early collection of the beneficiary's election.

Why the other choices are wrong

A. A later written date does not change when the form was solicited and delivered.

B. Possession of the completed request is itself the problem regardless of review.

D. Submission before the election period compounds rather than fixes the violation.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 340 | T-080

Correct answer: D. No; agent-initiated non-health cross-selling does not belong in the Medicare marketing appointment.

Explanation. A Medicare plan appointment cannot be used as blanket permission to sell unrequested non-health products. An unrelated financial discussion should occur only through a separate, compliant, beneficiary-initiated process when applicable.

Why the other choices are wrong

A. The SOA is limited to documented product categories and does not authorize unlimited cross-selling.

B. Compensation timing does not change the product's non-health character or the scope violation.

C. Educational events are not venues for annuity sales or plan enrollment activity.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 341 | T-081

Correct answer: A. True; collecting the future scope does not convert the event into a plan sales presentation.

Explanation. The statement accurately distinguishes a permitted PY2027 SOA collection from prohibited sales activity. The attendee may document products for a later appointment while the educational program itself remains objective and plan-neutral.

Why the other choices are wrong

B. Making an SOA available for a later appointment is permitted under the current rule.

C. Enrollment forms and plan sales activity are not appropriate during an educational event.

D. Named-plan benefit comparisons would cross the line into marketing before the educational segment has ended.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 342 | T-082

Correct answer: B. Educational event; marketing or sales event; personal marketing appointment.

Explanation. Objective general instruction is educational, a carrier-specific benefit seminar is a marketing or sales event, and an individualized scheduled comparison is a personal marketing appointment requiring a documented SOA.

Why the other choices are wrong

A. The first two classifications are reversed, and a scheduled one-on-one discussion is not merely informal.

C. The first and third labels do not match their settings.

D. A public common area describes a location, not the regulatory classification of the individualized appointment.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 343 | T-361

Correct answer: A. The added comparison chart now satisfies the marketing content prong for that page.

Explanation. A piece is evaluated on its own current content. Once the page names specific plans and states premium and copay detail, it meets the content prong of the marketing definition even though earlier versions of the same page did not.

Why the other choices are wrong

B. A page is classified by what it currently contains, not by whether its URL is new.

C. An enrollment form is not required for content already naming plans and costs to trigger the content prong.

D. Authorship by the agent does not change how the content itself is evaluated.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 344 | T-362

Correct answer: B. No; naming a specific copay to influence a stay-enrolled decision meets both marketing prongs.

Explanation. Marketing includes pieces designed to influence a beneficiary's decision to remain enrolled, not just to enroll. Stating a specific copay adds the content-prong detail, so the letter meets the full marketing definition regardless of the audience being current members.

Why the other choices are wrong

A. The intent prong expressly includes retention, not only new enrollment.

C. Targeting current members does not remove a piece from the marketing definition.

D. A Star Rating is not required to trigger the content prong; the copay detail already does.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 345 | T-363

Correct answer: C. Yes; a performance measure like a Star Rating satisfies the content prong on its own.

Explanation. CMS treats performance and quality measures, including Star Ratings, as content that can independently satisfy the marketing content prong. A flyer does not need cost or benefit language to be regulated as marketing once it displays this kind of rating information.

Why the other choices are wrong

A. Cost or benefit language is one path to the content prong, not the only one.

B. A Star Rating tied to a specific plan is a quality claim, not neutral operating information.

D. A phone number is irrelevant to whether the content prong is satisfied.

Applies to: AHIP
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 346 | T-364

Correct answer: D. As a communication, because no plan-specific content satisfies the content prong.

Explanation. Marketing requires both an intent element and specific content, such as benefit, cost, or comparison detail tied to a plan. An ad that promotes only the agency's name and general help without any plan-specific content does not satisfy the content prong.

Why the other choices are wrong

A. Agency-level promotion alone does not supply the required plan-specific content.

B. The broadcast channel does not determine the classification; the content does.

C. Inviting a phone call does not itself make the spot an enrollment mechanism.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 347 | T-365

Correct answer: A. Yes, once she has replied, but he still needs a signed SOA before discussing specific plan details.

Explanation. Her reply makes her the one initiating further contact, which allows Yusuf to follow up, including by phone, to schedule a conversation. He still must obtain a signed, product-specific Scope of Appointment before discussing particular plan benefits.

Why the other choices are wrong

B. A beneficiary-initiated reply is treated separately from the original outbound message.

C. A reply to an email does not identify product types and cannot substitute for an SOA.

D. The former universal waiting interval no longer governs this situation.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 348 | T-366

Correct answer: B. No; the card authorizes contact but not a discussion of specific products or enrollment.

Explanation. A Permission to Contact form lets a beneficiary authorize future outreach without creating unsolicited-contact concerns. It has no required product-type checklist and does not substitute for the Scope of Appointment needed before discussing or enrolling in specific plans.

Why the other choices are wrong

A. A PTC lacks the product-specific scope that an SOA requires.

C. Only the SOA carries a required list of product types to be discussed.

D. PTC cards are not restricted to educational-event settings.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 349 | T-367

Correct answer: C. The SOA no longer reflects the beneficiary's own agreement about which products to discuss.

Explanation. The Scope of Appointment must document the product types the beneficiary actually agreed to discuss. Pre-checking every box before any conversation converts the form into a blanket authorization rather than the beneficiary's own documented choice.

Why the other choices are wrong

A. Checking every box regardless of the beneficiary's wishes defeats the purpose of a scoped SOA.

B. An assistant cannot supply the beneficiary's own agreement about which products to discuss.

D. The paper format is not the defect; the missing beneficiary-driven scope is.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 350 | T-368

Correct answer: D. No; the 48-hour SOA waiting period is still in force until October 1, 2026.

Explanation. The elimination of the 48-hour SOA waiting period takes effect October 1, 2026. An appointment scheduled with only about a day between the signed SOA and the meeting in late September still falls under the earlier rule and does not comply.

Why the other choices are wrong

A. The elimination is not effective until October 1, 2026.

B. A one-day gap does not satisfy the 48-hour requirement that still applied that week.

C. Written SOAs are appropriate for in-person appointments; the defect is the insufficient gap.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 351 | T-369

Correct answer: A. Ingrid's, as the beneficiary, with the daughter signing under her documented authority.

Explanation. The Scope of Appointment identifies the beneficiary whose products are being discussed. When an authorized representative attends, that person signs on the beneficiary's behalf, and proof of the authority should be kept with the record, but the beneficiary's name still anchors it.

Why the other choices are wrong

B. The representative signs for the beneficiary but does not replace the beneficiary as the person the SOA is about.

C. Representative attendance does not eliminate the SOA requirement.

D. The agent is the one obtaining the form, not the person the scope is anchored to.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 352 | T-370

Correct answer: B. The beneficiary's identity, the specific products to be discussed, the date, and clear agreement.

Explanation. A verbal SOA taken on a recorded call must capture the same required elements as a written form: who the beneficiary is, which specific product types they agreed to discuss, the date, and their affirmative agreement, not merely a general willingness to be contacted.

Why the other choices are wrong

A. A generic agreement to future contact does not identify the products for the appointment.

C. The sales conversation itself is separate from what the scope must document.

D. A one-sided recap by the agent does not establish the beneficiary's own recorded agreement.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 353 | T-371

Correct answer: C. No; distributing plan-specific marketing material reclassifies the gathering as a sales event.

Explanation. An event is classified by its content and conduct, not by its title. Seating carrier-specific benefit material for attendees before the session even starts is plan-specific marketing activity that triggers sales-event treatment regardless of the flyer's label.

Why the other choices are wrong

A. The printed label does not override the plan-specific material actually distributed.

B. Seating arrangement has no bearing on the event's classification.

D. Timing the placement before the presentation does not remove the plan-specific promotion.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 354 | T-372

Correct answer: D. No; SOA collection at educational events remains banned until October 1, 2026.

Explanation. CMS reversed its prior ban on SOA collection at educational events, but that change takes effect October 1, 2026. A September 15, 2026 health fair still falls under the earlier rule that prohibited gathering SOAs at an educational event.

Why the other choices are wrong

A. SOA collection at educational events was banned before the CY2027 reversal took effect.

B. Public accessibility of the venue does not change the applicable timing rule.

C. Health fairs can be legitimate educational events; the defect is the SOA collection date, not the venue type.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 355 | T-373

Correct answer: A. Health screening at a marketing event can be used to target beneficiaries by health status.

Explanation. CMS training identifies health screenings at marketing or sales events as inappropriate because the results can be used to steer or target beneficiaries based on health status. Prioritizing follow-up by hearing-test results raises exactly that discriminatory-targeting concern.

Why the other choices are wrong

B. Even if Soren personally does not see the raw results, the plan to prioritize follow-up by outcome is the underlying problem.

C. Licensure of the tester does not address the targeting concern.

D. The station's placement in the room is unrelated to the health-status targeting issue.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 356 | T-374

Correct answer: B. A compliance flag for discussing plan benefits before a valid SOA was documented.

Explanation. Carriers and CMS-linked monitors routinely place mystery-shopper calls to test whether agents follow SOA timing before discussing benefits. Treating a phone conversation as informal does not remove the requirement, and skipping the SOA before the benefit discussion is a common compliance trigger.

Why the other choices are wrong

A. Secret-shopper calls are a genuine and commonly used compliance-monitoring method.

C. The SOA requirement applies to phone appointments as much as in-person ones.

D. The missing SOA is itself sufficient to create the flag, independent of the disclaimer issue.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 357 | T-375

Correct answer: C. Yes, but it remains a compliant contact governed by the normal marketing and SOA rules.

Explanation. An agent may proactively reach out to clients affected by a plan exiting the market, since existing clients are not an unsolicited-contact concern in the same way as cold prospects. The contact must still follow ordinary marketing rules, including a proper needs assessment and SOA before discussing replacement options.

Why the other choices are wrong

A. A plan exit does not create a permanent bar on contacting the agent's own clients.

B. The exit is not a pretext to skip the SOA or steer clients to a single replacement without assessing their needs.

D. Agents, not only the plan sponsor, may reach out to their own affected clients.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 358 | T-376

Correct answer: D. Respond with her documentation, such as call recordings and SOA timestamps, before the deadline.

Explanation. A complaint should be addressed by responding to the carrier's investigation with supporting documentation, such as recordings and timestamped SOA records, submitted before the stated deadline. Failing to respond on time is often treated as effectively validating the complaint.

Why the other choices are wrong

A. Complaints are not automatically dismissed for inaction, and missing the deadline can validate the claim.

B. Contacting the complainant directly to seek withdrawal is not the appropriate response path.

C. The carrier's own investigation process is the channel to address, not a wait for direct CMS contact.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 359 | T-377

Correct answer: A. The beneficiary must give prior express written consent naming each receiving TPMO.

Explanation. Personal beneficiary data collected for MA or Part D marketing or enrollment may be shared with another TPMO only after the beneficiary gives prior express written consent that identifies each receiving entity and lets the beneficiary accept or reject each one.

Why the other choices are wrong

B. The requirement for entity-specific, prior express written consent remains in place.

C. A shared disclaimer does not substitute for the beneficiary's own documented consent to that specific recipient.

D. Shared state licensure does not create the required consent for a data transfer.

Applies to: NABIP
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 360 | T-378

Correct answer: B. No; the email exception applies only when the opt-out mechanism actually works.

Explanation. Unsolicited marketing email is permitted specifically because a working opt-out mechanism lets recipients decline further contact. A broken or nonfunctional opt-out forfeits that permission, placing the messages back among prohibited unsolicited contact.

Why the other choices are wrong

A. A link that does not function does not satisfy the working opt-out condition.

C. The defect exists regardless of whether a recipient happens to complain.

D. A physical mailing address is a direct-mail requirement, not a substitute fix for a broken email opt-out.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 361 | T-379

Correct answer: C. No; ringless voicemail remains a prohibited unsolicited-contact method regardless of delivery technique.

Explanation. Voicemail drops, ringless or not, remain on the list of prohibited unsolicited direct-contact methods. Neither the delivery technique nor ownership of a purchased number list creates the beneficiary-specific permission required for this kind of outreach.

Why the other choices are wrong

A. Avoiding an audible ring does not exempt the message from the voicemail restriction.

B. Purchasing a phone number does not establish consent from the person who owns it.

D. Using a vendor to place the drops does not shift responsibility away from Otis's campaign.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 362 | T-380

Correct answer: D. Yes; direct mail carries no opt-out requirement under the unsolicited-contact rules.

Explanation. Unlike marketing email, which needs a working opt-out mechanism, compliant direct mail carries no opt-out or consent requirement under the current unsolicited-contact framework. A phone or text do-not-contact listing does not extend to postal mail.

Why the other choices are wrong

A. The do-not-contact restriction as described applies to phone and text channels, not mail.

B. Mail is not conditioned on the recipient's do-not-contact status in this way.

C. An SOA is required before a personal marketing appointment, not as a precondition for sending mail.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 363 | T-381

Correct answer: A. No; the waiting period was eliminated, and nothing requires a new minimum delay instead.

Explanation. Eliminating the 48-hour SOA waiting period removes a minimum required delay; it does not create a new mandate to contact the beneficiary sooner. Bruno may choose to wait or not, and a self-imposed delay after the effective date is simply his own workflow choice, not a violation.

Why the other choices are wrong

B. The 48-hour requirement no longer applies to appointments governed by the current rule.

C. Removing the old wait did not replace it with a mandate to act quickly.

D. A voluntary internal delay does not itself violate CMS rules, since nothing forces faster contact.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 364 | T-382

Correct answer: B. Not necessarily; the underlying ban on misleading or unsubstantiated claims still applies.

Explanation. CMS removing the requirement to keep documentation on file did not remove the general prohibition on misleading or inaccurate marketing claims. Retaining her substantiation remains useful as personal risk management, even though CMS no longer mandates the file itself.

Why the other choices are wrong

A. The claims themselves remain subject to accuracy requirements even without a mandatory file.

C. There is no separate CMS retention rule specifically requiring these records once the filing mandate was dropped.

D. Superlative claims still must be truthful and supportable; they are not unregulated.

Applies to: Both
Source: https://www.cms.gov/newsroom/fact-sheets/contract-year-2027-medicare-advantage-part-d-final-rule
Verified: 2026-08-13

ANSWER 365 | T-383

Correct answer: C. No; that specific proposal was not finalized, though other debit-card administration guardrails were.

Explanation. CMS proposed capping the marketing of a supplemental debit-card benefit's dollar value, but that specific proposal was not finalized. CMS did finalize separate administration guardrails for these cards, and the general ban on misleading or confusing marketing continues to apply.

Why the other choices are wrong

A. The dollar-value marketing cap did not become part of the finalized rule.

B. The claim is inaccurate regardless of the card's issue date, since the proposal itself was not adopted.

D. CMS did address debit-card benefits through administration guardrails, even though this specific marketing cap was not finalized.

Applies to: Both
Source: https://www.cms.gov/files/document/2027-announcement.pdf
Verified: 2026-08-13

ANSWER 366 | T-384

Correct answer: D. The enrollment-evidence portion stays on the longer clock even though the marketing-only portion can roll off sooner.

Explanation. The marketing/sales portion of a recorded call has a shorter retention period than the portion that evidences enrollment, which stays on the longer schedule. In practice this means segmenting or flagging the file rather than applying one period to the entire recording.

Why the other choices are wrong

A. Applying only the shorter period would discard enrollment-evidence content too soon.

B. Deleting the whole file once one portion's shorter limit passes would also destroy the still-required enrollment evidence.

C. Combining content types does not eliminate the applicable retention periods.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 367 | T-385

Correct answer: A. Yes; retention attaches to the SOA as a marketing-contact record regardless of the outcome.

Explanation. Retention duties attach to the Scope of Appointment as a compliance record documenting the marketing contact itself, not to whether the beneficiary went on to enroll. A declined SOA generates the same required retention as one connected to an eventual enrollment.

Why the other choices are wrong

B. Immediate discarding would violate the retention duty tied to the SOA record itself.

C. The retention obligation does not depend on whether enrollment occurred.

D. Retention is a compliance requirement, not a matter left to the agent's personal discretion.

Applies to: NABIP
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 368 | T-386

Correct answer: B. A clear transition notice and a meaningful opportunity to leave before marketing activity begins.

Explanation. Same-location transitions from an educational session to a sales event are permitted only with a clear notice that the session's character is changing and a genuine opportunity for attendees to leave first. An unclear, rushed transition into enrollment activity does not meet that standard.

Why the other choices are wrong

A. The former mandatory gap between sessions was eliminated and is not the missing safeguard here.

C. An SOA addresses appointment scope, not the transition notice requirement for the event itself.

D. Nothing requires attendees to sign a waiver to remain; the requirement is a genuine chance to leave.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 369 | T-387

Correct answer: C. No; the follow-up is evaluated separately and meets the content prong on its own.

Explanation. The originating reply card and the follow-up piece are classified on their own separate facts. A generic card without plan-specific content stays a communication, but a follow-up that adds specific deductible and copay figures meets the content prong regardless of what the original card said.

Why the other choices are wrong

A. Each piece is judged by its own content rather than inheriting the earlier piece's classification.

B. Even a response to a request can become marketing once it adds plan-specific benefit or cost detail.

D. The channel difference is not what drives the reclassification; the added cost detail is.

Applies to: AHIP
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 370 | T-388

Correct answer: D. Entry is conditioned on enrolling, making the raffle a prohibited inducement.

Explanation. A gift or prize offered to encourage attendance is treated differently from one that is conditioned on the beneficiary actually enrolling. Limiting raffle eligibility to those who complete an enrollment application ties the incentive to the enrollment decision itself, which is a prohibited inducement.

Why the other choices are wrong

A. Raffles are not categorically banned; a raffle open to all attendees regardless of enrollment can avoid this problem.

B. Value alone does not cure a prize tied to the enrollment decision.

C. Disclosed odds would not fix a structure that conditions entry on enrolling.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 371 | T-389

Correct answer: A. No; replying to the user's own public question is a response to beneficiary-initiated contact.

Explanation. A reply to a user's own public question is a response to beneficiary-initiated contact rather than an unsolicited approach. Proactively messaging users who never contacted Winona first would remain prohibited, but answering someone who asked first does not.

Why the other choices are wrong

B. The rule turns on who initiated contact, not on the fact that the channel used is a direct message.

C. Social media is a covered channel for unsolicited contact, but a reply to an initiated question is not unsolicited.

D. The platform is covered by the rule; the reason this reply is permitted is that the user spoke first.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 372 | T-390

Correct answer: B. As marketing, because it produces plan-specific comparative content designed to influence enrollment.

Explanation. Content that names specific plans and compares premiums to help a visitor choose a plan meets the marketing definition regardless of whether the content was generated automatically. Automation does not remove a piece from CMS's marketing requirements.

Why the other choices are wrong

A. The mode of generation does not change the classification of plan-specific comparative content.

C. Automated tools are not exempt from CMS marketing-material requirements.

D. The classification depends on the content produced, not on whether a particular visitor later requests an application.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 373 | T-391

Correct answer: C. Yes, with a proper SOA; today's call is beneficiary-initiated and stands on its own.

Explanation. Today's contact is initiated by Odalys herself and is evaluated on its own facts, so the agent may discuss plans with a proper Scope of Appointment in place. Last year's unsolicited call remains a separate compliance issue on record and is not resolved by today's beneficiary-initiated call.

Why the other choices are wrong

A. A past violation does not create a permanent bar on all future contact once the beneficiary initiates it herself.

B. Today's compliant contact does not erase or excuse the earlier violation.

D. A CMS report is not a precondition for responding to Odalys's own initiated call today.

Applies to: NABIP
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 374 | T-392

Correct answer: D. When the beneficiary unexpectedly walks in or calls the agent on their own initiative.

Explanation. CMS recognizes an exception for situations where a beneficiary unexpectedly walks in or calls an agent on their own initiative, allowing plan discussion without a signed SOA obtained first. Scheduled meetings in other formats still require the scope beforehand.

Why the other choices are wrong

A. A scheduled video meeting still requires a documented SOA before the plan discussion.

B. Current enrollment does not create this exception.

C. Educational events involve a separate set of restrictions and are not the walk-in/call-in exception.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 375 | T-393

Correct answer: A. Reading the required TPMO disclaimer to the beneficiary.

Explanation. The TPMO disclaimer must be read before plan benefits are discussed, independent of whether an SOA has already been obtained, such as in a walk-in or call-in situation. It is a distinct requirement from the scope of the appointment.

Why the other choices are wrong

B. A full comparison of every plan is not a prerequisite to discussing benefits.

C. The 48-hour wait no longer applies and was never tied to the disclaimer requirement.

D. Verifying identifying numbers is not the disclosure that must precede a benefits discussion.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 376 | T-394

Correct answer: B. The sentence referring beneficiaries to their State Health Insurance Assistance Program.

Explanation. Effective October 1, 2026, CMS removed the sentence referring beneficiaries to their SHIP from the standardized TPMO disclaimer. The statement about not representing every plan and the Medicare.gov and 1-800-MEDICARE references remained mandatory.

Why the other choices are wrong

A. That statement remains part of the required disclaimer.

C. The Medicare.gov reference was retained, not removed.

D. The 1-800-MEDICARE reference was also retained.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 377 | T-395

Correct answer: C. The portion of the call that evidences the beneficiary's enrollment.

Explanation. The marketing and sales portion of a recorded call moved to a shorter retention period, but the portion of the recording that evidences the beneficiary's enrollment remains on the longer, ten-year track.

Why the other choices are wrong

A. The greeting and disclaimer are part of the marketing portion, not the enrollment-evidence portion.

B. The two portions can carry different retention periods rather than the whole call following the longer one automatically.

D. A single six-year period for the entire call would improperly shorten the enrollment-evidence portion's retention.

Applies to: AHIP
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 378 | T-396

Correct answer: D. The waiting period was eliminated, though the SOA itself is still required.

Explanation. CMS eliminated the former 48-hour waiting period between a signed SOA and the personal marketing appointment, effective October 1, 2026. It did not eliminate the underlying requirement to obtain a written SOA before the appointment.

Why the other choices are wrong

A. The waiting period was removed, not extended.

B. The SOA requirement itself remains in place even though the waiting period was eliminated.

C. The elimination is not limited to phone-scheduled appointments.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 379 | T-397

Correct answer: A. A required clear transition notice and a meaningful opportunity for attendees to leave.

Explanation. The twelve-hour gap requirement was eliminated, but same-location transitions still require a clear notice that the event's character is changing plus a genuine opportunity for attendees to leave before marketing begins.

Why the other choices are wrong

B. A safeguard still applies even though the fixed time gap was removed.

C. No shortened mandatory gap replaced the eliminated twelve-hour rule.

D. Nothing requires attendees to sign a waiver; the requirement is a real opportunity to leave, not a promise to stay.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 380 | T-398

Correct answer: B. It dropped the requirement to keep supporting documentation on file, while still banning misleading claims.

Explanation. CMS removed the requirement that agents keep documentation on file to support superlative claims. The general prohibition on misleading, confusing, or materially inaccurate marketing continues to apply to superlative language.

Why the other choices are wrong

A. Superlative language itself was not banned; the documentation-on-file mandate was removed.

C. There is no new CMS pre-approval step described for each superlative use.

D. The claims remain subject to CMS's general marketing accuracy requirements, not only state review.

Applies to: Both
Source: https://www.cms.gov/newsroom/fact-sheets/contract-year-2027-medicare-advantage-part-d-final-rule
Verified: 2026-08-13

ANSWER 381 | T-399

Correct answer: C. A PTC authorizes future outreach, while only an SOA documents which product types may be discussed.

Explanation. A Permission to Contact form lets a beneficiary authorize future outreach and avoids unsolicited-contact concerns, but it carries no required product-type checklist. Only the Scope of Appointment documents the specific product categories the beneficiary agreed to discuss.

Why the other choices are wrong

A. The two forms serve different purposes and are not interchangeable.

B. The product-type checklist belongs to the SOA, not the PTC.

D. A PTC does not eliminate the separate requirement to obtain an SOA before discussing specific products.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 382 | T-400

Correct answer: D. Appropriate public common areas, such as a lobby or cafeteria.

Explanation. CMS permits marketing in appropriate common areas of a health-care setting, such as a public lobby or cafeteria, while prohibiting it in treatment and patient-care areas regardless of consent or identification.

Why the other choices are wrong

A. Examination rooms are treatment areas and remain off limits regardless of consent.

B. The pharmacy counter is part of the patient-service area and is not an appropriate marketing location.

C. A visible badge does not convert a treatment area into a permitted marketing location.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 383 | T-401

Correct answer: A. Making Scope of Appointment forms available and collecting them from attendees.

Explanation. CMS's CY2027 rule reversed the 2023-era ban and now allows SOA forms to be made available and collected at educational events. Plan-specific benefit promotion and enrollment activity remain prohibited at these events.

Why the other choices are wrong

B. Plan-specific benefit comparisons remain sales-event content, not permitted educational-event activity.

C. Enrollment applications still may not be collected at an educational event.

D. Discussing a named plan's premium is still plan-specific marketing content barred from educational events.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 384 | T-402

Correct answer: B. Yes; plan identification by itself can satisfy the content prong.

Explanation. The content prong of the marketing definition can be met by identifying a specific plan even without additional detail such as premium, benefit, or comparison language. The channel or setting of distribution does not change that outcome.

Why the other choices are wrong

A. Premium or benefit detail is one way to satisfy the content prong, but plan identification alone can also qualify.

C. A comparison to another plan is not required when plan identification itself is sufficient.

D. The setting where a piece is distributed does not determine whether plan identification satisfies the content prong.

Applies to: AHIP
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 385 | T-403

Correct answer: C. A working opt-out mechanism that the sender honors.

Explanation. Unsolicited marketing email is permitted specifically when it includes a working opt-out mechanism that the sender honors. Direct mail is permitted without that same opt-out condition under the current unsolicited-contact framework.

Why the other choices are wrong

A. An SOA relates to personal marketing appointments, not to sending an email or mail piece.

B. Neither channel requires prior CMS approval of the individual message before sending.

D. Neither channel is limited to current enrollees only.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 386 | T-404

Correct answer: D. A plan-specific performance measure, such as a Star Rating.

Explanation. A performance or quality measure tied to a specific plan, such as a Star Rating, can independently satisfy the content prong of the marketing definition, without any accompanying premium or benefit language.

Why the other choices are wrong

A. A general statement about helping with Medicare lacks the plan-specific content the prong requires.

B. The agent's personal experience is not plan-specific content.

C. An invitation to call does not by itself supply plan-specific content.

Applies to: AHIP
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 387 | T-405

Correct answer: A. An intent standard, showing it is designed to influence an enrollment or retention decision.

Explanation. Marketing is defined by both an intent standard and a content standard. The piece must be designed to draw a beneficiary's attention toward a specific plan and influence an enrollment or retention decision, in addition to containing the required kind of content.

Why the other choices are wrong

B. Physician approval has no role in the marketing-versus-communication classification.

C. Who distributes the piece does not determine whether it meets the intent standard.

D. Print-run size is not part of the marketing definition's two-part test.

Applies to: AHIP
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 388 | T-406

Correct answer: B. Report the event to CMS in advance.

Explanation. A CMS-defined marketing or sales event, where an agent presents specific plan benefits or takes enrollments, must be reported to CMS in advance, unlike an educational event, which does not carry that same advance-reporting requirement.

Why the other choices are wrong

A. An SOA is tied to individual personal marketing appointments, not to attendance at the group event itself.

C. There is no separate venue-specific marketing license described in the rule.

D. Advertising method is not the distinguishing advance-reporting requirement here.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 389 | T-407

Correct answer: C. Ten years, the same period as other enrollment-related compliance records.

Explanation. The Scope of Appointment is retained for ten years as a compliance record documenting the marketing contact, matching the longer retention period rather than the shortened six-year schedule that applies only to the marketing-only portion of recorded calls.

Why the other choices are wrong

A. The six-year period applies to the marketing-only portion of recorded calls, not to the SOA record.

B. Three years is only the first phase of the recorded-call audio retention, not the SOA retention period.

D. Retention of the SOA is a compliance requirement, not left to individual discretion.

Applies to: NABIP
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 390 | T-408

Correct answer: D. Each specific receiving entity, so the beneficiary can accept or reject each one.

Explanation. Under the TPMO data-sharing consent requirement, prior express written consent must identify each specific entity that will receive the beneficiary's data, so the beneficiary can accept or reject each recipient individually rather than agreeing to a blanket transfer.

Why the other choices are wrong

A. A general agreement to be contacted does not identify specific recipients as required.

B. A general product category does not substitute for naming the specific receiving entities.

C. State licensure of the recipient is not the element the consent must specify.

Applies to: NABIP
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 391 | T-409

Correct answer: A. A cap on marketing the dollar value of the debit-card benefit.

Explanation. CMS proposed capping how the dollar value of a supplemental debit-card benefit could be marketed, but that particular proposal was not finalized, even though separate administration guardrails for these cards were adopted.

Why the other choices are wrong

B. A Star Rating display requirement for the cards is not the proposal described as declined.

C. A ban on issuing cards to new members is not the finalized-or-not proposal at issue.

D. Physician pre-approval of card marketing is not part of the described rulemaking.

Applies to: Both
Source: https://www.cms.gov/files/document/2027-announcement.pdf
Verified: 2026-08-13

ANSWER 392 | T-410

Correct answer: B. A decision to remain enrolled in a plan, not only a decision to newly enroll.

Explanation. The intent standard covers pieces designed to influence a beneficiary's decision to enroll in a plan or to remain enrolled in it. Retention-focused communications aimed at existing members can meet this standard just as new-enrollment pieces can.

Why the other choices are wrong

A. Limiting the standard to new enrollment ignores the retention branch of the intent test.

C. A disenrollment decision is not the retention concept the intent standard specifically addresses here.

D. Switching sponsors is not required; staying with the current plan is enough to trigger the intent standard.

Applies to: AHIP
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 393 | T-411

Correct answer: C. By the lead-generation, marketing, sales, or enrollment functions it actually performs.

Explanation. TPMO status is a functional test based on whether an organization performs lead-generation, marketing, sales, or enrollment activity for MA or Part D plans, regardless of what label the organization applies to itself.

Why the other choices are wrong

A. Self-labeling does not determine TPMO status; the functions performed do.

B. Plan-sponsor status is a separate question from whether an entity's activities make it a TPMO.

D. The number of state licenses held is not the basis for the TPMO determination.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 394 | T-412

Correct answer: D. No; an unsolicited outbound call is prohibited regardless of the agent's stated purpose.

Explanation. Unsolicited outbound calls to a purchased list are prohibited direct contact regardless of whether the agent frames the call as an introduction rather than a sales pitch. Compliance should reject the plan on that basis alone.

Why the other choices are wrong

A. The prohibition does not turn on whether a plan is mentioned during the call.

B. Purchasing a list of numbers does not create the beneficiary-specific permission required for outbound contact.

C. Certification status is unrelated to the underlying unsolicited-contact violation.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 395 | T-413

Correct answer: A. No; the safe practice is to read the disclaimer before any call that could turn into a benefits discussion.

Explanation. Because the disclaimer must precede a discussion of plan benefits, and calls can easily turn in that direction, the compliant approach is to read it before benefits could come up rather than gambling on the call staying general. Compliance should not approve guidance that risks the disclaimer being skipped.

Why the other choices are wrong

B. The disclaimer requirement is tied to discussing benefits, not to whether an enrollment form is eventually signed.

C. An 'introductory' label does not reliably prevent the conversation from reaching plan specifics.

D. The objection is to the substance of the guidance, not to whether the manager has authority to speak.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 396 | T-414

Correct answer: B. No; SOA and enrollment-evidence records must be retained for the longer, ten-year period.

Explanation. SOA records and the enrollment-evidence portion of recorded calls remain on a ten-year retention schedule. Only the marketing-only portion of recorded sales calls moved to the shorter six-year period, so a blanket six-year policy would violate the longer requirement.

Why the other choices are wrong

A. The six-year period applies specifically to the marketing-only portion of recorded calls, not uniformly to all records.

C. Storage cost is not a basis CMS recognizes for shortening a mandated retention period.

D. The record format, paper or digital, does not change which retention schedule applies.

Applies to: NABIP
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 397 | T-415

Correct answer: C. No; conditioning a spendable card on enrollment is a prohibited inducement.

Explanation. A gift card conditioned on completing an enrollment application ties the incentive to the beneficiary's enrollment decision, which is a prohibited inducement regardless of the card's specific use or value. Nominal, unconditioned items offered to all attendees are treated differently.

Why the other choices are wrong

A. A spendable gift card conditioned on enrollment is not treated as a permissible nominal item.

B. The restriction is on conditioning the incentive on enrollment, not on what the card can purchase.

D. Fluctuating value is not the compliance problem; the enrollment condition is.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 398 | T-416

Correct answer: D. Reclassify the gathering as a marketing or sales event because of the branded rate sheets.

Explanation. Distributing carrier-branded, plan-specific rate sheets is plan-specific marketing content, which reclassifies the gathering as a marketing or sales event regardless of how it was labeled or advertised.

Why the other choices are wrong

A. The word used in the invitation does not control the classification once plan-specific material is distributed.

B. The absence of application forms does not offset the presence of branded rate sheets.

C. Removing the representatives while leaving their branded materials still leaves plan-specific content in the room.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 399 | T-417

Correct answer: A. No; consent must identify each specific receiving TPMO for the beneficiary to accept or reject.

Explanation. The TPMO data-sharing consent standard requires that the beneficiary's prior express written consent name each specific entity that will receive the data, allowing the beneficiary to accept or reject each recipient individually rather than agreeing to future, unnamed partners.

Why the other choices are wrong

B. A blanket signature does not identify the specific recipients as required.

C. Annual updating of the form does not substitute for naming each specific receiving entity at the time of consent.

D. The defect is the lack of entity-specific consent, not the plan-year timing of re-signing.

Applies to: NABIP
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 400 | T-418

Correct answer: B. Require the disclaimer before any benefits discussion, not deferred to the end of the call.

Explanation. The TPMO disclaimer must be read before the beneficiary hears about specific plan benefits. Reading it after the benefits discussion has already begun does not satisfy the requirement, regardless of whether it is eventually read before the call ends.

Why the other choices are wrong

A. Reading the disclaimer late does not cure discussing benefits before it was delivered.

C. Call length is not a basis for excusing the requirement to disclose before benefits are discussed.

D. The disclaimer requirement does not depend on whether the beneficiary raises compensation.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 401 | T-419

Correct answer: C. No; an unrequested text to enrollees who have not initiated contact is still prohibited.

Explanation. Existing enrollment status does not exempt a beneficiary from the unsolicited-contact restrictions. An unrequested text remains prohibited unless the beneficiary has initiated contact or another recognized exception applies, regardless of the message's topic.

Why the other choices are wrong

A. Being an enrolled member does not remove the beneficiary from unsolicited-contact protection for unrequested texts.

B. The rule is about the unrequested channel and lack of initiation, not the topic's neutrality.

D. The described problem is the unsolicited channel, not a missing CMS approval step.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 402 | T-420

Correct answer: D. No; the requirement was eliminated, though choosing to wait voluntarily is not itself a violation.

Explanation. CMS eliminated the 48-hour SOA waiting period, so it is not required for an SOA dated October 3, 2026. Choosing to wait anyway is not mandated but also is not prohibited, since nothing forces faster contact either.

Why the other choices are wrong

A. The mandatory wait no longer applies to SOAs after the elimination's effective date.

B. A voluntary delay is not itself a violation; it simply is not required.

C. The elimination is not limited to a particular election period.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 403 | T-421

Correct answer: A. No; SOA collection at educational events was still banned before the October 1, 2026 change.

Explanation. The reversal permitting SOA collection at educational events did not take effect until October 1, 2026. An August 2026 slide deck inviting on-the-spot SOA signing still falls under the earlier prohibition and must be revised for that date.

Why the other choices are wrong

B. SOA collection at educational events was banned before the CY2027 reversal took effect.

C. The problem is the SOA collection itself, independent of whether benefits are discussed elsewhere in the deck.

D. Whether decks require pre-approval generally is unrelated to this specific timing defect.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 404 | T-422

Correct answer: B. False; inside an organized sales event, standard SOA-before-discussion rules apply to every attendee.

Explanation. The walk-in/call-in exception covers unsolicited contact outside a CMS marketing or sales event, such as an office or phone call the beneficiary initiates. Inside an organized sales event, the ordinary requirement to obtain an SOA before discussing plan benefits applies to every attendee.

Why the other choices are wrong

A. The exception does not extend to attendees inside an organized sales event.

C. The exception still exists outside organized events; it was not eliminated with the 48-hour wait.

D. There is no described time-of-day carve-out inside an organized sales event.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 405 | T-423

Correct answer: C. False; the twelve-hour gap was eliminated, but the SOA requirement itself remains.

Explanation. CMS eliminated the mandatory twelve-hour gap between an educational event and a same-location sales event, along with the 48-hour SOA waiting period. It did not eliminate the underlying obligation to obtain a Scope of Appointment before a personal marketing appointment.

Why the other choices are wrong

A. The SOA requirement itself was not eliminated, only the waiting period tied to it.

B. The twelve-hour gap requirement did change; it was eliminated.

D. The statement has the two requirements reversed from what actually happened.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 406 | T-424

Correct answer: D. True; without benefit, cost, or comparison content, the piece does not meet the content prong.

Explanation. A neutral operational notice about service hours, without benefit, cost-sharing, or comparative content, does not meet the content prong of the marketing definition and remains a communication, even though it is still subject to other applicable CMS requirements.

Why the other choices are wrong

A. Plan authorship alone does not establish the required marketing content.

B. Service-hours information is operational, not comparative benefit or cost content.

C. The statement's reasoning about the content prong is correct as written, not because the intent standard alone fails.

Applies to: AHIP
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 407 | T-425

Correct answer: A. Business reply card; TPMO disclaimer; Permission to Contact.

Explanation. A generic business reply card is a mail-in request for information, the TPMO disclaimer is the required statement read before discussing plan benefits, and the Permission to Contact form authorizes future outreach without carrying a required product-type checklist.

Why the other choices are wrong

B. The first two items are swapped from their correct descriptions.

C. All three items are misassigned in this ordering.

D. The second and third items are reversed from their correct descriptions.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 408 | T-426

Correct answer: B. Six years; ten years; ten years.

Explanation. The marketing-only portion of a recorded sales call carries a shortened six-year retention period, while the portion evidencing enrollment and the signed Scope of Appointment itself both remain on the longer, ten-year retention schedule.

Why the other choices are wrong

A. This reverses the marketing-only portion's shorter period with the other two records' longer periods.

C. The enrollment-evidence portion belongs on the ten-year schedule, not the six-year one.

D. The Scope of Appointment belongs on the ten-year schedule, not the six-year one.

Applies to: NABIP
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 409 | T-427

Correct answer: C. Compliant postal direct mail and marketing email with a working, honored opt-out.

Explanation. Direct mail and marketing email with a working, honored opt-out mechanism are the channels that remain permitted for outreach without needing the beneficiary to initiate contact first. Texts, voicemail drops, door-to-door visits, unsolicited social direct messages, and cold calls all remain on the prohibited unsolicited-contact list.

Why the other choices are wrong

A. Unrequested texts and voicemail drops both remain prohibited unsolicited-contact channels.

B. Door-to-door visits and unsolicited social direct messages both remain prohibited.

D. Cold outbound calls and voicemail drops both remain prohibited regardless of list source.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 410 | T-428

Correct answer: D. Plan-specific benefit comparisons and collecting completed enrollment applications.

Explanation. Even after CY2027 allowed SOA collection at educational events, plan-specific benefit comparisons and collecting completed enrollment applications remain barred there, since those activities cross into marketing and sales-event territory that educational events must avoid.

Why the other choices are wrong

A. SOA forms may now be made available and collected at educational events under the current rule.

B. General instruction and answering questions are exactly what an educational event should include.

C. A printed schedule and light refreshments are administrative details that do not affect the event's classification.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

Topic Set - TPMOs, call recording, permission to contact

40 answer entries. Match each entry to the question number and ID printed in Part I.

ANSWER 411 | T-083

Correct answer: C. The marketing and sales audio must be recorded in its entirety.

Explanation. The call-recording obligation covers marketing, sales, and enrollment telephone interactions, including the audio portion of web-based calls. Recording cannot begin only after the beneficiary selects a plan because the earlier comparison is already marketing and sales content.

Why the other choices are wrong

A. The requirement covers the relevant call, not merely the enrollment screen.

B. Changing the platform does not remove the audio-recording duty.

D. Agent notes are not a substitute for the required complete recording.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 412 | T-084

Correct answer: D. No; this purely administrative interaction falls outside that particular recording mandate.

Explanation. The specific TPMO rule targets marketing, sales, and enrollment calls. A call limited to a neutral administrative service issue is outside that mandate, although sponsor procedures and other recordkeeping duties may still require documentation.

Why the other choices are wrong

A. The call's function and content matter; beneficiary status alone does not make it marketing.

B. Partial one-sided recording would not satisfy a rule when the rule actually applies.

C. Exclusion from this mandate does not erase general service, privacy, or record-retention obligations.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 413 | T-085

Correct answer: A. Keep the audio for the first three years and retain the marketing or sales record for at least six years.

Explanation. Under the current framework, marketing and sales calls must be retained for at least six years. Audio must be preserved during the first three years; in years four through six, either audio or a complete and accurate transcript may be used.

Why the other choices are wrong

B. A transcript alone is insufficient during the initial three-year audio period.

C. Retention attaches to the marketing or sales call even when no application results.

D. A short retention period and human recollection do not satisfy the required archive.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-423/subpart-V
Verified: 2026-08-02

ANSWER 414 | T-086

Correct answer: B. Each receiving TPMO must be named and separately accepted or rejected through prior written consent.

Explanation. Prior express written consent is required before one TPMO shares personal beneficiary data with another for marketing. The disclosure must identify each recipient and allow the beneficiary to accept or reject sharing with each one separately.

Why the other choices are wrong

A. Plan sameness does not cure an unidentified or bundled consent.

C. Consent obtained after transfer cannot retroactively authorize the earlier disclosure.

D. Forced blanket sharing is inconsistent with the required individualized choice.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-423/subpart-V
Verified: 2026-08-02

ANSWER 415 | T-087

Correct answer: C. Before discussing plan benefits, using the current required content.

Explanation. The current TPMO disclaimer must precede the plan-benefit discussion. It includes the required information about represented organizations and products and directs consumers to independent Medicare resources.

Why the other choices are wrong

A. Post-enrollment delivery is too late to inform the beneficiary's evaluation of representation.

B. The duty does not depend on a beneficiary prompting the disclosure.

D. Ending with the disclaimer fails the required timing because benefits were already discussed.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 416 | T-088

Correct answer: D. Permission allows outreach; the SOA documents product categories for a personal marketing appointment.

Explanation. Permission to Contact addresses whether the agent may initiate outreach to the beneficiary. A Scope of Appointment serves a different purpose by defining the product types the beneficiary agrees to discuss during an individualized sales meeting.

Why the other choices are wrong

A. The functions are reversed and neither document creates general cold-call authority.

B. They are distinct records and neither is simply the enrollment application.

C. An SOA does not authorize undisclosed inter-TPMO data sharing, and contact permission is not proof of a completed sale.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 417 | T-089

Correct answer: A. Obtain a valid beneficiary basis for contact and present required lead disclosures before the relevant data use or transfer.

Explanation. A purchased list does not create beneficiary permission for an unsolicited sales call. Lead generation and data sharing must follow the applicable contact, disclosure, privacy, and prior-consent rules before the beneficiary's information is used or transferred.

Why the other choices are wrong

B. Data possession is not the same as a beneficiary's authorization.

C. Later deletion does not cure an impermissible initial contact or transfer.

D. Required consent must identify recipients rather than conceal them behind a generic category.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-423/subpart-V
Verified: 2026-08-02

ANSWER 418 | T-090

Correct answer: B. Statements I, II, and III.

Explanation. Statements I, II, and III accurately reflect annual qualification and ongoing sponsor-oversight duties. A plan remains responsible for monitoring functions performed by contracted TPMOs and downstream entities.

Why the other choices are wrong

A. Statement IV is false because delegation does not end sponsor accountability.

C. Statement IV remains false, and the option omits the annual training duty in Statement I.

D. Statement IV is false, and this choice also omits the licensing and appointment monitoring in Statement II.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-423/subpart-V
Verified: 2026-08-02

ANSWER 419 | T-429

Correct answer: A. Keep the beneficiary's audio active throughout the entire marketing, sales, and enrollment portion of the call.

Explanation. The recording duty covers the marketing, sales, and enrollment portions of the call in their entirety, so muting either party during any covered segment leaves an incomplete record.

Why the other choices are wrong

B. One-sided audio does not satisfy a rule that covers the full interaction.

C. Video alone without audio omits the required spoken content.

D. Recording cannot start only once the beneficiary decides to apply.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 420 | T-430

Correct answer: B. Confirmation of the beneficiary's identity and the specific product types to be discussed.

Explanation. A valid SOA, whether written or verbal, must capture the beneficiary's identity, the specific product types to be discussed, the date, and clear affirmative agreement. A generic 'is it okay' does not identify any product type.

Why the other choices are wrong

A. Notarization is not part of the required SOA elements.

C. An SOA authorizes a conversation topic, not a guaranteed enrollment outcome.

D. A Permission to Contact form serves a different purpose and does not supply the missing SOA elements.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 421 | T-431

Correct answer: C. Yes, a properly captured recorded verbal confirmation can satisfy the requirement.

Explanation. CMS allows an SOA to be documented on paper, through electronic or e-signature, or through a recorded verbal confirmation, provided the required elements are captured either way.

Why the other choices are wrong

A. A handwritten signature is one acceptable method, not the only one.

B. Notarization is not part of the accepted verbal-SOA process.

D. A later in-person signature is not required when a valid recorded verbal SOA already exists.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 422 | T-432

Correct answer: D. No, prerecorded voice messages remain outside the permitted unsolicited-contact channels.

Explanation. The permitted unsolicited-contact list is limited to specific channels such as direct mail, print advertising, and marketing email with a working opt-out. Prerecorded or robocall-style voice messages are not among the permitted channels.

Why the other choices are wrong

A. Purchasing a list does not create beneficiary-initiated contact or consent.

B. Adding a sponsor disclosure does not move voicemail drops onto the permitted list.

C. Some unsolicited channels remain permitted; the prohibition is channel-specific, not universal.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 423 | T-433

Correct answer: A. Yes, marketing email is permitted when a functioning opt-out mechanism is included.

Explanation. Marketing email is on the permitted unsolicited-contact list when it includes a working opt-out mechanism, distinguishing it from prohibited channels like unsolicited text messages.

Why the other choices are wrong

B. A functioning opt-out is exactly what makes this channel permitted.

C. Prior purchase is not a condition for the email channel's permitted status.

D. Email and text are treated differently; text does not share this email exception.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 424 | T-434

Correct answer: B. No, unsolicited in-person outreach without an invitation is not a permitted channel.

Explanation. The permitted unsolicited-contact list covers specific channels like direct mail, print advertising, and opt-out marketing email. Unrequested door-to-door solicitation is not among those permitted channels.

Why the other choices are wrong

A. In-person cold outreach is not automatically excused from the unsolicited-contact framework.

C. Carrying printed material does not convert an unsolicited visit into a permitted channel.

D. The issue is the unsolicited nature of the visit, not a housing-specific waiver requirement.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 425 | T-435

Correct answer: C. Providing a notice of transition and a genuine opportunity for attendees to leave.

Explanation. Even after the fixed gap between educational events and sales activity was eliminated, converting the same venue into a sales pitch still requires a notice of transition and a real opportunity for attendees to leave before marketing begins.

Why the other choices are wrong

A. An SOA is tied to the sales portion itself, not a precondition for attending the seminar.

B. A fixed waiting period is no longer the operative safeguard for same-venue conversions.

D. State filing of an educational event is not the missing transition safeguard here.

Applies to: Both
Source: https://www.cms.gov/newsroom/fact-sheets/contract-year-2027-medicare-advantage-part-d-final-rule
Verified: 2026-08-13

ANSWER 426 | T-436

Correct answer: D. Yes, current rules permit SOA collection at the educational event itself.

Explanation. The current framework permits collecting a Scope of Appointment at an educational event, reflecting the removal of the earlier fixed waiting period between such events and related sales activity.

Why the other choices are wrong

A. Educational-event collection is now allowed, not categorically barred.

B. Mailing is not the exclusive method for capturing a valid SOA.

C. A mandatory fixed delay is no longer the controlling rule.

Applies to: Both
Source: https://www.cms.gov/newsroom/fact-sheets/contract-year-2027-medicare-advantage-part-d-final-rule
Verified: 2026-08-13

ANSWER 427 | T-437

Correct answer: A. The cash-redeemable gift card, because gifts may never function as cash equivalents.

Explanation. Permitted gifts must carry only nominal value, must be offered to attendees regardless of enrollment, and must never function as cash or a cash equivalent. A gift card redeemable for cash fails that last condition.

Why the other choices are wrong

B. Offering the tote bag to everyone regardless of enrollment is exactly what compliant gifting looks like.

C. No advance written waiver is required for a nominal-value gift.

D. Raffles are not categorically banned; the problem is the cash-equivalent prize.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 428 | T-438

Correct answer: B. The third TPMO received data without its own separately identified prior written consent.

Explanation. Prior express written consent must separately identify and be given for each receiving TPMO. Consent naming one partner does not extend to a different, unnamed downstream recipient.

Why the other choices are wrong

A. Consent tied to one named recipient does not automatically authorize further transfers.

C. The defect exists regardless of when the beneficiary later objects.

D. Written consent is the required form here, not a defect to be replaced with oral agreement.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-423/subpart-V
Verified: 2026-08-13

ANSWER 429 | T-439

Correct answer: C. No, oversight responsibility continues throughout the delegated first-tier, downstream, and TPMO chain.

Explanation. Sponsors and their contracted entities retain oversight responsibility for functions performed by first-tier, downstream, related, and TPMO parties. Delegating a task does not eliminate the duty to monitor how it is performed.

Why the other choices are wrong

A. Delegation shifts performance of the task, not accountability for oversight.

B. Self-labeling as independent does not remove flow-down compliance duties.

D. The absence of a formal written contract does not eliminate oversight responsibility for functions performed on the sponsor's behalf.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-423/subpart-V
Verified: 2026-08-13

ANSWER 430 | T-440

Correct answer: D. That any prospect call could be monitored or recorded and later reviewed.

Explanation. Carriers and CMS-linked monitors routinely place test calls to check disclaimer use and overall compliance. Agents should treat every prospect interaction as potentially monitored, regardless of how casual it feels.

Why the other choices are wrong

A. A call's tone does not create an exception to the disclosure requirement.

B. The disclaimer duty attaches to the call itself, not to a confirmed sales interest.

C. Monitoring extends to recorded calls and other channels, not only live events.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 431 | T-441

Correct answer: A. The audio-retention requirement covering the first three years after the call.

Explanation. Marketing and sales calls must be retained for at least six years, with audio required during the first three years; a transcript alone may substitute only in years four through six. Missing audio inside that initial period is a retention gap.

Why the other choices are wrong

B. A transcript-only file is insufficient during the required initial audio-retention window.

C. There is no thirty-day destruction requirement; the rule requires multi-year retention.

D. Calendar-year-only retention understates the multi-year duty that applies here.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-423/subpart-V
Verified: 2026-08-13

ANSWER 432 | T-442

Correct answer: B. No, if the voicemail still involves marketing, sales, or enrollment content it remains covered.

Explanation. The recording obligation applies based on the content and purpose of the interaction, not its position in a sequence of contacts. A follow-up message that still touches marketing, sales, or enrollment content remains within scope.

Why the other choices are wrong

A. Coverage depends on content, not simply being the first call in a chain.

C. Voicemail format alone does not remove marketing or sales content from the recording duty.

D. Handwritten confirmation is not a substitute for the applicable recording requirement.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-423/subpart-V
Verified: 2026-08-13

ANSWER 433 | T-443

Correct answer: C. Direct mail and print advertising.

Explanation. Direct mail and print advertising are on the current permitted unsolicited-contact list, alongside marketing email that includes a working opt-out mechanism.

Why the other choices are wrong

A. Prerecorded voice drops remain outside the permitted channels.

B. Unsolicited texting without consent is not a permitted channel.

D. Uninvited door-to-door contact is not among the permitted channels.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 434 | T-444

Correct answer: D. It was eliminated, though the SOA itself is still required.

Explanation. The fixed waiting period after SOA execution was eliminated. The SOA remains a required document; only the mandated delay before contact was removed.

Why the other choices are wrong

A. The change removed the wait rather than lengthening it.

B. Eliminating a minimum delay does not create a new same-day mandate.

C. The change was not limited to in-person appointments.

Applies to: Both
Source: https://www.cms.gov/newsroom/fact-sheets/contract-year-2027-medicare-advantage-part-d-final-rule
Verified: 2026-08-13

ANSWER 435 | T-445

Correct answer: A. Supporting documentation no longer must be kept on file, but misleading claims remain prohibited.

Explanation. CMS removed the requirement to keep documentation supporting a superlative claim on file, but the broader prohibition on misleading or unsubstantiated claims continues to apply.

Why the other choices are wrong

B. Superlatives were not banned outright; the documentation mandate was removed.

C. No notarization requirement exists for these claims.

D. The change is not tied to a specific election period.

Applies to: Both
Source: https://www.cms.gov/newsroom/fact-sheets/contract-year-2027-medicare-advantage-part-d-final-rule
Verified: 2026-08-13

ANSWER 436 | T-446

Correct answer: B. Whether the piece meets both an intent prong and a content prong.

Explanation. A piece is marketing when it satisfies both prongs of the applicable test: it is designed to draw attention to a specific plan and influence an enrollment or retention decision, and it includes qualifying content such as benefit, cost-sharing, or comparison detail.

Why the other choices are wrong

A. Format alone, print or electronic, does not determine marketing status.

C. Naming a physician is not part of the governing two-part test.

D. The producer's identity does not itself satisfy or defeat either prong.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 437 | T-447

Correct answer: C. The entity's position in the contract chain relative to the plan sponsor.

Explanation. Classification as first-tier or downstream generally follows the contract chain connecting an entity to the plan sponsor, rather than the entity's business type or compensation structure.

Why the other choices are wrong

A. Sales history does not itself establish the entity's tier classification.

B. Corporate form is not the deciding factor in this classification.

D. Charging a commission does not determine an entity's position in the contract chain.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-423/subpart-V
Verified: 2026-08-13

ANSWER 438 | T-448

Correct answer: D. It must never function as cash or a cash equivalent.

Explanation. Compliant gifts must carry only nominal value, be offered without regard to enrollment outcome, and never take the form of cash or a cash equivalent.

Why the other choices are wrong

A. Cash redemption is exactly the prohibited feature.

B. Restricting gifts to enrollees only violates the offered-to-all condition.

C. A high dollar value works against the nominal-value requirement.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 439 | T-449

Correct answer: A. Medicare.gov and 1-800-MEDICARE as independent information resources.

Explanation. The Medicare.gov and 1-800-MEDICARE references remain a required part of the disclaimer even though the earlier SHIP-referral sentence was removed.

Why the other choices are wrong

B. Personal ratings are not part of the required disclaimer content.

C. Directing consumers to a competitor's list is not a disclaimer requirement.

D. An internal-only hotline does not satisfy the independent-resource requirement.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 440 | T-450

Correct answer: B. An unrecorded verbal exchange with no documentation retained afterward.

Explanation. CMS accepts paper, electronic or e-signature, and recorded verbal confirmation as valid SOA formats. An unrecorded verbal exchange with nothing retained does not create a documented, verifiable record.

Why the other choices are wrong

A. Paper documentation is an accepted method.

C. Electronic or e-signature capture is an accepted method.

D. A properly recorded verbal confirmation is an accepted method.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 441 | T-451

Correct answer: C. To confirm agents and TPMO personnel understand current Medicare marketing and compliance rules before selling.

Explanation. Sponsors rely on this annual cycle to confirm, before anyone engages a beneficiary, that agents and TPMO staff have kept pace with the year's marketing and compliance standards rather than assuming last year's knowledge still applies.

Why the other choices are wrong

A. Training and testing do not substitute for a state insurance license.

B. The requirement is not limited to a single carrier's appointment.

D. The requirement recurs annually rather than applying only once.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 442 | T-452

Correct answer: D. The sponsor retains monitoring and oversight duties over the delegated functions.

Explanation. Delegating functions to a downstream TPMO does not eliminate the sponsor's underlying contract responsibilities; the sponsor must continue monitoring how those delegated functions are performed.

Why the other choices are wrong

A. Contract responsibility with CMS remains with the sponsor.

B. Delegation does not carry an automatic annual expiration by rule.

C. Beneficiary approval of the internal delegation arrangement is not a stated requirement.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-423/subpart-V
Verified: 2026-08-13

ANSWER 443 | T-453

Correct answer: A. Refuse, because the SOA must reflect the date it was actually executed.

Explanation. An SOA is a compliance record, and altering its date to misrepresent when it was executed creates an inaccurate record regardless of intent. The agent should decline the instruction and preserve the accurate date.

Why the other choices are wrong

B. A beneficiary's later confirmation does not authorize falsifying the original record.

C. A private note does not cure a record that misstates the actual execution date.

D. Waiting for a complaint is not the correct trigger for refusing an instruction to falsify a record.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 444 | T-454

Correct answer: B. Halting further sharing until consent separately identifies and is obtained for each specific recipient.

Explanation. Prior express written consent must identify each receiving TPMO and allow the beneficiary to accept or reject sharing with that specific recipient. A generic, unnamed checkbox does not meet that standard, so sharing should stop until it is corrected.

Why the other choices are wrong

A. The existing checkbox is exactly the deficient practice that must change.

C. A no-contact promise does not substitute for the required identified, prior consent.

D. An after-the-fact opt-out cannot retroactively authorize the earlier improper transfer.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-423/subpart-V
Verified: 2026-08-13

ANSWER 445 | T-455

Correct answer: C. Deliver the required disclaimer before any plan-benefit discussion, on every qualifying call.

Explanation. Timing controls this duty: the required disclosure has to land ahead of any conversation about what a plan covers or costs, so a caller's tone or apparent interest cannot justify pushing it later in the call.

Why the other choices are wrong

A. Assumptions about caller intent do not excuse the timing requirement.

B. The duty does not depend on the caller raising the topic first.

D. Moving the disclaimer to a different channel does not satisfy the requirement for the covered call.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 446 | T-456

Correct answer: D. Suspend the TPMO's covered sales activity until training and testing are completed and confirmed.

Explanation. Annual training and testing is a prerequisite for engaging in covered Medicare sales activity, and sponsors must ensure downstream and TPMO personnel meet it. Continued uncorrected sales activity without completed training is a compliance gap requiring prompt correction.

Why the other choices are wrong

A. Allowing continued sales without required training extends the compliance gap.

B. Indirect contracting does not remove the sponsor's oversight responsibility for this TPMO.

C. Waiting for a future audit delays a correction that should happen promptly upon discovery.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-423/subpart-V
Verified: 2026-08-13

ANSWER 447 | T-457

Correct answer: A. No, keeping the substantiation still helps manage misleading-claims and audit risk.

Explanation. Even though CMS removed the requirement to keep superlative-claim documentation on file, the general prohibition on misleading or unsubstantiated claims still applies, so retaining the backup remains a sound risk-management practice.

Why the other choices are wrong

B. Removing the filing requirement does not make the underlying claim automatically true.

C. Superlative claims were not banned; only the mandatory documentation was removed.

D. The reasoning here rests on ongoing misleading-claims exposure, not a state notarization rule.

Applies to: Both
Source: https://www.cms.gov/newsroom/fact-sheets/contract-year-2027-medicare-advantage-part-d-final-rule
Verified: 2026-08-13

ANSWER 448 | T-458

Correct answer: B. False; audio must be kept for the first three years within a longer overall retention period.

Explanation. The statement is false. Marketing and sales calls must be retained for at least six years overall, with audio specifically required for the first three years before a transcript may substitute.

Why the other choices are wrong

A. One year falls well short of the required three-year audio window.

C. The audio-retention duty does not depend on whether an enrollment resulted.

D. Audio, not video, is the format specifically required during the initial retention years.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-423/subpart-V
Verified: 2026-08-13

ANSWER 449 | T-459

Correct answer: C. 1-B and 2-A.

Explanation. Permission to Contact authorizes an agent to initiate future outreach without itself covering specific plan details, matching function B. A Scope of Appointment documents the product types agreed to for a personal marketing appointment, matching function A. The correct pairing is 1-B and 2-A.

Why the other choices are wrong

A. This pairing reverses both documents' functions.

B. Assigning function A to both documents ignores Permission to Contact's actual outreach-authorization role.

D. Assigning function B to both documents ignores the Scope of Appointment's actual product-type role.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 450 | T-460

Correct answer: D. Statements I, II, and IV.

Explanation. Statements I, II, and IV correctly describe recurring reporting, ongoing licensing and appointment monitoring, and the training-and-testing prerequisite. Statement III is false because a signed contract does not end continuing oversight responsibility.

Why the other choices are wrong

A. Statement III is false, and this option omits accurate Statements II and IV.

B. Statement III is false, and this option omits accurate Statement I and Statement IV.

C. Statement III is false, making this combination inaccurate despite including two correct statements.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-423/subpart-V
Verified: 2026-08-13

Topic Set - Fraud, waste and abuse; privacy; reporting

25 answer entries. Match each entry to the question number and ID printed in Part I.

ANSWER 451 | T-091

Correct answer: C. An error that requires correction but lacks the intent element of fraud.

Explanation. Fraud requires knowing and willful deception or misrepresentation for an unauthorized benefit. The facts instead describe an unintentional error, which still must be corrected and documented without being mislabeled as intentional misconduct.

Why the other choices are wrong

A. Inaccuracy alone does not prove the knowledge and intent required for fraud.

B. Abuse concerns improper practices inconsistent with accepted standards, not every corrected clerical mistake.

D. Waste involves unnecessary or inefficient use of program resources and is not the best classification for this isolated typo.

Applies to: Both
Source: https://oig.hhs.gov/reports-and-publications/featured-topics/ihs/training/fraud-waste-and-abuse-for-health-care-providers/content/
Verified: 2026-08-02

ANSWER 452 | T-092

Correct answer: D. Report the potential incident promptly through the designated privacy or security channel.

Explanation. Prompt reporting allows the responsible privacy and security team to investigate, mitigate risk, preserve evidence, and determine any notification obligations. The agent does not need to prove unauthorized access before reporting discovery of the loss.

Why the other choices are wrong

A. Waiting for demonstrated harm can prevent timely investigation and required action.

B. Concealing the loss and altering inventory creates additional compliance problems.

C. The organization, not affected beneficiaries, is responsible for conducting the formal incident assessment.

Applies to: Both
Source: https://www.hhs.gov/hipaa/for-professionals/privacy/index.html
Verified: 2026-08-02

ANSWER 453 | T-093

Correct answer: A. Limit access, use, or disclosure to information reasonably needed for the stated purpose.

Explanation. The minimum-necessary standard calls for reasonable limits on protected information used, disclosed, or requested for a particular purpose when the rule applies. Staff should access what the task requires, not unrelated details.

Why the other choices are wrong

B. Curiosity is not a permitted reason to view unnecessary clinical information.

C. Broad speculative distribution is inconsistent with purpose-based access controls.

D. The principle limits information; it does not prevent authorized use needed to perform the task.

Applies to: Both
Source: https://www.hhs.gov/hipaa/for-professionals/privacy/index.html
Verified: 2026-08-02

ANSWER 454 | T-094

Correct answer: B. Federal health-program payment generally cannot be made for items or services furnished, ordered, or prescribed by excluded parties.

Explanation. OIG exclusion can bar federal health-program payment for items or services connected to an excluded person or entity. Routine screening helps an organization avoid employing or contracting with ineligible parties in covered roles.

Why the other choices are wrong

A. The LEIE concerns formal exclusions, not every mistake.

C. Exclusion screening complements rather than replaces licensing and other required checks.

D. A member complaint does not automatically result in placement on the federal exclusion list.

Applies to: Both
Source: https://oig.hhs.gov/exclusions/
Verified: 2026-08-02

ANSWER 455 | T-095

Correct answer: C. Preserve the facts and report the concern through the designated compliance channel.

Explanation. A credible concern should be reported promptly to the sponsor's compliance function or another authorized channel. The reporter supplies observed facts and preserves evidence; trained investigators determine what occurred and what corrective action is required.

Why the other choices are wrong

A. Altering evidence can obstruct the investigation and create separate misconduct.

B. A private promise and destruction risk are inconsistent with an impartial review.

D. Public disclosure of beneficiary data violates privacy and bypasses the authorized process.

Applies to: Both
Source: https://oig.hhs.gov/reports-and-publications/featured-topics/ihs/training/fraud-waste-and-abuse-for-health-care-providers/content/
Verified: 2026-08-02

ANSWER 456 | T-461

Correct answer: A. Fraud, because it is a knowing, material misrepresentation made to obtain the enrollment.

Explanation. Knowingly telling a prospect a plan costs nothing when a premium in fact applies is a material misrepresentation made to obtain an unauthorized benefit for the agent, which fits the definition of fraud rather than waste, abuse, or an innocent error.

Why the other choices are wrong

B. Waste describes inefficient resource use, not a knowing false statement.

C. A later apology does not change the nature of a knowing misstatement made to close a sale.

D. The facts describe knowledge of the true cost, which rules out an innocent mistake.

Applies to: Both
Source: https://oig.hhs.gov/reports-and-publications/featured-topics/ihs/training/fraud-waste-and-abuse-for-health-care-providers/content/
Verified: 2026-08-13

ANSWER 457 | T-462

Correct answer: B. Screening should occur before the person is hired or contracted, not afterward.

Explanation. Organizations should screen prospective employees and contractors against the exclusion list before bringing them on, with ongoing periodic screening afterward, rather than allowing an excluded person to begin working first.

Why the other choices are wrong

A. A pending complaint is not the trigger for exclusion screening.

C. Exclusion status can change, which is why ongoing rescreening matters.

D. The screening duty is not limited to licensed personnel only.

Applies to: Both
Source: https://oig.hhs.gov/exclusions/
Verified: 2026-08-13

ANSWER 458 | T-463

Correct answer: C. Document further verification using identifiers such as date of birth before deciding.

Explanation. A partial name match is neither automatic proof of exclusion nor grounds for automatic clearance. It calls for documented follow-up verification using additional identifiers before the organization decides how to resolve the match.

Why the other choices are wrong

A. A single mismatched field does not by itself disprove a potential match.

B. Treating every partial match as confirmed skips necessary verification.

D. Ongoing monthly screening after initial hire is part of the expected screening practice, not optional.

Applies to: Both
Source: https://oig.hhs.gov/exclusions/
Verified: 2026-08-13

ANSWER 459 | T-464

Correct answer: D. A minimum-necessary and data-security concern requiring prompt reporting.

Explanation. Sending an entire client roster with sensitive identifiers to a personal account exceeds what is needed for a specific task and creates an uncontrolled copy of protected information, which should be reported through the designated privacy or security channel.

Why the other choices are wrong

A. Remote work does not excuse moving sensitive data outside approved, secured systems.

B. A later deletion does not undo the earlier unauthorized transfer and exposure.

C. The concern exists at the moment of the transfer, independent of whether a client later complains.

Applies to: Both
Source: https://www.hhs.gov/hipaa/for-professionals/privacy/index.html
Verified: 2026-08-13

ANSWER 460 | T-465

Correct answer: A. A business associate agreement binding the vendor to appropriate safeguards for the data it handles.

Explanation. A vendor that creates, stores, or transmits protected information on an agency's behalf should be bound by a business associate agreement obligating it to the same safeguards the agency itself must follow.

Why the other choices are wrong

B. A vendor providing software services does not need its own insurance producer license.

C. Individual client notarized approval is not the mechanism that governs vendor data-handling duties.

D. AHIP certification applies to selling agents, not to a software vendor's engineering staff.

Applies to: Both
Source: https://www.hhs.gov/hipaa/for-professionals/privacy/index.html
Verified: 2026-08-13

ANSWER 461 | T-466

Correct answer: B. Report the overpayment proactively through the applicable self-disclosure process.

Explanation. Proactively reporting a suspected overpayment or compliance issue through an applicable self-disclosure process is generally treated more favorably than allowing the matter to surface later through an outside audit, and it supports timely correction.

Why the other choices are wrong

A. Silence increases risk rather than reducing exposure once an issue is known.

C. Fixing only future claims leaves the identified past overpayment unaddressed.

D. Waiting for an external audit notice delays a correction the organization is already positioned to make.

Applies to: Both
Source: https://oig.hhs.gov/reports-and-publications/featured-topics/ihs/training/fraud-waste-and-abuse-for-health-care-providers/content/
Verified: 2026-08-13

ANSWER 462 | T-467

Correct answer: C. An Anti-Kickback Statute concern, because it rewards referrals connected to federal health-program business.

Explanation. The Anti-Kickback Statute prohibits knowingly offering or receiving remuneration to induce or reward referrals of federal health-program business. A side payment tied to directing enrollments toward a specific provider fits that concern.

Why the other choices are wrong

A. This scenario does not involve employee leave rights.

B. The concern here is a federal fraud-and-abuse issue, not a state advertising rule.

D. Payments outside the normal commission structure are not automatically lawful simply because they are private.

Applies to: Both
Source: https://oig.hhs.gov/reports-and-publications/featured-topics/ihs/training/fraud-waste-and-abuse-for-health-care-providers/content/
Verified: 2026-08-13

ANSWER 463 | T-468

Correct answer: D. No, obligations flow down the contract chain to entities handling data on the sponsor's behalf.

Explanation. Compliance obligations extend beyond entities with a direct sponsor contract to downstream and related entities handling data or functions connected to the sponsor's business, regardless of where they sit in the contract chain.

Why the other choices are wrong

A. A direct sponsor contract is not required to carry downstream compliance obligations.

B. Touching enrollment paperwork is not the deciding factor for this flow-down duty.

C. A separate licensing requirement is not the basis for the flow-down obligation described here.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-423/subpart-V
Verified: 2026-08-13

ANSWER 464 | T-469

Correct answer: A. Torn paper in regular recycling can still leave protected information readable with secure safeguards absent.

Explanation. Even after retention requirements are satisfied, protected records should be destroyed through a secure method that makes the information unreadable and unrecoverable. Torn paper in an ordinary recycling bin does not reliably meet that standard.

Why the other choices are wrong

B. Expiration of the retention period does not excuse using an insecure disposal method.

C. Simply tearing a page in half does not reliably prevent reconstruction of the information.

D. The core problem is the disposal method's security, not which vendor eventually empties the bin.

Applies to: Both
Source: https://www.hhs.gov/hipaa/for-professionals/privacy/index.html
Verified: 2026-08-13

ANSWER 465 | T-470

Correct answer: B. Whether the conduct involved knowing and willful deception for an unauthorized benefit.

Explanation. Fraud requires knowing and willful deception or misrepresentation intended to obtain an unauthorized benefit, which is the key element separating it from waste, which generally involves inefficient use of resources without that deceptive intent.

Why the other choices are wrong

A. Dollar amount alone does not establish or rule out the intent element.

C. A supervisor's awareness is not itself the defining element of fraud.

D. A beneficiary complaint is not required to establish or negate fraudulent intent.

Applies to: Both
Source: https://oig.hhs.gov/reports-and-publications/featured-topics/ihs/training/fraud-waste-and-abuse-for-health-care-providers/content/
Verified: 2026-08-13

ANSWER 466 | T-471

Correct answer: C. It bars knowingly offering, paying, soliciting, or receiving remuneration to induce federal health-program referrals.

Explanation. The Anti-Kickback Statute prohibits knowingly and willfully offering, paying, soliciting, or receiving remuneration intended to induce or reward referrals of business reimbursed by federal health programs, subject to applicable exceptions.

Why the other choices are wrong

A. The statute does not categorically bar agent-physician communication.

B. Public online disclosure of every commission is not what this statute requires.

D. Working with multiple carriers is not what this statute addresses.

Applies to: Both
Source: https://oig.hhs.gov/reports-and-publications/featured-topics/ihs/training/fraud-waste-and-abuse-for-health-care-providers/content/
Verified: 2026-08-13

ANSWER 467 | T-472

Correct answer: D. Liability attaches to knowingly submitting or causing false claims material to federal payment.

Explanation. This federal statute reaches conduct where someone knows a claim or a supporting record is false and still causes it to be presented for government payment, with materiality to that payment as the connecting thread.

Why the other choices are wrong

A. Physical injury to a beneficiary is not an element of this liability standard.

B. The Act is not limited to conduct occurring inside a hospital.

C. No confession is required; liability rests on the knowing conduct and its materiality to the claim.

Applies to: Both
Source: https://oig.hhs.gov/reports-and-publications/featured-topics/ihs/training/fraud-waste-and-abuse-for-health-care-providers/content/
Verified: 2026-08-13

ANSWER 468 | T-473

Correct answer: A. Having items or services they furnish, order, or prescribe paid for by federal health programs.

Explanation. Exclusion generally means federal health-program payment cannot be made for items or services furnished, ordered, or prescribed by the excluded individual or entity, which is why organizations screen against the exclusion list.

Why the other choices are wrong

B. Exclusion is a program-payment restriction, not a universal ban on professional licensure.

C. Exclusion has no bearing on voting rights.

D. An excluded party generally retains applicable rights to challenge the exclusion determination itself.

Applies to: Both
Source: https://oig.hhs.gov/exclusions/
Verified: 2026-08-13

ANSWER 469 | T-474

Correct answer: B. Limiting the protected information accessed, used, or disclosed to what the specific task reasonably requires.

Explanation. The minimum-necessary standard calls for reasonably limiting protected information used, disclosed, or requested to what a specific purpose requires, rather than granting broad or unrestricted access.

Why the other choices are wrong

A. Unrestricted full-history access is the opposite of the required limitation.

C. Speculative future need is not a basis for sharing protected information now.

D. The standard limits scope; it does not forbid access genuinely needed to complete the authorized task.

Applies to: Both
Source: https://www.hhs.gov/hipaa/for-professionals/privacy/index.html
Verified: 2026-08-13

ANSWER 470 | T-475

Correct answer: C. It obligates a vendor handling protected information to appropriate safeguards.

Explanation. A business associate agreement is a contract that binds a vendor creating, storing, or transmitting protected information on an organization's behalf to the same category of safeguards the organization itself must follow.

Why the other choices are wrong

A. The agreement does not substitute for ongoing staff confidentiality training.

B. Financial solvency certification is not the agreement's purpose.

D. The agreement does not authorize resale of client data; it constrains how the vendor may handle it.

Applies to: Both
Source: https://www.hhs.gov/hipaa/for-professionals/privacy/index.html
Verified: 2026-08-13

ANSWER 471 | T-476

Correct answer: D. Report the observed pattern promptly through the designated compliance channel.

Explanation. A credible pattern warrants prompt reporting through the designated compliance channel so trained investigators can determine what occurred; the reporter is not required to first establish intent or conduct an investigation.

Why the other choices are wrong

A. Waiting for an informal, unauthorized review can delay a proper investigation.

B. A direct confrontation risks compromising an eventual formal review.

C. Observing a concerning pattern in the course of work is a reason to report, not to stay silent.

Applies to: Both
Source: https://oig.hhs.gov/reports-and-publications/featured-topics/ihs/training/fraud-waste-and-abuse-for-health-care-providers/content/
Verified: 2026-08-13

ANSWER 472 | T-477

Correct answer: A. Clarify that flow-down obligations still apply because the vendor is a downstream or related entity in the chain.

Explanation. Compliance obligations flow down the entire contract chain to downstream and related entities handling functions or data connected to the sponsor's business, not only to parties with a direct sponsor contract.

Why the other choices are wrong

B. This restates the vendor's incorrect position rather than correcting it.

C. A new direct contract is not what triggers the existing flow-down obligation.

D. Obligations apply from the outset of the relevant activity, not only after a failure is discovered.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-423/subpart-V
Verified: 2026-08-13

ANSWER 473 | T-478

Correct answer: B. Escalate the matter for consideration through an applicable self-disclosure process.

Explanation. An unintentional overpayment identified internally should be escalated for evaluation through the applicable self-disclosure process rather than corrected silently going forward, since proactive reporting is treated more favorably than concealment.

Why the other choices are wrong

A. Quiet correction without disclosure leaves the identified past issue unaddressed and undisclosed.

C. Waiting for an external audit abandons the opportunity for favorable proactive reporting.

D. Limiting correction to complaining members ignores the broader identified overpayment.

Applies to: Both
Source: https://oig.hhs.gov/reports-and-publications/featured-topics/ihs/training/fraud-waste-and-abuse-for-health-care-providers/content/
Verified: 2026-08-13

ANSWER 474 | T-479

Correct answer: C. False; a business associate agreement and the minimum-necessary standard address separate, ongoing obligations.

Explanation. The statement is false. A business associate agreement governs a vendor relationship, while the minimum-necessary standard separately governs how the organization itself limits access, use, and disclosure of protected information; satisfying one does not satisfy the other.

Why the other choices are wrong

A. A signed agreement does not eliminate the organization's own minimum-necessary obligations.

B. Vendor location is not the reason the statement is false.

D. Business associate agreements are required, not optional, when a qualifying vendor relationship exists.

Applies to: Both
Source: https://www.hhs.gov/hipaa/for-professionals/privacy/index.html
Verified: 2026-08-13

ANSWER 475 | T-480

Correct answer: D. Statements I, III, and IV.

Explanation. Statements I, III, and IV correctly describe fraud's intent element, waste's lack of deceptive intent, and the treatment of a genuinely corrected clerical error. Statement II is false because abuse does not require the same knowing-deception element as fraud.

Why the other choices are wrong

A. Statement II is false, and this option omits accurate Statements III and IV.

B. Statement II is false, making this pairing inaccurate despite including true Statement III.

C. Statement II is false, so including it makes this combination inaccurate even though I and IV are true.

Applies to: Both
Source: https://oig.hhs.gov/reports-and-publications/featured-topics/ihs/training/fraud-waste-and-abuse-for-health-care-providers/content/
Verified: 2026-08-13

Topic Set - Beneficiary protections, appeals, grievances

25 answer entries. Match each entry to the question number and ID printed in Part I.

ANSWER 476 | T-096

Correct answer: D. A grievance addressing dissatisfaction with plan service and operations.

Explanation. A grievance is the proper channel for complaints about service quality, behavior, access to customer service, or other plan operations when the member is not challenging an adverse coverage decision.

Why the other choices are wrong

A. A formulary exception requests drug coverage and does not resolve customer-service conduct.

B. An expedited appeal reviews an adverse benefit decision when delay poses the required health risk.

C. An organization determination is an initial MA coverage or payment decision, which the facts do not seek.

Applies to: Both
Source: https://www.cms.gov/medicare/appeals-grievances/managed-care
Verified: 2026-08-02

ANSWER 477 | T-097

Correct answer: A. An expedited appeal supported by the urgent health facts.

Explanation. An expedited appeal uses a shortened timeframe when applying the ordinary schedule could seriously jeopardize life, health, or the ability to regain maximum function. The physician's support directly addresses that standard.

Why the other choices are wrong

B. A grievance does not overturn or reconsider the adverse coverage determination.

C. A marketing complaint does not automatically vacate a properly issued benefit decision.

D. Changing plans later is not a substitute for timely review of the present medical-service denial.

Applies to: Both
Source: https://www.cms.gov/medicare/appeals-grievances/managed-care
Verified: 2026-08-02

ANSWER 478 | T-098

Correct answer: B. An organization determination.

Explanation. An organization determination is the Medicare Advantage plan's initial decision about coverage, payment, or related Part C benefit matters. An adverse result carries notice and appeal rights.

Why the other choices are wrong

A. A coverage determination is the Part D term for an initial drug-coverage decision.

C. A grievance addresses dissatisfaction that is not an appeal of a benefit decision.

D. Independent review can occur at a later appeal level after the plan's initial and reconsideration processes.

Applies to: Both
Source: https://www.cms.gov/medicare/appeals-grievances/managed-care
Verified: 2026-08-02

ANSWER 479 | T-099

Correct answer: C. Reject it as discriminatory enrollment conduct based on expected health costs.

Explanation. MA and Part D enrollment must be administered without using health status to deter people who otherwise meet eligibility requirements. Expected utilization or cost is not a lawful basis for discouraging an eligible applicant.

Why the other choices are wrong

A. Plan financial preferences cannot override nondiscrimination requirements.

B. A question about benefits does not make health-based steering permissible.

D. Service-area residence is an eligibility fact, but it does not authorize discrimination among eligible residents.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 480 | T-100

Correct answer: D. False; emergency coverage protections are not conditioned on ordinary pre-service referral rules.

Explanation. The statement is false. Medicare Advantage beneficiary protections include emergency and urgently needed care under applicable rules, so routine network coordination cannot be imposed as though the emergency were elective care.

Why the other choices are wrong

A. Applying ordinary referral prerequisites to a genuine emergency misstates the protection.

B. Emergencies are not scheduled events requiring plan prearrangement.

C. The protection arises under the MA benefit rules and does not depend on owning Medigap.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 481 | T-481

Correct answer: A. A tiering exception request through the Part D coverage-determination process.

Explanation. A request to apply a lower cost-sharing tier for a covered drug is a tiering exception, handled through the Part D coverage-determination process rather than as a grievance or an MA organization determination.

Why the other choices are wrong

B. The member is not complaining about service conduct, so a grievance does not fit.

C. Organization determinations address Medicare Advantage medical benefits, not a Part D tier dispute.

D. A QIO complaint concerns care quality, not a drug's cost-sharing tier.

Applies to: Both
Source: https://www.cms.gov/medicare/appeals-grievances/managed-care
Verified: 2026-08-13

ANSWER 482 | T-482

Correct answer: B. A grievance addressing dissatisfaction with plan service and access.

Explanation. A complaint about the plan's service delivery, such as interpreter access during a call, is a grievance because the member is not disputing an adverse coverage or payment decision.

Why the other choices are wrong

A. No urgent health-jeopardy coverage decision is being challenged here.

C. A coverage determination addresses drug coverage decisions, not interpreter availability.

D. An organization determination addresses MA coverage or payment decisions, not service access.

Applies to: Both
Source: https://www.cms.gov/medicare/appeals-grievances/managed-care
Verified: 2026-08-13

ANSWER 483 | T-483

Correct answer: C. An expedited appeal supported by the physician's urgent-risk documentation.

Explanation. An expedited appeal applies a shortened review timeframe when the standard schedule could seriously jeopardize life, health, or the ability to regain maximum function, which the physician's documentation supports here.

Why the other choices are wrong

A. A grievance does not review or overturn the underlying coverage denial.

B. The physician is supporting the member's appeal, not the subject of a quality complaint.

D. Waiting for a future election period does not address the present denial needing timely review.

Applies to: Both
Source: https://www.cms.gov/medicare/appeals-grievances/managed-care
Verified: 2026-08-13

ANSWER 484 | T-484

Correct answer: D. A quality-of-care complaint filed with the applicable Quality Improvement Organization.

Explanation. Concerns about how well Medicare-covered care was actually delivered route to this independent reviewer, a path that exists whether or not the beneficiary is also disputing what the plan paid for.

Why the other choices are wrong

A. A tiering exception concerns Part D drug cost-sharing, not facility care quality.

B. The member is not disputing coverage of the stay, so an organization determination does not fit this concern.

C. An individual member cannot directly alter a facility's official Star Rating.

Applies to: Both
Source: https://www.cms.gov/medicare/appeals-grievances/managed-care
Verified: 2026-08-13

ANSWER 485 | T-485

Correct answer: A. It discriminates against an eligible applicant based on anticipated health-related utilization.

Explanation. Enrollment assistance may not be withheld from an eligible applicant because of expected utilization tied to a health condition. Steering away a suitable applicant on that basis is discriminatory conduct regardless of documentation or a later complaint.

Why the other choices are wrong

B. Agent discretion does not extend to excluding eligible applicants based on anticipated health costs.

C. Private documentation does not cure discriminatory conduct toward an eligible applicant.

D. The problem exists at the moment of the decision, independent of whether a grievance is later filed.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 486 | T-486

Correct answer: B. The portal must provide accurate notice explaining the applicable appeal path and review rights.

Explanation. A denial notice, including one delivered through a digital portal, must give members accurate information about how and when to pursue the applicable standard or expedited appeal, not a bare denial with no explanation of review rights.

Why the other choices are wrong

A. Digital delivery does not exempt the plan from providing required appeal-rights information.

C. A grievance does not substitute for the appeal process available to challenge this coverage denial.

D. Waiting for a future election period is not a substitute for the member's current appeal rights.

Applies to: Both
Source: https://www.cms.gov/medicare/appeals-grievances/managed-care
Verified: 2026-08-13

ANSWER 487 | T-487

Correct answer: C. No, emergency-care coverage is not conditioned on obtaining prior authorization beforehand.

Explanation. MA beneficiary protections for emergency and urgently needed care are not conditioned on pre-service authorization, since requiring prior approval before an emergency defeats the purpose of the protection.

Why the other choices are wrong

A. Prior authorization rules are generally built around non-emergency, scheduled services rather than genuine emergencies.

B. Distance traveled is not the basis for the emergency-care protection described here.

D. This protection arises under MA benefit rules, not a separate Medigap benefit.

Applies to: Both
Source: https://www.cms.gov/medicare/appeals-grievances/managed-care
Verified: 2026-08-13

ANSWER 488 | T-488

Correct answer: D. A reconsideration of the plan's initial organization determination.

Explanation. After an adverse organization determination, the member's next step is generally to request the plan's reconsideration of that same decision, which precedes any further outside review levels.

Why the other choices are wrong

A. A QIO complaint addresses care quality, not review of this coverage denial itself.

B. A new determination on an unrelated service does not revisit the decision the member is disputing.

C. A readability complaint about a letter is not the process for challenging the underlying denial.

Applies to: Both
Source: https://www.cms.gov/medicare/appeals-grievances/managed-care
Verified: 2026-08-13

ANSWER 489 | T-489

Correct answer: A. Accept the appeal once the representative's proper authorization is confirmed.

Explanation. Appeal rights generally belong to the beneficiary but may be exercised through a properly authorized representative, so a confirmed representative's submission should be accepted and processed as an appeal.

Why the other choices are wrong

B. A properly authorized representative may act on the member's behalf; the appeal is not automatically barred.

C. Converting a coverage-denial appeal into a grievance does not address the member's actual request.

D. Requiring an in-person resubmission is not necessary once representative authorization is confirmed.

Applies to: Both
Source: https://www.cms.gov/medicare/appeals-grievances/managed-care
Verified: 2026-08-13

ANSWER 490 | T-490

Correct answer: B. It addresses a member's dissatisfaction with plan service or operations, apart from a coverage decision.

Explanation. This pathway exists for members unhappy with how they were treated or served, covering conduct and operations rather than functioning as a vehicle to challenge whether a benefit was properly paid or denied.

Why the other choices are wrong

A. A grievance does not itself reverse a coverage or payment decision.

C. A grievance exists alongside, not in place of, the coverage-determination process.

D. Grievance rights are not limited to a specific election period.

Applies to: Both
Source: https://www.cms.gov/medicare/appeals-grievances/managed-care
Verified: 2026-08-13

ANSWER 491 | T-491

Correct answer: C. The Part D plan's initial decision on drug coverage or payment, including exception requests.

Explanation. When a member wants the drug plan to formally decide a coverage or payment question, including a request to bend a formulary or tiering rule, this is the process that produces that initial ruling.

Why the other choices are wrong

A. Call-center satisfaction is a service issue addressed through a grievance, not a coverage determination.

B. A medical-service decision by an MA plan is an organization determination, a separate concept.

D. A hospital's internal discharge planning decision is not a Part D coverage determination.

Applies to: Both
Source: https://www.cms.gov/medicare/appeals-grievances/managed-care
Verified: 2026-08-13

ANSWER 492 | T-492

Correct answer: D. Notice explaining the decision and the applicable appeal rights.

Explanation. An adverse organization determination must come with notice that explains the decision and the member's rights to pursue reconsideration or further appeal.

Why the other choices are wrong

A. A state insurance department referral is not the required response to this type of decision.

B. Automatic enrollment in a different plan is not a substitute for appeal-rights notice.

C. A bare apology without appeal information does not satisfy the required notice content.

Applies to: Both
Source: https://www.cms.gov/medicare/appeals-grievances/managed-care
Verified: 2026-08-13

ANSWER 493 | T-493

Correct answer: A. Applying the standard review timeframe could seriously jeopardize life, health, or the ability to regain function.

Explanation. An expedited appeal is available when using the standard timeframe could seriously jeopardize the member's life, health, or ability to regain maximum function, a standard tied to genuine urgency rather than mere preference.

Why the other choices are wrong

B. A general preference for speed does not by itself meet the required urgency standard.

C. A routine wellness visit does not typically present the described urgent risk.

D. Prior grievance history is not the basis for expedited-appeal eligibility.

Applies to: Both
Source: https://www.cms.gov/medicare/appeals-grievances/managed-care
Verified: 2026-08-13

ANSWER 494 | T-494

Correct answer: B. Eligible applicants may not be discouraged from enrolling because of their health status or expected utilization.

Explanation. Enrollment in MA and Part D must be administered without discouraging eligible applicants based on health status or anticipated utilization, since eligibility does not depend on expected cost.

Why the other choices are wrong

A. Prioritizing applicants by expected cost conflicts with the nondiscrimination requirement.

C. Health-based premium variation for an otherwise eligible applicant is inconsistent with this protection.

D. Enrollment eligibility does not depend on answering health-status questions in this way.

Applies to: Both
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 495 | T-495

Correct answer: C. It reviews quality-of-care complaints about Medicare-covered services.

Explanation. A Quality Improvement Organization reviews beneficiary complaints about the quality of Medicare-covered care, operating separately from a plan's coverage-determination and grievance processes.

Why the other choices are wrong

A. Claim-payment decisions are made through the coverage-determination and organization-determination processes, not by a QIO.

B. A QIO complaint exists alongside, not in place of, a plan's grievance process.

D. Star Ratings are not set unilaterally through an individual QIO complaint.

Applies to: Both
Source: https://www.cms.gov/medicare/appeals-grievances/managed-care
Verified: 2026-08-13

ANSWER 496 | T-496

Correct answer: D. Require complaints meeting the grievance definition to be logged and processed as grievances.

Explanation. A complaint that meets the definition of a grievance, such as dissatisfaction with plan service, must be logged and processed through the grievance process rather than reclassified to keep reported numbers artificially low.

Why the other choices are wrong

A. Administrative simplicity does not justify misclassifying a qualifying complaint.

B. Whether a caller asks for a supervisor is not the standard for grievance classification.

C. Call volume does not change the requirement to properly classify and process a qualifying complaint.

Applies to: Both
Source: https://www.cms.gov/medicare/appeals-grievances/managed-care
Verified: 2026-08-13

ANSWER 497 | T-497

Correct answer: A. Evaluate the substance of the request against the urgency standard, regardless of the specific wording used.

Explanation. Whether a request qualifies for expedited review turns on whether the facts meet the urgency standard, not on whether the member used a specific magic word, so the physician's documented risk should drive the evaluation.

Why the other choices are wrong

B. Denying based on missing terminology ignores the substantive urgency shown in the physician note.

C. Converting the request to a grievance does not address the coverage decision the member is appealing.

D. Requiring exact wording before reviewing the substance delays a request that already presents urgent facts.

Applies to: Both
Source: https://www.cms.gov/medicare/appeals-grievances/managed-care
Verified: 2026-08-13

ANSWER 498 | T-498

Correct answer: B. Apply the required expedited timeframe regardless of staffing and escalate the instruction if needed.

Explanation. The expedited appeal timeframe applies based on the urgency standard being met, not on staffing levels, so staff should continue applying it and raise concerns about the instruction rather than delaying qualifying reviews.

Why the other choices are wrong

A. Staffing pressure does not convert a required urgent timeframe into an optional guideline.

C. Time of day a request arrives is not a basis for whether the expedited timeframe applies.

D. Reclassifying overflow requests as grievances does not address the underlying coverage appeal.

Applies to: Both
Source: https://www.cms.gov/medicare/appeals-grievances/managed-care
Verified: 2026-08-13

ANSWER 499 | T-499

Correct answer: C. 1-C, 2-A, 3-B.

Explanation. A grievance matches description C as a service complaint, an organization determination matches description A as the plan's initial coverage decision, and an expedited appeal matches description B as the urgent-timeframe review. The correct pairing is 1-C, 2-A, 3-B.

Why the other choices are wrong

A. This pairing swaps the grievance and expedited-appeal descriptions incorrectly.

B. This pairing misassigns all three review types to the wrong descriptions.

D. This pairing incorrectly assigns the organization-determination description to the expedited appeal.

Applies to: Both
Source: https://www.cms.gov/medicare/appeals-grievances/managed-care
Verified: 2026-08-13

ANSWER 500 | T-500

Correct answer: D. False; a grievance and an appeal address different issues and neither is a prerequisite for the other.

Explanation. The statement is false. A grievance addresses service or conduct complaints, while an appeal challenges an adverse coverage or payment decision; a member does not need to file a grievance first in order to appeal a coverage denial.

Why the other choices are wrong

A. Grievances and appeals are not linked in a required sequential order.

B. Drug-related denials do not create an exception requiring a prior grievance.

C. Appeals are not limited to MA benefits only, and that is not why the statement is false.

Applies to: Both
Source: https://www.cms.gov/medicare/appeals-grievances/managed-care
Verified: 2026-08-13

Mock Exam 1 - 50 questions

50 answer entries. Match each entry to the question number and ID printed in Part I.

ANSWER 501 | M1-001

Correct answer: A. Formal patient status matters, and outpatient hospital services are generally handled under Part B.

Explanation. A person's location and length of stay do not by themselves establish an inpatient admission. Under Original Medicare, outpatient hospital and observation services are generally Part B matters, subject to coverage and status rules.

Why the other choices are wrong

B. Remaining overnight does not automatically change outpatient observation into formal inpatient status.

C. Part D addresses covered prescription drugs, not hospital patient classification.

D. Part C applies only to Medicare Advantage enrollees.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 502 | M1-002

Correct answer: B. Network and referral requirements may control whether the routine service is covered.

Explanation. HMO members generally use contracted providers for routine care and may need primary-care coordination or a referral. Emergency, urgently needed, and out-of-area dialysis protections are separate from a planned specialist visit.

Why the other choices are wrong

A. A scheduled routine consultation does not become an emergency to avoid HMO rules.

C. An HMO does not acquire a PPO benefit because a member chooses a non-network clinician.

D. Medicare participation alone does not supersede the private plan's network and referral terms.

Applies to: AHIP
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-02

ANSWER 503 | M1-003

Correct answer: C. Her Initial Coverage Election Period tied to entitlement to both Part A and Part B.

Explanation. The ICEP is the initial opportunity to elect Medicare Advantage when the individual first has both Part A and Part B. Its span depends on how the Part A and Part B effective dates align.

Why the other choices are wrong

A. The 5-star SEP depends on an available qualifying destination plan and is not the basic initial MA period.

B. The MA OEP serves eligible current MA enrollees.

D. Institutional rights require qualifying residence or discharge facts, not delayed Part B alone.

Applies to: AHIP
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-02

ANSWER 504 | M1-004

Correct answer: D. A quantity limit restricting the covered amount in a defined period.

Explanation. A quantity limit controls how much of a covered drug the plan will pay for over a stated interval. The beneficiary or prescriber may request an exception when a larger amount is medically necessary.

Why the other choices are wrong

A. The fact concerns the number of units, not whether the pharmacy participates.

B. Step therapy governs the order in which drugs must be tried.

C. A formulary exception seeks coverage for a drug absent from the plan's list.

Applies to: AHIP
Source: https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/plan-rules
Verified: 2026-08-02

ANSWER 505 | M1-005

Correct answer: A. The product scope should have been documented in writing before the in-person discussion.

Explanation. Current PY2027 guidance requires a written SOA before an in-person personal marketing appointment. Removal of the former waiting period did not eliminate the duty to define and document the agreed product categories.

Why the other choices are wrong

B. Post-enrollment documentation cannot establish the required pre-appointment scope.

C. Permission to Contact addresses outreach and is not blanket product authorization.

D. The scope requirement remains even though the timing rule changed.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 506 | M1-006

Correct answer: B. A call capturing the beneficiary's enrollment acknowledgments and election.

Explanation. CMS's training guidance includes marketing, sales, and enrollment calls in the recording obligation. A telephonic enrollment that captures required acknowledgments must therefore be recorded in its entirety.

Why the other choices are wrong

A. A neutral administrative call lacks marketing, sales, or enrollment content.

C. An internal meeting is not a beneficiary call within this mandate.

D. A refill reminder without plan content is not a Medicare plan marketing or enrollment interaction.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 507 | M1-007

Correct answer: C. Inefficient or excessive use of resources that creates unnecessary expense without clear fraudulent intent.

Explanation. Waste generally involves overuse or inefficient use of resources that causes unnecessary program cost without the knowing deception required for fraud. It can still require remediation even when intentional misconduct is not established.

Why the other choices are wrong

A. Knowing deception for unauthorized benefit describes fraud.

B. Conduct inconsistent with sound fiscal, business, or medical standards is the usual description of abuse.

D. An isolated clerical error is not automatically program waste.

Applies to: AHIP
Source: https://oig.hhs.gov/reports-and-publications/featured-topics/ihs/training/fraud-waste-and-abuse-for-health-care-providers/content/
Verified: 2026-08-02

ANSWER 508 | M1-008

Correct answer: D. A Part D coverage determination on the exception request.

Explanation. Requests to waive a Part D utilization-management rule are handled through the coverage-determination process. An adverse decision provides the notice needed to pursue the drug-plan appeal path.

Why the other choices are wrong

A. Organization determinations apply to Medicare Advantage medical benefits.

B. A grievance does not decide whether a drug rule will be waived.

C. A QIO addresses specified quality-of-care matters rather than an initial formulary-control exception.

Applies to: AHIP
Source: https://www.cms.gov/medicare/appeals-grievances/managed-care
Verified: 2026-08-02

ANSWER 509 | M1-009

Correct answer: A. Remove the health screening because it is inappropriate at a Medicare marketing event.

Explanation. CMS training identifies health screening at marketing events as inappropriate because it can be used to target or steer beneficiaries based on health status. The sales event should not include the proposed clinical screening.

Why the other choices are wrong

B. Selective sales attention based on the results intensifies the discriminatory concern.

C. Conditioning health information on enrollment creates an additional inducement problem.

D. A pharmacy counter is a patient-care area and is also unsuitable for plan marketing.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 510 | M1-010

Correct answer: B. Part A; Part B; Part D.

Explanation. Part A is principally associated with covered inpatient hospital care, Part B with physician and outpatient medical services, and Part D with covered outpatient prescription drugs.

Why the other choices are wrong

A. The first two parts are reversed and Part C is not the stand-alone outpatient drug benefit.

C. None of the three pairings matches the stated services.

D. Part C is an alternative private-plan route rather than the Original Medicare inpatient label, and the remaining parts are also mismatched.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 511 | M1-011

Correct answer: C. Whether the new plan availability gives Leon a move-related SEP.

Explanation. A relocation may create a Special Enrollment Period when the beneficiary gains different plan options at the new address, even if the current plan also serves that location. The agent must verify the move facts and the available destination plans.

Why the other choices are wrong

A. A move SEP is distinct from the MA OEP and does not authorize unlimited elections.

B. The current plan need not automatically end when the new address remains in its service area.

D. The destination still must serve the new residence.

Applies to: AHIP
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-02

ANSWER 512 | M1-012

Correct answer: D. Extra Help reduces qualifying Part D costs but does not by itself establish full Medicaid or D-SNP eligibility.

Explanation. Extra Help is the federal Part D low-income subsidy. A person may receive it without full-benefit Medicaid, so Medicaid category and any D-SNP qualification must be verified independently.

Why the other choices are wrong

A. Subsidy eligibility and full state Medicaid benefits are distinct determinations.

B. Extra Help does not compel enrollment in Medicare Advantage or a D-SNP.

C. The subsidy concerns Part D costs and is not a Medicare supplement policy.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 513 | M1-013

Correct answer: A. The account can help pay qualified expenses while the high-deductible plan has not begun paying covered medical claims.

Explanation. A Medicare MSA combines an account funded through the plan with a high-deductible health plan. Account money can pay qualified medical expenses before the deductible is met, but members must track uses because tax and deductible treatment can differ.

Why the other choices are wrong

B. An MSA does not include Part D; drug coverage may be obtained through a separate PDP.

C. Account use does not alter the plan's legal type.

D. Not every withdrawal necessarily counts toward the plan deductible, so recordkeeping and plan rules matter.

Applies to: AHIP
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-02

ANSWER 514 | M1-014

Correct answer: B. Invite the enrollee to share the agent's business card so interested friends can initiate contact.

Explanation. An agent may invite a current enrollee to pass along the agent's contact information. That approach lets the prospective beneficiary decide whether to initiate outreach and avoids treating a third party as authorized to provide consent.

Why the other choices are wrong

A. Collecting unrequested prospect data creates unsolicited-contact concerns.

C. Payment for personal data adds an improper referral incentive.

D. One person cannot execute another beneficiary's contact permission merely because they are friends.

Applies to: AHIP
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-02

ANSWER 515 | M1-015

Correct answer: C. A quality-of-care complaint to the applicable Quality Improvement Organization.

Explanation. A beneficiary may bring a quality-of-care complaint about Medicare-covered services to the applicable QIO. Any separate grievance, discharge, or coverage-review rights should also be preserved when relevant.

Why the other choices are wrong

A. A formulary exception concerns drug coverage, not hospital care quality.

B. An individual complaint does not directly rewrite a plan's official Star Rating.

D. Agent compensation has no connection to review of unsafe care.

Applies to: AHIP
Source: https://www.cms.gov/medicare/appeals-grievances/managed-care
Verified: 2026-08-02

ANSWER 516 | M1-016

Correct answer: D. The Summary of Benefits.

Explanation. The Summary of Benefits presents principal benefits and cost sharing in a concise form for comparison. The Evidence of Coverage contains the more detailed plan rules, exclusions, and member rights.

Why the other choices are wrong

A. The EOC is the comprehensive member document, not merely the high-level overview.

B. A Provider Directory is focused on network participation.

C. The formulary addresses covered drugs, tiers, and utilization indicators.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 517 | M1-017

Correct answer: A. The destination has Medicare's qualifying overall 5-star rating for the applicable year.

Explanation. The 5-star SEP permits a one-time move into an available plan with Medicare's qualifying overall 5-star rating during the applicable period. The destination's official rating and availability must be confirmed.

Why the other choices are wrong

B. The current plan's rating does not substitute for the destination's 5-star status.

C. Agent representation has no role in creating the SEP.

D. Premium rank is not the eligibility test for this election right.

Applies to: AHIP
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-02

ANSWER 518 | M1-018

Correct answer: B. In a permitted public lobby or cafeteria away from patient care.

Explanation. Marketing may occur in appropriate common areas of a health-care setting, subject to CMS and facility policies. Treatment rooms and other places where patients receive care are off limits for sales activity.

Why the other choices are wrong

A. An exam room is a patient-care area.

C. The dispensing counter is part of the pharmacy's patient-service area.

D. Approaching a patient during treatment violates the location restriction and undermines voluntary choice.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 519 | M1-019

Correct answer: C. No; the required express written consent must precede the inter-TPMO sharing.

Explanation. The consent must be obtained before personal beneficiary data is shared between TPMOs for marketing. A later signature cannot retroactively authorize the original disclosure, though valid prospective consent may govern later sharing.

Why the other choices are wrong

A. The recipients' business type does not eliminate prior-consent requirements.

B. A subsequent enrollment does not validate an earlier unauthorized transfer.

D. Sharing can occur when the specific prior written-consent safeguards are satisfied.

Applies to: AHIP
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-423/subpart-V
Verified: 2026-08-02

ANSWER 520 | M1-020

Correct answer: D. Statements I, II, and III.

Explanation. Statements I, II, and III correctly describe formulary, utilization-management, and transition protections. TrOOP follows defined beneficiary and qualifying third-party payments rather than every dollar paid by the drug plan.

Why the other choices are wrong

A. This choice omits the accurate step-therapy statement.

B. Statement IV is false because the plan's own payment does not automatically become beneficiary TrOOP.

C. Statement IV is false, and the option omits the accurate formulary and transition statements.

Applies to: AHIP
Source: https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/plan-rules
Verified: 2026-08-02

ANSWER 521 | M1-021

Correct answer: A. Emergency coverage protections apply without the HMO's ordinary routine-care network process.

Explanation. Medicare Advantage plans must cover emergency services under applicable rules. An HMO's routine network and referral arrangements cannot be applied as though an unexpected emergency were a planned office visit.

Why the other choices are wrong

B. Delaying urgent treatment to travel home conflicts with the emergency protection.

C. The member does not need to change plan types before receiving emergency care.

D. Part D concerns covered outpatient drugs, not an emergency hospital evaluation.

Applies to: AHIP
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-02

ANSWER 522 | M1-022

Correct answer: B. COBRA is not current-employment coverage and generally does not extend the Part B SEP clock.

Explanation. The Part B Special Enrollment Period is tied to current employment or group coverage based on that employment. COBRA continuation after the job ends does not postpone the clock in the same way.

Why the other choices are wrong

A. COBRA does not create the described enrollment period.

C. An MA form does not enroll someone in Part B.

D. Continuation or retiree coverage cannot support an indefinite delay without enrollment consequences.

Applies to: AHIP
Source: https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start
Verified: 2026-08-02

ANSWER 523 | M1-023

Correct answer: C. A tiering exception, subject to the plan's eligibility limits.

Explanation. A tiering exception asks a Part D plan to apply lower cost sharing to an eligible higher-tier drug when the medical support is sufficient. Limits apply, including special rules for specialty tiers.

Why the other choices are wrong

A. A transition supply is temporary access and does not remove a covered drug from the list.

B. Store hours do not decide the requested drug cost-sharing level.

D. Organization determinations concern Part C medical benefits, not Part D tiers.

Applies to: AHIP
Source: https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/plan-rules
Verified: 2026-08-02

ANSWER 524 | M1-024

Correct answer: D. State clearly that education is ending and allow enough time for attendees to exit.

Explanation. Back-to-back sessions at the same location are permissible when the organizer provides a clear transition notice and a meaningful opportunity to leave before plan marketing begins. The old waiting interval is no longer the controlling safeguard.

Why the other choices are wrong

A. Concealing the shift defeats the required notice.

B. Preventing departure eliminates voluntary participation.

C. Enrollment activity belongs to the marketing event and cannot precede the transition.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 525 | M1-025

Correct answer: A. Use a secure process that makes the protected information unreadable and unrecoverable.

Explanation. Once all retention and legal-hold duties are satisfied, sensitive records should be destroyed through approved methods that prevent reconstruction or recovery. The organization's privacy and security procedures govern the process.

Why the other choices are wrong

B. Public disposal exposes readable beneficiary information.

C. Personal-device copying creates a new unauthorized data store.

D. An unapproved vendor and missing safeguards do not provide secure disposal.

Applies to: AHIP
Source: https://www.hhs.gov/hipaa/for-professionals/privacy/index.html
Verified: 2026-08-02

ANSWER 526 | M1-026

Correct answer: B. Whether that PFFS plan actually uses contracted providers and how its payment terms operate.

Explanation. Some PFFS plans use contracted networks, while others rely on providers accepting the plan's terms. The actual plan documents and provider arrangements must be reviewed rather than applying a universal network-free label.

Why the other choices are wrong

A. Prior Medigap coverage does not determine the PFFS provider structure.

C. HMO referral rules do not establish this plan's arrangements.

D. A medical savings account is a feature of an MSA, not a PFFS network test.

Applies to: AHIP
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-02

ANSWER 527 | M1-027

Correct answer: C. The member permanently moves outside the plan's service area.

Explanation. Permanent residence outside the service area is a defined reason enrollment may have to end. The plan must follow CMS's involuntary-disenrollment notice and effective-date procedures while the member receives a replacement-coverage opportunity.

Why the other choices are wrong

A. Asking questions is not an eligibility loss.

B. Agent preference has no authority over plan enrollment.

D. A network change can create protections or other options but does not by itself mean the member no longer resides in the service area.

Applies to: AHIP
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-02

ANSWER 528 | M1-028

Correct answer: D. A compliant piece of postal direct mail.

Explanation. Direct mail is a permitted Medicare marketing channel when its content and presentation satisfy CMS rules. The material must not mislead recipients about government affiliation or plan terms.

Why the other choices are wrong

A. Door-to-door solicitation without a beneficiary request is prohibited direct contact.

B. Ringless delivery does not remove the unsolicited voicemail restriction.

C. Purchasing the number does not create consent for a sales text.

Applies to: AHIP
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-02

ANSWER 529 | M1-029

Correct answer: A. Refuse the direction because enrollment may not discriminate based on expected health costs.

Explanation. Eligible beneficiaries cannot be discouraged from MA or Part D enrollment because of health status or anticipated utilization. Agents must apply plan eligibility and suitability rules consistently rather than serving a risk-selection objective.

Why the other choices are wrong

B. Prescription count does not authorize discriminatory steering.

C. Nondiscrimination applies regardless of the election period.

D. Service-area eligibility depends on residence, not expected medical expense.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 530 | M1-030

Correct answer: B. True; the issue concerns service rather than an adverse coverage determination.

Explanation. The statement is true. A grievance addresses dissatisfaction with plan operations, conduct, or service when the member is not seeking reconsideration of a coverage or payment decision.

Why the other choices are wrong

A. Appeals address adverse benefit determinations, and expedition requires an urgent health-risk standard.

C. Members have complaint rights without waiting for an election period.

D. A grievance does not automatically overturn separate coverage decisions.

Applies to: AHIP
Source: https://www.cms.gov/medicare/appeals-grievances/managed-care
Verified: 2026-08-02

ANSWER 531 | M1-031

Correct answer: C. The six-month federal open-enrollment period begins with the first month he is both sixty-five or older and enrolled in Part B.

Explanation. Federal Medigap open enrollment is a one-time six-month period tied to being age 65 or older and enrolled in Part B. State law may create additional rights, so location-specific protections should also be checked.

Why the other choices are wrong

A. The federal open-enrollment rule is not conditioned on a prior year in MA.

B. The timing arises from federal protection rather than insurer discretion.

D. Medicare's fall AEP governs MA and Part D elections, not a recurring Medigap open enrollment.

Applies to: AHIP
Source: https://www.medicare.gov/health-drug-plans/medigap/basics/how-medigap-works
Verified: 2026-08-02

ANSWER 532 | M1-032

Correct answer: D. The plan must apply its published SSBCI criteria, so the agent should explain the process without promising approval.

Explanation. Eligibility for a chronically ill supplemental benefit is administered by the plan under its approved, publicly available criteria. A salesperson can describe those rules accurately but cannot issue or promise the plan's determination.

Why the other choices are wrong

A. A diagnosis alone may not satisfy the plan's specific eligibility standard.

B. Affordability and agent judgment do not confer plan-administration authority.

C. A benefit card does not create universal eligibility or unrestricted cash value.

Applies to: AHIP
Source: https://www.cms.gov/newsroom/fact-sheets/contract-year-2027-medicare-advantage-part-d-final-rule
Verified: 2026-08-02

ANSWER 533 | M1-033

Correct answer: A. Route the cancellation through the plan's approved process and document the request.

Explanation. A beneficiary may cancel a pending enrollment when the request is made within the applicable timing and procedures. The agent should transmit it promptly and preserve evidence rather than improvising another election.

Why the other choices are wrong

B. Pending elections can be canceled under defined rules before effectiveness.

C. Deliberate nonpayment is not an appropriate cancellation mechanism and can cause harmful consequences.

D. A new application still requires valid timing and may create unintended coverage changes.

Applies to: AHIP
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-02

ANSWER 534 | M1-034

Correct answer: B. Replace the meal with permissible light refreshments that are not tied to enrollment.

Explanation. Meals may not be provided at Medicare marketing or sales events. Modest snacks and refreshments may be permissible if they do not amount to a meal and are not conditioned on enrollment.

Why the other choices are wrong

A. Conditioning the meal on an application adds an enrollment inducement.

C. Patient-care areas are prohibited sales locations.

D. Cash is not a permissible substitute and creates an even clearer inducement problem.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 535 | M1-035

Correct answer: C. After a continuous gap of at least sixty-three days without Part D or other creditable drug coverage, absent an exception.

Explanation. A beneficiary may face the Part D late-enrollment penalty after going 63 or more consecutive days without Part D or other creditable prescription coverage once the initial period is over. Documented continuous creditable coverage prevents a plan switch alone from creating the penalty.

Why the other choices are wrong

A. A valid switch with continuous qualifying drug coverage does not itself create a gap.

B. Formulary tier changes concern cost sharing, not enrollment lateness.

D. Pharmacy choice does not determine whether the beneficiary maintained creditable coverage.

Applies to: AHIP
Source: https://www.medicare.gov/health-drug-plans/part-d/basics/costs
Verified: 2026-08-02

ANSWER 536 | M1-036

Correct answer: D. The required organization and product counts plus Medicare's independent information resources.

Explanation. The current disclaimer explains the number of organizations represented and products offered and retains directions to Medicare.gov and 1-800-MEDICARE. It must be delivered before the plan-benefit conversation.

Why the other choices are wrong

A. The disclaimer is designed to disclose limited representation accurately, not make a universal claim.

B. Other clients' identities are irrelevant and protected.

C. The required language directs beneficiaries to Medicare resources rather than denying their availability.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 537 | M1-037

Correct answer: A. A secret payment offered to induce referrals of federally reimbursed health-care business.

Explanation. The Anti-Kickback Statute prohibits knowingly and willfully offering, paying, soliciting, or receiving remuneration to induce or reward federal health-program referrals, subject to applicable exceptions and safe harbors.

Why the other choices are wrong

B. Legitimate compensation may be structured lawfully and is not inherently a kickback.

C. A member complaint is unrelated to referral remuneration.

D. Correcting an unintentional clerical mistake does not describe an inducement scheme.

Applies to: AHIP
Source: https://oig.hhs.gov/reports-and-publications/featured-topics/ihs/training/fraud-waste-and-abuse-for-health-care-providers/content/
Verified: 2026-08-02

ANSWER 538 | M1-038

Correct answer: B. Pause and ensure the beneficiary provides the required acknowledgment and consent through the approved mechanism.

Explanation. The enrollment mechanism must capture the beneficiary's own acknowledgment and consent to required elements. The agent can explain the questions and assist but cannot supply the beneficiary's agreement.

Why the other choices are wrong

A. Efficiency does not authorize fabricated consent.

C. Signing another person's name misrepresents who made the election.

D. Consent must be part of the valid enrollment request rather than added after effectiveness.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 539 | M1-039

Correct answer: C. Remove or substantiate the comparison with accurate current data and clear context.

Explanation. Plan comparisons and quality claims must be accurate, supportable, and tied to the relevant measure and period. An unqualified highest-rated assertion is misleading when the factual basis is not identified.

Why the other choices are wrong

A. Marketing claims remain subject to accuracy requirements.

B. A government seal would create an additional false-affiliation concern.

D. Personal opinion without current supporting evidence is not a valid substitute for official quality data.

Applies to: AHIP
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-02

ANSWER 540 | M1-040

Correct answer: D. MA Open Enrollment Period; institutional SEP; Annual Election Period.

Explanation. The existing MA member's February change uses MA OEP, the qualifying facility resident uses the institutional SEP, and the regular November election for the next plan year uses AEP.

Why the other choices are wrong

A. AEP does not match the February MA-specific fact, and the other labels also miss the circumstances.

B. The first two opportunities are reversed, and the last scenario does not depend on a 5-star plan.

C. ICEP concerns initial MA eligibility, while the remaining labels are likewise misplaced.

Applies to: AHIP
Source: https://www.medicare.gov/publications/11219-Understanding-Medicare-Advantage-Medicare-Drug-Plan-Enrollment-Periods.pdf
Verified: 2026-08-02

ANSWER 541 | M1-041

Correct answer: A. An Employer Group Waiver Plan sponsored through the employer or union arrangement.

Explanation. An EGWP is employer- or union-sponsored Medicare coverage for eligible group members. Its benefits and enrollment administration may differ from products available to individuals in the retail market.

Why the other choices are wrong

B. Medigap supplements Original Medicare and is not the employer's group MA category.

C. An MSA is a Medicare Advantage plan type and is not defined by former-physician sponsorship.

D. PACE has specific geographic and care-need eligibility criteria.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 542 | M1-042

Correct answer: B. No; C-SNP eligibility rests on a qualifying condition confirmed through the plan's process.

Explanation. C-SNPs serve people with specified severe or disabling chronic conditions and use a plan verification process. Medicaid status defines D-SNP eligibility, not every type of Special Needs Plan.

Why the other choices are wrong

A. The SNP categories have different qualifying criteria.

C. MSA enrollment is unrelated to confirming C-SNP status and ordinarily would be incompatible with a second MA plan.

D. The beneficiary must still satisfy the underlying Medicare Advantage and service-area requirements.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 543 | M1-043

Correct answer: C. The SEP for members of consistently low-performing plans.

Explanation. CMS provides a special election opportunity for beneficiaries enrolled in plans officially identified as consistently low performing. The plan's official status, destination availability, and the SEP's usage rules must be verified.

Why the other choices are wrong

A. A replacement plan must still serve the member's residence.

B. The SEP is not an unrestricted license for repeated elections.

D. Star performance does not create Medigap open enrollment.

Applies to: AHIP
Source: https://www.medicare.gov/publications/11219-Understanding-Medicare-Advantage-Medicare-Drug-Plan-Enrollment-Periods.pdf
Verified: 2026-08-02

ANSWER 544 | M1-044

Correct answer: D. The payment plan smooths timing, while Extra Help may actually reduce qualifying Part D costs.

Explanation. The Medicare Prescription Payment Plan can improve cash flow by spreading member cost sharing over the plan year, but it does not lower total liability. Extra Help is a subsidy that can reduce premiums, deductibles, and prescription cost sharing for eligible beneficiaries.

Why the other choices are wrong

A. The two programs have materially different effects on total cost.

B. Participation does not eliminate the need to assess subsidy eligibility.

C. The roles are reversed; the payment plan spreads payments, while Extra Help can reduce costs.

Applies to: AHIP
Source: https://www.cms.gov/files/document/2027-announcement.pdf
Verified: 2026-08-02

ANSWER 545 | M1-045

Correct answer: A. Teaching general Parts A through D concepts without naming plan benefits or collecting enrollment requests.

Explanation. An educational event provides objective, general Medicare information and avoids plan-specific promotion or enrollment activity. Carrier comparisons and application handling belong to regulated marketing contexts and must follow their own timing rules.

Why the other choices are wrong

B. Named benefit comparisons and applications are sales-event activities.

C. Cash tied to enrollment is an impermissible inducement.

D. Completed AEP requests cannot be solicited or possessed before the election period opens.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 546 | M1-046

Correct answer: B. The sponsor retains oversight duties throughout the delegated chain.

Explanation. Sponsors remain responsible for oversight of first-tier, downstream, related, and TPMO functions performed on their behalf. Contracts and delegation create monitoring obligations rather than eliminating accountability.

Why the other choices are wrong

A. Delegation does not extinguish the sponsor's Medicare-contract responsibilities.

C. Beneficiaries do not inherit sponsor compliance duties.

D. Regulatory status follows the functions and relationships, not the vendor's chosen label.

Applies to: AHIP
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-423/subpart-V
Verified: 2026-08-02

ANSWER 547 | M1-047

Correct answer: C. Knowingly causing false records to support claims for federal payment.

Explanation. The False Claims Act creates liability for knowingly submitting or causing false claims, including conduct involving false records material to federal payment. Its knowledge standard can reach more than direct personal submission.

Why the other choices are wrong

A. A promptly corrected accidental error lacks the described knowing conduct.

B. A service grievance is unrelated to a false federal payment claim.

D. A good-faith plan comparison is an ordinary suitability step.

Applies to: AHIP
Source: https://oig.hhs.gov/reports-and-publications/featured-topics/ihs/training/fraud-waste-and-abuse-for-health-care-providers/content/
Verified: 2026-08-02

ANSWER 548 | M1-048

Correct answer: D. Provide accurate notice of the applicable appeal path and review rights.

Explanation. MA and Part D members have rights to challenge adverse organization and coverage determinations. Required notices must explain how and when to seek the applicable standard or expedited review.

Why the other choices are wrong

A. Appeal rights belong to the beneficiary, though representatives may assist when authorized.

B. Election timing is not a substitute for review of a current denial.

C. A grievance addresses service complaints and does not replace a benefit appeal.

Applies to: AHIP
Source: https://www.cms.gov/medicare/appeals-grievances/managed-care
Verified: 2026-08-02

ANSWER 549 | M1-049

Correct answer: A. Remove the agent-initiated non-health cross-sale from the Medicare appointment.

Explanation. Medicare marketing appointments cannot be used as blanket opportunities to cross-sell unrequested non-health products. A distinct beneficiary-initiated and otherwise compliant interaction is needed for the unrelated product.

Why the other choices are wrong

B. The SOA documents defined product categories and is not unlimited consent.

C. Preventing questions does not cure the scope and cross-selling violation.

D. Combining unrelated coverage on the Medicare enrollment form would misrepresent the form and the products.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

ANSWER 550 | M1-050

Correct answer: B. I, II, and III are accurate.

Explanation. Statements I, II, and III accurately describe a core Medicare benefit, an HMO characteristic, and the usual AEP effective date. Permission to Contact and the SOA serve separate compliance functions.

Why the other choices are wrong

A. Statement IV is false, and the choice omits accurate Statements II and III.

C. Statement IV is false, while Statements I and III are also accurate.

D. Statement IV remains false, and the option omits the accurate HMO statement.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-02

Mock Exam 2 - 50 questions

50 answer entries. Match each entry to the question number and ID printed in Part I.

ANSWER 551 | M2-001

Correct answer: A. Whether his work history meets the threshold for premium-free Part A.

Explanation. Premium-free Part A generally depends on having enough Medicare-covered work history, so an agent should verify that threshold before addressing Wendell's premium status rather than looking at unrelated products.

Why the other choices are wrong

B. A Medigap policy supplements Original Medicare and does not determine Part A premium status.

C. A stand-alone PDP addresses Part D drug coverage and has no bearing on the Part A premium question.

D. An MA plan's premium is separate from whether Wendell owes a Part A premium under Original Medicare.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 552 | M2-002

Correct answer: B. Part B generally covers medically necessary outpatient laboratory services.

Explanation. Outpatient clinical laboratory testing ordered by a physician is generally a Part B service regardless of where the sample happens to be collected; the setting alone does not convert it into a Part A inpatient benefit.

Why the other choices are wrong

A. Sample collection location does not itself create Part A inpatient coverage.

C. Part C only applies to a Medicare Advantage enrollee, and Bridget has not joined one.

D. Part D concerns outpatient prescription drugs, not laboratory testing.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 553 | M2-003

Correct answer: C. Part A generally covers the covered inpatient hospital stay.

Explanation. Formal inpatient hospital admission is the core Part A benefit category; Part B instead addresses physician and outpatient medical services rendered during or apart from that stay.

Why the other choices are wrong

A. Part B generally addresses physician and outpatient services rather than the facility's inpatient charges.

B. Administering drugs during a covered stay does not shift the inpatient benefit to Part D.

D. Part C applies only to a beneficiary enrolled in Medicare Advantage.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 554 | M2-004

Correct answer: D. Joining Medicare Advantage keeps his underlying Part A and Part B entitlement while changing how benefits are delivered.

Explanation. Medicare Advantage is a private-plan delivery route for Medicare benefits; a beneficiary who elects it remains entitled to Parts A and B even though the plan, not Original Medicare, administers the covered services.

Why the other choices are wrong

A. Underlying entitlement continues under MA rather than ending.

B. An MA election has no bearing on Social Security retirement benefit status.

C. MA does not selectively cancel one part while leaving the other intact.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 555 | M2-005

Correct answer: B. The plan's Provider Directory.

Explanation. A Provider Directory lists the clinicians and facilities participating in a plan's network, which is the specific fact needed to confirm current specialist participation.

Why the other choices are wrong

A. The Evidence of Coverage sets out full contract terms rather than a current provider roster.

C. A formulary addresses covered drugs, not physician participation.

D. The Summary of Benefits is a concise cost overview and does not list network clinicians.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 556 | M2-006

Correct answer: C. Part C is a private-plan alternative through which a beneficiary can receive Medicare benefits.

Explanation. Part C, Medicare Advantage, is the private-plan route through which an eligible beneficiary can receive Medicare Part A and Part B benefits, often bundled with Part D and supplemental benefits.

Why the other choices are wrong

A. A supplemental Medigap policy is distinct from Part C and pairs with Original Medicare rather than replacing it.

B. A stand-alone drug plan is a PDP, not Part C.

D. Part C is a coverage delivery route, not a cash subsidy program.

Applies to: AHIP
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 557 | M2-007

Correct answer: A. The entitlement record maintained under the official Medicare enrollment process.

Explanation. A beneficiary's Medicare entitlement date is established through the official enrollment and entitlement record, not through an agent's calendar, an employer's internal paperwork, or a pharmacy transaction.

Why the other choices are wrong

B. An agent's appointment date does not create or move an entitlement date.

C. Employer records may inform timing but do not themselves set the federal entitlement date.

D. A pharmacy fill has no role in establishing Medicare entitlement.

Applies to: AHIP
Source: https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start
Verified: 2026-08-13

ANSWER 558 | M2-008

Correct answer: D. Confirm actual Part B enrollment before representing the application as eligible for Medicare Advantage.

Explanation. MA eligibility generally requires actual, not assumed, enrollment in both Part A and Part B; the agent must verify Part B status before treating the application as a valid MA election rather than relying on an unconfirmed assumption.

Why the other choices are wrong

A. Submitting first and resolving eligibility later exposes the beneficiary to an invalid enrollment.

B. Part B is a required element for MA eligibility, not an optional one.

C. An agent cannot direct Social Security to create enrollment through a plan-application note.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 559 | M2-009

Correct answer: A. Part A; Part B; Part D.

Explanation. A scheduled inpatient surgery is principally a Part A hospital benefit, a routine physician office visit is principally a Part B service, and a retail prescription refill is principally a Part D benefit.

Why the other choices are wrong

B. The first two parts are reversed, and Part C is not a stand-alone drug label.

C. None of these three pairings matches the described services.

D. Part C is a private delivery route rather than the inpatient-surgery label, and the remaining pairings are also mismatched.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 560 | M2-010

Correct answer: B. Routine access to a non-network cardiologist may be limited absent an applicable referral or exception.

Explanation. HMO members generally rely on the plan's network for routine specialty care, and access to a non-participating clinician can be limited unless a referral, exception, or specific protection applies.

Why the other choices are wrong

A. A routine referral request is not transformed into emergency care by network limits.

C. Choosing a non-network specialist does not change the HMO into a PPO.

D. Enrollment in Medicare Advantage generally supersedes Original Medicare's rules for how the member obtains routine care.

Applies to: AHIP
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 561 | M2-011

Correct answer: C. Confirm whether an alternative provider willing to accept the plan's terms is available.

Explanation. When a provider will not accept a PFFS plan's payment terms for a particular service, the practical response is to confirm whether another willing provider is available, since Medicare participation alone does not obligate a clinician to accept every PFFS arrangement.

Why the other choices are wrong

A. Medicare participation does not obligate acceptance of a specific PFFS plan's payment terms.

B. A grievance addresses plan service issues and cannot force an independent provider's participation decision.

D. A single provider's refusal does not establish that the plan itself lacks a valid Medicare contract.

Applies to: AHIP
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 562 | M2-012

Correct answer: D. Continued D-SNP eligibility depends on maintaining the plan's required dual-eligibility status, subject to any applicable grace period.

Explanation. D-SNP enrollment is tied to a qualifying Medicaid category, so losing that status raises a continued-eligibility question that should be reviewed under the plan's and CMS's applicable rules, including any grace period.

Why the other choices are wrong

A. Dual status is the defining eligibility criterion for a D-SNP.

B. A plan's SNP type is not automatically converted by a change in Medicaid status.

C. Losing Medicaid does not itself end federal Medicare Part A and Part B entitlement.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 563 | M2-013

Correct answer: A. A PFFS plan structured without a primary care referral requirement.

Explanation. A PFFS plan is generally structured so members are not required to select a primary care physician or obtain routine referrals, though provider acceptance of the plan's payment terms still matters.

Why the other choices are wrong

B. An HMO's structure typically relies on primary care coordination for routine referrals, which is what Desmond wants to avoid.

C. A D-SNP's defining feature is dual-eligibility status, not this network structure.

D. An I-SNP is defined by institutional or institutional-equivalent care needs, not the described flexibility.

Applies to: AHIP
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 564 | M2-014

Correct answer: B. An MA-PD combines Medicare Advantage medical benefits with embedded Part D coverage, while a stand-alone PDP provides only drug coverage.

Explanation. An MA-PD bundles Medicare Advantage medical coverage with Part D drug coverage in a single plan, while a stand-alone PDP supplies only prescription-drug coverage for use alongside Original Medicare.

Why the other choices are wrong

A. An MA-PD includes medical benefits, and a PDP does not cover Part A or Part B services.

C. MA-PD eligibility is not limited to dual-eligible beneficiaries.

D. The two plan types have distinct structures and are not interchangeable labels.

Applies to: AHIP
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 565 | M2-015

Correct answer: C. Whether the plan's approved service area is a local configuration or a CMS-defined region.

Explanation. The distinction between local and regional PPOs concerns the plan's approved geographic service-area configuration, with regional plans following CMS's region-specific rules.

Why the other choices are wrong

A. Both local and regional PPOs characteristically include some out-of-network benefit.

B. MA eligibility generally still requires Part A and Part B regardless of PPO type.

D. Local and regional status does not determine special-needs plan classification.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 566 | M2-016

Correct answer: D. Confirm the qualifying condition through the plan's required verification process before treating the enrollment as valid.

Explanation. C-SNP eligibility depends on a condition confirmed through the plan's required verification process, not an agent's informal impression; the file must be corrected to reflect a documented, plan-verified determination.

Why the other choices are wrong

A. A visual impression does not satisfy the plan's required clinical verification.

B. D-SNP eligibility depends on Medicaid status, which is a separate and unaddressed question here.

C. A personal guarantee from the agent cannot substitute for the plan's verification process.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 567 | M2-017

Correct answer: A. False; an HMO's non-network coverage is generally more limited than a PPO's out-of-network benefit.

Explanation. The statement is false. HMOs generally rely on network care for routine services, with any non-network access more limited than the broader out-of-network benefit that characterizes a PPO structure.

Why the other choices are wrong

B. CMS does not require identical out-of-network coverage across HMO and PPO structures.

C. HMOs are still subject to required emergency and urgently needed care protections.

D. A point-of-service feature is not automatically included in every HMO.

Applies to: AHIP
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 568 | M2-018

Correct answer: B. Whether the destination plan currently holds Medicare's qualifying overall 5-star rating and the SEP remains available.

Explanation. The 5-star SEP allows an eligible beneficiary to move into an available plan carrying Medicare's qualifying overall 5-star rating for the applicable period; the destination's official rating and the SEP's availability must both be verified before advising a mid-year switch.

Why the other choices are wrong

A. A lower current rating does not disqualify the beneficiary from every other election opportunity.

C. The 5-star SEP exists specifically to permit action outside the ordinary AEP timing.

D. The 5-star election does not require dropping Part B.

Applies to: AHIP
Source: https://www.medicare.gov/publications/11219-Understanding-Medicare-Advantage-Medicare-Drug-Plan-Enrollment-Periods.pdf
Verified: 2026-08-13

ANSWER 569 | M2-019

Correct answer: C. Whether the loss of that group coverage creates a time-limited Part D Special Enrollment Period.

Explanation. Involuntary loss of employer or union group coverage can create a Part D Special Enrollment Period with a defined timeframe, allowing Paulina to enroll without waiting for the fall AEP.

Why the other choices are wrong

A. A qualifying SEP is designed precisely to avoid forcing a wait until AEP.

B. Medicaid status is not a precondition for this particular loss-of-coverage SEP.

D. An employer does not directly enroll a former dependent in a Part D plan.

Applies to: AHIP
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-13

ANSWER 570 | M2-020

Correct answer: A. It should not be represented as a valid election unless an applicable enrollment period is established.

Explanation. A completed SOA and application do not by themselves create authority to enroll; the beneficiary's request must fall within AEP, an initial period, MA OEP if eligible, or a documented SEP before it can be treated as a valid election.

Why the other choices are wrong

B. Completeness in June does not convert the request into a fall AEP election.

C. A properly documented SOA addresses appointment scope, not election-period eligibility.

D. Institutional election rights depend on actual qualifying residence, not an assumption.

Applies to: AHIP
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-13

ANSWER 571 | M2-021

Correct answer: B. It may begin before the move month when advance notice is properly provided.

Explanation. A permanent move outside the current plan's service area can create a Special Enrollment Period, and advance notice of a planned move may allow the election opportunity to begin before the move actually occurs.

Why the other choices are wrong

A. Advance notice can move the starting point earlier rather than requiring the move to be already complete.

C. A qualifying move SEP applies to MA and Part D elections, not solely to Part D.

D. The move SEP is a distinct opportunity from Gideon's original ICEP.

Applies to: AHIP
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-13

ANSWER 572 | M2-022

Correct answer: C. A nonrenewal generally creates a special election window for choosing replacement coverage sooner.

Explanation. When a plan's contract is not being renewed, CMS rules generally provide affected members a special opportunity to select replacement coverage rather than requiring them to wait for the next AEP.

Why the other choices are wrong

A. A nonrenewal specifically creates its own election opportunity separate from AEP.

B. No default assignment to the lowest-premium plan occurs automatically.

D. A terminated contract cannot be kept active indefinitely by an individual member's request.

Applies to: AHIP
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-13

ANSWER 573 | M2-023

Correct answer: D. Whether the beneficiary is currently enrolled in Medicare Advantage.

Explanation. The MA OEP is available only to beneficiaries who are already enrolled in Medicare Advantage during the applicable period; current enrollment status is the threshold fact for using it.

Why the other choices are wrong

A. Prior Medigap ownership does not determine MA OEP eligibility.

B. Extra Help income status is unrelated to this particular election period.

C. Prescriber network participation does not control eligibility for the MA OEP.

Applies to: AHIP
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-13

ANSWER 574 | M2-024

Correct answer: A. The ICEP is tied to a beneficiary's first entitlement to both Part A and Part B, while AEP recurs each fall for all eligible beneficiaries.

Explanation. The ICEP is the beneficiary's initial opportunity to elect Medicare Advantage tied to first having both Part A and Part B, while AEP is a recurring fall period open to eligible beneficiaries generally.

Why the other choices are wrong

B. The timing described is reversed; AEP is the recurring fall period.

C. The ICEP applies to a person entering MA for the first time, not only to current MA members.

D. The two periods serve different purposes and are not interchangeable.

Applies to: AHIP
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-13

ANSWER 575 | M2-025

Correct answer: B. A qualifying declared emergency prevented use of another valid election opportunity.

Explanation. Disaster and emergency relief is intended for a beneficiary who had another valid election opportunity but could not use it because of a qualifying declared event affecting them specifically.

Why the other choices are wrong

A. A preference following a premium change is not a disaster-related inability to elect.

C. An agent's ordinary administrative lapse is not automatically a qualifying emergency.

D. The event must affect the beneficiary under applicable criteria, not an unrelated region.

Applies to: AHIP
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-13

ANSWER 576 | M2-026

Correct answer: C. Treat the altered date as a documentation integrity violation and investigate the actual election timing.

Explanation. Altering a signature date to misrepresent when an election was actually made is a documentation integrity problem that must be investigated, regardless of what the beneficiary ultimately wanted, and cannot be resolved by compounding the false record.

Why the other choices are wrong

A. Beneficiary intent does not excuse falsifying the actual election date.

B. Passing along a known discrepancy without action fails the required review.

D. Asking for a second falsified signature would compound rather than correct the violation.

Applies to: AHIP
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-13

ANSWER 577 | M2-027

Correct answer: D. Statements I, II, and IV.

Explanation. Statements I, II, and IV are accurate descriptions of the MA OEP's limited eligibility, the move-related SEP, and the usual AEP effective date. Statement III is false because completeness alone does not create a valid election outside an applicable enrollment period.

Why the other choices are wrong

A. Statement III is false, and this choice omits the accurate Statement II.

B. Statement III is false, and this choice omits Statements I and IV.

C. Statement III is false and should not be included.

Applies to: AHIP
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-13

ANSWER 578 | M2-028

Correct answer: A. A step-therapy exception request supported by the prescriber's medical statement.

Explanation. When a step-therapy sequence is medically unsuitable, the beneficiary or prescriber may request an exception to that utilization rule, supported by a medical statement explaining why the required drugs are inappropriate.

Why the other choices are wrong

B. A grievance addresses service dissatisfaction rather than a drug-coverage rule.

C. Organization determinations are Medicare Advantage medical-benefit decisions, not Part D drug exceptions.

D. A pharmacy cannot rewrite the plan's formulary.

Applies to: AHIP
Source: https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/plan-rules
Verified: 2026-08-13

ANSWER 579 | M2-029

Correct answer: B. Her qualifying deductible and coinsurance payments generally count, while the plan's own payment generally does not.

Explanation. TrOOP includes defined out-of-pocket amounts paid by or on behalf of the beneficiary for covered Part D drugs, such as qualifying deductible and coinsurance payments, while the plan's own payment generally does not count as her personal TrOOP.

Why the other choices are wrong

A. The plan-funded share of the price is not simply added to her personal TrOOP.

C. TrOOP is a Part D accounting concept and does not apply to Part B.

D. Changing pharmacies does not reset her accumulated TrOOP total.

Applies to: AHIP
Source: https://www.cms.gov/files/document/2027-announcement.pdf
Verified: 2026-08-13

ANSWER 580 | M2-030

Correct answer: C. A transition supply under the plan's required transition policy.

Explanation. Part D transition policies can provide a temporary supply for a new member taking a non-formulary drug, allowing time for a safe medication change or completion of a formal exception request.

Why the other choices are wrong

A. A pharmacy cannot permanently reassign a drug's tier.

B. A formulary exception still requires the plan's coverage-determination process rather than occurring automatically.

D. A retail prescription problem does not convert the drug into a Part B benefit.

Applies to: AHIP
Source: https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/plan-rules
Verified: 2026-08-13

ANSWER 581 | M2-031

Correct answer: D. The beneficiary owes no cost sharing for covered Part D drugs in catastrophic coverage.

Explanation. Under the current redesigned CY2027 benefit, once a beneficiary's qualifying TrOOP reaches the annual threshold and catastrophic coverage begins, the beneficiary owes no cost sharing for covered Part D drugs for the remainder of the year.

Why the other choices are wrong

A. Cost sharing does not increase at this stage; it is eliminated for covered drugs.

B. The former coverage-gap phase has been eliminated from the current standard benefit.

C. The beneficiary is not required to pay the full negotiated price once catastrophic coverage applies.

Applies to: AHIP
Source: https://www.cms.gov/files/document/2027-announcement.pdf
Verified: 2026-08-13

ANSWER 582 | M2-032

Correct answer: A. A formulary exception requests coverage of a drug not on the list, while a tiering exception requests lower cost sharing for an eligible covered drug on a higher tier.

Explanation. A formulary exception seeks coverage for a drug the plan does not list at all, while a tiering exception asks the plan to apply a lower cost-sharing tier to an eligible drug that is already covered at a higher tier.

Why the other choices are wrong

B. The described effects are reversed between the two request types.

C. The two exception types address different aspects of Part D coverage and are not identical.

D. Both request types concern Part D drug coverage, not Part B.

Applies to: AHIP
Source: https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/plan-rules
Verified: 2026-08-13

ANSWER 583 | M2-033

Correct answer: B. State accurately that the program spreads cost-sharing payments over the year without reducing the total amount owed.

Explanation. The Medicare Prescription Payment Plan changes the timing of a beneficiary's Part D cost-sharing payments across the remaining plan year; it is not a subsidy and does not reduce the underlying total amount owed, so the sheet must be corrected to reflect that.

Why the other choices are wrong

A. The claim that total spending is reduced misstates the program's actual effect.

C. Participation does not prevent a beneficiary from reaching the deductible phase.

D. TrOOP accounting continues to apply to participants under program rules.

Applies to: AHIP
Source: https://www.cms.gov/files/document/2027-announcement.pdf
Verified: 2026-08-13

ANSWER 584 | M2-034

Correct answer: C. A communication that does not meet both required marketing elements.

Explanation. Marketing requires meeting both an intent standard and a content standard involving plan benefits or comparisons; a neutral reminder about scheduling care, without that content, may remain a communication even though other requirements can still apply.

Why the other choices are wrong

A. Authorship by the plan alone does not establish both required marketing elements.

B. An appointment reminder does not itself request or process an enrollment.

D. The notice contains no sales-event invitation or plan-comparison content.

Applies to: AHIP
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 585 | M2-035

Correct answer: D. It becomes a marketing or sales event because of the plan-specific content and form distribution.

Explanation. Once a program moves from objective general information into promoting a named carrier's benefits and distributing that carrier's applications, it has taken on the character of a marketing or sales event regardless of its advertised title.

Why the other choices are wrong

A. The label on promotional material does not control the event's actual regulatory classification.

B. Distributing enrollment forms does not create a grievance proceeding.

C. An organization determination concerns a coverage decision, not the classification of a sales event.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 586 | M2-036

Correct answer: A. Yes, when the modest noncash items are offered to attendees regardless of whether they enroll.

Explanation. A modest noncash item that is not conditioned on enrollment and stays within applicable limits is generally consistent with CMS's nominal-gift approach for marketing events.

Why the other choices are wrong

B. A logo alone does not automatically prohibit an otherwise modest item.

C. Conditioning any gift on completing an application creates an inducement concern.

D. Nominal items are not restricted to educational events alone.

Applies to: AHIP
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 587 | M2-037

Correct answer: B. A clear announcement that the educational portion has ended, with real time to leave before marketing begins.

Explanation. Under current rules, a same-location transition from an educational session to marketing requires a clear notice that the character of the event is changing and a genuine, practical opportunity for attendees to leave before the sales portion begins.

Why the other choices are wrong

A. A concealed transition defeats the purpose of providing clear notice.

C. Preventing departure removes the required voluntary opportunity to leave.

D. Enrollment forms belong to the marketing portion and should not be collected during the educational segment.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 588 | M2-038

Correct answer: C. Current, traceable plan documents identifying the specific measure and plan year being compared.

Explanation. A supportable comparison relies on current, traceable plan documentation that identifies the particular measure and plan year involved, rather than impression, sweeping superlatives, or stale recollection.

Why the other choices are wrong

A. An unverified impression is not a factual basis for a comparative claim.

B. A blanket superlative without an identified measure is not supportable.

D. Memory from a prior plan year does not reliably reflect current benefits.

Applies to: AHIP
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 589 | M2-039

Correct answer: D. Setting up in an approved public common area such as a lobby or cafeteria.

Explanation. CMS permits marketing in appropriate common areas of a health-care setting, such as a public lobby or cafeteria, while treatment and patient-care areas remain off limits for sales activity.

Why the other choices are wrong

A. An examination room is a patient-care area and is not an approved marketing location.

B. Treatment chairs are part of a patient-care area under the location restriction.

C. The dispensing counter is part of the pharmacy's active patient-service area.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 590 | M2-040

Correct answer: A. Remove the enrollment condition, since tying any item to completing an application creates an inducement problem.

Explanation. Conditioning an item on completing an enrollment application, regardless of the item's modest value, creates an improper inducement; the offer must be revised so it is not tied to signing on the spot.

Why the other choices are wrong

B. A small value does not cure the problem created by conditioning it on enrollment.

C. Limiting the offer by age does not address the underlying inducement issue.

D. Substituting cash would create an even clearer inducement concern.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 591 | M2-041

Correct answer: B. A genuine review of the beneficiary's providers, drugs, pharmacies, and costs before any recommendation.

Explanation. The pre-enrollment discussion must actually address the beneficiary's providers, prescriptions, pharmacies, and costs; an artificially brief script that skips this review does not satisfy the needs-based comparison the appointment requires.

Why the other choices are wrong

A. Speed does not substitute for reviewing the beneficiary's actual circumstances.

C. Signing before questions are addressed undermines an informed decision.

D. Plans differ materially, so a universal suitability claim is inaccurate.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 592 | M2-042

Correct answer: C. False; discussing an additional product category requires appropriate scope documentation for that category.

Explanation. The statement is false. An SOA limited to Medicare Advantage does not by itself authorize discussing an unrelated product category such as a stand-alone PDP; expanding the discussion requires documenting the additional scope as required.

Why the other choices are wrong

A. An MA-only entry does not automatically cover a separate stand-alone drug plan discussion.

B. The limitation applies regardless of the time of year.

D. SOA documentation requirements are not eliminated for stand-alone PDP discussions.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 593 | M2-043

Correct answer: D. No; the marketing and sales portion of the call must be recorded in its entirety.

Explanation. The call-recording obligation applies to the marketing, sales, and enrollment portions of the call as a whole, so deleting the earlier benefit-comparison audio does not satisfy the requirement to retain the complete interaction.

Why the other choices are wrong

A. The requirement is not limited to the enrollment segment alone.

B. A written summary does not substitute for the required audio recording.

C. The platform used for the call does not exempt it from the recording obligation.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 594 | M2-044

Correct answer: A. Identification of each specific receiving TPMO with a separate opportunity to accept or decline sharing.

Explanation. Prior express written consent for inter-TPMO data sharing must identify each recipient and allow the beneficiary to accept or reject sharing with that specific organization, rather than relying on an undefined affiliate network.

Why the other choices are wrong

B. A single blanket checkbox for unnamed future partners does not satisfy the individualized consent requirement.

C. Consent obtained after the transfer cannot retroactively authorize the earlier disclosure.

D. Silence does not establish the required affirmative written consent.

Applies to: AHIP
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-423/subpart-V
Verified: 2026-08-13

ANSWER 595 | M2-045

Correct answer: B. It documents the specific product categories the beneficiary has agreed to discuss.

Explanation. The SOA documents which product types the beneficiary has agreed to discuss during an individualized appointment, keeping the meeting limited to the categories the beneficiary actually chose.

Why the other choices are wrong

A. Outbound-contact authority is addressed through Permission to Contact, not the SOA.

C. The SOA does not replace the enrollment mechanism used to complete an election.

D. A grievance is a separate complaint process unrelated to the SOA's purpose.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 596 | M2-046

Correct answer: C. Establish and maintain oversight of the vendor's licensing and appointment status as part of its ongoing compliance program.

Explanation. A sponsor remains responsible for monitoring the licensing, appointment, and other applicable qualifications of first-tier, downstream, and TPMO entities performing delegated functions; the gap must be corrected through active oversight rather than left unaddressed.

Why the other choices are wrong

A. Delegating a function does not eliminate the sponsor's underlying compliance responsibility.

B. Waiting for a complaint is inconsistent with the required ongoing monitoring duty.

D. Unverified self-certification does not satisfy the sponsor's independent oversight obligation.

Applies to: AHIP
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-423/subpart-V
Verified: 2026-08-13

ANSWER 597 | M2-047

Correct answer: D. Report the observed pattern promptly through the designated compliance channel and preserve the supporting facts.

Explanation. A suspicious billing pattern should be reported promptly through the organization's compliance channel, with the observed facts preserved, so trained reviewers can determine whether the conduct is legitimate or improper rather than the individual employee making that determination alone.

Why the other choices are wrong

A. An unexplained repeating pattern should not be assumed authorized without review.

B. A private confrontation risks tipping off potential misconduct and bypasses the proper reporting process.

C. Waiting for a personal full audit delays the timely reporting that compliance review requires.

Applies to: AHIP
Source: https://oig.hhs.gov/reports-and-publications/featured-topics/ihs/training/fraud-waste-and-abuse-for-health-care-providers/content/
Verified: 2026-08-13

ANSWER 598 | M2-048

Correct answer: A. Abuse involves practices inconsistent with accepted standards that create unnecessary cost, without the knowing deception required for fraud.

Explanation. Abuse generally describes conduct inconsistent with sound business, fiscal, or medical practices that results in unnecessary cost, distinguishing it from fraud, which requires knowing and willful deception for an unauthorized benefit.

Why the other choices are wrong

B. Fraud requires knowing intent to deceive, while abuse does not require that same intent element.

C. Abuse is broader than a single clerical mistake.

D. A service complaint is addressed through the grievance process, not the fraud-waste-abuse framework.

Applies to: AHIP
Source: https://oig.hhs.gov/reports-and-publications/featured-topics/ihs/training/fraud-waste-and-abuse-for-health-care-providers/content/
Verified: 2026-08-13

ANSWER 599 | M2-049

Correct answer: B. An expedited appeal supported by the physician's statement about the health risk of delay.

Explanation. An expedited appeal applies a shortened timeframe when the standard schedule could seriously jeopardize life, health, or the ability to regain maximum function, which the physician's statement here directly supports.

Why the other choices are wrong

A. A grievance does not reconsider the adverse coverage determination itself.

C. Changing plans does not provide timely review of the current denied service.

D. A quality-of-care complaint addresses a different concern and is not the expedited-appeal process.

Applies to: AHIP
Source: https://www.cms.gov/medicare/appeals-grievances/managed-care
Verified: 2026-08-13

ANSWER 600 | M2-050

Correct answer: C. It is an internal appeal level where the plan reexamines its initial coverage or payment decision.

Explanation. Reconsideration is an appeal level at which the plan reexamines its own initial organization determination on coverage or payment; an unfavorable outcome can lead to further review depending on the applicable rules.

Why the other choices are wrong

A. A Part D coverage determination is a distinct initial decision process for drug benefits.

B. Reconsideration is not necessarily the final available level of review.

D. Courtesy complaints are handled as grievances, not through reconsideration of a coverage decision.

Applies to: AHIP
Source: https://www.cms.gov/medicare/appeals-grievances/managed-care
Verified: 2026-08-13

Mock Exam 3 - 50 questions

50 answer entries. Match each entry to the question number and ID printed in Part I.

ANSWER 601 | M3-001

Correct answer: A. Part B generally covers medically necessary outpatient drug administration in this clinic setting.

Explanation. Part B is the medical-insurance part that generally addresses outpatient services, including physician-administered drugs given in a clinic setting. Hospital ownership of the building does not convert an outpatient service into an inpatient Part A benefit.

Why the other choices are wrong

B. Hospital ownership of the clinic does not itself create Part A inpatient coverage for an outpatient encounter.

C. Part D concerns outpatient prescription drugs obtained through a pharmacy, not physician-administered infusions covered under medical benefits.

D. Part C applies only to beneficiaries who have actually enrolled in a Medicare Advantage plan.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 602 | M3-002

Correct answer: B. Ivan's official entitlement record and its effective date, since this pathway differs from standard age-based entitlement.

Explanation. Medicare has a specific entitlement pathway tied to permanent kidney failure requiring maintenance dialysis or transplant, and the official Social Security or CMS record controls whether and when it applies. An agent should verify that record rather than assume eligibility from a diagnosis alone.

Why the other choices are wrong

A. A dialysis diagnosis does not eliminate Medicare eligibility; it can instead support entitlement outside the usual age rule.

C. A specialist referral alone does not satisfy the entitlement pathway's actual requirements.

D. Medicare Advantage enrollment is not a prerequisite for establishing the underlying Medicare entitlement.

Applies to: AHIP
Source: https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start
Verified: 2026-08-13

ANSWER 603 | M3-003

Correct answer: C. She may still be able to enroll in Part A by paying a monthly premium instead of receiving it premium-free.

Explanation. Beneficiaries who do not have enough qualifying work history for premium-free Part A may still be able to buy Part A coverage by paying a monthly premium, subject to Medicare's rules. Work history determines whether Part A is premium-free, not whether it is available at all.

Why the other choices are wrong

A. A shorter work history does not create a blanket disqualification from Part A.

B. Medicare Advantage enrollment does not create Part A eligibility; the reverse relationship generally applies.

D. Part A availability, whether premium-free or premium-based, is a distinct question from Part B eligibility.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 604 | M3-004

Correct answer: D. The Annual Notice of Change, which describes plan modifications for the coming year.

Explanation. Plans generally send an Annual Notice of Change describing modifications to premiums, cost sharing, benefits, and the formulary before the next plan year. Felix should review that notice rather than assume his current terms are permanent.

Why the other choices are wrong

A. A Provider Directory addresses network participation, not annual benefit changes.

B. An outdated benefit summary does not reflect current or upcoming plan terms.

C. The formulary addresses drug coverage and does not describe every plan benefit change.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 605 | M3-005

Correct answer: A. Part A principally addresses inpatient and certain institutional care, while Part B principally addresses outpatient and professional services.

Explanation. Part A is Hospital Insurance and principally addresses inpatient hospital care and certain other institutional benefits, while Part B is Medical Insurance covering physician services, outpatient care, and other medically necessary services. The two parts address different categories of care.

Why the other choices are wrong

B. Part A is not limited to prescription drugs, and hospital pharmacy dispensing is not its defining feature.

C. Part B is a component of Original Medicare and is not restricted to Medicare Advantage enrollees.

D. The two parts address materially different service categories, not identical coverage.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 606 | M3-006

Correct answer: B. Original Medicare generally does not cover long-term custodial care, so the limited skilled-care benefits it does provide should be clarified.

Explanation. Original Medicare's nursing-facility benefit is generally limited to certain skilled care following a qualifying hospital stay, not indefinite custodial care. An agent should be careful not to overstate the scope of the benefit.

Why the other choices are wrong

A. Unlimited custodial coverage is not an accurate description of Original Medicare's nursing-facility benefit.

C. A supplemental debit card is not a mechanism that converts into custodial long-term-care coverage.

D. Part D concerns outpatient prescription drugs, not nursing-facility room and board.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 607 | M3-007

Correct answer: C. Their coverage route, such as Original Medicare versus a specific Medicare Advantage plan, can set different cost-sharing structures for the same service.

Explanation. Cost sharing for the same outpatient service can differ depending on whether the beneficiary has Original Medicare or a particular Medicare Advantage plan, since MA plans set their own cost-sharing structures within CMS rules. Diagnosis alone does not determine the amount owed.

Why the other choices are wrong

A. Cost sharing is not uniform across all beneficiaries and plan types.

B. A physician's billed fee is not the sole determinant of the beneficiary's actual cost sharing.

D. Geography can be one relevant factor for certain plans but is not the only variable, and this option overstates its role.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 608 | M3-008

Correct answer: D. Clarify that Original Medicare generally has no single overall annual cap on Part A and Part B cost sharing.

Explanation. Original Medicare does not include one universal annual out-of-pocket cap for Part A and Part B services, unlike Medicare Advantage plans, which must include a maximum out-of-pocket limit. A compliant description must not misstate this exposure.

Why the other choices are wrong

A. The claim is inaccurate and cannot be approved as stated.

B. A signed acknowledgment does not cure a materially false statement about coverage.

C. Medigap can help with cost sharing but does not eliminate all possible future costs, and this response is an overcorrection.

Applies to: AHIP
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 609 | M3-009

Correct answer: A. True; this is a permitted pathway to Part A coverage separate from the premium-free route.

Explanation. The statement is true. Beneficiaries who do not qualify for premium-free Part A based on work history may still enroll by paying a monthly premium under Medicare's rules.

Why the other choices are wrong

B. A shorter work history does not create an absolute bar to Part A.

C. Part A, not only Part B, has this premium-based enrollment pathway.

D. The premium is not automatically waived simply because a beneficiary requests it.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 610 | M3-010

Correct answer: B. The HMO may require a referral or primary-care coordination before the specialist visit is covered.

Explanation. Standard HMOs generally rely on primary-care coordination and may require a referral before routine specialist care is covered, apart from recognized exceptions such as emergencies. Greta should confirm her plan's specific referral process before scheduling.

Why the other choices are wrong

A. Referral requirements are a common HMO feature, not something automatically waived.

C. A single visit does not change the beneficiary's plan type.

D. PPO rules do not apply to an HMO simply because the member wants broader access.

Applies to: AHIP
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 611 | M3-011

Correct answer: C. Coverage can depend on whether that specific provider has agreed to the plan's terms for the service provided.

Explanation. PFFS plans generally cover services from providers who have agreed to the plan's terms and conditions, whether through a contract or accepted deemed status for a particular service. Coverage is not automatic nationwide and depends on that specific provider relationship.

Why the other choices are wrong

A. Nationwide automatic deeming is not how PFFS provider acceptance works.

B. Part D enrollment does not determine PFFS medical-provider acceptance.

D. A provider's declination affects that encounter's coverage; it does not convert the underlying MA plan into Original Medicare.

Applies to: AHIP
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 612 | M3-012

Correct answer: D. A D-SNP serving beneficiaries with her qualifying dual-eligible category.

Explanation. A D-SNP is designed for beneficiaries whose Medicare and Medicaid status meets the plan's approved dual-eligibility categories, and can offer varying levels of coordination with Medicaid benefits. Her Medicaid and Medicare status should be verified against the plan's specific requirements.

Why the other choices are wrong

A. A C-SNP is organized around a qualifying severe or disabling chronic condition, not age or Medicaid status.

B. An MSA does not include an integrated Medicaid deposit feature.

C. A regional PPO's structure is about geography, not dual-eligibility coordination.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 613 | M3-013

Correct answer: A. Whether her employer-sponsored coverage or plan terms affect her ability to make an independent individual election.

Explanation. Employer or union group coverage such as an EGWP can carry its own terms affecting a member's ability to leave for an individual-market plan, so those specifics should be reviewed before assuming a standard AEP switch works the same way. Sound advice depends on the actual group plan terms.

Why the other choices are wrong

B. An EGWP does not automatically eliminate every election right; the actual plan and employer terms must be checked.

C. EGWP enrollment does not require first canceling underlying Original Medicare entitlement.

D. Part D enrollment is not, by itself, disqualifying for Medicare.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 614 | M3-014

Correct answer: B. It combines a high-deductible health plan with a medical savings account and does not include embedded Part D coverage.

Explanation. A Medicare MSA plan pairs a high-deductible health plan with an account that can be used for qualified medical expenses, and it does not include Part D drug coverage. A member who wants Part D generally must enroll separately in a stand-alone PDP.

Why the other choices are wrong

A. An MSA specifically lacks embedded Part D, unlike an MA-PD.

C. Referral requirements are not the defining structural feature of an MSA.

D. MSA eligibility is not limited to D-SNP-qualifying beneficiaries.

Applies to: AHIP
Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/compare
Verified: 2026-08-13

ANSWER 615 | M3-015

Correct answer: C. The regional PPO's service area is a CMS-defined region rather than a locally configured area.

Explanation. A regional PPO operates across a CMS-defined geographic region under region-specific plan rules, while a local PPO uses its own approved local service-area configuration. This is a structural and geographic distinction rather than a difference in medical eligibility.

Why the other choices are wrong

A. Part A and Part B eligibility rules generally apply to both regional and local PPOs.

B. Out-of-network benefits are a general PPO feature and are not exclusive to local plans.

D. Regional status concerns geography, not special-needs plan classification.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 616 | M3-016

Correct answer: D. Require the flyer to disclose the benefit's actual eligibility and covered-use limits accurately.

Explanation. Conditional supplemental benefits must be advertised with their real eligibility and covered-use restrictions rather than presented as guaranteed cash for every enrollee. The flyer's core misrepresentation must be corrected, not merely disclaimed in small print.

Why the other choices are wrong

A. Supplemental benefits are frequently conditional and are not automatically unrestricted spending money.

B. A small disclaimer does not cure a materially misleading headline claim.

C. Changing the logo leaves the false eligibility claim unchanged.

Applies to: AHIP
Source: https://www.cms.gov/newsroom/fact-sheets/contract-year-2027-medicare-advantage-part-d-final-rule
Verified: 2026-08-13

ANSWER 617 | M3-017

Correct answer: A. Regional PPO; Medicare MSA; D-SNP.

Explanation. A regional PPO is defined by its CMS-designated region, a Medicare MSA pairs a high-deductible plan with an account and no embedded Part D, and a D-SNP restricts enrollment to a qualifying dual-eligible category.

Why the other choices are wrong

B. The first two labels are mismatched with the described features.

C. None of the three pairings matches the stated structural facts.

D. The final two labels are reversed relative to their described features.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 618 | M3-018

Correct answer: B. The MA OEP generally allows only one qualifying change, so a second switch under that same period is not available.

Explanation. The Medicare Advantage Open Enrollment Period generally permits one qualifying change for an eligible current MA enrollee. Once that single change has been used, another MA OEP switch in the same period is not ordinarily available, though other election rights might apply.

Why the other choices are wrong

A. The MA OEP is limited to one qualifying change, not unlimited switches.

C. The 5-star SEP requires a qualifying 5-star destination plan and is not a general substitute.

D. Backdating a request misrepresents the actual submission date and does not create a valid additional election.

Applies to: AHIP
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-13

ANSWER 619 | M3-019

Correct answer: C. Whether the loss of creditable employer coverage opens a time-limited Part D Special Enrollment Period.

Explanation. Involuntary loss of creditable employer prescription coverage can trigger a Part D Special Enrollment Period with its own defined timing. The agent should confirm the loss date and applicable window rather than assume Priscilla must wait for AEP.

Why the other choices are wrong

A. A qualifying SEP can allow enrollment outside AEP.

B. A coverage loss does not automatically create a completed Part D election without the beneficiary's own request.

D. A former employer has no role in approving a Medicare Part D election.

Applies to: AHIP
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-13

ANSWER 620 | M3-020

Correct answer: D. A disaster or emergency SEP addressing his inability to use the AEP opportunity for which he was otherwise eligible.

Explanation. Disaster and emergency relief addresses a beneficiary who had another valid election opportunity but could not use it because of a qualifying event affecting the person or area. Winston's facts should be verified against the official affected-area and timing criteria.

Why the other choices are wrong

A. Relief is assessed for affected individuals and areas, not applied automatically nationwide.

B. The relief restores access to the missed opportunity; it does not create indefinite future election rights.

C. Reopening the office is not a precondition for CMS to review disaster-relief eligibility.

Applies to: AHIP
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-13

ANSWER 621 | M3-021

Correct answer: A. The monthly low-income Part D SEP available to qualifying Extra Help beneficiaries.

Explanation. A qualifying Extra Help beneficiary who is not restricted by an at-risk Part D drug-management designation may generally use a monthly Special Enrollment Period to switch stand-alone PDPs. This opportunity is separate from AEP.

Why the other choices are wrong

B. The MA OEP serves current MA enrollees and Carmen is not described as one.

C. Institutional election rights depend on qualifying facility residence, not Extra Help status.

D. The 5-star SEP requires a qualifying 5-star destination plan and is unrelated to Extra Help status.

Applies to: AHIP
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-13

ANSWER 622 | M3-022

Correct answer: B. Whether the move is permanent and results in different plan availability at the new address.

Explanation. A move-related SEP generally depends on a permanent change of residence that affects the beneficiary's available plan options. A short visit or same-name branding elsewhere does not establish the qualifying move facts.

Why the other choices are wrong

A. A temporary visit is not the permanent relocation the SEP is designed to address.

C. A shared brand name across locations does not establish or negate SEP eligibility.

D. Timing relative to AEP is not itself the qualifying fact for a move-related SEP.

Applies to: AHIP
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-13

ANSWER 623 | M3-023

Correct answer: C. It is a recognized Special Enrollment Period circumstance for joining available Medicare coverage after the return.

Explanation. Medicare.gov recognizes moving back to the United States after living abroad as a Special Enrollment Period circumstance, allowing the beneficiary to elect available MA or Part D coverage. It is not an automatic assignment to any particular plan.

Why the other choices are wrong

A. The SEP creates an opportunity to choose; it does not automatically enroll the person in a specific plan.

B. Keeping a foreign address is inconsistent with reestablishing U.S. residence for plan eligibility.

D. The return is directly relevant because it is an express SEP-triggering circumstance.

Applies to: AHIP
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-13

ANSWER 624 | M3-024

Correct answer: D. A special election window and required notices support the member's move to replacement coverage.

Explanation. When a Medicare plan's contract will not be renewed, CMS rules and required member notices create a special opportunity for affected members to choose replacement Medicare coverage, supporting continuity rather than a coverage gap.

Why the other choices are wrong

A. The purpose of the SEP and notices is to prevent, not require, a coverage gap.

B. A nonrenewed contract does not continue in force indefinitely.

C. Members are not automatically shifted into an unrelated commercial insurance product.

Applies to: AHIP
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-13

ANSWER 625 | M3-025

Correct answer: A. Do not treat the form as a valid election until an applicable enrollment period is documented.

Explanation. A technically complete application does not itself create authority to enroll a beneficiary outside a valid election period. The agent must confirm and document an applicable AEP, initial period, MA OEP, or SEP before treating the request as a lawful election.

Why the other choices are wrong

B. A plan cannot retroactively manufacture a qualifying SEP that did not exist.

C. Backdating a signature is false documentation and does not establish a lawful election.

D. Completeness of the form does not substitute for the required timing basis.

Applies to: AHIP
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-13

ANSWER 626 | M3-026

Correct answer: B. Stop and obtain the beneficiary's own acknowledgment and consent through the approved mechanism.

Explanation. Approved enrollment mechanisms require the beneficiary's own acknowledgment and consent to the required elements. A spouse cannot supply that consent on the beneficiary's behalf, so the agent must pause and involve the actual beneficiary.

Why the other choices are wrong

A. A family member's participation does not satisfy the requirement for the beneficiary's own consent.

C. Proceeding and hoping the issue is not raised later does not cure an invalid enrollment.

D. Having another person adopt the beneficiary's identity on the call misrepresents who is enrolling.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 627 | M3-027

Correct answer: C. I, II, and III only.

Explanation. Statements I, II, and III accurately describe the MA OEP, the move-related SEP, and the AEP's role in permitting an Original Medicare beneficiary to join MA for the next plan year. Statement IV is false because institutional election rights can continue for a limited time after leaving the facility.

Why the other choices are wrong

A. Statement IV is false, and this choice omits the accurate Statements II and III.

B. Statement IV remains false, and Statement I is omitted despite being accurate.

D. Statement IV is false because a post-discharge window can still apply, so it should not be included.

Applies to: AHIP
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-13

ANSWER 628 | M3-028

Correct answer: D. A transition supply that can provide temporary access while the required approval or exception is pursued.

Explanation. Part D transition policies can apply not only to new enrollees but to existing members facing a new utilization rule such as prior authorization, providing a temporary supply while the required approval or exception is completed. This differs from a permanent formulary change.

Why the other choices are wrong

A. A pharmacy cannot permanently rewrite the plan's formulary or utilization rules.

B. A transition supply is a temporary bridge, not a universal cancellation of the new rule.

C. A tiering exception addresses cost-sharing level, not the need for the authorization itself.

Applies to: AHIP
Source: https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/plan-rules
Verified: 2026-08-13

ANSWER 629 | M3-029

Correct answer: A. Certain manufacturer discounts may not count toward TrOOP in the same way as her own qualifying payments, so the specific rule should be checked.

Explanation. TrOOP accounting follows defined rules about which payments, including certain manufacturer assistance, count toward the beneficiary's true out-of-pocket total. Not every discount is treated identically, so Beatriz's assumption should be checked against the applicable Part D rules rather than assumed.

Why the other choices are wrong

B. Discount treatment for TrOOP purposes is not automatically uniform across every type of coupon or assistance.

C. Using a coupon does not remove the drug from the plan's formulary.

D. TrOOP tracking continues under the benefit's ongoing accounting rules; it does not stop because a discount was applied.

Applies to: AHIP
Source: https://www.cms.gov/files/document/2027-announcement.pdf
Verified: 2026-08-13

ANSWER 630 | M3-030

Correct answer: B. A partial subsidy can still reduce his qualifying premium, deductible, or cost sharing, even though it is less generous than the full-subsidy level.

Explanation. Extra Help has different subsidy levels, and even a partial subsidy can reduce a beneficiary's qualifying Part D premium, deductible, or cost sharing compared to standard costs. The subsidy level, not simply its existence, determines the degree of reduction.

Why the other choices are wrong

A. A partial subsidy still generally provides some reduction, unlike Hassan's assumption of none.

C. Extra Help subsidy level does not itself establish full state Medicaid benefits.

D. Extra Help eligibility does not require D-SNP enrollment.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 631 | M3-031

Correct answer: C. Formulary coverage and any applicable utilization-management rule, such as prior authorization or step therapy.

Explanation. Whether a drug is accessible depends on both formulary coverage and any utilization-management controls the plan applies, such as prior authorization, step therapy, or quantity limits. Checking only one element can miss a barrier to access.

Why the other choices are wrong

A. Tier placement concerns cost sharing, not whether utilization rules restrict access.

B. Geography alone does not establish formulary coverage or utilization requirements.

D. Pharmacy hours are an operational detail and do not determine underlying plan coverage rules.

Applies to: AHIP
Source: https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/plan-rules
Verified: 2026-08-13

ANSWER 632 | M3-032

Correct answer: D. Three phases — deductible, initial coverage, and catastrophic — with no separate coverage-gap phase.

Explanation. The redesigned defined-standard benefit has three phases: an annual deductible, an initial coverage phase, and catastrophic coverage after the out-of-pocket threshold. The old coverage-gap (“donut hole”) no longer exists as a separate phase, so her neighbor's experience does not reflect the current design.

Why the other choices are wrong

A. The separate coverage-gap phase was eliminated; it is not part of the current defined-standard structure.

B. The benefit is phased, not a single year-long flat coinsurance.

C. Enrollees in the initial coverage phase pay cost sharing, not the full negotiated price, before reaching the threshold.

Applies to: AHIP
Source: https://www.cms.gov/files/document/2027-announcement.pdf
Verified: 2026-08-13

ANSWER 633 | M3-033

Correct answer: A. Remove the claim and describe Extra Help as a separate subsidy requiring its own qualifying status.

Explanation. Extra Help is a distinct low-income subsidy with its own eligibility categories; it does not arise automatically from Part D enrollment alone. The marketing description must accurately separate general Part D enrollment from Extra Help qualification.

Why the other choices are wrong

B. Part D enrollment and Extra Help eligibility are governed by different requirements and are not the same program.

C. Placement in fine print does not cure a materially false claim about automatic eligibility.

D. Substituting an unrelated payment-timing program does not correct the false Extra Help claim.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 634 | M3-034

Correct answer: B. The agent should have obtained and documented a Scope of Appointment before the plan-specific discussion.

Explanation. A personal marketing appointment, including one conducted by telephone, requires a documented Scope of Appointment identifying the product categories to be discussed before the plan-specific conversation begins. The channel does not remove this requirement.

Why the other choices are wrong

A. Telephone appointments are still subject to the Scope of Appointment requirement.

C. Documenting scope after enrollment does not satisfy the requirement that it precede the discussion.

D. Permission to Contact concerns outreach authorization and does not define the products for a sales appointment.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 635 | M3-035

Correct answer: C. A broadly spendable gift card functions as a cash equivalent and is not treated the same as a modest noncash item.

Explanation. Even when not conditioned on enrollment, a general-purpose gift card usable like cash is generally treated as a cash equivalent rather than a permissible modest noncash item, raising inducement concerns under CMS rules. The nature of the item, not only the enrollment condition, matters.

Why the other choices are wrong

A. Not conditioning the gift on enrollment does not by itself make a cash-equivalent item compliant.

B. There is no blanket rule that automatically exempts a cash-equivalent gift from scrutiny.

D. Modest permissible noncash items may be allowed within CMS and sponsor limits, so a categorical prohibition on all items is inaccurate.

Applies to: AHIP
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 636 | M3-036

Correct answer: D. As prohibited unsolicited direct contact, similar to other restricted outbound channels.

Explanation. CMS restricts unsolicited direct contact across several channels, and unsolicited social media direct messages promoting a specific plan fall within that restriction. Simply using a newer communication channel does not exempt the outreach from the same beneficiary-contact protections.

Why the other choices are wrong

A. Social media direct outreach is not exempt from CMS's unsolicited-contact restrictions merely because of the platform.

B. A message promoting a specific plan is not neutral educational content.

C. Following a public page is not the same as the beneficiary requesting individualized outreach.

Applies to: AHIP
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 637 | M3-037

Correct answer: A. The chart should be updated to current plan-year figures with the source and applicable year clearly identified.

Explanation. A supportable plan comparison relies on current, traceable plan information and clearly identifies its basis and applicable plan year. Reusing stale figures without disclosure risks presenting inaccurate or misleading cost and benefit information.

Why the other choices are wrong

B. Historical accuracy for a prior year does not make the chart reliable for a current comparison.

C. Mislabeling the chart as an official CMS document would misrepresent its source.

D. Removing dates does not fix the accuracy problem and instead conceals it.

Applies to: AHIP
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 638 | M3-038

Correct answer: B. Whether it is an individualized, scheduled discussion of specific plan products with the beneficiary.

Explanation. The Scope of Appointment requirement is tied to individualized, scheduled personal marketing appointments where specific plan products are discussed, regardless of the exact setting or channel. It is the nature of the interaction, not the physical location, that controls.

Why the other choices are wrong

A. The requirement is not limited to in-person office meetings; other individualized settings can also qualify.

C. The presence of a family member does not itself define whether the appointment requires a scope.

D. The obligation is a regulatory requirement, not a matter of an individual agent's preference.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 639 | M3-039

Correct answer: C. A clear notice and a genuine opportunity to leave may permit the transition without the former waiting period.

Explanation. Under the current rule, an organizer may move from an educational event into a marketing presentation at the same location without the former waiting interval, provided attendees receive clear notice of the change and a genuine opportunity to leave before marketing begins.

Why the other choices are wrong

A. The former universal waiting period is not the controlling requirement under current rules.

B. Same-location transitions are permitted when the notice and departure-opportunity conditions are met.

D. A silent transition does not satisfy the requirement for clear notice.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 640 | M3-040

Correct answer: D. Do not solicit or take possession of completed AEP requests before the period opens, regardless of any planned holding period.

Explanation. Agents may not solicit or take possession of completed AEP enrollment requests before the election period opens, even if actual submission is delayed until the proper date. Early collection itself is the violation, not merely early transmission.

Why the other choices are wrong

A. Holding the applications until October 15 does not cure the earlier prohibited solicitation and collection.

B. Not reading the answers does not eliminate the problem of premature possession.

C. A beneficiary's acknowledgment cannot authorize a practice that CMS rules prohibit.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 641 | M3-041

Correct answer: A. Remove the guarantee and explain that the plan applies its own published eligibility criteria.

Explanation. Eligibility for a chronically ill supplemental benefit is determined by the plan under its own approved criteria and process. An agent cannot guarantee approval in advance, and the script must be corrected to reflect that the plan, not the agent, makes the determination.

Why the other choices are wrong

B. An agent's personal belief does not substitute for the plan's actual eligibility determination.

C. Mentioning an illness does not automatically satisfy the plan's specific published criteria.

D. Recasting the guarantee as automatic cash compounds rather than corrects the misrepresentation.

Applies to: AHIP
Source: https://www.cms.gov/newsroom/fact-sheets/contract-year-2027-medicare-advantage-part-d-final-rule
Verified: 2026-08-13

ANSWER 642 | M3-042

Correct answer: B. False; sponsor authorship alone does not satisfy both required marketing prongs.

Explanation. The statement is false. Marketing requires satisfying both an intent and a content standard, and a neutral operational notice without plan-benefit or comparative content can remain a communication rather than marketing, even though a plan sponsor authored it.

Why the other choices are wrong

A. Sponsor authorship alone does not establish both required marketing prongs.

C. The presence or absence of an enrollment form is not the deciding fact in this example, which lacks one.

D. The classification turns on the marketing-content and intent standards, not a categorical rule about phone numbers.

Applies to: AHIP
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 643 | M3-043

Correct answer: C. The specific audio-recording mandate targets telephonic calls, so a text-only chat is analyzed under the rules that actually apply to that channel.

Explanation. CMS's specific TPMO call-recording requirement is directed at telephonic marketing, sales, and enrollment calls. A text-based chat without an audio component is not the same interaction, though other applicable recordkeeping and documentation obligations for the chat itself still apply.

Why the other choices are wrong

A. The mandate as framed addresses telephonic audio, not every channel by default.

B. Other recordkeeping duties are not eliminated simply because this specific audio mandate does not apply to a chat.

D. The obligation is not conditioned on a beneficiary's specific request.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 644 | M3-044

Correct answer: D. The outreach exceeds the scope of the permission Odalys actually gave for contact.

Explanation. Permission to Contact should be tied to the specific product types the beneficiary agreed to, and using it to reach out about an unrelated product exceeds that authorization. A new, properly scoped permission or another compliant basis would be needed for the different product.

Why the other choices are wrong

A. Contact permission is not a blanket authorization for every future product or topic.

B. A dental discount product is not automatically included within permission limited to Medicare Advantage.

C. An apology at the outset does not cure an outreach made outside the beneficiary's given permission.

Applies to: AHIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 645 | M3-045

Correct answer: A. Audio must be kept during the initial three years, while a complete and accurate transcript may substitute during the remaining retention years.

Explanation. Under the current framework, marketing and sales calls must be retained for at least six years, with audio required for the first three years and either audio or a complete, accurate transcript acceptable for years four through six.

Why the other choices are wrong

B. The overall retention duty extends through the full six-year period, not just the first year.

C. Retaining only a name would not satisfy the required record of the marketing or sales call.

D. The retention duty attaches to qualifying marketing and sales calls generally, not solely to those producing an enrollment.

Applies to: AHIP
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-423/subpart-V
Verified: 2026-08-13

ANSWER 646 | M3-046

Correct answer: B. Give the beneficiary the ability to accept or reject each named recipient separately through prior express written consent.

Explanation. Prior express written consent for inter-TPMO data sharing must allow the beneficiary to make an individualized choice about each named recipient rather than being forced into a single all-or-nothing selection. The current form does not provide that separate choice.

Why the other choices are wrong

A. Naming the companies together in one bundled checkbox does not satisfy the requirement for a separate accept-or-reject choice per recipient.

C. Adding an unnamed additional company worsens rather than fixes the defect.

D. Removing names would make the consent even less specific and informed.

Applies to: AHIP
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-423/subpart-V
Verified: 2026-08-13

ANSWER 647 | M3-047

Correct answer: C. Report the potential disclosure promptly through the designated privacy or security channel.

Explanation. Prompt reporting of a suspected disclosure allows the organization's privacy and security function to investigate, mitigate risk, and determine any required next steps or notifications. Perla should not wait for external confirmation before reporting what she observed.

Why the other choices are wrong

A. Waiting for the recipient to raise the issue delays a timely organizational response.

B. Simply resending the fax correctly does not address the earlier unauthorized disclosure.

D. An informal coworker conversation does not substitute for using the designated compliance or privacy reporting channel.

Applies to: AHIP
Source: https://www.hhs.gov/hipaa/for-professionals/privacy/index.html
Verified: 2026-08-13

ANSWER 648 | M3-048

Correct answer: D. Waste is overutilization or careless use of resources that squanders program dollars, generally without criminal intent.

Explanation. CMS program-integrity training treats waste as the overutilization of services or other practices that, directly or indirectly, squander Medicare resources. Unlike fraud, waste does not hinge on intentional deception; it typically reflects careless or inefficient practices rather than a knowing scheme.

Why the other choices are wrong

A. Intentional deception is the hallmark of fraud, not waste.

B. Waste concerns how program resources are used across providers and plans, not just beneficiary billing mistakes.

C. Waste is generally not criminal; it is addressed through corrective action rather than automatic prosecution.

Applies to: AHIP
Source: https://oig.hhs.gov/reports-and-publications/featured-topics/ihs/training/fraud-waste-and-abuse-for-health-care-providers/content/
Verified: 2026-08-13

ANSWER 649 | M3-049

Correct answer: A. Whether the standard appeal timeframe could seriously jeopardize the member's life, health, or ability to regain maximum function.

Explanation. An expedited appeal timeframe applies when using the standard schedule could seriously jeopardize the member's life, health, or ability to regain maximum function, typically supported by the treating provider. Preference alone or an agent's prediction of success does not establish that standard.

Why the other choices are wrong

B. General preference for speed does not meet the expedited standard without the required health risk.

C. An agent's opinion about the likely outcome does not determine the applicable review timeframe.

D. A separate grievance concerns service dissatisfaction and does not by itself establish urgency for the appeal.

Applies to: AHIP
Source: https://www.cms.gov/medicare/appeals-grievances/managed-care
Verified: 2026-08-13

ANSWER 650 | M3-050

Correct answer: B. Grievance; organization determination; expedited appeal.

Explanation. Dissatisfaction with conduct or service is addressed through a grievance, an MA plan's initial coverage or payment decision is an organization determination, and a situation meeting the urgent health-risk standard calls for an expedited appeal.

Why the other choices are wrong

A. The first two channels are reversed relative to the described situations.

C. None of the three pairings matches its described situation.

D. The final two channels are reversed relative to their described situations.

Applies to: AHIP
Source: https://www.cms.gov/medicare/appeals-grievances/managed-care
Verified: 2026-08-13

Mock Exam 4 - 45 questions

45 answer entries. Match each entry to the question number and ID printed in Part I.

ANSWER 651 | M4-001

Correct answer: C. Part B generally covers the outpatient facility fee when Medicare's coverage rules are met.

Explanation. Outpatient surgical facility charges are generally a Part B matter under Original Medicare once the applicable coverage requirements are satisfied. The setting alone does not convert the charge into a Part A benefit.

Why the other choices are wrong

A. Part D addresses covered outpatient prescription drugs, not a facility fee.

B. Part A principally covers inpatient hospital stays and certain other institutional services.

D. Part C applies only to a beneficiary actually enrolled in Medicare Advantage.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 652 | M4-002

Correct answer: A. The MA plan delivers his Medicare Part A and Part B benefits through a private contract with CMS.

Explanation. A Medicare Advantage plan is the vehicle through which an enrollee receives Part A and Part B benefits, under a contract between the plan sponsor and CMS. The beneficiary remains part of the Medicare program even though a private plan manages the benefit.

Why the other choices are wrong

B. MA is an alternative way to receive Parts A and B, not a supplement layered on top of Original Medicare while it remains primary.

C. Enrollment in MA does not create employer-sponsored coverage.

D. Medigap is designed for Original Medicare and is not compatible with an MA enrollee's cost sharing.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 653 | M4-003

Correct answer: C. A physician's office evaluation is generally a Part B matter.

Explanation. Physician office visits and other professional evaluation services are generally covered under Part B when Medicare's requirements are met. Matching a service to its correct Medicare part depends on the nature of the service, not just where it happens.

Why the other choices are wrong

A. Inpatient rehabilitation is generally addressed under Part A rather than Part D.

B. Outpatient prescription drugs at a retail pharmacy generally fall under Part D, not Part A.

D. Hospice is a defined Original Medicare benefit and is not exclusively a Part C matter.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 654 | M4-004

Correct answer: D. A PFFS plan may allow her to see providers who accept the plan's terms without the HMO's routine referral structure.

Explanation. PFFS plans generally set their own payment terms, and a provider's willingness to accept those terms determines participation, without the referral and network structure typical of an HMO. This differs from an HMO, which generally coordinates routine care through its network.

Why the other choices are wrong

A. An HMO typically relies on its network and referral rules rather than offering the same open non-network access as a PFFS plan.

B. The two plan types do not necessarily share identical prior-authorization requirements.

C. Emergency coverage protections generally apply regardless of plan type.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 655 | M4-005

Correct answer: B. The letter should clarify that Part A and Part B are separate parts and outpatient therapy is generally addressed under Part B.

Explanation. An accurate description separates Part A's institutional focus from Part B's coverage of outpatient physician and therapy services. Outpatient physical therapy is generally addressed under Part B rather than Part A once Medicare's requirements are satisfied.

Why the other choices are wrong

A. A past hospital stay does not automatically make ongoing outpatient therapy a Part A benefit.

C. Part D concerns outpatient prescription drugs and is a separate benefit from outpatient therapy services.

D. Part C only applies to a person actually enrolled in Medicare Advantage.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 656 | M4-006

Correct answer: A. It can help pay qualified medical expenses while the high-deductible plan has not yet begun paying claims.

Explanation. A Medicare MSA combines a plan-funded account with a high-deductible health plan. The account can be used to pay qualified medical expenses before the plan's own claim payments begin, but it does not by itself supply Part D or change the plan's structure.

Why the other choices are wrong

B. An MSA does not include Part D; drug coverage requires a separate stand-alone PDP.

C. Using the account does not transform the plan into a PPO.

D. The account deposit does not alter the MSA's underlying high-deductible plan structure.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 657 | M4-007

Correct answer: B. Explain that MA eligibility generally requires both Part A and Part B, along with service-area residence and a valid election opportunity.

Explanation. Medicare Advantage eligibility generally depends on entitlement to Part A, enrollment in Part B, residence in the plan's service area, and an applicable election period. Wendell's enthusiasm for the extra benefits does not substitute for the missing Part B enrollment.

Why the other choices are wrong

A. Suitability judgments cannot override the statutory eligibility requirement.

C. An MA application does not function as a Part B enrollment mechanism.

D. A stand-alone PDP is designed to work with Original Medicare and does not resolve the underlying Part B question for an MA election.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 658 | M4-008

Correct answer: C. A D-SNP limited to beneficiaries meeting the plan's approved dual-eligibility categories.

Explanation. A D-SNP restricts enrollment to people whose Medicare and Medicaid status fits the plan's approved dual-eligibility categories. Ines's confirmed Medicaid category is the relevant qualifying fact for that plan type.

Why the other choices are wrong

A. I-SNP eligibility turns on institutional or qualifying institutional-equivalent status, not home address by itself.

B. A C-SNP is organized around a qualifying severe or disabling chronic condition rather than dual status.

D. A PFFS plan is defined by its payment-and-network structure, not a Medicaid eligibility category.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 659 | M4-009

Correct answer: D. End-Stage Renal Disease is a recognized basis for Medicare eligibility separate from the age-65 pathway, subject to its own rules.

Explanation. Medicare eligibility is not limited to reaching the standard age; a recognized ESRD-based pathway exists with its own application and timing rules, distinct from age-based or disability-based entitlement. The official entitlement record should be verified rather than assumed from a diagnosis alone.

Why the other choices are wrong

A. A diagnosis does not itself create automatic enrollment without following the required entitlement process.

B. The age-based route is not the only path to Medicare eligibility.

C. ESRD is a separate basis in addition to, not folded into, the disability pathway.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 660 | M4-010

Correct answer: C. The new election can cause disenrollment from the MA-PD arrangement unless an exception applies.

Explanation. When an HMO or PPO already includes embedded Part D, it functions as an MA-PD. Joining an incompatible stand-alone PDP can trigger disenrollment from the Medicare Advantage plan unless a specific exception applies.

Why the other choices are wrong

A. Medicare systems do not generally maintain the MA-PD's drug coverage and a separate PDP as coordinated primary and secondary plans.

B. The mechanism is disenrollment from the MA-PD, not an automatic cancellation described this way.

D. A second drug-plan election does not convert an MA plan into a Medigap policy.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 661 | M4-011

Correct answer: A. The beneficiary's official Medicare enrollment record, such as through the Social Security Administration or the beneficiary's Medicare account.

Explanation. Effective dates for Part A and Part B are established facts of record, not estimates. An agent should confirm them through the beneficiary's official enrollment documentation rather than inference or informal sources.

Why the other choices are wrong

B. An assumption based on age alone can miss delayed enrollment, disability-based entitlement, or other individual facts.

C. A marketing brochure describes general plan information, not a specific person's enrollment dates.

D. An informal post is not authoritative evidence of official Medicare dates.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 662 | M4-012

Correct answer: D. No, because a qualifying institutional-equivalent pathway may apply once the required assessment is satisfied.

Explanation. Some I-SNPs may serve community residents who meet the plan's institutional-equivalent level-of-care requirements for the required duration. Home residence does not by itself decide eligibility, but the formal assessment remains essential.

Why the other choices are wrong

A. CMS permits qualifying institutional-equivalent pathways in addition to residence inside an institution.

B. I-SNP qualification is a separate question from D-SNP Medicaid categories.

C. An agent has no authority to waive the required clinical or level-of-care assessment.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 663 | M4-013

Correct answer: A. True; the missing Part B enrollment leaves the eligibility picture incomplete for an MA election.

Explanation. The statement is true. Medicare Advantage eligibility generally requires both entitlement to Part A and enrollment in Part B, so Part A alone does not support an MA election.

Why the other choices are wrong

B. Part A by itself has not been treated as sufficient for MA enrollment.

C. A Medigap policy is unrelated to and not a substitute for the missing Part B enrollment.

D. An agent's recommendation cannot waive the statutory Part B requirement.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 664 | M4-014

Correct answer: A. Her Part B premium generally continues even though the MA plan itself carries no additional premium.

Explanation. A plan's own premium is distinct from the beneficiary's ongoing Part B obligation. A zero-dollar MA plan premium does not remove the general requirement to keep paying the Part B premium.

Why the other choices are wrong

B. Any premium-reduction feature must be verified plan by plan and is not an automatic full refund.

C. A zero-dollar plan premium does not change the underlying Part B premium rules for other enrollees.

D. MA enrollment does not require buying a stand-alone PDP, and a PDP premium does not substitute for Part B.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 665 | M4-015

Correct answer: D. A non-qualified withdrawal can carry different tax and deductible consequences than a qualified one.

Explanation. Medicare MSA account funds are intended for qualified medical expenses, and a withdrawal used for something else can have different tax treatment and may not count toward the deductible in the same way. Members should track how funds are used.

Why the other choices are wrong

A. Not every withdrawal necessarily counts toward the deductible, particularly one used for a non-qualified purpose.

B. CMS does not automatically reclaim non-qualified withdrawals in this way.

C. A withdrawal's purpose does not change the plan's underlying legal type.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 666 | M4-016

Correct answer: D. A special election opportunity for affected members to choose replacement Medicare coverage.

Explanation. Plan nonrenewal creates a special opportunity for affected members to select replacement Medicare coverage, guided by CMS rules and the required member notice. The purpose is to protect continuity of coverage rather than to force a gap.

Why the other choices are wrong

A. The nonrenewal SEP exists precisely to avoid an enforced coverage gap.

B. Commercial coverage cannot be assigned as a lifetime substitute for the Medicare plan.

C. A terminated Medicare contract cannot be kept in force indefinitely merely because the member takes no action.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 667 | M4-017

Correct answer: C. Requesting a step-therapy exception supported by the prescriber's medical statement.

Explanation. Step therapy generally requires trying one or more specified drugs first. When that sequence is medically unsuitable, the beneficiary or prescriber may request an exception to the coverage rule, supported by the prescriber's statement.

Why the other choices are wrong

A. Cash payment does not establish plan coverage or waive the utilization rule.

B. A pharmacy change does not ordinarily erase a plan's clinical utilization management.

D. A grievance addresses service dissatisfaction rather than the coverage-determination process needed for an exception.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 668 | M4-018

Correct answer: B. When a documented plan or federal error affected the individual's timely, informed election and relief is otherwise warranted.

Explanation. CMS may grant case-specific relief when a documented error by a plan sponsor or a federal employee affected a beneficiary's ability to make a timely, informed election. The facts must actually support that conclusion rather than being assumed.

Why the other choices are wrong

A. An ordinary change of mind is not the kind of documented error this relief addresses.

C. A grievance about service is a different process from a request for case-specific election relief.

D. Relief is not automatic; it depends on review of the specific facts.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 669 | M4-019

Correct answer: C. Prior authorization requiring plan approval before the drug is covered.

Explanation. Prior authorization requires the plan to confirm specified clinical criteria before it will cover a prescription. Yusuf or his prescriber may pursue the required approval or a supported exception request.

Why the other choices are wrong

A. A quantity limit restricts the covered amount rather than requiring advance clinical approval.

B. A tiering exception concerns cost-sharing placement and is not what caused this denial.

D. A transition supply is temporary and does not permanently remove plan rules.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 670 | M4-020

Correct answer: D. Reject the claimed basis because no such SEP exists, and separately confirm whether an actual qualifying election period applies.

Explanation. There is no recognized mail-delay special enrollment period. Compliance must reject the fabricated basis and independently determine whether the beneficiary has an actual qualifying enrollment opportunity, such as a documented SEP, AEP, or other valid period.

Why the other choices are wrong

A. A mail delay is not a recognized basis for a special enrollment period.

B. Entering a fabricated designation compounds the problem rather than resolving it.

C. A postal apology has no bearing on whether a valid Medicare election period exists.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 671 | M4-021

Correct answer: D. The beneficiary owes no cost sharing for covered Part D drugs during catastrophic coverage.

Explanation. Once a beneficiary's qualifying out-of-pocket spending reaches the annual threshold, the current redesigned Part D benefit provides catastrophic coverage with no beneficiary cost sharing on covered drugs for the rest of the year.

Why the other choices are wrong

A. Catastrophic-phase cost sharing is not simply a continuation of the initial-phase coinsurance percentage.

B. The former coverage-gap phase has been eliminated from the current standard benefit design.

C. Cost sharing at this phase is not billed as an unrelated flat annual fee.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 672 | M4-022

Correct answer: A. A move-related SEP lets her consider plans available at her new address.

Explanation. A permanent move outside the current plan's service area generally creates a Special Enrollment Period. Advance notice can allow the opportunity to begin before the move month, and Corinne may choose from plans serving her new residence.

Why the other choices are wrong

B. Permanent residence outside the service area can require disenrollment from the existing plan.

C. The destination plan must still serve Corinne's new address and satisfy other eligibility rules.

D. A qualifying geographic move is a recognized enrollment event independent of any health change.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 673 | M4-023

Correct answer: B. Requesting redetermination at the applicable next appeal level within the drug-plan process.

Explanation. An adverse Part D coverage determination generally carries appeal rights, and the next step is to request review at the applicable level under the drug-plan's appeal process, supported by the prescriber when needed.

Why the other choices are wrong

A. A grievance addresses service dissatisfaction rather than the merits of a denied drug-coverage request.

C. Appeal rights are not deferred until the next election period.

D. A pharmacist cannot unilaterally override the plan's coverage decision at dispensing.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 674 | M4-024

Correct answer: B. It continues for a defined limited period after departure rather than ending immediately or lasting indefinitely.

Explanation. The institutional SEP is not limited to the period of residence alone; it generally continues for a defined limited period after the qualifying resident leaves the facility, and then closes.

Why the other choices are wrong

A. An immediate cutoff at discharge misstates the defined post-departure window.

C. The opportunity is time-limited rather than open-ended for the rest of the person's Medicare enrollment.

D. Discharge does not convert the institutional SEP into the separate 5-star SEP.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 675 | M4-025

Correct answer: A. An expedited appeal supported by the documented urgent health facts.

Explanation. An expedited appeal applies a shortened timeframe when following the ordinary schedule could seriously jeopardize life, health, or the ability to regain maximum function. The physician's supporting statement addresses that standard directly.

Why the other choices are wrong

B. A grievance does not reconsider or overturn an adverse coverage determination.

C. A marketing complaint does not vacate a properly issued benefit decision.

D. Changing plans at a future date does not substitute for timely review of the present denial.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 676 | M4-026

Correct answer: C. The applicable loss-of-group-coverage SEP and its specific timing requirements.

Explanation. Loss of employer or union coverage can create a defined Special Enrollment Period for MA or Part D. The agent must confirm the event dates and distinguish this plan-election SEP from the separate Part B current-employment rule.

Why the other choices are wrong

A. Election periods are defined by law and documented facts, not an arbitrary application label.

B. Nonpayment does not automatically enroll a person in replacement Medicare coverage.

D. A SEP supplies timing authority; it does not waive Part A, Part B, or service-area eligibility.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 677 | M4-027

Correct answer: B. The beneficiary must hold a qualifying full-benefit dual status and the destination must be a qualifying aligned integrated D-SNP.

Explanation. The monthly integrated-care election opportunity depends on the beneficiary holding a qualifying full-benefit dual-eligible status and on the destination being a qualifying integrated D-SNP aligned with that Medicaid coverage. Both conditions must be satisfied together.

Why the other choices are wrong

A. Alignment with Medicaid coverage is central to this specific opportunity, not optional.

C. A prior year in Original Medicare is not a stated condition of this election right.

D. A 5-star rating is the basis for a separate, distinct SEP.

Applies to: NABIP
Source: https://www.medicare.gov/publications/11219-Understanding-Medicare-Advantage-Medicare-Drug-Plan-Enrollment-Periods.pdf
Verified: 2026-08-13

ANSWER 678 | M4-028

Correct answer: A. Paying cash does not satisfy the plan's coverage rule or make the drug a covered claim.

Explanation. Prior authorization is a coverage condition applied by the Part D plan. Paying out of pocket does not satisfy that requirement and does not itself establish plan coverage for the prescription.

Why the other choices are wrong

B. An exception must be requested and evaluated through the coverage-determination process, not created by a cash payment.

C. The requirement is not automatically waived for future fills because of one out-of-pocket purchase.

D. Original Medicare does not administer Part D utilization rules.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 679 | M4-029

Correct answer: C. No; agents may not solicit or take possession of completed AEP requests before the period opens.

Explanation. Agents may provide general education before AEP opens, but they may not solicit or accept possession of completed AEP enrollment requests before the period begins. Simply holding the forms until the correct date does not fix the earlier violation.

Why the other choices are wrong

A. Delayed submission does not undo the earlier improper solicitation and collection.

B. Altering the signature date is false documentation and compounds the problem.

D. October 15 is the correct AEP start date; the defect is the early collection, not the date itself.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 680 | M4-030

Correct answer: A. Organization determination appeal; Part D coverage determination; grievance.

Explanation. An MA coverage dispute is addressed through the organization determination and appeal process, a drug exception request is handled through the Part D coverage-determination process, and a service complaint without a coverage dispute is a grievance.

Why the other choices are wrong

B. The first two labels are reversed relative to the described facts.

C. None of the three pairings matches its scenario.

D. The final two labels are reversed relative to the described facts.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 681 | M4-031

Correct answer: A. Plan-specific sales content has changed the activity into a marketing or sales event.

Explanation. An educational event must stay limited to objective, general Medicare information without plan-specific promotion or enrollment activity. Comparing named carriers' benefits and distributing enrollment forms crosses into marketing and sales conduct.

Why the other choices are wrong

B. An educational opening does not preserve the classification once plan-specific promotion begins.

C. Distributing enrollment forms is inconsistent with an educational event even before any signature.

D. The room's location does not override the content and purpose of the session.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 682 | M4-032

Correct answer: D. No; the marketing and sales portion of the call must be recorded regardless of the outcome.

Explanation. The call-recording obligation attaches to marketing, sales, and enrollment calls, not only to calls that end in enrollment. Cutting off recording once a beneficiary declines still leaves the earlier marketing and sales content unrecorded.

Why the other choices are wrong

A. The requirement is not conditioned on the beneficiary ultimately enrolling.

B. A caller declining an offer does not turn a sales call into a neutral administrative one.

C. The rule targets marketing, sales, and enrollment calls specifically, not literally every phone call an agency makes.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 683 | M4-033

Correct answer: D. Remove or substantiate the comparison with accurate, current data and clear context.

Explanation. Plan comparisons and quality claims must be accurate, supportable, and tied to the relevant measure and period. An unqualified best-rated assertion is misleading when its factual basis is not identified.

Why the other choices are wrong

A. Marketing claims remain subject to accuracy and substantiation requirements.

B. A government-style seal would add a false-affiliation problem rather than cure the claim.

C. Substituting personal opinion without current supporting evidence does not fix the misleading comparison.

Applies to: NABIP
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 684 | M4-034

Correct answer: D. Preserve the observed facts and report the concern through the designated compliance channel.

Explanation. A credible concern should be reported promptly through the sponsor's compliance function or another authorized channel. Camille supplies the observed facts and preserves the evidence, while trained investigators determine what actually occurred.

Why the other choices are wrong

A. Altering evidence can obstruct an investigation and creates a separate compliance problem.

B. A private promise to destroy records is inconsistent with an impartial investigation.

C. Publicly releasing beneficiary signature data violates privacy and bypasses the authorized review process.

Applies to: NABIP
Source: https://oig.hhs.gov/reports-and-publications/featured-topics/ihs/training/fraud-waste-and-abuse-for-health-care-providers/content/
Verified: 2026-08-13

ANSWER 685 | M4-035

Correct answer: B. A stated basis or measure for the comparison, so the claim is not left unqualified.

Explanation. A supportable comparison needs a stated basis or measure, not just a current source and a labeled plan year, so a reader can see exactly what is being compared and on what terms.

Why the other choices are wrong

A. A future-year premium prediction is speculative and not part of a current, supportable comparison.

C. Compensation has no place in an accurate plan comparison.

D. Plan benefits can change, so a no-change guarantee is not a valid or supportable claim.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 686 | M4-036

Correct answer: B. Whether the piece meets both an intent standard and the specified marketing-content standard.

Explanation. Marketing is a defined subset of communications that satisfies both an intent element and a specified content element. A neutral operational notice can remain a general communication even though other rules still apply to it.

Why the other choices are wrong

A. Authorship alone does not establish both required marketing prongs.

C. Delivery method does not determine whether the content and intent tests are met.

D. Using a logo does not by itself convert a neutral notice into marketing.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 687 | M4-037

Correct answer: C. Explain that misleading or unsubstantiated statements are also prohibited, not just outright falsehoods.

Explanation. Marketing rules reach misleading, confusing, or unsubstantiated statements, not just claims that are literally false. Compliance must correct the narrower standard the director described before agents rely on it at events.

Why the other choices are wrong

A. Confirming the flawed instruction would leave agents making misleading but technically true statements.

B. Limiting the correction to premium claims ignores other categories of misleading content.

D. Spoken statements at an event are not exempt from the same accuracy standard.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 688 | M4-038

Correct answer: A. Statements I, II, and III.

Explanation. Statements I, II, and III accurately describe the distinctions among fraud, waste, and abuse. Fraud requires knowing deception, waste can be unintentional inefficiency, and abuse involves practices inconsistent with accepted standards.

Why the other choices are wrong

B. Statement IV is false because a single corrected typo lacks the intent required for fraud.

C. Statement IV is false, and this option omits the accurate Statement I.

D. Statement IV is false, and this option omits the accurate Statement II.

Applies to: NABIP
Source: https://oig.hhs.gov/reports-and-publications/featured-topics/ihs/training/fraud-waste-and-abuse-for-health-care-providers/content/
Verified: 2026-08-13

ANSWER 689 | M4-039

Correct answer: C. Yes, because CMS permits marketing in appropriate common areas subject to facility and CMS rules.

Explanation. CMS permits marketing in appropriate common areas of health-care settings, such as a public lobby, while prohibiting it in treatment and patient-care areas. Facility policies and other marketing rules still apply.

Why the other choices are wrong

A. The rules distinguish permitted common areas from prohibited care settings rather than banning the entire facility.

B. Avoiding premium discussion does not change whether the location itself is appropriate.

D. A treatment area is exactly the kind of location where marketing is prohibited.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 690 | M4-040

Correct answer: B. Retain the audio for the first three years, with audio or a complete transcript acceptable for the remaining years of the required period.

Explanation. Marketing and sales calls must be retained for a defined multi-year period, with audio required for the initial years and either audio or a complete, accurate transcript acceptable afterward. This obligation attaches regardless of whether the call resulted in enrollment.

Why the other choices are wrong

A. Thirty-day deletion falls far short of the required multi-year retention.

C. The audio requirement is not eliminated by retaining only a transcript from the outset.

D. Retention attaches to the marketing or sales call itself, not only to calls that end in enrollment.

Applies to: NABIP
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-423/subpart-V
Verified: 2026-08-13

ANSWER 691 | M4-041

Correct answer: D. Remove the agent-initiated unrelated cross-sale from the Medicare appointment.

Explanation. A Medicare marketing appointment is not blanket permission to cross-sell an unrequested, unrelated product. A separate, beneficiary-initiated, and independently compliant interaction is needed for a product outside the documented scope.

Why the other choices are wrong

A. The SOA documents defined product categories and does not authorize unrelated subscription sales.

B. Discouraging questions does not cure the underlying scope and cross-selling violation.

C. Combining an unrelated subscription onto the Medicare enrollment form would misrepresent both the form and the product.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

ANSWER 692 | M4-042

Correct answer: C. False; prompt reporting through the designated privacy or security channel is expected even before misuse is confirmed.

Explanation. The statement is false. Prompt reporting allows the responsible privacy and security function to investigate, mitigate risk, and determine any notification obligations, without waiting for proof that the exposed data was actually misused.

Why the other choices are wrong

A. Waiting for confirmed misuse can delay investigation and mitigation rather than conserve resources.

B. The organization, not individual beneficiaries, is responsible for the formal incident assessment.

D. Direct beneficiary notification is not the appropriate first step in place of the organization's own reporting channel.

Applies to: NABIP
Source: https://www.hhs.gov/hipaa/for-professionals/privacy/index.html
Verified: 2026-08-13

ANSWER 693 | M4-043

Correct answer: C. No; the required prior express written consent must precede the inter-TPMO data sharing.

Explanation. Prior express written consent must be obtained before one TPMO shares a beneficiary's personal data with another for marketing. A consent form sent after the transfer and the sales call cannot retroactively authorize the earlier disclosure.

Why the other choices are wrong

A. Licensing status does not eliminate the prior-consent requirement.

B. A later enrollment does not validate an earlier unauthorized transfer.

D. Sharing is permitted when the specific prior-consent and disclosure safeguards are actually satisfied in advance.

Applies to: NABIP
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-423/subpart-V
Verified: 2026-08-13

ANSWER 694 | M4-044

Correct answer: B. A modest noncash item offered to attendees regardless of whether they enroll.

Explanation. A modest noncash item offered without conditioning it on enrollment may be permissible within applicable limits. Cash, cash-equivalent cards, and enrollment-linked rebates raise beneficiary-inducement concerns instead.

Why the other choices are wrong

A. Cash tied to completing an enrollment is a prohibited inducement.

C. A broadly spendable card exchanged for another person's contact data raises both inducement and data-collection concerns.

D. A rebate that increases with plan selection is a prohibited monetary inducement.

Applies to: NABIP
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 695 | M4-045

Correct answer: B. Scope of Appointment; Permission to Contact; TPMO disclaimer.

Explanation. The Scope of Appointment defines the product categories for a personal marketing appointment, Permission to Contact authorizes reaching out to the beneficiary, and the TPMO disclaimer must be delivered before discussing plan benefits.

Why the other choices are wrong

A. The first two items are reversed relative to their described functions.

C. None of the three pairings matches its described function in this order.

D. The last two items are reversed relative to their described functions.

Applies to: NABIP
Source: https://www.cms.gov/files/document/cy2027-agent-broker-training-testing-guidelines-pdf.pdf
Verified: 2026-08-13

Bonus Drill - 5 questions

5 answer entries. Match each entry to the question number and ID printed in Part I.

ANSWER 696 | B-001

Correct answer: D. The alignment of his ICEP timing with the applicable MA enrollment effective-date rules.

Explanation. When Part A and Part B effective dates do not align, the ICEP spans a period tied to those entitlement dates, and the earliest possible MA effective date follows the applicable enrollment effective-date rules governing that period rather than an informal conversation or unrelated coverage.

Why the other choices are wrong

A. An informal conversation does not establish an enrollment effective date.

B. A Medigap application date is unrelated to MA effective-date rules.

C. A former employer plan's start date does not control the ICEP-based MA effective date.

Applies to: Both
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-13

ANSWER 697 | B-002

Correct answer: A. Whether the request was validly submitted within the AEP window itself.

Explanation. A valid election submitted within the AEP window generally becomes effective January 1 of the following year; submission timing within that window, not unrelated personal or marketing dates, is what controls the effective date.

Why the other choices are wrong

B. A beneficiary's birthday has no bearing on the AEP effective-date rule.

C. Agent preference does not set the legally controlling effective date.

D. The printing date of marketing material does not determine coverage timing.

Applies to: Both
Source: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Verified: 2026-08-13

ANSWER 698 | B-003

Correct answer: B. Whether the facts actually establish a qualifying permanent change of residence rather than temporary travel.

Explanation. A move-related SEP depends on an actual permanent change of residence; a short hotel stay does not by itself establish that fact, so the underlying residency facts must be resolved before treating the election as valid.

Why the other choices are wrong

A. A brief travel receipt does not automatically satisfy the permanent-move requirement.

C. A discount offered during the stay has no bearing on residency status.

D. Personal enjoyment of a trip does not establish a qualifying permanent move.

Applies to: Both
Source: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
Verified: 2026-08-13

ANSWER 699 | B-004

Correct answer: C. Marketing, because naming and comparing competing plans satisfies the required content standard.

Explanation. Including a comparison of named competing plans' benefits or costs supplies the plan-specific content that, together with the applicable intent standard, generally makes a piece marketing rather than a neutral communication.

Why the other choices are wrong

A. A phone number alone does not offset comparative plan content that satisfies the marketing standard.

B. Naming multiple companies for comparison is a marketing feature, not an educational one.

D. A grievance notice concerns member complaints, not a comparative benefit flyer.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13

ANSWER 700 | B-005

Correct answer: D. Statements I, II, and IV.

Explanation. Statements I, II, and IV correctly describe the two-part marketing standard, the possibility that a neutral operational notice remains a communication, and the marketing character of named-plan benefit comparisons. Statement III is false because authorship by a plan does not automatically satisfy both required marketing elements.

Why the other choices are wrong

A. Statement III is false, and this choice omits accurate Statement II.

B. Statement III is false, and this choice omits Statements I and IV.

C. Statement III is false and should not be included in an accurate answer.

Applies to: Both
Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V
Verified: 2026-08-13