

Individual Complete Coverage

The Company agrees that the following conditions form part of the Policy.

This insurance policy is insured by the insurer specified on the policy schedule and / or certificate of insurance, hereinafter referred to as the Company. The Company agrees to pay the benefits set out in this policy in exchange for the premium paid in full.

The policy conditions, the Schedule and certificate of insurance shall be read together and form an enforceable agreement between the insured and the Company. This policy only covers insured who are registered as insured with the Company.

The personal and medical data supplied by the insured, policyholder or any authorized person forms the basis for this insurance policy. The Company does not owe any reimbursement of costs and is authorized to terminate the policy if the information supplied by the insured or any authorized person were contrary to the truth or if circumstances were concealed which are of such nature that the insurance would not have been issued or not under the same conditions if the Company had knowledge of such.

The Company shall reimburse eligible expenses incurred while the insurance is in effect. Reimbursement of the covered expenses will be granted up to the limits stated by the government of Aruba. In case the charges are not regulated by the government the Company shall pay the charges based on the limits stated in the Schedule.

Definitions;

Company / Insurer	Netherlands Antilles & Aruba Assurance Company N.V. ("Citizens Insurance")
Policyholder	The insured named as such in the policy.
Insured	Any person named in the policy or in the schedule or the list attached to this policy.
Adult	Person between 13 years and 65 years of age.
Child	Person in the age between 0 years and 12 years of age.
Accident	With an accident shall be understood a sudden external involuntary violent impact on the body of the insured. The cause of such impact is direct, external to the victims own body and occurs beyond the victims control.
Ailment / Sickness	Illness or disease which first manifests itself while this policy is in force. It includes all bodily disorders complications and accidental bodily injuries. All bodily injuries sustained in a single accident, or all illnesses which are due to the same or related cause or causes shall be deemed one ailment.
Certificate / Policy	The document issued by the company which provides evidence of benefits payable under the policy and which includes the application form

Dependent	The insured persons spouse unless legally separated from such a person and or the insured persons unmarried children, older than one month and younger than 18 years of age.
Physician	A legally qualified physician licensed and registered with the Aruban authorities.
Hospital	An institution that is licensed to operate as a hospital. Is open 24 hours a day, operates primarily for the care and treatment of sick and / or injured persons.
Intensive care	A section or a wing within the hospital which is separated from other hospital facilities. Is operated exclusively for providing professional care and treatment for critically ill patients, has special supplies and equipment necessary for such care and treatment available on a standby basis for immediate use, provides constant observation and care by registered professionals nurses.
In-patient	A registered bed patient in a hospital who is charged for at least one day's room and board by the hospital.
Insured term	The term stated in the policy. Coverage beginning on the policies effective date at 00.00 am local time and automatically ending at the end of the insured term at 12.00.
Excess / deductible	If applicable, the excess / deductible is the amount shown on the policy that must be paid each year before a benefit becomes payable for that policy year. The insured must pay the deductible in full.
Maximum amount	The maximum amount paid by the insurer based on the tariffs stipulated in CZA 97 also referred to also Schedule
Medical necessary	A service or supply which is necessary and appropriate for the diagnoses or treatment of an illness or injury based on generally accepted current medical practice as determined by the company's medical advisor.
Period of confinement	One or more separate or combined periods of confinement in a hospital for the same or related causes not separated by a period of maximum 3 months.
Schedule	Schedule stating all the coverages and limits of these coverages.

MEDICAL BENEFITS

A. HOSPITALIZATION

The Company shall pay the expenses incurred by the insured for:

- (1) hospital room and board furnished to the Insured during a period of in-patient hospital confinement commencing while the policy is in force and resulting from accidental bodily injuries or sickness, excluding pregnancy and;
 - (a) with respect to such expenses incurred for hospital room and board on any one day of such payment shall not exceed Maximum Daily Benefit stated in the Schedule (CZA 97),
 - (b) with respect to any one period of such hospital confinement, such Maximum Daily Benefit shall not be payable for a period of excess of the number of days stated as Maximum Payment Period in said Schedule.

Successive period of hospital confinement shall be considered as having occurred during one continuous period of illness unless the subsequent confinement is due to an injury or sickness, entirely unrelated to the causes of the previous illness or unless separated by 90 days following the last discharge from hospital.

Hospital confinement must be for twelve consecutive hours before any benefits hereunder are payable, except that, for Miscellaneous Services no minimum period of hospital confinement is required because of surgical operation.

- (2) Special Services furnished to the Insured on any day for which benefits are payable except that:
 - (a) with respect to all such expenses incurred for Special Services during one period of such hospital confinement, such payment shall not exceed the maximum tariffs,
 - (b) with respect to the term "Special Service" as used herein, the definition shall be:
 - (i) necessary medical services and supplies furnished by a hospital other than room and board.
 - (j) anesthesia and its administration, whether furnished by a hospital or not, anesthetics and oxygen and their administration.
- (3) For the services in connection with (1) emergency medical treatment in a hospital, because of accidental bodily injury, within twenty-four hours after the accident or (2) surgical treatment in a hospital, the amount of the charges made for the following services furnished in connection with such treatment, such amount not exceed the amount shown for this benefit in the Schedule.

Miscellaneous Services shall not include, and no reimbursement shall be made for expenses incurred for the services of private nurses, technicians not regularly employed by the hospital, or doctor, room, board or general nursing care, or any services furnished by the hospital other than those listed under the Special Services.

A2. HOSPITALIZATION ABROAD

- (a) Services must be recommended by a regular attending General Practitioner and or a Specialist.
- (b) The medical services must be necessary and customary.
- (c) In case insured request treatment abroad prior approval of company medical advisor must be obtained
- (d) Any treatment other than A or B will be considered if acute illnesses or accidents occur whilst the insured is abroad on vacation leave, seminars, business conferences or sales trip.

- (e) Normal and customary charges will apply for services which can be had in Aruba and conversions currency may not apply if insured seek medical attention abroad without qualifying under A.B or D.

B. SPECIAL SERVICES

The Company agrees, subject to the limits of liability, exclusions, conditions and other terms of this Policy, to pay the expenses incurred by the Insured for necessary medical treatment, services or supplies hereinafter described furnished directly to the Insured for the sole purpose of treating accidental bodily injury sustained or sickness contracted and commencing while the Insured is insured under this Policy.

- (1) The fees of a licensed physician for visits, but not to exceed the maximum per visit shown in the Schedule. If the visits to the physician are occasioned by sickness or disease, only one visit per day will be covered and fees for the hospital visits are only payable for hospital confinements for which no surgical operation is required.
- (2) The fees of a specialist consulting physician, to whom the Insured has been referred by his/her attending physician, but not to exceed the Maximum per Consultation shown in the Schedule.
- (3) Ethical drugs prepared by a registered pharmacist in accordance with a prescription by the Insured's attending physician or surgeon while the said covered person is not hospitalized but not to exceed the maximum benefit shown in the Schedule during any one calendar year. Drug bills must be specified with the name of the prescribed drugs.
- (4) Because of a result of bodily sickness or injury, any Insured necessarily incurs expense for diagnostic x-ray examinations or any microscopic or other laboratory tests or analysis, the Insurance Company shall make reimbursement for such expenses up to the maximum benefit stated in the Schedule, provided such examinations are made or recommended by a licensed physician. The Company will supply the insured a guarantee letter after showing the diagnosis given by the attending Physician.

No benefits are payable under this section for:

Pregnancy examinations, medical examinations, routine medical check-ups, dental x-rays except for traumatic injury, therapeutic x-rays or any examinations made while patient is confined in a hospital as a registered bed patient.

C. SURGICAL EXPENSES

The Company shall pay the expenses incurred by the Insured for the services of a legally qualified physician or surgeon for the performance upon such person of a surgical operation, whether performed in a hospital specialized clinic, resulting from accidental bodily injuries or sickness, excluding pregnancy, provided that:

- (1) such operation is performed while the policy is in force; and
- (2) payment for any one operation shall not exceed the lesser of the surgical fee incurred by such person, for such operation or the Maximum Payment stated for such operation in the Schedule of Surgical Operations and

- (3) the total payment for all such operations performed during any one period of illness shall not exceed the Maximum Benefit stated in the Schedule for Surgical Operations,
- (4) if there is more than one surgical procedure performed through the same incision the benefit payable will be based on the procedure for which the higher percentage appears in the Schedule for the Surgical Operations,

Successive operations performed upon an Insured Person shall be considered to have been performed during one period of illness unless the subsequent operation results from causes entirely unrelated to the causes of the previous operation.

D. DOCTORS VISITS

A Physician or family practitioner of healing arts. Regular visits to the physician will be covered to a maximum per visit as stated in the Schedule. The Physician must be licensed and registered by the authorities of Aruba.

E. SPECIALIST

A physician established in Aruba who is specialized in a certain branch of medicine by means of training received, because of which the necessary acknowledgments have been obtained. Only after the insured has been referred to by his/her attending physician. Specialist who is registered by the authorities of Aruba. Limits as stated in the Schedule.

F. PRESCRIBED DRUGS

Medicine, prepared by a registered pharmacist in accordance with a prescription issued by the insured physician or specialist while the insured is not hospitalized, up to the limits stated in the Schedule.

G. DIAGNOSTIC X-RAY & LABORATORY

Diagnostic X-Ray examinations and microscopic or other laboratory tests and or analyses, while insured is not confined to the hospital, only after recommendation and referral by a licensed physician and or specialist. The company will reimburse for such an expense up to the maximum per ailment as stated in the Schedule.

H. MATERNITY

Upon receipt by the Company of due proof that the Insured, if female, has been confined in a hospital because of account of pregnancy or resulting childbirth or miscarriage. The Company will pay an amount equal to the actual expenses incurred, but the benefit payable hereunder for any one pregnancy shall in no event exceed the amount specified for this benefit in the Schedule. This is the only provision in this policy which insures against the expenses of childbirth, pregnancy or miscarriage, except in the event of a Caesarean section or tubal pregnancy, in which event an additional surgical fee will be allowed as provided for in the preceding Surgical Expense Benefit. For this benefit insured must be at least 280 days covered by this policy.

I. PHYSIOTHERAPY

The treatment of a disease, injury or deformity by physical methods such as massage, heat treatment and special exercise by a licensed physiotherapist registered with the Aruban authorities. The company will

reimburse for such an expense up to the maximum amount and number of visits as stated in the Schedule.

J. MENTAL DISEASES

A behavioral or mental pattern that causes significant distress or impairment of personal functioning. Such features be persistent, relapsing and remitting, or occur a single episode. Treatment by a specialist after referral of a physician.

- (a) Hospitalization – the first 365 days covered.
- (b) Out-of-Hospital Psychiatric visits
- (c) In hospital Medical Services
- (d) For the purpose of this provision all periods of hospital confinement for the care of treatment of mental or emotional illness, disorder or disturbance shall be deemed a single period of confinement unless the periods of hospital confinement are each separated by twelve consecutive months or longer during which the confined insured individual shall have resumed and continuously carried on the normal full time activities of a healthy individual of like age and sex. The Benefit afforded shall be available but once as to each such single period of hospital confinement.

Treatment is covered up to the maximum as stated in the Schedule.

K. INTENSIVE CARE

Intensive care in a licensed hospital for the treatment of severe or life-threatening illnesses and injuries, which requires constant care, close supervision from life support equipment and medication in order to ensure normal bodily functions. They are staffed by highly trained and skilled physicians and nurses who are specialized in caring for the critically ill patients. Intensive care will be covered to the maximum as stated in the Schedule.

L. ISOLATION ROOM

After referral by the treating specialist and if treatment and or the illness requires a stay in the Isolation Room will this be covered up to the maximum as stated in the Schedule.

M. AMBULANCE & AIRTRANSPORT

Transportation, by a specialized, official and licensed company or department, to and from the hospital or medical facility and to the airport or the boarding facilities. Coverages is limited to the amounts and times stated in the Schedule.

N. DENTAL BENEFIT

Expense for treatment by a dentist based in Aruba, qualified to practice and registered in the records of a competent authority.

PREVENTIVE PROCEDURES

- One oral examination per 6- month period,
- Cleaning twice a year once per 6-month period,
- fluoride application twice a year once per 6-month period,
- dental x-rays, except that
- bite wing x-ray are limited to one set in any one 6- month period;
- full mouth x-ray is limited to one set in any one 24- month period;

MINOR RESTORATIVE PROCEDURES

- First restoration: amalgam, silicate, acrylic or composite;
- Replacement of above, if an additional tooth surface is involved; or at least 12 consecutive months have passed since the last time the restoration was provided or replaced;
- treatment of periodontal and other diseases of the gums and tissues the mouth of;
- oral surgery of a dental origin;
- endodontic treatment, including root canal therapy.

MAJOR RESTORATIVE PROCEDURES

- First replacement of crowns, if the tooth is broken down by decay or traumatic injury and cannot be restored with an amalgam silicate, acrylic or composite restoration
- Replacement of crowns, if at least 12 consecutive months have passed since the last time the crown was provided;
- Replacement of gold inlays or onlays, if, the tooth is further broken down by decay or traumatic injury and an additional tooth surface is involved; or at least 12 consecutive months have passed since the last time the restoration was provided or replaced;
- First installation of a full or partial denture, or fixed bridgework, if; needed to replace one or more natural teeth, at least one of which is extracted after the effective date of the person's coverage under this benefit;
- Repair of denture (false) (prosthesis)
- Relining or adjustments to dentures, if;
- At least 6 consecutive months have passed since the denture was provided;
- Addition of teeth to the existing dentures or fixed bridgework, if; needed to replace one or more natural teeth at least one of which is extracted after the effective date of the person's coverage under this benefit;
- Replacement of:
 - * a full denture with a new full denture;
 - * a partial denture with a new partial denture; or
 - * a fixed bridgework with a new fixed bridgework, if:
 - (a) such replacement is needed to replace one or more natural teeth, at least one of which is extracted after the effective date of the person's coverage under this benefit; or
 - (b) the existing denture or fixed bridgework was installed 5 years prior to its replacement and cannot be serviceable.

Orthodontia; Only for insured under the age of 15 years old. 80% OF ALL CHARGES for Orthodontia for dependent children under age 15 up to a maximum of Awg. 3.000,00 expenditure over three years (LIFETIME)

ELIGIBLE DENTAL CHARGES

Eligible dental charges are those charges which are incurred by a person for dental procedure performed which:

1. are performed because of a result of any sickness or accidental bodily injury (a) which does not arise of or during course of any employment by the employee, and (b) for which he is not entitled to benefits under any Workmen's Compensation or Occupational Disease Law; and

2. are necessary care for treatment incurred on the recommendation of and performed by or under direct supervision of a legally qualified dentist,
3. are not more than excess of the regular and customary charges for the services performed or the materials furnished; and
4. are incurred for one or more of the following:
 - i dental services and supplies which are not excluded dental charges and are not otherwise excluded by the terms thereof,
 - ii dental x-ray examination.
5. Prior notice and evaluation of work done must be approved by the Company.

O. VISION CARE

For the cost of frame and standard white glasses every two years as mentioned in the Schedule.

- (a) Prescription must be recommended by an eye specialist and/or optometrist licensed to operate in Aruba.
- (b) One spectacle is allowed.
- (c) Valid for Dioptre 1-9 (Dioptre 10 up is covered under AZV).

LIMITATIONS

Eligible expenses shall not include charges for:

- (1) Injury arising out of the Insured's occupation.
- (2) Self-inflicted injury while sane or insane.
- (3) Injury of illness resulting from war, declared or undeclared, or any act of war of insurrection; or participating in a strike, riot, civil commotion or assault; or service in any military, naval or air force of any country while such country is engaged in war, or performing police duty as a member of any military or naval organization.
- (4) for services or material for cosmetic purposes, or repair of congenital malformation solely for cosmetic purposes, except charges for cosmetic dental procedures performed while insured and incurred because of result of and within twelve months after an accident suffered while insured for Dental Expense Benefits;
- (5) for orthodontic treatment (including treatment or correction of malocclusion), except charges for space maintainers for deciduous teeth this exclusion will not apply for dependent children;
- (6) for any dental procedure not initiated and completed while insured for Dental Expense Benefits, except charges for prosthetic devices ordered and fitted while insured hereunder and delivered not more than 31 days after the termination of such insurance;
- (7) for dental procedures performed by other than a licensed dentist, except dental prophylaxis performed by a licensed dental hygienist under the supervision and the direction of a licensed dentist;
- (8) for replacement of any lost or stolen denture, bridge, or other dental appliance;
- (9) for initial dentures and bridgework (including crowns, inlays and other abutment expense, except such dentures and bridgework necessary to replace teeth extracted while insured hereunder;
- (10) for replacement of existing dentures or fixed bridgework, unless the existing denture or bridgework has been installed five or more years prior to replacement and in the opinion of the attending dentist cannot be made serviceable;
- (11) for the addition of teeth to an existing partial removable denture or to replace extracted natural teeth, unless the natural teeth to be replaced were extracted while the patient was insured for Dental Expense Benefits hereunder;

- (12) for services or materials furnished during the first six- month period following the individual's effective date of coverage for Dental Expense Benefits unless such charge is incurred as a direct result of an accident occurring while so insured.
- (13) for extraction which are covered under the AZV-plan,
- (14) for prescription written by a dentist, other than antibiotics
- (15) Cosmetic surgery or treatment unless necessitated by an accidental bodily injury occurring while the insured is covered under this plan.
- (16) General health examinations.
- (17) Injury or illness resulting from racing on wheels or on horses or in boats, or water skiing or underwater diving or other hazardous sports.
- (18) Injury or illness resulting from participating in or in consequence of having participated in the committing of a felony or any attempt thereat.
- (19) Treatment to which the individual is entitled without charge or by any other insurance or payment plan.
- (20) Treatment of chronic alcoholism or drug addiction.
- (21) Rest cures, sanatorium or custodial care periods or quarantine or isolation.
- (22) Treatment for any disability which originated prior to the effective date of the insured's coverage hereunder; this exclusion will cease to apply, however, after two months of continuous coverage without medical expenses having been incurred for that disability.
- (23) Expenses due to the infectious ACQUIRED IMMUNE DEFICIENCY SYNDROME virus and related illnesses.
- (24) Repair of spectacle frames and replacement of broken lenses and loss of a/or both contact lenses.
- (25) Prescription for spectacles or contact lenses except that this would be paid once in two years.
- (26) Visits to an optician licensed to practice in ARUBA other than for the filling of prescriptions recommended by an eye specialist.
- (27) Treatment to which the individual would normally receive without charge, or which the charges are reimbursed by any other insurance or payment plan (but this exclusion shall only apply to the extent charges are reimbursed under such plan).
- (28) Charges that are more than the regular and customary charges for the services performed or the materials furnished.
- (29) Sunglasses.

GENERAL PROVISIONS

ENTIRE CONTRACT, CHANGES: This policy, including the endorsements and attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES:

- (a) After two years from date of issue of this Policy no mis-statements, except fraudulent mis-statements, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for loss incurred or disability as defined in this Policy) commencing after the expiration of such two years period.
- (b) No claim for loss incurred or disability (as defined in this Policy) commencing after two years from the date of issue of the Policy shall be reduced or denied claiming that a disease or physical condition not excluded from coverage by name or specific description effective date of loss had existed prior to the effective date of coverage of this Policy.

CANCELLATION BY THE INSURED: The insured may cancel this Policy at any time by written notice delivered to the Company effective upon receipt or on such date as may be specified in such notice.

NOTICE OF CLAIM: Written notice of claim must be given to the Company within thirty days after the occurrence or commencement of any loss covered by this Policy, or as soon thereafter as is reasonable possible. Notice given by or on behalf of the Insured or the Beneficiary to the Company, with information sufficient to identify the Insured, shall be deemed notice to the Company.

CLAIM FORMS: The Company, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filling proofs of loss. If such forms are not furnished within fifteen days after the giving of such notice the claimant shall be deemed to have complied with the requirement of the Policy as to proof of loss upon submitting, within the time fixed in this Policy for filling proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

DURATION AND TERMINATION OF THIS CONTRACT

This insurance starts on the commencement date and will be tacitly be renewed for the period specified in the policy. Nevertheless, this insurance will automatically terminate upon the policy anniversary on which the insured is age 65 next birth date. The acceptance by the Company of any premium or premiums after the Date of Automatic Termination shall make the Company liable for any benefits hereunder, but the Company shall refund to the Insured all such premium or premiums as soon as it is reasonable possibly after discovering the erroneous acceptance thereof.

WAITING PERIOD: Claims will not be considered for Medical Benefits within the FIRST TWO MONTHS of the date of issue of the Policy except for accidents.

Claims will not be considered for Dental and Vision within the FIRST SIX MONTHS of the date of issue of the Policy.

PROOF OF LOSS: Written proof of loss must be furnished to the Company at its Office in case of claim for loss for which this Policy provide any periodic payment contingent upon continuing loss for which the Company is liable and in case of claim for any other loss within ninety days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIMS: Indemnities payable under this Policy for any loss will be paid upon receipt of due written proof of loss.

PAYMENT OF PREMIUM: All premiums are payable in advance to the Company, in accordance with the Company's premium rate effect on the date of each renewal. The payment of any premium shall not continue this Policy in force beyond the date when the next premium is due and payable except as may otherwise provided herein.

PREMIUM INCREASE: Rates are guaranteed only if hospital tariffs remain in force for three consecutive years, any other increases will be based on claims experience.

REFUND PREMIUM: No premiums will be refunded unless the insured has emigrated. For the first year of insurance there will be no refund of premium and for the consecutive years if a claim has been paid.

METHOD OF REFUND:

Refund on ANNUAL premiums will be:

After 3 months- 8 months refund

After 4 months- 7 months refund

After 5 months- 6 months refund

After 6 months- 5 months refund

After 7 months- 4 months refund

After 8 months- NO REFUND

AGE LOADINGS: 45 – 50 PREMIUM INCREASES BY 20%

51 – 65 PREMIUM INCREASES BY 40%

SUPPLIES OF PHARMACEUTICALS NOT COVERED

Medicated soaps, toiletries, cosmetic compounds, band aids and bandages, birth control pills, vitamins, weight control pills, drugs because of pregnancies, cold tablets, cough mixture and anti-histamine, homeopathic drugs, alcohol, antiseptics, eye drops (murine, visine, optrex) vaccinations.