Group Suitability Assessment

Group Health Questionnaire

Please return to mwil.hba-ehb@marshmma.com for review.

This Group Health Questionnaire is utilized to assist in the assessment of the risk associated with your group and whether it is a good fit for HBA plan designs.

You acknowledge that you will answer these questions truthfully, completely, following reasonable commercial effort, and to the best of your knowledge. This form may be used and shared with all HBA vendors. This form will also be shared with other vendors outside of HBA that service the plan designs implemented for your group through HBA, including but not limited to insurance and/or reinsurance carriers. To the extent that this form is relied upon by these vendors, false or misleading statements could adversely impact the services provided as well as trigger termination rights. To the extent this form is separately used or analyzed by an insurance company, additional legal or contractual consequences, including, but not limited to, a loss of coverage or denial of coverage may occur.

Legal Name of Group:

Group Main Address:

SIC#/Industry:

# of Employees currently enrolled in health coverage by tier (N/A if no current plan): EE Only ____ EE + Spouse ____ EE + Child(ren) ____ Family ____

# of Employees to be offered health coverage: ____ Average Age of Employees to be offered health coverage: ____

HBA Plan Designs being considered: ☐ Essential Value ☐ MVP Bronze ☐ MVP Bronze Plus ☐ MVP Silver ☐ MVP Gold ☐ MVP Gold-S ☐ MVP Ultra Platinum ☐ MVP Ultra Platinum-S ☐ MVP Ultra HDHP

Requested Effective Date:

1. I will answer the following questions for all plan participants and dependents who may be covered under this healthcare coverage (referred to as "anyone" throughout the rest of this questionnaire) truthfully, completely, following reasonable commercial effort, and to the best of my knowledge.

☐ Yes, I agree ☐ No If no, please explain below or in Appendix as needed.

2. Have you sponsored a health plan before? If so, please list the carriers/third party administrators you have worked with over the past three (3) years.

☐ Yes ☐ No If yes, please explain below or in Appendix as needed.

3. What percentage of eligible participants and dependents smoke, vape, or use tobacco products. ____

4. Does anyone use controlled drugs or substances (including, even if legal in your local jurisdiction, cannabis products)? If so, please add an explanation of the number or percentage of eligible participants and dependents who use controlled drugs or substances, including cannabis products.

☐ Yes ☐ No If yes, please explain below or in Appendix as needed.

5. Has anyone missed more than five (5) consecutive workdays in the last twelve (12) months due to injuy or illness by them or their dependents?

☐ Yes ☐ No If yes, please explain below or in Appendix as needed.

6. Has anyone been treated in the last five (5) years, or does anyone anticipate being treated for a serious illness; immune system disorder; hemophilia; cancer; heart disorder/disease; hepatitis C; kidney, organ, or tissue disorder/transplant; stroke; AIDS/ARC; mental or nervous disorder; substance abuse; or other accident/injury?

☐ Yes ☐ No If yes, please explain below or in Appendix as needed.

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7. Does anyone have any known potential medical issues such that anyone has incurred or is anticipated to incur $10,000 or more in accident and/or health or prescription drug claims or costs within the last twelve (12) months or anticipated over the next twelve (12) months? To assist in responding to this question, please see the Potentially Catastrophic Diagnosis and High-Cost Drug listing page. This page is intended to help you accurately complete this questionnaire.

☐ Yes ☐ No If yes, please explain below or in Appendix as needed.

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8. Is anyone, or is anyone anticipated to become, disabled, confined in a hospital or treatment facility, certified/re-certified within the last three (3) months to have an upcoming procedure or treatment?

☐ Yes ☐ No If yes, please explain below or in Appendix as needed.

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9. Is anyone on a leave of absence to care for a dependent? If so, will either the caretaker or the dependent be eligible to participate in this health plan? (For employees, "disabled" means absent from work, on leave of absence, or Family and Medical Leave Act ("FMLA") benefits due to said employee's medical condition. For dependents, "disabled" means unable to perform his or her normal functions of a person of like age.)

☐ Yes ☐ No If yes, please explain below or in Appendix as needed.

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10. Has anyone within the last six (6) months been advised to have surgery or does anyone anticipate hospitalization or an outpatient surgical procedure?

☐ Yes ☐ No If yes, please explain below or in Appendix as needed.

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11. Are there any employees who are not performing or are anticipated over the next twelve (12) months to become unable to perform his or her normal duties due to illness or injury?

☐ Yes ☐ No If yes, please explain below or in Appendix as needed.

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12. Is anyone now or anticipated to become pregnant, considered to be at high risk for complications of pregnancy, or carrying multiple fetuses?

☐ Yes ☐ No If yes, please explain below or in Appendix as needed.

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13. Is anyone receiving treatment and/or medical services related to a worker's compensation claim? If so, please note in the explanation both the treatment/medical services and whether that claim is in dispute or is anticipated to be denied/not classified as a worker's compensation claim now or in the next twelve (12) months.

☐ Yes ☐ No If yes, please explain below or in Appendix as needed.

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14. If you are a current health plan sponsor, have you received your upcoming renewal? ☐ Yes ☐ No ☐ N/A

(a) If "Yes," is the proposed renewal rate action greater than +15%? ☐ Yes ☐ No ☐ N/A

(b) If "No," was the renewal rate action for your current plan year greater than +15%? ☐ Yes ☐ No ☐ N/A

Note: If answer to 14(a) or 14(b) is "Yes," submit full renewal documents with this GHQ.

I affirm I have answered all questions truthfully, completely, following reasonable commercial effort, and to the best of my knowledge, and I acknowledge the terms, notices, and disclaimers provided in this Group Health Questionnaire.

For Internal Use Only

Cov Start Cov End

Situs State

<MRP Name>

<MRP Email>

Company Name

Group/Plan Sponsor Responsible Party - Printed Name

Group/Plan Sponsor Responsible Party - Title

Group/Plan Sponsor Responsible Party - Signature

Date

Group/Plan Sponsor Responsible Party - Email

Broker/Referral Partner Signing Form – Printed Name

Broker/Referral Partner - Signature

Date

Please return to mwil.hba-ehb@marshmma.com for review. No group is authorized for consideration for the HBA Partnership Program without completion of this form by the group and review by HBA.

Health Benefit Alliance Partnership Program

Group Health Questionnaire Appendix

Please use this page to provide more detail to responses in the Group Health Questionnaire which requested further explanation.

Question	Explanation

THE HEALTH BENEFIT ALLIANCE™

Potentially Catastrophic (ICD-10) Diagnosis List

A00–B99	**Infectious Disease**
B17.1–B17.11	Hepatitis C
C00–D49	**Neoplasms**
C00–C14	Malignancy of oral cavity pharynx
C15–C26	Malignant neoplasm of digestive organs
C30–C39	Malignant neoplasm of respiratory organs
C43–C44	Melanoma
C50–C50	Breast Malignancies
C51–C68	Genitourinary Malignancies
C69–C72	Malignancies of Nervous System
C81–C96	Leukemias, Lymphomas and Myelomas
D50–D89	**Hematologic Disorders**
D57.1	Sickle Cell Anemia
D61.01	Aplastic Anemia
D66	Hemophilia/Hereditary Factor VIII Deficiency
D81.0	Severe Combined Immune Deficiency (SCID)
D82.1	DiGeorge Syndrome
D83.1	Immune Deficiency T Cells (AIDS)
D84.1	Alpha 1-Antitrypsin
E70-E88	**Metabolic Disorders**
E75.22	Gaucher's Disease
E84.0	Cystic Fibrosis
G00-G99	**Diseases of the Nervous System**
G12.21	Lou Gehrig's disease (ALS)
G61.0	Guillain-Barre Syndrome
G91.1	Obstructive Hydrocephalus
I00-I99	**Diseases of Circulatory System**
I27.0	Primary Pulmonary Hypertension
I42.0-I42.9	Cardiomyopathy
I46.9	Cardiac Arrest
I60.9	Subarachnoid Hemorrhage
J00-J99	**Disease of Respiratory System**
J96.00-96.92	Respiratory Failure
K00-K95	**Disease of Digestive System**
K70.0-74.69	Chronic Liver Disease
K72.00-72.91	Liver Failure
N00-N99	**Disease Genitourinary System**
N18.1-18.9	Chronic Renal Failure
O00-O9A	**Pregnancy, Childbirth & Puerperium**
O30.10-30.109	Triplet Pregnancy
O30.20-30.209	Quadruplet Pregnancy
O60.00-60.14	Preterm Labor
P00–P96	**Perinatal Conditions**
P07.00–07.36	Preterm Infant
P22.0	Respiratory Distress Syndrome of Newborn
Q00–Q99	**Congenital Malformations**
Q20–Q28	Congenital Heart Diseases
Q39.0–39.4	Tracheoesophageal Fistula
Q89.7	Multiple Anomalies
S00–T88	**Injury, Poisoning and Trauma**
S06.0–06.9	Brain Injuries
S12–S14	Spinal Cord Injuries
S88	Amputations
T07	Multiple Trauma Injuries
T20–T32	Burns
T79	Early Complications of Trauma
T86.00–86.09	Graft vs. Host Disease
T86.90–86.99	Complications of Transplants

High-Cost Drugs

A high-cost drug is defined as a drug for which monthly costs exceed approximately $10,000.

Examples:

Avastin, Iclusig, Taltz, Berinert, Kalbitor, Technivie, Cinryze, Kalydeco, Tyvaso, Daklinza, Keytruda, Uptravi, Epclusa, Kynamro, Entavis, Firazyr, Lumizyme, Viekira, Gleevec (imatinib), Opdivo, H.P. Acthar, Orkambi, Yervoy, Harvoni, Soliris, Zaltrap, Humira, Sovaldi, Zepatier, Ibrance, Stelara

Conditions leading to use of high-cost drugs may include: enzyme deficiencies (genetic mutations, Hereditary Angio Edema, Hunter's Syndrome and other), cancers, Cystic Fibrosis, MS, Nephrotic Syndrome, Psoriasis and inflammatory conditions, Hepatitis C, Hemophilia A,B,C, Hemolytic Uremia Syndrome, MDS, Narcolepsy and Pulmonary Arterial Hypertension.