POLICY CONDITIONS
AZPAS INTERNATIONAL PLATINUM

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ASSURIA MEDISCHE VERZEKERING N.V.

Recolaan 17 – Paramaribo, Suriname

Website: www.assuria.sr

AZPAS INTERNATIONAL PLATINUM

TABLE OF CONTENTS

AGREEMENT....2

SCHEDULE OF BENEFITS....3

DEFINITIONS....4

POLICY PROVISIONS....9

ADMINISTRATION....13

EXCLUSIONS AND LIMITATIONS....17

AGREEMENT

ASSURIA MEDISCHE VERZEKERING N.V. (hereinafter referred to as the "Insurer") agrees to pay you (hereinafter referred to as the "Policyholder") the benefits provided by this policy. All benefits are subject to the terms and conditions of this policy.

IMPORTANT NOTICE ABOUT THE APPLICATION: This policy is issued based on the application and payment of the premium. If any information shown on the application is incorrect or incomplete, or any information has been omitted, the policy may be rescinded, cancelled, or coverage may be modified, at the sole discretion of the Insurer.

TERRITORY OF COVERAGE: This insurance offers coverage outside the natural borders of the country of residence Suriname or Guyana and outside the natural borders of the United States of America.

ELIGIBILITY: This policy can only be issued to residents of Suriname and Guyana who are a minimum of eighteen (18) years of age (except for eligible dependents) and a maximum age of 73 years. The maximum age for coverage under the same terms and conditions of this policy for those Insureds renewing a policy is 84 years.

Eligible dependents include the Policyholder's spouse, natural born children, legally adopted children, stepchildren, or children to whom the Policyholder has been appointed legal guardian by a court of competent jurisdiction, who have been identified on the application and for whom coverage is provided for under the policy.

Dependent coverage is available for the Policyholder's dependent children up to their nineteenth (19th) birthday, if single, or up to their twenty-fifth (25th) birthday, if single and full-time (minimum twelve (12) credits per semester) students of an accredited college or university at the time that the policy is issued and renewed. Coverage for such dependents continues through the next anniversary date of the policy following the attainment of twenty-one (21) years of age, if single, or twenty-five (25) years of age if single and a full-time student.

If a dependent child marries, discontinues being a full-time student after the nineteenth (19th) birthday, moves to another country than the country of residence, or if a dependent spouse ceases to be married to the Policyholder by reason of divorce or annulment, coverage for such dependent will terminate on the next anniversary date of the policy.

Dependents who were covered under a prior policy with the Insurer and, who are otherwise eligible for coverage under their own separate policy, will be approved without underwriting for the same or higher deductible plan and with the same conditions and restrictions in existence under the prior policy which afforded them coverage with the Insurer. The application of the former dependent must be received before the end of the grace period of the policy which previously afforded the dependent coverage.

SCHEDULE OF BENEFITS	USD	USD	USD
Maximum benefits per insured, per policy year	**250.000,00**	**500.000,00**	**1.000.000,00**
Hospital room and board (private and semi-private)	Policy limit	Policy limit	Policy limit
Hospital Intensive Care unit room and board	Policy limit	Policy limit	Policy limit
Maximum stay in the hospital: 180 days within a period of 365 days (per cause) with a maximum of	Policy limit	Policy limit	Policy limit
Maternity care	4.000,00	8.000,00	16.000,00
Cover for newborns	25.000,00	50.000,00	100.000,00
Congenital and hereditary disorders			
- manifested before the age of 18 (per insured person, per lifetime)	50.000,00	100.000,00	200.000,00
- manifested at or after the age of 18 (per insured person, per lifetime)	250.000,00	500.000,00	1.000.000,00
Organ transplantation (per insured person, per lifetime)	100.000,00	200.000,00	400.000,00
Medical specialist care	Policy limit	Policy limit	Policy limit
Paramedical Care	Policy limit	Policy limit	Policy limit
Prescribed medication	Policy limit	Policy limit	Policy limit
Medical Transport in the event of an emergency			
* from the home country to the nearest healthcare provider	10.000,00	20.000,00	40.000,00
* medical treatment will be paid up to a maximum	Policy limit	Policy limit	Policy limit
* from the country of treatment to the home country	10.000,00	20.000,00	40.000,00
Transport by ambulance car (per cause)	1.000,00	1.000,00	1.000,00
Companion of a hospitalized child (per admission)	1.000,00	2.000,00	4.000,00
Repatriation of mortal remains (also following planable care)	5.000,00	10.000,00	20.000,00

SCHEDULE OF BENEFITS

COMMENCEMENT AND ENDING OF COVERAGE

Coverage begins at 00:00 hours Local Time Zone (Paramaribo or Georgetown) on the policy's effective date and terminates at 24:00 hours Local Time Zone (Paramaribo or Georgetown):

(a) on the expiration date of the policy; or
(b) upon non-payment of the premium; or
(c) upon written request from the Policyholder to terminate the Policyholder's coverage; or
(d) upon written request from the Policyholder to terminate a dependent's coverage; or
(e) upon written notification from the Insurer, as allowed by the conditions of this policy.

REQUIREMENT TO NOTIFY THE INSURER

THE INSURED MUST CONTACT *ASSURIA MEDISCHE VERZEKERING N.V. OR ASSURIA GUYANA OR THE SERVICE ADMINISTRATOR*, TWO (2) WEEKS IN ADVANCE OF RECEIVING ANY MEDICAL CARE.

EMERGENCY TREATMENT MUST BE NOTIFIED OR REPORTED WITHIN FORTY-EIGHT (48) HOURS OF COMMENCEMENT OF SUCH TREATMENT.

IF THE INSURED FAILS TO CONTACT *ASSURIA MEDISCHE VERZEKERING N.V. OR ASSURIA GUYANA OR THE SERVICE ADMINISTRATOR* AS STATED HEREIN, THE INSURED WILL BE RESPONSIBLE FOR THIRTY PERCENT (30%) OF ALL COVERED MEDICAL AND HOSPITAL CHARGES RELATED TO THE CLAIM, IN ADDITION TO THE PLAN'S DEDUCTIBLE AND COINSURANCE (IF APPLICABLE).

***ASSURIA MEDISCHE VERZEKERING N.V. OR ASSURIA GUYANA OR THE SERVICE ADMINISTRATOR* can be contacted 24 hours a day, 365 days a year at the following telephone numbers:**

During the insurer's business hours, the following telephone numbers can be used:
Within Suriname:
From 7:00 am to 15:00 pm: (+597) 473400 ext. 352/ 381
After business hours and for emergency assistance (+597) 7180042 or (+597) 7180036
Email: medische.verzekeringen@assuria.sr

Within Guyana:
During and after business hours and for emergency assistance (+592) 610-0545
Email: medische.verzekeringen@assuria.sr

For emergency assistance outside Suriname and Guyana, contact Redbridge Network and Healthcare (+001) 1.888.754.6969 (Toll free from USA & Canada)

Email: service@redbridge.cc

DEFINITIONS

1. **ACCIDENT:** a) Any sudden or unforeseen event produced by an external cause resulting in injury; b) a sudden and direct effect of a sudden external force, as a result of which bodily injury is caused, which can be medically established.

2. **AIR AMBULANCE TRANSPORTATION:** Emergency air transportation from the hospital where the Insured is admitted to the nearest suitable hospital where treatment can be provided.

3. **AMENDMENT:** A document added by the Insurer to the policy that clarifies, explains or modifies the policy.

4. **ANNIVERSARY DATE:** Annual occurrence of the effective date of the policy.

5. **APPLICANT:** The individual who executed the application for coverage.

6. **APPLICATION:** Written statements on a form by an Applicant about themselves and/or their dependents, used by the Insurer to determine acceptance or denial of the risk. Application includes any medical history, questionnaire, and other documents provided to or requested by the Insurer prior to the issuance of the policy.

9. **CALENDAR YEAR:** January 1st through December 31st of any given year.

10. **CERTIFICATE OF COVERAGE:** Document of the policy that specifies the commencement, conditions, extent and any limitations of the coverage, and lists each covered person.

11. **COMPLICATION OF BIRTH:** Any disorder related to the birth of a newborn, not caused by genetic factors, manifested during the first thirty-one (31) days of life, including but not limited to hyperbilirubinemia (jaundice), cerebral hypoxia, hypoglycemia, prematurity, respiratory distress and birth trauma.

12. **CONGENITAL AND HEREDITARY DISORDERS OR ILLNESSES:** Any disorder or illness existing before birth, regardless of its cause, whether or not manifested or diagnosed at birth, after birth or years later.

13. **COUNTRY OF RESIDENCE:** The country:
    (1) where the Insured resides the majority of any calendar or policy year; or
    (2) where the Insured has resided more than one hundred and eighty (180) continuous days during any three hundred and sixty five (365) day period while the policy is in force.

14. **COVERED PREGNANCY:** Covered pregnancies are those where the actual date of delivery is at least twelve (12) months after the effective date of coverage for the respective insured mother.

15. **CUSTODIAL CARE:** Services provided that do not require the skills of a professional and are generally provided on a long-term basis, that include but are not limited to room, board and personal assistance.

16. **DEDUCTIBLE:** The amount of covered charges that must be paid by the Insured before policy benefits become payable. Charges incurred in the country of residence are subject to an in-country deductible. Charges incurred outside of the country of residence are subject to an out-of-country deductible.
    One (1) deductible per Insured, per policy year.

17. **DIAGNOSTIC MEDICAL CENTER:** Medical facility licensed to perform comprehensive medical physical examinations.

18. **DUE DATE:** The date on which the premium is due and payable.

19. **EFFECTIVE DATE:** The date on which coverage under this policy begins and which is stated in the Certificate of Coverage.

20. **EMERGENCY**: A medical condition manifesting itself by acute signs or symptoms which could reasonably result in placing the Insured's life or physical integrity in immediate danger, if medical attention is not provided within twenty-four (24) hours.

21. **EMERGENCY DENTAL TREATMENT:** Treatment necessary to restore or replace sound natural teeth, damaged or lost in a covered accident.

22. **EMERGENCY TREATMENT:** Medically necessary treatment due to an emergency.

23. **GRACE PERIOD:** The period of time of thirty (30) days after the policy due date during which the Insurer will allow the policy to be renewed.

24. **GROUND AMBULANCE TRANSPORTATION:** Emergency transportation to a hospital by ground

ambulance.

25. **HAZARDOUS ACTIVITIES:** Any activity that exposes the participant to any foreseeable danger or risk. Examples of hazardous activities include but are not limited to: Aviation sports, rafting or canoeing involving white water rapids in excess of grade 4, tests of velocity, scuba diving at a depth of more than 30 meters, bungee jumping, participation in any extreme sport or participation in any sport for compensation or as a professional.

26. **HOME HEALTH CARE:** Care of the Insured in the Insured's home, which is prescribed and certified in writing by the Insured's attending physician, as required for the proper treatment of the illness or injury and used in place of inpatient treatment in a hospital. Home Health Care includes the services of a skilled licensed professional (nurse, therapist, etc.) outside of the hospital and does not include Custodial Care.

27. **HOSPITAL:** Any institution which is legally licensed as a medical or surgical facility in the country in which it is located, which is
(a) primarily engaged in providing diagnostic and therapeutic facilities for clinical and surgical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of physicians; and
(b) not a place of rest, a place for the aged or nursing or convalescent home or institution or a long term care facility;
(c) this description also covers the institute for rehabilitation;
(d) this description also covers nursing costs.

28. **HOSPITAL SERVICES:** Medically necessary treatments or services ordered by a physician for the Insured who is admitted to a hospital.

29. **HOSPITALIZATION:** stay of longer than 24 hours in a hospital, if and as long as on medical grounds, nursing, examination and treatment can only be offered in a hospital, while continuous treatment by a medical specialist must be necessary.

30. **REHABILITATION:** treatment, advice and guidance in a center for rehabilitation recognized as such by the competent government authorities, by a team that in any case consists of a paramedical professional and in addition, of a psychologist or a social, labor or rehabilitation expert, as well as the care pertaining thereto.

31. **REHABILITATION DAY TREATMENT:** as described with rehabilitation, but then a treatment for a day or a part of a day.

32. **NURSING COSTS:** the amount per day, due on account of nursing of at least 24 hours in a hospital, with the exception of the additional costs and the costs for specialist treatment.

33. **DENTAL COSTS:** treatment or examination that is aimed at or is connected with the improvement or restoration of the teeth, according to generally accepted medical standards and solely performed by a dentist of dental surgeon authorized thereto.

34. **ADDITIONAL COSTS:** medical expenses that are directly related to specialist treatment and which arose during such a treatment in a hospital, such as costs for X-rays, blood transfusions, lab exams, medicines, radiotherapy, anesthesia, dressing material and the use of the operating room.

35. **ILLNESS:** An abnormal condition of the body, manifested by signs, symptoms and/or abnormal findings in medical exams, which makes this condition different than the normal state of the body.

36. **INJURY:** Damage inflicted to the body by an external cause.

37. **INSURED:** An individual for whom an application has been completed, the premium paid, and for whom coverage has been approved by the Insurer and commenced. The term "Insured" includes the Policyholder and all dependents covered under this policy.

38. **MEDICALLY NECESSARY:** A treatment, service or medical supply which on grounds of international medical standards is considered to be necessary and appropriate for the diagnosis and/or treatment of an illness or injury. A treatment, service or supply will not be considered medically necessary if:
    (a) It is provided only as a convenience to the Insured, the Insured's family, or the provider; or
    (b) It is not appropriate for the Insured's diagnosis or treatment; or
    (c) It exceeds the level of care which is needed to provide adequate and appropriate diagnosis or treatment.

39. **MEDICAL ADVISOR:** The physician who advises Assuria on medical affairs such as medical necessity, diagnostic and treatment plans.

40. **MEDICAL COSTS:** the medically necessary costs for:
    (a) Physician's fee and treatments, examinations, medicines and dressing;
    (b) Materials prescribed by them;
    (c) Hospitalization;
    (d) Transport to and from the place where the medical treatment is provided in the country where the insured was present on the commencement of the transport.

41. **NEWBORN:** An infant from the moment of birth through the first thirty-one (31) days of life.

42. **NURSE:** An individual legally licensed to provide nursing care.

43. **ORGAN TRANSPLANT PROVIDER NETWORK:** A group of hospitals and physicians contracted on behalf of the Insurer for the purpose of providing organ transplant benefits to the Insured.

44. **OUTPATIENT SERVICES:** Medical treatments or services provided or ordered by a physician for the Insured when the Insured is not admitted at a Hospital. Outpatient services may include services performed in a hospital or emergency room.

45. **FAMILY DOCTOR:** A person who is legally licensed to practice medicine in the country where treatment is provided and while acting within the scope of his practice.

46. **SPECIALIST:** A person who is legally licensed to practice as a specialist in the country where treatment is provided and while acting within the scope of his practice.

47. **SPECIALIST TREATMENT:** Treatment or examination, generally accepted according to medical

standards and belonging to the specialism the specialist is registered for.

48. **PHYSICAL THERAPIST:** A person who is legally licensed to practice as a physical therapist in the country where treatment is provided and while acting within the scope of their practice

49. **DENTIST:** A person who is legally licensed to practice as a dentist in the country where treatment is provided and while acting within the scope of his practice.

50. **POLICYHOLDER:** The named applicant on the application for health insurance. This individual is the person entitled to receive reimbursement for covered medical expenses and the return of any unearned premium.

51. **POLICY YEAR:** The period of twelve (12) consecutive months beginning on the effective date of the policy and any subsequent twelve-month period thereafter.

52. **PRE-EXISTING CONDITION:** A condition:
    (a) Which was diagnosed by a physician prior to the effective date of the policy or its reinstatement; or
    (b) For which medical advice or treatment was recommended by or received from a physician prior to the effective date of the policy or its reinstatement; or
    (c) For which any symptom and/or sign, if presented to a physician prior to the effective date of the policy would have resulted in the diagnosis of an illness or medical condition.

53. **PRESCRIPTION MEDICATIONS:** Medications of which the sale and use are legally restricted to the order of a physician.

54. **MEDICINES:** remedies that may be legally traded as medicines and that are solely supplied by a pharmacy or dispensing family doctor on the orders of a family doctor or specialist.

55. **PRIVATE AIRCRAFT:** Any aircraft in a flight that is not regularly scheduled or chartered by a commercial airline.

56. **RENEWAL DATE:** The first day of the next policy year. The renewal date occurs only on the anniversary date of the policy.

57. **RIDER:** A document added to the policy by the insurer, which adds optional coverage.

58. **SECOND SURGICAL OPINION:** The medical opinion of a surgeon other than the current attending physician (approved and required **by Assuria**

59. **USUAL, CUSTOMARY AND REASONABLE:** The usual, customary and reasonable charges for provided medical services in a geographical area, regardless of whether direct payment or reimbursement was used.

60. **WELL BABY CARE:** Routine medical care provided to a healthy newborn.

POLICY PROVISIONS

1. **HOME HEALTH CARE AND OUTPATIENT PHYSICAL THERAPY:** Coverage for this care or treatment must be approved in advance by **Assuria Medische Verzekering N.V. or the Service Administrator**, including any and all extensions. In all cases, evidence of medical necessity and a treatment plan must be received by **Assuria Medische Verzekering N.V. or the Service Administrator**.

2. **EMERGENCY DENTAL TREATMENT:** Only emergency dental treatment that takes place within ninety (90) days of the date of a covered accident will be covered under this policy.

3. **EMERGENCY TRANSPORTATION:** Emergency transportation (by ground ambulance) is only covered if related to a covered condition for which treatment cannot be provided locally and transportation by any other method would result in loss of life or limb. Emergency transportation must be provided by a licensed and authorized transportation company to the nearest medical facility. The vehicle used must be staffed by medically trained personnel and must be equipped to handle a medical emergency.

4. **MATERNITY CARE:**
   (a) There is a maximum benefit according the schedule of benefit for each pregnancy with no deductible or coinsurance.
   (b) Pre and post-natal treatment, childbirth, complications of pregnancy or delivery, and well-baby care are included in the maximum maternity benefit listed in this policy.
   (c) This benefit shall apply for covered pregnancies. Covered pregnancies are those where the actual date of delivery is at least twelve (12) months after the effective date of coverage for the respective insured mother.
   (d) There is no maternity coverage for dependent children.
   (e) Those Policyholders that were previously a dependent child under another policy with the Insurer must have maintained their own individual policy for a minimum of twelve (12) months to be eligible for this maternity care benefit.
   (f) The twelve (12) month waiting period for maternity coverage always applies regardless of whether or not the ninety (90) day waiting period for coverage under this policy has been waived.

5. **NEWBORN COVERAGE:**
   I. If born from a Covered Pregnancy:
   (a) **Provisional coverage:** If born from a covered pregnancy, each newborn will automatically be covered for (a) complications of birth, and (b) any injury or illness for the first ninety (90) days after birth up to a maximum as mentioned in the schedule of benefit with no deductible or coinsurance.
   (b) **Permanent coverage**: For permanent coverage of a child born from a covered pregnancy, a "Notification of Birth" consisting of the newborn's full name, gender and date of birth must be submitted within ninety (90) days of birth. Effective as of the date of birth, coverage with applicable deductible will then be up to the policy limits.

   Policy limits for complications of birth related to a newborn are limited to the maximum benefits described in provision 5.I.(a).

   The premium for the addition is due at the time of the notification of birth. If such notification is not received within 90 days of birth, then an application for insurance is required on the addition and will be subject to underwriting.

(c) **Well baby care:** Only covered as stated in the "Maternity Care" provision of this policy.

II. **If NOT born from a Covered Pregnancy,** there is no provisional coverage for the newborn. To add a newborn to the policy, payment of the premium and submission of a completed application for insurance which is subject to underwriting by the Insurer, are required.

6. **CONGENITAL AND HEREDITARY DISORDERS: Coverage under this policy for congenital and hereditary disorders is as follows:**
   (a) The maximum benefits per lifetime per insured for any congenital and hereditary disorders that manifest themselves before the insured's eighteenth (18th) birthday as mentioned in the schedule of benefit per person, including any benefits already paid on an existing policy or rider, after deductible.

   (b) The maximum benefits per lifetime for any congenital and hereditary disorders that manifest themselves on or after the insured's eighteenth (18th) birthday are equal to the maximum as mentioned in the schedule of benefits herein, after deductible.

7. **ORGAN TRANSPLANTS:** Coverage for transplantation of human organs and tissues is provided within the Service Providers Network. There is no coverage outside the Organ Transplant Provider Network. If the provider's network is not used, the insurer will accept no more than the contracted fees that would be paid to a participating provider of the Transplant providers network. The maximum amount payable for this benefit is in conformity with the policy limit per schedule per Insured per lifetime. This organ transplant benefit begins once the need for transplantation has been determined by physician, has been certified by a second surgical or medical opinion and has been approved by **Assuria Medische Verzekering N.V.** and is subject to all the terms, provisions and exclusions of the policy.
   This benefit includes:
   (a) Pre-transplant care, which includes those services directly related to evaluation of the need for transplantation, evaluation of the Insured for the transplant procedure, and preparation and stabilization of the Insured for the transplant procedure.
   (b) Pre-surgical workup, including all laboratory and X-ray exams, CT scans, Magnetic Resonance Imaging (MRI's), ultrasounds, biopsies, scans, medications and supplies.
   (c) The costs of organ procurement, transportation, and harvesting up to a maximum as mentioned in the schedule of benefit, which is included as part of the maximum organ transplant benefit.
   (d) Post-transplant care including, but not limited to any follow-up, medically necessary treatment resulting from the transplant, and any complications that arise after the transplant procedure, whether a direct or indirect consequence of the transplant.
   (e) Any medication or therapeutic measure used to ensure the viability and permanence of the transplanted organ.
   (f) Any home health care, nursing care (e.g. wound care, infusion, assessment, etc.), emergency transportation, medical attention, clinic or office visits, transfusions, supplies, or medications related to the transplant.

8. **PRESCRIPTION DRUGS:** Prescription drugs are covered if prescribed by the family doctor, specialist or dentist, during a hospitalization or after outpatient surgery and as long as the policy ensues. In all cases, a copy of the prescription must accompany the claim.

9. **SPECIAL TREATMENTS:** Prosthesis, orthotic devices, durable medical equipment, implants, radiation therapy and highly specialized drugs (e.g. Interferon, Procrit, Avonex, Embrel, etc.) will be covered up to the policy limit schedule, but must be approved and coordinated in advance by **Assuria Medische**

Verzekering N.V. or the Service Administrator. Special treatments will be provided by the Insurer or reimbursed at the cost up to the policy limit per schedule that the Insurer would have incurred if purchased from its providers.

10. **PRE-EXISTING CONDITIONS:** Pre-existing conditions fall into two (2) categories:
    (a) **DISCLOSED AT THE TIME OF THE APPLICATION:**
        i. Free of symptoms, signs and treatment during the five (5) year period prior to the effective date of the policy, are covered upon expiration of the ninety (90) days waiting period, **unless specifically excluded** by an amendment to the policy.
        ii. With symptoms, signs or treatment any time during the five (5) year period prior to the effective date of the policy, will be covered after one year from the effective date of the policy, **unless specifically excluded** by an amendment to the policy.
    (b) **NOT DISCLOSED AT THE TIME OF APPLICATION:**
        Pre-existing conditions not disclosed at the time of the application will **NEVER** be covered during the period of the policy. Furthermore, the Insurer retains the right to rescind, cancel or modify the policy based on the Insured's failure to disclose any such conditions.

11. **ILLNESS OR INJURY IN A PRIVATE AIRCRAFT:** Any illness or injury sustained as a passenger in a Private Aircraft is covered up to a maximum of the policy limit per schedule per Insured, per policy year.

    There is an optional rider available to cover private pilot and crew members.

12. **REPATRIATION OF MORTAL REMAINS:** In the event an Insured dies outside of his/her country of residence, the Insurer will pay up to maximum as mentioned in the schedule of benefits toward repatriation of the deceased's remains to the deceased's country of residence if the death resulted from a condition which would have been covered under the terms of the policy had the Insured survived. Coverage is limited to only those services and supplies necessary to prepare the deceased's body and to transport the deceased to his country of residence. Arrangements must be coordinated in conjunction with **Assuria Medische Verzekering N.V. or the Service Administrator.**

13. **COMPANION OF HOSPITALIZED CHILD:** Charges incurred and included in the hospital bill for overnight accommodations in the hospital for the companion of a hospitalized insured child under the age of twelve (12) will be payable up to one hundred US dollars (USD 100) per day up to a maximum as mentioned in the schedule of benefits for hospital admission.

14. **REQUIRED SECOND SURGICAL OPINION:** If a surgeon has recommended that an Insured undergo any non-emergency surgical procedure, the Insured must notify **Assuria Medische Verzekering N.V. or the Service Administrator** at least seventy-two (72) hours prior to the scheduled procedure. If a second surgical opinion is deemed necessary by either the Insurer or **Assuria Medische Verzekering N.V. or the Service Administrator**, it must be conducted by a surgeon chosen and arranged by **Assuria Medische Verzekering N.V. or the Service Administrator.** Only those second surgical opinions required and coordinated by **Assuria Medische Verzekering N.V. or the Service Administrator** are covered. In the event the second surgical opinion contradicts or does not confirm the need for surgery, the Insurer will also pay for a third surgical opinion from a surgeon chosen by **Assuria Medische Verzekering N.V. or the Service Administrator.** If the second or third surgical opinion confirms the need for surgery, benefits for the surgery will be paid according to this policy.

IF THE INSURED DOES NOT OBTAIN A REQUIRED SECOND OR THIRD SURGICAL OPINION, THE INSURED WILL BE RESPONSIBLE FOR THIRTY PERCENT (30%) OF ALL COVERED MEDICAL AND HOSPITAL CHARGES RELATED TO THE CLAIM IN ADDITION TO THE PLAN DEDUCTIBLE

15. **OUTPATIENT SERVICES:** Coverage is only provided when medically necessary.

16. **MAXIMUM HOSPITAL STAY:** The maximum hospital stay for any specific illness or injury or any related treatment is one hundred and eighty (180) days during the next three hundred and sixty five (365) days after the first admission.

17. **NOSE & NASAL SEPTUM DEFORMITY:** When nose or nasal septum deformity is induced by a trauma in a covered accident, surgical treatment will be covered if authorized in advance by **Assuria Medische Verzekering N.V. or the Service Administrator.**

18. **WAITING PERIOD: This policy contains a ninety (90) day waiting period, during which, only** illnesses or injuries caused by an accident occurring within this period, or disease of infectious origin that first manifested itself within this period will be covered.

19. **WAIVING OF WAITING PERIOD:** The Insurer will waive the waiting period only if:
    (a) Other medical expense insurance was in force with another company for the Insured for at least one (1) continuous year; and
    (b) The effective date of this policy commences within thirty (30) days of the expiration of the previous coverage; and
    (c) The prior coverage is disclosed in the application for insurance; and
    (d) We receive the prior policy and a copy of the receipt for the last year's premium payment, with the application.

    If the waiting period is waived, benefits payable for any condition incurred during the first ninety (90) days of coverage are limited, while the policy is in force, to the lesser benefit provided either by this policy or the prior policy.

20. **US EMERGENCY RIDER:** Emergency medical expenses in the United States of America, that original insureds can purchase in combination with an AZPAS International Platinum policy:
    (a) The maximum coverage per insured person per policy is USD 50.000,00; and
    (b) Territorial scope: losses that occur in the United States of America including non-contiguous jurisdictions.

I.	**EMERGENCY MEDICAL SERVICES**	Limits expressed in USD.
1	Hospital Services for the stabilization and treatment of a sudden and unexpected emergency which occurs during the course of a trip, including but not limited to: • Emergency services for inpatient and ambulatory patients; • Anesthesia, blood transfusions, oxygen; • Casts, dressings, slings, etc.	Up to the maximum amount per person, as indicated below: Limit: **USD 50.000,00** (Services will only be provided until the emergency ends).
2	Physician services for the care, treatment or surgery required by an emergency.	Up to the amount indicated in item I.1. (above)
3	Prescription drugs required by the emergency.	Up to USD 750,00 per person
4	Diagnostic tests and procedures required by the emergency.	Up to the amount indicated in item I.1. (above)
5	Dental emergency (limited to control of pain and infection)	Up to USD 500,00 per person
II	**EMERGENCY ASSISTANCE SERVICES**	
1	Emergency medical transportation	Up to USD 2.500,00 per person
2	Emergency medical repatriation	Up to USD 2.500,00 per person
3	Hotel stay for prescribed convalescence as direct result of an emergency.	Up to USD 100,00 daily, maximum 10 days
4	Transportation for 1 companion due to a hospital confinement superior to 5 days as direct result of an emergency.	Up to USD 1.000,00
5	Hotel accommodation for 1 companion.	Up to USD 100,00 daily, maximum 10 days
6	Guaranteed return (different date than scheduled)	USD 500,00 - difference in fare cost or imposed penalty
7	Return of minors 15 years or less.	Up to USD 5.000,00
8	Repatriation of mortal remains.	Up to USD 10.000,00

ADMINISTRATION

1. **AUTHORITY:** No agent has the authority to change the policy or to waive any of its provisions. After issue, no change in the policy shall be valid unless approved in writing by an officer or the Chief Underwriter of the Insurer and such approval is endorsed by an amendment to the policy.

2. **CHANGES OF COUNTRY OF RESIDENCE:** The Insured must notify the Insurer in writing of any change of the Insured's country of residence within thirty (30) days of its occurrence. Changes of residence outside the Insured's stated country of residence will, at the Insurer's discretion, result in modification of coverage or cancellation of the policy. Changes of residence to the NETHERLANDS will result in non-renewal of the policy. Failure to notify the Insurer of any change of the Insured's country of residence may result in cancellation of the policy or modification of coverage on the next anniversary date, **at the Insurer's discretion. THE INSURED'S COUNTRY OF RESIDENCE MUST BE SURINAME OR GUYANA.**
3. **COMMENCEMENT OF INSURANCE:** Subject to the provisions of this policy, benefits begin on the Effective Date of the policy and not on the date of application for insurance.

4. **OTHER INSURANCE COVERAGE:** When another policy is in existence which provides benefits also covered by this policy, benefits will be coordinated. All claims incurred in the country of residence must be made in the first instance against the other policy. This policy shall only provide benefits when such

other benefits payable under the other policy have been exhausted. Outside the country of residence, ASSURIA MEDISCHE VERZEKERING N.V. will function as the primary Insurer and retains the right to collect any payment from local or other insurers.

5. **ENTIRE CONTRACT/CONTROLLING CONTRACT:** The policy, the application, the Certificate of Coverage and any riders or amendments thereto, shall constitute the entire contract between the parties. The Dutch translation is provided for the convenience of the Insured. The English version of this policy will prevail and is the controlling contract in the event of any question or dispute regarding this policy.

6. **GRACE PERIOD:** If premium is not received by the due date, the Insurer will allow a grace period of thirty (30) days from the due date for the premium to be paid. If the premium is not received by the Insurer prior to the end of the grace period, this policy and all of its benefits will be deemed terminated as of the original due date of the premium. Benefits are not provided under the policy during the grace period unless the policy is renewed.

7. **PAYMENT OF CLAIMS:** It is the Insurer's policy to make payments directly to physicians and hospitals in the covered countries. When this is not possible, the Insurer will reimburse the Policyholder the contractual rate given to the Insurer by the provider involved and/or in accordance with the usual, customary, and reasonable fees for that geographical area, whichever is less. Any charges or portions of charges in excess of these amounts are the responsibility of the Insured. If a Policyholder is not alive, the Insurer will pay any unpaid benefits to the inheritors of the deceased Policyholder.

8. **CURRENCY:** All currency values stated in this policy are in US dollars.

9. **PHYSICAL EXAMINATIONS:** The Insurer, at its own expense, shall have the right and opportunity to examine any Insured whose illness or injury is the basis of a claim, when and as often as considered necessary by the Insurer during the pendency of the claim. In the case of death, the Insurer has the right to request an autopsy at a facility of its choice.

10. **DUTY TO COOPERATE:** The Insured shall make available to the Insurer all medical reports and records and, when requested by the Insurer, shall sign all authorization forms necessary for the Insurer to obtain such medical reports and records. Failure to cooperate with the Insurer or failure to authorize the release of all medical records requested by the Insurer may cause a claim to be denied.

11. **POLICY CANCELLATION OR NON-RENEWAL:** The Insurer retains the right to cancel, modify or rescind the policy if statements on the application are found to be misrepresentations, incomplete or that fraud has been committed, leading the Insurer to approve an application when, with the correct or complete information, the Insurer would have issued a policy with restricted coverage or declined to provide insurance.
    The Insurer retains the right to cancel or modify a policy in terms of rates, deductibles or benefits, generally and specifically, if the Insured changes country of residence, regardless of how many years the policy has been in force.

    If an Insured does not reside in Suriname or Guyana on a continuous basis for more than one hundred and eighty (180) days during any three hundred and sixty five (365) day period regardless of the type of visa issued to the Insured for that purpose, then coverage for any condition will be limited to the Insurer's Preferred Provider Network until the policy's next renewal date at which time the policy will automatically

terminate.
Submission of a fraudulent claim is also grounds for rescission or cancellation of the policy.

No individual Insured shall be independently penalized by cancellation or modification of the policy due solely to the claim record.

12. **POLICY ISSUANCE:** This policy cannot be issued or delivered outside the country of residence Suriname or Guyana, except as may be specifically approved by Assuria Suriname and permitted under the laws . The policy is deemed issued or delivered upon receipt of the policy by the Policyholder in his/her country of residence.

13. **POLICY MODE:** All policies are deemed annual policies. Premiums are to be paid annually, unless the Insurer authorizes other modes of payment e.g. quarterly or half-yearly.

14. **PREMIUM PAYMENT:** Payment of the premium on time is the responsibility of the Policyholder. The premium is due on the renewal date of the policy or other due dates if authorized by the Insurer. Premium notices are provided as a courtesy and the Insurer provides no guarantee of delivering premium notices. If a Policyholder has not received a premium notice thirty (30) days prior to the due date and the Policyholder does not know the amount of the premium payment, the Policyholder should contact his/her agent or the Insurer.

15. **PREMIUM RATE CHANGES:** The Insurer retains the right to change the premium at the time of each renewal date. This right will be exercised only upon the renewal date of each respective policy.

    The premium may be annually indexed based on the average increase of the cost of medical treatment and will take place at the end of the annual coverage period. In case of multi-year policies, a supplementation quote will be presented to the insured for the premium index of the policy.

16. **PROOF OF CLAIM:** The following will apply for treatment outside of Suriname: Written proof of loss must be furnished to **Assuria Medische Verzekering N.V. at Henck Arronstraat 5-7 Paramaribo or the Service Administrator at 355 Alhambra circle, suite 1150, Coral Gables, FL 33134 USA**, within one hundred and twenty (120) days after the treatment or service date. Failure to do so will result in the claim being denied. **ORIGINAL** itemized bills **MUST** be submitted with the properly completed Insurer's claim form and medical records. Standard claim forms from **Assuria Medische Verzekeringen N.V. or the Service Administrator** providers may be accepted, but the Insurer reserves the right to have the claimant complete the Insurer's claim form. Claim forms are furnished with the policy or may be obtained by contacting your agent, **ASSURIA MEDISCHE VERZEKERING N.V or the Service Administrator** at the address shown herein. Bills received in currencies other than US dollars will be processed in accordance with the official exchange rate, as determined by the Insurer, on the date of service.

17. **REFUNDS:** If a Policyholder or the Insurer cancels the policy after it has been issued, reinstated or renewed, the Insurer will refund the unearned portion of the premium, less administrative charges and policy fees, to a maximum of sixty-five percent (65%) of the premium. The policy fee, **or the Service Administrator's** fee and thirty-five percent (35%) of the base premium are non-refundable. The unearned portion of the premium is based on the number of days corresponding to the payment mode, minus the number of days the policy was in force. In case of death, refunds will be dependent on review of outstanding medical bills.

18. **REINSTATEMENT**: All policies reinstated after the thirty (30) day grace period are deemed new policies with no antiquity or credit being afforded to the Insured. All medical conditions existing prior to the date of reinstatement of the policy shall be deemed and treated as pre-existing conditions under this policy.

19. **CLAIMS APPEALS:** In the event of any disagreement between the Insured and the Insurer regarding this Insurance Policy and/or its provisions, the Insured, before commencing any arbitration or legal proceedings, shall request a review of the matter by the "ASSURIA MEDISCHE VERZEKERING N.V. Appeals Committee". In order to begin such a review, the Insured must submit a written request to the Appeals Committee. This request shall include copies of all relevant information sought to be considered, as well as an explanation of what decision should be reviewed and why. Said appeals shall be sent to the attention of the ASSURIA MEDISCHE VERZEKERING N.V. Appeals Coordinator, c/o **the Service Administrator**. Upon the submission of a request for review, the Appeals Committee will determine whether any further information and/or documentation is needed and act to timely obtain such. Within thirty (30) days thereafter, the Appeals Committee will notify the Insured of its decision and the underlying rationale.

20. **ARBITRATION, LEGAL ACTIONS, AND JURY WAIVER:** Any disagreement that may persist upon completion of the claims appeal as determined herein, must first be submitted to arbitration. In such cases, the Insured and the Insurer will submit their difference to three (3) arbiters: Each party selecting an arbiter, and the third arbiter to be selected by the arbiters named by the parties herein. In the event of disagreement between the arbiters, the decision will rest with the majority. Either the Insured or the Insurer may initiate arbitration by written notice to the other party demanding arbitration and naming its arbiter. The other party shall have twenty (20) days after receipt of said notice within which to designate its arbiter. The two (2) arbiters named by the parties, within ten (10) days thereafter, shall choose the third arbiter and the arbitration shall be held at the place hereinafter set forth ten (10) days after the appointment of the third arbiter. If the other party does not name its arbiter within twenty (20) days, the complaining party may designate the second arbiter and the other party shall not be aggrieved thereby. Arbitration shall take place in Suriname and Guyana or if approved by the Insurer, in the Policyholder's country of residence. The expenses of the arbitration shall be shared equally between the parties.

    The Insured confers exclusive jurisdiction in Suriname or Guyana for determination of any rights under this policy. The Insurer and any Insured covered by this policy hereby expressly agree to trial by judge in any legal action arising directly or indirectly from this policy. The Insurer and the Insured further agree that each party will pay their own attorneys' fees and costs, including those incurred in arbitration.

21. **SUBROGATION AND INDEMNITY:** The Insurer has a right of subrogation or reimbursement from an Insured to whom it has paid any claims to or on behalf of, if such Insured has recovered all or part of such payments from a third party. Furthermore, the Insurer has the right to proceed at its own expense in the name of the Insured, against third parties who may be responsible for causing a claim under this policy or who may be responsible for providing indemnity of benefits for any claim under this policy.

22. **TERMINATION OF COVERAGE UPON TERMINATION OF POLICY:** In the event a policy terminates for any reason, coverage ceases on the effective date of the termination and the Insurer will only be responsible for treatment covered under the terms of the policy that took place before the effective date of termination of the policy. There is no coverage for any treatment that occurs after the effective date of the termination, regardless of when the condition first occurred or how much additional treatment may be required.

23. **CHANGE OF PLAN OR DEDUCTIBLE:** At any anniversary date, the Policyholder can request to change plan or deductible. Some requests are subject to underwriting evaluation.

EXCLUSIONS AND LIMITATIONS

This policy **does not provide** coverage or benefits for any of the following:

1. Treatment of any illness, injury, or any charges arising from any treatment, service or supply which is:
   a) not medically necessary; or
   b) for an Insured who is not under the care of a physician, doctor or skilled professional; or
   c) not authorized or prescribed by a physician or doctor; or
   d) custodial care.

2. Any care or treatment, while sane or insane, received due to self-inflicted illness or injury, suicide, failed suicide, alcohol use or abuse, drug use or abuse, or the use of illegal substances or illegal use of controlled substances. This includes any accident resulting from any of the aforementioned criteria.

3. Routine eye and ear examinations, hearing aids, eyeglasses, contact lenses, radial keratotomy and/or other procedures to correct eye refraction disorders.

4. Any medical examination or diagnostic study which part of a routine physical examination is, including vaccinations and the issuance of medical certificates and examinations as to the suitability for employment or travel.

5. Chiropractic care, homeopathic treatment, acupuncture or any type of alternative medicine.

6. Elective or cosmetic surgery or medical treatment which is primarily for beautification, unless necessitated by injury, deformity or illness which first occurs while the Insured is covered under this policy. This also includes any surgical treatment for nasal or septal deformity that was not induced by trauma, except as provided for in this policy.

7. Any charges in connection with pre-existing conditions, except as defined and addressed in this policy.

8. Any treatment, service or supply that is not scientifically or medically recognized for the prescribed treatment or which is considered experimental and/or not approved for general use by the *states food and health administration/ Ministry of Agriculture or Health.*

9. Treatment in any governmental facility or any expense if the Insured would be entitled to free care. Service or treatment for which payment would not have to be made had no insurance coverage existed.

10. Any portion of any charge that is in excess of the usual, customary and reasonable charge for the particular service or supply for the geographical area.

11. Treatment or service for any medical, mental or dental condition related to or arising as a complication to those medical, mental or dental services or other conditions specifically excluded by an amendment to or not covered by this policy.

12. Any expense, service or treatment for obesity, weight control or any form of food supplement (unless necessary to sustain life in a critically ill person).

13. Treatment for injuries resulting from participation in any hazardous activities.

14. All treatment to a mother or to a newborn related to a non-covered pregnancy.

15. Any voluntarily induced termination of pregnancy, unless imminent maternal demise is apparent.

16. An elective admission more than twenty-three (23) hours before a planned surgery, unless authorized in writing by the Insurer.

17. Treatment by the spouse, father, mother, brother, sister or child of any insured under this policy.

18. "Over the counter" or non-prescription drugs, prescription medications which are not first prescribed while the Insured is admitted in a hospital and prescription medications which are not prescribed as part of follow-up treatment after outpatient surgery.

19. Treatment for injury sustained while traveling as a pilot or crewmember in a private aircraft.

20. Diagnostic procedures or treatment of mental illnesses and/or psychiatric, behavioral or developmental disorders, Chronic Fatigue Syndrome, sleep apnea and any other sleep disorders.

21. Any expense for male or female sterilization, reversal of sterilization, sex change, sexual transformation, birth control, infertility, artificial insemination, sexual dysfunction or inadequacies, disorders related to Human Papillomavirus (HPV) and/or sexually transmittable disease.

22. Podiatric care to treat functional disorders of the structures of the feet, including but not limited to, corns, calluses, bunions, Hallux valgus, hammer toe, Morton's neuroma, flat feet, weak arches, weak feet or other symptomatic complaints of the feet, including pedicures, special shoes and inserts of any type or form.

23. Injury or illness directly or indirectly caused by or contributed to or arising from operations employing the process of nuclear fission or fusion or handling of radioactive material, or related to ionized radiation, pollution or contamination, radioactivity from any nuclear material, nuclear waste, or the combustion of nuclear fuel or nuclear device.

24. Any claim or expense arising directly or indirectly from, or occasioned by, happening through or in consequence of war, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection, military or usurped power, martial law or confiscation by order of any government or public authority.

25. Force Majeure: the Insurer(s) and Service Provider shall not be liable for any failure to meet any of the obligations or provide any of the services or benefits specified or required under the Agreement where such failure to perform is due to any contingency beyond the reasonable control of the parties, its employees, officers or directors. Such contingencies include, but are not limited to: acts or omissions of any person or entity not employed or reasonably controlled by the parties, their employees, officers or directors; acts of God; fires; wars; accidents; labor disputes or shortages; governmental laws, ordinances, rules, regulations, or the opinions rendered by any Court, whether valid or invalid.