MEDICAL ASSISTANCE BENEFITS

The company hereby agrees that the following provisions shall form part of the Contract.

DEFINITIONS

1. The term "Hospital" means an institution which:
   (a) is licensed as a Hospital(if Hospital licensing is required where it is situated),
   (b) is open at all times,
   (c) is operated primarily for the care and treatment of sick and/or injured persons as in-patients,
   (d) has a staff of one or more licensed physicians available at all times,
   (e) provides continuous 24-hour nursing service by graduate registered nurses(R.N.),
   (f) provides organization facilities for diagnosis and major surgery, and
   (g) is not primarily a clinic, nursing, rest of convalescence home or similar establishment.

2. The term "one continuous period of disability" means a period of time during which a person is disabled. Successive periods of disability due to the same or related cause or causes shall be considered one continuous period of disability unless they are separated by:
   (a) with respect to the employee, two or more weeks of continuous employment with the Employer on a full time basis, or
   (b) with respect to the dependent, a period of three or more months which no total disability due to the same or related cause or causes occur.

3. The term "one continuous period of Hospital confinement" means a period of time during which a person is confined in a Hospital as a registered bed patient. Successive periods of Hospital confinement due to same or related cause or causes shall be considered one period of Hospital confinement.

4. The term "illness "means a bodily disorder or disease, or accidental bodily injury. All bodily injuries sustained by an individual in a single accident, or all illnesses which are due to the same or related cause or causes shall be deemed one illness.

   Eligible charges will NOT include charges for:
   (a) illness – with respect to non specific anaemia,
   (b) allergies,
   (c) assistant to the surgeon,
   (d) blood bank.

5. The term "cosmetic surgery" means the surgical alteration of tissue for the improvement of bodily or facial appearance rather than improvement or restoration of bodily function.

6. The term "physician" means a legally qualified physician other than a relative of the insured.

7. The term "In-Patient" means a registered bed patient in a hospital who is charged for at least one day's room and board by the hospital.

8. The term "dependent" as used in the Policy, shall mean any of the following persons:

   (a) the eligible person's spouse unless legally separated from such person,

(b) the eligible person's unmarried children who are more than two weeks but less than 18 years of age. The word "children" as used herein shall include the eligible person's step-children, legally adopted children and foster children, provided such children are primarily dependent upon such person for support and maintenance in accordance with (b) above.

9. The term "Covered Dependent" as used herein shall mean each dependent, as defined above, or a person who is insured with respect to Dependents Coverage.

10. The term "Maximum Benefit" means the stipulated tariff for hospital daily room and board, hospital charges and doctor's fees in the particular area of the Netherlands Antilles & Aruba.

11. The term "reasonable and customary "means the usual charge made by the person, group or other entity rendering or furnishing the services, treatments or materials but in no event meaning a charge in excess of the general level of charge made by other rendering or furnishing such services, treatment or materials to person of similar income or net worth within the area in which the member normally resides, for illness comparable in severity and nature to the illness being treated. The term 'area" as applicable to any particular services, treatment or material meaning a country or such greater area is necessary to obtain in representative cross section or persons, groups or other entities rendering or furnishing such services, treatment or material to persons of similar income or net worth.

12. The term "intensive care unit" means a section, ward or wing within the hospital which is separated from other hospital facilities and:

    (a) is operated exclusively for the purpose of providing professional care and treatment for critically ill patients, has special supplies and equipment necessary for such care and treatment available on a stand by basis for immediate use, and
    (b) provides constant observation and care by registered professional nurses or other highly trained hospital personnel,
    (c) for those hospitals which make a separate charge for Room and Board and a separate charge for intensive Nursing Care is eligible,
    (d) for those hospitals which make a combined charge for Room and Board and intensive Nursing Care, that portion of the combined charge is in excess of the hospital's prevailing semi-private Board and Room Rate will be considered as the eligible charge for Intensive Nursing Care.

NOTE: A hospitalization facility maintained for the purpose of providing normal post-operative recovery treatment or service is not considered as an "intensive care unit".

A. HOSPITALIZATION

The Company shall pay the expenses incurred by the insured or a Covered Dependent for:

(1) hospital room and board furnished to the Insured or a Covered Dependent 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 Policy Schedule,

    (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 Policy Schedule of Insurance

Successive period of hospital confinement shall be considered as having occurred during one continuous period of disability unless the subsequent confinement is due to an injury or sickness, entirely

unrelated to the causes of the previous disability 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) Miscellaneous Services furnished to the Insured and Covered Dependent on any day for which benefits are payable except that:

(a) with respect to all such expenses incurred for Miscellaneous Services during one period of such hospital confinement, such payment shall not exceed the Miscellaneous Expense Benefit stated in the said Policy Schedule,
(b) with respect to the term "Miscellaneous 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 actually made for the following services furnished in connection with such treatment, such amount not exceed the amount shown for this benefit in the Policy 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 Miscellaneous Services.

B. SURGICAL EXPENSES

The Company shall pay the expenses incurred by the Insured or a Covered Dependent 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 or not, 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 actually incurred by such person, for such operation or the Maximum Payment stated for such operation in the Surgical Schedule of Surgical Operations and
(3) the total payment for all such operations performed during any one period of disability shall not exceed the Maximum Benefit stated in the Policy 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 Policy Schedule for the Surgical Operations,
(5) assistant to the Surgeon shall not be covered.

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

C. SPECIAL MEDICAL EXPENSES

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 or Covered Dependent for necessary medical treatment, services or supplies hereinafter described furnished directly to the Insured or Covered Dependent for the sole purpose of treating accidental bodily injury sustained or sickness contracted and commencing while the Insured or Covered Dependent 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 Policy 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 or Covered Dependent has been referred by his/her attending physician, but not to exceed the Maximum per Consultation shown in the Policy Schedule.
(3) Ethical drugs prepared by a registered pharmacist in accordance with a prescription by the Insured's or Covered Dependant's attending physician or surgeon while the said covered person is not hospitalized but not to exceed the maximum benefit shown in the Policy Schedule during any one calendar year. Drug bills must be specified with the name of the prescribed drugs.
(4) If, as 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 indicated in the Table of Diagnostic X-Ray and Laboratory Benefits below, 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.
(5) Prevention treatments:
Benefits will be paid for costs incurred for the following examinations and/or procedures by a general practitioner or specialist:
(a) Breast cancer examination (mammography)
(b) Cervical cancer examination (Pap smear) once a year.
(c) Prostate cancer examination once a year for insured persons older than 45 years.

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.

D. MATERNITY.

Upon receipt by the Company of due proof that the Insured, if female, or the wife of the Insured, if also covered under this Policy, has been confined in a hospital on 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 Policy Schedule.
Normal Delivery in Hospital – Doctors fee: fls. 850,=
at Home - Doctors fee: fls. 350,=
Hospital Care – reimbursement of 80% of 10 days MAXIMUM.

1 consult per month is covered up to a maximum of 10 consultation per maternity case.
Echo: 100% of the charges will be reimbursed up to 3x per maternity case.
Caesarean Section will be covered under normal Hospital Services Benefits and Surgery.

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 proceeding Surgical Expense Benefit. For this benefit insured must be at least 280 days covered.

E. DENTAL BENEFIT

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

PREVENTIVE PROCEDURES 100%

-One oral examination in each 6 month period, including scaling and cleaning of teeth (up to maximum of Naf. 75.00).
-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;
-one application of fluoride in each 6 month period.

MINOR RESTORATIVE PROCEDURES 80%

-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 50%

-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 on lays, 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 or 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.

MAXIMUM COVERAGE PER YEAR Naf. 2,000.00

80% OF ALL CHARGES FOR Orthodontia for dependent children under age 15 to a maximum of Naf. 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 as a result of any sickness or accidental bodily injury (a) which does not arise of or in the 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 in 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.

EXCLUDED DENTAL CHARGES ARE

1. 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 as a result of and within twelve months after an accident suffered while insured for Dental Expense Benefits;
2. 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;
3. 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 subsequent to the termination of such insurance;
4. 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;
5. for replacement of any lost or stolen denture, bridge, or other dental appliance;
6. 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;
7. 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;
8. 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;
9. 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.Written proof of accident should be presented to the company.
10. claims will be considered after six months;
11. NOT COVERED are prescription written by a dentist, other than antibiotics.
12. Dental treatment abroad.

F. OVERSEAS TREATMENT

(a) Services must be recommended by a regular attending General Practitioner and a Specialist or prior approval of the company.
(b) The medical services must be necessary and customary.
(c) 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.
(d) Normal and customary charges will apply for services which can be had in Curacao and Aruba and conversions currency may not apply if insured seek medical attention abroad without qualifying under A,B or C.

G. TRANSPORT BENEFIT

(a) Transportation to and from the airport of entry by ambulance to local hospital.
(b) Transportation by air to an amount of 80% of the cost of air fare to a maximum payment of Naf. 2,000.00 no more than twice a year. Insured must spend at least 3 days in hospital to warrant the use of this benefit.

H. MENTAL DISEASE BENEFIT

(a) Hospitalization – the first 365 days covered.
(b) Out-of-Hospital Psychiatric visit – a maximum of Naf. 1,000.00.
(c) In hospital Medical Services – a maximum of Naf. 1,500.00 per year.
(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.

I. VISION CARE

Expense for prescription recommended by an eye specialist or an optometrist licensed to operate in Curacao.

The cost for frame and standard white glasses or contact lenses will be reimbursed according to the amount stated in the schedule of benefit.

No expenses will be reimbursed for:

1. Repair of spectacle frames and replacement of broken lenses and loss of a/or both contact lenses.
2. Prescription for spectacles or contact lenses except that this would be paid once in a two year period.
3. Visits to an optician licensed to practice in Curacao other than for filling of prescriptions recommended by an eye specialist.
4. 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 that are reimbursed under such plan).
5. Charges that are in excess of the regular and customary charges for the services performed or the materials furnished.
6. For sunglasses.
7. The first three months.

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) Cosmetic surgery or treatment unless necessitated by an accidental bodily injury occurring while the insured is covered under this plan.
(5) General health examinations.
(6) Injury or illness resulting from racing on wheels or on horses or in boats, or water skiing or underwater diving or other hazardous sports.

(7) Injury or illness resulting from participating in or in consequence of having participated in the committing of a felony or any attempt thereat.
(8) Treatment to which the individual is entitled without charge or by any other insurance or payment plan.
(9) Treatment of chronic alcoholism or drug addiction.
(10) Rest cures, sanatorium or custodial care periods or quarantine or isolation.
(11) 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.
(12) Expenses due to the infectious ACQUIRED IMMUNE DEFICIENCY SYNDROME virus end related illnesses.

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 on the ground 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 furnish 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.

AUTOMATIC TERMINATION

This policy shall automatically terminate upon the policy anniversary on which the insured is age 60 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 within the FIRST TWO MONTHS of the date of issue of the Policy except for accidents.

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 maybe otherwise provided herein. Premiums as stated in the policy are annual premiums paid in advance. Any other arrangement agreed on the method of payment other than annually does not void the right of the Company to collect the annual premium."

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

REFUND PREMIUM: No premiums will be refunded unless the insured has emigrated or has changed his class of Benefit, and if claims are paid there will be also no refund. **FIRST YEAR OF INSURANCE NO REFUND**.

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 - 59 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.

These drugs are NOT COVERED even though they are prescribed by a house doctor or a specialist.

Arbitration

In the event of arbitration the Medical Advisor of the Insurance Company will be the final consideration.

Notification

The Company reserves the right to request a medical examination prior to the acceptance of the insurance.