Workday Pro Benefits Certification Practice Test (Sample)

Study Guide

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Questions

1. True or False? Open Enrollment can be initiated only once.

A. True

B. False

C. Only under special circumstances

D. It can be initiated multiple times

2. Which of the following is most relevant for a Benefit Group's age calculation?

A. Employee's hire date

B. Employee's retirement date

C. Employee's multiple roles

D. Employee's family details

3. Why would an employee not see a Change Benefit Election task in their Inbox?

A. Due to system errors only

B. Because of earlier events that must be completed

C. Once they choose not to participate

D. It's not applicable to every employee

4. Which of the following is NOT a classification of Healthcare?

A. PPO

B. HMO

C. DMO

D. FSA

5. What allows users to restrict relationship types in dependent configurations?

A. Dependent Electivity Settings

B. Restrict to Relationship Field

C. Coverage Eligibility Framework

D. Benefit Provider Guidelines

6. What key information is necessary for an Additional Benefit Plan?

- **A. Employer's contact information**
- **B. Rates and Targets, Employer Eligibility, Payroll Deductions**
- **C. Plan Year Definition, Eligibility Criteria**
- **D. Market Comparison, Employee Contributions**

7. What factor is NOT considered when determining benefit group eligibility?

- **A. Worker location**
- **B. Employee type**
- **C. Personality type**
- **D. Active status**

8. How can a user edit an existing cross plan enrollment prerequisite?

- **A. By accessing the main benefits dashboard**
- **B. Through the 'Edit User Profile' option**
- **C. By modifying the Cross Plan Enrollment Prerequisite settings**
- **D. By submitting a support ticket for changes**

9. What are the three types of benefit credits?

- **A. Paid Time Off, Sick Leave, Family Leave**
- **B. Employee-based, Plan Only, Dependent-based**
- **C. Standard, Premium, VIP**
- **D. Mandatory, Optional, Supplemental**

10. Which access is controlled by supervisory organization or location hierarchy?

- **A. Benefits Administrator**
- **B. Benefits Partner**
- **C. Open Enrollment**
- **D. Benefit Components**

Answers

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

Explanations

1. True or False? Open Enrollment can be initiated only once.

A. True

B. False

C. Only under special circumstances

D. It can be initiated multiple times

Open Enrollment is a designated period during which employees can make changes to their benefits selections. The key aspect of this process is that it can be initiated multiple times, typically on an annual basis or in response to specific life events (such as marriage, the birth of a child, or changes in employment status). This flexibility allows employees to regularly re-evaluate their benefits options and make adjustments as needed, ensuring that they can respond to changes in their personal circumstances or in available benefits. The concept that Open Enrollment can be initiated only once is inaccurate, as it does not reflect the annual cycle of benefit selections and the special enrollment periods that may occur throughout the year. Thus, stating that Open Enrollment can only happen once oversimplifies the benefits enrollment process and does not account for the multiple opportunities employees have to modify their choices.

2. Which of the following is most relevant for a Benefit Group's age calculation?

A. Employee's hire date

B. Employee's retirement date

C. Employee's multiple roles

D. Employee's family details

The most relevant factor for a Benefit Group's age calculation is the employee's hire date. This date is critical because it marks the beginning of an employee's period of employment and is often used as a reference point for determining eligibility for various benefits, including those that may vary based on age or length of service. In many organizations, benefits can be influenced by an employee's tenure, which directly ties back to the hire date. For example, certain retirement benefits and health insurance options may have age or service time stipulations that need to be accurately calculated from the point of hire. In contrast, the retirement date, although connected to the benefit planning process, is typically a future date and not directly related to the age calculation of employees for benefits. Multiple roles that an employee might hold within the organization can affect various benefits but are not specifically pertinent to age calculations. Employee family details, while important for dependent-related benefits, do not play a role in calculating the employee's age in the context of a Benefit Group. Thus, the hire date is the most crucial factor for this purpose.

3. Why would an employee not see a Change Benefit Election task in their Inbox?

A. Due to system errors only

B. Because of earlier events that must be completed

C. Once they choose not to participate

D. It's not applicable to every employee

An employee may not see a Change Benefit Election task in their Inbox primarily because there are earlier events or tasks that must be completed before that specific task can be accessed. In a typical benefits enrollment process, certain prerequisites or conditions often need to be satisfied. For example, if the employee has not completed their initial onboarding process or if their eligibility for certain benefits has not yet been established, they will not receive the benefit election task until those earlier steps are addressed. This approach ensures that employees are guided through the necessary phases of enrollment in a structured manner, preventing confusion and ensuring compliance with organizational policies regarding benefits administration. Not meeting prior requirements effectively prevents the task from appearing, reinforcing the workflow and dependency structure that exists in systems like Workday.

4. Which of the following is NOT a classification of Healthcare?

A. PPO

B. HMO

C. DMO

D. FSA

The classification of healthcare plans typically includes various types of managed care organizations and insurance models that dictate how healthcare services are delivered and accessed. In this context, Preferred Provider Organizations (PPO), Health Maintenance Organizations (HMO), and Dental Maintenance Organizations (DMO) are all established classifications within healthcare. These terms refer to specific structures and rules for how patients receive care, manage costs, and interact with healthcare providers. On the other hand, Flexible Spending Accounts (FSA) do not fall into a healthcare classification in the same way that PPO, HMO, and DMO do. An FSA is a financial account that allows employees to set aside pre-tax earnings for use on qualified medical expenses. It is more of a benefit or savings tool rather than a healthcare plan or classification. Therefore, identifying FSA as not a classification of healthcare is accurate, as it serves a different purpose within the healthcare financing system.

5. What allows users to restrict relationship types in dependent configurations?

A. Dependent Electivity Settings

B. Restrict to Relationship Field

C. Coverage Eligibility Framework

D. Benefit Provider Guidelines

The option that allows users to restrict relationship types in dependent configurations is the "Restrict to Relationship Field." This functionality is designed specifically to manage which types of relationships can be included when defining dependents for benefits. By utilizing this feature, organizations can ensure that only certain relationship types—such as spouse, child, or domestic partner—are allowed for selection when employees are enrolling dependents. This capability is critical for compliance and ensuring that benefit configurations align with company policies and state regulations. It helps to prevent any complexities in dependent verification and ensures consistency in how benefits are applied. While the other choices do relate to benefits administration, they do not directly address the restriction of relationship types in defining dependents. For instance, Dependent Electivity Settings are more focused on how choices are presented and managed, the Coverage Eligibility Framework outlines eligibility criteria for benefits but doesn't directly restrict relationships, and Benefit Provider Guidelines generally provide rules from external providers without managing internal configurations.

6. What key information is necessary for an Additional Benefit Plan?

A. Employer's contact information

B. Rates and Targets, Employer Eligibility, Payroll Deductions

C. Plan Year Definition, Eligibility Criteria

D. Market Comparison, Employee Contributions

The key information necessary for an Additional Benefit Plan includes Rates and Targets, Employer Eligibility, and Payroll Deductions. This is crucial because: - Rates and Targets provide a framework for understanding how the benefits will be implemented financially. They outline the costs associated with the benefit plans and any targets that the employer may be aiming for regarding participation or utilization of these benefits. - Employer Eligibility defines which employees or classes of employees are eligible to participate in the benefit plan. This is essential for ensuring compliance with regulatory standards and for guiding employees on what benefits they can access. - Payroll Deductions are a critical component as they dictate how the costs associated with the benefits will be taken from employees' paychecks. Understanding how deductions will be processed is vital for both budgeting from the employer's perspective and for employee satisfaction regarding their net pay. This combination of elements creates a comprehensive understanding of the Additional Benefit Plan, covering both the operational and financial aspects necessary for effective implementation.

7. What factor is NOT considered when determining benefit group eligibility?

A. Worker location

B. Employee type

C. Personality type

D. Active status

The factor that is not considered when determining benefit group eligibility is personality type. In the context of employee benefits, eligibility is typically based on objective criteria that relate directly to the employee's work situation and employment status. Factors such as worker location, employee type (such as full-time, part-time, or contractor), and active status (whether the employee is currently employed and eligible for benefits) are all essential elements in this determination. These criteria help organizations ensure that benefits are distributed fairly and in alignment with both legal requirements and company policy. Personality type, however, is subjective and does not influence eligibility for benefits. It does not relate to an employee's role, status, or any official classifications used to determine benefit offerings. Thus, it is not a valid basis for assessing eligibility for benefit groups.

8. How can a user edit an existing cross plan enrollment prerequisite?

A. By accessing the main benefits dashboard

B. Through the 'Edit User Profile' option

C. By modifying the Cross Plan Enrollment Prerequisite settings

D. By submitting a support ticket for changes

The ability to edit an existing cross plan enrollment prerequisite is accomplished by directly modifying the Cross Plan Enrollment Prerequisite settings. This approach allows users to specifically target the parameters and requirements that govern how individuals enroll in various benefit plans, ensuring that these settings align with the organization's policies and benefit offerings. Accessing the main benefits dashboard or utilizing the 'Edit User Profile' option does not provide the necessary tools for adjusting enrollment prerequisites, as these areas are typically focused on broader benefit selections or user-specific information rather than the specific eligibility criteria that govern cross plan enrollments. Submitting a support ticket may be a viable option but is generally more time-consuming and may not grant users the immediate control they need to adjust the settings as required. Thus, directly modifying the Cross Plan Enrollment Prerequisite settings is the most efficient and accurate method to make these changes.

9. What are the three types of benefit credits?

A. Paid Time Off, Sick Leave, Family Leave

B. Employee-based, Plan Only, Dependent-based

C. Standard, Premium, VIP

D. Mandatory, Optional, Supplemental

The classification of benefit credits is vital for understanding how employers structure their benefit offerings. The correct answer, which highlights employee-based, plan only, and dependent-based credits, aligns with how benefits are tailored to fit diverse employee needs and demographics. Employee-based credits refer to the allocation of benefits that are determined by an individual employee's status, role, or tenure within the organization. Plan only credits are specifically related to the types of benefit plans available, such as health insurance or retirement plans, allowing for the categorization of benefits based on their structure rather than individual employee metrics. Dependent-based credits take into account the coverage needed for the dependents of employees, ensuring that family considerations are integrated into the benefits package. In this context, the other answer choices do not accurately represent the structure of benefit credits. For example, Paid Time Off, Sick Leave, and Family Leave are types of benefits but do not categorize how credits are allocated. The Standard, Premium, and VIP classification focuses on the levels of benefits rather than the allocation of credits. Likewise, Mandatory, Optional, and Supplemental refers to the nature of benefits and whether they are required or chosen, rather than the principles of crediting them effectively. Thus, employee-based, plan only, and dependent-based are

10. Which access is controlled by supervisory organization or location hierarchy?

A. Benefits Administrator

B. Benefits Partner

C. Open Enrollment

D. Benefit Components

The correct answer is Benefits Partner because the role of the Benefits Partner is closely tied to specific supervisory organizations or location hierarchies within Workday. Access for Benefits Partners is typically determined based on organizational structures, which include criteria such as the supervisory relationships and the geographical locations assigned to those partners. This means that a Benefits Partner's ability to manage and oversee benefits-related functions is inherently linked to the organizational hierarchy they work within. Their access levels and the scope of their responsibilities can differ depending on the specific needs and configurations of the supervisory organization or location they are associated with. In contrast, other roles and elements listed, such as Benefits Administrator, Open Enrollment, and Benefit Components, do not have their access and functionalities directly controlled by the supervisory organization or location hierarchy in the same manner. For example, Benefits Administrators might have broader access that is more role-based rather than hierarchy-based, and Open Enrollment and Benefit Components represent processes and elements that are not inherently linked to an organizational structure. Thus, the distinctiveness of the Benefits Partner role in managing access relative to the hierarchical setup underscores why it is the correct choice here.