

CERTIFIED EMPLOYEE BENEFIT SPECIALIST (CEBS) GROUP BENEFITS ASSOCIATE (GBA) 2 PRACTICE EXAM (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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THE FULL VERSION STUDY GUIDE

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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. What is the purpose of employee benefit statements?**
 - A. To provide tax information to employees
 - B. To compare benefits against industry standards
 - C. To inform employees about the value of their benefits
 - D. To outline the administrative costs of offering benefits
- 2. Which of the following is true about Medicaid and long-term care?**
 - A. It only covers short-term rehabilitation services
 - B. Medicaid pays a significant amount for long-term care needs
 - C. Medicaid cannot cover long-term care under any circumstances
 - D. Medicaid is available only for elderly patients
- 3. Which of the following is considered a disadvantage of conventional group insurance?**
 - A. Flexible plan options
 - B. Transferability of policies
 - C. Lack of guaranteed benefits
 - D. High administrative costs
- 4. What are wellness programs designed to promote?**
 - A. Improved employee salaries
 - B. Healthier lifestyles among employees
 - C. Reduction in hiring costs
 - D. Accelerated professional development
- 5. Which statement about self-insured health plans is correct?**
 - A. Self-insured plans avoid state insurance regulation altogether.
 - B. The majority of workers are in self-insured plans.
 - C. Third-party administrators are often not used by employers.
 - D. Self-insured plans do not require any regulatory compliance.

- 6. What is the health insurance rating system that groups policyholders by loss characteristics called?**
- A. Calibrated rating
 - B. Manual rating
 - C. Objective rating
 - D. Durational rating
- 7. What is the established waiting period for Social Security Disability Income (SSDI) benefits?**
- A. One month
 - B. Three consecutive months
 - C. Five consecutive months
 - D. Six consecutive months
- 8. Which statement is true about the management of employee benefits?**
- A. It focuses exclusively on financial aspects
 - B. It includes strategies for effective plan administration
 - C. It has no impact on employee morale
 - D. It is solely managed by external consultants
- 9. Which statement about the services provided by third-party administrators (TPAs) to self-funded health plans is incorrect?**
- A. TPA services provided to self-funded plans are highly uniform among TPA firms.
 - B. TPAs handle a range of administrative services for self-funded plans.
 - C. Most TPAs will arrange access to provider networks.
 - D. TPAs may also perform customer services such as enrolling employees.
- 10. What concept is most closely related to objective risk for health insurers?**
- A. Expense ratios
 - B. Dispersion, often measured by standard deviation
 - C. Carve out coverage such as prescription drug benefits
 - D. Investment underwriting

Answers

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

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Explanations

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1. What is the purpose of employee benefit statements?

- A. To provide tax information to employees
- B. To compare benefits against industry standards
- C. To inform employees about the value of their benefits**
- D. To outline the administrative costs of offering benefits

Employee benefit statements serve primarily to inform employees about the value of their benefits. These statements typically summarize the total compensation package an employee receives beyond their direct salary, which includes various benefits such as health insurance, retirement plans, life insurance, and other perks. By providing a clear and detailed overview of these benefits, the statements help employees understand the full value of their compensation, which may not be apparent when looking only at their paychecks. This understanding can enhance employee engagement and satisfaction, as it showcases the employer's investment in their well-being and future. Additionally, when employees recognize the financial worth of benefits they may take for granted, it can foster a greater appreciation for the overall employment package. While the other options address various aspects of employee benefits, they do not align as closely with the primary aim of benefit statements. For instance, while understanding tax implications is important, the main role of these statements is not to provide tax guidance. Similarly, comparing benefits against industry standards is more about benchmarking rather than communicating individual value. Finally, although outlining administrative costs could be informative for management or HR purposes, it's not the goal of employee benefit statements, which are intended for the employees themselves.

2. Which of the following is true about Medicaid and long-term care?

- A. It only covers short-term rehabilitation services
- B. Medicaid pays a significant amount for long-term care needs**
- C. Medicaid cannot cover long-term care under any circumstances
- D. Medicaid is available only for elderly patients

Medicaid plays a crucial role in providing coverage for long-term care needs, which is why the statement regarding its payment for such services is accurate. Medicaid is a state and federally funded program designed to assist eligible individuals, particularly those with low income and limited resources, in covering medical costs, including various types of long-term care services. This program is particularly significant because it fills a gap for those who require extended care due to chronic illnesses or disabilities, which can often be financially burdensome. Long-term care services covered by Medicaid can include nursing home care, assistance with daily living activities, and home-based care services. Many individuals rely on Medicaid as their primary source of funding for these essential services as they can be quite costly and may not be covered by traditional health insurance. In contrast to this statement, the other options inaccurately reflect Medicaid's capabilities. For instance, Medicaid does not limit coverage to only short-term rehabilitation services; it indeed supports long-term needs. It also stands to clarify that Medicaid does not exclude coverage of long-term care under any circumstances, nor is it solely for elderly patients; younger individuals with disabilities can also qualify for Medicaid. Thus, the assertion about Medicaid's significant financial support for long-term care needs accurately represents the program's purpose and

3. Which of the following is considered a disadvantage of conventional group insurance?

- A. Flexible plan options
- B. Transferability of policies
- C. Lack of guaranteed benefits**
- D. High administrative costs

The choice of high administrative costs as a disadvantage of conventional group insurance is significant and highlights a critical area of concern for employers and organizations offering these plans. Conventional group insurance typically involves various fixed costs associated with administration, such as enrollment, claims processing, compliance with regulations, and ongoing customer service needs. These administrative expenses can accumulate to represent a substantial portion of the overall costs of providing insurance benefits. On the other hand, flexible plan options can be viewed as an advantage rather than a disadvantage, as they offer tailored benefits that meet the diverse needs of employees. Transferability of policies also tends to be a benefit; in many group insurance scenarios, policyholders may be able to transfer coverage when they leave the group, which adds convenience and security. The lack of guaranteed benefits typically relates to certain variable factors such as claims experience and market conditions but is not the most pressing disadvantage in the context of conventional group insurance, especially when weighed against the burden of high administrative costs that can affect the sustainability and the viability of the insurance program.

4. What are wellness programs designed to promote?

- A. Improved employee salaries
- B. Healthier lifestyles among employees**
- C. Reduction in hiring costs
- D. Accelerated professional development

Wellness programs are designed primarily to promote healthier lifestyles among employees. This involves a variety of initiatives that encourage individuals to engage in physical activity, make healthier dietary choices, manage stress effectively, and maintain overall well-being. By focusing on preventive health measures, wellness programs aim to reduce the incidence of chronic diseases and enhance employees' quality of life, ultimately leading to a more productive workforce. The emphasis on healthier lifestyles supports both individual employees and the organization as a whole, often resulting in lower healthcare costs, fewer sick days, and improved morale. These outcomes contribute significantly to creating a healthier work environment that aligns with the core objectives of wellness initiatives.

5. Which statement about self-insured health plans is correct?

- A. Self-insured plans avoid state insurance regulation altogether.**
- B. The majority of workers are in self-insured plans.
- C. Third-party administrators are often not used by employers.
- D. Self-insured plans do not require any regulatory compliance.

Self-insured health plans are an arrangement where the employer takes on the financial risk of providing health care benefits to its employees. One common misconception is that self-insured plans avoid all state insurance regulations. In reality, while it is true that self-insured plans are not subject to the same degree of regulation as fully-insured plans, they are still subject to certain federal laws, such as the Employee Retirement Income Security Act (ERISA). Employers offering self-insured plans must comply with ERISA requirements, which pertain to the reporting and disclosure of health plan information. This ensures transparency and provides protections for employees. Additionally, the plans must comply with other federal regulations like the Affordable Care Act (ACA). This makes it clear that while state regulations may not apply directly, self-insured plans are not exempt from all regulatory compliance. The other statements presented about self-insured plans can be misleading. For example, while a significant number of larger employers may utilize self-insured arrangements, the statement about the majority of workers being in such plans does not reflect the broader picture, as many smaller companies may still prefer fully insured options. The assertion that third-party administrators are often not used is incorrect, as many employers utilize these services to manage the self-ins

6. What is the health insurance rating system that groups policyholders by loss characteristics called?

- A. Calibrated rating
- B. Manual rating**
- C. Objective rating
- D. Durational rating

The health insurance rating system that groups policyholders based on their loss characteristics is known as manual rating. Manual rating involves the use of statistical data and historical loss information to categorize groups of policyholders who have similar risk profiles. This method allows insurers to set premiums and design policies that reflect the predicted costs associated with those specific groups. Manual rating is advantageous because it utilizes a standardized approach to rate setting, making it easier for insurers to create consistent pricing strategies across similar groups. It relies on the principle that similar risks should incur similar costs, which helps maintain the financial stability of the insurance pool and ensures fairness in premium contributions among policyholders. Other terms in the options provided do not refer to this specific classification method. Calibrated rating might imply an adjustment to rates based on specific factors but does not encapsulate the grouping of policyholders. Objective rating refers to an unbiased method of evaluation but lacks the context of loss characteristics. Durational rating typically involves adjustments based on the duration of coverage or exposure but is not focused on the initial grouping of policyholders by similar loss characteristics.

7. What is the established waiting period for Social Security Disability Income (SSDI) benefits?

- A. One month
- B. Three consecutive months
- C. Five consecutive months**
- D. Six consecutive months

The established waiting period for Social Security Disability Income (SSDI) benefits is five consecutive months. This means that after a claimant is determined to be disabled, there is a mandatory five-month waiting period before they begin receiving benefits. The intention behind this waiting period is to ensure that the disability is long-term and not temporary, allowing the Social Security Administration (SSA) to assess the condition and confirm eligibility. During this waiting period, beneficiaries do not receive any SSDI payments, and the five-month countdown starts after the onset date of the disability as determined by the SSA. It's important to understand that this waiting period does not affect the individual's eligibility; it simply delays the start of benefit payments. Once the waiting period completes, SSDI benefits are paid retroactively to the sixth month after the disability onset date.

8. Which statement is true about the management of employee benefits?

- A. It focuses exclusively on financial aspects
- B. It includes strategies for effective plan administration**
- C. It has no impact on employee morale
- D. It is solely managed by external consultants

The management of employee benefits encompasses a wide range of responsibilities that extend beyond just financial considerations. Effective management includes developing strategies for plan administration to ensure that benefits are delivered efficiently and in alignment with the needs of both the employees and the organization. Proper administration includes tasks such as compliance with regulations, communication with employees about their benefits, and regularly evaluating and adjusting plans to enhance their effectiveness. By incorporating strategies for effective plan administration, organizations can not only optimize the cost and efficiency of their benefits programs but also enhance employee engagement and satisfaction. This holistic approach is crucial in ensuring that the benefits provided support the overall business objectives and meet the expectations of employees. Other options, while they touch on aspects of employee benefits management, do not capture the complete picture. Focusing exclusively on financial aspects would neglect the importance of communication and employee understanding of benefits. The claim that managing employee benefits has no impact on morale contradicts substantial evidence showing that well-managed benefits can significantly improve employee satisfaction and retention. Lastly, while external consultants may play a role in advising and designing benefits programs, reliance solely on them excludes the essential input and engagement from the internal management team that is required to tailor benefits to the specific workforce.

9. Which statement about the services provided by third-party administrators (TPAs) to self-funded health plans is incorrect?

- A. TPA services provided to self-funded plans are highly uniform among TPA firms.**
- B. TPAs handle a range of administrative services for self-funded plans.
- C. Most TPAs will arrange access to provider networks.
- D. TPAs may also perform customer services such as enrolling employees.

The statement indicating that TPA services provided to self-funded plans are highly uniform among TPA firms is incorrect because the services offered by different TPAs can vary significantly. While many TPAs may offer core administrative services, such as claims processing, those services can differ in terms of quality, technology, pricing, and additional options provided. Each TPA often has its unique strengths, specializations, and service offerings tailored to the needs of their clients. In contrast, the other statements accurately reflect the roles and responsibilities of TPAs. They do indeed handle a broad range of administrative services such as managing claims, compliance, and reporting for self-funded plans. Additionally, most TPAs facilitate access to provider networks, providing self-funded plans with essential resources. Finally, customer services – which may include enrolling employees, managing inquiries, and supporting plan participants – are commonly offered by TPAs to enhance user experience and streamline administrative processes. This variability in TPA offerings highlights the importance of selecting the right administrator based on a plan's specific needs and preferences.

10. What concept is most closely related to objective risk for health insurers?

- A. Expense ratios
- B. Dispersion, often measured by standard deviation**
- C. Carve out coverage such as prescription drug benefits
- D. Investment underwriting

Objective risk is a key concept in insurance that refers to the variability of potential losses. It is often quantified using statistical measures, with dispersion being a primary focus as it represents how spread out the potential outcomes are. Standard deviation, as a measure of dispersion, quantifies how much the values of a variable differ from the mean value, which is critical for health insurers to assess the unpredictability in claims and manage reserves appropriately. Understanding the dispersion of insurance claims helps insurers in pricing their products accurately and ensuring they are adequately prepared for future claims. This statistical approach allows for a more objective evaluation of risk, as it relies on empirical data rather than subjective perceptions. In contrast, the other options touch on related but distinct concepts. Expense ratios pertain to operational efficiency and costs relative to premiums; carve-out coverage relates to specific healthcare services being provided separately from general health plans; and investment underwriting focuses on the management of the insurer's investment portfolio rather than the direct assessment of risk associated with health insurance.

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:

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

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