

CERTIFIED EMPLOYEE BENEFIT SPECIALIST (CEBS) GROUP BENEFITS ASSOCIATE (GBA) 1 PRACTICE EXAM (SAMPLE)

STUDY GUIDE



Prepare with structure. Pass with confidence



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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 of the following was a major objective of the Affordable Care Act?**
 - A. Eliminate all private health insurance plans
 - B. Reduce the healthcare workforce
 - C. Improve quality and lower healthcare costs
 - D. Increase the number of uninsured individuals
- 2. What impact did the Affordable Care Act (ACA) have on CDHPs concerning minimum actuarial requirements?**
 - A. The ACA ensured all CDHPs met minimum requirements
 - B. The ACA created uncertainty, with concerns that many CDHPs wouldn't meet minimum requirements
 - C. The ACA had no impact on CDHPs
 - D. The ACA abolished CDHPs entirely
- 3. What is included in the concept of medical expenses under needs covered by Employee Benefit Plans?**
 - A. Retirement Needs
 - B. Dependent Care Assistance
 - C. Loss due to Property Damage
 - D. Medical Expenses for Employee and Dependents
- 4. Which of the following is a payment structure commonly used for healthcare providers?**
 - A. Per time period
 - B. Per consultation
 - C. Per individual basis
 - D. Per letter of recommendation
- 5. What is the common reimbursement structure for hearing care services?**
 - A. 100% coverage without limits
 - B. 80% reimbursement with a maximum limit
 - C. 60% cost coverage with no caps
 - D. 50% coverage only for exams

- 6. What is one key component of a good ROI evaluation?**
- A. Focus solely on financial outputs
 - B. Ignore limitations and assumptions
 - C. Identify and measure all costs and benefits important to user decisions
 - D. Utilize only historical data without current relevance
- 7. Which of the following is NOT a key ingredient of an effective workplace wellness program?**
- A. Health screenings
 - B. Organized activities
 - C. Traditional retirement planning
 - D. Incentives
- 8. What is one event that entitles an employee to COBRA coverage?**
- A. Promotion
 - B. Death of a family member
 - C. Termination of employment
 - D. Change of address
- 9. What distinction is made between "immediate subjects" and "long-term aims" of reforms?**
- A. Immediate subjects are short-term targets; long-term aims focus on immediate cost reduction
 - B. Immediate subjects can be more easily measured; long-term aims affect procedure change
 - C. Immediate subjects relate to organizational changes; long-term aims aim to improve health outcomes
 - D. Immediate subjects involve legislative changes; long-term aims are about stakeholder engagement
- 10. What do HIPAA non-discrimination prohibitions prevent regarding employee benefits?**
- A. Denying eligibility based on health factors
 - B. Increasing coverage costs for all employees
 - C. Offering fewer options for group plans
 - D. Limiting coverage to age

Answers

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

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Explanations

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1. Which of the following was a major objective of the Affordable Care Act?

- A. Eliminate all private health insurance plans
- B. Reduce the healthcare workforce
- C. Improve quality and lower healthcare costs**
- D. Increase the number of uninsured individuals

The major objective of the Affordable Care Act (ACA) was to improve quality and lower healthcare costs. This comprehensive healthcare reform aimed to make health insurance more affordable and accessible to a larger segment of the population, as well as to enhance the quality of care received by patients. The ACA introduced various measures to achieve these objectives, such as expanding Medicaid eligibility, creating health insurance marketplaces, and implementing regulations to prevent discriminatory practices by insurers, like denying coverage due to pre-existing conditions. The act also included provisions for preventive services to be provided at no cost, which encourages early detection and health promotion, ultimately leading to better health outcomes and reduced costs over time. By focusing on both quality and cost, the ACA sought to create a more efficient healthcare system that would not only increase access to care but also ensure that individuals received high-quality health services without financial strain. This emphasis on improving quality while managing costs reflects the broader goal of achieving a sustainable healthcare system in the United States.

2. What impact did the Affordable Care Act (ACA) have on CDHPs concerning minimum actuarial requirements?

- A. The ACA ensured all CDHPs met minimum requirements
- B. The ACA created uncertainty, with concerns that many CDHPs wouldn't meet minimum requirements**
- C. The ACA had no impact on CDHPs
- D. The ACA abolished CDHPs entirely

The Affordable Care Act (ACA) introduced a range of reforms aimed at improving healthcare coverage and accessibility. One significant aspect of the ACA was the establishment of minimum actuarial value requirements for health insurance plans, which influenced Consumer-Driven Health Plans (CDHPs). The correct answer highlights that the ACA created uncertainty regarding whether many CDHPs would meet these newly established minimum actuarial requirements. This uncertainty stemmed from the variability in plan designs and benefits offered under CDHPs, as some may not have aligned with the minimum standards set forth by the ACA. Consequently, some employers and insurance carriers expressed concerns about the future viability of certain CDHPs, anticipating challenges in ensuring that all features of these plans complied with the ACA's stipulations on essential health benefits and cost-sharing limits. In contrast, the other options do not accurately reflect the nuanced realities brought about by the ACA. While the ACA did emphasize the need for plans to adhere to specific requirements, it did not guarantee that all CDHPs would automatically meet these standards, nor did it abolish them. CDHPs remained a viable option, allowing flexibility and cost savings for both employers and employees, albeit within the context of new regulations. Thus, the impact was one of caution and adaptation

3. What is included in the concept of medical expenses under needs covered by Employee Benefit Plans?

- A. Retirement Needs
- B. Dependent Care Assistance
- C. Loss due to Property Damage

D. Medical Expenses for Employee and Dependents

The concept of medical expenses under needs covered by Employee Benefit Plans is primarily focused on providing financial support for healthcare-related costs incurred by employees and their dependents. This coverage typically includes expenditures for hospital stays, surgeries, doctor visits, prescription medications, and other health-related services that directly impact the medical care of individuals. Choosing the option that includes "medical expenses for employee and dependents" aligns perfectly with the primary function of employee benefit plans, particularly health insurance. These plans are designed to mitigate the financial burden of medical costs, ensuring employees and their families have access to necessary medical care without facing overwhelming expenses. Other choices such as retirement needs, dependent care assistance, and loss due to property damage fall outside the scope of typical health-related expenses covered by these benefit plans. These aspects focus on different areas of employee support and do not directly relate to medical expenditure, differentiating them from the designated purpose of health benefits.

4. Which of the following is a payment structure commonly used for healthcare providers?

- A. Per time period
- B. Per consultation
- C. Per individual basis
- D. Per letter of recommendation

The payment structure referred to as "per time period" typically involves a model where healthcare providers are compensated based on a set timeframe, such as a monthly or annual fee. This structure is often seen in prepaid health plans or capitation agreements, where providers receive a fixed amount for patient care over a specific duration, regardless of the number of services rendered. This model incentivizes providers to focus on preventive care and overall population health management, as it gives them a steady income stream while encouraging them to keep their patients healthy to minimize the need for more costly interventions. The other options do not reflect standard healthcare payment models. "Per consultation" would imply payment for each individual visit, which is more common in fee-for-service models but is not as frequently used as a general payment structure across a broad range of healthcare practices. "Per individual basis" is too vague and does not accurately describe a structured payment model. "Per letter of recommendation" is not a recognized payment structure in healthcare; it more closely pertains to academic or professional scenarios rather than medical payment systems.

5. What is the common reimbursement structure for hearing care services?

- A. 100% coverage without limits
- B. 80% reimbursement with a maximum limit**
- C. 60% cost coverage with no caps
- D. 50% coverage only for exams

The common reimbursement structure for hearing care services typically involves a percentage of costs being covered along with a maximum limit on the amount that can be reimbursed. This approach aligns with standard practices in many health insurance plans, where a percentage of eligible expenses is covered to encourage preventative care while also managing costs for the insurance provider. Choosing 80% reimbursement with a maximum limit reflects a balanced approach, often allowing patients to receive significant financial support while also capping the insurer's liability for high-cost services. This structure ensures that patients are motivated to seek necessary hearing care without overwhelming financial burdens, yet maintains a safeguard for the insurance provider against excessively high claims that could arise from unlimited coverage or lower percentage reimbursements. In contrast, 100% coverage without limits may lead to high costs for insurers, making it less common. Similarly, 60% coverage with no caps and 50% coverage only for exams may not provide the comprehensive support needed for various hearing care services, limiting access and affordability for patients. Thus, the selected reimbursement model effectively balances care accessibility with cost management for both insurers and their members.

6. What is one key component of a good ROI evaluation?

- A. Focus solely on financial outputs
- B. Ignore limitations and assumptions
- C. Identify and measure all costs and benefits important to user decisions**
- D. Utilize only historical data without current relevance

A fundamental aspect of a good return on investment (ROI) evaluation involves identifying and measuring all costs and benefits that are significant to user decisions. This comprehensive approach ensures that each element influencing the investment's success is accounted for, fostering an accurate assessment of its overall value. By capturing both tangible and intangible benefits, as well as all relevant costs, stakeholders can make informed decisions based on a complete understanding of the potential ROI. Focusing only on financial outputs sacrifices a more holistic view, which may overlook crucial non-financial benefits that could impact the investment's success. Ignoring limitations and assumptions can lead to unrealistic evaluations, potentially creating blind spots in the analysis that misrepresent the investment's viability. Relying solely on historical data without considering current conditions may fail to capture emerging trends or shifts in the market that are essential for making prudent investment decisions. Overall, a thorough consideration of all costs and benefits involved provides the clearest picture of ROI, enabling organizations to justify their investments effectively and set realistic expectations for outcomes.

7. Which of the following is NOT a key ingredient of an effective workplace wellness program?

- A. Health screenings
- B. Organized activities
- C. Traditional retirement planning**
- D. Incentives

An effective workplace wellness program focuses on improving employees' overall health and well-being through various initiatives. Health screenings, organized activities, and incentives are all designed to promote a healthier workforce. Health screenings help identify health risks early, allowing for interventions that can enhance employee health. Organized activities foster engagement and participation in health-related initiatives, contributing to a culture of wellness. Incentives encourage employees to participate in wellness programs, reinforcing positive health behaviors and motivating them to make healthier choices. On the other hand, traditional retirement planning is centered around preparing employees for financial stability in their later years and does not directly relate to the health and wellness metrics that a wellness program addresses. Thus, it is not considered a key ingredient of an effective workplace wellness program, as it does not contribute to improving employee health and well-being.

8. What is one event that entitles an employee to COBRA coverage?

- A. Promotion
- B. Death of a family member
- C. Termination of employment**
- D. Change of address

COBRA, or the Consolidated Omnibus Budget Reconciliation Act, provides eligible employees and their qualifying dependents the right to continue health insurance coverage in certain instances where they would otherwise lose their group health benefits. One key event that triggers this entitlement is the termination of employment. This includes both voluntary and involuntary terminations, such as if an employee resigns or is laid off. The purpose of this provision is to give employees and their families the opportunity to maintain health coverage during a transitional period, allowing them time to seek new employment or find alternative health insurance options. Other events involving family changes or promotions do not qualify for COBRA coverage, as they do not result in the loss of health insurance benefits from the employer.

9. What distinction is made between "immediate subjects" and "long-term aims" of reforms?

- A. Immediate subjects are short-term targets; long-term aims focus on immediate cost reduction
- B. Immediate subjects can be more easily measured; long-term aims affect procedure change
- C. Immediate subjects relate to organizational changes; long-term aims aim to improve health outcomes**
- D. Immediate subjects involve legislative changes; long-term aims are about stakeholder engagement

The distinction between "immediate subjects" and "long-term aims" of reforms is best captured by the assertion that immediate subjects relate to organizational changes while long-term aims focus on improving health outcomes. Immediate subjects typically involve practical, actionable steps that can enhance the organizational structure or processes within a system. These changes might include implementing new procedures or protocols that directly affect how an organization operates in the short term. On the other hand, long-term aims are broader and are concerned with overarching goals, such as improving health outcomes for a population over time. This might involve not only the implementation of policies but also changes that require sustained efforts, such as behavioral adjustments within a healthcare system, preventive care initiatives, or long-term investments in community health. This understanding highlights the operational nature of immediate subjects in addressing current inefficiencies or organizational needs, whereas long-term aims emphasize strategic planning and visionary outcomes that enhance public health or operational efficacy in a more enduring manner.

10. What do HIPAA non-discrimination prohibitions prevent regarding employee benefits?

- A. Denying eligibility based on health factors**
- B. Increasing coverage costs for all employees
- C. Offering fewer options for group plans
- D. Limiting coverage to age

The correct answer addresses the core focus of HIPAA's non-discrimination prohibitions, which is to ensure that health factors do not lead to unfair treatment of individuals when it comes to eligibility for employee benefits. Under HIPAA, employers are prohibited from denying benefits or eligibility to individuals based on their health status, medical conditions, or any other health-related factors. This is crucial in promoting fairness and equity in employee benefit programs, allowing all employees to access the benefits they are entitled to, regardless of their health. The intention behind these prohibitions is to protect individuals from being discriminated against solely because of their health status, which could otherwise lead to disparities in access to necessary health coverage and resources. This helps to create a healthier workplace environment and encourages a more inclusive approach to employee benefits. While other options may touch on important aspects of employee benefits, they do not directly align with the focus of HIPAA's non-discrimination provisions. For instance, increasing costs or limiting coverage options might pose challenges in benefits design, but they are not explicitly covered under the non-discrimination prohibitions in the same way that health status-based eligibility restrictions are.

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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