MEDICAL

ONEMEDIC PLUS

Flexible Medical Coverage, Tailored for You

Member of PIDM

PROTECTION BY PIDM ON BENEFITS PAYABLE FROM THE UNIT PORTION OF THIS PRODUCT IS SUBJECT TO LIMITATIONS. Please refer to PIDM's TIPS Brochure or contact Generali Life Insurance Malaysia Berhad or PIDM (visit www.pidm.gov.my).

GENERALI

Introducing

ONEMEDIC PLUS

Your health is unique and your medical coverage should be too. OneMedic Plus offers **flexible and affordable medical protection** that grows with you. Whether it is essential hospitalisation or various cost-saving features, you are in control. With OneMedic Plus, you can manage healthcare needs your way without compromising on quality care. It is a medical protection plan that fits your needs, today and tomorrow.

Key Benefits

1 Lifelong medical protection

OneMedic Plus offers a high Annual Limit of up to RM2.5 million with no lifetime limit, providing coverage up to age 100[1]. This plan offers you a special feature that automatically increases your medical coverage, to give you peace of mind on the rising medical costs in the future and to ensure long-term financial protection while you focus on recovery.

Inflation Defender

Enjoy a 10% increase of the initial Annual Limit at the end of every 5 policy years, up to 100% of 100% of the initial Annual Limit.

Room and Board Enhancer

Enjoy a 10% increase of the initial Room and Board limit at the end of every 5 policy years, up to 100% of the initial Room and Board limit.

2 Enhanced cancer coverage

We understand the importance of advanced cancer treatments to increase cancer survival and improve the quality of life. OneMedic Plus provides coverage on enhanced cancer treatment such as out-patient treatment including but not limited to radiotherapy, chemotherapy, targeted therapy or immunotherapy.

3 Flexible cost-savings options

With OneMedic Plus, you have the option to lower your premium by choosing a basic co-insurance or deductible plan. Pay less and only share part of the cost if and when you need medical treatment. It is a flexible and cost-savvy way to manage healthcare expenses while keeping the coverage you need.

Below is a breakdown of the basic co-insurance and deductible options we provide.

Plans	Basic Co-Payment Options	
	Basic Co-Insurance	Deductible
Lite 1	Co-insurance 5%, minimum RM500 and maximum RM1,000 per policy year	RM5,000 or RM10,000 per policy year
Lite 2		
Elite 1	Co-insurance 5%, minimum RM500 and maximum RM2,000 per policy year	
Elite 2		

With Co-payment Waiver, you will not be required to pay the Basic Co-payment and Co-insurance under Out-Patient Illness Treatment Benefit amount for:

i. Any treatment, hospitalization or surgeries due to an accident or emergency treatment;
ii. Any treatment, hospitalization or surgeries sought at a Malaysia government hospital or government healthcare facility such as government clinic; or
iii. Any claims under the benefits of Out-Patient Kidney Dialysis Treatment and Out-Patient Cancer Treatment.

[1] With optional coverage term of 15 years, 30 years or up to age 80, this plan will be guaranteed to be renewed without evidence of insurability at your option up to age 100 provided that the basic plan is still in-force. You will be notified in writing at least 90 days prior to the expiry age of this rider.

Schedule of Benefits

Plans (RM)	Lite 1	Lite 2	Elite 1	Elite 2
Annual Limit (applicable to benefits no.1 to no.20)	250,000	500,000	1,500,000	2,500,000
Inflation Defender	Not applicable		Annual Limit will be increased by 10% of the initial Annual Limit at the end of every 5 policy years starting from the rider effective date. This benefit shall not exceed 100% of the initial Annual Limit of the plan.	
Lifetime Limit	No limit			
Basic Co-Payment (applicable to benefits no.1 to no.15)	(a) Basic Co-Insurance: Co-insurance 5%, minimum 500 and maximum 1,000 per policy year; or (b) Deductible: 5,000 or 10,000 per policy year		(a) Basic Co-Insurance: Co-insurance 5%, minimum 500 and maximum 2,000 per policy year; or (b) Deductible: 5,000 or 10,000 per policy year	

	Section A: In-Patient and Surgical Benefit (for any one disability)			
1	**Hospital Room and Board** (daily maximum)	150	250	300
	Maximum number of days	150 days for any one disability	No limit	
2	**Room and Board Enhancer**	Hospital Room and Board will be increased by 10% of the initial Hospital Room and Board at the end of every 5 policy years starting from the rider effective date. This benefit shall not exceed 100% of the initial Hospital Room and Board of the plan.		
3	**Intensive Care Unit**	As charged		
	Maximum number of days	150 days for any one disability	200 days for any one disability	
4	**In-Patient Related Fees** (a) Hospital Supplies and Services (including medical report charges up to MYR 200 per Hospitalisation) (b) Surgical Fees (c) Anaesthetist Fees (d) Operating Theatre Fees (e) In-Patient Prescribed Medicines (f) In-Patient Diagnostic Procedures and In-Patient Physiotherapy (g) In-Patient Physician Visit (up to 2 visits per day per physician)	As charged		
5	**Pacemaker and Implantable Cardiac Defibrillator**	Up to 20,000 for any one disability		
6	**Ambulance Fees**	Up to 500 per hospitalisation	As charged	
7	**Daily Guardian Benefit** (for child or Insured aged above 65 years)	As charged		
	Maximum number of days	150 days for any one disability		

Schedule of Benefits

8	**Daily Allowance for Hospitalisation in Government Hospital**	60 per day		
	Maximum number of days	60 days for any one disability		
9	**Additional Daily Allowance for Hospitalisation in Government Hospital Isolation Ward**	60 per day		
	Maximum number of days	30 days for any one disability		

Section B: Out-Patient Benefit (for any one disability)				
10	**Day Surgery and Daycare Surgical Procedure**	As charged		
11	**Pre-Hospitalisation Benefit** (within 90 days before hospitalisation) (a) Consultation (b) Diagnostic Tests (c) Medication and Treatment	Up to 5,000	Up to 10,000	As charged
12	**Post-Hospitalisation Benefit** (within 210 days after hospital discharge) (a) Medication and Treatment (b) Out-Patient Physiotherapy	Up to 5,000	Up to 10,000	As charged
13	**Chiropractic Treatment** (within 150 days after hospital discharge)	Not applicable		Up to 1,000
14	**Traditional and Complementary Medicine Treatment** (within 150 days after hospital discharge)	Not applicable		Up to 200 per visit and 2,000 for any one disability
15	**Home Nursing Care**	Up to 5,000 per hospitalisation	Up to 10,000 per hospitalisation	As charged
	Maximum number of days	180 days per lifetime		
16	**Out-Patient Illness Treatment Benefit** (a) Acute Bronchitis / Acute Bronchiolitis (b) Acute Gastroenteritis (c) Dengue Fever (d) Influenzas (e) Pneumonia	Up to 150 per visit and 1,500 per policy year, after deduction of co-insurance 5%		
17	**Out-Patient Kidney Dialysis Treatment**	As charged		
18	**Out-Patient Cancer Treatment** (including but not limited to radiotherapy, chemotherapy, targeted therapy, hormonal therapy or immunotherapy, and including consultation, examination tests and prescribed medicines)	As charged		
19	**Emergency Accidental Out-Patient and Follow-up Treatment** (within 30 days from the date of an accident)	As charged		

Schedule of Benefits

Section C: Special Benefit			
20	**Intraocular Lens**	Up to 3,000 per lifetime	Up to 6,000 per lifetime
21	**Prosthetic Devices and Hearing Aids**	Not applicable	Up to 10,000 per lifetime
22	**Genomic Test for Cancer**	Not applicable	Up to 10,000 per lifetime

- Additional Daily Allowance for Hospitalisation in Government Hospital Isolation Ward is payable in addition to the Daily Allowance for Hospitalisation in Government Hospital.
- The list of illnesses under Out-Patient Illness Treatment Benefit is subject to our review and may be extended to include additional illness(es) from time to time.
- Genomic Test for Cancer and Prosthetic Devices and Hearing Aids are not subject to Annual Limit, and any claims made under these benefits will not reduce the Annual Limit.
- Please refer to the Frequently Asked Questions for more details on the Basic Co-Payment and Genomic Test for Cancer.
- Please refer to the supplementary contract for full benefit description.

Frequently Asked Questions

1. Who can be insured under OneMedic Plus?

Coverage Term Option	Entry Age	
	Minimum	Maximum
15 years	15 days old	70 years old
30 years	15 days old	70 years old
Up to age 80	15 days old	50 years old

However, it is subject to our underwriting requirements.

2. How can I take up OneMedic Plus?

This is a unit deducting rider. You can add OneMedic Plus to our investment-linked basic plan. Please check with your agent or contact us for more details.

3. How long is the coverage?

OneMedic Plus gives you choices of coverage term of 15 years, 30 years or up to age 80. It will be guaranteed to be renewed without evidence of insurability at your option at the end of your selected coverage term, up to the Insured's 100th birthday and provided the basic plan is still in-force. You will be notified at least 90 days prior to the expiry age of this rider.

4. How much insurance charges do I have to pay?

The insurance charges you have to pay depends on your attained age, gender, occupation, health condition and the type of plan you choose. The insurance charges payable will increase according to your attained age.

Insurance charges are payable throughout the entire duration of the riders. You must inform us of any change in your occupation, avocation and sports activities as it may affect the insurance charges and terms and conditions of the plan.

5. Are the insurance charges payable guaranteed?

Insurance charges are not guaranteed but renewability is guaranteed. We reserve the right to revise the insurance charges at policy anniversary by giving you at least 30 days' notice if the overall claim experience of this class of business is worse than expected.

6. How does Basic Co-Payment work?

The reimbursement of any eligible expenses is always subject to Basic Co-Payment amount, which applies to benefit as per listed in the table below. For the avoidance of doubt, the total eligible expenses accumulated for a particular policy year shall not be carried forward to the next policy year.

Frequently Asked Questions

Claim Scenario 1
Plan: Elite 1
Basic Co-payment: Basic co-insurance 5%, subject to a minimum RM500 and maximum RM2,000 per policy year

Policy Year	Hospital Admission Due To	Eligible Expenses	Basic Co-insurance Paid by Customer	Generali Pay	Accumulated Amount Paid by Customer	Accumulated Amount Paid by Generali
Year 3	Appendix Surgery	RM5,000	RM500 (The higher of: (a) 5% x 5,000; or (b) Minimum basic co-insurance of RM500 per policy year)	RM4,500	RM500	RM4,500
Year 3	Accident	RM10,000	RM0 (Co-payment Waiver)	RM10,000	RM500	RM14,500
Year 3	Brain Tumor Surgery	RM250,000	RM1,500* (The lower of: (a) 5% x 250,000; or (b) Maximum basic co-insurance of RM2,000 per policy year)	RM248,500	RM2,000 (maximum basic co-insurance)	RM263,000
Year 3	Follow-up treatment	RM1,000	RM0 (exceeded maximum basic co-insurance)	RM1,000	RM2,000 (maximum basic co-insurance)	RM264,000

*The maximum total basic co-insurance payable by the customer in a policy year is RM2,000, excluding eligible expenses under Co-payment waiver. Since customer has paid RM500 during the first admission, customer would only need to pay the remaining basic co-insurance amount of RM1,500.

Claim Scenario 2
Plan: Elite 1
Basic Co-payment: Deductible of RM10,000 per policy year

Policy Year	Hospital Admission Due To	Eligible Expenses	Deductible Paid by Customer	Generali Pay	Accumulated Amount Paid by Customer	Accumulated Amount Paid by Generali
Year 3	Heart Attack	RM45,000	RM10,000	RM35,000	RM10,000	RM35,000
Year 3	Appendix Surgery	RM15,000	RM 0	RM15,000	RM10,000	RM50,000

Frequently Asked Questions

7. How does Genomic Test for Cancer work?

OneMedic Plus covers the genomic testing for Cancer which is used to determine the treatment option upon diagnosis of Cancer. Predictive genetic testing is specifically excluded for this benefit.

This benefit is subject to the lifetime limit as stated in the Schedule of Benefits. Once the lifetime limit is exhausted, this benefit shall immediately cease to be payable.

8. When does the cover begin?

The coverage begins immediately after the rider has commenced for hospitalisation due to accidents. There is a waiting period of 120 days for specified illnesses and 30 days for any other causes.

Specified illnesses refer to the following disabilities and its related complications:

- Hypertension, diabetes mellitus or cardiovascular disease;
- Growths of any kind including tumours, cancers, cysts, nodules, polyps, kidney stones or gall bladder stones;
- Any diseases of the ear, nose (including sinuses) or throat;
- Hernias, haemorrhoids, fistulae, hydrocele or varicocele;
- Any diseases of the reproductive system including endometriosis; or
- Any disorders of the spine (including but not limited to a slipped disc) or any knee conditions.

9. Is the renewal guaranteed?

OneMedic Plus is guaranteed to be renewed without evidence of insurability at your option up to age 100 provided the basic plan is still in-force. There is no selective renewal loading or exclusion regardless of the claim made during the previous year. However, the renewal of the rider is at your option until the occurrence of any one of the following:

- Fraud or misrepresentation of material fact during application;
- This rider is cancelled/surrendered at your request;
- On the death of the insured;
- The basic plan to which this rider is attached to terminates, matures, expires or lapses;
- On the policy anniversary prior to the insured attaining the expiry age of this rider, provided that the renewal privilege of this rider has not been exercised; or
- On the policy anniversary on or following insured's 100th birthday, provided that the renewal privilege of this rider has been exercised.

10. Where can I get the latest list of panel hospitals?

You can view our latest list of panel hospitals on our official website at www.generali.com.my.

Frequently Asked Questions

11. How do I make a claim?

Where applicable, cashless facility will be provided to the panel hospital for your admission. It is best for you to arrange for the medical report before any hospital admission for a pre-planned treatment. Depending on the hospital, you may be required to pay a deposit and the deposit amount may vary from hospital to hospital. Upon discharge, the hospital will provide the final diagnosis and the itemised bill. You only need to settle any co-payment, ineligible or excess expenses which are not covered.

In the circumstances of non-cashless admission, you are advised to pay for the treatment first and after being discharged, file a claim with us.

Cashless facility does not guarantee full payment of your final medical bill which may include excess and excluded items which must be paid by you.

Please notify us within 30 days of any occurrences for admission to non-panel hospitals, out-patient treatment or any claims which have been settled by you. Please submit the claim form, original itemised bills, receipts and other relevant claim documents to us for processing.

12. Where can I check my policy coverage and limits?

You can check on MyGenerali Customer Portal or call us at 1 300 13 2121 or +603 3007 2121.

13. What are the consequences of switching policy from one insurer to another?

You may be subject to new underwriting requirements, full waiting period and any applicable period for the exclusion of specific illnesses or pre-existing conditions of the new plan.

Important Notes

We believe it is important that you fully appreciate and understand all the benefits and charges under this plan.

1. This insurance plan is underwritten by Generali Life Insurance Malaysia Berhad 200601003992 (723739-W) ("We/ Us/ Our"), a company licensed under the Financial Services Act 2013 and regulated by Bank Negara Malaysia.

2. You should satisfy yourself that this rider will best serve your needs and that the premium payable under the policy is an amount you can afford.

3. If you are not completely satisfied with this rider, you may return this rider and request the cancellation of this rider within 15 days from the date this rider is delivered to you provided no claim has been made. We will then refund to you any insurance charge that has been deducted for this rider less any medical expenses incurred.

4. Please read this brochure together with the basic plan's brochure. For further information, you may refer to the sales illustration.

5. OneMedic Plus does not cover any hospitalisation, surgeries or charges incurred caused directly or indirectly, wholly or partly, by any one of the following occurrences:
   - Pre-existing illnesses;
   - Specified Illnesses occurring within the waiting period;
   - Any disabilities, medical or physical conditions and its signs and symptoms occurring within the waiting period, except for injuries due to accidents;
   - Circumcision, eye examination, refractive surgery or surgical procedure for visual impairments due to astigmatism, farsightedness or nearsightedness (Radial Keratotomy or Lasik), glasses or contact lenses and the use or acquisition of external prosthetic appliances or devices such as artificial limbs, hearing aids, implanted pacemakers and prescriptions thereof (This exclusion does not apply to Pacemaker and Implantable Cardiac Defibrillator, and Prosthetic Devices and Hearing Aids as stated in the Schedule of Benefits);
   - Dental conditions including dental treatment or oral surgery except as necessitated by injuries due to accidents to sound natural teeth occurring during the period of insurance;
   - Private nursing, rest cures or sanitaria care, illegal drugs, intoxication, sterilisation, venereal disease and its sequelae, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) and Human Immunodeficiency Virus (HIV) related Diseases, and any communicable diseases requiring quarantine by law (This exclusion does not apply to any hospitalisation, surgery, charges incurred or death, whichever is applicable, due to Coronavirus Disease (COVID-19));
   - Any treatments or surgical operation for congenital conditions or deformities including hereditary conditions;
   - Pregnancy, pregnancy related condition or its complications, child birth (including surgical delivery), miscarriage, abortion and prenatal or postnatal care and surgical, mechanical or chemical contraceptive methods of birth control or treatment pertaining to infertility, erectile dysfunction and tests or treatment related to impotence or sterilisation;

Important Notes

- Hospitalisation primarily for investigatory purposes, diagnosis, X-ray examinations, general physical or medical examinations that are not related whether directly or indirectly to treatment or diagnosis of a covered disability, any treatments which is not medically necessary, tests and investigations done for the purpose of excluding diagnosis other than the final diagnosis in which final treatment is rendered, any preventive treatments, preventive medicines or examinations carried out by a physician, and any treatments specifically for weight reduction or gain or bariatric surgery;
- Suicide, attempted suicide or intentionally self-inflicted injury while sane or insane;
- War or any act of war, declared or undeclared, criminal or terrorist activities, active duty in any armed forces, direct participation in strikes, riots, civil commotion or insurrection;
- Biological or chemical contamination, ionising radiation or contamination by radioactivity from any nuclear fuel or nuclear waste from process of nuclear fission or from any nuclear weapons material;
- Expenses incurred for donation of any body parts or organs by the Insured and costs of acquisition of the organ including all costs incurred by the donor during organ transplant and its complications;
- Investigation and treatment of sleep and snoring disorders, hormone replacement therapy, placenta/serum therapy, chelation therapy and alternative therapy such as treatment, medical service or supplies, including but not limited to acupressure reflexology, bone setting, herbalist treatment, traditional and complementary medicine, supplementary medicine, vitamin, nutritional herb, massage or aroma therapy or other alternative treatment (This exclusion does not apply to Chiropractic Treatment, and Traditional and Complementary Medicine Treatment as stated in the Schedule of Benefits);
- Care or treatment for which payment is not required or to the extent which is payable by any other insurance or indemnity covering the Insured and disabilities arising out of duties of employment or profession that is covered under a workman's compensation insurance contract;
- Psychotic, mental or nervous disorders (including any neuroses and their physiological or psychosomatic manifestations) and any other conditions classified under the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV Codes) as published by American Psychiatric Association;
- Costs/expenses of services of a non-medical nature, such as television, telephones, telex services, radios or similar facilities, admission kit/pack and other ineligible non-medical items;
- Sickness or injury arising from violation of any law, participating in racing of any kind (except foot racing), hazardous sports such as but not limited to skydiving, water skiing, underwater activities requiring breathing apparatus, winter sports, professional sports and illegal activities;
- Private flying other than as a fare-paying passenger in any commercial scheduled airlines licensed to carry passengers over established routes;
- Expenses incurred for sex changes;
- Any treatments directed towards developmental delays and/or learning disabilities of an Insured;

Important Notes

- Any diagnostic tests, procedures, blood tests, investigations or screenings that are not directly related to the final diagnosis and treatment for the covered disability; or
- Cosmetic/aesthetic/plastic surgery or treatment, or treatment which relates to or is needed because of previous cosmetic treatment. However, We will pay for the reconstructive surgery if:
  a. it is carried out to restore function or appearance after an accident or following surgery for a medical condition, provided that the Insured has been continuously covered under this rider since before the occurrence of accident or surgery;
  b. it is done at a medically appropriate stage after the accident or surgery; and
  c. We agree, in writing, to the cost of the treatment before it is done.

6. This brochure contains only general information about the products and does not in any way represent a policy. For a detailed description of the terms and conditions and exclusions of the products please refer to the official policy issued by us.

Our comprehensive range of insurance plans to meet your financial needs at every stage of your life:

PROTECTION

MEDICAL

SAVINGS

INVESTMENT-LINKED

OneMedic Plus 012026

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