PREMIUM ASSISTANCE UNDER MEDICAID & THE CHILDREN'S HEALTH INSURANCE PLAN (CHIPRA) NOTICE

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaidor CHIP officeto find out if premium assistanceisavailable.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums foranemployer-sponsoredplan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA(3272)**.

If you live in one of the followingstates, you may be eligible for assistancepaying your employerhealthplan premiums. The followinglistof statesis current as of January31, 2017. Contactyour Statefor more informationon eligibility–

ALABAMA – Medicaid

Website:http://myalhipp.com/
Phone:1-855-692-5447

ALASKA – Medicaid

The AK HealthInsurancePremiumPaymentProgram
Website:http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
MedicaidEligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

COLORADO – Health FirstColorado (Colorado's Medicaid Program)& Child Health Plan Plus(CHP+)

Health FirstColoradoWebsite:
https://www.healthfirstcolorado.com/
Health First ColoradoMemberContactCenter:
1-800-221-3943/ State Relay711
CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus
CHP+ CustomerService:1-800-359-1991/
State Relay711

KANSAS – Medicaid

Website:http://www.kdheks.gov/hcf/
Phone:1-785-296-3512

FLORIDA – Medicaid

Website:http://flmedicaidtplrecovery.com/hipp/
Phone:1-877-357-3268

GEORGIA – Medicaid

Website:http://dch.georgia.gov/medicaid
- Click on Health InsurancePremium Payment(HIPP)
Phone:404-656-4507

IOWA – Medicaid

Website:
http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
Phone:1-888-346-9562

NEW HAMPSHIRE – Medicaid

Website:
http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone:603-271-5218

KENTUCKY – Medicaid	NEW JERSEY – Medicaid and CHIP
Website:http://chfs.ky.gov/dms/default.htm Phone:1-800-635-2570	MedicaidWebsite: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone:609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone:1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone:1-888-695-2447	Website:https://www.health.ny.gov/health_care/medicaid/ Phone:1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website:http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone:1-800-442-6003 TTY: Maine relay711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone:1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone:1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website:http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone:1-800-657-3739	Website:http://www.insureoklahoma.org Phone:1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone:573-751-2005	Website:http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone:1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone:1-800-694-3084	Website:http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone:1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone:1-855-632-7633	Website:http://www.eohhs.ri.gov/ Phone:401-462-5300
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website:https://www.scdhhs.gov Phone:1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website:http://dss.sd.gov Phone:1-888-828-0059	Website:http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website:http://gethipptexas.com/ Phone:1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS ThirdPartyLiability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid andCHIP**
Medicaid Website:https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone:1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone:1-800-362-3002
VERMONT–Medicaid	**WYOMING – Medicaid**
Website:http://www.greenmountaincare.org/ Phone:1-800-250-8427	Website:https://wyequalitycare.acs-inc.com/ Phone:307-777-7531
VIRGINIA – Medicaid andCHIP	
MedicaidWebsite: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone:1-855-242-8282	

To see if any other stateshave added a premiumassistanceprogramsinceJanuary31, 2017, or for more informationon special enrollmentrights,contacteither:

U.S. DepartmentofLabor
Employee BenefitsSecurityAdministration
www.dol.gov/agencies/ebsa
1-866-444-EBSA(3272)

U.S.Departmentof Health and Human ServicesCentersfor Medicare & MedicaidServices
www.cms.hhs.gov
1-877-267-2323, menu Option 4,Ext.61565

PAPERWORK REDUCTION ACT STATEMENT

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not displaya currently valid OMB controlnumber.See 44 U.S.C.3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington,DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number1210-0137.

GENERAL COMPLIANCE NOTICES

The Newborns' andMothers'Health Protection Act of1996

The Newborns' and Mothers' Health Protection Act of 1996 prohibits group and individual health insurance policies from restricting benefits for any hospital length of stay for the mother or newborn child in connection with childbirth; (1) following a normal vaginal delivery, to less than 48 hours, and (2) following a cesarean section, to less than 96 hours. Health insurance policies may not require that a provider obtain authorization from the health insurance plan or the issuer for prescribing any such length of stay. Regardless of these standards an attending health care provider may, in consultation with the mother, discharge the mother or newborn child prior to the expiration of such minimum length of stay.

Further, a health insurer or health maintenance organization may not:

1. Deny to the mother or newborn child eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely to avoid providing such length of stay coverage;
2. Provide monetary payments or rebates to mothers to encourage such mothers to accept less than the minimum coverage;
3. Provide monetary incentives to an attending medical provider to induce such provider to provide care inconsistentwith suchlength of staycoverage;
4. Require a mother to give birth in a hospital;or
5. Restrict benefits for any portion of a period within a hospital length of stay described in thisnotice.

These benefits are subject to the plan's regular deductible and co-pay. For further details, refer to your Summary Plan Description. Keep this notice for your records and call Human Resources for more information.

Section 111

Effective January 1, 2009 group health plans are required by Federal government to comply with Section 111 of the Medicare, Medicaid, and SCHIP Extensions of 2007's new Medicare Secondary Payer regulations. The mandate is designed to assist in establishing financial liability of claims assignments. In other words, it will help establish who pays first. The mandate requires group health plans to collect additional information, more specifically Social Security numbers for all enrollees, including dependents 6 months of age orolder.

Please be prepared to provide this information on your benefits enrollment form whenenrollingintobenefits.

Women'sHealthand Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act of 1998 requires Caremax Medical Centers to notify you, as a participant or beneficiary of the Caremax Medical Centers Health and Welfare Plan, of your rights related to benefits provided through the plan in connection with a mastectomy. You, as a participant or beneficiary, have rights to coverage to be provided in a mannerdetermined in consultation with your attending physicianfor:

1. All stages of reconstruction of the breastonwhich the mastectomy was performed;
2. Surgery and reconstruction of the otherbreastto produce a symmetricalappearance;and
3. Prostheses and treatment of physicalcompilationsof the mastectomy, includinglymphedema.

These benefits are subject to the plan'sregulardeductible and co-pay. For further details, refer to your Summary Plan Description. Keep this notice for your records and call Human Resources for more information.

Michelle's Law

The law allows for continued coverage for dependent children who are covered under your group health plan as a student if they lose their student status because of a medically necessary leave of absence from school. Thislaw appliesto medicallynecessaryleaves of absencethat begin on or after January1,2010

If your child is no longer a student, as defined in your Certificate of Coverage, because he or she is on amedically necessary leave of absence, your child may continue tobe covered under the plan for up to one year from the beginning of the leave of absence. Thiscontinuedcoverage applies if your child was (1) covered under the plan and (2) enrolled as at student at a post- secondaryeducational institution (includes colleges, universities, some trade schools and certainother post-secondaryinstitutions).

Your employer will require a written certification from the child'sphysician that states that the child is suffering from a serious illness or injury and that the leave of absence is medicallynecessary.

GENERAL COMPLIANCE NOTICES

HIPAAPrivacyPolicyfor Fully-InsuredPlanswith no Access toPHI

The grouphealth plan is a fully-insuredgroup health plan sponsored by the"PlanSponsor". The group health plan and the plan sponsor intend to comply withthe requirementsof 45 C.F.R. §164.530 (k) so that the grouphealthplan is not subject to most of HIPAA's privacy requirements.

No access to protected health information (PHI) except for summary health information for limited purposeandenrollment/dis-enrollmentinformation.

Neither the group health plan nor the plan sponsor (or any member of the plan sponsor's workforce) shall create or receive protected health information (PHI) as defined in 45 C.F.R. §160.103 except for (1) summary health information for purpose of (a) obtaining premium bids or (b) modifying,amending, or terminating the group health plan, and (2) enrollment anddis-enrollmentinformation.

Insurerfor grouphealthplanwillprovideprivacy notice

The insurer for the group health plan will provide the group health plan's notice of privacy practices and will satisfy the other requirements under HIPAA related to the group health plan's PHI. The notice of privacy practices will notify participants of the potential disclosure of summary health information and enrollment / dis-enrollment information to the group health plan and the plansponsor.

No intimidatingorretaliatoryacts

The group health plan shall not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against individuals for exercising their rights , filing a complaint, participating in an investigation, or opposing any improper practice underHIPAAA.

No Waiver

The group health plan shall not require anindividual to waive his or her privacy rights under HIPAA as a condition of treatment, payment, enrollment or eligibility. If such an action should occur by one of the plan sponsor's employees, the action shallnot be attributed to the group healthplan.

GeneticInformation NondiscriminationAct(GINA)

GINA protects individuals against discrimination based on their genetic information in health coverage and in employment. GINA is divided into two sections, orTitles. Title I of GINA prohibits discrimination based on genetic information in health coverage. Title II of GINA prohibits discrimination based on genetic information in employment.

Patient Protection:

If the Group Health Plan generally requires the designation of a primary care provider who participates in the network and who is available to accept you or your family members. For children, your may designate a pediatrician as the primarycareprovider.

You do not need prior authorization from the carrier orfromany other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professionals, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan or procedures for makingreferrals.

For a list of participating health care professionals whospecialize in obstetrics or gynecology, or for information on how to selecta primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator or refer to the carrierwebsite.

It is your responsibility to ensure that the informationprovidedon your application is accurate and complete. Any omissions or incorrect statements made by you on your application may invalidate your coverage. The carrier has the right to rescind coverage on the basis of fraudormisrepresentation.

Children's HealthInsuranceProgram Reauthorization Act (CHIPRA)of2009

Effective April 1, 2009, a special enrollment period provision is added to comply with the requirements of the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009. If you or a dependent is covered under a Medicaid or CHIP plan and coverage is terminated as a result of the loss of eligibility for Medicaid or CHIP coverage, you may be able to enroll yourself and/or your dependent(s). However, you must enroll within 60 days after the date eligibility is lost. If you or a dependent becomes eligible for premium assistance under an applicable State Medicaid or CHIP plan to purchase coverage under the group health plan, you may be able to enroll yourself and/or your dependent(s). However, you must enroll within 60 days after you or your dependent is determined to be eligible for State premium assistance. Please note that premium assistance is not available inallstates.

MEDICARE PART D – CREDITABLE COVERAGE NOTICE

Medicare Part D CREDITABLE COVERAGE

This notice applies to employees and covered dependentswho are eligible for MedicarePartD.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Aetna and about your options under Medicare's prescription drug Plan. If you are consideringjoining, you should compare your current coverage including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the endof thisnotice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plan (like an HMO or PPO) that offer prescription drug coverage. All Medicare prescription drug plans provideat least a standard level of coverage set by Medicare.Some plans may also offer more coverage for a higher monthly premium.
2. Aetna has determined that the prescription drug overage offered by the Welfare Plan for Employees of Caremax Medical Centers under the Aetna option are, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicaredrugplan.

You shouldalso know that if you drop or lose your coverage with Aetna and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may paymore (a penalty) to enroll in Medicare prescription drug coverage later.

When can you join a Medicare Drug Plan? You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will alsobeeligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drugplan.

Whathappensto yourcurrentcoverageif you decideto joina MedicareDrugPlan?

If you decide to join a Medicare drug plan, your current Aetna coverage will not be affected. You can keep this coverage if you elect part D and this plan will coordinate with Part D coverage.

Ifyou decide to join a Medicare drug plan and drop your current Aetnacoverage, be aware that you and your dependents will be able to get this coverageback.

Whenwill you pay a higherpremium(penalty)to join a Medicare drugPlan?

You should also know that if you drop or lose your current coverage with Aetna and don't join a Medicare drug plan within 63 continuous days after your current coverageends,you may pay a higher premium (a penalty) to join a Medicare drug planlater.

If you go 63 continuous days or longer withoutcreditable prescription drug coverage, your monthly premiummay go up at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage.For example, if you go nineteen months without creditable coverage, your premium may consistently be at least19%higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the followingOctobertojoin.

For more informationaboutthisnoticeor yourcurrent prescriptiondrugcoverage…

Contact our office for further information (see contact informationbelow). NOTE: You'll get this notice each year.You will also get it before the next period you can join a Medicare drug plan, and if this coverage through BlueCross BlueShield of Alabamachanges.

You also may request a copy of this noticeatanytime.

For more informationaboutyouroptionsunderMedicare prescriptiondrugcoverage…

More detailed information about Medicare plansthat offer prescription drug coverage is in the "Medicare &You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directlyby Medicare drug plans. For more information about Medicare prescription drugcoverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program(see your copy of the Medicare & You handbook for their telephone number) forpersonalizedhelp,
- Call **1-800-MEDICARE (1-800-633-4227).**TTYusersshould call**1-877-486-2048.**

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at **1-800-772-1213** (TTY **1-800-325-0778**).**Remember: Keep this notice. If you enrollin one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higherpremiumamount.**

Name of Entity/Sender:	**Caremax, Inc.**
Contact--Position/Office:	**Daisy Bru Ferrer, Human Resources**
Address:	**1000 NW 57th Court** **Suite 400** **Miami, FL 33126**
PhoneNumber:	**305-649-8100 ex 1132**

New Health Insurance Marketplace Coverage Options and Your Health Coverage

FormApproved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employmentbased health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9 . 5 % of your household income for the year, or if the coverage your employer provides does not meet the " minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources Department

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The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **Health Care. gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Caremax, Inc.
Daisy Bru Ferrer – Human Resources
1000 NW 57th Court, Suite 400
Miami, FL 33126
305-649-8100 ex. 1132
dferrer@IMCHealth.com

[1] An employer- sponsored health plan meets the " minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.