Assuria VERZEKERINGEN

POLICY CONDITIONS & COMPENSATION AZPAS BUDGET

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TABLE OF CONTENTS

ARTICLE 1 | DEFINITIONS 2
ARTICLE 2 | BASIS OF THE INSURANCE 5
ARTICLE 3 | REGISTRATION 5
ARTICLE 4 | INCEPTION DATE, TERM AND EXPIRY OF THE INSURANCE 6
ARTICLE 5 | OBLIGATIONS OF THE INSURED 7
ARTICLE 6 | COMPENSATION PROCEDURES 6
ARTICLE 7 | EXCLUSIONS 8
ARTICLE 8 | PREMIUM 10
ARTICLE 9 | CHOICE OF PHYSICIAN AND OTHER HEALTH CARE PROVIDERS 11
ARTICLE 10 | AMENDMENTS TO PREMIUMS AND CONDITIONS 12
ARTICLE 11 | COMPENSATION 13
ARTICLE 12 | DISPUTES 15
ARTICLE 13 | LOSS OF THE AZPAS CARD 15

ARTICLE 1 | DEFINITIONS

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 Budget 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 payments 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 professional 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 and if applicable, has a residence permit or letter of consent;
- practices the general medical practice as is customary;
- has entered into a service provider agreement with the Company.

1.8 AZPAS-card
(Digital) 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 shall be claimed by the hospital or other agency where such costs were made.

1.10 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.

1.11 Pharmaceutical care
Pharmaceutical care includes the delivery of the medicines and dressing materials described in article 11.7.

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

1.13 Medical necessity
The necessity for the purchase, treatment, examination, or nursing of the insured person in accordance with generally recognised and medically scientific considerations.

1.14 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.

1.15 Medical Consumables Index (*MVK)*
List of medical consumables as compiled by the Ministry of Health of Suriname.

1.16 Accident
A sudden impact of violence on the body of the insured person, external in origin, causing medically demonstrable physical injuries.

1.17 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*
  Hospitalisation 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.

1.18 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.

1.19 Premium
The amount that the policyholder must pay to the insurer in order to be entitled to the medical care to be compensated by the insurer.

1.20 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.

1.21 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.

1.22 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.

1.23 SEH
Accident and Emergency Department of a hospital in Suriname.

1.24 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.

1.25 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.

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

1.27 Policy territory
The insurance is solely effective within the natural borders of Suriname.

1.28 Chronic diseases
Long-term diseases that do not disappear spontaneously and rarely heal completely.

Paramedic care
Care whose purpose is to maintain the patient's health as well as possible and focuses on improving the functioning of the body.

Psychotherapy
Psychotherapy is a form of treatment by a psychotherapist that focuses on treating mental disorders or life problems through talking.

ARTICLE 2 | BASIS OF THE INSURANCE

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 a(n) (digital) 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 has a claim thereto in terms of content and scope.

ARTICLE 3 | REGISTRATION

3.1 The policyholder and the insured person undertake 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, 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 obliged to provide the Company all information, reports and data to the Company as well as 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.

ARTICLE 4 | INCEPTION DATE, TERM AND EXPIRY OF THE INSURANCE

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 term 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 a(n) (digital) 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 receipt of such conditions;
- In case the insured person takes up permanent residence abroad; this shall 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.

ARTICLE 5 | OBLIGATIONS OF THE INSURED

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 such 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 compensate 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, yet no later than 30 days after the occurrence of such event. If such 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, moving house, changing telephone number, or joining another health insurance.

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

ARTICLE 6 | COMPENSATION PROCEDURES

6.1. Payment of the compensation

6.1.1 In principal the Company compensates the costs directly to the health care providers or to the policyholder/insured based on the effective agreed rate and this as soon as the right thereto has been established. (also refer to article 6.2.2)

6.2 Compensation 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 6.1.1, the right to compensation 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 be submitted, accompanied by a valid referral letter from the doctor, whose referral date shall precede the treatment date, as well as clear information about diagnosis and treatment.

6.2.3 The Company pays only invoices of healthcare costs incurred if these invoices are denominated in Surinamese dollars.

6.2.4 Costs as referred to in article 6.1.1 shall only be compensated 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 a referral as referred to in article 9.4 and 9.5.

6.2.5 Medical costs are compensated on the basis of the tariff and the conditions agreed between the health care provider and the Company in effect at the time of taking such care.

6.2.6 The costs for medically necessary treatments will be compensated.

6.3 Concurrence of insurances

Pursuant to art. 5.2 and in the event, costs have arisen as a result of illnesses or accidents which the insured person may claim under a statutory insurance, a government regulation, a subsidy scheme or - had this insurance contract not been entered into - under any other agreement for the costs arising therefrom, these costs shall not be compensated 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.

ARTICLE 7 | EXCLUSIONS

7.1. Costs related to ailments, complaints and/or physical anomalies that the insured person suffers from or has suffered from on or before the inception date of the insurance are not compensated. Even if the insured was not aware of this himself/herself. Costs related to such ailment, complaint or anomaly are also not eligible for reimbursement.

7.2. Costs related to chronic diseases are not compensated.

7.3. Costs related to primary and secondary fertility disorders, sterilization, and heredity are not compensated.

7.4. Costs related to pregnancy, childbirth and induced abortion are not compensated.

7.5. Costs related to kidney dialysis are not compensated.

7.6. Costs of artificial devices and aids are not compensated.

7.7. Costs related to paramedical care are not compensated.

7.8. Costs related to psychotherapy are not compensated.

7.9. Costs related to gallstones and kidney stones are not compensated.

7.10. Costs related to preventive care are not compensated.

7.11. Costs related to rehabilitation are not compensated.

7.12. Costs related to home care, nursing home and hospice are not compensated.

7.13 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 be subject to 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.

7.14 Costs related to unrecognized medicine are not compensated by the Company.

7.15 Costs of medication related to venereal diseases, HIV and AIDS are not compensated by the Company.

7.16 Costs of inspections and medical certificates are not compensated by the Company.

7.17 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 compensated.

7.18 Costs during detention are not compensated.

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

7.20 Costs related to health care specialities, which are not mentioned in the policy conditions, are not compensated.

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

7.22 Costs of dental treatment are not compensated.

7.23 Costs of vaccinations and all preventive measures when travelling both domestically and abroad are not compensated.

7.24 Costs of medicines not prescribed under this policy and not covered by the coverage mentioned in these policy conditions are not compensated.

7.25 Costs relating to all forms of transplantation are not compensated.

ARTICLE 8 | PREMIUM

8.1 **Amount of the premium**

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

8.1.2 The Company determines the level of the premium for the insurance, subject to the age.

8.2 **Payment of the premium**

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

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 payments yet to be received from the Company.

8.2.4 The premium is payable via the bank by giro transfer or at the office of the Company.

The fact that the Company does not offer a notification does not discharge the 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 be entitled to terminate the insurance and to charge administrative costs.

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 (digital) AZPAS card.

- In case the insured person takes up permanent residence abroad, by submitting a certificate of deregistration from the Central Civil Registry;
- In case of 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, administrative costs will be charged. There is no refund of the premium as long as the AZPAS card 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.

ARTICLE 9 | CHOICE OF PHYSICIAN AND OTHER HEALTH CARE PROVIDERS

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 request for change. To make a new (digital) AZPAS card, the policyholder will be charged administrative costs.

9.3 Without prejudice to the provisions set out in 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 health care provider not affiliated with the Company at the expense of the Company.

ARTICLE 10 | AMENDMENTS TO PREMIUMS AND CONDITIONS

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. Such 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 effective 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, yet 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 under the new premium and/or conditions.

10.5 The adjustments as mentioned will automatically apply to the policyholder if:
- He / she has not yet been insured with the Company for 12 months;
- The premium is increased by exceeding the limit of an age group by the insured person(s).

ARTICLE 11 | COMPENSATION

The Company shall compensate necessary medical costs incurred in Suriname and related to activities obtained by means of presenting a valid (digital) Azpas card and letter of guarantee in accordance with the conditions set out in the policy and if these are covered by the policy. The required letter of guarantee does not apply to the general practitioner and the SEH.
Agreements have been made with the pharmacies associated with the Company as to the medicines and dressing materials available in Suriname according to the Assuria Medicines Index.

The medically necessary costs are compensated if:
- These are covered by the insurance coverage;
- These arose during the term of the insurance;
- These were incurred during the term of the insurance;
- These were not foreseeable at the time the insurance was taken out, nor could they have been foreseen under normal circumstances.

The hospital and healthcare provider where the insured receives care may be chosen by the insured. For treatments by a healthcare provider, the latter must be recognized by competent authorities and authorized to perform the treatments.

The medical treatments eligible for compensation are:

11.1. General practitioner

This includes:
- Consultations not exceeding an amount of **SRD 1,500. -** per policy year;

- Medical operations in accordance with the operations list agreed with the general practitioner not exceeding SRD **3,500. -** per policy year.

11.2. Medical Diagnostic Examination not exceeding an amount of **SRD 7,500. -** per policy year:

This includes:
- Laboratory examination cf. the prescription of a general practitioner/medical specialist.
- Radiological examination cf. the prescription of a general practitioner/medical specialist.

11.3. Pharmaceutical care not exceeding an amount of SRD **3,500. -** per policy year.

This includes:
Registered medicines listed in the AZPAS Medicines Index, prescribed by a general practitioner or medical specialist, dispensed by prescription through a pharmacy to the extent prescribed under this policy and covered under the coverage specified in these policy conditions.

11.4. Medical Specialist Care

Outpatient Consultations not exceeding **SRD 2,000**. - per policy year.

Medical specialist treatments and examinations not exceeding **SRD 50,000**. - per policy year. This includes:

- Specialist treatment and/or examination by a medical specialist where the treatment or examination belongs to the specialty for which the doctor is registered;
- Additional medical expenses for specialist treatment, such as costs of blood transfusions, anaesthesia and use of the operating room.

11.5. Hospitalization/ Clinical day treatment/ Outpatient surgical procedures not exceeding SRD 150,000.00 per policy year only in connection with and due to acute medical necessity:

This includes:
- Inpatient days only in the 3rd class;
- Medical Specialist treatments and surgical procedures during the admission;
- Follow-up treatments only following the acute medical necessity for which the hospitalization/clinical day treatment/outpatient surgical procedure was necessary to the extent such care is covered under this policy.

11.6. Emergency Care (*SEH*) not exceeding **SRD 2,500. -** per policy year.

This includes:
Acute medical care in emergency department and urgent treatment by the doctor on duty.

11.7. **Medically necessary ambulance transportation** over land not exceeding **SRD 1,000. -** per policy year.

ARTICLE 12 | DISPUTES

12.1. This agreement is governed by the laws of Suriname.

12.2. In case of a dispute between the parties concerning the amount of compensation for damages to which the Company is obliged under the policy conditions, such dispute shall be submitted to an advisory committee consisting of three members. The decision of the committee shall be accepted by the parties as binding.

12.3. The members of the advisory committee shall be chosen from persons who may be deemed to be experts in the subject matter of dispute. Each of the parties shall appoint one member; the members appointed by the parties shall appoint the third member by mutual agreement. If the parties cannot reach agreement on the appointment of this third member, the third member shall be appointed by the competent court in Suriname, at the request of both parties or by any of the parties, which shall notify the other party of the submission of such application. The appointment of the members of the advisory committee shall be evidenced by an instrument signed by the parties and the members, which shall include a description of the subject of the dispute.

12.4. The members of the advisory committee shall give their advice in reasonableness and fairness. Each party shall bear the costs of its designated member. The costs of the third member shall be borne half by each party. The third member shall be authorized to require the parties to furnish such sum as he shall determine as security before hearing the case. The parties shall then be obliged to provide such deposit.

ARTICLE 13 | LOSS OF THE AZPAS CARD

Administrative costs will be charged to create a new AZPAS card.