# POLICY CONDITIONS & COMPENSATIONS
AZPAS PLUS

Assuria
VERZEKERINGEN

SOLID AND SECURE

# VALIDITY POLICY CONDITIONS

**These AZPAS Plus Policy Conditions & Indemnities, valid from 1 July 2018, completely replace the previous policy conditions with accordingly only these policy conditions being valid. Hence, rights may only be derived from these policy conditions.**

# CONTACT DETAILS

## Sale and information

For quotes or information about a possible change to your insurance, for example:

- addition of dental insurance;
- change of address or telephone number;
- indemnities for which prior permission is required;
- provisions for which a maximum indemnity applies;
- settlement of refunds;

please call: (597)473400 ext. 240, 244, and 300 or contact one of our agents.
E-mail: customer.service@assuria.sr
Website: www.assuria.sr

## Emergencies

Outside the office hours of your AZPAS doctor, you may contact the Private General Practitioners Practice on the premises of the Academic Hospital Paramaribo for acute care by calling: (597) 442222. You may also contact Medicall, located at Van Roosmalenstraat no. 31, by telephone at emergency number: 181. The opening hours of Medicall are Monday through Sunday from 8:00 am to 00:00 pm.

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# DEFINITIONS

Article 1

1.1 **Company/insurer**
Assuria Medische Verzekering N.V. [Medical Insurance N.V.]

1.2 **Policyholder**
The person who has entered into the insurance contract with the insurer.

1.3 **Insured**
Anyone listed as such on the policy schedule, the policy appendix or insurance card and on grounds thereof is entitled to the provisions according to the policy conditions.

1.4 **Insurance**
The AZPAS Plus health insurance policy taken out by policyholder with the company.

1.5 **Policy year**
A period of twelve months from the premium due date and each consecutive period of equal duration. If the period from the inception date of the insurance to the premium due date or from the premium due date to the expiry date is less than twelve months, the indemnities to which you are legally entitled according to these policy conditions will be determined pro rata. This also applies to a period of validity of less than twelve months.

1.6 **Ambulance**
A means of transport intended for the transport of the sick and/ or victims.

1.7 **Physician**
The person who under Surinamese law is competent to practice medicine and:
- is registered as such with the competent authority;
- practices the general medical practice as is customary; and
- has entered into a service provider agreement with the company.

1.8 **AZPAS-card**
Proof of entitlement to medical care according to the policy conditions, provided by the insurer to the insured.

1.9 **Additional costs**
Medical expenses that are directly related to specialist treatment and/or examination, such as costs for X-rays, blood transfusions, laboratory examinations, medicines, radiotherapy, anaesthesia, dressing material and the use of the operating room. The additional costs need to be claimed by the hospital or other agency where such costs were made.

1.10 **Congenital anomalies (Birth defects)**
Any defect or disease present at birth, irrespective of the cause thereof, whether or not manifested or diagnosed at birth.

1.11 **List of Service Providers**
List of health care providers / service providers with whom the insurer has an agreement to provide services to AZPAS insured persons.

1.12 **Pharmaceutical care**
Pharmaceutical care includes the delivery of the medicines and dressing materials described in article 11.8

1.13 **Medical advisor**
The physician who advises the insurer on medical matters.

1.14 **Medical necessity**
The necessity for the purchase, treatment, examination or nursing in accordance with generally recognized and medically scientific considerations.

1.15 **Health care provider / service provider**
The natural person or legal person domiciled in Suriname who is legally authorized to provide medical care. Health care providers also include suppliers of medicines and medical devices. A list of the care providers / service providers who have an agreement with the insurer (service provider list) may be obtained from the insurer on request.

1.16 **Medical Consumables Index (*MVK- Dutch abbreviation*)**
List of medical consumables as compiled by the Ministry of Health.

1.17 **Accident**
A sudden effect of violence on the body of the insured person, coming from the outside, causing medically demonstrable physical injuries.

1.18 **Hospitalization**
Admission to a hospital if and as long as nursing, examination and treatment have to be provided in a hospital on medical grounds. This is meant to refer to:

- *Day nursing*

Bed nursing in a hospital *shorter* than 24 hours, necessary to undergo examination or treatment on that same day by a specialist.

- *Hospital nursing*

Hospitalization *longer* than 24 hours in a hospital, if and as long as on medical grounds nursing, examination and treatment can solely be offered in a hospital, while continuous treatment by a specialist is medically necessary.

1.19 **Optical care**
Care with regard to the vision or eyesight.

1.20 **Supplementary cover**
Care offered optionally by the insurer and which the prospective policyholder / insured person may opt for.

1.21 **AZPAS-Medicines Index**
List of medicines especially compiled by the insurer for AZPAS insured persons, which is more extensive than the National Medicines Index. This list is revised once a year and is available for the insured persons.

1.22 **Premium**
The amount that the policyholder must pay to the insurer in order to be entitled to the medical care to be indemnified by the insurer.

1.23 **Preventive care**
Services provided by a health institution or a health care professional to the insured person, aimed at maintaining the normal health of the insured person or the timely identification of a deterioration thereof.

1.24 **Rehabilitation**
Examination, advice, guidance and treatment of a specialist, paramedical, behavioural scientific and rehabilitation-specific nature. This aid is provided by a multi-disciplinary team of experts under the leadership of a specialist.

1.25 **Reckless behaviour**
To behave or to act in such manner, without taking into account the consequence of the behaviour or the action, or the danger that may ensue for oneself and others.

1.26 **SEH**
Accident and Emergency Department of a hospital in Suriname.

1.27 **Home care**
Nursing or care in the home situation on request of the practitioner, policyholder or the insured person with permission of the insurer.

1.28 **Hospital**
An institution domiciled in Suriname to nurse, examine or treat the sick, which institution is registered as such in Suriname. A list of the hospitals that have an agreement with the insurer (services providers list) is available from the insurer on request.

1.29 **Nursing home**
An institution located in Suriname where patients can be nursed, who no longer need to be admitted to a hospital for medical treatment.

1.30 **Hospice**
A place where people with a terminal illness, whose life expectancy is less than 3 months. Have a home with the required specialized care.

1.31 **Specialist**
The person who is competent under the Surinamese law to practice medicine and:
- is registered as such with the competent authority;
- practices the specialist medical practice as is customary;
- has entered into a service provider agreement with the insurer.

1.32 **Policy territory**
The insurance is solely effective within the natural borders of Suriname

# BASIS OF THE INSURANCE

Article 2

2.1. The insurance agreement is based on the application form with the written statements either or not personally written by the policyholder or the insured person and any written information that has been provided separately by the policyholder or the insured person.

2.2. The insurer provides a policy and an insurance card as proof of the insurance to the policyholder or the insured person.

2.3. The insured person is only entitled to reimbursement of the costs of care insofar as on reasonable grounds he is designated thereto in terms of content and scope.

# REGISTRATION

Article 3

3.1 Policyholder/insured person is obliged to fill out the application form completely and truthfully and to provide it with a date and signature.

3.2. If it turns out during the application procedure that by or on behalf of policyholder/insured person, matters were concealed, which are important for the decision-making by the insurer, or questions were answered incorrectly or incompletely, then the application will not be taken into consideration anymore.

3.3. If it turns out after the approval of the application that by or on behalf of policyholder/insured person, matters were concealed which are important for the decision-making by the insurer, or questions were answered incorrectly or incompletely, then in pursuance of article 320 of the Commercial Code, the acceptance of the insurance will be deemed to be null and void up to the inception date, on penalty of forfeiture of the premium paid. Expenses arisen during the acceptance period and resulting from wrongly using this insurance, will be recovered from the policyholder/the insured person.

3.4 The company has the right to collect medical information about the insured person and to share it with the doctors by whom the insured person is or will be treated. The insured person is obliged to authorize his healthcare providers to provide all necessary information to the company and its medical adviser. The service provider is asked to provide all information, reports and data to the company and to provide all cooperation necessary for the implementation and/or the supervision of the care provided.

3.5 Necessary and relevant medical information shall be communicated with the medical adviser(s) of Assuria. Other relevant information shall be communicated with the Assuria employee(s) who is/ are charged with the monitoring of the coverage and the invoices of the healthcare providers.

3.6 Newborns of an insured mother are insured free of charge in the first 2 weeks after birth, if an insurance subsequently taken out for the child for the remainder of the mother's insurance year.

# INCEPTION DATE, TERM AND EXPIRY OF THE INSURANCE

Article 4

4.1 **Inception date and term of the insurance**

4.1.1 The insurance becomes effective on the date referred to as the inception date on the policy schedule, provided that the premium due has been paid as at such date.

4.1.2 The insurance is entered into for a period of 1 year;

4.1.3 The insurance is each time renewed with a period of 1 year unless it has been cancelled no later than 14 days prior to the expiry of the validity term by registered letter, subject to the case described in article 8.3.

4.1.4 Upon entering into the insurance the insured person gets an Azpas card.

4.2 **Expiry / Cancellation of the insurance**

The insurance expires or is cancelled in the following cases:

- by means of a notification in writing as to not agreeing with the adjustments of the policy conditions and this within 30 days following the receipt of said conditions;
- In case the insured person takes up permanent residence abroad; this must be communicated in writing by the policyholder at least 30 days prior to departure;
- In case of art. 3.3;
- In case of fraud or abuse of circumstances and if the policyholder does not properly comply with one of the obligations arising from the insurance;
- In case of arrears of payment of the premium in accordance with article 8.3.1;
- In case of death of the insured;
- Upon termination of employment in case of a collective Insurance.

# OBLIGATIONS OF THE INSURED PERSON

Article 5

5.1 Policyholder/insured person undertakes to provide (or cause to be provided) the company all the information so desired.

5.2 If through the actions of a third party policyholder/insured person incurs costs, which costs have been compensated by the company, policyholder/insured person is obliged to entirely cooperate to recover said costs from the third party in question. Without the permission in writing of the company, it is not permitted to effect a settlement, (cause to effect a settlement) with said third party or with his insurance company.

5.3 In case the interests of the company are impaired as a result of the fact that policyholder/insured person does not comply with the obligations referred to under article 5.1 and 5.2, the company is not obliged to indemnify the costs.

5.4 Policyholder undertakes to notify the company in writing of any event that may be of importance for the correct implementation of the insurance, but no later than 30 days after the occurrence of such event. If this notification reaches the company after 30 days, the date of receipt of the notification will be used as the inception date of the necessary change as a result of the relevant event.

5.5 Events that may be important for the correct implementation of the insurance include birth, divorce, death, relocation, changing telephone number or joining another health insurance policy.

5.6 Notifications to the policyholder, addressed to the last known (email) address are deemed to have reached the policyholder.

# INDEMNITIES PROCEDURES

Article 6

6.1 **Payment of the indemnity**

6.1.1 Assuria indemnifies the costs directly to the physician and the health care provider.

6.1.2 In case due to special circumstances policyholder/insured person pays the costs himself, then the company indemnifies the costs as soon as the right thereto has been established. (also refer to article 6.2.2).

6.2 **Indemnity conditions**

6.2.1 The company solely compensates costs made during the validity of this insurance.

6.2.2 In applying the provisions set out in article 6.1.2, the right to indemnity will only be established after submission of original and clearly itemised invoices. The invoices shall be provided by the care provider with a signature, stamp and treatment date. If applicable, the invoice shall include a valid referral letter from the doctor as well as clear information about diagnosis and treatment.

6.2.3 The company indemnifies only invoices of healthcare costs incurred if these invoices are expressed in Surinamese dollars.

6.2.4 Costs as referred to in article 6.1.2 shall only be indemnified if the relevant invoices are submitted to the company no later than 2 weeks following the date of treatment. A requirement in this respect is that the treatment was done by means of referral as referred to in article 9.4 and 9.5.

6.2.5 Medical costs are indemnified on the basis of the tariff and the conditions agreed between the health care provider and the company.

6.2.6 The costs for medically necessary treatments will be indemnified.

6.3 **Concurrence of insurances**

Pursuant to article 5.2 and in case the costs ensued from diseases or accidents in case the insured is entitled to damages or any other indemnity due to any legally regulated insurance, government arrangement, subsidy scheme, or - if this insurance did not exist - an agreement other than this one, shall not be indemnified and/or recovered.

The insurance shall only apply as supplement to the cover that has been or would be granted under another insurance, government arrangement and/or subsidy scheme, if this insurance did not exist.

# EXCLUSIONS

Article 7

7.1 Costs related to **the treatment** of primary and secondary fertility disorders are not indemnified.

7.2 Costs that are directly or indirectly the result of nucleus reactions and radiation – unless applied by a medical treatment – acts of God and acts of war are not compensated. 'Act of war' is meant to refer to any cause of nursing and/or treatment, which ensues from violence inflicted by human-beings, not by nature, such as unrest, riots or political conflicts, war, terrorism or of the enforcement of measures taken by any military, paramilitary or civil government or by any power that may appoint itself as such. If at the time and on the site of the creation of the cause for nursing and/or treatment the risk of an act of war existed, the company may have the payment depend on proof to be established by the policyholder/insured person, that the cause for nursing and/or treatment was not caused by an act of war.

7.3 Costs related to unrecognized medicine are not indemnified by the company.

7.4 Costs of medication related to venereal diseases, HIV and AIDS are not indemnified by the company.

7.5 Costs of inspections and medical certificates are not indemnified by the company.

7.6 Costs that are related to negligent or reckless behaviour and/or caused by or as a result of excessive use of alcohol and/or the use of drugs as well as costs resulting from intoxications and suicide (attempts) are not indemnified.

7.7 Costs during detention are not indemnified.

7.8 Costs that are related to assistance provided by a specialist in an area that does not belong to his speciality are not indemnified.

7.9 Costs related to specialities, which are not mentioned in the policy conditions, are not indemnified.

7.10 Costs of additional examination that do not fall under the cover specified in these policy conditions are not indemnified.

7.11 Costs of dental treatment are not indemnified unless these costs are the direct consequence of an accident, up to an accumulated maximum of SRD 3,350 per policy year.

7.12 Costs of vaccinations and all preventive measures when travelling both domestically and abroad are not indemnified.

7.13 Unless otherwise agreed, costs of medicines that do not occur in the AZPAS Medicines Index are not indemnified.

7.14 Costs relating to any form of transplantation are not indemnified.

# PREMIUM

Article 8

8.1 **Amount of the premium**

8.1.1 The policy schedule / payment statement states the amount of the premium for the insurance and the policy and card costs.

8.1.2 The company determines the amount of the premium for the insurance, depending on the age and the optional additional cover.

8.2 **Premium Payment**

8.2.1 The policyholder is obliged to pay in advance the premium (incl. policy and card costs).

8.2.2 The premium paid, will always first be deducted from the longest outstanding claim.

8.2.3 It is not permitted to setoff the premium with indemnities yet to be received by the company.

8.2.4 The premium is payable via the bank per giro or at the office of the company. The fact that the company does not offer a notification does not discharge policyholder from the obligation to pay the premium.

8.3 **Late payment of instalments**

8.3.1 Non-payment of the premium

In case the premium is not paid within 14 days following the premium due date, the company shall have the right to terminate the insurance and to charge costs of administration.

8.3.2 Costs attached to the collection of overdue premium

The company has the right, in addition to the overdue premium, to claim or cause to be claimed the administrative costs and the legal interest. In case collection measures are taken, both the judicial and the extra-judicial costs shall be at the expense of the policyholder. These costs shall minimally amount to 15% of the premium amount due.

8.3.3 Recurring overdue premium

In case of recurring overdue premium, the company has the right to claim or cause to be claimed on call and in full, the premium over the remaining part of the period over which the insurance was entered into or was thereafter continued.

8.4 **Premium refund**

8.4.1 In the following cases the premium will be refunded up to the day of returning the Azpas card.

- In case the insured person takes up permanent residence abroad, by submitting a certificate of deregistration from the Central Civil Registry.
- Termination of an employment with a collective Azpas Insurance other than the case referred to in article 8.4.2.

In case of premium refund, administration costs will be charged. There is no refund of the premium as long as the AZPAS pass has not been surrendered.

8.4.2 No refund of premium applies if the insurance is terminated due to the death of the insured person.

# CHOICE OF PHYSICIAN AND OTHER HEALTH CARE PROVIDERS

Article 9

9.1 Upon inception of the insurance, the insured person makes a choice, preferably from the list of general practitioners with whom the company has a service contract, provided that there is no limit for the chosen general practitioner in terms of the number of Assuria insured persons. If the insured person wants a general practitioner who is not affiliated with the company and there is no objection in this respect pursuant to the norms and standards used by the company, the company will try to reach an agreement with the general practitioner concerned.

9.2 Only in case of renewal of the insurance may insured change physician. If the occasion arises, the company may conduct an investigation into the reason for such a change request.
To make a new AZPAS pass, the policyholder will be charged for administration costs.

9.3 Without prejudice to the provisions of the previous paragraphs, change of physician may be done free of charge if the company has been informed of this in writing at the latest 30 days prior to the renewal of the insurance, in the event of death of the physician or if the agreement between the company and the physician is terminated.

9.4 After referral by the physician, the insured person is free to make use of the services of any health care provider affiliated with the company. This information may also be found on the website of Assuria Verzekeringen.

9.5 Only after obtaining written permission from the company may use be made of the services of a care provider not affiliated with the company at the expense of the company.

# AMENDMENTS TO PREMIUMS AND CONDITIONS

Article 10

10.1 With due observance of the law, the company has the right to revise the premium and/or conditions and to adjust this insurance in the interim to the new premium and/or conditions. In the event of an amendment to conditions, the conditions that applied before such amendment will cease to exist. Any adjustment to premiums and/or policy conditions is made available to the policyholder by the company through various channels, including the Assuria website, www.assuria.sr.

10.2 The policyholder who does not agree with the amendment to the conditions of the insurance may terminate the insurance unless the revision directly results from an amendment to any statutory provision. The termination shall be notified in writing to the company within 30 days of the day on which the policyholder is notified of the adjustment of the conditions of the insurance. The insurance is then terminated on the inception date of the adjustment.

10.3 The policyholder who does not agree with an adjustment to the premium may terminate the insurance. The termination shall be notified in writing to the company in the period between the date on which the policyholder was notified of the adjustment and the date of adjustment, but not later than 30 days after the day on which the policyholder was notified of such adjustment.

10.4 If the company has not received a written notification from the policyholder within the response times specified in paragraphs 2 and 3, the insurance will be continued against the new premium and/or conditions.

10.5 The adjustments as mentioned will automatically apply to the policyholder if:

- He / she has been insured with the company for less than 12 months;
- The premium gets higher by exceeding the limit of an age group by the insured person(s).

# INDEMNITY

Article 11

The company shall compensate necessary medical costs incurred in Suriname and related to activities obtained by means of presenting a valid Azpas card and guarantee letter in accordance with the conditions set out in the policy. The required guarantee letter does not apply to the general practitioner, the SHE, the optician or the pharmacist.
Agreements have been made with the pharmacies associated with the company as to the medicines and dressing materials available in Suriname according to the MVK and the AZPAS Medicines Index.

Medical costs are meant to include:

11.1 **General Practitioners**

This includes:

- Doctor's visits.
- Medical operations according to the agreement with the general practitioner.

11.2 **Electrograms**

Electrocardiogram (ECG), Electro encephalogram (EEG), Electromyogram (EMG) at the request of the general practitioner or medical specialist.

11.3 **Laboratory exam**

Performed at the request of the general practitioner or medical specialist.
This includes tests on the AZPAS laboratory operations list.
For all other additional exams that do not appear on the AZPAS laboratory operations list and for which the medical diagnostic need becomes evident, prior permission shall be granted by the company.

11.4 **Pregnancy, delivery and infants**

- Prenatal monitoring by the general practitioner, midwife or gynaecologist, including the twelve and twenty-week ultrasound.
- Delivery in the hospital, at home or in a nursery institution by an authorized service provider according to the agreed rates.
- Indemnity of visits to a health center, except for vaccinations, which are part of the National Immunization Program under the public health care scheme and are part of the permanent preventive national programs.

11.5 **Congenital anomalies**

11.5.1 In the case of newborns insured from birth, the costs of examination, treatment, and nursing of congenital disorders, irrespective of when these are manifested or diagnosed.

11.5.2 For insured persons who are not insured from birth, the clinical costs of examination of treatment and nursing of congenital disorders an accumulated maximum of SRD 20.100. - per insurance year applies. *

** Subject to a guarantee letter / statement of approval to be issued solely by the company*

11.6 **Emergency care (SEH)**

Costs related to the acute care at the Accident and Emergency Department.

11.7 **Pharmaceutical help**

Which is prescribed by the general practitioner or specialist, namely:

- Registered medicines that occur in the AZPAS Medicines Index, which are provided on prescription via a pharmacy.
- AP colostomy bags and stickers.
- For chemotherapeutics, an accumulated maximum indemnity of SRD 25.125, - per policy year* applies.
- Blood products.
- Dressings that occur in the Medical Consumables Index (MVK).
- Hormone preparations up to an accumulated maximum of SRD 3.350, - per policy year*

11.8 **Paramedical care***

- Occupational therapy, a maximum of 15 visits per policy year.
- Physical therapy, a maximum of 18 visits per policy year.
- Skin therapy, a maximum of 6 visits per policy year.
- Speech therapy, a maximum of 15 visits per policy year.
- Psychology, a maximum of 10 visits per policy year.
- Remedial education, a maximum of 10 visits per policy year.
- Medical pedicure, a maximum of 2 visits per policy year if Diabetes mellitus is concerned.
- Dietetics, a maximum of 18 visits per policy year, solely if it is a question of (at least 1 condition applies):
  - BMI > 27
  - Diabetes Mellitus
  - Hypertension
  - Haemodialysis
  - Clinical patients

11.9 **Optical care**

- Eye measurements by the optometrist or optician.
- Indemnity of optical care on prescription of the ophthalmologist, optician, or optometrist. *

11.9.1 After your right has been established you may separately choose among the following:

A. A spectacle frame with glasses
B. Glasses
C. Contact lenses

11.9.1 The following indemnities apply to Optical care **Classic**:

- Maximally SRD 850, -, for Spectacle frame maximally SRD 450, -.
- Once every 2 insurance years, with a strength change of at least 0.5.
- On prescription from the ophthalmologist, optician, or optometrist.
- The same conditions apply for contact lenses.

11.9.2 If the insured person in any year has received compensation for contact lenses and wishes to receive a compensation for a spectacle frame and glasses, then the qualification period is 2 policy years

11.9.3 If the insured in any year has received compensation for a spectacle frame and glasses and wishes to receive a compensation for contact lenses, then the qualification period is 2 policy years

11.10 **Preventive care***

11.11 **Specialist care**

The following specialties or (as the case may be) specialist treatments available in Suriname are eligible for indemnity (costs of medical specialist treatment by foreign missions are only indemnified after the health insurer has granted permission in advance).

NB: Where the specialty is mentioned, **the integral costs are indemnified in connection with the specialist treatment mentioned.**

**Anaesthesiology**

**General Surgery**

**Cardiology and cardiac surgery***

- Pacemaker, an accumulated maximum indemnity of SRD 15.000, - per policy year applies for purchase costs, a maximum of once per policy year.
- Costs related to cardiac catheterization as a diagnostic examination, a maximum of twice per policy year.
- Costs related to interventional cardiac therapy, including percutaneous angioplasty and / or placement of stents and vascular surgery (including bypass and valve surgery, insertion and possibly repositioning of a pacemaker), an accumulated maximum of SRD 26.800, - per policy year.

**Dermatology**

**Gynaecology**

Costs related to **examination** of primary and secondary fertility disorders; this includes the costs for:

- Laboratory tests.
- Medical imaging.
    - Hysterosalpingogram or HSG, once a lifetime.
    - Laparoscopic tuba test (or blue test), once a lifetime.
    - Ultrasound monitoring of the follicle growth: once a lifetime.
- Post-coitus test: once a lifetime.

** Subject to a guarantee letter / statement of approval to be issued solely by the company*

**Sterilization***
Indemnity for sterilization, if medically necessary. Per insured person, sterilization is indemnified once per lifetime and this in the following way: the full cost of sterilization, provided that in case of male sterilization, maximally the costs of an outpatient treatment are indemnified.

**Internal Medicine**
**As regards haemodialysis:**
- Costs are indemnified up to an accumulated maximum of SRD 62,500. - per policy year. The costs are inclusive of medicines and the costs related to placing a shunt*.
- Indemnity for the acquisition of a dialysis catheter in connection with haemodialysis up to a maximum of 50% of such costs up to an accumulated maximum of SRD 2.000. - per policy year. *

**Dental surgery***

**ENT [Ear, Nose and Throat] science**
Hearing aid, maximally SRD 1.180, - per ear once every 2 policy years, if the strength has changed**

**Paediatrics**

**Neurosurgery***
Costs for neurosurgery: an accumulated maximum of SRD 26.800, - per policy year.

**Neurology**

**Orthopaedics**

**Artificial means and aids***
- Indemnity up to a maximum of 100% of the purchase costs for all protheses on medical prescription up to an accumulated maximum of SRD 50.000, - per policy year.
- Leg and/ or arm prostheses in case of amputation as a result of an accident or as a resultof a chronic illness that was not present at the time of the insurance, up to an accumulated maximum of SRD 25.000,- per insured person per insurance year on prescription of the orthopaedic surgeon and after approval by the company.
- Orthopaedic footwear and arch support up to 1x per insurance year on prescription of the orthopaedic surgeon or rehabilitation specialist and after approval by the company up to a maximum of SRD 670, -. per insurance year.
- The hiring of orthopaedic aids for rehabilitation, e.g. splints, orthopaedic crutches and orthopaedic collar, only on prescription of the orthopaedic surgeon or rehabilitation specialist.
- Reimbursement of costs of hip loc, plates and screws.

**Subject to a guarantee letter / statement of approval to be issued solely by the company*

**Ophthalmology**

**Parasitology**

**Plastic surgery***
The costs of plastic surgery are indemnified, if medically necessary, in case of mutilation because of an accident or illness. Costs associated with treatments arising from personal need, circumstance or necessity are not indemnified.

**Psychiatry***
- As an outpatient, maximally 20 visits per policy year.
- Clinical, maximally 6 weeks per policy year, either or not consecutively.

**Pulmonology**

**Radiology**
Performed at the request of the general practitioner or medical specialist. This includes:
- Ultrasound.
- X-rays.
- Scopies (exploratory exam);
- CT scan and / or MRI scan *; a maximum of 4 per policy year.

**Rehabilitation medicine**

**Urology***
Regarding Extracorporeal shock wave lithotripsy (ESWL) a maximum of 3 times per policy year. Multiple treatments, if necessary, only after approval of Assuria.

11.12 **Medical home care***
To prevent or shorten a hospitalization. Maximum and cumulated are reimbursed 120 days per policy year, consecutively or not.

11.13 **Hospital***

11.13.1 The costs of medically necessary hospital stay in a hospital, in other words any hospital facility including Lung Pavilion and Psychiatric Centre Suriname are based on third class for the benefit of specialist treatment, examinations and nursing. This includes admission in connection with neonatal care, admission to the intensive care unit and admission to a nursing home. An admission to a nursing home takes place on indication of the treating medical specialist and only if this follows discharge from a hospital, up to a maximum of 120 days of hospitalization per policy year.

11.13.2 For costs of admission to a higher class, the costs are indemnified according to the tariff of the insured class (unless a higher class is co-insured).

**Subject to a guarantee letter / statement of approval to be issued solely by the company*

11.13.3 For costs of hospitalisation of children up to and including 5 years, the following applies:
Compensation solely of rooming-in costs of a total of 7 days per policy year for one parent, on the conditions that one of the parents is insured with Assuria *Medische Verzekering N.V*.

11.14 **Hospice***
Hospice coverage of 3 months. This is only reimbursed for terminal patients. The Hospice is located on the grounds of the Diakonessenhuis Paramaribo.

11.15 **Ambulance transport**

- The costs of ambulance transport by land from and / or to a health facility based on an indication from the general practitioner or treating specialist, if subsequently there is an admission, or after discharge.
- In the case of acute medical air transport, the maximum indemnity is SRD 3.350, - per policy year. *

**Subject to a guarantee letter / statement of approval to be issued solely by the company*

# DISPUTES

Article 12

12.1 The laws of Suriname shall apply to this agreement.

12.2 In case of a dispute between parties regarding the amount of the damages the company is obliged to pay by virtue of the policy conditions, such dispute shall be subject to the decision of an advisory committee, consisting of three members. The decision of the committee shall be accepted by parties as a binding advice.

12.3 The members of the advisory committee are chosen among persons who may be deemed to be experts as regards the subject of the dispute. Each party appoints a member; the members appointed by parties shall appoint the third member in mutual consultation. If parties do not reach an agreement on the appointment of such third member, then said third member shall be appointed by the competent judge in Suriname, at the request thereto by either party. The latter then notifies the other party as to the submission of said request. A deed signed by parties and the members of the advisory council shall prove the appointment of the members of said committee. Said deed shall describe the subject of the dispute as well.

12.4 The members of the advisory committee shall give their advice in all reasonableness and fairness. Each party shall bear the costs of the member appointed by him. The costs of the third member shall be shared by parties on a fifty-fifty basis. The third member is authorized to require from parties an amount as security to be so determined by him, prior to dealing with the case. Parties shall then be obliged to create such a deposit.

# LOSS OF THE AZPAS CARD

Article 13

Administration costs will be charged for creating a new AZPAS card.

# SUPPLEMENTARY COVERAGE

Article 14

Assuria Medische Verzekering N.V. offers additional coverage on the AZPAS Plus insurance against premium loading. Below is a description of such coverage. Your policy schedule states which additional coverage(s) is / are applicable.

**Hospital coverage**

When applying for the insurance you may opt for 1st or 2nd class. This entitles you to better facilities compared to 3rd class hospitalization. For children up to and including 12 years old, the children's class is equal to the 3rd class.

The following applies to costs for admission to a higher or lower class:

- In the case of admission to a class higher than the insurance coverage, the costs are indemnified in accordance with the rate of the insured class.
- In the case of admission to a class lower than the insurance coverage, the costs are indemnified up to the rate of the lower class.

**Optical care Supreme**

If this coverage has been chosen, it will replace the optical care coverage Classic.
Once your claim has been determined, you may separately choose from the following options:

- Maximally SRD 1.100, -, for spectacle frame maximally SRD 700, -.
- Once every 2 insurance years, with a strength change of at least 0.5.
- On prescription from the ophthalmologist, optician, or optometrist.
- The same conditions apply for contact lenses.

**Optical care Supreme+**

If this coverage has been chosen, it will replace the optical care coverage Classic.
Once your claim has been determined, you may separately choose from the following options:

- Maximally **SRD 2.200, -**, for spectacle frame maximally SRD **1.400, -.**
- Once every 2 insurance years, with a strength change of at least 0.5.
- On prescription from the ophthalmologist, optician, or optometrist.
- The same conditions apply for contact lenses.

**Alternative medicine Basic**

Alternative medicine is different from the usual (regular) treatments. It often complements this but may also be isolated treatments.

- Alternative medicine is not indemnified.
- Visits are only indemnified if provided by a physician and / or therapist with a recognized training that is registered with the Ministry of Health.
- The indemnity of the visits takes place on an expense basis. This means that the visit is paid by the insured person, after which an invoice may be submitted to the company.
- The following alternative treatments are indemnified, with a total maximum indemnity of **SRD 1.236, -** per policy year:
  - Acupuncture
  - Homeopathy
  - Podotherapy
  - Chiropractic

**Alternative medicine Classic**

Alternative medicine is different from the usual (regular) treatments. It often complements this but may also be isolated treatments.

- Alternative medicine is not indemnified.
- Visits are only indemnified if provided by a physician and / or therapist with a recognized training that is registered with the Ministry of Health.
- The indemnity of the visits takes place on an expense basis. This means that the visit is paid by the insured person, after which an invoice may be submitted to the company.

- The following alternative treatments are indemnified, with a total maximum indemnity of **SRD 2.472, -** per policy year:
  - Acupuncture
  - Homeopathy
  - Podotherapy
  - Chiropractic

**Azpas medicines index GOLD**
By choosing this extra coverage you are eligible for a wider range of medicines. See the current Azpas medicines index.

**Dental surgery**
Separate policy conditions are available for a description of the coverage for dental costs. These are provided when this coverage is co-insured.