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INTERNATIONALEXCLUSIVE HOSPITAL & SURGICAL INSURANCE POLICY

Section 1- Introduction
This handbook has been designed to set out all the features and benefits of the **InternationalExclusive** plan. On the next few pages **you** will find details of your cover followed by the membership agreement which includes definitions relevant to your **plan**. If there is anything **you** do not understand please do not hesitate to call **our** Health Service Team at the number shown on the reverse of your membership card.

Take a few moments to refresh your memory about your I**nternationalExclusive** plan then relax andlook forward to the highest standards of service from Generali. **You** can be rest assured that, whatever the coming year brings, **we**'ll be there to support **you**.

What your healthcare insurance cover is designed to do
As with all insurance policies your **InternationalExclusive** plan is there to cover **you** for costs arising froman unforeseen event. For healthcare insurance this means the cost of **eligible treatment** resulting from an unexpected illness or **accident**.

You must take care of your own health and not only rely totally on **medical practitioners** to do this for **you**. When something unfortunate *does* affect your health **we** will do **our** best to help **you** but **we** must always act within the limits of your **policy**.

A personal service
At Generali **we** are always aware that behind every claim there is a person who needs help and assistance.

What our service team is there to do
It is the role of **our** Health Service Team to assist **you**, wherever possible, within the terms and limits of your **InternationalExclusive** plan. **You** will find the number of **our** Health Service Team on the reverse of your membership card. Please also see Section 10 of this handbook for details of your local Generali office.

Please do not use the Emergency Control Centre number shown below for general & claims enquiries that can be dealt with by **our** Health Service Team.

Please take a note of this and keep your membership card in a safe place where **you** can find it easily. Please have your membership card with **you** whenever **you** call **our** Health Service Team. Theinformation on your card will help them to deal with your enquiry as quickly as possible.

International Emergency Medical Assistance
You have access to International Emergency Medical Assistance. This is a worldwide, 24 hours a day,
365 days a year **emergency** service providing evacuation or repatriation services. If **you** need immediate **emergency** in-patient **treatment**, where local facilities are unavailable or inadequate, a phone call to the Emergency Control Centre at the number shown on the reverse of your membership card. Please see the separate booklet and/or Section 3 of this handbook for full details. Please notethat, for your own protection, calls may be recorded in case of subsequent query.

Please note that entitlement to the evacuation service does not mean that the **member's treatment** following evacuation or repatriation will be **eligible** for benefit. Any such **treatment** will be subject to the terms and conditions of the **member's plan**.

Decisions about your treatment
We do not decide whether the **treatment you** receive is given on an in-patient, daycare or out-patient basis. This is decided by the attending **medical practitioner**. **We** will not usually question this unless, in the opinion of **our** medical team, it would have been more appropriate for **treatment** to have been given differently. In the unlikely event of this happening **we** will ask for an explanation of why the particular method of **treatment** was chosen. **We** recognize that there may have been a valid reason for the choice made by the **medical practitioner**. **Our** intention in questioning such matters is to be able to fairly and accurately assess any claim.

In the event of any differences in opinion between **our** medical team and the attending **medical practitioner**, **our** medical teams' opinion shall prevail.

Persons eligible
Members eligible to be covered under this **policy** must be aged eighty (80) years or less at the time of application

Our philosophy is to continue offering renewal beyond age eighty (80) so that **members** can enjoy the peace of mind of continuing their cover for as long as possible subject to **you** paying the applicable premium.

This **policy** may provide cover for **members** residing outside of Malaysia, however, in most cases **we** cannot cover **you** if **you** are a national of your resident country (other than Malaysia). In addition, country specific regulations may impact a person's eligibility to be a **member**. Generali Insurance Malaysia Bhd may be required to apply legitimate international sanctions to this **policy**. In such a case Generali may be unable to meet its full obligations under the terms of this **policy** where to do so would render it subject to legal action under international or domestic law. Generali may be required to applylegitimate international law. **We** and other service providers will not provide cover or pay claims under this **policy** if doing so would expose **us** or the service provider to a breach of international economic sanctions, laws or regulations, including but not limited to those provided for by the European Union, United States of America or under a United Nations resolution. If a potential breach is discovered, where possible **we** will advise **you** in writing as soon as **we** can.

Sanction Limitation Clause
No (re) insurer shall be deemed to provide cover and no (re) insurer shall be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose that (re) insurer to any sanction, prohibition, or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, United States of America or Malaysia.

Section 2 -What you're covered for

Where applicable, in applying deductibles and co-insurance (the percentage of **eligible** benefits payable by the **member**) **we** will subtract the deductible first and then apply the co-insurance to the balance of **eligible** benefit remaining.

Please refer to Section 11 – 'Benefits table' for further information on the benefit levels of your **plan**.

Benefits	**Clarifications**
Yearly maximum	**We** will pay up to the maximum shown for each **member** each **policy year.** Allbenefits paid during the **policy** period will count against the yearly maximum. Cover does not extend beyond the **area** shown for your **plan** unless **you** are **eligible** for'outside **area of cover**' benefit.
Outside **area of cover**	This is to cover '**emergency' treatment** whilst outside the **member's area of cover**. **We** will, in consultation with the treating **medical practitioner**, retain the right to determine what constitutes '**emergency' treatment**. This benefit does not provide cover for **treatment** for any condition if **you** have travelled outside your **area of cover** to get **treatment** (whether or not that was the only reason) or for any **treatment** which was, or may have reasonably been known about, before travel commenced. Under no circumstance will benefit be payable for any aspect of pregnancy or childbirth. Once **we** have determined, in conjunction with the treating **medical practitioner**, that the **eligible medical condition** is stabilized or the health status of the **member**allows him/her to travel back into his/her **area of cover**, **we** will stop paying for '**emergency' treatment**. Please also refer to Section 3 - 'International Emergency Medical Assistance (IEMA)' of this handbook.
Level of reimbursement	**Reasonable and customary** (R&C) charges.

In-patient and daycare treatment – general information
By in-patient **treatment**, **we** mean **treatment** at a **hospital** where the **member** has to stay in a **hospital** bed for one or more nights. By daycare **treatment**, **we** mean **treatment** at a **hospital** or daycare unit (where a discharge summary is issued by the **hospital)** and the **member** requires a procedure, **eligible** for benefit, necessitating admission to a **hospital** bed but not requiring an overnight stay.

Subject to the limits shown for your **plan you** are covered for **hospital** charges incurred for **eligible treatment** given by a medical practitioner between admission and discharge such as:

- daily accommodation charges
- diagnostic procedures
- operating theatre charges
- nursing care, drugs and dressings
- surgical appliances used by the **medical practitioner** during surgery except external prosthesis or orthosis or appliances
- surgeons' and anaesthetists' charges
- intensive care unit charges
- consultations and physiotherapy while admitted for **treatment** of a **medical condition** and when such **treatment** directly relates to it
- radiotherapy and/or chemotherapy
- computerized tomography, magnetic resonance imaging, x-rays and other such proven medical imaging techniques
- special nursing in **hospital** and/or nursing at home, after discharge, when agreed in writing beforehand that it is **medically necessary** and appropriate
- service tax on **eligible** room & board charges

Please note: All non-emergency admissions require our written pre-authorization before admission.

The approval **we** give to the service provider will indicate the amount which is **reasonable and customary (R&C)** forthe proposed **treatment**. Please refer to Section 4 – 'Claims procedure' of this handbook.

Please refer to Section 11 – 'Benefits table' for further information on the benefit levels of your **plan**.

Benefits	Clarifications
Daily accommodation charges	While admitted as an in-patient or daycare, **we** will pay for the costs of **member's** accommodation in the type of room shown in your **benefits table**. Wherever a **member** receives **treatment**, if the **hospital** offers several classes for the room type he is entitled for, **we** will only pay for the cost of a room of a standardclass. This corresponds to the lowest cost room class offered in that **hospital** for that type of room. If a **member** stays in a room which is more expensive than the standard room, the **member** may have to pay for the difference in room charges. The **member** may also have to pay for a share of other medical expenses wherever these increase asa result of the room upgrade. Please check with **us** prior to admission to avoid unnecessary out-of-pocket expenses.
Parent accommodation	**We** will pay when the child **member** is under eighteen (18) years old and receiving an **eligible** in-patient **treatment** within the child **member**'s **area of cover**. This is paid from the child's benefit.
Cash benefit	This is payable for **eligible** in-patient **treatment** only when the **member** receives **treatment**, within the **area of cover**, provided no cost is borne by **us**. No other benefit will be payable in respect of the period for which the cash benefit has been claimed. **We** will pay a cash benefit up to the '**Pre-existing Condition'** benefit, if applicable to the **member's plan**, when the in-patient treatment is resulting from a covered **pre-existing condition.** 'Cash benefit' is only payable when no other benefit is claimed for under this **policy** as per in-patient **treatment**.
Pre-hospitalisation benefit	For Plan 1, 2 and 3, this benefit is included within the 'General Practitioner and Specialist Consultation Charges' benefit and is subject to the term and conditions applied for 'General Practitioner and Specialist Consultation Charges' benefit. For Plan 4, **we** will only pay for one (1) consultation, prescribed investigations and essential medications by a **medical practitioner** received as an out-patient, within sixty (60) days prior to a hospitalisation, where such hospitalisation is **eligible** for cover under **member's plan** and where the need for such hospitalisation has arisen as a direct result of the medical examination and investigation findings drawn from that consultation.
Post-hospitalisation benefit	For Plan 1, 2 and 3, this benefit is included within the 'General Practitioner and Specialist Consultation Charges' benefit and is subject to the term and conditions applied for 'General Practitioner and Specialist Consultation Charges' benefit. For Plan 4, **we** will only pay for follow-up out-patient consultation and **treatment** following an **eligible** in-patient **treatment** or daycare surgery

	when suchconsultation is carried out by the in-patient treating **medical practitioner** or a referred **medical practitioner** and provided such consultation or **treatment** occurs within ninety (90) days immediately following the date of discharge from **hospital**for which the **member** was confined as an in-patient or the date of the daycare surgery**.**

In-patient and direct billing
All non-emergency in-patient **treatment** must be approved by **us**, in writing, prior to admission. **You** can take advantage of direct billing facilities for **eligible** in-patient care within **our** international **directory of hospitals**.

Please note: prior to admission or receiving **treatment you** must identify yourself and your eligibility for discounts by showing your membership card together with a recognized official form of identification (such as a passport) to *any* network provider as evidence that **you** are an insured **member** of an **InternationalExclusive policy**. Failure to ensure that the network provider recognizes your entitlement to **our** discounted services may result in the **member** being required to pay any difference between the invoice value and **our** negotiated price.

Please note that Generali reserves the right to recover from the **member** any ineligible expenses it has incurred on behalfof that insured **member** under this **policy**.

Out-patient treatment – general information

Out-patient **treatment** is **treatment** given by a **medical practitioner** at an out-patient clinic, a **medical practitioner's** consulting room or in a **hospital** where the **member** is not admitted to a bed. **You** are covered, subject to the limits shown, for:

- **medical practitioner** charges for consultations
- diagnostic procedures
- **prescriptions** (note any prescribed drug or other medication required for more than thirty (30) days must be pre-authorized by **us**)
- physiotherapy received as an out-patient (this is subject to **our** pre-authorization)
- computerized tomography, magnetic resonance imaging, positron emission tomography, x-rays and gait scans received as an out-patient (this is subject to **our** pre-authorization)
- radiotherapy and chemotherapy received as an out-patient
- **surgical procedures** received as an out-patient

Please refer to Section 11 – 'Benefits table' for further information on the benefit levels of your **plan**.

Benefits	**Clarifications**
General Practitioner and Specialist Consultation Charges	A consultation is a **visit** to any **medical practitioner** for the **treatment** of an **eligible medical condition**. *Second opinion for the same condition:* • pre-authorization *is not* required for Plan 1 • written pre-authorization *is* required for Plan 2 and Plan 3 *Thereafter subsequent opinions and referrals for the same* **medical condition***:* • written pre-authorization *is* required for all **plans** For Plan 4, this benefit is included if it is part of pre- and/or post-hospitalisation treatments for an **eligible** in-patient **treatment or** daycare surgery. Hence it is subject to the limitations applied under Plan 4 for 'Pre-hospitalisation treatment' and/or 'Post-hospitalisation treatment' benefits, respectively.
Courses of chiropractic treatment, acupuncture, homeopathy and osteopathy (Plan 1, 2 and 3 only)	Such **treatment** must be pre-authorized by **us** in writing and be given by a qualifiedpractitioner who is recognized by **us** and registered to practice this where the **treatment** is given. **Treatment** given by a chiropractor, osteopath, homeopath or acupuncturist must be under the medical supervision of a **medical practitioner**. Medical supervision means that the reason for referral, where applicable, has been initiated by the **medical practitioner** who has defined a diagnosis. There must be a clear **treatment** plan from the chiropractor, osteopath, homeopath or acupuncturist with an end point and expected outcome. Please also see Section 6. 2.1(d).
Traditional Chinese medicine (Plan 1, 2 and 3 only)	Such **treatment** must be given by a qualified traditional Chinese **medical practitioner** who is recognized by **us** and registered to practice this where the **treatment** is given. The benefit covers for a maximum of twenty (20) sessions each**year** and up to the limit per **visit** shown for your **plan**. There must be a clear **treatment** plan from the traditional Chinese **medical practitioner** with an end point and expected outcome. Please also see Section 6. 2.1(d).
Courses of physiotherapy	Such **treatment** must be pre-authorized by **us** in writing and be given by a qualified **physiotherapist** who is recognized by **us** and registered to practice this where the **treatment** is given. **Treatment** given by a **physiotherapist** must be under the medical supervision of a **medical practitioner**. Medical supervision means that the reason for referral, where applicable, has been initiated by the **medicalpractitioner** who has defined a diagnosis. There must be a clear **treatment** plan from the **physiotherapist** with an end point and expected outcome. For Plan 4, this benefit is included if it is part of post-hospitalisation treatment for an**eligible** in-patient **treatment** or daycare surgery. Hence it is subject to the limitations applied under Plan 4 for 'Post-hospitalisation treatment' benefit. Please also see Section 6. 2.1(d).

Radiotherapy and Chemotherapy	**We** will pay for radiotherapy and/or chemotherapy received as an out-patient for active treatment of cancer at a registered medical facility recognised by **us**. The maintenance phase of any treatment (such as the administering of herceptin orsimilar drugs which are not classed as active cancer treatments) will be paid for under the 'General Practitioner and Specialist Consultation Charges' benefit where available under **your plan**. Plan 4 does not provide cover for maintenance of any treatment received as an outpatient. Upgrades will not be accepted for cancer care, after initial diagnosis, under anycircumstances. In any event benefits for oncology and related treatment will only be payable forthree (3) years (in aggregate) in a **member**'s lifetime
Kidney Dialysis	**We** will pay for kidney dialysis received as an out-patient for an **eligible medicalcondition** at a registered medical facility recognised by **us**.

All benefits are subject to assessment on the basis of what is **reasonable and customary** (R&C) within **our** network **hospitals**. This assessment will apply even when the treating **medical practitioner** refers **you** for **treatment** outside **our** network if that **treatment** would have been available within **our** network. **Reasonable and customary** (R&C) willapply in any event. If in doubt please contact **us** before receiving **treatment**.

Other benefits – general information
These are the additional features of your **plan**. Please note that all deductibles, limitations and terms apply to these benefits exactly as for the main in-patient/daycare and out-patient benefits depending on whether **treatment** is received as an out-patient, in-patient or daycare patient.

Please refer to Section 11- 'Benefits table' for further information on the benefit levels of your **plan**.

Benefits	Clarifications
Health Screen (Plan 1 only)	Benefit is payable only once in each **year** of membership and is subject to a **waiting period** of a **year**. By this **we** mean that **you** must have been continuously covered on the Plan 1 for twelve (12) consecutive months and have effected the annual renewal of that **plan** for the coming **policy year.** This **waiting period** is calculated initially from your date of joining your **plan**. The limit shown for your **plan** includes the cost of any **eligible** consultation needed as part of the screening process.
Pre-existing conditions, maintenance of pre-existing**chronic** conditions and the 'acute phase' of a pre-existing **chronic** condition	Benefits only become available and **eligible** claims payable for expenses incurred after the **member** has been continuously covered under his/her chosen **plan** for thelength of **waiting period** applicable to the **member's plan** stated on the **benefits table** and has paid the annual premium. For Plan 1 and 2, benefits are further limited, within the first two (2) **years** of membership to the lower limit shown for this benefit in **the benefits table**. All **eligible pre-existing conditions** that existed or for which there were symptoms before the inception of the **policy** or the introduction of this additional benefit will bepaid for from this benefit and subject to the limit shown for your **plan**. All such **pre- existing conditions** must, in good faith, be declared to **us**, in writing, at the time of application. Please note that the **treatment** of the acute phase of any **pre-existing condition**, whether **chronic** or not, will be paid for out of this benefit and the limits of this benefit will apply in any event. **We** reserve the right to refuse to pay benefit for any such condition which was not declared on a **member's** application form.
Maintenance of non **pre-existing chronic** conditions (Plan 1, 2 and 3 only)	This benefit provides for the maintenance of one or more **chronic** conditions up to the limit shown each **year**. The initial diagnosis and stabilization of a **chronic** condition arising after **policy** inception is covered under the main benefits of your **plan**. Thereafter the maintenance, including any acute phase of a **chronic** condition will be covered under this benefit. Please note that the **treatment** of the acute phase of any **pre-existing condition**, whether **chronic** or not, will be paid for out of the '**Pre-existing conditions**' benefit above and the limits of that benefit will apply in any event. Please note: Only recognized, proven and necessary **treatment** that is prescribed by a **medical practitioner** will be **eligible** for benefit.

All benefits are subject to assessment on the basis of what is **reasonable and customary** (R&C) within **our** network **hospitals**. This assessment will apply even when the treating **medical practitioner** refers **you** for **treatment** outside **our** network if that **treatment** would have been available within **our** network. **Reasonable and customary** (R&C) willapply in any event. If in doubt please contact **us** before receiving **treatment**.

Please refer to Section 11 – 'Benefits table' for further information on the benefit levels of your **plan**.

Benefits	**Clarifications**
Oral and maxillofacialsurgery	This benefit pays for the following procedures performed by an oral and maxillofacial surgeon: (i) Surgical removal of impacted/un-erupted teeth and buried teeth which arediseased or causing symptoms; (ii) Surgical removal of complicated buried roots which are diseased or causing symptoms; (iii) Enucleation (removal) of cysts of the jaw; (iv) **Treatment** of cancers (For lesion or lump in the mouth) Necessary **treatment** to Temporal Mandibular Joint (TMJ) such as physiotherapy and surgery are covered under the respective benefits of this **policy**. For avoidance of doubt, the maximum benefit payable shall be limited to the amount applicable on the **'Pre-existing conditions**' benefit after the length of **waiting period** stated on the **benefits table** applicable to the **member's plan** if theoral and maxillofacial surgery is required for an **eligible pre-existing condition**. Please note: this benefit does not cover routine dental care.
Local Road Ambulance transport	This is to pay for a local road ambulance for **medically necessary emergency** transport to or between **hospitals.** Your **medical practitioner** will determine if this is medically essential. **We** reserve the right to ultimately determine whether such transportation was medically appropriate. *(This does not form part of the International Emergency Medical Assistance service shown below)*
International Emergency Medical Assistance	This is a worldwide, 24 hours a day, 365 days a year **emergency** service providing evacuation or repatriation services. If a **member** needs immediate **emergency** in- patient **treatment**, where local facilities are unavailable or inadequate, a phone call to the Health Service Team will alert the International Emergency Medical Assistance service. Please note that, for the **member**'s own protection, calls maybe recorded in case of subsequent query or for calls for training or quality monitoring purposes. Please refer to Section 3 – 'International Emergency Medical Assistance (IEMA)' formore details.
Psychiatric **treatment** (Plan 1, 2 and 3 only)	This benefit is subject to **our** pre-authorization. The limit shown applies to in-patient, daycare and out-patient **treatment** in aggregate.
Accidental damage to teeth	Under accidental damage to teeth, **we** will pay for **treatment** required immediately within seven (7) days following accidental damage to natural teeth caused by an external trauma when that **treatment** is given by a **medical practitioner**. This is forthe initial **treatment** only; it does not include any follow-up **treatment**. Benefit is not payable if: • the damage was caused by normal wear and tear • the **injury** was caused when boxing or playing rugby (except school rugby) unlessappropriate mouth protection was worn • the damage was caused by tooth brushing or any other oral hygiene procedure • the damage is not apparent within seven (7) days of the impact which caused the **injury** Please note: there is no cover for **treatment** required as a result of the consumption of food or drink or any foreign bodies contained in such food or drink.

Pre- and post-natal complications (Plan 1, 2 and 3 only)	Benefit only becomes available and **eligible** claims payable for expenses incurred after the **member,** who must be over the age of eighteen (18), has been continuously covered under her chosen **plan** for twelve (12) consecutive months and has effected the annual renewal of that **plan** for the coming **policy year**. This benefit will, subject to the limitations and exclusions of this **policy**, cover **treatment** of both the mother and any unborn child up to the moment of delivery. Thereafter cover will be restricted to **eligible treatment** for the mother alone. Underpost-natal complications, **we** will only pay for t**reatment** received within ninety (90)days following the delivery of child. This benefit does not cover: • the costs of delivery of any child whether such delivery is normal, by caesareansection or by any other assisted means, or • any complication arising from non **medically necessary** caesarean section birth, or • if the conception of the child is by assisted conception, or • **treatment** of any **medical condition** which is due to and occurs during the pregnancy prior to the delivery or after the delivery if the pregnancy was a result of any form of **assisted conception**. The list of eligible pre- and post- natal complications include the following: • Antiphospholipid syndrome, • Cervical incompetence, • Ectopic pregnancy, • Gestational diabetes, • Hydatidiform mole – molar pregnancy, • Hyperemesis gravidarum, • Obstetric cholestasis, • Pre-eclampsia / Eclampsia, • Rhesus (RH) factor, • Threatened miscarriage, • Post partum haemorrhage, • Retained placental membrane Whilst **we** recognize that caesarean section may sometimes be a medical necessity, caesarean section can only be covered under the 'Pregnancy and delivery' benefit for **member** insured on **Plan** 1. Any newborn infant may be added to the mother's **policy** and enjoy cover commencing at the time of birth provided **we** are requested to add that infant to the mother's **policy** within thirty (30) days from the time of birth and the parental cover is in force at the time of delivery. If the mother is not covered by **us** at the time of delivery a newborn baby may only be added to the father's **policy** and be **eligible** for benefit after final discharge of the child into parental care. This benefit does not cover the costs of delivery of any child whether such delivery is normal, by caesarean section or by any other assisted means. This benefit will not automatically be upgraded to a higher level of **plan**. In the case of an upgrade in cover this benefit will be restricted to the level of the original **plan** until the **member** has been covered under the upgraded **plan** for a period of not less than twelve (12) consecutive months and has effected the annual renewal of the upgraded **plan**. Please also see Section 6.3.1(f).

All benefits are subject to assessment on the basis of what is **reasonable and customary** (R&C) within **our** network **hospitals**. This assessment will apply even when the treating **medical practitioner** refers **you** for **treatment** outside **our** network if that **treatment** would have been available within **our** network. **Reasonable and customary** (R&C) willapply in any event. If in doubt please contact **us** before receiving **treatment**.

Please refer to Section 11 – 'Benefits table' for further information on the benefit levels of your **plan**.

Benefits	Clarifications
Pregnancy and delivery (Plan 1 only)	Benefit only becomes available and **eligible** claims payable for expenses incurred after the **member** has been continuously covered under the **InternationalExclusive** Plan 1 for twelve (12) consecutive months and has effected the annual renewal of that **plan** for the coming **policy year**. This benefit is only available for female **member** over the age of eighteen (18) years and covers pre-natal care, delivery and post-natal care up to forty-two (42) days following birth, in aggregate, up to the limit shown for your **plan**. The limit shown is the maximum **we** will pay under this benefit for each: • **policy year**, even if there is more than one pregnancy in that **policy year** • pregnancy, even if a pregnancy, which is **eligible** for benefit, falls across the **policy** anniversary, and provided the **policy**, including this benefit, has been renewed for the subsequent **policy year** For birth through vaginal delivery and **medically necessary** caesarean section, **we**will pay for the delivery costs up to the limit shown for this benefit in the **benefits table**. Any complications arising from such delivery will be paid by the 'Pre-and post-natal complications' benefit. For birth through non-**medically necessary** caesarean section, **we** will pay for the delivery costs up to the costs of a normal delivery. The complications arising from such delivery will be paid up to the remainder of the 'Pregnancy and delivery' limit. Please note: If **we** are not able to determine that a caesarean section is **medically necessary we** will consider it as not **medically necessary**. This benefit will not automatically be upgraded to a higher level of **plan**. In the caseof an upgrade in cover this benefit will be restricted to the level of the original **plan** until the **member** has been covered under the upgraded **plan** for a period of not less than twelve (12) consecutive calendar months and has effected the annual renewal of the upgraded **plan**. Please also see Section 6.3.1(f).
Vaccinations (Plan 1, 2 and 3 only)	Benefit is payable for vaccinations up to the limit shown for your **plan**.
Routine dental care (Plan 1 only)	This benefit provides for extraction, composite fillings, root canal **treatment**,scaling/polishing, bridgework, crowns and the **treatment** of gum disease. **We** will pay eighty percent (80%) of all **eligible treatment** shown above up to thelimit shown for your **plan**.
Routine optical care (Plan 1 only)	This benefit provides for the fees charged for eye examinations carried out by a qualified and registered ophthalmologist recognized by **us**, the cost of spectacle frames, corrective lenses prescribed by the ophthalmologist, up to the limit shown for your **plan**. This excludes tinted/reactive lenses, sunglasses, non-corrective contact lenses, lasik/laser eye surgery and/or similar, whether prescribed or not.

All benefits are subject to assessment on the basis of what is **reasonable and customary** (R&C) within **our** network **hospitals**. This assessment will apply even when the treating **medical practitioner** refers **you** for **treatment** outside **our** network if that **treatment** would have been available within **our** network. **Reasonable and customary** (R&C) willapply in any event. If in doubt please contact **us** before receiving **treatment**.

Please refer to Section 11 – 'Benefits table' for further information on the benefit levels of your **plan**.

Hospice and palliative care	Benefit only becomes available and **eligible** claims payable for expenses incurred up to the limits applicable to the **member's plan** after the **member** has been continuously covered under his/her chosen **plan** for twelve (12) consecutive calendar months and has effected the annual renewal of that **plan** for the coming **policy year**. This benefit becomes available when the **member** is admitted to a specialist palliative care centre or hospice, recognized by **us**, following diagnosis, written confirmation (including medical evidence) by a **medical practitioner** that the **member** is suffering from an **eligible terminal medical condition** and its associated **medical conditions**. The benefit must be pre-authorized, in writing, by **us** in advance of admission. Once the **member** is admitted, all costs of care and any **treatment** related to the **terminal medical condition** and related **medical conditions** will be taken from this benefit and may not be claimed from any other benefit applicable to the **member's plan**. Any **eligible medical conditions** not related to the **member's terminal medical condition** will be covered under the **member's** normal **plan** benefits. **We** reserve the right to determine, on the advice of **our** medical panel, whether a **medical condition** is or is not related to the **terminal medical condition**. This benefit is payable, up to the **lifetime** limit shown for the **member's plan,** once in a **member's lifetime**, in aggregate for all such conditions. The **member** must maintain the same level of cover throughout the palliative or hospice care admission. This means that, if the period of palliative or hospice care falls across a **policy** anniversary, the **member** must pay the premium for the subsequent **year** or benefit will cease at the **policy** anniversary. In the event that the costs of the **member's** admission reach the limit shown for this benefit no further benefit will be payable. Once the limit of this benefit is reached no benefit of any kind will be payable in respect of any **medical condition** for which palliative and/or hospice care has been received. This benefit will not automatically be upgraded to a higher level of **plan**. In the case of an upgrade in cover this benefit will be restricted to the level of the original **plan** until the **member** has been covered under the upgraded **plan** for a period of not less than twelve (12) consecutive months and has effected the annual renewal of the upgraded **plan**. The **waiting period** will apply in the event of an upgrade in cover.

All benefits are subject to assessment on the basis of what is **reasonable and customary** (R&C) within **our** network **hospitals**. This assessment will apply even when the treating **medical practitioner** refers **you** for **treatment** outside **our** network if that **treatment** would have been available within **our** network. **Reasonable and customary** (R&C) willapply in any event. If in doubt please contact **us** before receiving **treatment**.

Section 3 – International Emergency MedicalAssistance ('IEMA')

1) Can a **member** be repatriated to his/her **principal country of residence** or **area of cover** for **treatment**?
There may be reasons why a **member** would prefer to return to his/**her principal country of residence**or **area of cover** for **treatment** which does not involve an **emergency** admission. In this case, **the member** will be covered by the benefits of his/her **plan** on return to his/her **principal country of residence** or **area of cover** and can claim in the usual way. The cost of returning to **the member principal country of residence** or **area of cover** in these circumstances will be his/her responsibility.

2) What if **a member** is taken ill but the local medical facilities are not adequate to treat **the member**?Should **the member** be injured or become ill and need immediate **emergency in-patient treatment** then the **evacuation or repatriation service** will become available to **the member.**

The exclusions in other parts of this **policy** document do not apply to the **evacuation or repatriation service** but will apply to **treatment** in **the member principal country of residence**, home country or any country to which **he/she** has been evacuated. If **the member** need the **evacuation or repatriationservice, he/she** must contact **our** Health Service Team so that immediate help or advice can be given over the phone.

Arrangements may then be made for **our** appointed **medical practitioner** to see **the member** and to move him/her or bring him/her back to his/her **principal country of residence** if necessary. If **our** appointed **medical practitioner** thinks it is necessary then the **evacuation or repatriation service** will be carried out under medical supervision.

The full rules relating to the **evacuation or repatriation service** can be found in the following items 3 and 4.

3) Specific terms relating to the overseas **evacuation or repatriation service**

3.1) The overseas **evacuation or repatriation service** is available to provide the following services onlywhen the arrangements are made by **us**:

a) Transferring **the member** by air ambulance, regular airline or any other method of transport **we** consider appropriate. **We** will decide the method of transport and the date and time.

b) If **the member** is admitted to **hospital** then, if in the opinion of **our** appointed **medical practitioner** the medical facilities in the **hospital** are not suitable or adequate, **the member** will be evacuated to the nearest place where appropriate services are available.

c) Cover for the reasonable and necessary transport and additional accommodation costs for another person, who must be **age** eighteen (18) years or over, to accompany **the member** if he/she is under **age** eighteen (18) years (or in other cases where **we** believe that **the member medical condition** makes it appropriate) while he/she is being moved.

d) Cover for the reasonable additional travelling and accommodation costs incurred in returning to the **principal country of residence** any family **member** covered by an InternationalExclusive policy who is accompanying **your member** on the overseas journey.

e) Bringing **the member** body back to a port or airport in his/her **principal country of residence** or his/her home country, if **the member** dies outside of his/her home country, except if he/she die in thecircumstances shown in below item 4(b).

4) The overseas **evacuation or repatriation service** will not be available for the following:

a) Any **medical condition** which does not prevent **the member** from continuing to travel or work and which does not need immediate **emergency in-patient treatment**.

b) Any costs incurred which arise from, or are directly or indirectly caused by a deliberately self- inflicted injury, suicide or an attempt at suicide.

c) Any costs incurred which arise from or are in any way connected with, alcohol abuse, drug abuse orsubstance abuse.

d) Any costs incurred as a result of engaging in or training for any sport for which **the member** receives a salary or monetary reimbursement, including grants or sponsorship (unless **the member** receives travel costs only).

e) **Treatment** of injuries sustained from base jumping, cliff diving, flying in an unlicensed aircraft or as a learner, martial arts, free climbing, mountaineering with or without ropes, scuba diving to a depthof more than 10 metres, trekking to a height of over 2,500 metres, bungee jumping, canyoning, hang- gliding, paragliding or microlighting, parachuting, potholing, skiing off piste or any other winter sports activity carried out off piste.

f) Moving **the member** from a ship, oil-rig platform or similar off-shore location.

g) Any costs that **we** do not approve beforehand.

h) **Treatment** costs other than for the necessary **treatment** administered by the international assistance company appointed by **us** while they are moving **the member**.

i) Any unused portion of **the member** travel ticket, and that of any accompanying person, will immediately become **our** property and **you** must give it to **us**.

j) Any costs incurred as a result of nuclear, biological or chemical contamination, war (whether declared or not), act of foreign enemy, invasion, civil war, riot, rebellion, insurrection, revolution, overthrow of a legally constituted government, explosions of war weapons or any event similar to oneof those listed.

k) Any costs incurred when **the member** is on a leisure trip and he/she is travelling to a country or area that the UK Foreign and Commonwealth Office lists as a place which they either advise against:

- all travel to; or
- all travel on holiday or non-essential business

5) **We** will not be liable in respect of the **overseas evacuation or repatriation service** for:

a) Any failure to provide the **overseas evacuation or repatriation service** or for any delays in providingit, unless the failure or delay is caused by **our** negligence including that of the international assistance company **we** have appointed to act of **us**), or of agents appointed by either party.

b) Failure or delay in providing the **overseas evacuation or repatriation service** if:

- by law **the overseas evacuation or repatriation service** cannot be provided in the country inwhich it is needed; or
- the failure or delay is caused by any reason beyond **our** control including, but not limited to,strikes and flight conditions.

Important :
For avoidance of doubt, **we** will not pay for any **evacuation or repatriation service** if **you** or **your member** have not obtained pre-approval from **us**.

All cases must be assessed by **our** Customer Service team, to be deemed necessary for **evacuation or repatriation service**, and all arrangements must be made by **our** Customer Service team in order to ensure that related costs are covered by the **service**.

If an **insured person** makes his/her own arrangements, its costs will not be covered. Entitlement to the **service** does not mean that **the insured person treatment** following evacuation or repatriation will be eligible for benefit. Any such **treatment** will be subject to the terms and conditions of **insured person plan**.

Health Service Team
Member can contact the Health Service Team at any time of the night or day, 7 days a week, 52 weeks of the year. When in contact with the Health Service Team, the **member** will need to state that they area **member** of **InternationalExclusive plan** and give their **policy** number.

24-Hours Hotline: The number shown on the reverse of your membership card This **service** is provided by an

international assistance company who acts for **us**.

Section 4 - Claims procedure
The following notes deal with some specific aspects and commonly asked questions relating to your cover. **You** should contact **us** for advice on any aspect of your **policy** that **you** do not understand.

How you obtain the benefits your plan provides
In any event, if **you** are receiving **treatment** in any part of **our** international **directory of hospitals you** must always identify yourself as a **member** to ensure that your **treatment** enjoys the advantages of **our** negotiated rates. Failure to do this may expose **you** to additional costs which **you** will have to bear.

What to do before receiving in-patient and daycare treatment
Before receiving any planned in-patient or daycare **treatment** recommended by your **medical practitioner**, **you** or the treating **hospital** must contact **us** to obtain **our** authorization for your proposed **treatment**. **We** will confirm, in writing, to y**ou** and/or the **hospital** the extent of your cover for the proposed **treatment** and the amount **we** are prepared to pay for it. In the unlikely event that there is any difference between **our** confirmed level of cover and what is requested by the **hospital** when **you** are discharged **you** must make arrangements to pay this when **you** are leaving the **hospital.**

Pre-authorization
The reason that **we** require pre-authorization of planned **treatment** is to protect **you** from unexpected costs. When issuing confirmation of cover in this way, **we** confirm the following:

- the planned **treatment** is **eligible** under your **policy**
- the planned **treatment** is **medically necessary**
- the planned **treatment** is within **reasonable and customary** (R&C) cost
- the planned **treatment** cost falls within the remaining benefit limit of your **plan**

Our agreement with **you** requires **you** to seek pre-authorization for the following **treatment** and services:

In-patient and daycare

- all in-patient and daycare admissions
- all non-emergency tests, diagnostics, **treatment**, surgery and other medical services
- all in-patient maternity services
- all in-patient dental services
- special nursing in hospital and/or any nursing at home after discharge
- hospice and palliative care
- reconstructive surgery
- psychiatric **treatment**

Out-patient

- non-emergency computerized tomography, magnetic resonance imaging, positron emission tomography, x-rays, gait scans and internal diagnostics such as but not limited to endoscopy, colonoscopy, gastroscopy and other such scans
- courses of chiropractic **treatment**, acupuncture, homeopathy, osteopathy and physiotherapy
- **prescriptions** covering consumables for thirty (30) days or more
- psychiatric **treatment**
- second and subsequent opinions and referrals for the same **medical condition**

Failure to obtain pre-authorization as required above may prevent **us** from settling all or part of any claim. In the event that **we** are obliged to pay for any item not covered by **our** confirmation **we** will recover that amount from **you**. In any event any cost that is not directly related to **treatment** will be borne by the **member**.

Emergency treatment
The only exception to this will be if the **treatment** requires an **emergency** admission, then **you** may not be able to contact **us** beforehand. Do, however, ask somebody to contact **us** as soon as possible and make sure that, when **you** are admitted to **hospital**, the **hospital** is given your membership card and proof of identity so that it can contact **us** straight away. In any event, under these circumstances, **our** authorization must be sought and given before **you** are discharged otherwise **you** may be required to pay the entire cost of your admission.

Claim forms
You can visit **our** website at generali.com.my to obtain a printable claim form if **you** need one or call **our** Health Service Team at the number shown on the reverse of your membership card.

You must provide a completed claim form, signed by the **medical practitioner** and the **member**, forany **visit** made whether this is to a practitioner, **hospital**, clinic, pharmacy, diagnostic centre or any other facility where medical services may be received.

Claim forms outside our direct-billing network
You must take a claim form with **you** (also available from **our** website) and make sure it is filled in and signed by yourself and the **medical practitioner** treating **you** and sent back to **us** as quickly as possible, giving **us** all the information **we** request. (Only original receipted invoices can be accepted withyour claim). A fully completed claim form will ensure that your claim will be processed promptly. An incomplete or unsigned claim form may delay settlement of your claim and in some cases may lead to the claim form being returned to **you** for completion. It may be necessary for **us** to obtain a medical report from the attending **medical practitioner**. If the **medical practitioner** does not respond quickly to such a request your claim may be delayed. **We** do not pay for medical reports. For **treatment** requiring **our** pre-authorization, such authorization must be received from **us**, in writing, prior to **treatment** commencing. A copy of that authorization must be included in your subsequent claim. Please note that, for reimbursement claims, **we** will only consider claims made within ninety (90) days of **treatment** being received.

Where to send your claims
Any bills, together with your completed claim form, should be sent to:

Generali Insurance Malaysia Berhad Level 1, Menara Generali, 27 Jalan Sultan Ismail, 50250 Kuala Lumpur, Malaysia. or to your local Generali branch in Malaysia

Schedule of procedures
In this handbook **we** refer to a **schedule of procedures** which is a document that lists the proven **surgical procedures** for which **we** pay benefit and classifies them by complexity. Each of the procedures is also given a code number for administrative purposes. There are in excess of 1,000 procedures listed, of which about 250 are commonly performed on a daily basis. This document iswritten in medical language and it is intended for internal use by **medical practitioners** and **us** to assess the eligibility of proposed **treatment** and your claim. The schedule is regularly updated to includenew, proven, procedures and is retained by **us**.

Specific claims conditions
(a) The payment of any claim does not discharge **you/member's** obligations on the fulfilment of the terms and conditions under this **policy**; and

(b) **We** are not obliged to pay the ongoing costs of continuing, or similar, **treatment**, even where **we** have previously paid for this type of or similar **treatment**, if it is subsequently noted that this claim is not an **eligible treatment.**

Second opinion
We can ask an independent **medical practitioner** to advise **us** about the medical facts relating to a claim or to examine the **member** concerned in connection with the claim. This is needed only very rarelyand **we** use this right only where there is uncertainty as to the nature or extent of the **medical condition**and/or **our** liability under the **policy**. In the event of any differences between **our** medical team and the attending **medical practitioner**, **our** medical team's opinion shall prevail.

If you need treatment abroad
If **you** need **treatment** abroad, **you** will need to call **our** Health Service Team on the number shown on the reverse of your membership card.

If your **medical practitioner** recommends hospitalisation or a major out-patient procedure then call the above telephone number to confirm that **you** are entitled to benefit.

Any bills, together with your completed claim form, should be sent to:

Generali Insurance Malaysia Berhad Level 1, Menara Generali, 27 Jalan Sultan Ismail, 50250 Kuala Lumpur, Malaysia. or to your local Generali branch in Malaysia

Currency
Your premiums are payable in Malaysian Ringgit. Claim reimbursement will be paid in the same **currency** unless **we** have previously agreed otherwise in writing.

Medical expenses incurred in any **currency** other than Malaysian Ringgit will be converted using the spot rates prevailing at the time **we** assess the claim.

We shall not be liable for any bank charges or credit charges.

Any questions?
Although **we** have tried to include as much useful information in this handbook as possible, if **you** have any questions about your cover then please direct these to **our** Health Service Team. Please refer to Section 10 – 'Your Generali office' of this handbook for details on your local Generali office.

Section 5 - Important information about your plan

Our policy on changing your level of cover or moving to another plan
We reserve the right to refuse any request to upgrade or amend cover. In the event that **we** do accept a request for an upgrade **we** may restrict cover for conditions existing at the time of the upgrade to the level of benefits enjoyed under the original **policy**. In any event, final acceptance of any amendment by **us** and particularly the application of upgraded benefits will only be made at the next renewal following such a request. Neither amendments nor upgrades can be made during the **policy year**. Any condition known about or that should reasonably be known about at the time of an amendment or upgrade mustbe advised to **us** before the **policy** amendment takes effect.

What to do if you wish to add other members to your policy
If **you** want to add someone else to an existing **policy we** will send **you** the forms to complete and **you** must give all the information **we** request.

All applications for adding **members** are subject to **our** acceptance, and addition of a member must be due to a special event such as marriage or new born baby. The additional member's policy anniversary will be the same as that of the original policy issued to the policyholder. Please refer to Section 1 for eligibility of member.

For deletion of **member**, **we** will refund premium for such **member** if he has not incurred any claim inthe current **policy year**.

Any newborn infant may be added to the mother's **policy** and enjoy cover commencing at the time of birth provided **we** are requested to add that infant to the mother's **policy** within thirty (30) days from the time of birth and the parental cover is in force at the time of delivery. If the mother is not covered by **us**at the time of delivery a newborn baby may only be added to the father's **policy** and be **eligible** for benefit after final discharge of the child into parental care.

For avoidance of doubt, we do not pay for the hospital charges of newborn infant.

Please note that **we** are not obliged to accept any additional **member**. If **we** do accept an additional **member** during the **policy year we** may add an administration fee to the premium charged.

What happens if you change your principal country of residence
If **you** are planning to change your **principal country of residence** (where **you** live for most of the year) **you** must tell **us** as this may affect your eligibility.

InternationalExclusive is also available from Generali in several other Asian countries and Generali PPPhealthcare also offers similar plans both in the UK and elsewhere. Where appropriate, **we** may be able to transfer **you** to another Generali plan, with no additional medical underwriting exclusions.

Please contact **us** for information on availability and terms and conditions.

What happens if you wish to cancel your policy
You have a free-look period of fifteen (15) business days from the date that **you** receive this **Policy** to review it. **You** are deemed to have received the **Policy** within three (3) days after **we** have dispatched it.If **you** decide that this **Policy** does not suit your needs, **you** may request to cancel it by giving **us** clear, written instructions and returning the **Policy** documents and membership card(s) to **us** within the free- look period. Provided that no claims have been made during this period, **we** shall refund the premiums paid by **you**, in full, without interest. This free-look period shall not apply to **policy** renewals.

In addition, **you** may cancel your **policy** at any time by giving **us** notice in writing. Bearing in mind that this is an annual contract **we** will not refund premiums if any claim, however small, has been made inthe current **policy year**. In the event that **we** do agree to make a refund, **we** will only refund premiumson a pro-rata basis from the end of the Gregorian calendar month in which cancellation takes effect and provided **you** have returned to **us** the **policy** documents including the membership card(s).

Please also note that no claim of any kind will be considered after notification by **you** and acceptance by **us** of any cancellation.

When the terms of your policy might change

We have the right to cancel or change all or any part of your **policy** by giving you at least thirty (30) days written notice prior to the renewal date. **We** will not change the terms of your **policy** alone simplyas a result of your personal claims. However, **we** will make changes only to reflect any past orforeseeable changes in medical practice or procedures and the claims experience. The purpose of such changes will be to seek, as far as possible, to maintain substantially the same level and type of cover in place while ensuring that the **plan** remains affordable.

We may also change premiums if costs, taxation, regulations or benefit changes make this necessary.In the event that **we** are required by law to make a change during the **policy year**, for example if a new tax is introduced, **we** will be obliged to do so before the next renewal date. **We** do reserve the right to apply underwriting terms to your **policy** at any time if a **medical condition** that should reasonably have been declared comes to **our** attention, a **chronic** condition manifests itself within an excluded period ora **medical condition** becomes **chronic** in nature during a **policy year**.

Our position on chronic and other medical conditions which existed, or of whichyou were aware, before you applied for your plan

Our plans provide cover for **treatment** of conditions declared on the original application form, whether **chronic** or not, which existed before each **member** became **eligible** for benefit under a particular **plan**. This is subject to the **waiting period** applicable to the **member's plan** stated on the **benefits table.** During the **waiting period**, specific **medical conditions** may be excluded. However, **treatment** of certain **medical conditions**, which are unlikely to recur, may be covered from the date each **member** is first **eligible** for benefits under a particular **plan**.

For **us** to be able to determine whether **treatment** of a **medical condition** will be covered after the **waiting period** and/or to be **eligible** for benefit thereafter each **member** must have completed a full medical declaration, in detail, when first applying for any level of cover. Upon completion of a full medical history declaration your membership statement will clearly show the **medical conditions** for which **you** are not covered for **treatment** during the **waiting period**. **We** may ask for a medical report, at your own cost, to clarify the status of any **medical condition**.

No **treatment** of any **pre-existing** condition, whether **chronic** or not, will be **eligible** for benefit at any time if the condition has not been declared to **us** on the **member's** original application form.

Please note that it is important **you** give **us** full details of any **member's** medical history on anapplication. Failure to declare any **medical condition** of which **you** should reasonably have been awaremay result in **treatment** of that condition being excluded from all future cover with **us** or cancellation of your **policy**.

For avoidance of doubt, no benefit shall be payable if it is for maintenance of non-**pre-existing** chronic conditions on Plan 4.

Our position on chronic conditions first arising after you have been accepted formembership (Applicable to Plan 1, 2 and 3 only)

Cover for such condition is provided up to the limit shown in the **benefits table** for your **plan**, which applies for each **member** each **year**. This benefit is only available for **treatment** of **chronic** conditions for which first symptoms became apparent after the **member** was accepted, by **us**, for cover on a particular **plan**.

If there were any symptoms prior to inception of your **policy** these must have been declared to **us**, in good faith, on the **member's** original application form. Provided such a declaration was made and accepted by **us treatment** of the condition would be covered under the '**Pre-existing conditions'** benefit in the clarifications and **benefits table** appropriate to your **plan**.

Please note that the limit shown in the **benefits table** for your **plan**, which applies for each **member** each **year**, is an aggregate one. Thus each **member** may benefit annually up to the level shown for their**plan** for all such conditions collectively. Only recognized, proven and necessary **treatment** that is prescribed by a **medical practitioner** will be **eligible** for benefit. As for all reimbursement claims, claimsmust still be submitted within ninety (90) days of the date of **treatment** being given.

Our position on treatment for pre-existing conditions
As with all insurance policies **your plan** is there to cover **you** for costs arising from an unforeseen event. For healthcare insurance this means the cost of **treatment** resulting from an unexpected illness or **accident**.

For this policy, **pre-existing condition** exclusions and limitations shall apply to all benefits unless otherwise stated on the **benefits table** and/or **policy schedule** applicable to the **member's plan**.

A **pre-existing condition** is referred to as a **medical condition** the **member** is affected by or is suffering from prior to the **policy commencement date** and that he or she should reasonably be aware of when he or she is applying for cover.

We define **policy commencement date** as the date on which the insurance coverage starts as set forthin the **policy schedule** for the **member.**

Some of these **pre-existing conditions** may require medical attention after the **policy commencementdate**.

Based on **our** medical knowledge and global experience **we** may sometimes, for those **pre-existing conditions**, consider the medical attention required after the **policy commencement date** a foreseen event. As the purpose of this **policy** is to cover **you** against the costs of unexpected illness or **accident we** will assess claim for **pre-existing conditions** differently.

Our definitions are very important to read as they will affect the way **we** will pay your claims, if any, so **we** recommend **you** take some time to read and understand them.

As defined in Section 6.1.25, **we** define '**Pre-existing condition'** as:
medical condition/disability that the **member** has reasonable knowledge of. A **member** may be considered to have reasonable knowledge of a **pre-existing condition** where the condition is one for which:

- the **member** had received or is receiving **treatment**; or
- medical advice, diagnosis, care or **treatment** has been recommended; or
- clear and distinct symptoms are or were evident; or its existence would have been apparent to areasonable person in the circumstances.

We will assess a **medical condition** associated with a **pre-existing condition** as a **pre-existing condition**.

We will determine that a **medical condition** is associated with a **pre-existing condition** when this **pre- existing condition** is commonly recognized as a risk factor, however small, or if it is directly or indirectlyrelated to such **medical condition**. **We** reserve the right to determine whether a **medical condition** is associated with a **pre-existing condition** or not.

Please do not hesitate to contact our Health Service Team to check whether a **treatment** will be **eligible**for cover before receiving **treatment** and incurring costs, if it is medically safe for **you** to take the time tocontact **us**.

In some circumstances **you** may have joined on different terms to those described above and **you** will find those terms on **your policy schedule** and/or **membership listing**. For example, if **you** have joined from another insurer **we** may have transferred the medical underwriting terms from **your** previous policy for **medical conditions** that existed prior to **you** joining that policy.

Our position on genetic testing
As **you** can see from the membership agreement **we** only pay for illness or injury. There is also an exclusion saying that **we** do not pay for preventative **treatment**. It follows, therefore, that **we** do not pay for genetic tests, nor for any counselling made necessary following genetic tests, when those tests are undertaken to establish whether or not the **member** may be genetically disposed to the development ofa **medical condition** in the future. This is because such tests are carried out for purposes of establishing whether a **medical condition** might develop and not for the **treatment** of a **medical condition**. It follows that benefit cannot be paid for genetic testing or associated counselling carried out for such purposes.

Our position on psychiatric illness (Applicable to Plan 1, 2 and 3 only)
Your **policy** covers **treatment** of psychiatric illness up to the level shown in the **benefits table** for your **plan**. The **member** being treated or any **member** of his/her immediate family must contact us to obtain our written approval of the **treatment** planned and the proposed cost before **treatment** begins.

Section 6 - What this membership agreement means

This document sets out the terms of your membership agreement with **us** and must be read in conjunction with any supplementary documentation **we** provide to **you** from time to time (e.g. your **policy schedule**, membership card and International Emergency Medical Assistance terms). **We** have tried to keep this as simple as possible however, if there is anything **you** do not understand or would liketo clarify, please contact **us**. Decisions regarding your benefits and/or changes to the terms of your membership agreement cannot be made verbally but must be confirmed by **us** in writing. **We** may record calls for your protection in the event of subsequent query or for training purposes.

In any insurance document **you** will find detailed definitions, terms and exclusions. This is where **you** will find those that form a part of the contract between **us**. Please read them carefully and ask **us** if thereis anything **you** do not understand.

6.1 Definitions

Some words and phrases have special meanings. These meanings are set out below. When **we** use these terms they are in bold print.

6.1.1 **accident** – any external, sudden, non-disease, unforeseen and unexpected physical event beyond the control of the **policyholder** or the **member** resulting in bodily injury, caused by external, visible and violent means.

6.1.2 **area/area of cover** – one of the following:
Worldwide: worldwide
Worldwide excluding USA: worldwide excluding the USA and US Minor Outlying Islands
Asia: Afghanistan, Bangladesh, Bhutan, Brunei, Cambodia, China, Hong Kong, India, Indonesia, Japan, Kazakhstan, Kyrgyzstan, Laos, Macau, Malaysia, Maldives, Mongolia, Myanmar, Nepal, North Korea, Pakistan, Philippines, Singapore, South Korea, Sri Lanka, Taiwan, Tajikistan, Thailand, Timor-Leste,Turkmenistan, Uzbekistan, Vietnam.

The **member's principal country of residence** must bein a country within his/her selected **area of cover**.

6.1.3 **area of residence** – your **principal country of residence** as defined in Section 6.1.27.

6.1.4 **assisted conception** – Refers to the use of medical technology to increase the number of eggs during ovulation or to bring a human sperm and an egg, or eggs, close together, thereby increasing the chance of conception. This includes but is not limited to Intra- uterine insemination (IUI), In vitro fertilisation (IVF), Intracytoplasmic sperm injection (ICSI) or the use of any form of **treatment** to induce or increase ovulation. This will include baby conceived via surrogacy.

6.1.5 **benefits table** – the table applicable to your **plan** showing the maximum benefits **we** will pay for each **member**.

6.1.6 **chronic** – a **medical condition** or episode of ill health which persists for a long period or indefinitely.

6.1.7 **congenital conditions** – shall mean a geneticphysical or biochemical defect, malformation or anomaly,present at birth and whether or not manifest, diagnosed or known about at birth.

6.1.8 **currency** – the currency in which claims reimbursed to the **member** will be paid and in which premiums must be paid.

6.1.9 **eligible** – those **treatments** and charges which arecovered by your **policy** before the application of any deductible, co-insurance that will be borne by **you**. In order to determine whether a **treatment** or charge is covered, all sections of your **policy** should be read together, and are subject to all the terms, benefits and exclusions set out in this **policy**.

6.1.10 **emergency** – a sudden, unexpected acute **medical condition** which, in **our** opinion, constitutes a serious or life threatening emergency which will require immediate surgical or medical attention to avoid death orpermanent and irreversible total loss of function.

6.1.11 **enrolment/time of enrolment** – with effect from 00:01 hours on the date that a **member** is accepted by **us** and premium for the **member's plan** has been received and accepted by **us**. Any anniversary at which **we** have accepted the **member** under the conditionsabove.

6.1.12 **family member** – your partner and your unmarried children (or those of your partner) living with **you** when **you** take out the **policy** or when it is renewed.By partner **we** mean your current legally married spouse whom you live permanently, and who is aged between eighteen (18) to eighty (80) or less. Children cannot stay on your **policy** after the renewal date following their 21st birthday.

6.1.13 **hospital** – any establishment which is licensed asa medical or surgical **hospital**, clinic, specialist centre or provider in the country where it operates and which is recognised by **us**.

6.1.14 **directory of hospitals/ direct billing network list** – a document **we** maintain in which those **hospitals** with which **we** have direct settlement facilities are shown. **Policyholders** should use a **hospital** listed in the **directory of hospitals** except in the case of **emergency** where this may not be possible.

6.1.15 **lifetime** – the period in which the **member** is alive. This does not refer to the duration of the policy.

6.1.16 medical condition/disability – any **eligible** disease, illness or injury, including psychiatric illness.

6.1.17 **medical practitioner** – a person (other than the **policyholder**, **member**, or a member of the **policyholder** or the **member**'s immediate family) who, being recognised by **us**, has the primary degrees in the practice of western medicine and surgery following attendance at a recognised medical school and who is licensed to practice western medicine by the relevant licensing authority where the **treatment** is given. By 'recognised medical school' **we** mean "a medical school which is listed in the current World Directory of Medical Schools published by the World Health Organisation".

This would also, whenever appropriate, include a person qualified as a dental practitioner (other than the **policyholder**, **member**, or a member of the **policyholder** or the **member**'s immediate family) by a degree in dentistry and duly licensed and registered with the relevant statutory dental board or council to provide dental **treatment**.

6.1.18 **medically necessary** – any **treatment**, test, medication, or stay in **hospital** or part of a stay in **hospital** which:

- is required for the medical management of the illness or injury suffered by the **member**;
- must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
- must have been prescribed by a **medical practitioner**;
- must conform to the professional standard widely accepted;

6.1.19 **member/policyholder** – **you** and any **family member** included in your **policy**.

6.1.20 **Notice of Cancellation at policy renewal/ Anniversary Date** – unless **we** and/or **you** have agreed before the end of the **year** to renew the **policy**, cover will cease on the **policy** renewal/anniversary date. This will happen whether or not written notice of cancellation has been given by **us** to **you**.

6.1.21 **nurse** – a qualified nurse who is registered to practice as such where the **treatment** is given and is recognised by **us**.

6.1.22 **physiotherapist** – a person (other than the **policyholder**, **member**, or a member of the **policyholder** or the **member**'s immediate family) who is qualified and licensed to practice as a physiotherapist where the **treatment** is given and who is recognised by **us**.

6.1.23 **plan** – any **InternationalExclusive** plan.

6.1.24 **policy** – the insurance contract between **you** and **us**. Its full terms are set out in the current versions of the following documents as sent to **you** from time to time:

- any application form **we** ask **you** to fill in
- these terms and the **benefits table** setting outthe cover under your **plan**
- your **policy** schedule and certificate of insurance, **our** letter of acceptance and/or endorsements
- the international **directory of hospitals**

Changes to these terms must be confirmed in writing and**we** will write to **you** to confirm any changes, undertakings or promises that **we** make.

6.1.25 **pre-existing condition -** shall mean **medical condition/disability** that the **member** has reasonable knowledge of. A **member** may be considered to have reasonable knowledge of a pre-existing condition where the condition is one for which:

- the **member** had received or is receiving **treatment**; or
- medical advice, diagnosis, care or **treatment** has been recommended; or
- clear and distinct symptoms are or were evident; or its existence would have been apparent to a reasonable person in the circumstances.

6.1.26 **prescription** – out-patient drugs and dressings as prescribed by a **medical practitioner** for the **treatment** of a **medical condition** covered by the **member's policy**.

For avoidance of doubt, prescription does not include vitamins or supplements, regardless whether it is prescribed or not.

6.1.27 **principal country of residence** – the country where **you** live or intend to live for most of the **year** being 185 days or more and which will be shown as youraddress and place of residence in **our** records.

6.1.28 **reasonable and customary (R&C)** – this refers to charges for medical care which shall be considered by**us** or by **our** medical advisers to be reasonable and customary to the extent that they do not exceed thegeneral level of charges being made by others of similar standing in the locality where the charges are incurred when giving like or comparable **treatment**.

We will base that calculation on a combination of **our** global experience, statistical information provided by local health authoritative body and information collected from medical specialists and surgeons practicing in the country or **area** where the **treatment** is received.

For the avoidance of doubt when comparing **treatment**, **we** will take into account the complexity of the procedure and the standard of the medical facility where the **treatment** is received.

If the charges are higher than is customary, **we** will only pay the amount which is, in **our** experience, customarily charged and **you** will have to pay the rest.

6.1.29 **schedule of procedures** – a document **we** maintain which lists the **surgical procedures we** pay benefits for and classifies them according to their complexity.

6.1.30 **surgical procedure** – an operation or other invasive surgical intervention listed in the **schedule of procedures**.

6.1.31 **terminal medical condition** – the conclusive diagnosis if an illness that is expected to result in the death of the **member** within three hundred sixty-five
(365) days. This diagnosis must be supported by a specialist and confirmed by **our medical practitioner**. Terminal illness in the presence of Human Immunodeficiency Virus infection is excluded.

6.1.32 **treatment** – a **surgical procedure** or medical procedure carried out by a **medical practitioner**. This may include:

- diagnostic procedures – consultations and investigations needed to establish a diagnosis
- in-patient treatment – treatment at a **hospital** where the **member** has to stay in a **hospital** bed for one or more nights. This excludes all forms of alternative treatment such as but not limited to traditional chinese medicine and acupuncture
- daycare treatment – treatment at a **hospital or** daycare unit (where a discharge summary is issued by the **hospital)** and the **member** is admitted to a **hospital** bed but does not stay overnight
- out-patient treatment – treatment at an out-patient clinic, a **medical practitioner's** consulting rooms or in a **hospital** where the **member** is not admitted to a bed

For avoidance of doubt, the treatments listed above are subject to the **benefit table** according to the **member's plan** stated on the **policy** schedule. Certain benefits may exclude an entire class of treatment.

6.1.33 **United Kingdom** – Great Britain and Northern Ireland, including the Channel Islands and the Isle of Man.

6.1.34 **visit** – each separate occasion that the **member** meets with a **medical practitioner** and receives a consultation and/or **treatment** for a **medical condition**.

6.1.35 **we/us/our** – Generali Insurance Malaysia Berhad, being the Generali company issuing your **policy**.

6.1.36 **waiting period** - the period the benefit concernedwill not be payable.

6.1.37 **year** – twelve (12) Gregorian calendar months from when your **policy** began or was last renewed unless **we** have agreed something different.

6.1.38 **you** – the **policyholder** named on your **policy** schedule.

6.2 What we pay for

6.2.1 This **policy** insures the **members** against the cost of **medically necessary eligible treatment** carried out by a **medical practitioner**. **We** will pay only:

(a) for charges actually incurred for items listed in your **benefits table** subject to the limits shown there. Note: if **you** incur costs in excess of the limits **you** will have to pay the difference;

(b) for **treatment** of a **medical condition** which iscommonly known to respond quickly to **treatment**. Whenthe **medical condition** has been stabilized **we** may stopmaking payments. **We** reserve the right to determinewhen a **medical condition** has become **chronic** or recurrent in nature;

(c) charges made by the **medical practitioner,** laboratory or other such medical services which are **reasonable and customary**. **We** can delay paying the claim until **we** are satisfied that the charges are appropriate. If the charges made are higher than **reasonable and customary, we** will only pay the amount which is, in **our** experience, **reasonable and customary** and the **member** will have to pay the rest;

(d) for **treatment** by a suitably qualified **physiotherapist**, chiropractor, osteopath, homeopath, acupuncturist and traditional Chinese **medical practitioner** recognised by us or for the services of a **nurse** if the **plan** covers it and then only as allowed by the **benefits table**;

(e) provided the costs are not for something excluded by the terms of this **policy**;

(f) for eligible treatment incurred during a period for which the premium has been paid;

(g) **treatment** of conditions that existed, and were specifically declared to **us**, prior to inception of this **plan** except where such **treatment** relates to a condition that has previously been excluded or subject to a moratorium(**waiting period**) by Generali or any previous insurer and such exclusion or moratorium has not expired; or asallowed for by your **plan;**

(h) the initial diagnosis and stabilization of a **chronic** condition (a **medical condition** that does not respond quickly to **treatment** or recurs). Stabilization means, in the event of such a **medical condition** entering an acutephase (flaring-up), **treatment** to return the condition to a stable state. **We** will not normally pay for subsequent stabilization, routine, long term maintenance aimed at controlling and monitoring the condition once stabilized such as routine consultation and/or medications whether or not these are prescribed by a **medical practitioner** unless allowed for by the **benefits table** and accepted by **us** in writing;

(i) **Prescriptions,** being out-patient drugs and dressings as prescribed by a **medical practitioner** for the **treatment** of a **medical condition** covered by the **member's policy** provided that this cover is included in your **plan**.

Please note that **we** do not pay for standard toiletries such as, but not limited to shampoos, soaps, toothpastes, contraceptives, proprietary headache and cold cures, and vitamins or supplements nor do **we** pay for telephone calls.

6.3 What we do not pay for (exclusions and limitations)

6.3.1 The following tests, investigations, **treatments**, items, conditions, activities and their related or consequential expenses are excluded from this **policy** and **we** shall not be liable for:

(a) **treatment** of any **medical conditions** which the **member** already had when he or she joined and which **you** should have told **us** about but did not tell **us** at all or did not tell **us** everything unless **we** had agreed otherwise in writing that there was no need for **you** to tell **us**. This includes any **medical condition** or symptoms whether or not being treated and any previous **medical condition** which recurs or which the **member** should reasonably have known about even if he or she has not consulted a **medical practitioner**;

(b) non-surgical **treatment** of a **medical condition** which does not respond quickly to **treatment** or which continues or recurs unless allowed for by the **benefits table** and accepted by **us** in writing;

(c) the monitoring of a **medical condition** once it has been stabilized unless allowed for by the **benefits table** and accepted by **us** in writing;

(d) any **surgical procedure** which is not listed in the **schedule of procedures**, unless **we** have agreed, in writing, beforehand;

(e) any **treatment** which only offers temporary relief of symptoms rather than dealing, when it is reasonable to do so, with the underlying **medical condition**;

(f) pregnancy or childbirth (delivery) unless this is *specifically* included in your **benefits.** Caesarean section and any complications thereof is covered under 'Pregnancy and Delivery' benefit and would be subject tothe limit shown there if allowed for by the **member's plan** stated on the **policy schedule**;

Please note for clarity: if the **member**'s **plan** provides for'Pre- and post natal complications' benefit **we** will pay for **treatment** of a **medical condition** which is due to and occurs during the pregnancy. However **we** will not pay for such **treatment** if the pregnancy was a result of assisted means or any form of **assisted conception** or ifthe child is through surrogacy:

(g) **treatment** begun, or for which the need had arisen, during the first ninety (90) days after birth for any child conceived by artificial means or any form of **assisted conception** including artificial insemination or if the child is through surrogacy;

(h) termination of pregnancy or any consequences of it, except where **eligible** under the pre and post-natal complications benefit; **treatment** directly related tosurrogacy where the member is acting as surrogate, or isthe intended parent; foetal surgery; parenting or other teaching classes or ante-natal classes;

(i) investigations into and **treatment** of infertility, contraception, assisted reproduction, sterilization (or its reversal) or any consequence of any of them or of any **treatment** for them;

(j) **treatment** of impotence or any consequence of it;

(k) **treatment** of sexually transmitted diseases;

(l) sex change including **treatment** which arises from oris directly or indirectly made necessary by a sex change;

(m) **treatment** of any **medical condition** which arises inany way from HIV infection;

(n) **treatment** of obesity (Body Mass Index or BMI equal to 30 and above) or any **medical condition** which arisesfrom, or is related to, obesity in any way including but notlimited to the use of gastric banding or stapling, the removal of fat or surplus tissue from any part of the body whether or not it is needed for medical or psychological reasons;

(o) the costs of collecting donor organs for transplant surgery or any administration costs involved even if such transplants are allowed by the terms of this **plan**;

(p) **treatment** which arises from or is directly or indirectlycaused by a deliberately self-inflicted injury or an attemptat suicide;

(q) **treatment** which arises from or is in any way connected with alcohol or drug or substance abuse; all types of classes/courses/programs such as but not limited to cessation of alcohol, smoking/nicotine, drugs, substance;

(r) any **treatment** to correct refractive defects of the eyessuch as long or short-sightedness or astigmatism unless allowed for by your **plan**;

(s) **treatment** related to learning disorders, educational problems, behavioural problems, physical developmentor psychological development, including assessment or grading of such problems. This includes, but is not limited to, problems such as dyslexia, dyspraxia, autistic spectrum disorder, attention deficit hyperactivity disorder (ADHD) and speech and language problems;

(t) preventive (i.e. prophylactic) **treatment**;

(u) **treatment** to relieve symptoms commonly associatedwith any bodily change arising from any physiological or natural cause such as ageing, menopause or pubertyand which is not due to any underlying disease, **illness** or **injury**;

(v) vaccinations and routine or preventative medical examinations, including routine follow-up consultations, unless allowed for by the **benefits table** and accepted by **us** in writing;

(w) the costs of providing or fitting any externalprosthesis or orthosis or appliance or medical aids or durable medical equipment;

(x) out-patient drugs or dressings except those defined in 6.2.1(i), **prescriptions**, and where your **policy** provides this cover;

(y) orthodontics, periodontics, endodontics, preventative dentistry, and general dental care including fillings, no matter who gives the **treatment** unless provided for by your **plan** and agreed, in writing, by **us**;

(z) claims in respect of **treatment** received outside the **area of cover** or if the **member** travelled against medical advice even inside the **area of cover**;

(aa) **treatment** of injuries sustained from playing professional sport or from base jumping, cliff diving,flying in an unlicensed aircraft or as a learner, martial arts, free climbing, mountaineering with or without ropes,scuba diving to a depth of more than 10 metres, trekking to a height of over 2,500 metres, bungee jumping, canyoning, hang-gliding, paragliding or microlighting, parachuting, potholing, skiing off piste or any other wintersports activity carried out off piste;

(bb) any **treatment** specifically excluded by the terms shown on your membership statement or the schedules forming part of this Agreement;

(cc) any charges which are incurred for social or domestic reasons or for reasons which are not directly connected with **treatment**;

(dd) aquatic therapy or any charges from health hydros, spas, nature cure clinics (or practitioners) or any similar place, even if it is registered as a **hospital**;

(ee) any claim or part of a claim in respect of which **you** have to pay an excess (or deductible or co-insurance). Inthis case **we** will only pay the balance of the claim after **we** have deducted the excess (or deductible or co-insurance) amount;

(ff) in-patient charges for any **hospital** which are not **reasonable and customary** (R&C). **We** will pay only for the reasonable cost of the lowest cost standard single room associated with the **treatment** given;

(gg) any charges for **treatment** related to and/or thecorrection of **congenital conditions** and/or deformities whether or not manifest and/or diagnosed or known about at birth;

(hh) any administrative costs or reports of any kind (unless otherwise advised by **us**) or any other charges ofa non medical nature in connection with the provision and/or performance of medical supplies and/or services;

(ii) all bank or credit charges;

(jj) vitamins or supplements whether prescribed or not;

(kk) **treatment** for all types of sleep disorder including snoring;

6.3.2 Special terms apply in the following cases.
The following tests, investigations, **treatments**, items, conditions, activities and their related or consequential expenses are excluded from this **policy** and **we** shall notbe liable for:

(a) cosmetic (aesthetic) surgery or **treatment**, or any **treatment** which relates to or is needed because of previous cosmetic **treatment**. However **we** will pay for the initial reconstructive surgery if:
(i) it is carried out to restore function or appearance after an **accident** or following surgery for a **medical condition**, provided that the **member** has been continuously covered under a **plan** of **ours** since before the **accident** or surgery happened; and
(ii) it is done at a medically appropriate stage after the **accident** or surgery; and
(iii) **we** agree the cost of the **treatment** in writing before itis done.

(b) any dental procedure unless provided for by your **plan**. However, **we** will pay for some **surgical procedures** which need to be carried out by an oral and maxillofacial surgeon. **We** will send **you** a list of these procedures if **you** ask **us**.

(c) special nursing in **hospital** and/or any nursing athome unless **we** have agreed in writing beforehand that it is necessary and appropriate.

(d) hormone replacement therapy, except when it is medically indicated (rather than for the relief of physiological symptoms), when **we** will pay for the consultations and for the cost of the implants or patches (but not tablets). **We** will only pay benefits for a maximum of eighteen (18) months from the date of the first consultation.

(e) in-patient rehabilitation except when:
- it is an integral part of **treatment**; and
- it is carried out by a **medical practitioner** specialising in rehabilitation; and
- it is carried out in a rehabilitation **hospital** or unitwhich is recognised by **us**; and
- the costs have been agreed, in writing, by **us** beforethe rehabilitation begins.

We will not pay for in-patient rehabilitation for more than twenty-eight (28) days except in cases such as in severecentral nervous system damage caused by external trauma. For cases such as in severe central nervous system damage caused by external trauma, **we** will not pay for in-patient rehabilitation for more than one hundred eighty (180) days.

(f) the use of drug which has not been established as being effective or which is experimental or within clinical trials. This means they must be licensed by the European Medicines Agency if the **member** is receiving **treatment** in Europe, or the US Food and Drug Administration (FDA) if the **member** is receiving **treatment** anywhere else in the world, and be used within the terms of that license.

(g) **treatment** which has not been established as being effective or which is experimental. However **we** will pay if, before the **treatment** begins, it is established that the **treatment** is recognised as appropriate by anauthoritative medical body and **we** have agreed in writing, with the **medical practitioner**, what the fees will be.

(h) **treatment** which is not **medically necessary**. By **medically necessary** we mean a **treatment** which is:
(i) consistent with the diagnosis and customary medical **treatment** for a covered **medical condition/disability**, and
(ii) in accordance with standards of good medical practice, consistent with current standard of professional medical care, and of proven medical benefits, and
(iii) not for the convenience of the **member** or the **medical practitioner**, and unable to be reasonably rendered out of **hospital** (if admitted as an in-patient).

6.3.3 **We** will not pay benefits for more than 100 days in total in any **member's lifetime** for in-patient **treatment** of psychiatric illness.

6.3.4 **We** will not pay for any **treatment** or for International Emergency Medical Assistance, if they are needed as a result of nuclear contamination, biological contamination or chemical contamination, whilst engaging in or taking part in war, act of foreign enemy, invasion, civil war, riot, rebellion, insurrection, revolution, overthrow of a legally constituted government, explosions of war weapons or any event similar to one ofthose listed.

Please note, for clarity: There is cover for **treatment** required as a result of a terrorist act providing that terrorist act does not result in nuclear, biological or chemical contamination.

6.3.5 **We** will not pay benefits for any **treatment** if **we** have not received a properly completed claim form and original invoices within ninety (90) days of the **treatment** being given.

6.3.6 **We** will not pay benefits for any **treatment** needed as a result of work related accident or injury where the cost of such **treatment** is recoverable under a Workman's Compensation policy or similar cover required by Government Act prevailing in the country where the work related accident or injury took place or elsewhere at the time of injury or **accident**. **We** may, at **our** absolute discretion, consider the claims provided **we** are able to recover such costs. **You** must advise **us** if any claim is work related.

6.3.7 **We** will not allow **members** to upgrade their level of cover except at each **policy** anniversary and only thenwhen requested, in writing, to do so. Acceptance by **us** of such an upgrade must be confirmed in writing by **us** before the upgrade can become effective.

6.3.8 **We** will not pay upgraded benefit levels for **treatment** of any **medical condition** which arose or should reasonably have been foreseen by the **member** prior to the upgrade becoming effective. **Members** are required to declare any such **medical condition** to **us** when requesting the upgrade. Where such a **medical condition** is, or becomes, apparent benefits for such a **medical condition** will be restricted to the level of cover that would have been applicable to such a **medical condition** prior to the upgrade.

6.4 Making claims

Please refer to Section 4 – 'Claims procedure' for detailsof how to make a claim.

6.4.1 Before **we** can consider a claim **you** must ensure that:
- the **member** sends us a completed claim form as soon as they can and no later than ninety (90) days from the date the **treatment** starts; and
- **we** receive original invoices for **treatment** costs; and
- the **member** promptly gives **us** all the information **we** request.

6.4.2 The **member** must tell **us** on the claim form if they think any of the cost can be claimed from anyone else or under another insurance policy or source (such as but not limited to any Workman's Compensation policy). If so, then:

- If a **member** carries other insurance covering any illness or injury insured by this **policy**, **we** shall not be liable for a greater proportion of such illness or injury than the amount applicable hereto under this **policy** and the amount payable by **us** and other insurers shall not exceed the total bill of the **eligible medical condition.**

- if benefits are claimed for **treatment** to a **member**whose injury or **medical condition** was caused by some other person (the "third party"), **we** will pay only thosebenefits the **member** can claim under the **policy** (unless these are covered by another insurance policy, when **we**will only pay **our** proper share of the benefits). However,in paying those benefits **we** obtain both through the terms of the **policy** and by law a right to recover the amount of those benefits from the third party. In this case the following shall apply:

(a) **we** shall be subrogated to the extent of such paymentto all the rights and remedies of the **member** against any party and shall be entitled at its own expense to sue in the name of the **member**. The **member** shall give or cause to be given to **us** all such assistance in his/her power as **we** shall require to secure the rights and remedies and at **our** request shall execute or cause to be executed all documents necessary to enable **us** to effectively bring suit in the name of the Insured Person.

(b) **you** must tell **us** as quickly as possible that the injury or **medical condition** was caused by, or was the fault of,a third party. **We** will then send **you** a form on which the **member** can give **us** full written details;

(c) if **you** or the **member** is making a claim, or has not made (or refuses to make) a claim against the third party, **you** or the **member** must act in good faith and do all the things **we** shall require to ensure that monies are recovered from the third party and are repaid to **us** up to the amount of the benefits **we** have paid (and any interest). **You** will be asked to sign a written undertaking to this effect; and

(d) if **you** or the **member** do not repay to **us** monies recovered from the third party up to the amount of benefits (and any interest), **we** shall be entitled torecover the same from **you** and/or the **member**.

6.4.3 **We** can appoint and pay for an independent **medical practitioner** to advise **us** on the medical issues relating to any claim. If required by **us** the independent **medical practitioner** will also medically examine the **member** making the claim and provide **us** with a report. The **member** must co-operate with the independent **medical practitioner** otherwise **we** will not pay the claim.

6.4.4 If a **member** makes a claim which is in any way dishonest:
- **we** will not pay any benefits for that claim; and
- if **we** have already paid benefits for that claim before **we** discovered the dishonesty **we** can recover those benefits from **you** (or the **member)**; and
- **we** can take any of the actions listed in Section 6.7.3, below.

6.4.5 Claim costs incurred in any **currency**, other than Malaysian Ringgit**,** will be converted using the prevailing spot rates when **we** assess the claim. If **we** agree, in writing in advance, to *reimburse* benefits to a **member** in a **currency** other than the above, the exchange rate used will be as stated. Any exchange costs incurred will be payable by the **member** and will be subtracted from any payment made to the **member** in respect of such a claim.

6.5 Joining and renewing

Please refer to Generali for details of how to change your **policy**.

6.5.1 **We** will tell **you** in writing the date your **policy** starts and any special terms which apply to it. **We** can refuse to give cover and will tell **you** if **we** do.

6.5.2 Your **policy** is for one **year** unless **we** have agreed something different. At the end of that time, provided the **plan you** are on is still available, **you** can renew it on the terms and conditions applicable at that time. **You** will be bound by those terms. However, **we** reserve the right to refuse to accept **you** as a customer or to renew your **policy** at any **policy** anniversary for reasons shown in Section 6.7.3.

6.6 What we expect from you

6.6.1 **You** must make sure that whenever **you** are required to give **us** information all the information **you** give is true, accurate and complete. If it is not then **we** can set the **policy** aside or apply different terms of cover.

6.6.2 **You** must tell **us** if a **member** changes their **principal country of residence** even if they are staying in the same **area**. If **you** don't tell **us we** can refuse to pay benefits.

6.6.3 **You** must pay your premium when it is due. **We** will decide the amount at the start of each **year** and tell **you** how much it is. **You** can pay it in the way **you** have agreed with **us**. As your **policy** runs for a **year you** must pay your premium for the whole **year** no matter how it is paid. If your premium payments are not up to date your **policy** will end.

6.6.4 **You** must write and tell **us** if **you** (or any **member**) change your address. **You** are acting on behalf of any **member** covered by your **policy** so **we** will send all correspondence about the **policy** to your address.

6.6.5 If there is a dispute between **you** and **us we** have a complaints procedure, set out in Section 6.7 – 'General', which the **member** must follow so that **we** can resolve it.

6.7 General

6.7.1 (a) This is a yearly renewable **policy**. On or before the expiry of your **policy**, and subject to **our** acceptance, **you** may renew this **policy** by paying the premium applicable at the time of renewal. This shall not apply in the event that the **policy** expires, or is terminated or cancelled in accordance with the terms of this **policy** and **you** should subsequently wish to reapply for insurance cover under this **policy**.

6.7.1 (b) Portfolio Withdrawal Condition
We reserve the right to cancel the portfolio as a whole if **we** decide to discontinue underwriting or offer this product or this **plan**. Cancellation of the portfolio as a whole shall be given to **you** by written notice at least thirty(30) days and when this notice is served, **your policy** shall be terminated at renewal date.

6.7.1 (c) Premium rates are not guaranteed and the premium payable at renewal shall be determined at each renewal based on the attained age of each **member**, the premium rates then in effect, and any other factors which may materially affect the risks insured.

6.7.2 **We** can change all or any part of the **policy** including the **benefits table** or these terms, but only for the reasons shown in **our** handbook or Agreement, and the changes will only apply to **you** when **you** renew unless **we** are obliged by law to apply any change with immediate effect. **We** will give **you** thirty (30) days prior notice of the changes and will send details of them by ordinary post to the address **we** have for **you** on **our** records. The changes will take effect from when **you** renew or when applied by law even if, for any reason, any **member** does not receive details of them.

6.7.3 If any **member** breaks any of the terms of the **policy** or makes, or attempts to make, any dishonest claim, **we** can:
- refuse to make any payment; and
- refuse to renew your **policy**; or
- impose different terms to any cover **we** are prepared to provide; or
- end your **policy** and all cover under it immediately.

6.7.4 This **policy** is issued under the laws of Malaysia and is subject and governed by the laws prevailing in Malaysia. The parties hereby submit to the jurisdiction of the courts of Malaysia.

6.7.5 **We** do not pay for administration costs or reports of any kind.

6.7.6 The terms of your **policy** cannot be changed nor claims authorization given by any verbal communication between **you** and **us**. Any changes, approvals, or other statements relating to your **policy** must be confirmed, in writing, by **us**. **We** are not bound by any verbal commitment not confirmed by **us** in writing.

6.7.7(a) For the purposes of determining premiums payable, a **member's** age shall be deemed to be his attained age, and any premium tables or other material **we** provide in this connection shall be read accordingly.

6.7.7(b) If the age of the **member** has been misstated and the premium paid as a result thereof is insufficient, any claim payable under this **policy** shall be prorated based on the ratio of the actual premium paid to the correct premium which should have been charged for the **year**. Any excess premium, which may have been paid as a result of such misstatement of age, shall be refunded without interest.

If at the correct age the **member** would not have been **eligible** for cover under this **policy**, no benefit shall be payable.

6.7.8 Subject to the other terms of this **policy**, cover under this **policy** for the respective **member** shall also automatically terminate on the earliest occurrence of anyof the following events:

(i) the date the **policy** is terminated;
(ii) the date a **member's** coverage is terminated;
(iii) death of such **member**;
(iv) **we** withdraw this product or **plan** completely in accordance with the 'portfolio withdrawal condition' stated) in Section 6.7.1(b).

Termination of your **policy** shall automatically terminatecover for all **members** as well.

6.7.9 Unless otherwise expressly provided for by endorsement in the **policy**, **we** shall be entitled to treat **you** as the absolute owner of the **policy**. **We** shall not bebound to recognise any equitable or other claim to or interest in the **policy**, and the receipt of the **policy** or a benefit by **you** (or by your legal or authorized representative) alone shall be an effective discharge of all obligations and liabilities of **ours**. **You** shall be deemed to be the responsible Principal or Agent of the **members** covered under this **policy**.

6.7.10 The due observance and the fulfilment of the terms, provisions and conditions of this **policy** by the **member** and in so far as they relate to anything to be done or complied with by the **member** shall be conditions precedent to any liability of **ours**.

6.7.11 If the proposal or declaration of the **member** is untrue in any respect or if any material fact affecting the risk be incorrectly stated herein or omitted therefrom, orif this insurance, or any renewal thereof shall have been obtained through any misstatement, misrepresentation orsuppression, or if any claim made shall be fraudulent or exaggerated, or if any false declaration or statement shall be made in support thereof, then in any of these cases, this **policy** shall be void.

6.7.12 No action at law or in equity shall be brought to recover on this **policy** prior to expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this **policy**. If the **member** shall fail to supply the requisite proof of loss as stipulated by the terms, provisions and conditions of the **policy**, the **member** may, within a grace period of one calendar year from the time that the written proof of loss to be furnished, submit the relevant proof of loss to **us** with cogent reason(s) for the failure to comply with the **policy** terms, provisions and conditions. The acceptanceof such proof of loss shall be at the sole and entire discretion of **ours**. After such grace period has expired, **we** will not accept, for any reason whatsoever, suchwritten proof of loss.

6.7.13 All differences arising out of this **policy** shall be referred to an Arbitrator who shall be appointed in writingby the parties in difference. In the event they are unable to agree on who is to be the Arbitrator within one (1) month of being required in writing to do so then both parties shall be entitled to appoint an Arbitrator each whoshall proceed to hear the differences together with an Umpire to be appointed by both Arbitrators. However this is provided that any disclaimer of liability by **us** for any claim hereunder must be referred to an Arbitrator within twelve (12) calendar months from date of such disclaimer.

Section 7 - Expert health information
Expert health information you can trust +44 (0)1892 556 753

We're here whenever you need to talk to a medical expert – not just when you need to claim.

Get the latest information on vaccinations or health precautions before travelling. Check on symptoms that are worrying you. Understand the facts on a health condition. Or simply call for support and reassurance.
- Nurses, midwives, pharmacists and counsellors ready to talk to you. Nurses and counsellors are available 24/7.
- Midwives and pharmacists are available Monday to Friday from 08:00 to 20:00 GMT; Saturday and UK public holidays from 08:00 to 16:00 GMT; and Sunday 08:00 to 12:00 GMT
- Completely confidential and completely separate from our claims service.

You can choose to remain anonymous with no record of your call. Or you can ask us to make a note of your call in case you want to call again.

We can't diagnose medical conditions or prescribe medicine, but we can give the latest information about specific illnesses and conditions, treatments and medicine, as well as provide guidance and support.

Section 8 - If any problems arise…
With the best will in the world, concern about some aspect of **our** service can occasionally arise. In such circumstances, **Generali managers have wide authority to settle problems and will do all that they can to help**. This must be your first point of contact.

In the unlikely event that your complaint is unresolved, please write to:

Generali Customer Service Centre
Generali Insurance Malaysia Berhad
Level 1, Menara Generali, 27 Jalan Sultan Ismail, 50250 Kuala Lumpur, Malaysia.

who will investigate the matter independently.

Having received a reply from our Customer Service Department, if **you** are still not happy with the way in which a complaint has been handled, **you** must then write to:

Generali Insurance Malaysia Berhad
Level 1, Menara Generali, 27 Jalan Sultan Ismail, 50250 Kuala Lumpur, Malaysia.

If your complaint arises over a claims issue, **you** may reach out to the Financial Markets Ombudsman Service (formerly known as Ombudsman for Financial Services) at the following details:

Financial Markets Ombudsman Service (formerly known as Ombudsman for Financial Services)
Company No: 200401025885
Level 14, Main Block, Menara Takaful Malaysia, No. 4, Jalan Sultan Sulaiman, 50000 Kuala Lumpur.
Tel: +603 2272 2811 Website: www.fmos.org.my

For general matters **you** can write to:

Customer Service Bureau, Insurance Regulations Department - 11th Floor Block A Bank Negara Malaysia, Jalan Dato' Onn 50480 Kuala Lumpur.

Please note: you can only write to the Bureau when **you** have gone through the required stages of the complaints procedure set out above.

Please remember to quote policy/membership numbers on all correspondence.

Section 9 - Your customer charter
As a valued customer of Generali **you** have important rights and entitlements. **You** are entitled to expect:

Courtesy. Your requirements will always be dealt with promptly, considerately and courteously. No customer query is too trivial or too much trouble to sort out.

Helpful advice and guidance. Generali staff will help **you**, if **you** have any doubts, to understand the termsof your contract and any other factors which affect your cover. They will help **you** to make proper use of your cover should **you** need to make a claim.

Confidential handling of your personal details and affairs wherever possible. Any medical details **we** require will always be kept confidential if possible. Generali may be required to provide information regarding claims **you** make or have made in the past or other details **you** have given **us** to your sponsoror employer or a government department if they are paying for all or part of this **policy** or are entitled by law to require this of **us**. No liability will be accepted by **us** for any outcome resulting from the provision of such information to any of the aforementioned parties.

Advance notification of change in cover. Essential changes to the terms of the cover (including benefits, premiums and your membership agreement) will be notified to **you**, in writing, thirty (30) days in advance of the date from which the changes take effect.

Professional and efficient service. All requests for assistance and any claims **you** submit will be considered impartially (without any bias or preference) in accordance with the benefits and membership agreement of your **plan**.

For further information contact your Generali office, details of which can be found in Section 10 – 'Your Generali office'.

Section 10 – Your Generali office

Generali Insurance Malaysia Berhad
Level 1, Menara Generali,
27 Jalan Sultan Ismail,
50250 Kuala Lumpur,
Malaysia.

Tel: 1 300 12 2121 or +603 3007 2121
Email: customer.service.gi@generali.com.my
Website: www.generali.com.my

Service Tax

The Premium payable by you is subject to the Service Tax Act 2018, including any subsidiary legislations, orders or regulations governing the application of such tax, as may be imposed, or amended by the relevant authorities from time to time.

When we pay a claim, the amount of claims paid (including any service tax imposed by the relevant authorities) shall be subject to the sum insured or limits of insurance covered under the Policy.

Health Service Team: Kindly contact the number shown on the reverse of your membership card

Expert Health: +44 (0)1892 556 753

Data Privacy Notice

You hereby agree that by using our services and providing your personal data to us, you consent to Generali's collection, use, disclosure and/or processing of your personal data as described in the Data Privacy Notice made available at our website www.generali.com.my. We reserve the right to update and amend our Data Privacy Notice from time to time. We will notify you of any amendments to our Data Privacy Notice via announcement on our website or other appropriate means.

Section 11 - Benefits table (Plan 1)

Benefits			
Please note: benefit values are per person each year unless otherwise specified and are reduced each time youclaim only by the net amount (less any deductible, excess or co-insurance) we have actually paid			
Area of Cover	**Asia**	**Worldwide excluding USA**	**Worldwide**
Yearly Maximum up to	RM9,000,000		
Outside Area of Cover	Emergency treatment only	Emergency treatment only	All areas covered
Level of Reimbursement	Reasonable and customary (R&C) charges		
In-patient and Daycare Treatment (including surgery, consultations, consumables etc.)			
Daily Accommodation Charges	Standard Single Room		
Parent Accommodation up to	RM500 per night		
Cash Benefit	RM700 per night		
Pre-hospitalisation Treatment	Included within the 'General Practitioner andSpecialist Consultation Charges' benefit. Subject to terms and conditions applied for 'General Practitioner and Specialist Consultation Charges' benefit.		
Post-hospitalisation Treatment	Included within the 'General Practitioner andSpecialist Consultation Charges' benefit. Subject to terms and conditions applied for 'General Practitioner and Specialist Consultation Charges' benefit.		
Out-patient Treatment (including diagnostics, prescribed drugs, dressings etc.)			
General Practitioner and Specialist Consultation Charges	Included		
Courses of Chiropractic Treatment, Acupuncture,Homeopathy and Osteopathy up to	RM3,600		
Traditional Chinese Medicine up to	RM180 per visit up to 20 visits per year		
Courses of Physiotherapy	Included		
Radiotherapy and/or Chemotherapy	Included		
Kidney Dialysis	Included		
Other Benefits			
Health Screen up to	RM3,000 Available only after 12 months membership		
Pre-existing Conditions up to	Years 1 & 2: RM7,000 Available only after 9 months membership Subsequent years: RM14,000		
Maintenance of Non Pre-existing Chronic Conditions	Included		
Oral and Maxillofacial Surgery	Included		
Ambulance Transport	Included		
International Emergency Medical Assistance	Included		
Psychiatric Treatment up to	RM24,000		
Accidental Damage to Teeth	Included		
Pre and Post-natal Complications	Included – available only after 12 months membership		
Pregnancy and Delivery up to	RM43,000 Available only after 12 months membership		
Vaccination up to	RM4,800		
Routine Dental Care up to	80% of eligible expenses incurred up toRM3,800		
Routine Optical Care up to	RM900		
Hospice and Palliative Care up to	RM120,000 in a member's lifetime Available only after 12 months membership		

Please see Section 2 - 'What you're covered for' for terms applying to these benefits.

Section 11 - Benefits table (Plan 2)

Benefits			
Please note: benefit values are per person each year unless otherwise specified and are reduced each time youclaim only by the net amount (less any deductible, excess or co-insurance) we have actually paid			
Area of Cover	**Asia**	**Worldwide excluding USA**	**Worldwide**
Yearly Maximum up to	RM7,000,000		
Outside Area of Cover	Emergency treatment only	Emergency treatment only	All areas covered
Level of Reimbursement	Reasonable and customary (R&C) charges		
In-patient and Daycare Treatment (including surgery, consultations, consumables etc.)			
Daily Accommodation Charges	Standard Single Room		
Parent Accommodation up to	RM500 per night		
Cash Benefit	RM500 per night		
Pre-hospitalisation Treatment	Included within the 'General Practitioner andSpecialist Consultation Charges' benefit. Subject to terms and conditions applied for 'General Practitioner and Specialist Consultation Charges' benefit.		
Post-hospitalisation Treatment	Included within the 'General Practitioner andSpecialist Consultation Charges' benefit. Subject to terms and conditions applied for 'General Practitioner and Specialist Consultation Charges'benefit.		
Out-patient Treatment (including diagnostics, prescribed drugs, dressings etc.)			
General Practitioner and Specialist Consultation Charges	Included		
Courses of Chiropractic Treatment, Acupuncture,Homeopathy and Osteopathy up to	RM3,600		
Traditional Chinese Medicine up to	RM180 per visit up to 20 visits per year		
Courses of Physiotherapy	Included		
Radiotherapy and/or Chemotherapy	Included		
Kidney Dialysis	Included		
Other Benefits			
Health Screen up to	No benefit		
Pre-existing Conditions up to	Years 1 & 2: RM7,000 Available only after 9 months membership Subsequent years: RM14,000		
Maintenance of Non Pre-existing Chronic Conditions	Included		
Oral and Maxillofacial Surgery	Included		
Ambulance Transport	Included		
International Emergency Medical Assistance	Included		
Psychiatric Treatment up to	RM14,000		
Accidental Damage to Teeth	Included		
Pre and Post-natal Complications	Included – available only after 12 monthsmembership		
Pregnancy and Delivery up to	No benefit		
Vaccination up to	RM3,800		
Routine Dental Care up to	No benefit		
Routine Optical Care up to	No benefit		
Hospice and Palliative Care up to	RM95,000 in a member's lifetime Available only after 12 months membership		

Please see Section 2 - 'What you're covered for' for terms applying to these benefits.

Section 11 - Benefits table (Plan 3)

Benefits			
Please note: benefit values are per person each year unless otherwise specified and are reduced each time youclaim only by the net amount (less any deductible, excess or co-insurance) we have actually paid			
Area of Cover	**Asia**	**Worldwide excluding USA**	**Worldwide**
Yearly Maximum up to	RM3,000,000		
Outside Area of Cover	Emergency treatment only	Emergency treatment only	All areas covered
Level of Reimbursement	Reasonable and customary (R&C) charges		
In-patient and Daycare Treatment (including surgery, consultations, consumables etc.)			
Daily Accommodation Charges	Standard Single Room		
Parent Accommodation up to	RM500 per night		
Cash Benefit	RM500 per night		
Pre-hospitalisation Treatment	Included within the 'General Practitioner andSpecialist Consultation Charges' benefit. Subject to terms and conditions applied for 'General Practitioner and Specialist Consultation Charges' benefit.		
Post-hospitalisation Treatment	Included within the 'General Practitioner andSpecialist Consultation Charges' benefit. Subject to terms and conditions applied for 'General Practitioner and Specialist Consultation Charges'benefit.		
Out-patient Treatment (including diagnostics, prescribed drugs, dressings etc.)			
General Practitioner and Specialist Consultation Charges	Included		
Courses of Chiropractic Treatment, Acupuncture,Homeopathy and Osteopathy up to	RM3,600		
Traditional Chinese medicine up to	RM180 per visit up to 20 visits per year		
Courses of Physiotherapy	Included		
Radiotherapy and/or Chemotherapy	Included		
Kidney Dialysis	Included		
Other Benefits			
Health Screen up to	No benefit		
Pre-existing Conditions up to	RM3,500 Available only after 12 months membership		
Maintenance of Non Pre-existing Chronic Conditions	Included		
Oral and Maxillofacial Surgery	Included		
Ambulance Transport	Included		
International Emergency Medical Assistance	Included		
Psychiatric Treatment up to	RM14,000		
Accidental Damage to Teeth	Included		
Pre and Post-natal Complications	Included – available only after 12 months membership		
Pregnancy and Delivery up to	No benefit		
Vaccination up to	RM1,300		
Routine Dental Care up to	No benefit		
Routine Optical Care up to	No benefit		
Hospice and Palliative Care up to	RM95,000 in a member's lifetime Available only after 12 months membership		

Please see Section 2 - 'What you're covered for' for terms applying to these benefits.

Section 11 - Benefits table (Plan 4)

Benefits			
Please note: benefit values are per person each year unless otherwise specified and are reduced each time youclaim only by the net amount (less any deductible, excess or co-insurance) we have actually paid			
Area of Cover	**Asia**	**Worldwide excluding USA**	**Worldwide**
Yearly Maximum up to	RM3,000,000		
Outside Area of Cover	Emergency treatment only	Emergency treatment only	All areas covered
Level of Reimbursement	Reasonable and customary (R&C) charges		
In-patient and Daycare Treatment (including surgery, consultations, consumables etc.)			
Daily Accommodation Charges	Standard Single Room		
Parent Accommodation up to	RM500 per night		
Cash Benefit	RM500 per night		
Pre Hospitalisation Treatment	Included for one (1) consultation, prescribed investigations and essential medications received as an out-patient within 60 days prior to a hospitalisation		
Post Hospitalisation Treatment	Included for follow-up out-patient consultation andtreatment received within 90 days following the discharge from the hospital		
Out-patient Treatment (including diagnostics, prescribed drugs, dressings etc.)			
General Practitioner and Specialist Consultation Charges	Included if it is part of pre-hospitalisation treatmentor post-hospitalisation treatment. Subject to the limitations applied for 'Pre-hospitalisation treatment' or 'Post-hospitalisation treatment'benefit.		
Courses of Chiropractic Treatment, Acupuncture,Homeopathy and Osteopathy up to	No benefit		
Traditional Chinese Medicine up to	No benefit		
Courses of Physiotherapy	Included if it is part of post-hospitalisation treatmentand subject to the limitations applied for 'Post- Hospitalisation treatment' benefit		
Radiotherapy and/or Chemotherapy	Included		
Kidney Dialysis	Included		
Other Benefits			
Health Screen up to	No benefit		
Pre-existing Conditions up to	RM3,500 Available only after 12 months membership		
Maintenance of Non Pre-existing Chronic Conditions	No benefit		
Oral and Maxillofacial Surgery	Included		
Ambulance Transport	Included		
International Emergency Medical Assistance	Included		
Psychiatric Treatment up to	No benefit		
Accidental Damage to Teeth	Included		
Pre and Post-natal Complications	No benefit		
Pregnancy and Delivery up to	No benefit		
Vaccination up to	No benefit		
Routine Dental Care up to	No benefit		
Routine Optical Care up to	No benefit		
Hospice and Palliative Care up to	RM60,000 in a member's lifetime Available only after 12 months membership		

Please see Section 2 - 'What you're covered for' for terms applying to these benefits.