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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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.

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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!

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Questions

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1. Which of the following statements about managed health care is accurate?

A. It generally results in higher quality care

B. Managed care achieves lower claims because of favorable patient selection

C. It does not produce any cost savings

D. Quality measurement in managed care is straightforward

2. Which statement about private health insurance exchanges is incorrect?

A. In private exchanges, the vendor helps explain exchanges to each employee.

B. Most private exchanges render telephone hotlines redundant.

C. Private exchanges provide extensive software for decision support.

D. Exchange websites can include pop-up information to explain benefits.

3. Which statement about the usual and customary rate (UCR) in health insurer reimbursement is NOT correct?

A. An independent entity manages the database for UCR

B. More insurers are abandoning traditional UCR pay formulas

C. UCR changes have reduced balance billing significantly

D. Changes involving the UCR have not affected balance billing

4. What is one significant policy of the Affordable Care Act regarding medical loss ratios?

A. It eliminates the requirement for insurers to report medical loss ratios

B. It mandates a maximum limit on the medical loss ratio

C. It encourages insurers to keep higher loss ratios

D. It applies solely to large group insurers

5. What is a correct statement regarding discounts managed care plans negotiate with hospitals?

A. Managed care plans typically pay full billed charges.

B. Discounts rarely exceed 40 percent.

C. The size of the discount varies directly with the actual price of services.

D. Both A and C are correct.

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6. Who is NOT typically a beneficiary of an employer-sponsored group term life insurance contract?

A. The employee's estate.

B. The employee's children.

C. A charity.

D. The employer.

7. What is one outcome of managed care plans selectively contracting with providers?

A. Higher overall healthcare costs

B. Increased barriers to accessing care

C. Better quality of care

D. Reduced cost savings

8. What does the Family and Medical Leave Act (FMLA) allow employees to do?

A. Take paid leave for any reason

B. Take unpaid leave for specific family and medical reasons

C. Transfer benefits to another employee

D. Take leave only for personal illness

9. What best describes the "death spiral" in health insurance premiums?

A. It is caused by a large disparity in provider costs

B. Risk adjustment methods transfer funds effectively

C. All health plans face the same premium challenges

D. Competition between insurers eliminates "death spirals"

10. Which statement correctly describes the Small Business Health Options Program (SHOP) exchanges?

A. SHOP exchanges allow small employers to choose fully insured plans.

B. Plans on SHOP exchanges are exempt from all federal requirements.

C. Employees must contribute at least 50% of premium costs.

D. SHOP exchanges are targeted at employers with fewer than 50 employees.

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Answers

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

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Explanations

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1. Which of the following statements about managed health care is accurate?

A. It generally results in higher quality care

B. Managed care achieves lower claims because of favorable patient selection

C. It does not produce any cost savings

D. Quality measurement in managed care is straightforward

Managed care often involves utilizing strategies that focus on cost containment while aiming to deliver quality care. The statement regarding managed care achieving lower claims due to favorable patient selection highlights a critical aspect of how many managed care organizations operate. By carefully selecting members, such as those who are generally healthier or less costly to treat, managed care plans can reduce the overall expenses associated with claims. This process includes risk management techniques and strategic partnerships with providers to negotiate better rates and services. Other statements do not align as closely with the commonly understood principles of managed health care. Saying that managed care generally results in higher quality care can be misleading, as quality outcomes can vary depending on the network and specific practices of a managed care organization. The assertion that managed care does not produce any cost savings contradicts the fundamental purpose of such plans, which is to reduce healthcare costs. Lastly, the complexity of clinical outcomes and varying standards among providers means that quality measurement in managed care is often not straightforward, encompassing various metrics and subjective evaluations rather than a simple assessment.

2. Which statement about private health insurance exchanges is incorrect?

A. In private exchanges, the vendor helps explain exchanges to each employee.

B. Most private exchanges render telephone hotlines redundant.

C. Private exchanges provide extensive software for decision support.

D. Exchange websites can include pop-up information to explain benefits.

The statement indicating that most private exchanges render telephone hotlines redundant is incorrect because telephone hotlines often remain a crucial resource for employees navigating the complexities of benefit options. While private health insurance exchanges may provide an array of online tools and resources to assist employees, the nuances of individual situations can require personalized assistance. Hotlines serve as a valuable complement to digital resources, offering direct interaction with knowledgeable representatives who can address specific inquiries, explain benefits in depth, and assist in making more informed decisions. Therefore, the presence of effective telephone support is essential, as it accommodates employees who may prefer human interaction over online resources or who may have questions that are not easily answered through the available software or website tools.

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3. Which statement about the usual and customary rate (UCR) in health insurer reimbursement is NOT correct?

A. An independent entity manages the database for UCR

B. More insurers are abandoning traditional UCR pay formulas

C. UCR changes have reduced balance billing significantly

D. Changes involving the UCR have not affected balance billing

The statement regarding changes involving the usual and customary rate (UCR) having no effect on balance billing is not accurate. In practice, modifications to how UCR is determined and reimbursed can have a significant impact on balance billing. When insurers adjust their UCR calculations, it may lead to lower reimbursements for services, which in turn can increase the likelihood that patients will experience balance billing. This occurs when providers bill patients for the difference between what the insurer pays and what they charge for their services. In contrast, when there are improvements or adjustments to the UCR system, it often aims to align payments more closely with the average costs of services in a given geographic area. Such changes can help reduce the discrepancies between what patients owe and what insurers pay. Therefore, variations in UCR impact balance billing practices and patient financial responsibility. The other statements hold validity within the context of UCR, such as the involvement of independent entities in managing UCR databases, shifts in insurer practices regarding traditional UCR formulas, and the correlation between UCR adjustments and reduced balance billing instances.

4. What is one significant policy of the Affordable Care Act regarding medical loss ratios?

A. It eliminates the requirement for insurers to report medical loss ratios

B. It mandates a maximum limit on the medical loss ratio

C. It encourages insurers to keep higher loss ratios

D. It applies solely to large group insurers

The Affordable Care Act (ACA) includes significant provisions regarding medical loss ratios (MLRs), which are designed to ensure that a substantial portion of premium revenues is spent on actual medical care rather than on administrative costs or profits. One of the landmark policies within the ACA dictates that health insurers must maintain a minimum medical loss ratio; specifically, they are required to spend at least 80% of premium dollars on medical care and quality improvement activities for individual and small group plans, and at least 85% for large group plans. This policy is important for consumers as it helps to create more accountability among insurers, ensuring that a majority of their spending is directed towards providing health care services rather than administrative costs or dividend payouts to shareholders. Insurers that fail to meet these thresholds must provide rebates to their policyholders. The requirement for these minimum ratios promotes transparency and encourages insurers to manage their resources effectively, enhancing the quality of care provided to members. As such, this provision is a fundamental aspect of the ACA aimed at improving the efficiency and quality of health care funding in the United States.

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5. What is a correct statement regarding discounts managed care plans negotiate with hospitals?

A. Managed care plans typically pay full billed charges.

B. Discounts rarely exceed 40 percent.

C. The size of the discount varies directly with the actual price of services.

D. Both A and C are correct.

The statement that the size of the discount varies directly with the actual price of services is accurate. Managed care plans engage in negotiations with hospitals to secure discounts on the prices of services provided to their members. The amount of discount often correlates with the hospitals' standard pricing; thus, when the actual price of services is higher, managed care plans may negotiate higher discounts in order to make the service more financially viable for the plan and its members. This dynamic reflects the leveraging of purchasing power that managed care plans hold, which allows them to obtain better pricing structures based on the volume of patients they direct to specific hospitals. In essence, the relationship between the prices hospitals charge and the discounts that managed care plans negotiate is typically direct: higher prices may lead to more substantial discounts during negotiations, as hospitals may be more willing to lower prices to maintain patient volumes. Other statements may reflect misunderstandings about how managed care operates. For instance, managed care plans rarely pay full billed charges, as they actively negotiate lower rates to keep costs down for both the plan and members. Furthermore, discounts exceeding 40 percent are not uncommon, depending on the services involved and the agreements reached in negotiations. Thus, the nuances of pricing in healthcare underscore why option C stands out as the

6. Who is NOT typically a beneficiary of an employer-sponsored group term life insurance contract?

A. The employee's estate.

B. The employee's children.

C. A charity.

D. The employer.

In an employer-sponsored group term life insurance contract, the beneficiaries are typically individuals or entities designated to receive the death benefit upon the insured employee's passing. The primary purpose of these contracts is to provide a financial benefit to the loved ones or designated beneficiaries of the employee. The employer, however, is not a beneficiary in this context because the employer's role is that of a plan sponsor or administrator who facilitates the insurance coverage for employees. The benefits are intended to support the employees' dependents or other selected beneficiaries, not the employer. Therefore, it is not standard practice for an employer to be a beneficiary in this type of contract, as that would conflict with the essence of providing life insurance as a benefit to employees and their families. In contrast, the employee's estate, children, or a charity can all be considered valid beneficiaries since these entities can receive the death benefit directly, fulfilling the intended purpose of providing financial support in the event of the employee's death.

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7. What is one outcome of managed care plans selectively contracting with providers?

A. Higher overall healthcare costs

B. Increased barriers to accessing care

C. Better quality of care

D. Reduced cost savings

One outcome of managed care plans selectively contracting with providers is better quality of care. Managed care organizations create networks of healthcare providers with whom they negotiate contracts to deliver services to their members. By selectively contracting with providers who meet specific standards for quality and efficiency, managed care plans can enhance the overall care that their members receive. These provider networks often include hospitals, specialists, and primary care physicians that have demonstrated a commitment to delivering high-quality healthcare services. When a managed care plan focuses on quality, it can encourage providers to maintain high standards, as they want to remain within the network and attract more patients. Furthermore, through various quality management programs and initiatives, managed care plans may implement practices that enhance patient care, such as preventive health services, chronic disease management, and improved coordination of care. This creates an environment where members may experience better health outcomes due to the emphasis on quality and coordinated care. While other options might suggest possible drawbacks or challenges in the managed care model (such as increased barriers to accessing care or higher healthcare costs), the focus on quality in the selective contracting process is a key benefit that can lead to improved outcomes for patients.

8. What does the Family and Medical Leave Act (FMLA) allow employees to do?

A. Take paid leave for any reason

B. Take unpaid leave for specific family and medical reasons

C. Transfer benefits to another employee

D. Take leave only for personal illness

The Family and Medical Leave Act (FMLA) is designed to provide employees with the ability to take unpaid leave for specific family and medical reasons while ensuring job protection. This includes situations such as the birth of a child, adoption, personal or family illness, or caring for a family member with a serious health condition. The key feature of FMLA is that it allows employees to take up to 12 weeks of job-protected unpaid leave in a 12-month period under qualifying conditions. This option reflects the primary intent of the FMLA, which is to balance the demands of the workplace with the needs of families, fostering a healthier work-life balance for employees. It does not provide for paid leave, nor does it allow the transfer of benefits or restrict leave solely to personal illness, making it distinct from other types of leave and benefit provisions.

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9. What best describes the "death spiral" in health insurance premiums?

A. It is caused by a large disparity in provider costs

B. Risk adjustment methods transfer funds effectively

C. All health plans face the same premium challenges

D. Competition between insurers eliminates "death spirals"

The term "death spiral" in health insurance refers to a situation where rising premiums lead to a smaller, less healthy risk pool, which in turn causes further premium increases. As healthier individuals opt out of the insurance pool due to high costs, the insurance company is left with a pool that is more likely to require medical care, driving up costs and consequently premiums. Understanding why the correct answer relates to risk adjustment methods is crucial. Risk adjustment methods are designed to redistribute funds among health plans to account for differences in the health status of their insured populations. This approach helps stabilize premiums by ensuring that insurers with higher-risk members receive compensation, which can mitigate the impact of the death spiral. It encourages insurers to enroll a diverse pool of members, including those who are healthier, thereby maintaining more stable premiums over time. Recognizing the nuances of the other options is also beneficial. Large disparities in provider costs may contribute to premium variability but do not directly encapsulate the concept of the death spiral. The notion that all health plans face the same premium challenges oversimplifies the complexities of market dynamics and doesn't address the particular vulnerabilities that lead to a death spiral. Lastly, while competition among insurers is important, it does not inherently eliminate death spirals; in fact, heightened

10. Which statement correctly describes the Small Business Health Options Program (SHOP) exchanges?

A. SHOP exchanges allow small employers to choose fully insured plans.

B. Plans on SHOP exchanges are exempt from all federal requirements.

C. Employees must contribute at least 50% of premium costs.

D. SHOP exchanges are targeted at employers with fewer than 50 employees.

The statement that accurately describes the Small Business Health Options Program (SHOP) exchanges is that SHOP exchanges allow small employers to choose fully insured plans. This is a key feature of SHOP exchanges designed to help small businesses provide health insurance options to their employees. SHOP exchanges facilitate market access for small employers, allowing them to compare and select from a range of fully insured health plans, which provides them with choices that may suit their employee demographic and budget. These exchanges were created to help small businesses benefit from the same economies of scale that larger employers enjoy regarding health insurance options. In contrast, plans on SHOP exchanges are not exempt from federal requirements, as all health insurance plans must adhere to the regulations established by the Affordable Care Act. The requirement for employees to contribute at least 50% of premium costs is not a condition of the SHOP exchanges; rather, small employers can determine the extent of employee contributions. Additionally, while SHOP exchanges were originally targeted at employers with up to 100 employees, the more nuanced restriction is that the primary target is indeed employers with fewer than 50 employees, aligning with the intent of supporting small businesses.

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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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