

Certified Employee Benefit Specialist (CEBS) Group Benefits Associate (GBA) 1 Practice Exam (Sample)

Study Guide



Everything you need from our exam experts!

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 - 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

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- 1. Which type of employer is more significantly affected by risk selection among employer groups?**
 - A. Small employers with a single health plan**
 - B. Large employers with multiple health plans**
 - C. Employers offering only traditional health plans**
 - D. Employers who do not offer health benefits**

- 2. What is the effect of asymmetric information in insurance design related to CDHPs?**
 - A. It encourages insurers to provide more comprehensive coverage**
 - B. It leads to consumers self-selecting coverage based on their risk level**
 - C. It eliminates the concept of risk segmentation**
 - D. It guarantees equal coverage for all enrollees**

- 3. Which essential health benefit addresses the needs of individuals requiring substance abuse treatment?**
 - A. Emergency services**
 - B. Behavioral health services**
 - C. Preventive health services**
 - D. Pediatric services**

- 4. When does group health insurance pay as the primary payer for individuals under the Medicare Secondary Payer rules?**
 - A. When an employee is self-employed**
 - B. When an employee is covered through family employment and the employer has more than 100 employees**
 - C. For all Medicare beneficiaries**
 - D. Only for government employees**

- 5. What is one of the key benefits of a comprehensive workplace wellness program?**
 - A. Increased turnover**
 - B. Higher absenteeism**
 - C. Improved productivity**
 - D. Increased health insurance premiums**

- 6. What is an evergreen election in a Cafeteria plan?**
- A. A two-time election that lasts for six months**
 - B. A one-time election that carries over each plan year unless changed**
 - C. A type of election that resets each year**
 - D. A mandatory selection for health coverage only**
- 7. What aspect of wellness programs showed limited effectiveness according to the RAND Study?**
- A. Involvement of employee assistance programs**
 - B. Outreach for chronic condition management**
 - C. Scope of lifestyle management services**
 - D. Screening for genetic predispositions**
- 8. Which risk handling technique is considered mutually exclusive to others?**
- A. Control**
 - B. Transfer**
 - C. Avoidance**
 - D. Retention**
- 9. What payment method change did Medicare implement related to diagnosis related groups (DRGs) in the 1980s?**
- A. It reduced physician payments significantly**
 - B. It increased hospital costs dramatically**
 - C. It transitioned to payment based on DRGs instead of costs**
 - D. It eliminated outpatient services completely**
- 10. How does the compensation/service-oriented philosophy differ from the needs-oriented philosophy?**
- A. The compensation/service-oriented philosophy is more flexible**
 - B. The needs-oriented approach focuses on employee needs and dependents**
 - C. The compensation/service-oriented approach emphasizes employee input**
 - D. The needs-oriented philosophy offers fewer benefits**

Answers

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

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Explanations

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1. Which type of employer is more significantly affected by risk selection among employer groups?

- A. Small employers with a single health plan**
- B. Large employers with multiple health plans**
- C. Employers offering only traditional health plans**
- D. Employers who do not offer health benefits**

Large employers with multiple health plans are more significantly affected by risk selection among employer groups due to the greater diversity in their employee demographics and health needs. With multiple health plans, larger employers can experience a wider variance in the risk profiles of their employee populations across different plans. Some plans may attract healthier individuals, while others may attract those with higher healthcare needs. This selection effect can lead to considerable disparities in claims costs and can impact the overall stability and pricing of the health plans offered. In contrast, small employers with a single health plan might have a more homogeneous group, leading to less risk selection because their employee pool does not have as much variance in health status. Employers offering only traditional health plans may also limit the diversity in risk profiles since these plans might not appeal to a broader range of health statuses. Employers who do not offer health benefits face no risk selection issues, as there are no health plans to consider. Hence, large employers with multiple plans are the most affected by the nuances of risk selection.

2. What is the effect of asymmetric information in insurance design related to CDHPs?

- A. It encourages insurers to provide more comprehensive coverage**
- B. It leads to consumers self-selecting coverage based on their risk level**
- C. It eliminates the concept of risk segmentation**
- D. It guarantees equal coverage for all enrollees**

Asymmetric information occurs when one party in a transaction has more or better information than the other party. In the context of insurance design related to Consumer-Directed Health Plans (CDHPs), this situation significantly influences how individuals select their coverage. Consumers possess varying levels of information regarding their own health risks while insurers may not have access to this specific health information. As a result, consumers with higher health risks are more likely to opt for plans that provide more extensive coverage, as they anticipate a greater need for medical care. Conversely, individuals who perceive themselves as healthier may prefer plans with lower premiums and higher deductibles, as they estimate their likelihood of utilizing health services to be lower. This self-selection based on individual risk levels directly impacts the insurance pool. It creates a situation where individuals with higher expected healthcare costs enroll in more comprehensive plans, while those with lower costs choose less coverage. This dynamic can lead to higher premiums for the plans that attract higher-risk individuals and can drive healthier individuals away from comprehensive plans, potentially resulting in an imbalance in the risk pool. Understanding this concept is crucial for designing effective insurance plans that account for the variation in consumer risk perception and ensure equitable pricing and coverage options for different segments of the population.

3. Which essential health benefit addresses the needs of individuals requiring substance abuse treatment?

- A. Emergency services
- B. Behavioral health services**
- C. Preventive health services
- D. Pediatric services

The correct answer is behavioral health services because this essential health benefit specifically encompasses the treatment of mental health and substance use disorders. Behavioral health services include therapy, counseling, and rehabilitation programs that are vital for individuals seeking help for substance abuse issues. This recognition ensures that individuals have access to necessary treatment options, reflecting the importance of mental health in overall health care. Emergency services, while crucial, primarily focus on immediate medical needs rather than ongoing treatment for substance abuse. Preventive health services are intended for early intervention and disease prevention but do not directly target the treatment of substance use disorders. Pediatric services are designed for the health care needs of children, which may include some behavioral health aspects but do not specifically address substance abuse treatment in adults. Thus, behavioral health services is the most appropriate designation for addressing substance abuse needs.

4. When does group health insurance pay as the primary payer for individuals under the Medicare Secondary Payer rules?

- A. When an employee is self-employed
- B. When an employee is covered through family employment and the employer has more than 100 employees**
- C. For all Medicare beneficiaries
- D. Only for government employees

Group health insurance pays as the primary payer under the Medicare Secondary Payer rules when the Medicare beneficiary is covered through an employer-sponsored plan. Specifically, if the employer has more than 100 employees, the group health plan typically assumes primary responsibility for claims before Medicare benefits are applied. This is especially true for individuals who are still actively employed and are covered by their employer's group plan. In general, Medicare Secondary Payer rules outline scenarios where Medicare does not pay first. When a large employer (with more than 100 employees) provides coverage, they are considered primary, ensuring coverage for employees and their dependents before Medicare applies. This helps facilitate better access to health benefits for workers and their families. In contrast, situations involving self-employment or small employers with fewer than 100 employees lead to different interactions between Medicare and group health plans. Similarly, whether individuals are government employees or general Medicare beneficiaries doesn't inherently dictate the primary payer status, as it is predominantly driven by the specifics of their employment coverage and the size of the employer.

5. What is one of the key benefits of a comprehensive workplace wellness program?

- A. Increased turnover**
- B. Higher absenteeism**
- C. Improved productivity**
- D. Increased health insurance premiums**

A comprehensive workplace wellness program is designed to promote the health and well-being of employees, which can lead to improved productivity. When employees engage in wellness initiatives such as physical activity, healthy eating, stress management, and preventive care, they often experience better overall health. This enhancement in health status can reduce fatigue and increase energy levels, resulting in higher engagement and performance while at work. As a direct consequence, organizations that implement such programs frequently observe a decrease in absenteeism and presenteeism, both of which can further boost productivity levels. In contrast, increased turnover, higher absenteeism, and increased health insurance premiums do not represent the positive outcomes associated with comprehensive wellness programs. In fact, the goal of these programs is to mitigate turnover and absenteeism while potentially managing or reducing health insurance costs through improved employee health. Thus, the focus on improved productivity through a proactive approach to employee wellness is a fundamental advantage of such programs.

6. What is an evergreen election in a Cafeteria plan?

- A. A two-time election that lasts for six months**
- B. A one-time election that carries over each plan year unless changed**
- C. A type of election that resets each year**
- D. A mandatory selection for health coverage only**

An evergreen election in a Cafeteria plan refers to a one-time election that carries over from year to year unless the employee chooses to change it. This means once an employee makes their election, that choice automatically continues into subsequent plan years without needing to be re-elected each time, providing convenience and consistency for both the employee and the employer. This arrangement allows participants the ability to plan and manage their benefit selections with greater ease, as they do not have to re-evaluate their choices every year unless their circumstances or needs change. It ensures that if an employee is satisfied with their previous elections, they can maintain them without additional action, fostering a sense of stability. The other options do not represent the correct concept of an evergreen election. For instance, the idea of a two-time election lasting six months or a type of election that resets each year does not align with the definition of evergreen elections, which emphasize continuity rather than repeated selections. The notion of a mandatory selection for health coverage only also does not capture the broader context of evergreen elections within the flexibility of a Cafeteria plan.

7. What aspect of wellness programs showed limited effectiveness according to the RAND Study?

- A. Involvement of employee assistance programs**
- B. Outreach for chronic condition management**
- C. Scope of lifestyle management services**
- D. Screening for genetic predispositions**

The aspect of wellness programs that showed limited effectiveness according to the RAND Study is the scope of lifestyle management services. This finding highlights that while lifestyle management initiatives are commonly incorporated into wellness programs with the intent of promoting healthier behaviors among employees, the impact of these services on improving health outcomes and reducing overall healthcare costs can be minimal. The limited effectiveness suggests that simply providing a broader range of lifestyle management options—such as diet, exercise, and stress management programs—does not guarantee participation or engagement from employees or lead to sustained behavioral change. Effective wellness programs often require a more tailored approach that considers the unique needs and preferences of the workforce rather than a generic offering of services. In contrast, the other aspects mentioned, such as involvement of employee assistance programs, outreach for chronic condition management, and screening for genetic predispositions, have traditionally shown more promise in positively influencing employee health and wellness. These areas typically involve more direct engagement with employees and can lead to improved health outcomes, making them more valuable components of an effective wellness strategy.

8. Which risk handling technique is considered mutually exclusive to others?

- A. Control**
- B. Transfer**
- C. Avoidance**
- D. Retention**

The correct answer is avoidance, as it represents a unique approach to handling risk that fundamentally differs from the other techniques. When an organization opts for avoidance, it chooses to eliminate any exposure to a particular risk entirely, which can mean discontinuing a particular project, activity, or investment that poses a potential hazard. This approach contrasts with the others, which either accept or manage the risk in some capacity. For example, control involves implementing measures to reduce the likelihood or impact of the risk, transfer shifts the risk to another party (such as through insurance), and retention means accepting the risk with the understanding that it might materialize. None of these methods eliminate the risk altogether, as avoidance does. Thus, avoidance stands out as mutually exclusive, as it does not engage with the risk in the same way that the other techniques do.

9. What payment method change did Medicare implement related to diagnosis related groups (DRGs) in the 1980s?

- A. It reduced physician payments significantly**
- B. It increased hospital costs dramatically**
- C. It transitioned to payment based on DRGs instead of costs**
- D. It eliminated outpatient services completely**

In the 1980s, Medicare implemented a significant change in its payment structure by transitioning to a system that reimbursed hospitals based on Diagnosis Related Groups (DRGs) instead of reimbursing them for the actual costs incurred during patient care. This change was pivotal because it established a fixed payment rate determined by the patient's diagnosis and the severity of their condition, which was designed to encourage hospitals to operate more efficiently and reduce unnecessary services. The DRG payment system aimed to control rising healthcare costs by incentivizing hospitals to provide care within a predetermined budget. Under this system, hospitals are paid a flat fee for treating a patient based on their diagnosis, rather than being reimbursed for all individual services provided. This shift from a cost-based payment model to a prospective payment model is foundational in the way Medicare operates today, affecting how services are billed and how care is managed within hospitals. The other options do not accurately reflect the primary change made to Medicare's payment model with regard to DRGs in the 1980s. The focus was on the switch to a fixed payment method based on specific diagnoses, rather than the nature of the individual services rendered or eliminating services entirely.

10. How does the compensation/service-oriented philosophy differ from the needs-oriented philosophy?

- A. The compensation/service-oriented philosophy is more flexible**
- B. The needs-oriented approach focuses on employee needs and dependents**
- C. The compensation/service-oriented approach emphasizes employee input**
- D. The needs-oriented philosophy offers fewer benefits**

The needs-oriented approach focuses on employee needs and dependents, which is key to understanding its purpose and implementation. This philosophy prioritizes the specific requirements and circumstances of employees, considering factors such as their family status, personal challenges, and various life stages. By identifying and addressing these particular needs, employers can tailor their benefits offerings to better support their workforce, ultimately fostering loyalty and satisfaction among employees. In contrast, the compensation/service-oriented philosophy generally emphasizes more standardized compensation structures and the services provided by the employer, without necessarily focusing on the unique, individual requirements of each employee. This distinction highlights why the needs-oriented philosophy is particularly effective for addressing personal and familial considerations, allowing organizations to create a more inclusive and supportive work environment.

Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

<https://cebsgba1.examzify.com>

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

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