Florida Health Solution Corp. is a Florida corporation organized and operating as a prepaid health clinic under the laws of the State of Florida. This Contract is delivered in and governed by the laws of the State of Florida.

Florida Health Solution Corp., (herein after referred to as “FHS”) agrees to provide Coverage for prepaid health care clinic services and benefits to the extent described herein, to the Subscriber and the Subscriber’s family Members if any, subject to the terms, conditions, exclusions and limitations of this Contract. This Contract is issued on the basis of the Subscriber’s application and payment of the required premium and fees.

This Contract includes the Schedules of Benefits, the Subscriber’s application, and rate letters, riders, and amendments which are or may be incorporated in this Contract from time to time. Any changes in this Contract must be approved by an officer of the company, and endorsed on the Contract or attached to it. Any verbal promise made by an officer or employee of FHS or any other person, including an agent, will not be binding on the company unless it is contained in writing in this Contract or an endorsement to it.

This Contract shall take effect on the date specified on the Plan Information Page and will be continued in force by the timely payment of the required Premium when due, subject to termination of this Contract as provided herein. All Coverage under this Contract shall begin at 12:01 a.m. and end at 12:00 midnight Eastern Standard Time.

NOTE: THIS CONTRACT ONLY PROVIDES COVERAGE FOR SPECIFIC OUTPATIENT SERVICES. INPATIENT HOSPITAL SERVICES ARE NOT COVERED.

________________________________________
Officer’s Signature and Title
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ATTACHMENT A: Plan Information Page

SCHEDULES OF BENEFITS

This Prepaid Health Clinic Contract (includes this document and attachments to it, Your Membership Identification Card, Application for Coverage, and any Membership Status Change Forms) contains the terms and conditions of Member Coverage (the Covered Services that You are entitled) provided by Florida Health Solution Corp. (also referred to as "FHS"). a Florida corporation organized and operating as a prepaid health clinic under the laws of the State of Florida.
I. DEFINITIONS

“Agency” means the Agency for Health Care Administration.

“Condition” means any sickness, disease, disorder, infection, injury, or bodily dysfunction of a Member, except self-inflicted Conditions.

"Contract" means this Prepaid Health Clinic Contract.

“Contract Year” means a period of twelve (12) consecutive months as determined from the Effective Date of this Contract.

"Copayment" means the amount required to be paid by the Member prior to Covered Services being rendered as set forth in this Contract.

“Controlled Specialist” means a Participating Physician to whom the Member is referred by his or her Participating Primary Care Physician, General Practitioner or Specialist Physician for consultation, diagnostics, treatment or care.

"Coverage or Covered" means inclusion of an individual for payment of expenses related to Covered Services under this Contract.

“Covered Services” (as expressly set forth as covered, excluded or limited by this Contract) means those professional services provided by a Participating Physicians and Participating Providers.

“Department, Office” means the Florida Department of Financial Services, Office of Insurance Regulation.

“Dependent” means an eligible Dependent or Relative who meets the eligibility requirements for coverage as set forth in Part III of this contract.

“EFT” Electronic Fund Transfer.

“Emergency” means a medical condition manifesting itself by acute symptoms of sufficient severity, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual’s health.

“Experimental and/or Investigational Treatment” means, for the purposes of this Contract, a drug, treatment, device, surgery or procedure that may be determined to be experimental and/or investigational if any of the following applies:

a. the Food and Drug Administration (FDA) has not granted the approval for general use; or

b. there are insufficient outcomes data available from controlled clinical trials published in peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or

c. there is no consensus among practicing Physicians that the drug, treatment, therapy, procedure or device is safe or effective for the treatment in question or such drug, treatment, therapy, procedure or device is not the standard treatment, therapy, procedure or device utilized by practicing Physician in treating other patients with the same or similar condition; or

d. such drug treatment, procedure or device is the subject of an ongoing Phase I or Phase II clinical investigation, or experimental or research arm of a Phase III clinical investigation, or under study to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the condition in question.

“Grievance” means a written complaint submitted by or on behalf of the Member to FHS or a state agency regarding the: a) availability, coverage for the delivery, or quality of health care services, including a complaint regarding an Adverse Determination made pursuant to utilization review; b) claims payment, handling, or reimbursement for Covered Services; or c) matters pertaining to the contractual relationship between a Member and FHS.

A Grievance does not include a written complaint submitted by or on behalf of a Member eligible for a grievance and appeals procedure provided by an organization pursuant to contract with the Federal Government under Title XVII of the Social Security Act.
“Grievance Committee” means the formal structure which reviews a Grievance that has not been resolved by informal means or direct intervention of the Grievance Coordinator.

“Grievance Coordinator” means a person with problem solving authority acting on formal and informal complaints and brings them to a resolution.

“Grievance Procedure” means an organized process by which a Member may express dissatisfaction with care, services or benefits received under this Contract and the resolution of the dissatisfaction.

"Hospital" means an institution which is licensed pursuant to law, including osteopathic institutions, and is primarily engaged in providing on an inpatient basis for the medical care and treatment of sick and injured persons through Medical, and diagnostic facilities, all of which facilities must be provided on its premises, under the supervision of a staff of Physicians and with twenty-four (24) hours a day nursing and Physician service. The term "Hospital" does not include a convalescent nursing home or any institution or part thereof which is used principally as a custodial facility or facility for the aged.

"Medically Necessary" means the use of Covered Services or supplies (as expressly limited or excluded by this Contract) provided by a Participating Provider required to identify or treat the Member’s Condition and which, as determined by Our Medical Director, is: (i) consistent with the symptoms or diagnosis and treatment of the Member’s Condition; (ii) appropriate with regard to standards of good Medical practice; (iii) not solely for the convenience of You or a Physician or other Health Care Professional.

“Member” means the Subscriber or an Eligible Dependent who is covered under this Contract and for whom premium has been received.

“Non-Participating Provider” means a Physician or any other duly licensed Health Care Professional that is not contracted with FHS to provide Covered Services to FHS Members.

“Participating Health Care Professional” means: Physicians, Specialists and other professionals engaged in the delivery of health services, who are licensed by the State of Florida and practice within the scope of that license, and who have entered into a written contract to provide Covered Services to FHS Members.

"Participating Physician" means a Physician or osteopath who is licensed by the State of Florida and practices within the scope of that license and who has contracted with FHS to provide or arrange Covered Services to FHS Members.

"Participating Provider" means a Physician or Health Care Professional, organization, supplier of healthcare items, or a health care facility having a written contract with FHS to provide medical services to a FHS Member.

"Participating Primary Care Physician (‘PCP’)" is a General Practitioner Physician who is licensed by the State of Florida and practices within the scope of that license and who has contracted with FHS to provide or arrange Covered Services to FHS Members and who is primarily responsible for the overall medical care of the Member.

“Participating Specialist” means a Participating Physician duly licensed to practice specialized medicine or osteopathy in the State of Florida.

“Premium” means the monthly payment made to FHS by You, or on the Member’s behalf, that entitles the Member to the benefits outlined in this Contract.

“Relative” means a brother, sister, mother, father, uncle, aunt or first cousins of the Subscriber or Subscriber’s spouse or Domestic Partners

"Service Area" means the geographic area in which FHS is authorized to provide Covered Services. FHS’s Service Area is [Dade, Broward, Palm Beach, Orange, Osceola, Seminole, Pinellas and Pasco] counties in the State of Florida. The Service Area may be amended from time to time to include other areas as may be approved by the Agency for Health Care Administration.

“Subscriber” means a person who has entered into a contract with Florida Health Solution Corp., and for whom the required premium has been received by FHS. A Subscriber’s coverage is not effective unless approved by FHS.

“Urgent Care” means acute medical situations which may require prompt medical attention, although not considered an emergency.
“Urgent Grievance” means when the standard time frame of the Grievance Procedure would seriously jeopardize the Member’s ability to continue or regain maximum functions.

“Usual and Customary” is the payment methodology FHS uses when paying Non-Participating Providers for second medical opinions. The usual and customary charge will be based on the current Medicare fee schedule.

“Waiting Period” means the period, if any, commencing from the individual’s effective date of coverage, that must pass before the individual is eligible to receive Covered Services.

“We, Our” means Florida Health Solution, Corp.

"You, Your" means the Member.

II. HOW THE PLAN WORKS

FHS arranges for Covered Services to be provided to Members through a network of contracted Physicians and other Participating Providers. **FHS will only cover the cost of Covered Services rendered by Participating Providers.** If you follow these simple requirements, you will be required to only pay a Copayment amount for the Covered Service.

**A. The Member’s Primary Care Physician (PCP)**

If a Member requires health care services, the Member should make an appointment with any General Practitioner (GP) listed in the FHS Provider Directory. Although you can elect to receive Covered Services from any general practitioner, FHS encourages you to select and develop a relationship with one general practitioner as your Primary Care Physician (PCP) who will coordinate any diagnosis, treatment, care and progress. Your Primary Care Physician or Specialist Physician is also responsible for arranging any referrals to Controlled Specialists and other Covered Services requiring a referral.

**B. Referral Requirements for Using Other Participating Providers**

Except for Specialist Office Visits (not including Controlled Specialists), Urgent Care or Vision Care, a Member may not seek care from any Plan Health Care Professional without a referral from the Member’s PCP, GP or Specialist Physician. Most referrals will be made only for a single visit or service. If the Participating Physician believes that additional visits or services are required, the Participating Physician will obtain authorization from FHS for the appropriate number of additional visits or services.

**C. Additional Provider Information**

1. If a Participating Physician terminates his or her contract with FHS or is terminated by FHS for any reason other than for cause, a Member receiving active treatment may continue coverage and care with that Provider when Medically Necessary and through completion of treatment of a Condition for which the Member was receiving care at the time of the termination until the Member selects another treating Provider, but not longer than six (6) months after termination of the Provider’s contract. A Provider may refuse to continue to provide care to a Member who is abusive, non-compliant, or in arrears in payment for services provided.

2. Certain types of Covered Services may be provided by Participating Physicians’ Physician assistants, nurse practitioners, or other individuals who are not licensed Physicians.

**D. When You Need Care After Regular Office Hours**

**Except for urgent care, if You are sick or injured after regular office hours, please call Your Primary Care Physician or General Practitioner. The Participating Physician may give the Member treatment advice by telephone, prescribe medication or instruct the Member to make an appointment during office hours. If You have an emergency or urgent situation, Your Participating Physician may advise you to go to the nearest hospital emergency room or urgent care center.**

**E. Urgent Care**

Urgent Care is a Covered Service if Medically Necessary and the care is provided in order to treat an unexpected illness or accidental injury and prevent a serious deterioration in the Member’s health if treatment were delayed. Urgent Care Covered Services are limited as set forth in Section VI.
The Member is encouraged to contact his or her PCP or GP for guidance when time and circumstances permit. If the Member cannot call his or her PCP or GP, or requires care without an appointment or after office hours, the Member should go to the nearest Participating Urgent Care Center. The Member should notify his or her PCP of any treatment received for after-care and follow-up.

**Urgent Care Services set forth in the Covered Services Section which is received from Non-Participating Providers or Providers located outside the FHS Service Area are not covered.**

**F. Emergency Care**
Emergency Care Services are not Covered Services. If such a situation arises, a Member is urged to go immediately to the nearest hospital emergency room for medical care. You should advise your Primary Care Physician or General Practitioner of any treatment received on an emergency basis for after-care and follow-up in Your Physician’s office.

**G. Medical Necessity**
All Covered Services provided under this Contract, as set forth in Section VI, will be provided in accordance with FHS utilization guidelines that FHS establishes regarding the provision of such services.

**H. Membership Identification Card**
The Membership Identification Card FHS issues to a Member, is for identification purposes only. You should carry the card at all times and present the card every time you receive health services from FHS Participating Providers. A Member does not have to fill out any claim forms. When the Member presents his or her Member Identification Card, the Participating Provider will handle the paperwork on the Member’s behalf.

Possession of a Membership Card confers no right to services or other benefits under this Contract. To be entitled to services or benefits, You must be a Member on whose behalf all applicable Premium payments under this Contract have been paid. Any person receiving services or benefits, for which they are not entitled, will be responsible for all costs of such services or benefits. A Member must not give his or her Membership Card to any other person. FHS may terminate the Member’s coverage if he or she allows another person to use the FHS Membership Card.

**The Member must obtain Covered Services from Participating Providers only. Failure to obtain care according to the rules of this Contract may make the Member personally responsible for payment for the services rendered.**

**I. Copayments**
A Member is responsible for paying a portion of the cost of Covered Services. Usually, this portion is a flat dollar amount referred to as a Copayment. Copayments are required to be paid by the Member prior to Covered Services being rendered. The Copayment requirements for this Contract are set forth in the Schedules of Benefits.

**III. ELIGIBILITY AND COVERAGE EFFECTIVE DATE**

**A. Member Eligibility**
In order to maintain eligibility as a Subscriber under this Contract, the Subscriber subject to the following requirements:

1. The Subscriber must continually live or work within FHS’s Service Area.
2. The Subscriber must remit to FHS the applicable monthly Premium payment. Legal representatives of Members who are incapable of legally contracting must remit the applicable monthly premium on behalf of the Member under the same terms described herein.
3. The Subscriber must notify FHS of any changes to the information requested or provided on the FHS Member Application within thirty (30) days of the change. This information includes the Member’s address, relocation out of the FHS Service Area and eligibility or enrollment in Medicare.
By electing Membership under this Contract, all Members legally capable of contracting and the legal representatives of all Members incapable of contracting shall agree to all the terms, conditions, and provisions herein.

B. Eligibility for Dependents and Relatives

The Subscriber’s Dependents and Relatives are eligible for coverage. The Dependent or Relative must live in the FHS Service Area and reside with the Subscriber. Dependents or Relatives eligible for coverage are:

1. **Spouse:** The Subscriber’s lawful Spouse or Domestic Partner

2. **Children:** A child of the Member including natural children, legally adopted children, foster children, step-children, or any child who lives with the Subscriber:
   - a) Under the age of eighteen (18), or
   - b) A dependent child from the age of eighteen (18) until the child reach the age of twenty-six (26), if the child is a full-time student. A full-time student is defined as a child attending to school and receiving 12 credits per semester or quarter. If a child turns age eighteen (18) and is not a full-time student, the child will be terminated from this plan and is eligible to apply for his or her own coverage.

3. **Relative:** A brother, sister, mother, father, uncle, aunt or first cousins of the Subscriber or Subscriber’s spouse or Domestic Partners.

If a Subscriber wants to apply for coverage for a Dependent or Relative, please contact FHS at 1-877-827-0711 or a FHS agent and request a Member application. A completed application and premium must be submitted to FHS at least 30 days of the requested coverage date.

C. Enrolling New Family Members – Coverage Effective Date

The Subscriber may add an eligible Dependent or Relative at any time by contacting FHS or an FHS agent. If the Dependent or Relative is ineligible for coverage, the Subscriber may pay additional premium if applicable. FHS has seventy-two (72) business hours from receipt of the request for enrollment to accept or decline the enrollment. If declined and premium was submitted with the request, FHS will return the applicable premium. If accepted for coverage, the Dependent or Relative will receive a Membership ID Card which reflects the Member’s Coverage Effective date to received Covered Services.

IV. RENEWAL AND TERMINATION OF COVERAGE

A. How Does the Member Terminate Coverage?

A Subscriber may terminate coverage by signing (or, if a minor, having signed on his/her behalf by a legal guardian) and submitting either a FHS Member Change Form or a written notice. This termination will be effective on the first (1st) day of the month following our receipt of such FHS Member Change Form provided such form is received by FHS at least five (5) business days before the end of the month preceding the month in which termination of coverage is to be effective.

B. Terms of Renewal and Termination of Coverage

FHS may at its discretion and at any time, discontinue this contract. We will give the Member thirty (30) day written notice prior to terminating this Contract. Coverage for each Member, including Covered Services rendered after the date of termination for Conditions arising prior to the date of termination, shall automatically terminate as set forth below:

1. The last day of any calendar month that this Contract is terminated or FHS ceases offering this Contract to all Members.
2. Twelve o’clock midnight on the day premium is due if the premium is not paid by the end of the grace period. Coverage automatically terminates retroactive to the last paid date of coverage.
3. The date specified by FHS that all coverage will terminate because the Member has performed an act or practice that constitutes fraud or made a misrepresentation of material fact under the terms of this Contract.
4. The date specified by FHS that all coverage will terminate because the Member permitted the use of his or her Membership Identification Card by an unauthorized person or used another Member’s card.
5. The date a Member no longer lives or works in FHS’s Service Area. The Member is responsible for notifying FHS of a Member’s move from the Service Area. Coverage will terminate on the date of such move, even if the required notice is not provided to FHS.

6. The date specified by FHS that Coverage will terminate due to fraud or material misrepresentation or omission in the Member’s applying for or presenting any claim for benefits.

7. The date specified by FHS that Coverage will terminate for cause, due to disruptive, unruly, abusive or uncooperative behavior to the extent that such Member’s continued Membership with FHS impairs FHS’s ability to administer this Contract. FHS will ascertain to the extent possible, that the behavior is not related to the use of Covered Services or mental illness and will document the problems, efforts and medical conditions. FHS will make a reasonable effort to resolve the problem including the use of attempted use of the Grievance Procedures.

8. The date in which the Covered Dependent or Relative no longer lives with the Subscriber. The Member is responsible for notifying FHS. Coverage will terminate on the date of such move, even if the required notice is not provided to FHS.

9. The last day of any calendar month in which the Member ceases to be eligible as a Member.

C. Coverage Alternatives after Termination

If a Member’s coverage terminates, the Member may, depending on his or her situation, have the right to apply for individual coverage. Eligibility and coverage information may be obtained by calling FHS at (305)269-2000 or Toll free 1-877-827-0711 or by contacting an FHS agent.

V. GRIEVANCE PROCEDURES

Grievance Procedure

Florida Health Solution Corp. (FHS) has a grievance and appeal procedure which complies with applicable state and federal law (“The Grievance Procedure”). We will try to resolve any problems you may encounter over the telephone, but sometimes, additional steps are necessary. In these cases, we have a Grievance Procedure available that provides channels for you, or a Provider acting on your behalf, to voice your concerns and have them reviewed and addressed at several levels within the Plan.

The Grievance Procedure includes informal as well as formal grievance steps. A grievance is not considered formal until a written request for grievance review or a completed FHS “Formal Grievance/Appeal Form” requesting formal action is received by FHS’s Grievance & Appeal Administrator. You have one year from the date of the event/occurrence upon which the complaint is based to file a verbal or written request for grievance review.

Level 1 – Informal Grievance or Complaint

If you have a complaint, please discuss your concern with our Customer Service Department by calling (305)269-2000 or Toll Free 1-877-827-0711 or visiting FHS during normal working hours. In accordance with Section 641.47 (5) F.S., a complaint is any expression of dissatisfaction by a Subscriber, including dissatisfaction with the administration, claims practices, or provision of services, which relates to the quality of care provided by a Provider pursuant to FHS’s contract and which is submitted to FHS or to a state agency. Every attempt will be made to resolve your concern during your initial phone call or visit.

If you are not satisfied with our response, you have the right to file a formal written grievance. In accordance with Section 641.47 (10) F.S., a grievance is a written complaint submitted by or on the behalf of a Member or Provider to the plan or the agency regarding the: availability, coverage for the delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; claims payment, handling, or reimbursement for health care services; or matters pertaining to the contractual relationship between a Member or Provider and the plan or agency.

You may write us a letter specifically requesting a grievance review. Ask our Customer Service Department to provide you with a FHS “Formal Grievance / Appeal Form”, or you may obtain it through our website at: floridahealthsolution.com

If necessary, a Customer Service Representative will assist you with preparing your grievance. You may file a Grievance or Complaint one of three ways:
Level 2 – Formal Grievance

If you disagree with the outcome of the Level – 1 review of an informal grievance, FHS provides Members with an optional Level – 2 Formal Grievance process. Level – 2 grievances may be submitted in writing, as long as it is received by FHS within 30 days of your receipt of the Level – 1 determination. You may also file your formal grievance with the Florida Agency for Health Care Administration or the Florida Department of Financial Services. Please be sure to include all additional information and copies of pertinent documentation such as your medical records.

If your grievance is due to an adverse determination and denied, you also have the right to request a Level – 2 formal grievance within 30 days of the determination. An adverse determination is a determination by us that an admission, availability of care, continued stay, or other health care service was reviewed and, based upon the information provided, is not a covered benefit under your plan. Coverage for the requested service is therefore denied, reduced or terminated.

All formal grievances will be acknowledged by FHS within five (5) business days of receipt. You will receive written notification from FHS of the grievance outcome once a determination has been made, or within thirty (30) business days from the date of receipt. If your grievance involves activities which occurred outside the service area, or requires the collection of information from outside the service area, FHS shall have an additional thirty (30) days in addition to each of the response / notice periods set forth above, to process your grievance.

If you disagree with our Level – 2 determinations, you may request either verbally or in writing a review by the FHS Grievance Review Panel (“the Panel”). For adverse determinations, the majority of the Panel will be persons who have the appropriate expertise, and who were not involved in the initial adverse determination. A person who was previously involved in the adverse determination may appear before the Panel to present information or answer questions. Each party related to the grievance has the right to appear in person to present arguments. The Panel will issue a final decision to the Subscriber, and Provider if any, who files on behalf of the Subscriber, within thirty (30) business days of a request for a Panel review. All grievances will be finalized within sixty (60) days of receipt of the formal grievance, unless thirty (30) additional days are needed to collect information outside the FHS service area.

Expedited (Urgent) Grievance Review

In all cases where the standard 30-day grievance review time frame would jeopardize your life, health, or ability to regain maximum function, you, your legal representative, or Physician authorized to act on your behalf (who is directly involved in your treatment or diagnosis) may file a request for an expedited (urgent) grievance review. You may request this review either verbally or in writing by contacting FHS as specified above. This process only applies to a pre-service or concurrent, and not retrospective, denial. For example, this does not apply to a request for payment of services already rendered but denied, other claims review, or reimbursement. If the expedited review process does not resolve a difference of opinion between FHS and the Member or the Provider acting on behalf of the Member, the Member or Provider may submit a written grievance to the Subscriber Assistance Program.

FHS will, after review and validation of your request, expedite the grievance procedure, and render a determination within seventy-two (72) hours of receipt of your request. This review will be conducted by appropriate clinical peers who were not involved in the initial determination within twenty-four (24) hours after receiving a request for an expedited appeal. We will decide within seventy-two (72) hours and notify you of our decision. Any verbal notice will be followed with written notice within two (2) working days.

Level 3 – State Appeals

If you do not accept the decision of the Panel, you have the right to appeal to the Florida Agency for Health Care Administration (AHCA) or the Department of Financial Services (FDFS) within one (1) year from the date of receipt of our decision. If you appeal FHS’s decision, your grievance will be reviewed by the Subscriber Assistance Program. You also have the right to contact AHCA or FDFS at any time to inform them of an unresolved grievance.

The Subscriber Assistance Program will not hear a grievance if the Member has not completed the entire FHS Grievance process, nor if the Member has instituted an action pending in the state or federal court.

Other Agencies

Pursuant to Florida law, FHS may not provide information to you concerning the outcome of quality of care complaints. If you need further assistance, you may contact:
VI. COVERED SERVICES

All Covered Services set forth in this section and in the Schedules of Benefits must be deemed to be Medically Necessary by Florida Health Solution. All Covered Services are also subject to the Limitations, Exclusions and Conditions Section. Please refer to the Schedules of Benefits for terms and conditions and the applicable Copayment for each Covered Service.

* Benefits or Co-payments may change subject to Office Insurance of Regulation Approval.

Please note that if you are unable to keep your appointment, please notify the Participating Provider by calling him/her at least 48 hours in advance and re-schedule for a more convenient date and time.

Except for Specialist Physician Office Visits, Urgent Care and Vision Care (Optometrist), all Covered Services require a referral from your Primary Care Physician, General Practitioner or Specialist Physician before services can be rendered by a Participating Provider.

A. Primary Care Physician (PCP or GP) Office Visit. If a Member requires health care services, the Member should make an appointment with his/her Participating Primary Care Physician (PCP) or General Practitioner (GP). An office visit includes a consultation and/or an examination for a medical condition. Any Covered Services performed during an office visit is subject to a separate Copayment as set forth in the Schedules of Benefits. Whenever a Medically Necessary Covered Service is needed and cannot be provided by your PCP or GP, he/she will provide you with a referral to another Participating Provider.

B. Specialist Physician Office Visit. Examinations and consultations performed by a Participating Specialist are Covered Services. Any Covered Services performed during an office visit is subject to a separate Copayment as set forth in the Schedules of Benefits. Whenever a Medically Necessary Covered Service is needed and cannot be provided by the Specialist, he/she will provide you with a referral to another Participating Provider. The following Participating Providers are considered Specialist Physicians:

- Dermatology*
- Gynecology *
- Internal Medicine *
- Orthopedic*
- Pediatric*
- Podiatry*
- Psychiatry *
- Urology*

*Please note that all Participating Specialists may not be available in all Service Areas.

C. Controlled Specialist Office Visit. Examinations and consultations are Covered Services when referred by the Member’s PCP, GP or Specialist Physician and the services are authorized by FHS. Any Covered Services performed during an office visit is subject to a separate Copayment as set forth in the Schedules of Benefits. If the Member does not receive a referral to a Controlled Specialist prior to the office visit, the visit is not covered. The following Participating Providers are considered Controlled Specialists:

- Cardiology *
- Endocrinology*
- Gastroenterology*+
- Ophthalmology *
- Otorhinolaryngology (ENT)*
- Surgeons*
- Pulmonology*
- Neurology*

*Please note that all Participating Specialists may not be available in all Service Areas.

++ Controlled Specialty requires a sixty (60) day waiting period commencing from the member’s coverage effective date.
D. Diagnostic Procedures. Invasive and non-invasive diagnostic procedures must be Medically Necessary and performed in a Participating Physician’s office or with a written referral to another Participating Provider. Please consult the Diagnostic Procedure Schedule of Benefits for Covered Services and Copayments.

E. Additional Benefits. Services described in the Schedule are covered and subject to the Copayment amount listed. Additionally, a Member is entitled to a prescribed number of Covered Services described in the Additional Benefits Schedule at no charge to the Member based on the length of time the Member has been covered under this Contract. All services must be Medically Necessary, require a referral from a Participating Physician. Additional Benefits must be requested by the Member by calling Customer Services.

F. Control Panels. Services described in the Schedule of Benefits are subject to either no copayment or a nominal copayment:

1. **Panel A:** After a one (1) month waiting period commencing from the Member’s coverage effective date, a Member is eligible for one preventive care check-up per contract year. The physical examination must be performed by a Participating Provider/Physician, general practitioner or pediatrician.

2. **Panels B, C, D, and F:** After a three (3) month waiting period commencing from the Member’s coverage effective date, a Member is eligible to have one of Panels B - F every 3 months per contract year. Panels A-F cannot be repeated and/or accumulated during each contract year. The procedure must be performed in a Participating Provider Physician/Specialist’s, based upon age specifications.

3. **Panel H:** After a one (1) month waiting period commencing from the Member’s coverage effective date, a Member is eligible to have during an office visit either singular or multi lab tests (Panel H) performed 3 times per contract year. The first and second office visits whereby Panel H tests are performed are covered after the one month waiting period. The third office visits whereby Panel H tests are performed are covered only if the lab tests are performed more than three months after the second office visit. The tests must be medically necessary and be performed in the Participating Provider Primary Care Physician or General Practitioner’s office. Panel H Lab tests can be combined with procedures from Preventive Panel Female B and F, excluding other Panels.

4. **Panel I:** After a one (1) month waiting period commencing from the Member’s coverage effective date, a Member is eligible to have procedures described in Panel I performed. This panel has a $200.00 credit every contract year. This credit accumulates every contract year. If the full $200.00 credit is not used during a contract year, the balance of the credit rolls over and is added to the next contract year’s $200 credit amount. The procedure(s) must be performed in a Participating Provider Physician/Specialist’s office or Participating Diagnostic Center upon referral from a Participating Physician and subject to a previous appt request, with the exception of child immunizations and flu shots. Must be medically necessary.

5. **Panel J:** After a one (1) month waiting period commencing from the Member’s coverage effective date, a Member is eligible to have procedures described in Panel J once per contract year. The procedure must be performed by a Participating Provider Dental Office.

G. Urgent Care Services. Urgent Care received at a Participating Walk-in Clinic is a Covered Service for Members requiring immediate attention for an unexpected illness or accidental injury which is not considered an emergency condition. Services that are considered Covered Services are described in the Urgent Care Schedule of Benefits. FHS recommends the Member contact his/her Physician during office hours following receipt of urgent care services.

H. Endoscopic Procedures. FHS will cover endoscopies and colonoscopies upon referral from the Member’s Participating Physician as set forth in the Endoscopic Procedures Schedule of Benefits. The copayment is applicable for the procedure and Physician/Specialist’s charges. The Member is wholly responsible for any facility charges if Covered Services are performed outside the Physician/Specialist’s office.

I. Vision Care Services. Members may choose from three options. Each option includes a vision exam, frame, tint, U.V. protection, case and eyeglass adjustments one time per Contract Year. The Copayment is dependent on the option elected as specified in the Optometry Schedule of Benefits.

J. Second Medical Opinion. As a FHS Member, You are entitled to a second medical opinion under the following conditions:

1. Whenever a minor surgical procedure is recommended to confirm the need for the procedure;
2. Whenever a serious injury or illness exists; or
3. Whenever you find that you are not responding to the current treatment plan in a satisfactory manner.

If requested, the second opinion consultation is to be provided by a Physician of the Member’s choice. The Member may select a Participating Physician listed in the FHS Provider Directory or a Non-Participating Physician located in the FHS Service Area. If a Member chooses a Participating Physician, he or she will only be responsible for the applicable Co-payment for the consultation. If a Member chooses a Non-Participating Physician, FHS will pay 60% of the usual and customary charge for the second opinion. At the time of service, the Member must pay the Non-Participating Physician the entire charges incurred for the second opinion and submit a claim to FHS. FHS will reimburse the Member the usual and customary amount for the second opinion consultation less 40% of such amount.

If a Member would like a second medical opinion, the Member must first notify his or her Primary Care Physician or Participating General Practitioner who will initiate a request for consultation. Any Covered diagnostic tests requested by the Physician providing the second opinion must be coordinated by the Member’s Primary Care Physician or Participating General Practitioner, and if Medically Necessary, performed by a FHS Participating Physician. Any lab tests and/or Diagnostic and Therapeutic Services are subject to the additional Co-payment.

The Physician providing the second opinion will provide the Member’s Primary Care Physician or Participating General Practitioner with a written opinion. Please note that the Physician who provides the second opinion will not perform the surgery or initiate any treatment to correct the condition for which the original recommendation was given, unless authorized by the Member’s Primary Care Physician or Participating General Practitioner.

**VII. LIMITATIONS, EXCLUSIONS AND CONDITIONS**

All Covered Services must be provided by or arranged for by the Member’s Primary Care Physician or Participating General Practitioner. Covered Services that are not provided by or arranged for by the Member’s PCP or Participating General Practitioner are excluded. Additionally, all services and benefits set forth below are specifically excluded from coverage under this Contract except if otherwise expressly provided for in the Covered Services Section or a Schedule of Benefits.

1. Acupuncture services.
2. All costs associated with the delivery of a newborn child.
3. Allergy testing and treatments.
4. Anesthesia, except those services specifically provided for in the Covered Services Section and Schedules of Benefits.
5. Any Covered care or treatment provided by Non-Participating Physicians, health professionals or outpatient facilities.
6. Any Covered treatment, procedure, service or supply which is not determined by the Member’s Participating Physician or FHS to be Medically Necessary to prevent, diagnose, or treat a Condition, illness, injury or bodily malfunction.
7. Any prescription or regimen, Medical or surgical or non-surgical procedure or treatment, for the purpose of reducing or controlling weight.
8. Any service or supply in connection with a transplant, implant; any service or supply in connection with identification of an organ donor from a local, state, or national listing, or any service provided to an organ donor or prospective donor.
9. Any services related to autologous blood collection and storage, and synthetic blood products.
10. Any treatments, procedures, services or supplies other than those specified in the Covered Services Section or Schedules of Benefits.
11. Arch supports, orthopedic shoes, sneakers, ready-made compression hose or support hose, or similar type devices/appliances regardless of intended use.
12. Biofeedback, self-help training and educational programs, including programs primarily for pain management or vocational rehabilitation.
14. Care and treatment for any condition for which state or local laws require treatment in a state or local government facility.
15. Care and treatment for injuries sustained while the Member is under the influence of any illegal or illicit drug, or any controlled or legend drug or substance if the drug or substance is not then subject to a valid prescription issued in the name of the Member by a Physician and being administered to treat a current episode of illness.

16. Care and treatment for military-service connected disabilities for which the Member receives or is paid benefits for which the care and treatment available to the Member from military or other federal, state, or local facilities, contractors, or programs, except as otherwise required by law.

17. Care and treatment incurred in connection with injuries which occurred during a crime committed by a Member or which the Member tries to commit whether or not the Member is charged with or convicted of any criminal offense.

18. Care and treatment or treatment incurred in connection with any injuries sustained by a Member when the Member’s blood alcohol content is in excess of the legal limit whether or not the Member is charged or convicted of any criminal offense.

19. Care for Conditions that are required by State or Local law to be treated in a public facility or care for Conditions that are paid under Workers’ Compensation or any other third-party-payer who has primary responsibility.

20. Care for illness, injury, complications, and conditions resulting from the provision of non-Covered Services.


22. Contraceptive devices and supplies, including but not limited to oral contraceptives, IUD’s, NorPlant, sterilization procedures, diaphragms, spermicidal suppositories, including the fitting, insertion and removal of such devices.

23. Cosmetic surgical and non-surgical procedures and complications from such procedures.

24. Custodial, respite, domiciliary, rest, or convalescent care, and care and treatment in extended care facilities, boarding homes, long-term home health care nursing services, residential treatment facilities, and adult congregate living facilities, homemaker services and services primarily for rest and any services or supplies rendered by, through or on behalf of any of these facilities.

25. Dental care, surgical and non-surgical treatments, services and supplies, except those services specifically provided for in the Covered Services Section or Schedules of Benefits.

26. Durable Medical Equipment.

27. Expenses for services provided by someone who ordinarily resides in the Member’s home or who is a relative of the Member.

28. Expenses incurred in connection with any self-inflicted wound, injury, illness or condition, whether sane or insane.

29. Experimental and investigative treatment (as defined in this Contract).

30. Eye Care, except for services set forth in the Covered Services section or the Optometry Schedule of Benefits.

31. Facility charges incurred for Covered Services performed on an outpatient basis in a hospital, hospital outpatient department or ambulatory surgical facility. However, some Participating Physician services are covered as set forth in the Covered Services Section and Schedules of Benefits.

32. Furnishing, fitting, installing, replacing or repairing, or use of, corrective appliances, braces, artificial aids, blood pressure kits, artificial limbs, and all prosthetics and orthotics.

33. Gene therapy.

34. Genetic counseling, treatment, services and supplies.

35. Health care services rendered by a non-Participating Provider or facility.

36. Health care services performed in a Hospital on an inpatient basis or Emergency basis.

37. Hearing aids (external or implantable) and services related to the fitting or provision of hearing aids, including tinnitus maskers.

38. Hemodialysis, radiation therapy and chemotherapy.

39. Home infusion therapy.

40. Hypnotism or hypnotic anesthesia.

41. Infertility treatment, service and supplies.

42. Injectable syringes and needles and injectable medication.
43. Inpatient or outpatient services and treatment for mental health alcohol and substance abuse, except for general consultation in a general practitioner’s office or upon referral to a Participating Psychiatrist.

44. Inpatient treatment, procedures, supplies and services, including services requiring spinal or general anesthesia, provided while the Member is an inpatient in a hospital or another inpatient facility.

45. Items and services for which the Member has no legal obligation to pay.

46. Laboratory tests except where specifically provided for in the Additional Benefits and Control Panel Schedules of Benefits.

47. Long-term and short-term inpatient or outpatient rehabilitative services.

48. Massage services.

49. Maternity care including childbirth, complications of pregnancy, and termination of pregnancy whether voluntary or involuntary.

50. Medical air or ground transportation services.

51. Non-prescription drugs, including any non-prescription medicine, remedy, vaccine, biological product, pharmaceuticals or chemical compounds, vitamin, mineral supplements, fluoride products, or health foods.

52. Nursing care at home, home monitoring devices, meals delivered to the home, homemaker services, Physician house calls, and other care provided in the home.

53. Prescription drugs and medicines prescribed by any Physician on an outpatient basis and dispensed at a pharmacy.

54. Pumps, including but not limited to insulin, except when required by state or federal law.

55. Private duty nursing care.

56. Reversal of voluntary surgically induced sterility including the reversal of tubal ligations and vasectomies, including related medications.

57. Routine foot care such as services in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic foot complaints, unless in the judgment of a Physician, such care is required due to a Member’s medical condition affecting the feet, such as severe diabetes or peripheral vascular disease.

58. Services and supplies for the treatment of an illness or injury resulting from war or an act of war, whether declared or not, or services in the armed forces, or Participating in any act which would constitute a riot or rebellion., or engaging in an illegal occupation.

59. Services of psychologists, mental health counselors, pastoral counselors, clinical psychologists, and marital, family and child counselors.

60. Services to any Member incarcerated at the time of service.

61. Services, supplies, medication, care and treatment for impotence.

62. Sexual reassignment or modification services, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.

63. Smoking cessation programs, including any service or supply to eliminate or reduce the dependency on or addiction to tobacco, including but not limited to nicotine withdrawal programs, nicotine products, and prescription drugs (e.g. Zyban).

64. Special education and treatment for mental retardation and mental deficiency.

65. Surgical procedures performed on an outpatient basis other than those services specifically provided for in the Covered Services Section and the Schedules of Benefits for Surgical Procedures, Additional Benefits and Urgent Care.

66. Unless otherwise covered as a benefit, reports, evaluations or physical examinations not required for health reasons, including, but not limited to, employment, insurance or government licenses, and court ordered, forensic or custodial evaluation.

67. Voluntary family planning and related drug therapy including, without limitation, supplies and devices. Voluntary sterilization procedures including tubal ligation and vasectomy are also excluded from coverage.

68. Weight control services, including any service to lose, gain, or maintain weight, including without limitation: any weight control/loss program, appetite suppressants, dietary regimens, food or food supplements, exercise programs and equipment or any other dietary regimen or treatment for obesity or reducing or controlling weight.
69. Wigs or cranial prosthesis.

70. Work-related condition services to the extent the Member is paid or receives compensation required by Workers’ Compensation law.

VIII. THIS CONTRACT AND OTHER PLAN PAYMENT ARRANGEMENTS

A. Subrogation

Sometimes, the situations that cause a Member to need the Covered Services provided under this Contract also result in actions by the Member to recover damages related to that situation. Such actions may often result in duplicate payments for the services and supplies that FHS has already provided to the Member. To protect FHS from this type of duplicate payment, FHS reserves the right to get involved in that recovery process. FHS's right to get involved is called "subrogation".

1. If FHS has paid for services or supplies to a Member under this Contract, the Member will, to the extent of such services or supplies rendered, have subrogated FHS to all causes of action and rights of recovery that the Member may have or has against any persons and/or organizations that are related to the incident that necessitated the rendering of the services or supplies. These subrogation rights extend and apply to any settlement of a claim, irrespective of whether litigation has been initiated.

2. The Member must promptly execute and deliver instruments and papers related to these subrogation rights as may be requested by FHS. Further, the Member shall promptly notify FHS of any settlement negotiations prior to entering into a settlement agreement affecting FHS's subrogation rights.

3. In no event should a Member fail to take any action where action is appropriate, or take any action that may prejudice FHS's subrogation rights. No waiver, release of liability, settlement, or other documents executed by a Member without prior notice to and approval by FHS, shall be binding upon FHS.

4. FHS retains the right to recover such payments and/or the reasonable value of the benefits provided from any person or organization to the fullest extent permitted by law.

B. Right to Receive and Release Information

FHS has the right to receive and release necessary information. By accepting coverage under this Contract, the Member gives permission for FHS to obtain from or release to any insurance company or other organization or person any information necessary to determine whether this provision or any similar provision in other plans applies to a claim and to implement such provisions. FHS may obtain or release this information without consent from or notice to anyone. Any person who claims benefits under this Contract agrees to furnish to FHS information that may be necessary to implement this provision.

C. Facility of Payment

Whenever payment which should have been made by FHS is made to any other person, plan, or organization, FHS shall have the right to pay to that other person, plan or organization any amounts FHS determines to be necessary under this provision. Amounts paid to another plan in this manner will be considered benefits paid under this Contract. FHS is discharged from liability under this Contract to the extent of any amounts so paid.

D. Right of Recovery

If FHS makes larger payments than are required under this Contract, then FHS has the right to recover any excess benefit payment from any person to whom such payments were made.

E. Non-Duplication of Government Programs

The benefits of this Contract shall not duplicate any benefits that are received or paid to the Member under governmental programs such as Medicare, Veterans Administration, CHAMPUS, or any Workers' Compensation Law, to the extent allowed by law. In any event, if this Contract has duplicated such benefits, all sums paid or payable under such programs shall be paid or payable to FHS to the extent of such duplication.
F. Workers’ Compensation
This Contract does not affect or take the place of Worker’s Compensation.

G. Non-Duplication of Other Coverage
The benefits under this Contract do not duplicate any benefits to which Members are entitled by law, and/or for which they are eligible under any extension of benefits and/or coverage provisions of any other plan, policy, program, or contract.

H. Cooperation of Members
Each Member shall cooperate with FHS, and shall execute and submit to FHS such consents, releases, assignments, and other documents as may be requested by FHS in order to administer and exercise its rights under the subrogation provision or to process claims. Failure to do so may result in the reduction of benefit payments under this Contract.

I. Coordination of Benefits
In the event that the application of coordination of benefit rules require that coverage be primarily provided by a Plan other than this FHS Contract, a Member will be entitled to benefits under this Contract, only to the extent such benefits are not provided under any other Plan. The rules establishing the order of benefits determination between this Contract and any other Policy or Plan, are as follows:

1. If the other Plan does not contain a coordination of benefits provision, the benefits of the other Plan shall be primary with respect to the benefits of this Contract.

2. If the other Plan or Plan has applicable coordination of benefits provisions, the following rules shall apply:
   a. The benefits of a Plan or Plan which covers the Member other than as a Dependent or Relative are determined before the benefits of the Plan or Plan which covers the Member as a Dependent or Relative;
   b. Except as provided in paragraph (c) below, when two or more policies or Plans cover the same dependent child of different parents:
      i. The benefits of the Plan or Plan of the parent whose birthday, excluding year of birth, falls earlier in a year are determined before those of the Plan or Plan of the parent whose birthday, excluding year of birth, falls later in the year; but,
      ii. If both parents have the same birthday, the benefits of the Plan or Plan which covered the parent for a longer period of time are determined before those of the Plan or Plan which covered the parent for a shorter period of time.

      Notwithstanding the foregoing, if a Plan or Plan subject to the rules based on the birthdays of the parents as stated above coordinates with an out-of-state Plan or Plan which contains provisions under which the benefits of a Plan or Plan which covers a person as a Dependent of a male are determined before those of a Plan or Plan which covers the person as a Dependent of a female, and if as a result, the policies or Plans do not agree on the order of benefits, the provisions of the other Plan or Plan shall determine the order of benefits.
   c. If two or more policies or Plans cover a dependent child of divorced or separated parents, benefits for the dependent child shall be determined as follows:
      i. First, the Plan or Plan of the parent with the custody of the dependent child;
      ii. Second, the Plan or Plan of the spouse of the parent with custody of the child, and
      iii. Third, the Plan or Plan of the parent not having custody of the child.

      Notwithstanding the foregoing, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obliged to pay or provide the benefits of
the Plan or Plan of that parent has actual knowledge of those terms, the benefits of that Plan or Plan are determined first, provided, however, benefits under such Plan or Plan shall not be determined first with respect to any claim determination period or Plan or Plan year during which any benefit are actually paid or provided before that entity has the aforementioned actual knowledge.

d. The benefit of a Plan or Plan which covers a person as an employee who is neither laid-off nor retired, or as that employee's Dependent or Relative, are determined before those of a Plan or Plan which covers that person as a laid-off or retired employee or as that employee's Dependent or Relative. In the event the other Plan or Plan is not subject to this paragraph (d), and if, as a result, the policies or Plans do not agree on the order of benefits, this paragraph (d) shall not apply.

e. In the event the rules set forth in paragraphs (a), (b), (c), or (d) are inapplicable in determining the order of benefits, the benefits of the Plan or Plan which covered the Member for a longer period of time are determined before those of the Plan or Plan which covered the Member for the shorter period of time.

f. Whenever a Member under this Contract is also a Medicaid recipient, FHS shall be primary to the recipient’s Medicaid benefits and FHS shall be a third party to the provisions of s.409.910(4)

IX. PREMIUM PROVISIONS

A. Acceptance

By electing Membership under this Contract, a Member legally capable of contracting and the legal representatives of any Member incapable of contracting shall agree to all the terms, conditions, and provisions herein.

B. Premium Payments

Premiums are due as of the premium due date of any month that coverage is provided. Only Members for whom the agreed payment is actually received by FHS within the time specified will be entitled to coverage under this Contract and then only for the period for which payment was received. Subject to the approval of the Florida Department of Financial Services, FHS reserves the right to adjust the premium charged to a Member upon thirty (30) days notice to the Member. All premium adjustments will be deemed accepted by the Member unless notice of non-acceptance is received by FHS at least 15 days prior to the effective date of the adjustment. If notice of non-acceptance is received from the Subscriber within the time established above, this Contract will terminate on the date the adjustment would have been effective.

EFT payment method is available through a signed Electronic Fund Transfer Form.

C. Grace Period

This contract has a thirty (30) day grace period. This means that if any required premium is not paid on or before the date it is due, it may be paid during the grace period immediately following the premium due date. During the grace period, the contract will stay in force. The grace period does not apply if the Subscriber has given FHS notice that the contract is to be terminated prior to the premium due date.

Any payment received after the grace period will be returned to the Subscriber. A Subscriber whose coverage has been terminated due to non-payment of premium is allowed to apply for coverage with FHS once immediately after cancellation. If a Subscriber is cancelled a second time for non-payment of premium, he/she must wait 30 days before re-applying for coverage. A Subscriber will not be eligible for coverage if coverage is cancelled three times for non-payment of premium. An individual re-applying for coverage under these guidelines must complete a new enrollment application which is subject to the regular policies and procedures of FHS for evaluating Membership, which will include medical underwriting.

X. GENERAL PROVISIONS

A. Negligence of Participating Providers

The relationship between FHS and Participating Providers is an independent contractor relationship. In no case will FHS be liable for the negligence, wrongful acts, or omissions of any independent contractor Participating Provider or Participating Physician.
B. Applications and Statements

As a Member, You agree to complete and submit to FHS such applications or other forms or statements as FHS may request. The Member further agrees that:

(1) all such information provided to FHS regarding the past and present health of the Member is true, correct, and complete to the best of his or her knowledge and belief, and

(2) that all rights to benefits and coverage under this Contract are subject to the condition that all such written information is true, correct and complete to the Member’s knowledge and belief.

C. Medical Information

FHS is entitled to receive from any Provider of services to a Member, information reasonably necessary in connection with the administration of this Contract but subject to all applicable confidentiality requirements. By accepting coverage under this Contract, You authorize every Provider rendering services to disclose all facts pertaining to such care and treatment and the Member’s physical condition to FHS upon request, render reports pertaining to the same to FHS, and permit copying of records by FHS. Information from the Member’s medical records and information received from Physicians or Hospitals incident to the Physician/patient or Hospital/patient relationship will be kept confidential, except for use reasonably necessary in connection with the administration of this Contract and to comply with governmental requirements established by law.

D. Waiver and Notice

No agent or other person, except an officer of FHS, has the authority to waive any conditions or restrictions of this Contract, to extend the time for making a payment, or to bind FHS by making any promise or representation, or by giving or receiving any information. No change in this Contract will be valid unless signed by one of the previously mentioned officers. Any written notice under this Contract will be sufficient when addressed to the Member at the Member’s last known address as it appears on FHS’s records.

E. Entire Contract

This written Contract is the agreement between the Member and FHS whereby coverage and benefits specified herein will be provided to the Member. This Contract includes all applications, rate letters, face sheets, riders, amendments, addenda, and exhibits which are or may be incorporated in this Contract from time to time. A Member is not entitled to any benefits other than those specified in this Contract. All prior representations or agreements, whether oral or written, not expressly incorporated into this Contract are superseded. This Contract is subject to amendment or modification by FHS upon thirty (30) days written notice to the Member (or a lesser period if required to permit FHS to comply with any provision of applicable law).

F. Time Limit on Certain Defenses

Relative to a misstatement in the application, after 2 years from the issue date, only fraudulent misstatements in the application may be used to void this Contract or deny any claim for loss incurred or disability starting after the 2-year period.

G. Civil Remedy

In any civil action brought to enforce the terms and conditions of the FHS contract, the prevailing party is entitled to recover reasonable attorney’s fees and court costs. This section shall not be construed to authorize a civil action against the Department of Financial Services, its employees, or the Department’s Chief Financial Officer.

H. Assignment

Neither this Contract, nor the benefits provided under this Contract, may be assigned except as otherwise specifically described in this Contract.