



Generali Insurance Malaysia Berhad

Reg No: 197501002042 (23820-W)

Generali Customer Service Centre

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Member of PIDM

The benefit (s) payable under eligible product is protected by PIDM up to limits. Please refer to PIDM's TIPS Brochure or contact Generali Insurance Malaysia Berhad or PIDM (visit www.pidm.gov.my)

Generali Insurance Malaysia Berhad is licensed under the Financial Services Act 2013 and regulated by Bank Negara Malaysia

MEDIC SME MEDICAL POLICY

IMPORTANT NOTICE

Welcome to your Medic SME Medical Policy. Please read this Policy carefully together with your Schedule to ensure that You understand the terms and conditions and that the cover You require is being provided. If You have any questions after reading this document, please contact Your insurance advisor or Generali Insurance Malaysia Berhad. If there are any changes in Your circumstances that may affect the insurance provided, please notify Us immediately, otherwise You may not receive the full benefits of this Policy.

To help preserve the environment, Generali will send You one policy booklet only. Please keep this policy booklet in a safe place. In case of renewal and/or policy condition amendment, the Company will send you the policy schedule and endorsement only. If at any time You would like a replacement for this document, please contact Us and We will be happy to provide one.

If, for any reason, You are unhappy with the service You have received from Us, You can take the following steps:

1. In the first instance, please write to Our Customer Service Department at Our current address. Alternatively, You can e-mail Us at: customer.service.gi@generali.com.my
2. If You are still not satisfied with the way any issue has been handled, You can:
 - (a) Refer matters concerning claims to:
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
 - (b) Submit your complaints/feedback to:
BNMLINK
4th Floor, Podium Bangunan AICB, No. 10, Jalan Dato' Onn, 50480 Kuala Lumpur.
Tel: 1-300-88-5465
(Overseas: +603 2174 1717)
BNMLINK Webpage : bnm.gov.my/BNMLINK

WHEREAS the Insured has made to **Generali Insurance Malaysia Berhad**, (hereinafter called "the Company") a written proposal and declaration which together with all other statements made in writing for the Insurance herein described and has paid the premium or agreed to pay the premium stated in the Schedule shall be the basis of this contract and be considered as incorporated herein.

In consideration of the payment of Premiums and in reliance upon the General Provisions, Definitions, Conditions, Exclusion and Endorsements attached hereto that if any of the Insured or Insured Person is confined to the hospital as a direct result of a covered Disability, as defined herein, the Company will pay the Benefits stated in the Schedule of Benefits based on the actual, usual, customary and reasonable expenses incurred under the Policy.

Provided that no Benefits will be payable unless the entire hospital confinement had been recommended and approved by a legally qualified medical practitioner. The due observance and fulfillment by the Insured Person of the terms and conditions contained herein or endorsed hereon, which terms and conditions shall form part of this Policy, shall insofar as the context permits, be deemed to be conditions precedent to any liability under this Policy.

DEFINITIONS

1. **ACCIDENT** shall mean a sudden, unintentional, unexpected, unusual, and specific event that occurs at an identifiable time and place which shall, independently of any other cause, be the sole cause of bodily injury.
2. **ACCIDENTAL DENTAL TREATMENT** shall mean dental procedure necessitated as a result of an Accident.
3. **ACTIVE SERVICE** shall mean active expenditure of time and energy in the service of the Employer at the Employer's usual place of business on a regularly scheduled full-time basis performing every duty pertaining to his occupation or employment, except that an Employee shall be deemed on active full-time work on each day of a paid leave or on a regular non-working day on which he is not disabled or hospitalized provided he was on active full-time work on the last preceding regular working day.

4. **ANY ONE DISABILITY** shall mean all of the period of Disability arising from the same cause including any and all complications therefrom except that if the Insured Person completely recovers and remain free from further treatment (including drugs, medicines, special diet or injection or advice for the condition) of the Disability for at least ninety (90) days following the latest date of discharge and subsequent Disability from the same cause shall be considered as though it were a new Disability.
5. **CHILD** shall mean any person who has attained the age of 30 days and is an unmarried person, is financially dependent upon the Insured Employee and is under the age of 19, or up to the age of 23 for those registered as full time students at a recognised educational institution in Malaysia.
6. **CONGENITAL CONDITIONS** shall mean any medical or physical abnormalities existing at the time of birth, as well as neo-natal physical abnormalities developing within six (6) months from the time of birth. They will include hernias of all types and epilepsy except when caused by a trauma which occurred after the date that the Insured Person was continuously covered under this Policy.
7. **DAYCARE SURGERY** A patient who needs the use of a recovery facility for a surgical procedure on a pre-plan basis at the Hospital/Specialist clinic (but not for overnight stay).
8. **DENTIST** shall mean a person who is duly licensed or registered to practice dentistry in the geographical area in which a service is provided but excluding a Physician or Surgeon who is the Insured Person himself.
9. **DEPENDENT** shall mean a legally married spouse or unmarried Child(ren).
10. **DISABILITY** shall mean a Sickness, Disease, Illness or the entire Injuries arising out of a single or continuous series of causes.
11. **DOCTOR, GENERAL PRACTITIONER, PHYSICIAN OR SURGEON** shall mean a registered medical practitioner qualified and licensed to practice western medicine and who, in rendering such treatment, is practicing within the scope of his licensing and training in the geographical area of practice, but excluding a Doctor, General Practitioner, Physician or Surgeon who is the Insured Person himself.
12. **ELIGIBLE EXPENSES** shall mean Medically Necessary expenses incurred due to a covered Disability but not exceeding the limits in the Schedule of Benefits.
13. **EMERGENCY** shall mean treatment needed in the event whereby immediate medical attention is required within twelve (12) hours for Injury, Illness or symptoms which are sudden and severe failing which the Member's life could be threatened (e.g. accident and heart attack) or lead to significant deterioration of health.
14. **HOSPITAL** shall mean only an establishment duly constituted and registered as a Hospital for the care and treatment of sick and injured persons as bed paying patients, and which:
 - a. Has facilities for diagnosis and major surgery;
 - b. Provides twenty-four (24) hour a day nursing services by registered and graduate nurses;
 - c. Is under the supervision of a Physician; and
 - d. Is not primarily a clinic; a place for alcoholics or drug addicts; a nursing, rest or convalescent home or a home for the aged or similar establishment.
15. **HOSPITALISATION** shall mean admission to a Hospital as a registered inpatient for Medically Necessary treatments for a covered Disability upon recommendation of a Physician. A patient shall not be considered as an inpatient if the patient does not physically stay in the Hospital for the whole period of confinement.
16. **INJURY** shall mean bodily injury caused solely by Accident.
17. **INSURED PERSON** shall mean the person described in the Policy Schedule including his/her Dependent (if applicable).
18. **INTENSIVE CARE UNIT** shall mean a section within a Hospital which is designated as an Intensive Care Unit by the Hospital, and which is maintained on a twenty-four (24) hour basis solely for treatment of patients in critical condition and is equipped to provide special nursing and medical services not available elsewhere in the Hospital.
19. **MALAYSIAN GOVERNMENT HOSPITAL** shall mean a Hospital where service charges are subject to the Fee Act 1951 Fees (Medical) Order 1982 and/or its subsequent amendments if any.
20. **MEDICALLY NECESSARY** shall mean a medical service which is:
 - a. Consistent with the diagnosis and customary medical treatment for a covered Disability; and
 - b. In accordance with standards of good medical practice, consistent with current standard of professional medical care, and of proven medical benefits; and
 - c. Not for the convenience of the Insured Person or the Physician, and unable to be reasonably rendered out of Hospital (if admitted as an inpatient); and
 - d. Not of an experimental, investigational or research nature, preventive or screening nature; and
 - e. For which the charges are fair and Reasonable and Customary for the Disability.
21. **OVERALL ANNUAL LIMIT**
Benefits payable in respect of expenses incurred for treatment provided to the Insured Person during the Period of Insurance shall be limited to the Overall Annual Limit. In the event that the Overall Annual Limit be exhausted, all insurance for the Insured Person hereunder shall immediately cease to be payable for the remaining Policy Year.
22. **OUTPATIENT** shall mean the Insured Person is receiving medical care or treatment without being hospitalized and includes treatment in a Daycare centre.

23. **PANEL PROVIDER** shall mean a health service provider (Clinic, Specialist or hospital) appointed by the Company or its legal representative to provide health services to the Insured Persons.
24. **POLICYHOLDER / INSURED** shall mean a person or a corporate body to whom the Policy has been issued in respect of cover for persons specifically identified as Insured Persons in this policy.
25. **POLICY YEAR** shall mean the one (1) year period including the effective date of commencement of Insurance and immediately following that date, or the one-year period following the Renewal or Renewed Policy.
26. **PRE-EXISTING CONDITIONS** shall mean disabilities that the Insured Person has reasonable knowledge of. An Insured Person may be considered to have reasonable knowledge of a pre-existing condition where the condition is one for which:
 - a. The Insured Person had received or is receiving treatment;
 - b. Medical advice, diagnosis, care or treatment has been recommended;
 - c. Clear and distinct symptoms are or were evident; or
 - d. Its existence would have been apparent to a reasonable person in the circumstances.
27. **PRESCRIBED MEDICINES** shall mean medicines that are dispensed by a Physician, a General Practitioner, a Registered Pharmacist or a Hospital and which have been prescribed by a Physician or Specialist in respect of treatment for a covered Disability.
28. **REASONABLE AND CUSTOMARY CHARGES** shall mean charges for medical care which is Medically Necessary shall be considered reasonable and customary to the extent that it does not exceed the general level of charges being made by others of similar standing in the locality where the charge is incurred, when furnishing like or comparable treatment, services or supplies to individual of the same sex and of comparable age for a similar Sickness, Disease or Injury and in accordance with accepted medical standards and practice could not have been omitted without adversely affecting Insured Person's medical condition.
29. **RENEWAL OR RENEWED POLICY** shall mean a Policy which has been renewed without any lapse of time upon expiry of a preceding Policy with the same content.
30. **SICKNESS, DISEASE OR ILLNESS** shall mean a physical condition marked by a pathological deviation from the normal healthy state.
31. **SPECIALIST** shall mean a medical or dental practitioner registered and licensed as such in the geographical area of his practice where treatment takes place and who is classified by the appropriate health authorities as a person with superior and special expertise in specified fields of medicine or dentistry but excluding a Physician or Surgeon who is the Insured Person himself.
32. **SPECIFIED ILLNESSES** shall mean the following disabilities and its related complications, occurring within the first one hundred and twenty (120) days of Insurance of the Insured Person:
 - a. Hypertension, diabetes mellitus and cardiovascular disease;
 - b. All tumours, cancers, cysts, nodules, polyps, stones in the urinary system and biliary system;
 - c. All ear, nose (including sinuses) and throat conditions;
 - d. Hernias, haemorrhoids, fistulae, hydrocele, varicocele;
 - e. Endometriosis including disease of the reproduction system;
 - f. Vertebro-spinal disorders (including disc) and knee conditions.
33. **SURGERY** shall mean any of the following medical procedures:
 - a. To incise, excise or electrocauterize any organ or body part, except for dental services;
 - b. To repair, revise, or reconstruct any organ or body part;
 - c. To reduce by manipulation a fracture or dislocation;
 - d. Use of endoscopy to remove a stone or object from the larynx, bronchus, trachea, esophagus, stomach, intestine, urinary bladder or urethra.

SCHEDULE OF BENEFITS

A) Hospitalisation and Surgical Insurance Plan

Schedule of Benefits (in RM)	MS130	MS160	MS220	MS300	MS450
Hospital Room & Board (daily limit up to 180 days)	130	160	220	300	450
Intensive Care Unit (max 45 days)					
Surgical Fees (inclusive of 2nd Surgical Opinion)					
Anesthetist Fees					
Operating Theatre Fees					
In-Hospital Physician Visits (max 2 visits per day, up to max 180 days)					
Hospital Services & Supplies					
Pre-Hospital Diagnosis Tests (within 60 days)					
Pre-Hospital Specialist Consultation (within 60 days)					
Post-Hospitalisation Treatment (within 60 days)					
Emergency Outpatient Accidental Treatment (within 24 hours up to 30 days)					
Accidental Dental Treatment (within 24 hours up to 30 days)					
Ambulance Fee					
Home Nursing Care					
Outpatient Physiotherapy Treatment					
Daycare procedure					
Outpatient Cancer Treatment					
Outpatient Kidney Dialysis Treatment					
Daily Cash Allowance at Malaysian Government Hospitals (max 180 days)	100	100	100	150	200
Medical Report Fees	100	100	100	100	100
Overall Annual Limit (Per Person)	18,000	30,000	45,000	75,000	100,000
Accidental Death Benefit	10,000	10,000	10,000	10,000	10,000

As Charged subject to
'Reasonable and
Customary Charges'
and Overall Annual Limit

B) Clinical / Outpatient Insurance Plan (Rider)

Schedule of Benefits (in RM)	MSD	MSC	MSB	MSA
Benefits applicable within Malaysia				
Covers the medical charges for Consultation, Medicine, Injection, Diagnostic test and procedures performed by:				
1. General Practitioner (GP) Visit in Panel Clinic	As Charged with Medical Card			
2. General Practitioner Visit in Non-Panel Clinic (Limit Per Day)	40	40	40	50
3. Outpatient Specialist Care - upon referral by Panel GP only (Limit Per Policy Year)	800	1,200	1,600	2,000
Benefits applicable outside Malaysia				
Covers the medical charges for Consultation, Medicine, Injection, Diagnostic test and procedures performed by:				
4a. General Practitioner Visit (Limit Per Day)	Nil	60	80	100
4b. Outpatient Specialist Care - upon referral by GP only (Limit Per Day)	Nil	150	175	200

DESCRIPTION OF BENEFITS HOSPITALISATION AND SURGICAL INSURANCE PLAN

The amount indemnified by the Company shall not exceed the actual costs of the treatment and services rendered and the maximum liability of the Company shall be based on the actual, Medically Necessary, Reasonable and Customary Charges incurred but not to exceed the Limits in accordance with the Benefit Plan set out in the Schedule of Benefits. No benefits whatsoever shall be payable for charges, fees or expenses of every kind and description which are not specifically mentioned hereunder.

1. **Hospital Room And Board**

Reimbursement of the daily charges for hospital room accommodation and meals. The amount of the benefit shall be equal to the actual charges made by the Hospital during the Insured Person's confinement, but in no event shall the benefit exceed, for any one day, the rate of Room and Board Benefit and the maximum one hundred and eighty (180) days as set forth in the Schedule of Benefits. The Insured Person will only be entitled to this benefit while confined to a Hospital as an inpatient.

2. **Intensive Care Unit**

Reimbursement of charges actual Room and Board incurred during confinement as an inpatient in the Intensive Care Unit of the Hospital. This benefit shall be payable equal to the actual charges made by the Hospital subject to the maximum benefit for any one day and maximum forty-five (45) days, as set forth in the Schedule of Benefits. Where the period of confinement in an Intensive Care Unit exceeds the maximum set forth in the Schedule of Benefits, reimbursement will be restricted to the standard Daily Hospital Room and Board rate.

No Hospital Room and Board Benefits shall be paid for the same confinement period where the Daily Intensive Care Unit Benefits is payable.

3. **Surgical Fees**

Reimbursement of the professional fees for a surgery performed by the Specialists, including pre-surgical assessment Specialist's visits to the Insured Person and post-surgery care up to maximum sixty (60) days from the date of surgery. This benefit shall include professional fee charges by a second Specialist for consultation or opinion within sixty (60) days from the first consultation by the first Specialist to determine whether a surgical operation is necessary or required in view of the Insured Person's medical condition. This benefit will not be payable if the Insured Person does not result in Hospital confinement for the treatment of the medical condition diagnosed.

4. **Anaesthetist Fees**

Reimbursement of the professional fees charged by the Anaesthetist for the supply and administration of anesthesia incidental to the performance of a Surgery.

5. **Operating Theatre**

Reimbursement of the charges made by Hospital for the use of an Operating Theatre Room incidental to the performance of a Surgery.

6. **In-Hospital Physician Visit**

Reimbursement of the professional fees charges by a Physician for visiting a registered inpatient while confined for a non-surgical Disability subject to a maximum of two (2) visits per day not exceeding the maximum one hundred and eighty (180) days as set forth in the Schedule of Benefits.

7. **Hospital Supplies And Services**

Reimbursement of the charges incurred for general nursing, prescribed and consumed drugs and medicines, dressings, splints, plaster casts, x-ray, laboratory examinations, electrocardiograms, physiotherapy, rental of appliances, Surgical Implant, basal metabolism tests, intravenous injections and solutions, taxes (if applicable), administration of blood and blood plasma but excluding the cost of blood and plasma whilst the Insured Person is confined as an inpatient in a Hospital, up to the amount stated in the Schedule of Benefits.

8. **Pre-Hospital Diagnostic Tests**

Reimbursement of the medical charges for ECG, x-ray and laboratory tests which are performed for diagnostic purposes on account of an Injury or Illness when in connection with a Disability preceding hospitalisation within the maximum sixty (60) days and which are recommended by a Physician.

Payment will not be made if upon such diagnostic services, the Insured Person does not result in Hospital confinement for the treatment of the medical condition diagnosed. Medications and consultation charged by the Doctor will not be payable.

9. **Pre-Hospital Specialist Consultation**

Reimbursement of the professional fees charges by a Specialist for the first-time consultation in connection with a Disability within the maximum sixty (60) days preceding confinement in a Hospital and provided that such consultation is Medically Necessary and has been recommended in writing by the attending Doctor.

Payment will not be made for clinical treatment (including medications and subsequent consultation after the illness is diagnosed) or where the Insured Person does not result in Hospital confinement for the treatment of the medical condition diagnosed.

10. **Post-Hospitalisation Treatment**

Reimbursement of the medical charges incurred for follow-up treatment by the same attending Physician, within the maximum sixty (60) days immediately following discharge from Hospital for a non-surgical Disability. This shall include medicines prescribed during the follow-up treatment but shall not exceed the supply needed for the maximum sixty (60) days as set forth in the Schedule of Benefits.

11. Emergency Outpatient Accidental Treatment

Reimbursement of the medical charges incurred as a result of a covered bodily Injury arising from an Accident for treatment as an Outpatient at any registered clinic or Hospital within twenty-four (24) hours of the Accident causing the covered bodily Injury. Follow up treatment by the same Doctor or same registered clinic or Hospital for the same covered bodily Injury will be provided up to the maximum thirty (30) days as set forth in the Schedule of Benefits.

12. Accidental Dental Treatment

Reimbursement of the Reasonable and Customary Charges charged by a legally registered dentist or at a dental clinic or hospital within 24 hours of the Accident for the treatment of accidental injuries to sound natural teeth. Subsequent restorative, periodontal, orthodontal and prosthodontal services are not covered. Follow-up treatment by the same dentist or same registered clinic or Hospital for the same accidental injuries to sound natural teeth will be provided up to the maximum thirty (30) days as set forth in the Schedule of Benefits.

13. Ambulance Fees

Reimbursement of the transportation charges & professional fees incurred for necessary domestic ambulance services by road inclusive of attendant to and/or from the Hospital of confinement. Payment will not be made if the Insured Person is not hospitalized and is subject to the limits set forth in the Schedule of Benefits.

14. Home Nursing Care

Reimburses the daily professional fees for the services rendered by a medically qualified and licensed Nurse in the Insured Person's home and incurred within sixty (60) days immediately following discharged from Hospital Provided that such services are deemed to be Medically Necessary by the attending Physician in writing. The plan and schedule of the treatment for this Home Nursing Care must be established and prescribed in writing by the attending Physician. No payment will be made for custodial care, meal, general housekeeping services, companion, rest cure or personal comfort items.

15. Outpatient Physiotherapy Treatment

Reimbursement of the daily professional fees charged by a legally and medically qualified Physiotherapist for outpatient physiotherapy treatment and incurred within one hundred (100) days immediately following discharged from Hospital Provided that such service is deemed to be Medically Necessary by the attending Physician in writing.

16. Daycare Procedure

Reimbursement of the medical charges which is inclusive of all incidental costs levied by the Hospital or Daycare Specialist Centre for Daycare Procedure (Surgical and Medical) performed in an Outpatient setting (without Hospital admission). Medical procedures shall include Endoscopy (All Types), Intravenous Phylography (IVP/IVU), Barium Studies and Angiographic Studies and other such diagnostic procedures as deemed Medically Necessary and duly referred in writing by a Doctor.

17. Outpatient Cancer Treatment

If an Insured Person is diagnosed with Cancer as defined below, the Company will reimburse the medical charges incurred for the treatment of Cancer performed at a legally registered Cancer treatment centre subject to the limit of this Disability as specified in the Schedule of Benefits.

Such treatment (radiotherapy or chemotherapy excluding consultation, examination tests, take home drugs) must be received at the out-patient department of a Hospital or a registered Cancer treatment centre immediately following discharge from Hospital confinement or Surgery.

Cancer is defined as the uncontrollable growth and spread of malignant cells and the invasion and destruction of normal tissue for which major interventionist treatment or surgery (excluding endoscopic procedures alone) is considered necessary. The cancer must be confirmed by histological evidence of malignancy. The following conditions are excluded:

- a. Carcinoma in situ including of the cervix;
- b. Ductal carcinoma in situ of the breast;
- c. Papillary carcinoma of the bladder and Stage 1 Prostate Cancer;
- d. All skin cancers except malignant melanoma;
- e. Stage 1 Hodgkin's disease;
- f. Tumours manifesting as complications of AIDS.

It is a specific condition of this Benefit that notwithstanding the exclusion of Pre-Existing Conditions, this Benefit will not be payable for any Insured Person who had been diagnosed as a Cancer patient and/or is receiving Cancer treatment prior to the effective date of Insurance.

18. Outpatient Kidney Dialysis Treatment

If an Insured Person is diagnosed with Kidney Failure as defined below, the Company will reimburse the Reasonable and Customary Charged incurred for the Medically Necessary treatment of kidney dialysis performed at a legally registered dialysis centre subject to the limit of this Disability as specified in the Schedule of Benefit.

Such treatment (dialysis excluding consultation, examination tests, take home drugs) must be received at the out-patient department of a Hospital or a registered dialysis treatment centre immediately following discharge from Hospital confinement or surgery.

Kidney Failure means end stage renal failure presenting as chronic, irreversible failure of both kidneys to function as a result of which renal dialysis is initiated.

It is a specific condition of this Benefit that notwithstanding the exclusion of Pre-Existing Conditions, this Benefit will not be payable for any Insured Person who has developed chronic renal diseases and/or is receiving dialysis treatment prior to the effective date of Insurance.

19. **Daily-Cash Allowance At Government Hospital**
Pays a daily allowance for each day of confinement in a Malaysian Government Hospital for a covered Disability. No Payment will be made for any transfer to or from any Private Hospital and Malaysian Government Hospital.
20. **Medical Report Fee**
Reimbursement of the actual charges for a Medical Report required by the Company up to the maximum limit per Disability stated in the Schedule of Benefits.
21. **Accidental Death Benefit**
Pays the Insured a stated lump sum benefit in the event of Accidental Death of an Insured Person if death occurs within six (6) months from the date of the Accident.

DESCRIPTION OF BENEFITS

CLINICAL / OUTPATIENT INSURANCE PLAN (RIDER)

This Plan is optional, which is subject to additional premium. These Benefits will only be applicable if it is stated in the Policy Schedule and Insurer has received the premium payment.

The amount indemnified by the Company shall not exceed the actual costs of the treatment and services rendered and the maximum liability of the Company shall be based on the actual, Medically Necessary, Reasonable and Customary Charges incurred but not to exceed the Limits in accordance with the Benefit Plan set out in the Schedule of Benefits. No benefits whatsoever shall be payable for charges, fees or expenses of every kind and description which are not specifically mentioned hereunder

1. General Practitioner (GP) visit – Panel Clinic

This benefit only applicable for consultation & treatment within Malaysia by Panel Clinics only.

The benefit covers for expenses incurred for the consultation with GP as a result of Sickness and Injuries for a covered Disability where hospitalisation is not required up to a limit as set forth in the Schedule of Benefits.

This benefit does not cover routine medical examinations and Dietician services are not covered.

The benefit covers:

1.1 Consultation

Covers the professional fees incurred for consultation by a General Practitioner (GP) at a panel clinic only.

1.2 Medication

Covers the cost of medication for a covered disability, which requires a GP's prescription for a maximum of one (1) month supply.

1.3 Injection

Covers the charges incurred for the Injection which requires a GP's administration for treatment of a covered disability and mandatory vaccinations/immunization. The mandatory vaccinations are applicable to eligible Children only but limited to BCG (booster), Hepatitis B (infants up to one year old), Triple Antigen & TETRAct-HIB (infants up to one year old), Double Antigen (booster), Oral Polio, MMR and Rubella.

1.4 Diagnostic Lab/X-ray Procedures

Covers the cost of laboratory and x-ray procedures done at a GP's clinic in accordance with the Disability treated. Ultrasound / sonotron / heat therapy are not covered under this benefit. The benefits stated hereunder are subject to the limits of the Schedule of Benefits.

1.5 Outpatient Surgical Procedure

Covers the charges for procedures done by a GP at the panel clinic. The benefits stated hereunder are subject to the limits of the Schedule of Benefits.

2. General Practitioner (GP) visit – Non-Panel

This benefit only applicable for consultation & treatment within Malaysia by a Non-Panel Clinic in the event of Emergency only.

The description of Benefits and Coverage for Consultation, Medication, Injection, Diagnostic Lab/X-ray Procedures and Outpatient Surgical Procedure are as per description mentioned in note (1) above (i.e. General Practitioner Visit) and payable up to a limit as set forth in the Schedule of Benefits.

3. Outpatient Specialist Care

A benefit only applicable for treatment within Malaysia. The benefits cover the expenses incurred for the consultation with a Specialist as a result of specific Sickness and Injuries for a covered Disability where hospitalisation is not required, up to a limit as set forth in the Schedule of Benefits provided there is a referral letter by a GP from a panel clinic prior to the Specialist visit. The referral letter is only valid for thirty (30) days from the date of visit of the GP's panel clinic.

This benefit does not cover routine medical examinations and Dietician services are not covered.

The benefit covers:

3.1 Consultation

Covers the consultation charges by a Specialist except when such consultation is follow-up treatment after discharge from Hospital or Daycare procedure for surgical or non-surgical Hospital stay, which is covered under the Hospitalisation and Surgical Plan. No cross referrals are allowed except if it is related to the same Disability.

3.2 Medication

Covers the cost of medication, which requires a Specialist's prescription for a maximum of one (1) month supply.

3.3 Injection

Covers the cost of injection, which requires a Specialist's administration. Preventive immunization or vaccination is not covered.

3.4 Diagnostic Lab/X-ray Procedures

Covers the cost of laboratory and x-ray procedures done by a Specialist in accordance with the Disability treated.

3.5 Outpatient Specialist procedures

Covers the charges for procedures done by a Specialist in his/her clinic on an Outpatient basis.

4. Treatment outside Malaysia

Covers both General Practitioner (GP) visit and Outpatient Specialist Care incurred outside Malaysia subjected to the respective description, terms and conditions mentioned under notes (1) and (3) above. Benefits payable up to a limit as set forth in the Schedule of Benefits.

CONDITIONS

1. Alterations

The Company reserves the right to amend the terms and provisions of this Policy by giving a thirty (30) day prior notice in writing by ordinary post to the Owner's last known address in the Company's records, and such amendment will be applicable from the next renewal of this Policy. No alteration to this Policy shall be valid unless Authorized by the Company and such approval is endorsed thereon. The Company should give thirty (30) days prior written notice to the Policyholder according to the last recorded address for any alterations made.

2. Arbitration

All differences arising out of this Policy shall be referred to an Arbitrator who shall be appointed in writing by 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 who shall 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 the Company for any claim hereunder must be referred to an Arbitrator within twelve (12) calendar months from date of such disclaimer.

3. Cancellation

This Policy may be cancelled by the Policyholder at any time by giving a written notice to the Company; and provided that no claims have been made during the current Policy Year, the Policyholder shall be entitled to a refund of the premium as follows:

Period Not Exceeding	Refund of Annual Premium
15 days*	90%
1 month	80%
2 months	70%
3 months	60%
4 months	50%
5 months	40%
6 months	30%
7 months	25%
8 months	20%
9 months	15%
10 months	10%
11 months	5%
Period exceeding 11 months	No Refund

*Applicable to renewal Policy only

4. Certification, Information and Evidence

All certificates, information, medical reports and evidence as required by the Company shall be furnished at the expense of the Insured Person, and in such a form that the Company may require. In any event all notices which the Company shall require the Policyholder to give must be in writing and addressed to the Company. An Insured Person shall, at the Company's request, submit to a medical examination whenever such is deemed necessary.

5. Change in Risk

The Insured Person shall give immediate notice in writing to the Company of any material change in his or her occupation, business, duties or pursuits and pay any additional premium that may be required by the Company.

6. Claims Procedures

- a. The Insured Person shall within thirty (30) days of a Disability that incurs claimable expenses, give written notice to the Company stating full particulars of such event, including all original bills and receipts, and a full Physician's report stipulating the diagnosis of the condition treated and the date the Disability commenced in the Physician's opinion and the Physician's summary of the cost of treatment including medicines and services rendered. Failure to furnish such notice within the time allowed shall not invalidate any claim if it is shown not to have been reasonably possible to furnish such notice and that such notice was furnished as soon as was reasonably possible;
- b. The Insured Person shall immediately procure and act on proper medical advice and the Company shall not be held liable in the event a treatment or service becomes necessary due to failure of the Insured Person to do so;
- c. The Insured Person shall submit detailed itemization of charges/treatment/medication(s) to the Company for Outpatient GP and Specialist claim reimbursement above RM50.00;
- d. The Insured Person shall submit a claim form to be filled by the attending Physician or Outpatient Specialist for claims above RM250.00.

7. **Condition Precedent to Liability**

The due observance and the fulfillment of the terms, provisions and conditions of this Policy by the Insured Person and in so far as they relate to anything to be done or complied with by the Insured Person shall be conditions precedent to any liability of the Company.

8. **Contribution**

If an Insured Person carries other insurance covering any illness or injury insured by this Policy, the Company shall not be liable for a greater proportion of such illness or Injury than how the amount applicable hereto under this Policy bears to the total amount of all valid insurance covering such illness or injury.

9. **Cooling-Off Period**

If this Policy shall have been issued and for any reason whatsoever the Insured Person shall decide not to take up the Policy, the Insured Person may return the Policy to the Company for cancellation provided such request for cancellation is delivered by the Insured Person to the Company within fifteen (15) days from the date of delivery of the Policy. The Insured Person is entitled to the return of the full premium paid less deduction of medical expenses incurred by the Company in the issuance of the Policy.

10. **Currency of Payment**

All payments under this Policy shall be made in the legal currency of Malaysia. Should any payment be requested by the Insured Person to be payable in any other currency, then such amount shall be payable in the demand currency as may be purchased in Malaysia at the prevailing currency market rates on the date of the claim settlement.

11. **Geographical Territory**

All benefits provided in this policy are applicable worldwide for twenty-four (24) hours a day, subject to Policy Condition on 'Overseas Treatment'.

12. **Governing Law**

This policy is issued under the laws of Malaysia and is subject to and governed by the laws prevailing in Malaysia.

13. **Incomplete Claims**

All claims must be submitted to the Company within thirty (30) days of completion of the events for which the claim is being made. Claims are not deemed complete and Eligible Benefits are not payable unless all bills for such claims have been submitted and agreed upon by the Company. Only actual costs incurred shall be considered for reimbursement. Any variation or waiver of the foregoing shall be at the Company's sole discretion.

14. **Legal Proceedings**

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 Insured Person shall fail to supply the requisite proof of loss as stipulated by the terms, provisions and conditions of the Policy, the Insured Person may, within a grace period of one (1) calendar year from the time that the written proof of loss was furnished or required to be furnished, submit the relevant proof of loss to the Company with cogent reason(s) for the failure to comply with the Policy terms, provisions and conditions. The acceptance of such proof of loss shall be at the sole and entire discretion of the Company. After such grace period has expired, the Company will not accept, for any reason whatsoever, such written proof of loss.

15. **Misstatement or Omission of Material Fact**

Subject to the relevant duty of disclosure of the Insured Person, if any answer, disclosure or representation by the Insured Person, before this contract of insurance is entered into, varied or renewed, in or to any proposal or declaration or query, has been deliberately or recklessly stated in any respect; or before this contract of insurance is entered into, varied or renewed, the Insured Person have failed to disclose any fact that the Insured Person knew to be relevant to the Company's decision on whether to accept this risk or not and the rates and the terms to be applied; or any claim made shall be fraudulent or exaggerated, or if any false declaration or statement shall be made in support of such claim, then in any of the above cases, this Policy shall be void.

16. **Misstatement of Age**

If the age of the Insured Person 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 Insured Person would not have been eligible for cover under this Policy, no benefit shall be payable.

17. **Notice**

Every notice or communication to the Company shall be in writing and sent to the Company. No alterations in the terms of this Policy or any endorsement thereon will be held valid unless the same is signed or initialed by an authorized representative of the Company.

18. **Overseas Treatment**

If the Insured Person seeks treatment overseas, benefits in respect of the treatment shall be covered subject to the exclusions, limitations and conditions specified in this Policy and all benefits will be payable based on the official exchange rate ruling on the last day of the Period of Confinement and shall exclude the cost of transport to the place of treatment provided:

- a. An Insured Person travelling abroad for a reason other than for medical treatment needs to be confined to a Hospital outside Malaysia as a consequence of a Medical Emergency.
- b. An Insured Person upon recommendation of a Physician and has to be transferred to a Hospital outside Malaysia because the specialised nature of the treatment, aid, information or decision required can neither be rendered nor furnished nor taken in Malaysia.

Overseas treatment of a Disease, Sickness or Injury which was diagnosed in Malaysia and non-emergency or chronic conditions where treatment can reasonably be postponed until return to Malaysia are excluded.

19. **Ownership of Policy**
Unless otherwise expressly provided for by Endorsement in the Policy, the Company shall be entitled to treat the Policyholder as the absolute owner of the Policy. The Company shall not be bound to recognize any equitable or other claim to or interest in the Policy, and the receipt of the Policy or a benefit by the Policyholder (or by his legal or authorized representative) alone shall be an effective discharge of all obligations and liabilities of the Company. The Policyholder shall be deemed to be the responsible Principal Agent of the Insured Persons covered under this Policy.
20. **Period of Cover And Renewal**
This Policy shall become effective as of the date stated in the Schedule. The Policy Anniversary shall be one (1) year after the effective date and annually thereafter. On each such anniversary, this Policy is yearly renewable at the premium rates in effect at that time and any change in the renewal premium shall be notified in writing at least thirty (30) days before change is effective. This Policy is renewable at the option of the Company.
21. **Portfolio Withdrawal Condition**
The Company reserves the right to cancel the portfolio as a whole if it decides to discontinue underwriting this insurance product. Cancellation of the portfolio as a whole shall be given within thirty (30) days in writing to the Policyholder and the Company will run off all policies to expiry of the period of cover within the portfolio.
22. **Proof of Claim**
The Company requires as part of the proof of claim, original bills and receipts with respect to Hospital confinement and the charges and fees incurred.
23. **Residence Overseas**
No benefit whatsoever shall be payable for any medical treatment received by the Insured Person outside Malaysia, if the Insured Person resides or travels outside Malaysia for more than ninety (90) consecutive days.
24. **Subrogation**
If the Company shall become liable for any payment under this Policy, the Company shall be subrogated to the extent of such payment to all the rights and remedies of the Insured Person against any party and shall be entitled at its own expense to sue in the name of the Insured Person. The Insured Person shall give or cause to be given to the Company all such assistance in his/her power as the Company shall require securing the rights and remedies and at the Company's request shall execute or cause to be executed all documents necessary to enable the Company to effectively to bring suit in the name of the Insured Person.
25. **Upgraded Policies**
If the Eligible Benefits to any Insured Person under the terms of this Policy be increased while it is in force or at the time of Renewal or replacement and if such Insured Person shall have been afflicted with a Disability prior or at the time the Benefits were increased, the Limits of Benefits payable in respect of such Disability shall not exceed the Limit of Benefits prior to the date the Benefits were upgraded.
26. **Upgraded Room and Board Co-Payment**
If the Insured Person is hospitalized at a published Room and Board rate which is higher than his/her eligible benefit, the Insured Person shall bear 20% of the other eligible benefits described in the Schedule of Benefits.
27. **Waiting Period**
Eligibility for benefits starts thirty (30) days after the Insured Person has been included in the Policy, except for a covered Accident occurring after the effective date of coverage.
28. **Duty of Disclosure**
- a. **Consumer Insurance Contract**
Pursuant to Paragraph 5 of Schedule 9 of the Financial Services Act 2013, if the Insured Person had applied for this Insurance wholly for purposes unrelated to the Insured Person's trade, business or profession, the Insured Person had a duty to take reasonable care not to make a misrepresentation in answering the questions in the Proposal Form and all the questions required by the Company fully and accurately and also disclose any other matter that the Insured Person knows to be relevant to the Company's decision in accepting the risks and determining the rates and terms to be applied, otherwise it may result in a avoidance of contract, claim denied or reduced, terms changed or varied, or contract terminated. This duty of disclosure continues at all times, including the time the contract was entered into, varied or renewed.
 - b. **Non-Consumer Insurance Contract**
Pursuant to Paragraph 4(1) of Schedule 9 of the Financial Services Act 2013, if the Insured Person had applied for this Insurance for purposes related to Insured Person's trade, business or profession, the Insured Person had a duty to disclose any matter that the Insured Person knows to be relevant to the Company's decision in accepting the risks and determining the rates and terms to be applied and any matter a reasonable person in the circumstances could be expected to know to be relevant, otherwise it may result in avoidance of contract, claim denied or reduced, terms changed or varied, or contract terminated. This duty of disclosure continues at all times, including the time the contract was entered into, varied or renewed.
 - c. The Insured Person also has a duty to tell the Company immediately if at any time, after this Policy contract has been entered into, varied or renewed with the Company, any of the information given for this Policy contract is inaccurate or has changed.

29. **Tax impact on Claims Settlement**

The Company will pay the Policyholder's claim inclusive of any taxes (where applicable) on items which are taxable supplies, up to the Overall Annual Limit.

In the event that the Policyholder is entitled to claim for any Input Tax Credit (if applicable) and if the Company make a payment under this policy as compensation to the Policyholder, the Company will reduce the amount of the payment by deducting the Policyholder's Input Tax Credit entitlement irrespective of whether the Policyholder has or has not claimed the Input Tax Credit, up to the Overall Annual Limit.

30. **Automatic Addition/Deletion/Change Status**

Addition of new Insured Person (due to new employment, confirmation of employment, marriage, birth of child, etc.), deletion of existing employees and/or dependent (due to resignation, termination of employment, divorce or death), or any change in employee status (due to promotion) must be notified to the Company in advance or within thirty (30) days from the effective date of coverage of the Insured Person

31. **Change of Benefits and Coverage**

Application for Change of Benefits to a higher Plan and/or Coverage to include Spouse and/or Dependent(s) can only be made on Policy Anniversary Date and is subject to satisfactory evidence of insurability and acceptance by the Company.

32. **Effective Date of Individual Insurance**

Subject to any evidence of health, the insurance of each present and future eligible employee shall take effect on the employee's eligibility date provided the Insured notifies the Company within thirty (30) days after eligibility date required on the Employee's insurance for the period from the Effective Date of the insurance to the Policy expiry date. If the Company is notified after thirty (30) days from the eligibility date, the insurance shall take effect on the date the Company receives notification, subject to and acceptance by the Company.

Subject to any evidence of health, the insurance of a Dependent shall take effect on the dependent's eligibility date, provided the Insured notifies the Company within thirty (30) days after the eligibility date and pays the premium required on the dependent's insurance for the period from the effective date of the insurance to the Policy expiry date. If the Company is notified after thirty (30) days from the eligibility date, the insurance shall take effect on the date the Company receives notification, subject to satisfactory evidence of insurability and acceptance by the Company.

33. **Eligibility**

Persons eligible for insurance under the Policy are present and future employees of the Insured who are in Active Service with the Insured and has attained the age of sixteen (16) years and up to the age of 65 years (and renewal is allowed up to 70 years if he/she is insured prior to age 66 years) (on last birthday basis).

Future full-time employees actively at work as at the date of eligibility will be eligible to participate in the insurance according to the date mentioned in the Employee Enrollment Form.

If an Employee is not Active in Service on the date he/she would otherwise become eligible, the effective date of insurance shall be deferred to the first (1st) day of the month immediately following his/her return to active service work.

Dependents are also eligible to be insured on the dates the employees themselves become eligible, if applicable. If a dependent is disabled by sickness or injury on the date he/she would otherwise be eligible, his/her eligibility date shall be deferred to the day following his/her complete recovery from the disability.

34. **Participation Requirement**

This Policy requires that all present and future full-time eligible employees be insured under this Policy.

35. **Premiums**

The premium rates shall be reviewed on a yearly basis and subject to adjustment, if required, based on the experience of the portfolio. However, the Company can review renewal rates on an individual basis if required instead of the group as a whole. This would be based on satisfactory health condition.

36. **Records**

The Employer shall furnish periodically to the Company, information relating to new employees and dependents to be insured and termination of insurance of Employees and Dependents that may be required by the Company to administer the coverage. Upon request by the Company, not more than once a year, the Employer shall furnish a statement to the Company of the ages, occupations and such other relevant data concerning the Employees as may reasonably be considered to have a bearing on the administration of the coverage and on the determination of the future premium rates. Such information and records shall be open for inspection by the Company at any reasonable time.

37. **Termination of Individual Insurance**

The insurance of an Insured Person shall terminate on the earliest happening of any of the following:

- a. On the date this Policy is terminated;
- b. On the premium due date if the Insured fails to pay the required premium for the Insured Person.
- c. On the death of the Insured Person; or
- d. On the date in which an Employee is retired or pensioned.
- e. On the Policy Anniversary immediately following the 70th birthday of the Insured Person; or
- f. At midnight standard Malaysian time on the last day of the Period of Insurance unless the Insured Person is confined to a Hospital at such time. If this being the case, the time of termination shall be extended to:
 - i. The time the Insured Person is immediately discharge from Hospital; or
 - ii. The time the Overall Annual Limit has been exhausted.

The insurance of an Insured Employee's Dependent shall terminate:

- a. On the date of termination of the insurance afforded to the insured Employee
- b. On the date such Dependent ceases to be a Dependent as defined herein

38. Evidence of Health

Satisfactory evidence of health shall be required by the Company before an Employee and Dependent, if any, is accepted for insurance and is also required in the case of an increase in hospitalisation benefits for the insured Employee and Dependent. If the result of medical examination proves to be unsatisfactory, the Company may accept the insurance in other than the usual terms or decline the insurance for the Employee and/or Dependent.

EXCLUSIONS

A) Applicable to the Hospitalisation and Surgical Insurance Plan

This contract does not cover any hospitalisation, surgery or charges caused directly or indirectly, wholly or partly, by any one (1) of the following occurrences:

1. Pre-existing illness for the first twelve (12) months of cover.
2. Specified Illnesses occurring during the first one hundred and twenty (120) days of continuous cover.
3. Any medical or physical conditions arising within the first thirty (30) days of the Insured Person's cover or date of reinstatement whichever is latest except for accidental Injuries.
4. Plastic/Cosmetic surgery, circumcision, eye examination, glasses and refraction or surgical correction of nearsightedness (Radial Keratotomy or Lasik) and the use or acquisition of external prosthetic appliances or devices such as artificial limbs, hearing aids, implanted pacemakers and prescriptions thereof.
5. Dental conditions including dental treatment or oral surgery except as necessitated by Accidental Injuries to sound natural teeth occurring wholly during the Period of Insurance.
6. Private nursing, rest cures or sanatoria care, illegal drugs, intoxication, sterilization, venereal disease and its sequelae, AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex) and HIV related diseases, and any communicable diseases required quarantine by law.
7. Any treatment or surgical operation for congenital abnormalities or deformities including hereditary conditions.
8. Pregnancy, 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 sterilization.
9. Hospitalisation primarily for investigatory purposes, diagnosis, X-ray examination, general physical or medical examinations, not incidental to treatment or diagnosis of covered Disability or any treatment which is not Medically Necessary and any preventive treatments, preventive medicines or examinations carried out by a Physician, and treatments specifically for weight reduction or gain.
10. Suicide, attempted suicide or intentionally self-inflicted injury while sane or insane.
11. War or any act of war, declared or undeclared, criminal or terrorist activities, active duty in any armed forces, direct participation in strikes, riots and civil commotion or insurrection.
12. Ionising radiation or contamination by radioactivity from any nuclear fuel or nuclear waste from process of nuclear fission or from any nuclear weapons material.
13. Expenses incurred for donation of any body organ by an Insured Person and costs of acquisition of the organ including all costs incurred by the donor during organ transplant and its complications.
14. Investigation and treatment of sleep and snoring disorders, hormone replacement therapy and alternative therapy such as treatment, medical service or supplies, including but not limited to chiropractic services, acupuncture, acupressure, reflexology, bone-setting, herbalist treatment, massage or aroma therapy or other alternative treatment.
15. 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 Person and Disabilities arising out of duties of employment or profession that is covered under a Workman's Compensation Insurance Contract.
16. Psychotic, mental or nervous disorders, (including any neuroses and their physiological or psychosomatic manifestations).
17. 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.
18. Sickness or Injury arising from 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.
19. Expenses incurred for sex change.

B) Applicable to the Clinical / Outpatient Insurance Plan (Rider)

This Policy does not cover any Clinical, General Practitioner, Doctor and Specialist charges and costs caused directly or indirectly, wholly or partly, by any one (1) of the following occurrences:

1. Purchase or acquisition of all types of external and internal appliances or devices (i.e. wheelchairs, implants, hearing aids, walking aids, equipment for nebulizing, orthopedic pads).
2. Dental conditions including dental treatment or surgery except as a result of an Accident. Restorative procedures such as crowning, bridging, implant and root canal treatment are not covered.
3. Plastic/cosmetic treatment and its complication thereafter, except as necessitated by Accidental injury.
4. Eye examination, refractive errors of the eyes and its correction, supply of corrective glasses or contact lens.
5. Alternative therapies including but not limited to chiropractic services, acupuncture, acupressure, reflexology, bone-setting, herbalist treatment, massage or aroma therapy, non-western medicine and other alternative treatment.
6. Surgical, mechanical or chemical contraceptive methods of birth control, and Hormone therapy.
7. Sexual dysfunction, sex transformation whether by surgical or chemical.
8. Sexually transmitted diseases and its sequel, AIDS or HIV and its related complications, any communicable diseases requiring quarantine by law.
9. Pregnancy, childbirth (including delivery), pre-natal, post-natal care, abortion, infertility and miscarriage.
10. Suicide, attempted suicide, self-inflicted injury or overdose of any kind intentional or otherwise while sane or insane.
11. Routine health check-ups, routine physical examination, including gynaecological check-ups.
12. Outpatient physical therapy or physiotherapy except upon written referral of a Specialist.
13. Speech and occupational therapy, Blood and topical allergy testing.
14. Treatment for congenital abnormalities, deformities and disabilities.
15. Vitamins, food supplements, soaps, shampoos, toiletries items, herbal cures, weight reduction or induction agents, off the counter medications, and preventive vaccinations /immunization except as mentioned in Description of Benefits.
16. Treatment of Injuries sustained while under the influence of alcohol or narcotics or whilst in participation in any illegal or dangerous activities.
17. Psychotic, mental or nervous disorders (including any neuroses and their physiological or psychosomatic manifestations).
18. Private nursing care or services for rest cures or sanatoria care provided by rest/nursing home, and house calls by doctors for any reason.
19. Purchase of treatment of rehabilitation drugs (i.e. smoking patches and etc.).
20. Facial or treatment for Acne, any circumcision unless Medically Necessary.
21. Dispense of member's current medication for a period of more than two (2) weeks except for member with chronic conditions e.g. diabetes, hypertension, etc. where up to one (1) month supply is allowed.
22. Treatment/dispense of medication which are not consistent with diagnosis and costs/expenses of services of a non-medical nature.
23. 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 Person and Disabilities arising out of duties of employment or profession that is covered under a Workman's Compensation Insurance Contract.
24. More than one (1) consultation per day to a General Practitioner, doctor or Specialist.
25. Outpatient rehabilitation therapy, chemotherapy, radiation therapy and kidney dialysis.
26. Sickness or Injury arising from 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.
27. War or any act of war, declared or undeclared, criminal or terrorist activities, active duty in any armed forces, direct participation in strikes, riots and civil commotion or insurrection.
28. Ionising radiation or contamination by radioactivity from any nuclear fuel or nuclear waste from process of nuclear fission or from any nuclear weapons material.

LIMITATIONS

1. No benefit shall be payable with respect to any period of Hospital confinement unless the entire confinement and all the special Hospital services rendered, and operations performed, if any, had been recommended and approved by a legally qualified medical practitioner;
2. No benefit shall be payable if the Hospital confinement upon which the claim is based is not related to the diagnosis and treatment of the condition for which Hospital confinement is required by the attending medical practitioner;
3. No benefit is payable for charges, fees or expenses not mentioned under the benefits description provided herein.

IMPORTANT

The Policyholder shall read this Policy carefully, and if any error or differences be found herein, or if the cover is not in accordance with the wishes of the Policyholder, notice should at once be given to the Company and this Policy returned for amendment or cancellation.

Generali Insurance Malaysia Berhad
Reg No: 197501002042 (23820-W)

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