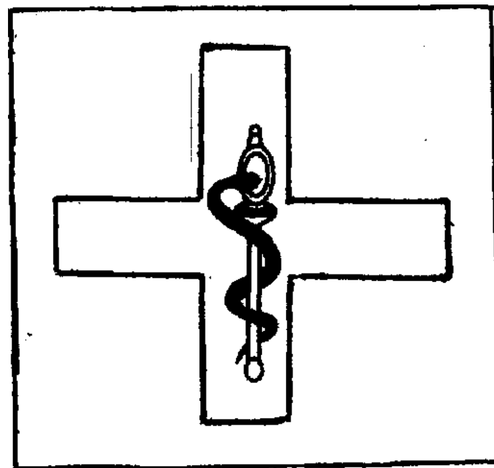
NATIONAL GENERAL INSURANCE CORPORATION N.V.
P.O. Box 79
I- airplay Complex
The Valley, Anguilla
Tel: 264-497-2976 • Fax: 264-497-3303

NAGICARE GOLD HEALTH POLICY



**"Quite simply, one of the best...
private health care plans that money can buy."**

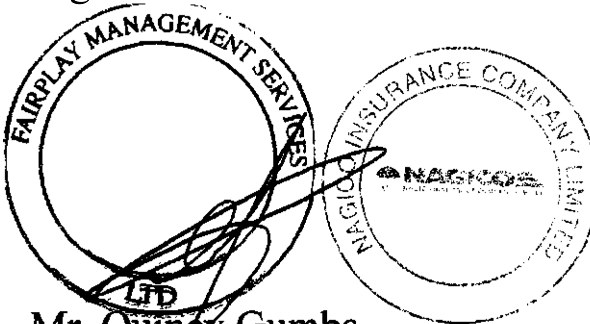
National General Insurance Corporation N.V.

Insured Name: The Government of Anguilla **Endorsement: 1**

Policy Number: AGLH029/09 **Effective Date: November 1,2009**

It is agreed and understood that the names of Employees of the government and benefices provided by the treasury department form the basis of this policy and will be deem to be the official list until all applications are been submitted and process.

Sign for and on behalf of the company



Mr. Quincy Gumbs
Manager
Fairplay Insurance

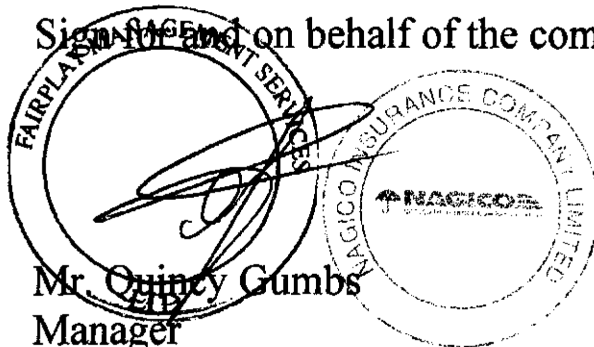
NAGICO
NAGICO INSURANCE COMPANY LIMITED

Insured Name: The Government of Anguilla **Endorsement: 2**

Policy Number: AGLH029/09 **Effective Date: November 1,2009**

It is agreed and understood that it is the responsibility of the Government of Anguilla through it establishment department to collect the health insurance cards from any employee give notice of resignation from the Government service. They will notify the insurance company of the date of the employee departure from the service and when the redeem card will be return to the insurance company. Should there be a failure to follow the procedure above the Government will be held responsible to pay the premium of that said employee until formal notices is given and the card return to the company.

Sign for and on behalf of the company



Mr. Quincy Gumbs
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Albert Lake Drive .P.O. Box 428 .The Valley -Anguilla -B.W.I.
T (264) 497-5940 «F (264) 497-0510 .info@nagico.com .www.nagico.com

NAGICO
NAGICO INSURANCE COMPANY LIMITED

Insured Name: The Government of Anguilla **Endorsement: 3**

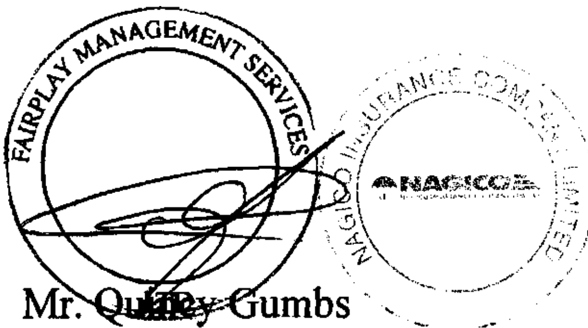
Policy Number: AGLH029/09 **Effective Date: November 1,2009**

It is hereby agreed and understood that all persons deem to be terminally ill and employed by the Government of Anguilla as of November 1, 2009 is included for an extra 10% of the total premium. The coverage provided is limited to Life Time Coverage of EC$200,000.00 with an annual maximum of EC$ 100,000.00.

It is understood that the persons covered under this endorsement will be excluded form life insurance coverage.

All other Terms and Conditions of this policy remain the same.

Sign for and on behalf of the company



Mr. Quincy Gumbs
Manager
Fairplay Insurance

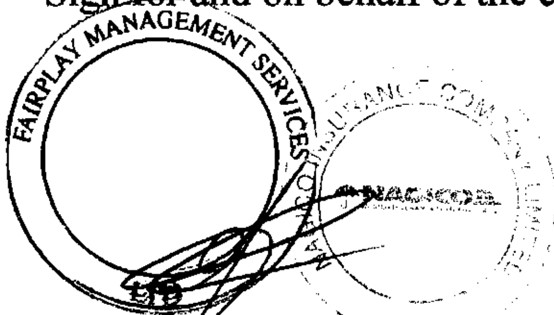
Insured Name: The Government of Anguilla **Endorsement: 4**

Policy Number: AGLH029/09 **Effective Date: November 1,2009**

It is hereby understood and agreed that the effective inception date of this policy that the maximum amount under the policy allowed for **Organ Transplant** is **EC$100,000.00.**

A11 other Terms and Conditions of this policy remain the same.

Sign for and on behalf of the company



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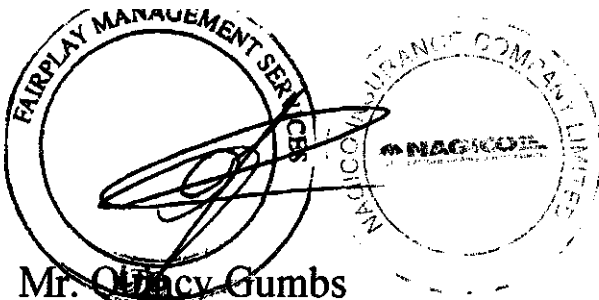
Insured Name: The Government of Anguilla **Endorsement: 5**

Policy Number: AGLH029/09 **Effective Date: November 1,2009**

It is hereby understood and agreed that except in case of critical emergency all none regional referrals must be pre-certify by the insurance company. Who will act as quickly as possible to ascertain the best possible hospital to recommend the patient.

Facilities recommended by the doctors will also be considered.

Sign for and on behalf of the company



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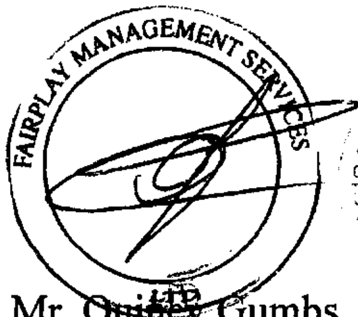
Insured Name: The Government of Anguilla **Endorsement: 6**

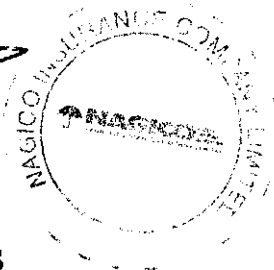
Policy Number: AGLH029/09 **Effective Date: November 1,2009**

It is hereby understood and agreed from the inception date of this co insurance policy that the policy is strictly 80%/20% and that all medical providers will be responsible for the collection of 20% of the cost of service from the card holders.

All other terms and condition of this policy remain the same.

Sign for and on behalf of the company





Mr. Quincey Gumbs
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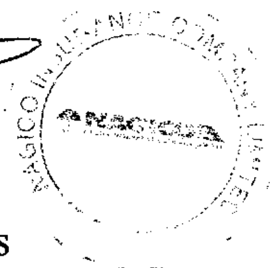
NAGICO
NAGICO INSURANCE COMPANY LIMITED

Insured Name: The Government of Anguilla **Endorsement: 7**

Policy Number: AGLH029/09 **Effective Date: November 1,2009**

It is hereby understood and agreed that the bid submitted to the Tenders Board by Fairplay Agencies Ltd with NAGICO Insurance Company Ltd is the insurance carrier. Inclusive of all its attached Terms and Conditions including amendments form part of this policy and should be read as one with the policy.

Sign for and on behalf of the company



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NAGICO INSURANCES

Schedule of Benefits

Government of Anguilla Medical Insurance

Item No	Item	Govt. Request	Company Offer
1	Medical Expenses (max)	EC$ 1.0 Million	EC$ 1.0 Million lifetime. EC$400,000 max any one year per person
2	Life Benefits (max)	EC$ 50,000.00	EC$ 50,000.00
3	Accident Death Benefit (max)	EC$ 50,000.00	EC$ 50,000.00
4	Dismemberment (max)	EC$ 25,000.00	ECS 25,000.00
5	Air Ambulance (max)	EC% 40,000.00 per accident	EC% 40,000.00 per accident
6	PPO / Network	100%	80% with referral up to EC$100,000.00,100% thereafter
7	Aids/Drugs	EC$ 10,000.00/Treatment	EC$ 10,000.00 /Treatment
8	Treatment (Area of Validity)	100%	80/20% up to EC$100,000.00,100% thereafter
9	Operations PPO/Network	100%	80/20% up to EC$100,000.00,100% thereafter
10	Regular Airfares	EC$ 3,000.00 Per Accident	EC$ 3,000.00 Per Accident
11	PCS / Pharmacy	As Medical	As Medical 80/20%
12	Maternity (Local or without referral)	EC$3,000.00 (Normal Delivery)	EC$3,000.00 (Normal Delivery)
13	Maternity (Oversees)	As Medical	2x No.12
14	Income for Disability	. Optional	Not Covered
15	Overseas Outside PPO /Network	Standard Policy.	Standard Policy with referral
16	Max Age	69 Years	69 Years
17	Pre Certification	Penalty 50% for first EC$ 10,000.00	Penalty 50% for first EC$ 10,000.00
18	Admission on Weekends	Optional	Covered
19	Diagnostics	100%	80/20%
20	Mental and Nervous Disorder	Max EC$25,000.00	Max EC$25,000.00
21	Artificial Implants	Optional	Optional
22	Organ Transplant	MaxEX$53,000.00	Max EX$100,000.00
23	Birth Defects	As Medical	As Medical for 14 days only
24	Out patient Drugs	100%	80/20%
25	AIDS/HIV	Max EC$50,000.00	Max EC$50,000.00
26	Out of Pocket	Max EC$2,000.00	Max EC$2,000.00 on overseas travel expenses (hotel, meals etc.)
27	Pre Existing Conditions	6 Months	6 Months
28	Vision		Optional
29	Dental		Optional
30	Retirees		see notes

Notes:

No.6 PPO/Network:

NAGICO maintains a PPO Network with United Healthcare International (USA) and Innovative Quality Consulting, Corp. (Puerto Rico). However, NAGICO will recognize all Health care providers within the Area of Validity. Outside Area of Validity NAGICO will accept all claims referred by the chief Medical Adviser (CMO).

NO.8 Area of Validity:

Anguilla, St. Maarten, St. Martin and the rest of the English speaking Caribbean.

Coverage also applies outside the Area of Validity while on vacation or business trips as follows:

A: for acute and existing cases on medical indication, after agreement of our chief Medical Adviser (CMO), reimbursement will be made up to maximum two times the local tariffs of the most recognized hospital in the area of validity;

B. for non-acute and existing cases, on referral, which require treatment abroad due to non-availability in the Area of Validity, the costs shall be compensated in accordance with (A) above. The Company will further reimburse hotel accommodation costs for referred cases which do not require hospitalization:

C. For non-acute and existing cases without prior agreement of our Medical Adviser, reimbursement will be made according to the local tariffs of the most recognized hospital in the Area of Validity.

No. 14 Hospital/Provider of Choice:

a. Patient may choose Hospital/Provider of Choice within Area of Validity. Benefits will be paid at 80%,

b. Referral Endorsement number 5

c. Hospitals/Providers outside of Area of Validity without referral will be paid at the rate of the Princess Alexander Hospital.

d. Accommodation for parent or guardian accompanying patient in hospital overseas.

No. 16 Pre-Certlfication:

All elective surgery and maternity procedures must be certified.

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No. 27 Pre-existing Conditions:

All pre-existing condition honored by previous carrier will be accepted as is. However, all new applicants will be subject to a 6 month waiting period and all terminally ill persons would be excluded.

No. 28 Vision:

Coverage:

Lenses will be paid based on the prices listed below:

Complete eye examination	$136
Lenses (per lens)	
Single	$154
Bifocal	$330
Multifocal	$375
Frames (Standard)	$135
Contact Lenses (pair)	$206

Lenses are limited to one set per 12-month period and frames to one per 24-month period. Eye examinations are limited to one per 12-month period. Replacement if glasses or duplicate set are excluded. Also excluded are conditions which already existed, or for which there already were complaints, before or while applying for the insurance and of which the insured was aware at the moment or for which the insured received medical or surgical advice or treatment within 12 months prior to the date coverage begins.

No. 28 Dental:

A: The plan will cover 80% of the cost of procedures done at the Dental Unit in Anguilla. Procedures performed at any private establishment within the Area of Validity will be reimbursed at 50% of the cost. Students covered under the plan will be reimbursed for 50% of the dental expenses incurred while outside the Area of Validity. The Maximum allowable per calendar year is $1,000.00, subject to a compulsory half-yearly examination, the cost of which is exclusive of the maximum allowable under the plan.

No compensation shall be granted for the costs of oral orthopedic treatment (orthodontics) and straightening of teeth and dental prostheses, -except when the prostheses are necessitated by an accident. Dental prostheses are understood to mean full or partial dentures, a bridge or parts of a bridge. Compensation is also excluded for replacement of lost or stolen prostheses;

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Compensation for treatments with gold fillings is given on the basis of treatment with other materials (such as plastic, porcelain etc.)

No. 30 Retirees:

Retirees will be covered up to the age of sixty nine (69) providing that an additional Premium of seventy-five percent (75%) will commence at age fifty-five (55). Life and ADD coverage will be excluded.

MEDICAL INSURANCE BENEFITS

- Highlights of the Policy
- Lifetime EC$1.0 million
- Hospital all others 80%
- Maternity coverage, maximum EG$3,000.00; Normal Delivery.
- Dental Care for children up to age 18
- Dental care for adults
- Air Ambulance Service up to EC$40,000.00.
- Coverage for disabled dependent chifdren
- Vision Care

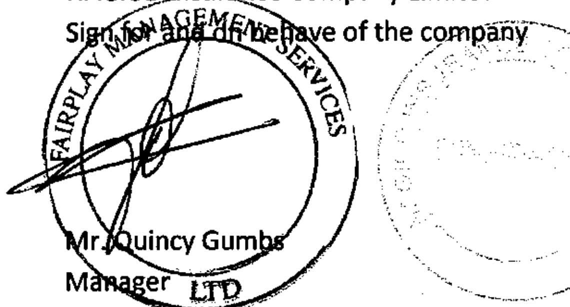
Other Notes:

1. Children are covered at EC$65.00 monthly per child. A child is between the ages of 0 to 18. However children in higher institutions of leaming will be covered up to age 24, with a change of premium of ECS130.79 at age 18.
2. The policy will be a strict 80/20 co-insurance policy, meaning that the insured pays the 20% and the insurance company pays 80% of the cost.

Sincerely,

NAGICO Insurance Company Limited

Sign for and on behave of the company



Mr. Quincy Gumbs

Manager

Fairplay Insurance

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01. DEFINITIONS

01.1. NAGICO (National General Insurance corporation N.V.)

NAGICO N.V.(hereinafter called the Company) established in Phi.lips.burg, St.Maarten, Netherlands. Antilles.

01.2. Subscriber

1: The person who signed the application for coverage
or
2: In the case of group insurance, an Employer who is insuring no less than ten (10) Employees.

01.3. Insured

The person or persons with whom this agreement is executed and mentioned as such in the Policy schedule or an endorsement thereto and registered in the records of the Company.

01.4. Policy

The agreement between the Company and the Subscriber. The Policy includes any application forms, the last issued, identification card(s), this Policy and any amendment(s) which is issued under this Policy.

01.5. Area of Validity

All territories where the Company or an authorized representative thereof is registered to conduct, business, namely Netherlands"Antilles, Aruba, French St. Martin, Anguilla, Dominica, Antigua and Tortola.

01.6. Provider

An organization or person registered in the area of validity performing or supplying health care services, supplies or medicines«.

01.7. Prescription Medicines

Substances registered in the area of validity which under the Medicine Act, other than, those administered by injection by the attending physician, are used in the cure or treatment of a disease or illness; can only be obtained upon a doctor's prescription; and are approved by the Company as prescription medicines.

01.8. Hospital

An institution or sanatorium, situated in the area of validity, licensed or approved by the appropriate regulatory agency and/or'the Company which on an in-patient basis is'primarily engaged in providing diagnostic and therapeutic facilities ror surgical and medical diagnosis and treatment and in care of obstetrical'cases, and for which it charges and receives compensation from, its patients, and whose facilities or services are under the supervision of or rendered by a staff of doctors who are duly licensed to practice medicine, and which continuously provides twenty-four (24) hours a day nursing service under the supervision or direction of registered graduate nurses.

01.9. General Practitioner

A physician established in the area of validity, who Is registered with the competent government authorities in the register of physician's, and who carries on general practice'in the generally accepted manner. With carrying on general practice shall be understood the rendering of medical assistance both at the home of the insured and during the consulting hours of the physician.

01.10. Medical Specialist

A physician established in the area of validity who is specialized in a certain branch of medicine through studies and training, to which the necessary recognition has been given, and who is registered in the register of physicians with the competent government authorities.

A dentist established in the area of validity, who is specialized in mouth diseases and oral surgery through studies and training, to which the necessary recognition has been given, and who is registered in the register of dentists "with the competent authorities

Specialist treatment is understood to mean treatment or examination according to accepted general medical standards and within the specialty for which the specialist is registered.

01.11. Birthing Center

An approved freestanding maternity facility recognized, or provisionally recognized, as such by the competent government authorities which is operated for the purposes of monitoring normal pregnancies and performing uncomplicated deliveries.

01.12. District maternity care

The care given to mother and child by a maternity nurse connected with a maternity centre, as a rule twice a day in the first week, and thereafter once a day or, if medically required, more than once a day.

01.13. Midwife

A midwife established and practising in the area of validity, who is registered as such with the competent authorities.

01.14. Dentist

A physician established in the area of validity who is legally qualified to practise dentistry and who is registered in the register of dentists with the competent government authorities.

01.15. Physiotherapist

A physical therapist established and practising in the area ot validity, who is registered as such with the competent government authorities.

01.16. Speech therapist

A speed} therapist established and practising in the area of validity, who is registered with the competent government authorities.

01.17. Laboratory

An institution recognized, or provisionally recognized, as such by the competent authorities.

01.18. Case of Illness

A. case of illness is understood to mean each uninterrupted need for medical treatment arising from the same cause(s) of illness or same accident. All bodily injuries sustained in any one accident shall be considered one disability. All bodily disorders existing simultaneously" which are due to the same or related causes, shall be considered, one disability. If a disability is due to causes which are the same or related to the cause of a prior disability (including complications arising there from) the'disability"shall be considered a continuation of the"prior disability and not a separate disability. However, for cases requiring hospital confinement, after 90 (ninety) days following the latest discharge from the hospital, subsequent hospital confinement arising from the same cause shall be considered a new disability; for cases not requiring hospital confinement, a new-disability is established after a period of 90 (ninety) days has elapsed following the day upon which the last reimbursement expense was incurred, unless expenses are not reimbursed because of the exhaustion of the Maximum. In-Hospital Benefit Period as specified in the Policy.

01.19. Practitioner_of alternative healing methods

Is an established doctor in the area of validity, who is authorized by the competent authorities in charge to exercise this method.

01.20. <u>Accident;</u>

By accident is meant a sudden external violent impact on the body of the Insured. By accident is also meant:

a. Freezing, burning, drowning, striking by lightning
or any other kind of electrical discharge, etching through caustic fluids, suffocation (not as a result of sickness) and sun-stroke;

b. Sun-burn, exhaustion, starvation, dehydration, resulting from involuntary isolation,' such as shipwreck, emergency landing, a. collapse or a catastrophe;

c. Involuntary penetration of particles or objects from the outside into the respiratory tract, the digestive tract, the auditory" ducts and. the eyes, as a result of which internal injury is caused;

d. Spraining, dislocation, muscular rupture, even if caused by a sudden voluntary exertion of strength, provided they are accompanied by externally visible symptoms.
A herniated vertebral disc (hernia nuclei pulposi) and abdominal hernia are not considered an accident or the result thereof, unless the medical adviser of the Company finds causal connection with a recent accident plausible;

e. Complications and deterioration resulting from, a first aid or medical treatment required because of an accident.
Except as provided in the preceding paragraph, any kind of medical operation leaving ill-effect in not considered an accident either;

f. Acute poisoning by inhaling gases, vapor, solid or liquid substances, with the exception of the use of medicines or stimulants;

g. Contamination, by disease germs as a result of an involuntary fall into water or any other liquid or solid substance;

h. Infection and blood poisoning as a consequence of penetration of disease germs into an injury caused by an accident, provided nature and place of the injury can be medically ascertained. An. insect bite or stinq shall not be considered an injury caused by an accident;

i. Splenic fever and cow-pox (for those insured who are in regular contact with cattle on account of their profession)

j. Accidental injuries to natural teeth (not related to eating, biting or chewing) . Treatment in connection with the replacement of "such natural teeth must be given within, six (6) months of the accident.

01.21. Deductible (Optional)

A per calendar year (Jan. 1 - Dec. 31) deductible, if selected, is applied, with a maximum of three (3) deductibles per family. Under "Family" coverage, when a family member's expenses reach, the" deductible each calendar year, that, person alone is will receive benefits.

After three (3) family members reach the deductible, in any combination, then all covered family members are eligible to receive benefits for that year without any additional deductibles.

01.22. Dependent

The Subscriber's legally recognized spouse under age sixty-one (61) and/or unmarried children who have not attained age nineteen (19) at the time of application.

01.23. Eligibility

Coverage is only available for full-time legal residents of the area of validity. Residency must be for at least seven (7) or more months per calendar year.

Dependents covered under family contracts must also be full-time residents of the area of validity. Coverage is only extended to dependents living abroad," who are" full-time students at a college or university and. for whom a notarized Student Certification Form has been submitted.

Coverage is not provided to persons working outside of the area of validity on a permanent or temporary basis.

Individuals may apply for Self-Only or Family coverage. Enrollment according to marital status is not necessary.

Eligible dependents under family coverage include:

1. Your spouse;
2. Your unmarried dependent children, if any, until the end.
   of the Policy year in which each reaches nineteen (19) years of age. Dependents include foster children (placed
   by the government) and legally adopted children, children who live in a parent/child relationship and for
   whom the Dependent Questionnaire has been completed and
   notarized stating that the child is financially dependent upon the Subscriber;
3. Your unmarried dependent children, age nineteen (19) or
   older if they cannot support themselves because of mental or physical disease or defect which occurred prior to age nineteen (19) . A disability Certification
   will. be required;

4. Your unmarried dependent children, aae nineteen (19) or older if they are full-time students in accredited schools or colleges. (A Student Certification is required and can be obtained from your Aqent/Broker or our Head Office) . Students are covered until aqe twenty-four (24).

The Subscriber and all eligible dependents, if any, are subject to satisfactory evidence of insurability and must:

a) Complete and submit an Application form (I NCG-001/93) ;

b) Complete and submit Part 2 (LTL f 3-10/90) , side A, of the application if between thirty-five (35) and forty-five (45) years of age at the time of the application. In most cases, no medical examination will be necessary.

Subscribers forty-six (46) years of age and older must have a physical examination and complete and submit Part *2* (LTL f 3-10/90), side A & B, at the time of application.

The Company does not pay for medical reports, completing of claim forms or similar information which it may need.

01.24. <u>In-patient</u>

A person admitted to an approved hospital, skilled nursing facility or other health care facility for overnight stay.

01.25. out-patient

A person who is receiving services or supplies while not an in-patient in an approved hospital, skilled nursing facility or other'health care facility.

01.26

The period from the time the Insured enters a hospital, approved skilled nursing facility, or any other health care facility as an in-patient until discharge. The date of service for any admission is the date that the Insured enters the facility. Benefits for room and board charges are provided for the day of admission or the day of discharge, but not both.

01.27. Allowable Charge

The fee or price the Company determines to be reasonable & customary for services provided. This charge is based on the amount the provider usually charges for the service, the average of fees or prices providers usually charae in similar cases and the officially approved rates or the rates as laid down in the guidelines of the National Association of Specialists in the Netherlands Antilles or similar association in the area of validity. In the absence of officially approved guidelines and/or rates,, the Company will make an independent determination of the value of the service. The Insured is responsible for the payment of any balances over the allowable charge.

01.28. Durable Medical^Equipment

Orthopedic braces, artificial devices replacing body parts and other equipment customarily and generally useful, to a person only during an illness or injury and determined by the Company 'to be medically necessary.

01*29. Pre-existing Condition Waiting Period

Subject to the provisions herein stated, benefits under this Policy shall be available to a subscriber for the following, only after he/she has been covered under this Policy for a period of six (6) consecutive months, except benefits shall be available to a Family Member under Family Coverage only after the Family coverage has been in effect for a period of six(6) months, immediately preceding the date of which a covered service or supply is first rendered to the Subscriber:

* Pre-existing conditions: namely, any illness (including any condition resulting from or arisinq out of and during pregnancy) which existed on the Effective Date or which existed with respect to an added Family Member when such Family Member became a Participant under this Policy, the symptom(s) of which (including conception in the case of pregnancy) were present on or before the Effective Date of coverage, whether or not the subscriber had knowledge that such symptom(s) were related to such illness; or any illness (including any condition resulting from or arising out of and during pregnancy) for which medical or surgical treatment or advice has been rendered within' twenty-four (24) months prior to the date on. which'this Policy became effective for the Subscriber requiring the service. Any maternity benefits will not be covered by this program during the first ten (10) months of coverage.

* Complicationsresultingfrompre-existing conditions;

* Tonsillectomies and/or adenoidectomies, including complications resulting there from, if for a pre-existingcondition;

* Sterilization, including complications resulting there from.

The waiting period stated, above shall not be applicable to:

1. Any newborn to a. Subscriber with existing Family coverage or if a mother's Self- Only coverage is converted to Family coverage within thirty (30) days from the"* date of""birth; and

2. Conditions, abnormalities, complaints and/or pregnancy if the Subscriber has notified the Company in writing and no special conditions were set when the coverage was accepted.

01.30 Medically

Those services or supplies which are provided by a hospital, physician or other approved medical provider that are required to identify or treat an illness or injury and which, as determined by the Company, are:

a. consistent with the symptom, or diagnosis and treatment of the condition, disease or injury; and

b. appropriate with to standards of accepted professional practice; and not solely for the Insured's convenience, the physician's convenience or any other provider's convenience; and

c. the most appropriate supply or level of service which can be provided.

When applied to an in-patient, it further means that the medical symptoms or condition require that the services or supplies cannot be safely provided as an out-patient.

01.31 Register Professional Nurse

A person licensed as such by the appropriate licensing authority in the area in which he/she practises nursing.

01.32 Skilled Nursing Facility

Extended care facilities, approved skilled nursing homes and rehabilitation centres (other than for treatment of drugs addiction or alcoholism approves by the Company.

02. BASIS OF INSURANCE

Unless otherwise agreed, the application form with the statements supplied by the Subscriber or the Insured, whether or not personally written, as any written information supplied separately by the Subscriber or the Insured shall regarded as the basis of this insurance and deemed to be an integral part of the Policy.

The Company shall not be liable to pay any compensation and shall have the right to terminate the insurance as any time at its discretion without giving notice of termination if the information in the application form or the information supplied separately is contrary to the truth, or facts have been withheld which are if such a nature that the insurance would not have been concluded or would not have been concluded on the same conditions, if the Company had been cognizant of these facts.

03. SCOPE OF INSURANCE

For each Insured mentioned in the Policy or an endorsement, compensation of the cost in connection with medical treatment shall be granted, provided and as long as this treatment is medically required and in so far as it is insured and described according to the Policy conditions. Compensation of the costs insured under this Policy can be claimed up to the highest amount which would, according to locally accepted standards in the area of validity, be due by the patient, if he were not insured. The burden of proof that the amount appearing on a submitted bill is higher than the amount actually due rests with the Company. With due observance of the provisions elsewhere in this Policy, compensation of the costs shall be granted up to the highest amount which would be due according to the officially approved rates, or the rates as laid down in the guidelines of the National Association of Specialists in the Netherlands Antilles or any similar association in the area of validity. In the absence of officially approved guidelines and / or rates, the Company will make an independent determination of the value of the service. The insured is responsible for the payment of any balances over the allowable charge.

04. BENEFIT SUMMARY

BENEFITS WAITING PERIOD: No waiting period for person who were insured with

with British American Insurance

FROM THE EFFECTIVE DATE: November 1,2009

*** Coverage for accidents and infectious diseases begins immediately:**

*** Coverage for new employees without pre-existing conditions begins three (3) months from effective date**

*** Coverage for new employees with pre-existing conditions begins six (6) months from effective date**

The Company shall grant in case of:

04.1 Hospitalization in the insured's class, 80% compensation of;

A) Room and Board (including nursing fees, meals and special diets);

B) The costs of specialist treatment and the additional charges, on the understanding that for the nursing care and treatment on account of mental afflictions compensation of the costs insured under A and B shall be limited to three-hundred and sixty-five (365) days per case of illness;

C) the accommodation costs for a parent or child accompanying the patient (for children under fifteen (15) years of age, maximum of twenty (20) nights in any one (1) year) to a maximum of EC$214.40 per night, with the understanding that the company's permission must be given beforehand;

D) the costs of medically required transportation by local ground ambulance to and from a local hospital at prevailing rates or up to EC$ 134.00 for ground ambulance services beyond the local area; all this with due observance of the exclusions described in 06., items 26 .

04.2 A) haemodialysis (kidney dialysis), the cost of each treatment provided in a hospital, even if same is accompanied by a stay in hospital for a period shorter than twenty-four (24) hours. In addition, the expense for treatment at home shall be covered, but only up to a maximum of the amount that would have been charged by the hospital.

B) hospital care, examination and treatment expense of the donor, which are directly connected with the transplantation of an organ from such donor to the Insured, up to the maximum amount that shall be due in the class valid for the insured in question. In case the donor is already insured with the Company, the compensation shall be made according to the Insured's class. In addition, a donor shall have the right to receive compensation for the expenses incurred during a period of not more that three (3) months from the date of discharge from the hospital to which the donor had been admitted for the selection or removal of the transplantation material, provided that such expenses are related to this hospitalization.

04.3 tissue-specification, including the related computer administration charges, incurred in connection with kidney ailments, as charge by Eurotransplant in the Netherlands or by similar institution in the area of validity.

04.4 delivery and maternity care on account of pregnancies which had their inception ten (10) months after the effective date of the insurance, covering: the fee in connection with maternity care (including pre and post-natal care) charged by a midwife, general practitioner or medical specialist refer to policy highlight.

In addition, for:

1. **Delivery and maternity care at home: the cost of district maternity care during a period of ten (10) days at most, to a maximum of EC$80.40 per day;**

2. **Delivery and maternity care in a maternity home or hospital in the Insured's class: the nursing cost for the stay of mother and child together for a period of ten (10) days at most (in which the fee for the rendering of obstetric care is not calculated). The compensation will be cover 80% of the cost.**

3. Delivery in hospital, if hospitalization is medically required due to Complications as a result of the delivery, compensation shall take place in accordance with 04.1.

4. Maternity care after a stay of maximum four (4) days in a maternity home or hospital for delivery for a period of ten (10) days at most. The compensation shall be made according to provisions mentioned under 1 of 04.4, if following the stay in a hospital or maternity home, resident or district maternity care is provided.

5. The nursing cost according to the applicable rates for healthy babies, due for a child born during the course of this insurance, which child shall have to remain in hospital for breastfeeding by the mother provided the following conditions are fulfilled:

A) The child shall be registered for insurance within one (1) month from Its birth; and

B) all eligible children shall be insured under this policy;

C) the expenses due at the same time for the mother must be considered as insured cost. If the conditions mentioned under A and B are fulfilled, the child in question shall be considered an insured as from its birth irrespective of any congenital diseases or abnormalities.

04.5 sterilization/abortion, the medical cost related to sterilization/abortion shall be compensation, provided that the treatment is given hospital by a medical specialist. In cases of sterilization of a male, the cost to be compensated shall not exceed the amount that would have been due for similar treatment as an out-patient. The medical cost related to the reversal of the above is excluded.

04.6 nursing care in a sanatorium for tuberculosis patients, unlimited compensation of:

A) the nursing fees;

B) the costs of treatment and the additional charges;

C) the costs of medically required transportation by ground ambulance to and from a sanatorium.

04.7 costs of specialist treatment for an illness or accident:

A) IN-PATIENT

The specialist's fees for treatment provided during hospitalization and the medical costs which, in addition to the nursing fees and costs of specialist treatment, are directly connected with and incurred during hospitalization (such) as costs of x-rays, laboratory tests, blood transfusions, medicines, radiation treatments, anesthetics, dressing and the use of the operating room).

B) OUT-PATIENT

In cases of out-patient treatment, the fees charges by a specialist consulted on the advice of the general practitioner or dentist, including prescribed medicines, for treatment not requiring hospitalization (such as cost of laboratory tests on the advice of the general practitioner in so far as these costs are charged by a hospital or laboratory as well as the cost of the use of the clinic). In addition, the costs of psychiatric treatment will be granted up to a maximum of E$5360.00. (including prescribed medicines) per person per calendar year, if this treatment is related to an illness or accident.

04.8 out-patient treatment for physical therapy, manual therapy, speech and phono-therapy, provided by a therapist as mentioned in "DEFINITIONS", sub-items 01.15 and 01.16, prescribed by a general practitioner or a medical specialist consulted on the former's recommendations, up to 80% of the cost per illness, with a calendar year maximum of EC$2948.00 per Insured. The costs of physical therapy are understood not to include pre and postnatal gymnastics, and sportsmassage.

04.9 durable medical equipment; A non-recurrent compensation is included under the policy for the costs of purchase or rental of the artificial aids and devices mentions on item 04.9 paragraph 5 (standard model), provided that the purchase or rental is made on prescription of a medical specialist for a deviation which occurred after the insurance had been applied for.

If such equipment is determined medically necessary or appropriate, the Company may choose either to rent purchase such equipment, but in no event will the total rental allowance to be paid exceed the purchase price. No benefits are payable as a result of a case of illness or accident which is excluded from the insurance or for equipment provided for comfort or convenience whether or not it is prescribed by a physician.

This includes the following artificial aids and devices.

Artificial leg with a knee joint, artificial leg up to the knee, artificial foot, artificial arm up to the elbow, artificial hand, braces (except for teeth alignment), artificial eye, hearing aid, breast prosthesis, wheelchair, crutches, facial prosthesis, corrective corset, cranial cap, trachea canula, voice box, hernia belts, orthopedic shoes (except support soles), catheter, walking devices, elastic stocking, oxygen equipment, lung vibrator, humidifier, external electric stimulator for the treatment of chronic pain, wig.

Any compensation for the purchase or rental of other medical equipment not mentioned shall be decided by the Company when a request has been submitted beforehand. If the Company approves, it may set further conditions.

Compensation for the purchases and replacement of a heart stimulator (pacemaker Is also included under the policy.

The compensation therefore shall not be recurrent, but shall run to the extent of EC$37,520.00 in the every period of one-hundred and twenty (120) consecutive months.

Also included are the costs related to daily rehabilitation treatment during the day or part therefore of heart patients, with the understanding that the cost of the rehabilitation treatment for the entry test, the training, and the exit test shall be compensated according to the officially approves rates.

04.1.0. day and night care, compensation of the costs of:

a) rehabilitation day care in accordance with the treatment plan prescribed by the medical specialists and approval was given beforehand by the Company;

b) dermatologieal night care;

c) psychiatric day and niqht care for a maximum of ninety (90) days or nights per calendar year per person in accordance with the treatment plan prescribed by the medical specialists and approval was given beforehand by the Company.

04.11. dental care for children up to age fifteen (17): compensation of 50% of the actual costs of treatment by a private dentist or juvenile dental care unit to a maximum of EC$1000.00 per year, subject to a compulsory half-yearly examination.

04.12. general practitioner's consultations and examinations on account of medical treatment for an illness or accident:
Compensation shall be given at 80% per consultation, examination or treatment in the physician's office, clinic or the insured's home. Payment shall not. be made for more than one visit, of any type, on one day and shall not exceed the amount actually charged.

04.13. prescribed drugs (out-of-hospital):
Compensation or 80% of the costs of medicines prescribed by a general practitioner and/or specialist reqistered in the area of validity which under the Medicine Act, other than those administered bv injection by the attending physician, may only be supplied on prescription of a general practitioner or a specialist consulted on the former's advice, by a pharmacist or by a dispensing physician.

No compensation will be given for medicines which are available WITHOUT a prescription (over-the-counter items) even though such medicines were recommended by a physician.

04.14. preventive medical treatment:
Compensation, when made within the area of validity, of preventive medical treatment, under which is understood:

* examination of the heart-and bloodvessels (maximum once every two years per insured)
* examination for cervical-find breast cancer
* tetanus injection, inoculation against, influenza, viruela, rabies and injections against epidemics or other preventive examinations prescribed by the family'doctor or specialist, with the understanding that In these cases, prior approval must be given by the Company.

04.15. consultations, examinations and treatment on account of an illness or accident by a practitioner of alternative healing methods, provided the treatment is administered by one of the following professionals:
* a practitioner of homeopathy;
* a practitioner of acupuncture, who possesses the necessary certificate from the International College of Oriental Medicine;
* a chiropractor, who is acknowledged as such by the International Association of Chiropractors.
* an osteopath, who possesses the MRO qualifications and who is also a current member of the recognized association or its equivalent overseas.

The compensation will be limited to the single consultation fee of a general practitioner including the medication registered in the area of validity which under the Medicine Act may only be supplied on prescription of a general practitioner or a specialist, consulted on the former's advice, by a pharmacist or by a. dispensing physician.

04.16. transportation by an incorporated commercial airliner for necessary non-acute medical treatment, as a result of bodily injury or illness, for which the required facilities are not available in the place where the injury or illness was contracted, to the nearest area where such facilities do exist, per the most reasonable, direct air connection to and from, the area of validity, provided such transportation and care was on the"recommendation of the attending physician and the Company's Medical Adviser has explicitly given his permission beforehand. In the case of a"patient, age fifteen (15) or less, the transportation cost of an accompanying adult will also be comoensated.

Per Accident: ECS3000.00

04.17. transportation by air ambulance or other recognized charter service for medical, emergency evacuation, as a. result of bodily injury or illness, for which the required facilities are not available in the place where the injury or illness was contracted, to the nearest area where such facilities do exist, provided such transportation and care was on the recommendation of the attending physician. Maximum, per occurrence: $ 5,000.00. The maximum payment includes professional fees associated with the transport (i.e.,"" charges billed by an M.D., R.N., E.M.T., etc.).

04.18. **private duty nursing services:**
when the Insured is an in-patient, benefits are provided for the services of a registered professional nurse for a maximum of two-hundred and forty (240) hours per twelve (12) month period. This benefit is provided only when ALL of the following conditions are met:

* the nursing service is available;
* the services is prescribed by the attending physician; t is p'rovided for the condition for which hospital care and treatment are being rendered;
* it is medically necessary; and
* the service is approved by the hospital.

Private duty nursing is not covered when:

* it is provided as a convenience for the patient, whether or not prescribed by a physician, or when it is provided at the request of the patient or his/her family.

* it is rendered in such special care facilities of the hospital as self-care, selective care and intensive care units.

The Company may elect to review a case in advance and then approve benefits for this service for up to eighty (80) hours at a time. If a registered nurse is not available, the Company may elect to provide the benefit for the services of a licensed practical nurse.

04.19. **nursing care at home:**
when nursing care becomes medically necessary at the home of the insured in order to reduce the duration of or as an alternative to a hospitalization, the fees of a certified, nurse or healthcare attendant shall be compensated to a maximum of twelve (12) hours per day or night to a calendar year maximum of sixty (60) days per insured, with the understanding that prior approval must be given by the Company.

04.20. **nursing care in a nursing-home:**
if due to the nature and/or the duration of the illness an insured has to be admitted to a nursing-home which has been recognized, as such, the expenses involved with this admission, shall be fully reimbursed according to the officially established rates up to a maximum of one-hundred (100) days per event, provided the Company has given its approval beforehand.

04.21. **second opinion:**
if on the advice of the specialist consulted, surgery is recommended, above all other acceptable methods of medical treatment, the expenses of a second-opinion by another locally established specialist shall be reimbursed.

04.22. **intensive care**
when use of an intensive care facility is medically necessary, benefits will be provided in the amount of the allowable charge of the most recognized hospital in the area of validity.

04.23. **rape victims:**
if a female participant becomes pregnant due to rape, the Company will compensate the costs for the termination of the "unwanted" pregnancy, provided that a fully documented report surrounding the circumstances had been filed with the police authorities within seventy-two (72) hours after the crime was committed.

05. SPECIAL CLAIMS AND RIGHTS

Abroad:

1) If while the Insured(s) is (are) on holidays or a business trip outside the area of validity medical treatment becomes medically necessary due to an acute illness or accident, compensation of the costs incurred shall be qranted, on the understanding that:

   * the costs of hospitalization in a locally recognized general hospital shall be compensated UP to a maximum of three-hundred and sixty-five (365) days per case of illness and. up to a maximum of two times the amount of the costs of comparable nursinq care and treatment, in the Insured's class of the most recognized hospital in the area of validity;
   * the other costs shall be compensated up to a maximum of two times the rates applicable in the area of validity, without prejudice to the provisions of Article 03., ,
   * the accommodation costs for a parent or child accompanying the patient (for children under fifteen (15) years of age, maximum of twenty (20) nights in any one year) to a maximum of EC$214.40 per night, with the understanding that the Company's permission must be given beforehand;
   * the costs of medically required transportation by ground ambulance to the nearest hospital shall be compensated to a maximum of EC$134.00 .

2) If hospitalization and medical treatment take place abroad on referral of the specialist consulted, due to non-availability of the necessary specialized treatment within the area of validity, and trie Company's Medical Adviser has explicitly given his permission beforehand, the costs shall be compensated in accordance with the provisions, of paragraph 1 of this article.
   The Company will further reimburse Hotel accommodation (room charges only) expenses of up to EC$214.00 per night to a maximum of twenty (20) nights per calendar year for referred cases which do not require hospitalization. The itemized hotel bill must be submitted for reimbursement.

3) If hospitalization and medical treatment take place abroad while no acute illness or accident is involved and the permission of the Company's Medical Adviser has not been given beforehand, the costs shall be compensated up to maximum the amount equal to the local rates then in effect in the area of validity for similar nursing care and treatment, such at the discretion of the medical adviser, and up to a maximum of three-hundred and sixty-five (365) days per case of illness,

A specialist abroad is understood to mean a locally recognized qualified physician who according to local medical standards is considered a specialist.

Compensation shall be made in the currency of the Policy with due observance of the rate of exchange on the day of payment.

06. EXCLUSIONS

The following services and other items are excluded under this Policy:

1. Allergy Testing.

2. Blood donor services

3. Contraceptives (even if used for other than contraceptive purposes).

4. Acquired Immune Deficiency Syndrome (A.I.D.S.), Aids Related Complex (A.R.C.) or Disorders of the Immune System.

5. Self-inflicted injury while sane or insane; treatment: of chronic alcoholism or drug addiction.

6. Injury or illness resultinq from insurrection or war, declared or undeclared, or as a result of a riot, strike, civil commotion or nuclear accident.

7. Custodial care or periods of quarantine or isolation.

8. Cosmetic or plastic surgery, including treatment of acne, except on account of mutilation as a. result of an accident or illness or a serious birth defect ascertained immediately at birth.

9. Dental services rendered by a physician, dentist or dental surgeon (including teeth alignment) for persons older than the age of firteen (15), except for the treatment of accidental injuries to natural teeth through violent external means within six (6) months of the accident (the treatment to include replacement of such natural teeth within said period).

10. Supply or fitting of eye glasses, contact lenses or the examination, prescription or fitting of same; orthopedic devices and similar artificial aids and devices insofar as these do not fall under 04.9.

11. Services and supplies related to visual therapy or orthoptics.

12. Charges exceeding the cost of treatment and nursing of mentally ill. patients in the lowest class of a hospital or institution 'for mentally ill patients, after the expiry of three-hundred and sixty-five (365) consecutive nursing days.

13. Immunizations and inoculations, except for the explicit cases mentioned in the Policy.

14. Routine foot care.

15. Computerized gait analysis or electrodynographic testing.

16. Services or any benefits provided by or available under any Worker's Compensation law or Occupational Disease law or similar law concerning job related conditions or Social Security Acts or automobile insurance of any country.

17. Services rendered bv any member of the Insured's family or any other person living with the Insured. For the purpose of this paragraph, the family includes parents, spouse, and natural adopted children, of whatever age.

18. Services as an in-patient for convenience or for observation, diagnostic examinations or diagnostic laboratory testing when these services could have been received as an out-patient.

19. Services by your employer's medical, department.

20. Any charge by a school infirmary or a student health center or it's staff.

21. Services not directly related to or necessary for the diagnosis or treatment of an illness or injury. The Company will cover only those services or supplies provided by a hospital, physician, or other provider that are required to identify or treat an illness or injury and which, as determined by the Company are:

   * Consistent with the symptom or diagnosis and treatment of the condition, disease or injury;

   * Appropriate with regard to standards of accepted professional practise;

   * Not solely for the Insured's convenience, the physician's convenience, or any other provider's convenience; and,

* The most: appropriate supply or level of service which can safely ne provided to the Insured. When applied to an in-patient, it further means that the medical symptoms or condition require that the services or supplies cannot be safely provided to the Insured as an out-patient.

22. Services, including diagnostic tests, x-rays and routine physical examinations not incidental to, or necessary to, diagnosis of an illness or accidental bodily injury including, but not limited to, well-baby care, school entry, premarital, work permit, insurance or employment examinations.

23. Services and drugs in any way related to weight reduction, whether or not recommended by a physician.

24. Services, supplies and treatment which are deemed by the Company to be experimental or investigational in nature or which do not belong to the specialist branch for which the physician is registered. This includes any treatment, procedure, facility, equipment, drug, drug usage, device or supplies not recognized as accepted medical practice in the area of validity or elsewhere or any such items requiring governmental agency approval for use and for which such approval has not been granted at the time the services were rendered.

25. Cell therapy, bone marrow transplant and related procedures or oral orthopedic treatment (orthodontics).

26. Transportation costs of any sort other than local licensed ground ambulance service, incorporated commercial airliner, air ambulance or other recognized charter service.

27. Any expense incurred for the treatment of Temporomandibular Joint Dysfunction (TMJ) or Syndrome including the examination and fitting for the TMJ device, nutritional counselinq and occlusal adjustment.

28. When more than one service, procedure, or treatment modality is performed in a single day by a professional provider, the Company will pay the allowance for whichever service has the greater allowable charge. Payment for more than one service, procedure or treatment modality per day will be solely at the discretion of the Company.

29. Pregnancy and/or any condition related to pregnancy is excluded from coverage for the first ten (10) raonths of the Policy.

30. Services, supplies or drugs for or related to fertility including but"not limited to in vitro fertilization and artificial insemination.

31. Services, supplies or drugs obtained in violation of applicable law or drugs which are available WITHOUT a prescription even though such drugs were recommended by a physician.

32. Any expense incurred within two (2) months after the inception of the insurance, unless these arise from acute illnesses or an accident.

33. Services, supplies or drugs from a psychologist, unless the costs of" the treatment by a psychologist form part of a psychiatric treatment as mentioned in 04.10, item. c.

34. Conditions, abnormalities and/or pregnancy existing on the date the Insured received medical or surgical advice or treatment within twenty-four (24) months prior to the date coverage begins or of which the Insured was already aware of such facts or had complaints at that moment. The foregoing shall not apply to conditions, abnormalities, complaints and/or pregnancy if the Insured, has notified the Company in writing and no special conditions were set when, the coverage was 'accepted.

35. Treatment received for injuries while performing in all hazardous sports. These include but are not limited to mountaineering; rock climbing; skydiving; parachuting; ballooning; hang gliding, flight In ultra-light aircraft; deep sea diving; scuba diving; snorkeling; racing of any form and all professional sports.

36. Any portion of the charge for medical services which is in excess of the usual, customary or reasonable charge.

37. Rental or purchase of deluxe medical equipment or supplies such as televisions, telephones and other convenience items.

38. Bills/invoices relating to services received during the past calendar year submitted after June 1st of following year.

39. Services or supplies for, or in connection with, sexual transformations, dysfunctions or inadequacies.

07. FREEE CHOICE-HOSPITALIZAIION IN' A HIGHER CLASS

07.1. FREE CHOICE

The Insured is free in his choice of qenerai practitioner, pharmacist, physiotherapist, speech therapist, dentist, midwife, medical specialist, hospital, sanatorium, maternity center, and in his choice of the class in which he shall receive treatment, without prejudice to the provisions of 07.2., below.

07.2. HOSPITALIZATION IN A HIGHER CLASS

In the event of hospitalization in a higher class than the insured class, compensation will be' granted for the amount which would have been due according to the hospital's rates and for the specialist in the insured Cl.3.SS«
If due to special unforeseen circumstances, an Insured, who is insured against the costs of nursing care and treatment in the B or C section of a hospital class, is cared for and treated in a hospital class which does not have such a subdivision, no reduction of compensation will take place on account of underinsurance.

08. INCEPTION AND TERMINATION OF BENEFITS

08.1. The Insured shall be entitled to compensation of the expenses insured in so far as they have been incurred during the period that this insurance is in force.

09. OBLIGATIONS

09.1. CLAIMS:

1. Prior to visiting a medical specialist, the Insured or Insures must rirst be referred by his or their Family Doctor or "House Doctor" and such referral should be accompanied by a statement of the reasons of the attending specialist. Failure to do so will result in (1) either the claim being denied or (2) the visit to the specialist being paid at the rate or your Family Doctor. This requirement is not necessary in the case of consultations and/or treatments by an Ophthalmologist (eye specialist), Pediatrician (child specialist), Ear-nose and throat specialist or a Dermatologist (skin specialist).

2. The Company shall be notifies in advance in the event of intended hospitalization, or intended rehabilitation day-treatment, or psychiatric day or niqht treatment or, in the case of delivery and maternity care, as soon as it is known that hospitalization is necessary. Such notification should be accompanied by a statement of the reasons of the attending specialist.

3. In the event of emergency hospitalization, the Company shall be notified hereof within three (3) days or as soon as it is reasonably possible.

4. When requested, the Insured or Insures shall fully cooperate with the Company, its medical adviser or those parties who are entrusted with the supervision of claims, so that the desired information can be obtained.

5. A separate CLAIMFORM must be completely filled-in for each Insured. All claimforms and bills/invoices must be specified in such a way that without any further inquiries it is clear what compensation the Company must give. Claims will be honored on the basis of original bills/invoices only. Computer generated invoices are acceptable in so far as these are supported by an endorsement from the provider of medical services.

6. The Insured or Insures must submit all the bills/invoices for which reimbursement is claimed with regard to the past calendar year in which the treatment to which these bills/invoices relate before June 1st of the following year.

7. In the event of medical examinations performed by means of (1) X-ray, (2) Laboratory, (3) Ultrasound or any other out-patient medical examinations, the Company's medical adviser shall have to receive information regarding the results of these examinations.

8. All bills/invoices for dental treatment must be accompanied by a specification. In case of non-fulfillment of the above mentioned obligations no claims for compensation can be made.

9. After establishing the compensation of a claim, the deductible amount, if shown in the Policy and/or an endorsement, will be subtracted from the final payment.

This deductible also applies to certain services mentioned in the Policy, where maximum amounts are indicated. These maximum amounts will remain in force both for the deductible in question as well as for the compensation afterwards.

In cases where, in addition to the regular deductible, a special deductible has been applied, this special deductible will be subtracted first and thereafter the regular deductible as indicated in the Policy will be subtracted from the final payment.

In any calendar year, the Insured may carry over into the new calendar year any allowable charges which were incurred and applied towards the deductible in October, November and December. However< the carry over is permitted only for the period in which coverage is continuous. If coveraqe is suspended or terminates and the Insured re-enrolls, no refund or reduction of the deductible then applied will take place and expenses will begin being counted as of the effective date or the latest Policy.
Under the Family coverage, a maximum of three (3) persons, in any combination, will be charged a deductible.

10. If a claim is made and rejected and no action or suit at law or in equity is brouqht against the Company to recover under this Policy within sixty (60) days after such rejection, or, in case of an arbitration taking place in oursuance of condition 16.08,of this policy within two (2) years after the arbitrator or arbitrators or umpire shall have made their award, all benefits under this policy shall be forfeited.

10. PREMIUM PAYMENT/SUSPENSION/CANCELLATION/

10.01. Premiums under this Policy must be made payable in advance to the Company or at such office or offices of the Company as the Company may designate in writing to the Policyholder from time to time. Premium payment is due at the Company's office on or before the first day of the Insured's billing cycle.

Such premiums are due and payable as specified on the face oaae of the Policv or an endorsement hereon, provided that by 'mutual agreement between the Policyholder and the Company the interval of payment may be changed, with appropriate adjustment, to provide for payment annually, or semi-annually.

Non-payment of the premiums when due will be grounds for termination of this' Policy.

10.2. Premium payment more than fifteen (15) days delinquent will include a fee for late payment., When a premium payment is overdue, payment of the Insureds claim(s) will be suspended without previous notice of default being required.

10.3. If payment is not received by the forty-fifth (45th) day, the coveraqe is canceled. A cancellation notice will be sent to the Policyholder or Insured(s) at the latest address given to tne Company.

10.4. No refund of premium shall take place in respect of this Policy except in the case of termination as referred to in 10.07 paragraph c. Sub item 11.02.,and in other cases at the discretion of the Company.

10.5. If coveraqe is cancelled due to non-payment of premium, the Policyholder or Insured(s) mav, within fortv-five (45) davs of the date of cancellation, apply for reinstatement under the following conditions:

* The Insured must submit Part II of the application completed by a physician approved by the Company for each individual covered on the Policy, which is subject to underwriting approval, and

* the delinquent premium, and

* an administration fee.

If the Insured qualifies for reinstatement, the coveraqe will be reinstated to the first day of the Insured's billinq cycle. All claims will be suspended durinq the lapsed period of the Policy and no compensation shall be due for expenses of which the necessity or expectation to make them has become manifest durinq the period that the Policy has or had been suspended.

After ninety (90) days have elapsed, application can be made for new coverage following the same procedure as followed by any new applicant for new coverage. If the application is approved and premium payment made, the Insured will be notified of the effective date of his or her new coverage and will be subject to all waiting periods, deductibles (when applicable), and co-pay requirements as though this individual had never been covered by the Company.

10.6. There will be a service fee for any cheques returned for insufficient funds, closed accounts, or for stop payments on cheques.[1] Returned cheques will be treated as non-payment of premiums.

10.7. This Policy can be canceled by the Company for any of the following reasons?

a. non-payment of premiums or fees;

b. misuse of health care benefits, misrepresentation or fraud in procuring health care benefits;

c. falsification of any information.! including claims, or misstatement or omission of information on the Insured's application form, or subsequent thereto;

d. residence outside the area of validity.

If the Insured or an Insured dependent is hospitalized and the Policy is cancelled due to outside the area of validity resident status, coverage for the illness or injury requiring hospitalization will continue only until the hospital discharge.

In the case of pregnancy, maternity benefits will continue through the delivery. However, no coverage will be provided for the newborn.

10.08. To add a dependent to the Policy, the Insured must submit a completed application form(si ,for each dependent. Any additions to the Insureds Policy is subject to the underwriting regulations of the Company.

CONVERSION PRIVILEGES

It is the responsibility of the Insured to notify the Company of any change in marital status within thirty (30) days of the change.

a. If marital, status changes due to divorce, the Insured spouse's coverage under this Policy will be terminated as of the end of the month in which the Company is notified in writing of the divorce. Any coverage for the former spouse must, be under a separate Policy and available at. the rates then in effect. If he or she applies for his or her own coverage within thirty (30) days from the date the divorce is finalized, separate coverage will be issued.

b. The premiums for the children's ward is based on. the age limit which the most recognized hospital in the area of validity applies to determine its rates for this class. For an Insured dependent child who reaches this age limit during the course of this insurance, the premium applicable to adults shall be due as of the next premium expiry date.

   When an. Insured dependent child, attains age nineteen (19), his/her coverage will be terminated at. the end of that Policy year. He or she may apply for individual coverage of the type then available and at the rates then in effect. Application must be made within, thirty (30) days of the date of termination to provide continuous coverage.

c. Upon death of the primary Insured, the premium will be waived for one (1) year for the spouse and/or dependents who are insured at the time of death.

11. REVISION OF PREMIUMS AND/OR CONDITIONS

11.01. This Policy, as defined herein, is the entire agreement between the Subscriber and. the

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No agent/broker has the right to change this Policy or to waive any of its conditions. However, the Company has that right. If there are changes or termination of any conditions or changes in the rates, the Company will mail notification of such change(s) to the Subscriber thirty (30) days prior to the effective date of change. The Company can do this by sending a written notice to the latest address on file for the Insured.

The Subscriber shall not rely on any oral statement to:

* Modify or otherwise affect the benefits, limitations, and/or exclusions of this Policy; or

* Increase or void any coverage or reduce any benefits under this Policy.

Such oral statement shall not be used in the prosecution or defense of a claim under this Policy.

11.2. The Subscriber has the right to reject such revision. If the Subscriber has informed the Company of this rejection in writing within thirty (30) days after receipt of notification of the proposed revision, the insurance shall be terminated by law as from, the date of the revision, with refund of premium for the non-elapsed period for which the premium is paid.

11.3. If there is continued payment of premiums, there will be no interruption of coverage and such payment will be confirmation of the Subscriber's acceptance of the revision(s).

12. POLICY (CONTRACT) PERIOD

The insurance has been effected for a period as described in this Policy and shall tacitly be renewed for an equal., period for Insureds up to and includinq sixty-four (64) years of age, unless the Subscriber has given, notice of termination to the Company by registered"mail at least three (3) months prior to the renewal date. If the Company should elect not to renew, notice shall be mailed by the Company to the Policyholder at least thirty (30) days prior to the renewal date.

13. _INTERIM_CHANGES

Changes of (1) the deductible, (2) the addition or deletion of optional items or (3) changes of the Insured's class is possible per January 1st of any year, however this change must be applied for in writing at least thirty (30) days in advance and must be accompanied by a duly completed Part II, LTL form # 3 10/90,"Side A.

14. CHANGE OF ADDRESS

It is the responsibility of the Insured to notify the Company, in writing, of any change in residence within, thirty (30) days of the change.

15. CONDITIONS...INCONNECTION WITH GROUPINSURANCE

15.01. Participation must be no less than one-hundred (100%) of all eligible Employees. If an. insured Employee's classification or salary changes during the term of the Group Insurance and due to these changes no longer qualifies for coverage under one of the social security acts, the Employee's insurance shall be adjusted automatically* without evidence of insurability, to a 2nd class insurance. This exception applies to new Employees as well.

15.02. Upon death of the primary Insured, the spouse and/or dependents may continue the Policy, without selection, at the normal individual premiums and conditions. However, a request in writing must be sent, to the Company within sixty (60) days after the death of the primary Insured.

15.03. If an Employee's insurance ceases by reason of

(a) termination of employment, or
(b) termination of his membership in the classes eligible for insurance, or
(c) termination of insurance,

He shall be entitled to continue his coverage under the conditions and rates of the Group Policy until thirty (30) days after his insurance terminates. He shall, thereafter, be entitled to convert his insurance, without evidence of insurability, to an individual, health Policy, provided written application is made to the Company within thirty (30) days from the date of such termination. The premium payable shall be based upon the Company's rate applicable to the class of risk to which the Employee belongs and to his age on the effective date of the individual Policy.

This conversion privilege is not available to an Employee in the event of termination of this Policy or amendment of this Policy making the class of Employees to which he is a member ineligible for group health insurance.
Any individual Policy issued under the provisions of this section shall take effect at the end of the thirty (30) days period during which application for the Policy may be made, and shall be in place of all benefits under this Policy.

15.04. The Company reserves the right to terminate this Group Policy at any time during the period of insurance when the Employees insured hereunder are less than ten (10) in number, taking thirty (30) days notice into consideration.

15.05. For a Family, a premium will be charged for a maximum of three (3) children under the age of nineteen (19) years.

16. GENERAL CONDITIONS

16.01. Claims

1. For Claims incurred within the area of validity:

   a. If the provider is a participating institution or provider, the claims will be submitted to the Company directly by the institution or provider.

   b. If the provider is not a participating institution or provider, the claims will'be submitted to the Company by the Insured and the Company will elect to pay, in accordance with the terms of this_Policy, either the provider, the institution or the¯ insured. If the Insured has already paid the non-participating institution or provider, the Company will pay the Insured.

2. For claims incurred outside the area of validity:

   The Insured must submit his or her claim directly to the Company. The Company will elect to pay in accordance with the terms of this Policy, either the provider, the institution or the Insured. If the Insured has already paid the institution or provider, the Company will pay the Insured.

   A claims kit will be provided to assist the Insured in filing claims.

16.02. Medical Review

To insure compliance with the terms of this Policy, the Company reserves the right to require:

1. That the Insured be examined by a doctor chosen by the Company, or that the Insured obtain a second opinion by a doctor approved by the Company, and/or

2. That the Insured's plan of treatment be reviewed by a physician chosen or approved by the Company.

Releasing Necessary Information

Hospitals, physicians, pharmacies and other providers have information the Company needs to determine eligibility for both enrollment and benefits under this Policy. By applying for coverage, the Insured agrees to let any physician, hospital, pharmacy or provider give the Company all medical information needed. This may include diagnosis and history of any illness, disease, condition or symptom the Insured may have had, or had for which coverage is sought, or other medical information. The Company will keep this information confidential to the extent permitted by law. However, by applying for coverage, the Insured authorizes the Company to furnish any and all records including complete diagnosis and medical information to an appropriate medical review board, utilization review board", utilization review organization an/or to any-other insurance carrier, administrator or health maintenance organization for purposes of administration of this health care benefits Policy. If such information relates to fraud or other misrepresentation, the Company may disclose it to legal authorities or use it in legal proceedings.

Request for Reproduction of Records

The Company reserves the right to charge a fee for the reproductions of claims records requested by the Insured or his/her representative.

Denial of Liability

The Company is not responsible for the quality of care received from any institution or individual. This Policy does not. give the Insured any claim, right or cause of action against the Company based on an act of omission or commission of a hospital, skilled nursing facility, physician or other provider of care or service.

AssIgnability

The Company has full and exclusive discretion in determining whether to make payments to the Insured or to the provider. Payments are not assignable without, the written approval of the Company.

Any rights for the Insured or his or her family to receive services hereunder are personal and may not be assigned.

COORDINATION OF BENEFITS

16.07. Duplicate Coverage

When an Insured has coverage under two or more insurance Policies which provide similar benefits and a service is received by more than one of the Policies, benefits will be reduced to"avoid duplication of benefits available under the other Policies, including benefits that would have been payable had the Insured claimed for them, in no event will more than 100% of the covered services be reimbursed. It is the duty of the Insured to inform the Company of ALL duplicate coverage.

16.08. Disputes- final definition

a. Disputes regarding the extent of the benefit, the extent of the disablement and the period for which the benefit will be in force, are submitted to an expert, to be appointed by parties in mutual consultation, whose award'is accepted by the parties as binding. The costs will be equally shared by both parties. Should the parties not reach an. agreement on the appointment of an expert, the dispute will be • presented, to a committee of three experts. Each party shall proceed to appoint an expert. The third is appointed by the two experts. If they do not reach an agreement, the two parties will file"' a petition with the court in first instance to name said expert. The costs of the third expert will be equally shared by the parties.

b. Any other differences resulting from this agreement will be brought before the authorized court.

c. The Company may elect to pay individual claims which do not come within the specific benefit provisions of this Policy if the Company determines that such payment is within the intent of this Policy; however, such payment, although it shall be a valid charge under this Policy need not be considered to be a precedent in the disposition of similar cases. The Company also may extend benefits or provide alternative benefits to a Subscriber which are not required by this Policy, if the Company concludes that payment of said benefits to the Subscriber is equitable and in the best interest of this plan.

GROUP ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE RIDER

issued by

NETHERLANDS ANTILLES GENERAL INSURANCE CORP. N.V.
(herein called the Insurance Company)

THE INSURANCE COMPANY hereby agrees that the following provisions, as modified and defined under the attached Group Accidental Death and Dismemberment Insurance Rider Specifications, hereinafter referred to as "Rider Specifications", shall form part of the Policy.

Clause 1 BENEFITS

If an Employee, while insured under this Rider, sustains bodily injuries effected solely through external, violent and purely accidental means, and within ninety days after such injuries are sustained, suffers the loss of life, sight or limb as a direct result of such injuries and independently of all other causes, the Insurance Company will, subject to the provisions hereinafter stated, pay in one sum to the Employee, if living, otherwise to the person or persons entitled thereto under the provisions of the Policy, the amount provided for such loss.

FOR LOSS OF		BENEFIT AMOUNT
Life	EC$50,000.00	Full amount paid to the Beneficiary
Both hands or Both Feet or Sight of Both Eyes	EC$25,000.00	Full amount paid to Employee
Any combination of Foot, Hand, or Sight of One Eye	EC$25,000.00	Full amount paid to Employee
One Hand, One Foot or Sight of One Eye	ECS 12,500.00	½ the full amount paid to Employee

Loss of Hand and Foot shall mean loss by severance at or above the wrist or ankle joints respectively, and loss of Sight shall mean total and irrecoverable loss of Sight.

Clause 2 INSURANCE COVERAGE

The insurance coverage applicable to each Employee insured in accordance with the provisions of Clause 7 of The Policy-General Provisions shall be as set forth in (c) Insurance Coverage-Rider Specifications.

Clause 3 EXCLUSIONS AND REDUCTIONS

If an Employee suffers more than one of the losses described under Clause 1 of this Rider as a result of accidental means arising out of the same accident, the total amount payable under this Rider on account of such losses shall be limited to 100% of Insurance Coverage.
If an Employee has sustained, either prior to becoming insured under this Rider or thereafter, the loss of either one hand, or one foot, or sight of one eye, as defined above, the insurance hereunder on such Employee shall be issued or continued for 100% of insurance coverage provided that for any subsequent loss for which payment is to be made hereunder, payment shall be made for the specified loss resulting from such subsequent accident without reference to any previous loss.

Clause 4 LIMITATIONS

The insurance provided hereunder does not cover any loss resulting from or caused directly or indirectly, wholly or partly, by:
(I) disease or bodily or mental infirmity, or medical or surgical treatment thereof, or hernia, ptomaine or bacterial infections (except pyogenic infections of and through a visible wound accidentally sustained); or

(II) self-destruction or self-inflicted injury, while sane or insane; or

(III) racing on wheels or on horses or in boats, or water skiing; or

(IV) war, declared or undeclared, or any act of war or insurrection; or as a result of a strike, riot, civil commotion or assault, or 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 navel organization; or

(V) the commission of or attempted commission of an assault or any unlawful act, or being engaged in any illegal activity; or

(VI) service, travel or flight in any kind of aircraft except as a fare paying passenger in an aircraft operated on a regular schedule by an incorporated common carrier for passenger service over its established air route.

Clause 5 NO ASSIGNMENT

An Employee's insurance under this Rider shall be non-assignable.

GROUP LIFE INSURANCE RIDER SPECIFICATIONS

[ ] Includes **[ ] Does not include**

Group Accidental Death & Dismemberment Rider Specifications

POLICY HOLDER: THE GOVERNMENT OF ANGUILLA

POLICY NUMBER: AGLH029/09 RIDER EFFECTIVE DATE: NOVEMBER 1,2009

(a) Basis of Insurance: The Basis of Insurance under this rider shall be.................Under this provision, Contributory insurance means insurance for which the Employee contributes toward the premium and Non-Contributory insurance shall mean insurance, which is provided at no cost to me Employee.

(b) Eligibility:
(see Clause 6- The Policy-General Provisions)

(c) Insurance Coverage:
(see Clause *2* of the Rider)

(d) Changes in Insurance Coverage
(see Clause 8-The Policy-General Provisions)

Any changes in insurance coverage due to the provisions of Clause 8 shall be effective on the premium due date coinciding with or next following the change.

(e) TERMINATION OF INDIVIDUAL EMPLOYEE'S INSURANCE:
(See Clause 9 - The Policy - General Provisions)
The Employee's insurance shall terminate under the provision of Clause 9 on the date the Employee reaches his sixty-fifth (65th) birthday.

APPLICABLE ONLY TO GROUP LIFE RIDER

(f) EXTENSION OF DEATH BENEFIT:
(See Clause 5 of the Group Life Rider)

Benefits shall only be payable under the terms of Clause 5, if following the discontinuance of premium payments, the Employee dies, within twelve (12) consecutive months.

(g) COMPUTATION OF PREMIUMS:

The average monthly premium rates per 1,000 of Life Insurance prior to the first Policy Anniversary shall be....................................

APPLICABLE ONLY TO GROUP AD & D R.IDER

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The premium rate per 1,000 of Insurance under the Accidental Death & Dismemberment Rider shall be ECS25,000.00

TOTAL PERMANENT DISABILITY RIDER

If an Employee:

(a) becomes totally and permanently disabled from bodily injury or disease so as to be wholly prevented from performing any occupation for remuneration or profit.

while less than 60 years of age and at least six months after he becomes insured under this Rider, but prior to the termination on his insurance under this Rider in accordance with the section, "Termination of Individual Insurance" and,

(b) within twelve months after the date Policyholder ceases premium payments on his behalf, furnishes due proof that such disability has existed continuously for at least twelve (12) months,

the Insurance Company will terminate the insurance on the life of such Employee and in lieu of all other benefits under this Rider, will pay the amount of insurance applicable to this provision in sixty (60) equal monthly installments.
The first installment shall be due twelve (12) months after the commencement of such disability or, three (3) months after due proof is furnished to the Insurance Company, if later.

AMOUNT OF PAYMENT OF BENEFITS

The amount of insurance applicable to this provision shall be the amount of insurance in force on the life of such Employee on the date of commencement of total and permanent disability. During continuance of total and permanent disability, all installment payments under this provision shall be payable to the Employee.

DEATH OF EMPLOYEE

If the Employee should die after due proof of disability has been furnished to the Insurance Company, but before payment of any installment, the amount of insurance under this provision shall be paid to the Employee's beneficiary. If the Employee should die while installments remain unpaid, the remaining installments shall be paid in one sum to the beneficiary.

CESSATION OF TOTAL & PERMANENT DISABILITY

If total and permanent disability should cease before all installments under this provision have been paid, the following conditions shall apply.

No Further installment payments shall be made: