

POLICY CONTRACT

DEFINITIONS

In this Policy, the words set out below shall have the corresponding meaning assigned to them.

You, Your, Yours and **Owner** means the Policy Owner named in the Policy Schedule.

We, Us, Our, Ours and **Company** means AXA AFFIN LIFE INSURANCE BERHAD at its Registered Office in Kuala Lumpur, Malaysia.

Accident means 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 the Bodily Injury.

Bodily Injury means an Injury caused directly and independently of all other causes by Accident of which there is evidence of a visible bruise or wound on the body.

Age means the Age on last birthday.

Annual Premium means the premium for the Basic Plan and is shown in the Policy Schedule.

Basic Plan means Your chosen plan as stated in the Policy Schedule.

Company's Office means the Company's Service Department located in its main office, or as determined by the Company from time to time.

Congenital Conditions means any medical or physical abnormalities existing at the time of birth, as well as neo-natal physical abnormalities developing within 6 months from the time of birth. This will include ALL Congenital Conditions as classified and listed by the World Health Organization on Congenital, Malformations, Deformations and Chromosomal Abnormalities. They will include hernias of all types and epilepsy except when caused by a trauma which occurred after the date that the Insured was continuously covered under this plan.

Date Applied means the date the Policy is applied and is shown in the Policy Schedule.

Day means a charging Day adopted by the Hospital concerned.

Daycare Surgical Procedure means 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).

Deductible refers to the amount of Eligible Expenses that You should pay before We pay the benefit as stated in the Schedule of Benefits.

Dental Treatment means the Treatment required to establish or maintain oral health, tooth repair, scaling, filings, tooth extraction, malocclusion, restoration of tooth function and alignment.

Dentist means a person who is duly licensed or registered to practice dentistry in the geographical area in which a service is provided, but excluding a Dentist who is the Insured himself.

Disability means a Sickness, Disease, Illness or the entire Injuries arising from a single or continuous series of causes. Any One Disability shall mean all of the periods of Disability arising from the same cause including any and all complications there from. However, if the Insured completely recovers and remains free from further Treatment (including drugs, Medicines, special diet or injection or advice for the condition) for the Disability for at least 90 days following the latest date of discharge, subsequent Disability from the same cause shall be considered as a new Disability.

Doctor or Physician or Surgeon or Anaesthetist means a registered Medical Practitioner qualified and licensed to practice western medicine and who, in rendering such Treatment, is practising within the scope of his licence and training in the geographical area of practice, but excluding a Doctor, Physician, Surgeon or Anaesthetist who is the Insured himself.

Eligible Expenses means Medically Necessary expenses incurred due to a covered Disability but not exceeding the Limit as stated in the Schedule of Benefits.

Expiry Date means the date when the Policy expires and is shown in the Policy Schedule.

Hospital means an establishment duly constituted and registered as a Hospital for the care and Treatment of sick and injured persons as paying bed-patients, and which:

- (a) has facilities for diagnosis and major Surgery;
- (b) provides 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.

Hospitalisation means admission to a Hospital as a registered In-patient for Medically Necessary Treatments for a covered Disability upon recommendation of a Physician. A patient shall not be considered as an In-patient if the patient does not physically stay in the Hospital for the whole period of confinement.

Injury means Bodily Injury caused solely by Accident.

Illness, Disease or Sickness means a physical condition marked by a pathological deviation from the normal healthy state.

In-patient means an overnight admission of an Insured into a Hospital in order to receive Treatment.

Insured means the person named in the Policy Schedule who is insured under this Policy.

Intensive Care Unit means a section within a Hospital which is designated as an Intensive Care Unit by the Hospital, and which is maintained on a 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.

Issue Date means the date We issue this Policy as specified in the Policy Schedule, or in the case of any attached supplement or endorsement as specified in the supplement or endorsement. It is the month, day and year this Policy and any supplement or endorsement takes effect.

Lifetime means the entire duration where the Insured is covered under this Policy.

Limit means Deductible Limit, Annual Limit, Lifetime Limit and/or Maximum Limit Per Disability, whichever is/are applicable.

Medically Necessary means a medical service which is:

- (a) consistent with the diagnosis and customary medical Treatment for a covered Disability;
- (b) in accordance with standards of good medical practice, consistent with current standard of professional medical care, and of proven medical benefits;
- (c) not for the convenience of the Insured or the Physician, and unable to be reasonably rendered out of Hospital (if admitted as an In-patient);
- (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.

Medical Practitioner means a registered Physician 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 Medical Practitioner who is the Owner/Insured, or the spouse of the Owner/Insured or any immediate family member of the Owner/Insured.

MYR means the currency of Malaysia (i.e. Ringgit Malaysia (RM)) and it is used interchangeably with RM.

Out-patient means the Insured is receiving medical care or Treatment without being hospitalised and includes Treatment of Daycare Surgical Procedure.

Policy Anniversary means the same day and month each year as the Policy Date.

Policy Date means the Policy Date as shown in the Policy Schedule.

Pre-existing Illness means the Disabilities that the Insured has reasonable knowledge of. An Insured may be considered to have reasonable knowledge of a Pre-existing Condition where the condition is one for which:

- (a) the Insured 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.

Prescribed Medicines means the Medicines that are dispensed by a Physician, a registered pharmacist or a Hospital and which have been prescribed by a Physician or Specialist in respect of Treatment for a covered Disability.

Reasonable and Customary Charges means charges for medical care which is Medically Necessary 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 individuals 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 the Insured's medical condition. In Malaysia, Reasonable and Customary Charges shall be deemed to be those laid down in the Malaysian Medical Association's Schedule of Fees including any amendments or enactments to it.

Regulator means Bank Negara Malaysia, the government body in charge of the enforcement of all laws and regulations relating to insurance (except in the Federal Territory of Labuan).

Specialist means 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 Dentist, Physician or Surgeon who is the Insured himself.

Specified Illnesses means any one of the following Disabilities and its related complications:

- (a) Hypertension, diabetes mellitus and cardiovascular disease;
- (b) All tumours, cancers, cysts, nodules, polyps, stones of 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.

Surgery means 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.

Treatment means Surgery or medical procedures carried out by a Specialist (other than for diagnostic procedures).

Waiting Period means eligibility for benefits starts 120 days for Specified Illness and 30 days for any other causes after the Issue Date, except for covered Accident occurring after the Issue Date.

Please e-mail to the Company's Office in respect of the payment of any benefit under this Policy or contact Our nearest authorized representative. We will furnish the required forms free of charge together with any necessary advice and instructions.

ELIGIBILITY AND SCOPE

1. Eligible Persons

Persons eligible to be covered under this Policy must be a person who legally resides in Malaysia, Brunei or Singapore. Persons become ineligible when they have resided continuously for 90 days, or spend more than 180 days in a calendar year, outside Malaysia, Brunei or Singapore.

2. Overseas Treatment

If the Insured who is a Malaysian citizen, elects to or is referred to be treated outside Malaysia by the attending Physician, benefits in respect of the Treatment shall be limited to the Reasonable and Customary and Medically Necessary Charges for such equivalent local Treatment in Malaysia and shall exclude the cost of transport to the place of Treatment. Reasonable and Customary and Medically Necessary Charges shall be deemed to be those laid down in the Malaysian Medical Association's Schedule of Fees inclusive of any amendments/enactments made to it.

This benefit is not applicable to non-Malaysian citizen. Only treatment sought in Malaysia would be covered.

3. Overseas Residence

No benefit whatsoever shall be payable for any medical treatment received by the Insured outside Malaysia, Singapore or Brunei, if the Insured resides or travels outside these countries for more than 90 consecutive days.

For non-Malaysian citizen, no benefit shall be payable for any medical treatment received by the Insured outside Malaysia regardless the period of resides or travels.

4. Waiting Period

Eligibility for benefits starts 120 days for Specified Illness and 30 days for any other causes after the Issue Date, except for covered Accident occurring after the Issue Date.

GENERAL PROVISIONS

1. Contract

This Policy is issued in consideration of the payment of premium as specified in the Policy Schedule and pursuant to Your answers to the questions in Your enrolment form or in any of Our subsequent questionnaires on any matters relating to Your enrolment form and any disclosures that You made between the time of submission of Your enrolment form and the time this contract is entered into (collectively referred to as “the material information”) and such material information shall form part of this contract of insurance between Us and You.

However, in the event of any pre-contractual misrepresentation made in relation to such material information, only the remedies in Schedule 9 of the Financial Services Act 2013 will apply.

If We require You, before the Policy is renewed or varied, to answer any questions or if You are required to confirm or amend any matter that You previously disclosed to Us in relation to this Policy, it is Your duty to take reasonable care not to make a misrepresentation when answering the questions or confirming or amending any matter previously disclosed.

This is a non-participating Policy. The entire contract is made up of this Policy with all its pages, the attached copy of the application, Policy Schedule and any attached endorsement or supplement provided that the name and form number for such endorsement or supplement is listed in the Policy Schedule and shall constitute the entire contract between Us and You.

The contract cannot be changed after this Policy has been issued without Your consent and Our agreement, except that the Company may, without Your consent, amend this Policy to reflect changes required by law.

This Policy is governed by the laws of Malaysia and the parties agree to be subjected to the exclusive jurisdiction of the Malaysian courts.

2. Incontestability

Except for fraud, We will not contest the validity of this Policy after it has been in effect during the Insured’s Lifetime for 2 years from the Issue Date. However, if We can show that there is a suppression of a material fact or a statement by You on a material matter was inaccurate, false, misleading or it was fraudulently made or omitted, We shall have the right to void this Policy accordingly.

Where the Policy has been in force during the Lifetime of the Insured for 2 years or less from the Issue Date, We may void this Policy and refuse all claims if a misrepresentation was found to be deliberate or reckless.

If the misrepresentation was careless or innocent, We may at Our absolute discretion:

- (i) Void this Policy and refuse all claims, in which case We shall refund all premiums paid. This payment shall be a complete and valid discharge of any of Our liability under this Policy; or
- (ii) Take any necessary remedies in accordance with the Financial Services Act 2013.

3. Misrepresentation or Fraud

If the proposal or declaration made by the Insured is untrue in any respect or if any material fact affecting the risk be incorrectly stated herein or omitted therefrom, or if this insurance, or any renewal thereof shall have been obtained through any misstatement, misrepresentation or suppression, 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 supplement shall be void.

4. Misstatement of Age

Subject to Our rights in the case of fraud, if the Insured’s Age has been misstated, the benefits, the premiums and the coverage terms under this Policy will be adjusted according to the correct Age.

- (a) If the Age of the Insured is understated, the Company will pay the benefits that the premium paid would have purchased according to the rate at the true Age, and not the benefits as shown in Policy Schedule or any subsequent endorsement issued by the Company;
- (b) If the Age of the Insured is overstated, the Company will refund the excess of premium paid without interest;
- (c) If the Insured was not insurable under this Policy according to the Company’s requirements, this Policy (including any attached endorsement and supplement) will be void from the Policy Date and all premiums paid without interest will be refunded.

Proof of Age of the Insured shall be required prior to payment of any benefit under this Policy.

5. Non-participating

This is a non-participating Policy and is not entitled to participate in the distribution of surplus by Us.

6. Termination

This Policy will automatically terminate upon the first occurrence of any one of the following:

- (a) when this Policy is or is deemed to be surrendered according to the terms of this Policy; or
- (b) upon termination in accordance with the Grace Period clause under the Premium and Charges Provision; or
- (c) on the Expiry Date; or
- (d) death of the Insured.

Once terminated, this Policy shall cease to be in force. The payment or acceptance of any premium hereunder subsequent to the termination of this Policy shall not create any liability on the part of the Company but the Company shall refund any such premium without interest.

7. Notice

Any notice to be given to You under this Policy will be sent to You via the e-mail address that You have registered with Us during the proposal or change request in Our records at the Company's Office. Any such notice will run from the time such notice is sent. In the case that any notice is returned undelivered to You, the Company may, at its sole and absolute discretion, at Your own risk, withhold all subsequent notice until You notify the Company of Your new e-mail address.

Every notice or communication to Us shall be in writing and sent to Us at Our authorized e-mail address.

8. Claim Procedure

- (a) The Insured shall within 30 days of a Disability that incurs claimable expenses, give Us written notice 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 shall immediately procure and act on proper medical advice and We shall not be held liable in the event a Treatment or service becomes necessary due to failure of the Insured to do so.

9. Incomplete Claims

All claims must be submitted to Us within 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 Us. Only actual costs incurred shall be considered for reimbursement. Any variation or waiver of the foregoing shall be at Our sole discretion.

10. Currency of Payment

All payments under this Policy shall be made in the legal currency of Malaysia. Should You request any payment to be made 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. Source of Funds; No Money Laundering; No Tax Evasion

The Owner represents, warrants and certifies to the Company that

- (a) all amounts invested in this Policy have been or will be properly declared to relevant tax authorities in the jurisdiction of the Owner's tax residence and/or any other jurisdictions as necessary or appropriate in accordance with applicable laws and regulations, and
- (b) none of the funds derive, directly or indirectly, from illegal activities or sources and/or tax evasion.

12. Breach of Representations; Company's Right to Rescind and impose Surrender Charges; Right to Freeze Refund Amount

The Owner acknowledges that in the event of a violation of the foregoing Owner representation and warranty, the Owner hereby expressly acknowledges and agrees that the Company shall, to the fullest extent permitted by applicable law and regulation, have the right to:

- (a) terminate the Policy immediately;
- (b) notwithstanding the actual date of termination pursuant to clause (a), impose the maximum surrender and any other charges impossible on the Owner under the Policy as if the Policy had been surrendered immediately after issuance;
- (c) notify relevant governmental authorities and furnish all information deemed necessary or appropriate in the entire discretion of the insurer concerning the Owner and/or the Policy; and
- (d) if deemed appropriate after consultation with governmental authorities and legal counsel, either
 - (i) refund the premiums paid less any medical expenses which may have been incurred, any applicable surrender and other charges in accordance with clause (b) above (the "Refund Amount"), or
 - (ii) if requested or required to do so by competent governmental authorities, freeze or pay over to relevant governmental authorities all or a portion of the Refund Amount or take such other actions as the competent governmental authorities may request or require.

13. Goods and Services Tax

In the event that any goods and services tax, value added tax or any similar tax (collectively referred to as "Goods and Services Tax" or "GST") and any other duties, taxes, levies or imposts whatsoever are introduced by any authority and are payable under the laws of Malaysia in connection with any supply of goods and/or services made or deemed to be made under this Policy, We will be entitled to charge You for such amounts and You agree to pay Us the GST and any other duties, taxes, levies or imposts whatsoever allowed by the laws of Malaysia. Such GST and any other duties, taxes, levies or imposts payable shall be paid in addition to the applicable premiums and other charges. All provisions in this Policy on payment of premiums and default thereof shall apply equally to GST and any other duties, taxes, levies or imposts.

14. Policy of Cooperating with Tax and other Governmental Authorities; Consent to Disclose Information to Tax and other Governmental Authorities

The AXA Group and the Company have a longstanding Policy of cooperating with tax and other governmental authorities to combat money laundering, tax evasion or other illegal activities. In cases where the Owner is not a tax resident of the jurisdiction in which the Policy is issued (a "Cross-Border Transaction") the AXA Group may disclose to the Owner's home country tax and/or other governmental authorities the identity of the Owner and certain information concerning the Policy and the Owner hereby consents and agrees that the Company may, in its discretion, make such disclosure.

15. Alterations

We reserve the right to amend the terms and provisions of this Policy by giving a 90 days prior written notice via e-mail to Your last known e-mail address in Our record, and such amendment will be applicable from the next renewal of this Policy. No alteration to this Policy shall be valid unless authorized by Us and such approval is endorsed thereon. The Policy shall then be read subject to such amendment.

16. Waiver

No failure or delay on the part of the Company in exercising any right or power under this contract shall operate as a waiver thereof, nor any single or partial exercise of any such right or power preclude any other right or power.

17. Certification, Information and Evidence

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

18. Period of Cover and Renewal

This Policy shall become effective following the Issue Date stated in the Policy Schedule or the endorsement, if any. The Policy Anniversary shall be 1 year after the Policy Date and annually thereafter. On each such anniversary, this Policy is renewable at the premium rates in effect at that time and We shall notify You in writing of any change in the renewal premium at least 90 days before the change is effect.

This Policy will be renewable at Your option subject to Our terms, conditions and termination at each of the anniversary of the Policy Date. The renewal premium will increase with age and is not guaranteed. We reserve the right to revise the premium rate based on risk factors applicable at the time of renewal. Such changes, if any, shall be applicable to all Owners irrespective of their claim experience according to Our risk assessment.

This Policy is renewable at Your option until the occurrence of any of the following:

- (a) Non-payment of premium or premium not made on time;
- (b) Fraud or misrepresentation of material fact during application;
- (c) This Policy is cancelled/surrendered at Your request;
- (d) The Insured attains the coverage age as specified in Policy Schedule;
- (e) On the death of the Insured.

19. Change in Risk

The Insured shall give Us immediate written notice in writing of any material change in his or her occupation, business, duties or pursuits and pay any additional premium that We may require.

20. Subrogation

If We become liable for any payment under this Policy, We shall be subrogated to the extent of such payment to Your or the Insured's rights and remedies of the Insured against any party and shall be entitled at Our own expense to sue in Your or Insured's name. You or the Insured 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 a suit in Your or Insured's name.

21. Contribution

If an Insured 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 bears to the total amount of all valid insurance covering such Illness or Injury.

22. Upgraded Room and Board

If the Insured is hospitalised at a published Hospital Room and Board rate which is higher than his/her eligible benefit, You shall pay the difference in the Room and Board rate.

23. Change of Plan

Any increase in the insurance coverage for the Insured which is due to a change in plan will become effective only on the next Policy Anniversary date provided We approved such change.

24. Surrender

You may cancel this Policy at any time by giving a written notice to Us. This Policy will terminate at the end of the month in which We approve Your request for the cancellation. We will refund to You a portion of the premium (if any) as follows, provided no claim has been made under the Policy:

Period from Policy Anniversary, Not exceeding	Premium Payment Mode	
	Annually	Monthly
15 days*	90%	No Refund
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	

* Not applicable to 1st Policy year.

25. Condition Precedent to Liability

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

26. Legal Proceedings

No action at law or in equity shall be brought to recover on this Policy prior to expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. If the Insured shall fail to supply the requisite proof of loss as stipulated by the terms, provisions and conditions of the Policy, the Insured may, within the grace period of 1 calendar year from the time that the written proof of loss to be furnished, submit to Us the relevant proof of loss 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 Our sole and entire discretion. After such grace period has expired, we will not accept, for any reason whatsoever, such written proof of loss.

PREMIUM AND CHARGES PROVISION

1. Premium

Premium as specified in the Policy Schedule is the first premium payable to the Company. Premium must be paid in the same payment frequency and is payable to Us on or before the due date.

2. Grace Period

You are allowed a grace period of 31 days after the due date for payment of each premium. This Policy will continue to be in effect during this grace period.

If a premium is still unpaid at the end of the grace period, the premium is in default. If a premium is in default, this Policy is no longer in effect.

3. Change or Addition of Charges or Fees

We have the right to change or apply additional charges or fees, with prior approval from the Regulator, by giving You at least 90 days' written notice prior to a Policy Anniversary date.

BENEFIT PROVISION

SCHEDULE OF BENEFITS

BENEFIT	Plan 100	Plan 50	Plan 20
Section A In-patient & Daycare Surgical Procedure			
Room & Board, daily	RM250		
Intensive Care Unit	As charged		
Daycare Surgical Procedure			
Prescription Drugs			
Ambulance Fees			
Nursing, Operating Theatre Consumables and other Ancillary Charges			
Surgeon's Fees	As charged subject to Limits provided charges are within the recommendations of the Malaysian Medical Association Guidelines and are Reasonable and Customary Charges		
Anaesthetist's Fee			
Diagnostic Procedures and Physiotherapy			
Physician/Specialist Fees, 2 visits per day			
Operating Theatre	As charged		
Section B Out-patient Treatment			
Consultations & Diagnostic Procedures up to 3 times within 31 days before Hospital confinement (including medication)	As charged		
Post Hospitalisation Care and Physiotherapy Treatment within 60 Days from Hospital discharge			
Accident and Emergency Treatment up to 3 times per Any One Disability			
Annual Limit (Combined limit for Section A and B)	RM100,000	RM50,000	RM20,000
Deductible Limit per hospital admission (For Section A and Section B)	RM1,000		

DESCRIPTION OF BENEFITS

Important Notice: The Benefits described below may be subject to maximum Limits. Please check the Schedule of Benefits for details.

1. Deductible Limit

Eligible Expenses incurred for all Insured Benefits accumulated, are subject to the Deductible per hospital admission whereby You will be responsible for paying the Deductible amount based on the Limit as stated in the Schedule of Benefits. The Company will reimburse the balance of the Eligible Expenses in excess of the Deductible, subject to the Limit of the plan as stated in the Schedule of Benefits.

2. Annual Limit

Benefits payable in respect of expenses incurred for Treatment provided to the Insured during the period of insurance shall be limited to Annual Limit as stated in the Schedule of Benefits irrespective of the type/types of Disability. In the event the Annual Limit having been paid, all insurance for the Insured hereunder shall immediately cease to be payable for the remaining policy year.

3. Room and Board

Reimbursement of the Reasonable and Customary Charges Medically Necessary for room accommodation and meals, subject to the Limit of the plan as stated in the Schedule of Benefits. The amount of the benefit shall be equal to the actual charges made by the Hospital during the Insured's confinement, but in no event shall the benefit exceed, for any 1 day, the rate of Room and Board Benefit as stated in the Schedule of Benefits. The Insured will only be entitled to this benefit while confined to a Hospital as an In-patient or for Daycare Surgical Procedures.

4. Intensive Care Unit

Reimbursement of the Reasonable and Customary Charges Medically Necessary for actual room and board incurred during confinement as an In-patient in the Intensive Care Unit of the Hospital, subject to the Limit of the plan as stated in the Schedule of Benefits. This benefit shall be payable equal to the actual charges made by the Hospital.

No Hospital Room and Board benefits shall be paid for the same confinement period where the daily Intensive Care Unit benefits are payable.

5. Daycare Surgical Procedures

Reimbursement of fees actually charged by the Hospital or Specialist clinic and for all professional fees charged for minor Daycare Surgical Procedures performed as an Out-patient without confinement in a Hospital. Such fees or charges shall include all incidental services and supplies provided for the procedures up to the Limit of the plan as stated in the Schedule of Benefits. The Daycare Surgical Procedures should include minor operations such as but not limited to: Adenoidectomy, Arthroscopy, Bronchoscopy, Bunionectomy, Cataract removal, Cholecystectomy, Colonoscopy, Coronary Angiography, Digestive tract endoscopy, Dilatation and curettage of uterus, simple excision of pilonodal cyst, Haemorrhoidectomy, Hammer toe repair, Laparoscopy, Laryngoscopy and tracheoscopy, Lumbosacral manipulation, Myringotomy, Prostate biopsy, Reduction of nasal fracture, Strabismus repair and Tonsillectomy, that is commonly performed safely on an Out-patient basis.

Any Daycare Surgical Procedures done for investigative and diagnostic purpose not related to Treatment for any specified Disabilities is not covered.

6. In-patient Prescription Drugs

Reimbursement for drugs prescribed which is Medically Necessary and directly in connection with Insured's Disability, subject to the Limit of the plan as stated in the Schedule of Benefits. Only the costs of drugs used for the Treatment of the Disability are covered and must be listed in the Malaysian Index Medical Supplies (MIMS) as amended or supplemented from time to time, excluding traditional / complementary medicines, supplementary medicines, vitamins or nutritional herbs.

7. In-patient Diagnostic Procedures and Physiotherapy

Reimbursement of Reasonable and Customary charges for In-patient diagnostic procedures or In-patient physiotherapy that relates directly to the Disability and is Medically Necessary for which the Insured receives Treatment as an In-patient. Such reimbursement shall be subject to the Limit of the plan as stated in the Schedule of Benefits.

8. Ambulance Fees

Reimbursement of the Reasonable and Customary Charges incurred for necessary domestic road ambulance services (inclusive of attendant) to and/or from the Hospital of confinement, subject to the Limit of the plan as stated in the Schedule of Benefits. Payment will not be made if the Insured is not hospitalised.

9. Nursing, Theatre Consumables and Other Ancillary Charges

Reimbursement for medical report charges, general nursing services, Government Service Tax on eligible Hospital Room and Board charges and charges for Medically Necessary ancillary services and consumable items which relate directly to the Treatment which the Insured receives as an In-patient or for Daycare Surgical Procedures, subject to the Limit of the plan as stated in the Schedule of Benefits. Payment will not be made for the acquisition, extraction procedure and cultivation of tissues and cells (inclusive of stem cells) required for Treatment.

10. Surgeon's Fees

Reimbursement of the Reasonable and Customary Charges for a Medically Necessary Surgery by the Specialists, including pre-surgical assessment Specialist's visits to the Insured and post-Surgery care, subject to the Limit of the plan as stated in the Schedule of Benefits. If more than 1 Surgery is performed for Any One Disability, the total payments for all the Surgeries performed shall not exceed the Limit of the plan as stated in the Schedule of Benefits.

11. Anaesthetist's Fee

Reimbursement of the Reasonable and Customary Charges by the Anaesthetist for the Medically Necessary administration of anaesthesia, subject to the Limit of the plan as stated in the Schedule of Benefits.

12. Operating Theatre

Reimbursement of the Reasonable and Customary Operating Room charges incidental to the surgical procedure, subject to the Limit of the plan as stated in the Schedule of Benefits.

13. Inpatient Physician/Specialist Fees

Reimbursement of the Reasonable and Customary Charges by a Physician/Specialist for Medically Necessary visits to an In-patient while confined for non-surgical Disability, subject to a maximum of 2 visits per day, up to the Limit of the plan as stated in the Schedule of Benefits.

14. Consultations before Hospital Confinement

Reimbursement of the Reasonable and Customary Charges for consultation (including medication) in connection to the Disability up to 3 times within the maximum number of days and subject to the Limit of the plan as stated in the Schedule of Benefits preceding confinement in a Hospital and provided that such consultation is Medically Necessary and has been recommended in writing.

Payment will not be made for clinical Treatment (subsequent consultation after the Illness is diagnosed) or where the consultation does not result in Hospital confinement of the Insured for the Treatment of the medical condition diagnosed.

15. Diagnostic Procedures before Hospital Confinement

Reimbursement of the Reasonable and Customary Charges for Medically Necessary ECG, X-ray and laboratory tests which are recommended and performed for diagnostic purposes on account of an Injury or Illness by the admitting Physician or Surgeon in connection to the Disability preceding confinement in a Hospital up to 3 times within the maximum number of days and subject to the Limit of the plan as stated in the Schedule of Benefits in a Hospital.

No payment shall be made if upon such diagnostic services, does not result in Hospital confinement of the Insured for the Treatment of the medical condition diagnosed.

16. Post Hospitalisation Care

Reimbursement of the Reasonable and Customary Charges incurred in Medically Necessary follow-up Treatment by the same attending Physician or post-Surgery Care by the Specialist, within the number of days and Limit of the plan as stated in the Schedule of Benefits immediately following discharge from Hospital for a surgical or non-surgical Disability. This shall include medicines prescribed during the follow-up Treatment but the total supply needed shall not exceed the maximum number of days of the plan as stated in the Schedule of Benefits.

17. Out-Patient Physiotherapy Treatment

Reimbursement of Reasonable and Customary Charges for Out-Patient Physiotherapy Treatment referred in writing by a licensed Specialist or Physician after Surgery or in-Hospital Treatment, within the number of days and the Limit of the plan as stated in the Schedule of Benefits. However, no payment will be made for medication or Treatment and subsequent consultations with the same Specialist or Physician.

18. Out-Patient Accident and Emergency Treatment

Reimbursement of the Reasonable and Customary Charges incurred for up to the Limit of the plan as stated in the Schedule of Benefits, as a result of a covered Bodily Injury arising from an Accident up to 3 times per Any One Disability for Medically Necessary Treatment as an Out-patient at any registered clinic or Hospital within 24 hours of the Accident causing the covered Bodily Injury.

If as a result of an Accident on teeth, we will reimburse charges for pain relieving dental Treatment excluding restorative procedure such as crowning, bridging, as well as root canal treatment.

EXCLUSIONS

This Policy does not cover any Hospitalisation, Surgery or charges caused directly or indirectly, wholly or partly, by any one of the following occurrences:

1. Pre-existing Illness.
2. Specified Illnesses occurring during the first 120 days of continuous cover.
3. Any medical or physical conditions arising within the first 30 days following the Issue Date, except for Bodily Injury due to accidental causes.
4. Plastic/Cosmetic Surgery, circumcision, eye examination, glasses and refraction or surgical correction of near sightedness (Radial Keratotomy or Lasik) or all corrective glasses, contact lenses and intraocular lens (except monofocal intraocular lenses in cataract Surgery) or robotics Surgery that aid a surgical procedure 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 teeth occurring wholly during the period of insurance.
6. Private nursing, rest cures or sanatoria care, illegal drugs, intoxication, sterilisation, venereal Disease and its sequelae, AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex) and HIV related Diseases, and any communicable Diseases requiring quarantine by law.
7. Any Treatment or surgical operation for congenital abnormalities or deformities including hereditary conditions.
8. 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.
9. Hospitalisation primarily for investigatory purposes, diagnosis, X-ray examination, general physical or medical examinations, not incidental to Treatment or diagnosis of a 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 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. 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.
16. 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.
17. 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.
18. Expenses incurred for sex changes.
19. Cosmetic (aesthetic) Surgery or Treatment, or any Treatment which relates to or is needed because of previous cosmetic Treatment. However, we will pay for 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 the Policy since before the Accident or Surgery happened; and
 - (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.

20. Biological or chemical contamination.