

Certified Employee Benefit Specialist (CEBS) Group Benefits Associate (GBA) 2 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. All the following are major requirements of a long-term care (LTC) policy EXCEPT:**
 - A. The policy must provide a cash surrender value**
 - B. The policy must provide certain consumer protection provisions**
 - C. The policy must be guaranteed renewable**
 - D. The policy must cover only qualified LTC services**

- 2. What may happen to employers who do not offer affordable health coverage under the ACA?**
 - A. They may receive a bonus**
 - B. They may incur penalties**
 - C. There are no consequences**
 - D. They will be required to provide additional benefits**

- 3. Which of the following statements is correct regarding patient-centered medical homes (PCMHs)?**
 - A. PCMHs disregard patient involvement**
 - B. PCMHs provide a solitary approach to care**
 - C. PCMHs emphasize shared decision making with patients**
 - D. PCMHs do not require team collaboration**

- 4. What does "mgmt" stand for in employee health benefit plans?**
 - A. Managing employee salaries**
 - B. Management strategies for benefit plan administration**
 - C. Mechanisms for gathering employee feedback**
 - D. Monitoring job satisfaction levels**

- 5. What is a key difference between a Health Savings Account (HSA) and a flexible spending account (FSA)?**
 - A. An HSA belongs to the employer, an FSA to the employee**
 - B. An HSA requires annual contributions, an FSA does not**
 - C. An HSA can roll over funds, while an FSA typically cannot**
 - D. An HSA only covers emergency expenses, an FSA covers all expenses**

- 6. Which of the following assumptions about long-term care (LTC) policies in the 1980s and 1990s were proven incorrect?**
- A. Morbidity experience was lower than expected.**
 - B. Lapse rates were lower than expected.**
 - C. Higher-than-expected margins were needed for adverse selection.**
 - D. I and III are correct.**
- 7. What is the primary purpose of employee benefits legislation enforced by the Department of Labor?**
- A. To maximize profit margins for insurance companies**
 - B. To ensure employee rights are protected under ERISA**
 - C. To reduce the number of employees receiving benefits**
 - D. To establish minimum wage requirements**
- 8. Which statement about the U.S. health care market is accurate?**
- A. It operates with complete transparency between consumers and providers**
 - B. It has minimal insurance asymmetry**
 - C. There is significant information asymmetry**
 - D. It is characterized by uniform pricing**
- 9. In the patient-centered medical home (PCMH) model, what is true about primary care visits?**
- A. Only generalists can be the first contact during visits**
 - B. Medical homes never use electronic communication for consultations**
 - C. Daily team "huddles" are common to discuss cases**
 - D. Specialists conduct all primary care visits**
- 10. What does adverse selection refer to in group insurance?**
- A. High enrollment rates of healthy individuals**
 - B. A situation where insurance costs are lowered**
 - C. When high-risk individuals are more likely to enroll**
 - D. An equal distribution of health risks among enrollees**

Answers

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

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Explanations

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1. All the following are major requirements of a long-term care (LTC) policy EXCEPT:

- A. The policy must provide a cash surrender value**
- B. The policy must provide certain consumer protection provisions**
- C. The policy must be guaranteed renewable**
- D. The policy must cover only qualified LTC services**

A major requirement of a long-term care (LTC) policy is that it should be aligned with specific consumer protections and accessibility standards to ensure that individuals can adequately prepare for their potential long-term care needs. Options that include consumer protection provisions and guaranteed renewability are in place to help protect the policyholder and ensure that they can maintain coverage over time, despite changes in health status or the need for care. A cash surrender value is typically a feature found in life insurance policies and not a standard requirement for LTC policies. Long-term care insurance is designed primarily to provide benefits for care services rather than to accrue cash value like a life insurance policy does. This distinction clarifies why the absence of a cash surrender value is not considered a requirement for long-term care policies. Similarly, while LTC policies must cover qualified LTC services, this is part of the fundamental design of these policies, ensuring that they fulfill their purpose of covering long-term care needs. Therefore, the absence of a cash surrender value stands out as the characteristic that does not align with the primary requirements for such policies.

2. What may happen to employers who do not offer affordable health coverage under the ACA?

- A. They may receive a bonus**
- B. They may incur penalties**
- C. There are no consequences**
- D. They will be required to provide additional benefits**

Employers who do not offer affordable health coverage under the Affordable Care Act (ACA) may incur penalties, which is the correct understanding of the consequences associated with non-compliance. The ACA includes specific provisions that require large employers (those with 50 or more full-time employees) to provide health insurance that meets certain standards for affordability and minimum value. If an employer fails to do so, they may face financial penalties, specifically through the Employer Shared Responsibility Payment. This penalty is designed to encourage employers to provide adequate health coverage for their employees. It serves as a measure to offset some of the costs associated with uninsured individuals who may seek coverage through government programs or subsidies. In contrast, receiving a bonus is not a consequence of failing to offer health coverage, and there are certainly implications for employers that do not comply; the statement that there are no consequences is inaccurate. Additionally, while there are requirements for employers to provide benefits under the ACA, additional benefits are not mandated as a direct consequence of failing to provide affordable health coverage. Thus, the potential financial liabilities are the critical focus if an employer does not adhere to the ACA guidelines.

3. Which of the following statements is correct regarding patient-centered medical homes (PCMHs)?

- A. PCMHs disregard patient involvement**
- B. PCMHs provide a solitary approach to care**
- C. PCMHs emphasize shared decision making with patients**
- D. PCMHs do not require team collaboration**

Patient-centered medical homes (PCMHs) are designed to enhance the quality of care by prioritizing patient involvement and engagement in their own healthcare decisions. The framework of a PCMH emphasizes shared decision-making, which encourages patients to participate actively in their treatment options and care plans. This approach fosters a collaborative relationship between patients and their healthcare providers, ensuring that care is tailored to the individual needs and preferences of each patient. By promoting shared decision-making, PCMHs not only empower patients but also lead to better health outcomes, as patients feel more invested in their care when they have a say in the decisions that affect their health. This model aligns well with modern healthcare trends that recognize the importance of patient engagement in achieving improved health results. The other options inaccurately reflect the principles of a PCMH, as they suggest a lack of collaboration, patient involvement, or a focus solely on individual care, which goes against the fundamental tenets of the PCMH model.

4. What does "mgmt" stand for in employee health benefit plans?

- A. Managing employee salaries**
- B. Management strategies for benefit plan administration**
- C. Mechanisms for gathering employee feedback**
- D. Monitoring job satisfaction levels**

In employee health benefit plans, "mgmt" typically refers to the structured approaches and strategies employed in the administration of those benefit plans, encompassing oversight, policy creation, and operational procedures. Effective management strategies ensure that the plans are compliant, meet the needs of employees, and are administered efficiently. This involves utilizing tools and practices to facilitate the delivery of benefits, manage costs, and ensure that the objectives of the health benefit offerings are met. The focus on management strategies highlights the importance of a systematic and organized approach to handling employee benefits, which can include everything from selecting insurance providers to navigating changes in legislation that affect benefits. In contrast, options mentioning employee salaries, feedback mechanisms, or job satisfaction levels do not directly relate to the administrative aspects of health benefit plans. While they are important components of overall employee management, they are not encompassed by the term "mgmt" as it pertains specifically to health benefits. This distinction clarifies why the correct answer is centered on management strategies for benefit plan administration.

5. What is a key difference between a Health Savings Account (HSA) and a flexible spending account (FSA)?

- A. An HSA belongs to the employer, an FSA to the employee**
- B. An HSA requires annual contributions, an FSA does not**
- C. An HSA can roll over funds, while an FSA typically cannot**
- D. An HSA only covers emergency expenses, an FSA covers all expenses**

A Health Savings Account (HSA) is designed for individuals with high-deductible health plans and allows for the rollover of unused funds from year to year. This feature highlights that funds in an HSA are not subjected to the "use-it-or-lose-it" rule; instead, they can continue to grow and accumulate, providing a long-term savings vehicle for medical expenses. In contrast, a flexible spending account (FSA) typically requires that any unspent funds at the end of the plan year are forfeited, unless the plan has a carryover provision or a grace period, which is limited and defined by the employer. This fundamental difference in how the funds can be used and carried over helps individuals manage their healthcare expenses over time, making HSAs more appealing for long-term savings compared to FSAs. Understanding this distinction is crucial for employees when making informed choices about their benefit options. It illustrates the HSA's role not just as a payment method for current expenses, but as a strategic savings tool for future healthcare costs.

6. Which of the following assumptions about long-term care (LTC) policies in the 1980s and 1990s were proven incorrect?

- A. Morbidity experience was lower than expected.**
- B. Lapse rates were lower than expected.**
- C. Higher-than-expected margins were needed for adverse selection.**
- D. I and III are correct.**

The assumption regarding the need for higher-than-expected margins for adverse selection is considered incorrect based on the experiences in the LTC insurance market during the 1980s and 1990s. At that time, insurers underestimated the impact of adverse selection, which occurs when those who are most likely to need the insurance are the ones most inclined to purchase it. This led to financial strains on many long-term care policies, as carriers did not initially recognize the need for higher margins to accommodate this selection bias. Carriers often found that they had not set sufficient reserves or premiums to manage the higher-than-anticipated claims resulting from adverse selection. Therefore, the assertion that higher margins were needed proved to be inaccurate, as the actual financial experience revealed a far more significant risk of adverse selection than they had accounted for. In contrast, the other assumptions about morbidity experience and lapse rates were more aligned with the actual outcomes observed in the market of that era. Morbidity rates were indeed higher than expected, leading to a greater number of claims, and lapse rates, which reflect how many policyholders let their coverage expire, were also lower than anticipated, meaning that more people held onto their policies longer than originally forecasted. This confirms that the correct choice highlights a critical misconception

7. What is the primary purpose of employee benefits legislation enforced by the Department of Labor?

- A. To maximize profit margins for insurance companies**
- B. To ensure employee rights are protected under ERISA**
- C. To reduce the number of employees receiving benefits**
- D. To establish minimum wage requirements**

The primary purpose of employee benefits legislation enforced by the Department of Labor is to ensure that employee rights are protected under the Employee Retirement Income Security Act (ERISA). This legislation provides essential safeguards for employees concerning their pension and health plans. By establishing standards for the administration of these benefits, ERISA aims to protect the interests of employees and their beneficiaries, ensuring they receive the benefits promised by employers. This ensures transparency and accountability in the management of benefits, which is crucial for fostering trust and security among the workforce. The other options do not align with the primary objectives of employee benefits legislation. For instance, maximizing profit margins for insurance companies does not reflect the intent of laws designed to protect employee rights. Similarly, reducing the number of employees receiving benefits contradicts the goal of enhancing the welfare of the workforce. Establishing minimum wage requirements, while important, falls under a different regulatory framework and does not directly pertain to employee benefits legislation. Thus, the focus on employee rights under ERISA is the central theme of the legislation enforced by the Department of Labor.

8. Which statement about the U.S. health care market is accurate?

- A. It operates with complete transparency between consumers and providers**
- B. It has minimal insurance asymmetry**
- C. There is significant information asymmetry**
- D. It is characterized by uniform pricing**

The statement that there is significant information asymmetry in the U.S. health care market accurately reflects the dynamics of how health care services and insurance operate. Information asymmetry refers to a situation where one party in a transaction has more or better information than the other party. In the context of health care, this often means that providers (such as doctors and hospitals) possess more information regarding treatment options, costs, and medical outcomes than consumers (the patients). Patients typically rely on health care professionals to guide their decisions, but they generally lack comprehensive knowledge about their medical conditions, the necessity and effectiveness of certain treatments, and the actual costs involved. This disparity in knowledge can lead to challenges in making informed decisions about care. Moreover, because health care pricing is often complex and opaque, patients might not understand what they will ultimately pay for services, further contributing to the information asymmetry in the market. This unique characteristic of the health care market can impede the ability of consumers to shop for services based on price or quality, which is a traditional expectation in a competitive market. Therefore, recognizing the significance of information asymmetry helps in understanding the complexities of consumer behavior in health care and the challenges faced within the health care system as a whole.

9. In the patient-centered medical home (PCMH) model, what is true about primary care visits?

- A. Only generalists can be the first contact during visits**
- B. Medical homes never use electronic communication for consultations**
- C. Daily team "huddles" are common to discuss cases**
- D. Specialists conduct all primary care visits**

In the patient-centered medical home (PCMH) model, daily team "huddles" are emphasized as a common practice to discuss cases and coordinate care. This collaborative approach allows healthcare providers—including nurses, physicians, and other staff—to meet regularly and share insights on patient care, current cases, and treatment plans. Such team huddles help streamline care delivery, enhance communication among team members, and ensure that patients receive comprehensive and coordinated care. By facilitating teamwork and encouraging discussions about patient management, this practice supports the core principles of the PCMH model, which aims to improve patient outcomes and enhance the overall patient experience. It fosters a multidisciplinary approach to care, ensuring that all team members are aligned and that patient needs are addressed holistically. The other choices do not reflect the realities of the PCMH model. For instance, the model encourages the use of various providers, not just generalists, and recognizes the importance of electronic communication in improving access to care. Additionally, primary care visits are not solely conducted by specialists, but rather are typically managed by primary care providers who may consult with specialists as necessary.

10. What does adverse selection refer to in group insurance?

- A. High enrollment rates of healthy individuals**
- B. A situation where insurance costs are lowered**
- C. When high-risk individuals are more likely to enroll**
- D. An equal distribution of health risks among enrollees**

Adverse selection in group insurance refers specifically to the phenomenon where individuals with a higher risk of needing healthcare services are more likely to enroll in an insurance plan. This situation arises because those who expect to incur greater medical expenses are motivated to obtain insurance to mitigate their potential out-of-pocket costs. As a result, the insurance pool may become skewed towards higher-risk individuals, leading to potentially higher claims and costs for the insurer. This concept is crucial in understanding how group insurance operates because it impacts the pricing and availability of insurance plans. When a significant number of high-risk individuals enroll without a balancing influx of low-risk individuals, it can drive up premiums and create unsustainable financial pressures on the insurance provider. In contrast, the other options reflect situations that do not align with the definition of adverse selection. For instance, high enrollment rates of healthy individuals would typically mitigate adverse selection, leading to a healthier premium pool. Similarly, a situation where insurance costs are lowered would not occur in the presence of adverse selection, as high-risk groups increase overall costs. Lastly, an equal distribution of health risks among enrollees represents an ideal scenario for insurance companies, which aligns with the opposite of adverse selection.

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://cebsgba2.examzify.com>

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

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