BERJAYA SOMPO INSURANCE

Policy

Group Health Insurance

Berjaya Sompo Insurance Berhad
Registration No. 198001008821 (62605-U)
Level 36, Menara Bangkok Bank,
105, Jalan Ampang, 50450 Kuala Lumpur.
Toll Free No: 1-800-889 933
Tel.: 03-2170 7300
E-mail: customer@bsompo.com.my
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GHS0322

Table of Contents

IMPORTANT NOTICE

This is Your **Group Health Insurance** Policy. You should satisfy yourself that this Policy will best serve Your needs. You should read and understand the Policy terms, conditions and warranties and discuss with Your agent and/or with Us directly for more information and/or to clarify any doubts You may have, before You purchase this Policy.

You must fully observe and fulfill the terms, conditions and warranties of this Policy to enjoy the coverage provided. If You have any questions after reading these documents or if there are any change in Your circumstances that may affect the insurance provided, please notify Us immediately, otherwise You may not receive the benefits of this Policy.

If You have any complaints relating to this Policy, please contact

COMPLAINTS UNIT – CUSTOMER SERVICE CENTRE
Berjaya Sompo Insurance Berhad
Registration No. 198001008821 (62605-U)
Level 36, Menara Bangkok Bank
105 Jalan Ampang
50450 Kuala Lumpur

Tel	: 03-2170 7300
Tol Free	: 1-800-889-933
Fax	: 03-2170 4800
Email	: customer@bsompo.com.my

If You are not happy with Our response, You may opt to contact either:

OMBUDSMAN FOR FINANCIAL SERVICES
Level 14, Main Block
Menara Takaful Malaysia
4, Jalan Sultan Sulaiman
50000 Kuala Lumpur

Tel.	: 03-2272 2811
Fax	: 03-2272 1577
E-mail	: enquiry@ofs.org.my
Website	: www.ofs.org.my

LAMAN INFORMASI NASIHAT DAN KHIDMAT (LINK)
Bank Negara Malaysia
Ground Floor, Blok D
Jalan Dato Onn
50480 Kuala Lumpur

Tel	: 603-2698-8044 / 2698 9044 / 9179 2888
Tol free	: 1-300-88-5465
Fax	: 03-2174 1515
Email	: bnmtelelink@bnm.gov.my
eLINK	: telelink.bnm.gov.my
SMS	: 15888

OUR AGREEMENT

The Policy, Schedule and any Endorsements must be read together as they form Your insurance contract with Us. These documents reflect the Terms and Conditions of the contract of insurance as agreed between You and Us and is issued in consideration of the payment of premium as specified in the Schedule and pursuant to the answers given in the Proposal Form completed by You (or on Your behalf by Your intermediary) and any other disclosures made by You between the time of submission of Your Proposal Form and the time this Contract is entered into.

DUTY OF DISCLOSURE

You have a duty to take reasonable care not to make any misrepresentation when You applied for this insurance. You should answer all questions fully and accurately. Failure to take reasonable care in answering the questions may result in avoidance of Your contract of insurance, refusal or reduction of Your claim(s), change of terms or termination of Your insurance contract. In the event of any pre-contractual misrepresentations by You relation to Your answers and disclosures, only remedies in **Schedule 9 of the Financial Services Act 2013** will apply.

You have a duty to tell Us immediately if at any time after Your insurance contract has been entered into, varied or renewed with Us, any of the information given when You applied for this insurance is inaccurate or has changed.

At the point of purchasing this Policy and at any point during the validity of this insurance contract, You must immediately inform Us of any other insurance You have bought which provides like or similar type of coverage to the items insured under this insurance contract.

DEFINITIONS

SECTION I - RELATING TO CONTRACTUAL DETAILS

1. **POLICYHOLDER/YOU/YOUR** 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.

2. **INSURED PERSONS OR INSUREDS** shall mean the person described in the Policy Schedule including his/her Dependant (if applicable).

3. **WE/OUR/US/THE COMPANY** shall mean Berjaya Sompo Insurance Berhad

4. **GROUP MEMBERS** shall mean all the members of an organization or work-force or all the members of a bona-fide sub-division of such organization or workforce.

5. **POLICY YEAR OR PERIOD OF INSURANCE** shall mean the one 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.

6. **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.

SECTION II - RELATING TO INSURANCE COVER

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. **INJURY** shall mean bodily damage caused solely by Accident.

3. **SICKNESS, DISEASE OR ILLNESS** shall mean a physical condition marked by a pathological deviation from the normal healthy state.

4. **DISABILITY** shall mean a Sickness, Disease, Illness or the entire Injuries arising out of a single or continuous series of causes.

5. **CONGENITAL CONDITIONS** shall mean 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. 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 Policy.

6. **CHILD** shall mean any person who has attained the age of 30 days and is an unmarried person, is financially dependent upon the Insured and is under the age of 19, or up to the age of 23 for those registered as full time student at a recognised educational institution in Malaysia.

7. **DEPENDANT** shall mean any of the following persons:
   a) a legally married spouse

b) unmarried children over 30 days old but under nineteen (19) years of age or twenty-three (23) years of age and is still on full-time higher education and who are not gainfully employed.

8. **ELIGIBLE EXPENSES** shall mean Medically Necessary expenses incurred during the Period of Insurance due to a covered Disability but not exceeding the limits in the schedule.

9. **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 the current standard of professional medical care, and of proven medical benefits, and
   c) not for the convenience of the Insured 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, preventive or screening nature, and
   e) for which the charges are fair and reasonable and customary for the Disability.

10. **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 the Insured Person's medical condition.

11. **PRE-EXISTING ILLNESSES** shall mean disabilities that existed before the Effective date of Insurance 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.

12. **SPECIFIED ILLNESSES** shall mean the following disabilities and its related complications, occurring within the first 120 days of Insurance of the Insured Person:
   (a) Hypertension, diabetes mellitus and Cardiovascular disease
   (b) All tumours, cancer, cysts, nodules, polyps, stones of the urinary system and biliary system
   (c) All ear, nose (including sinuses) and throat condition
   (d) Hernias, haemorrhoids, fistulae, hydrocele, varicocele
   (e) Endometriosis including disease of the Reproduction System
   (f) Vertebro-spinal disorders (including disc) and knee conditions.

13. **HOSPITALISATION** shall mean 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.

14. **INTENSIVE CARE UNIT** shall mean a section within the 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.

15. **COSMETIC SURGERY** shall mean any surgery performed primarily to improve physical appearance or to change or restore bodily form without materially correcting a bodily malfunction.

16. **ANY ONE DISABILITY** shall mean all of the periods of disability arising from the same cause including any and all complications there from 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.

17. **OUT-PATIENT** shall mean the Insured Person is receiving medical care or treatment without being hospitalised and includes treatment in a Daycare centre.

18. **WAITING PERIOD** shall mean the first 30 days between the beginning of an Insured Person's disability and the commencement of this Policy date/reinstatement date and is applied only when the person is first covered. This shall not be applicable after the first year of cover. However, if there is a break in insurance, the Waiting Period will apply again.

SECTION III - RELATING TO MEDICAL SUPPLIERS

1. **DAY-SURGERY** shall mean a patient who needs the use of a recovery facility for a surgical procedure on a pre-planned basis at the hospital/specialist clinic (but not for an overnight stay).

2. **HOSPITAL** shall mean only 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 hours 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.

3. **MALAYSIAN GOVERNMENT HOSPITAL** shall mean a hospital which charges of services are subject to the Fee Act 1951 Fees (Medical) Order 1982 and/or its subsequent amendments, if any.

4. **PRESCRIBED MEDICINES** shall mean 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.

5. **DOCTOR OR 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, physician or surgeon who is the Insured himself.

6. **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 himself.

7. **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 himself.

8. **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.

COVERAGE

During the Period of Insurance**,** subject to the terms, conditions, exclusions and definitions as stated in this policy, policy schedule and any endorsements herein, We will indemnify the Policyholder for eligible medical expenses incurred if any Insured Person is confined to hospital as a direct result of an accidental bodily injury, illness or disease in respect of treatment or services undertaken by or on the recommendation of a physician or surgeon

DESCRIPTION OF BENEFITS

The limits of eligible Benefits are set forth in the Policy Schedule of Benefits and described below (if applicable). Certain Benefits described below need not necessary be applicable in this Policy.

HOSPITAL ROOM AND BOARD - Reimbursement of the Reasonable and Customary Charges Medically Necessary for 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 number of 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 in-patient.

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. 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 number of 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 benefit shall be paid for the same confinement period where the daily Intensive Care Unit benefit is payable.

SURGEON FEE - Reimbursement of the Reasonable and Customary Charges for Medically Necessary surgery by the Specialists, including pre-surgical assessment, Specialist's visits to the Insured Person and post-surgery care up to 60 days inclusive both before and after the date of surgery, but within the maximum indicated in the Schedule of Benefits. If more then one surgery is performed for Any One Disability, the total payments for all the surgeries performed shall not exceed the maximum stated in the Schedule of Benefits.

MAJOR SURGICAL BONUS – Pays as bonus an additional benefit for all major operations at a percentage of the Basic Surgeon's Fee as specified in the Surgical Schedule for any operation performed.

ANAESTHETIST FEE - Reimbursement of the Reasonable and Customary Charges by the Anaesthetist for the Medically Necessary administration of anaesthesia not exceeding the limits as set forth in the Schedule of Benefit.

OPERATING THEATRE - Reimbursement of the Reasonable and Customary Operating Room charges incidental to the surgical procedure.

HOSPITAL SERVICES & SUPPLIES - Reimbursement of the Reasonable and Customary Charges actually incurred for Medically Necessary general nursing, prescribed and consumed drugs and medicines, dressings, splints, plaster casts, x-ray, laboratory examinations, electrocardiograms, physiotherapy, basal metabolism tests, intravenous injections and solutions, administration of blood and blood plasma but excluding the cost of blood and plasma whilst the Insured Person is confined as an in-patient in a Hospital, up to the amount stated in the Schedule of Benefits.

IN-HOSPITAL PHYSICIAN VISIT - Reimbursement of the Reasonable and Customary Charges by a Physician for Medically Necessary visiting an in-paying patient while confined for a non-surgical disability subject to a maximum of 1 visit per day not exceeding the maximum number of days as set forth in the Schedule of Benefit.

PRE-HOSPITAL DIAGNOSTIC TESTS - Reimbursement of the Reasonable and Customary Charges for Medically Necessary 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 60 days preceding confinement in a Hospital and which are recommended by a qualified medical practitioner.

No payment shall be made if upon such diagnostic services, the Insured does not result in hospital confinement for the treatment of the medical condition diagnosed. Medications and consultation charged by the medical practitioner will not be payable.

PRE-HOSPITAL SPECIALIST CONSULTATION - Reimbursement of the Reasonable and Customary Charges for the first time consultation by a Specialist in connection with a Disability within 60 days preceding confinement in a Hospital and provided that such consultation is Medically Necessary and has been recommended in writing by the attending general practitioner.

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

EMERGENCY ACCIDENTAL OUTPATIENT TREATMENT - Reimbursement of the Reasonable and Customary Charges incurred for up to the maximum stated in the Schedule of Benefits, as a result of a covered bodily injury arising from an Accident for Medically Necessary treatment as an outpatient at any registered clinic or hospital within 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 31 days as set forth in the Schedule of Benefits.

EMERGENCY ACCIDENTAL DENTAL TREATMENT - Reimbursement of the Reasonable and Customary Charges incurred for up to the maximum stated in the Schedule of Benefits as a result of a bodily injury arising from an ACCIDENT occurring to wholly sound natural teeth, and received as an out-patient within 24 hours of the occurrence of the accident. Follow-up treatment will be provided up to 14 days of the Accident causing the Injury and in a legally registered dental clinic or Hospital.

POST-HOSPITALISATION TREATMENT - Reimbursement of the Reasonable and Customary Charges incurred in Medically Necessary follow-up treatment by the same attending Physician, within the maximum number of days and amount as set forth in the Schedule of Benefits 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 maximum number of days as set forth in the Schedule of Benefits.

AMBULANCE FEE - Reimbursement of the Reasonable and Customary Charges incurred for necessary domestic ambulance services inclusive of attendant to and or from the Hospital of confinement. Payment will not be made if the Insured Person is not hospitalised and subject to the limits set forth in the Schedule of Benefits.

DAILY CASH ALLOWANCE AT GOVERNMENT HOSPITAL - Pays a daily allowance for each day of confinement for a covered Disability in a Malaysian Government Hospital, provided that the Insured shall confine to a Room and Board rate that does not exceed the amount shown in the Schedule of Benefit. No Payment will be made for any transfer to or from any Private Hospital and Malaysian Government Hospital for the covered disability.

ACCIDENTAL DEATH BENEFIT – In the event of the Insured's death resulting from a Covered Accident, the Company shall pay the Policyholder or legal representative of the Insured, the lump sum benefit in accordance to the Plan as set forth in the Schedule of Benefits. An official death certificate shall establish the death of the Insured Person.

MEDICAL REPORT FEE – Reimbursement of the fee actually charged for the completion of the Medical Report up to the maximum limit as stated in the Schedule of Benefits.

MALAYSIA GOVERNMENT SERVICE TAX - Reimbursement of the 6% Service Tax levied by the Malaysian Government on charges actually incurred for benefits as stated in the Schedule of Benefits.

MONTHLY/ANNUAL OUT-PATIENT CANCER TREATMENT - If an Insured is diagnosed with Cancer as defined below, the Company will reimburse the Reasonable and Customary Charges incurred for the Medically Necessary treatment of cancer performed at a legally registered cancer treatment centre subject to the limit of this disability as specified in the Schedule of Benefit.

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 & 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 who had been diagnosed as a cancer patient and/or is receiving cancer treatment prior to the effective date of Insurance.

MONTHLY/ANNUAL OUT-PATIENT KIDNEY DIALYSIS TREATMENT - If an Insured is diagnosed with Kidney Failure as defined below, the Company will reimburse the Reasonable and Customary Charges incurred for the Medically Necessary treatment of kidney dialysis 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 who has developed chronic renal diseases and/or is receiving dialysis treatment prior to the effective date of Insurance.

ORGAN TRANSPLANT - Reimburses Reasonable and Customary Charges incurred on transplantation surgery for the Insured Person being the recipient of the transplant of a kidney, heart, lung, liver or bone marrow. Payment for this Benefit is applicable only once per lifetime whilst the Policy is in force and shall be subject to the limit as set forth in the Schedule of Benefit. The costs of acquisition of the organs and all costs incurred by the donors are not covered.

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 Overall Annual Limits as stated in the Schedule of Benefits irrespective of a type/types of disability. In the event the Overall Annual limit having been paid, all insurance for the Insured Person hereunder shall immediately cease to be payable for the remaining Policy year.

HOSPITALISATION INCOME (DUE TO COVID-19 VACCINATION SIDE EFFECT) - The Company will pay RM100.00 per day for the period of Hospitalisation not exceeding 10 days as a result of Sickness, Disease or Illness due to side-effects of the COVID-19 vaccination requiring Hospitalisation as advised by a Physician. Any Hospitalisation due to the same cause shall be considered as one Disability.

MENTAL ILLNESS TREATMENT – Reimbursement of the Reasonable and Customary Charges incurred for Medically Necessary treatment of the following mental illnesses, which shall cover medication prescribed, consultation by a Specialist or Electroconvulsive Therapy, subject to the limit as specified in the Schedule of Benefit.

a) Bipolar Disorder
b) Schizophrenia

The total amount payable shall not exceed the limit specified in the Schedule of Benefit which shall apply to inpatient, daycare and out-patient treatment in aggregate per Policy Year

CONDITIONS

1. AGE LIMITS

No person shall be included for cover under this Policy who has not as yet attained the age of 30 days. This Policy does not cover Insured Persons over the age of 65 years, unless such a person has been continuously insured under this Policy prior to the age of 60, in which case continuous insurance up to the end of the Policy Year in which such Insured turns 70 years old is allowed under this Policy.

2. ELIGIBILITY FOR GROUP COVERAGE

a) All present full time employees shall be eligible for cover under this Policy on the commencement date of this Policy. if the Employer contributes all or some of the premium due, then all the eligible employees must be covered. In all other cases at least 75% must be covered.
b) All future full time employees shall be eligible for cover under this Policy on the first day of the month co-incident with or following their completion of a waiting period as specified by the Policyholder.
c) If an employee is not actively at work on the date that he or she would otherwise be eligible in accordance with the above, then the eligibility date shall be deferred to be the first working day of active employment.
d) Where Dependants are eligible for cover under this Policy, and the Employer contributes all or some of the premium due for Dependants, then all the eligible Dependants must be covered. In other cases 75% must be covered.
e) If a Dependant is confined to a Hospital on the date that he or she is eligible for cover under this Policy, then the eligibility date shall be deferred to the date that the dependant is discharged from Hospital.

3. PERIOD OF COVER AND RENEWAL

This Policy shall become effective as of the date stated in the Schedule. The Policy Anniversary shall be one year after the effective date and annually thereafter. On each such anniversary, this Policy is renewable at the premium rates in effect at that time as notified by the Company.

This Policy is renewable at the option of the Company. Application for change of benefits to a higher plan can only be made on renewal and is subject to acceptance by the Company upon renewal.

4. GEOGRAPHICAL TERRITORY

All benefits provided in this Policy are applicable worldwide for twenty-four (24) hours a day.

5. OVERSEAS TREATMENT

If the Insured Person 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.

6. ALTERATIONS

The Company reserves the right to amend the terms and provisions of this Policy by giving a 30 days 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 Authorised by the Company and such approval is endorsed thereon. The Company should give 30 days prior written notice to the Policyholder according to the last recorded address for any alterations made.

7. CANCELLATION OF POLICY

The Policyholder may cancel this Policy at any time by giving notice in writing to the Company. Such notification shall become effective from the date the Company receives the notice or on the date specified in the notice, whichever is later. The Company will refund the pro-rated premium to the Policyholder for the unexpired Period of Insurance, provided no claims have been made under the Policy and subject to a minimum premium of RM75.

The Company may cancel this Policy by giving the Policyholder 14 days' notice in writing to the Policyholder's address known to the Company, and refund the pro-rated premium to the Policyholder for the unexpired Period of Insurance

8. 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, 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 shall, at the Company's request and expense, submit to a medical examination whenever such is deemed necessary.

9. GOVERNING LAW

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

10. 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.

11. 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 to secure 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.

12. 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 the amount applicable hereto under this Policy bears to the total amount of all valid insurance covering such illness or injury.

13. UPGRADED ROOM & BOARD CO-PAYMENT

If the Insured Person is hospitalised at a published Room & 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.

14. 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 recognise 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 authorised representative) alone shall be an effective discharge of all obligations and liabilities of the Company. The Policyholder shall be deemed to be responsible Principal or Agent of the Insured Persons covered under this Policy.

15. RECORDS

The Policyholder shall keep a record of the Insured Persons and dependants containing for each Insured Person the essential particulars of the insurance. Such information relating to new employees and dependants becoming insured, adjustment because of the changes in classification and termination of insurance as may be required by the Company to administer this insurance shall be furnished to the Company at the end of each policy month. The Company upon receipt of such information shall make the necessary changes to the premium payments.

16. MISSTATEMENT OR OMISSION OF MATERIAL FACT

If:

(a) any answer, disclosure or representation by the Policyholder, 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

(b) before this contract of insurance is entered into, varied or renewed, the Policyholder have failed to disclose any fact the Policyholder 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

(c) 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.

17. WAITING PERIOD

Eligibility for benefits starts 30 days after the Insured has been included in the Policy, except for a covered Accident occurring after the effective date of coverage.

18. RESIDENCE OVERSEAS

No benefit whatsoever shall be payable for any medical treatment received by the Insured outside Malaysia, if the Insured resides or travels outside Malaysia for more than ninety (90) consecutive days.

19. TAKE-OVER POLICIES

If this Policy shall have commenced immediately upon termination of a preceding Policy and if an Insured shall have been afflicted with a medical disability prior or at the time this Policy started (and benefits under the preceding Policy would have been available to him), such Insured shall continue to be covered for the existing disability, but not to exceed the limits of the previous Policy on condition the Company has secured a copy of the preceding Policy.

20. UPGRADED POLICIES

If the Eligible Benefits to any Insured 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 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.

21. CONVERSION POLICIES

If the Eligible Benefits provided under this Policy shall have been converted from an existing coverage of an ‘Inner Limits’ to an ‘As Charged/Full Reimbursement’ coverage, and if such Insured shall have been afflicted with a Disability prior or at the time the Benefits were converted the benefits payable in respect of the Disability shall be in accordance with the Schedule of Benefits prior to the date the Eligible Benefits were converted.

22. TERMINATION OF COVER

An Insured Person’s cover shall terminate at the earliest of these dates:

a) on the Policy Anniversary Date as stated in the Policy Schedule,

b) on the death of the Insured,

c) on the date of termination of employment with the Insured,

d) on the date the Insured attained the maximum age limit of this Policy,

e) on the due date the required premium is not paid,

f) on the date the Overall Annual Limit Benefit is paid.

Insurance cover of Insured Person's Dependants shall terminate:
a) on the death of the dependants
b) on the date the Insured Person's cover terminates
c) on the date such dependant ceases to be dependant as defined in the Policy

23. TERMINATION OF BENEFITS

The Benefits under this Policy shall terminate at such time the Benefits covered shall have been exhausted or at mid-night (Malaysia 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 the time the Insured Person is discharged from Hospital.

Follow up treatment shall not be covered under this extension.

24. PREMIUM WARRANTY

It is a fundamental and absolute special condition of this contract of insurance that the premium due must be paid and received by the Company within sixty (60) days from the inception date of this policy/endorsement/renewal certificate.

If this condition is not complied with then this contract is automatically cancelled and the Company shall be entitled to the pro-rata premium for the period they have been on risk.

Where the premium payable pursuant to this warranty is received by an authorised agent of the Company the payment shall be deemed to be received by the Company for the purposes of this warranty and the onus of proving that the premium payable was received by a person including an insurance agent who was not authorised to receive such premium shall lie on the Company.

EXCLUSIONS

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

1. Pre-existing illnesses.

2. Specified Illnesses occurring during the first 120 days of continuous cover.

3. Any medical or physical conditions arising within the first 30 days of the Insured Person's cover or date reinstatement whichever is latest except for accidental injuries.

4. Care or treatment for which payment is not required or to the extent which is payable by any other insurance or indemnity covering the Insured and Disabilities arising out of duties of employment or profession that is covered under a Workman's Compensation Insurance Contract.

5. Plastic/Cosmetic surgery, circumcision, eye examination, glasses and refraction or surgical correction of nearsightedness (Radial Keratotomy or Lasik) and the use or acquisition of prosthetic appliances or devices such as artificial limbs, hearing aids, implanted pacemakers and prescriptions thereof.

6. 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.

7. Private nursing, rest cures or sanitaria 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 required quarantine by law.

8. Any treatment or surgical operation for congenital abnormalities or deformities including hereditary conditions.

9. Pregnancy, child birth (including surgical delivery), and its related complications, 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.

10. Psychotic, mental or nervous disorders, (including any neuroses and their physiological or psychosomatic manifestations).

11. Hospitalisation primarily for investigatory purposes, all diagnostic tests including and not limited to Positron Emission Tomography (PET) Scan, Computed Tomography (CT) Scan, Computed Axial Tomography (CAT) Scan, Magnetic Resonance Imaging (MRI), 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 hyperhidrosis, weight reduction or gain.

12. 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.

13. 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.

14. Suicide, attempted suicide or intentionally self-inflicted injury while sane or insane.

15. Private flying other than as a fare-paying passenger in any commercial scheduled airlines licensed to carry passengers over established routes.

16. 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.

17. Ionising radiation or contamination by radioactivity from any nuclear fuel or nuclear waste from process of nuclear fission or from any nuclear weapons material.

18. 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.

19. Expenses incurred for sex changes

20. Investigation and treatment of sleep and snoring disorders, hormone replacement therapy and stem cell treatment and alternative therapy such as treatment, medical service or supplies, including but not limited to chiropractic services, acupuncture, acupressure, reflexology, bonesetting, herbalist treatment, massage or aroma therapy or other alternative treatment.

CLAIMS PROCEDURES

1. EVENTS LEADING TO CLAIMS

(a) The Insured shall within 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 invalid 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 the Company shall not be held liable in the event a treatment or service becomes necessary due to failure of the Insured to do so.

2. INCOMPLETE CLAIMS

All claims must be submitted to the Company 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 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.

3. 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 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.

4. 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.

5. 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 initialled by an authorised representative of the Company.

6. 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 calendar year from the time that the written proof of loss 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.

7. 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.

8. SUITS AGAINST THIRD PARTIES

Nothing in this Policy shall render the Company liable or be responsible or to be added as a party in any way whatsoever to any suit for damages which may be instituted by the Policyholder or an Insured nominated under this Policy against any provider of Medical or Dental Services or Treatments, wherein such may sue the same for reasons of neglect, malpractice or other causes arising from his/her acts or omissions in the treatment or examination of any Insured under the terms of this Policy

SURGICAL SCHEDULE

Notes:-

1. The following surgical schedule indicate the percentage payable on the insured benefit for Surgeon Fee stated in the Policy Schedule of Benefits for the corresponding surgical operation. Where shown, the Bonus payment on major surgery will be payable in addition to the percentage indicated in the Basic Schedule provided always that, there is the insured benefit for Surgical Bonus in the Policy Schedule of Benefits.

2. In basic Plan, the amount of the insured Surgeon Fee (listed in the Schedule of Benefits) shall be the limit payable in aggregate for surgical procedure for all operations arising out of one disability.

3. If an operation be performed which is not listed in the schedule, the Company shall pay an amount which would be payable for a scheduled operation of equivalent gravity.

4. If more than one surgical procedure was performed through the same incision, the Company shall pay only for the surgical procedure in respect of which the largest amount becomes payable.

5. If more than one surgical procedure was performed at the same surgical session through different incisions the Company will pay, subject to the provisions of Note 4 above, as follows:-

a) 100% fees for the procedure for which the greatest fee is payable.
b) 50% for the next most costly procedure.
c) 25% for the third and subsequent most costly procedure.

	Basic Schedule Per 100 of Benefit (%)	Bonus On Basic Schedule in % (%)
Abdomen And Digestive System		
Abdomen, exploratory laparotomy, celiotomy	65.00	-
Peritoneum, abscess, drainage	68.00	-
Anus, Abscess, incision and drainage	14.00	-
Fistulectomy, subcutaneous	17.00	-
Submuscular	56.00	-
Fissurectomy, with/without sphincterotomy	31.00	-
Haemorrhoidectomy, external, complete	37.00	-
internal and external, simple	45.00	-
Appendix, Abscess, incision and drainage	46.00	-
Appendectomy	58.00	-
Cholecystectomy	82.00	-
with open exploration of common duct	100.00	5.00
Cholecystotomy or cholecystostomy	74.00	-
Endoscopy, Anoscopy, with collection specimen	4.00	-
Colonoscopy, beyond splenic flexure	42.00	-
with removal polyp	71.00	-
Esophagoscopy, with collection specimen	23.00	-
with biopsy, one or more	25.00	-
Esophagogastroscopy, with collection specimen	27.00	-
with biopsy, one or more	29.00	-
Gastroscopy, with collection specimen	22.00	-
Esophagus, Esophagotomy, cervical approach, with/without removal foreign body	83.00	-
Esophagectomy, resection with gastric anastomosis	100.00	90.00
Diverticulectomy, esophagus or hypopharynx,cervical approach	85.00	-
Esophagoplasty, with repair of tracheo-esophagal fistula	100.00	25.00
Intestines, Duodenotomy	94.00	-
Enterotomy, with exploration/removal foreign body, small bowel	94.00	-
Excision, one or more lesions small/large bowel, single enterotomy	92.00	-
Enterectomy, resection small intestines	100.00	10.00
Colectomy, partial, with anastomosis	100.00	20.00
with colostomy	100.00	65.00
Tube enterostomy or cecostomy	65.00	-
Ileostomy	94.00	-
Liver, needle biopsy, percutaneous	9.00	-
wedge biopsy	65.00	-
hepatectomy, partial lobectomy	100.00	25.00
Cyst or abscess, marsupialisation of	94.00	-
Hepatorrhaphy – suture wound, simple	92.00	-
Mouth & Tongue, Glossectomy, partial, with unilateral radical dissection	100.00	40.00
total, with unilateral radical neck dissection	100.00	65.00
Pancreas, Biopsy pancreas	92.00	
Excision lesion of pancreas	100.00	10.00
Pancreatectomy, with pancreatico-jejunostomy	100.00	40.00
whipple type	100.00	120.00
Marsupialisation, cyst of pancreas	94.00	-
Pharynx, Adenoid, Tonsils, Drainage, abscess, peritonsillar	3.50	-
retropharyngeal/parapharyngeal, intra oral	15.00	-
Tonsillectomy, with or without adenoidectomy, age 12 and over	27.00	-
Adenoidectomy	18.00	-
Rectum, incision and drainage, deep supra levator/ perirectal/retrorectal abscess	31.00	-
Biopsy incisional, ano-rectal wall anal approach	27.00	-
Proctectomy, complete, combined abdominoperineal	100.00	55.00
Proctoplasty, for prolapse mucous membrane	76.00	-
Protopexy for prolapse, with sigmoid resection	100.00	40.00
Closure, rectovesical, rectourethral fistula, with Colostomy	100.00	45.00
Stomach, Gastrotomy, with exploration or foreign body removal	78.00	-
Pyloromyotomy	64.00	-
Local excision ulcer or tumor	94.00	-
Total gastrectomy, with repair by intestinal transplant	100.00	100.00
Sub-total or hemigastrectomy, with vagotomy	100.00	30.00
Vagotomy and pyloroplasty, with or without gastrotomy	100.00	10.00
Pyloroplasty	83.00	-
Herniorrhaphy	35.00	-
Herniotomy	60.00	-
Strangulated Hernia	75.00	-
Amputation And Disarticulations		
Arms, through humerus, with implant	80.00	-
Ankle, disarticulation/amputation, through malleoli, tibia and fibula	73.00	-
Finger or thumb, amputation at any joint, single, including neurectomy	25.00	-

	Basic Schedule Per 100 of Benefit (%)	Bonus On Basic Schedule in % (%)
Foot, amputation, mid-tarsal or transmetatarsal	67.00	-
Forearm, through radius and ulna	60.00	-
Hand, transmetacarpal	60.00	-
Hip, interpelviabdominal amputation	100.00	230.00
disarticulation	100.00	100.00
Leg through tibia and fibula, with immediate fitting Technique	80.00	-
Shoulder, amputation, inter thoracoscapular	100.00	100.00
Disarticulation	100.00	45.00
Thigh, amputation through femur, any level	87.00	-
Disarticulation at knee	83.00	-
Toe, amputation, metatarsophalangeal joint	20.00	-
Wrist, amputation	53.00	-
Brain Nervous System		
Skull, burr holes, not followed by other surgery	48.00	-
burr hole or trephine for drainage intracranial abscess or cyst	100.00	35.00
craniectomy or craniotomy, exploratory	100.00	95.00
supratentorial infratentorial	100.00	130.00
exploration or orbit or decompression, unilateral	100.00	45.00
Elevation of depressed fracture, simple	100.00	10.00
extradural compound or comminuted	100.00	35.00
with debridement brain and repair of dura	100.00	55.00
BRAIN, lobotomy, including cingulotomy	100.00	35.00
bilateral	100.00	70.00
Brain tumor, excision of supratentorial except meningioma	100.00	100.00
meningioma	100.00	130.00
Brain abscess, excision of	100.00	100.00
Cyst, excision of fenestration, supratentorial	100.00	100.00
Brain tumor, infratentorial or posterior fossa	100.00	140.00
meningioma, infratentorial or posterior fossa	100.00	150.00
Lobectomy, partial or total	100.00	120.00
Hemispherectomy	100.00	170.00
Craniectomy for craniostenosis, multiple sutures	100.00	70.00
Foreign body, excision of from brain	100.00	95.00
SPINE: spinal puncture, lumbar, diagnostic	4.00	-
for decompression	6.00	-
Laminectomy for exploration intraspinal canal, one or two segments cervical or thoracic	100.00	80.00
lumbar	100.00	60.00
for decompression spinal cord and/or Cauda equina, one or two segments, cervical thoracic	100.00	75.00
lumbar	100.00	45.00
Laminotomy, one interspace, for herniated disc and/or decompression root nerve, cervical	100.00	45.00
bilateral	100.00	80.00
lumbar	100.00	35.00
Laminectomy, for herniated disc, thoracic, posterior approach	100.00	80.00
Discectomy, single interspace, cervical	100.00	40.00
thoracic	100.00	95.00
lumbar	100.00	70.00
Dislocations		
ANKLE, closed, manipulative reduction with anaesthesia	17.00	-
closed or open, open reduction	80.00	-
Distal tibio-fibulor joint, closed or open reduction	53.00	-
ELBOW: closed, manipulative reduction with anaesthesia	17.00	-
closed or open, open reduction	67.00	-
FINGERS: Metacarpophalangeal, closed requiring anaesthesia	17.00	-
open, uncomplicated, manipulative	20.00	-
closed or open, open reduction	40.00	-
HIP: traumatic dislocation, manipulative, with anaesthesia	32.00	-
closed or open, with acetabular hip fixation	100.00	45.00
JAW: temporo-mandibular, simple, closed reduction	12.00	-
open reduction with interdental fixation	100.00	10.00
KNEE: closed, manipulative reduction, with anaesthesia	20.00	-
close or open, open reduction	100.00	-
KNEE CAP: closed manipulative reduction, with anaesthesia	17.00	-
closed or open reduction, with/without patellectomy	80.00	-
SHOULDER: sternoclavicular, manipulative reduction	18.00	-
closed or open, acute or chronic, open reduction/ repair	67.00	-
TOES: tarsal bone, closed, manipulative, with anaesthesia	13.00	-
closed or open, open reduction	40.00	-
astragalo-tarsal joint, closed, manipulative, without anaesthesia	6.50	-
with anaesthesia	17.00	-
open, uncomplicated, manipulative	23.00	-
closed or open, open reduction	53.00	-
Tarso-metatarsal, closed manipulative, with anaesthesia	13.00	-
with percutaneous skeletal fixation	20.00	-
closed or open, open reduction	40.00	-
metatarsophalangeal, closed, manipulative with anaesthesia	9.50	-
closed or open, open reduction	27.00	-
Interphalangeal joint, closed, manipulative with anaesthesia	5.00	-
closed or open, open reduction	16.00	-
WRIST: radio-carpal or intercarpal, closed, manipulative reduction	17.00	-
closed or open, open reduction	50.00	-
Distal radio-ulnar, closed, manipulative	20.00	-
Removal of kuntscher nail	8.50	-
Ear		
Myringotomy by needle,with/without spiration/eustachian inflation	9.50	-
Tympanostomy (requires insertion of ventilating tube) with opening microscope, office	9.00	-
in surgical suite	23.00	-
Transmastoid antrotomy	64.00	-
Mastoidectomy modified radical or radical, unilateral	100.00	30.00
Excision, aural polyp	5.50	-
Tympanoplasty, with mastoidectomy	100.00	55.00
with ossicular chain reconstruction	100.00	75.00
Fenestration, unilateral	100.00	50.00
Stapes mobilisation	77.00	-
Excision aural polyp	5.50	-
Myringoplasty	88.00	-
Endocrine System		
THYROID: Thyro-glossal cyst, incision and drainage	4.00	-
biopsy, needle	8.00	-
cyst or adenoma, small, excision of, or transection of isthmus	62.00	-
Lobectomy, total, unilateral, with contralateral subtotal lobectomy	92.00	-
Thyroidectomy, total or complete	97.00	-
total or sub-total with radical neck resection	100.00	85.00
Excision, fixation or repair by cutting operations		
ANKLE: Achilles Tendon repair; primary	73.00	-
lengthening or shortening of tendon, single	47.00	-
ELBOW: Tendon lengthening, single	40.00	-
Flexorplasty	80.00	-
Arthroplasty, radical head, with implant	67.00	-
FEMUR, excision bone cyst/benign tumor	69.00	-
with autogenous graft (including obtaining graft)	100.00	-
HAND and FINGERS, excision/curettage bone cyst/benign tumors, metacarpal, with autogenous graft (includes obtaining graft)	54.00	-
phalanx	38.00	-
with autogenous graft (includes obtaining graft)	50.00	-
HIP: external oblique muscle transfer to greater trochanter, including graft	100.00	-

	Basic Schedule Per 100 of Benefit (%)	Bonus On Basic Schedule in % (%)
iliopsoas transfer to greater trochanter	100.00	35.00
arthroplasty with acetabuloplasty	100.00	100.00
acetabular and proximal femoral prosthetic replacement	100.00	160.00
osteotomy, iliac or acetabular	100.00	35.00
arthrodesis, hip joint, with subtrochanteric osteotomy	100.00	110.00
HUMERUS: excision/curettage bone cyst/benign tumor	63.00	-
KNEE: suture infrapatellar tendon, primary	67.00	-
lengthening hamstring tendon, multiple one leg	53.00	-
repair, primary, torn/severed collateral ligament with or without meniscectomy	93.00	-
collateral and cruciate ligaments	100.00	20.00
PELVIS: excision bone cyst/benign tumor, superficial pelvis, with or without graft	33.00	-
Eye		
EYEBALL: evisceration ocular contents, with implant	62.00	-
exenteration of orbit, with temporalis muscle transfer	100.00	35.00
removal foreign body, conjunctival, superficial	1.00	-
embedded, subconjunctival or scleral	8.00	-
corneal, with slit lamp	4.00	-
EXTRAOCULAR MUSCLE, repair wound	22.00	-
CORNEA: excision of lesion	45.00	-
excision or transposition of pterygium	34.00	-
SCLERA: fistulisation for glaucoma, trephine with iridectomy	78.00	-
repair scleral staphyloma, with graft	100.00	35.00
IRIS: Iridotomy, stab incision	28.00	-
Iridotomy, with cyclotomy	100.00	25.00
LENS: removal after cataract or membranous cataract	78.00	-
removal lens material, aspiration technique	100.00	10.00
expression of cataract, linear	100.00	10.00
RETINA: repair retinal detachment	100.00	25.00
with vitrectomy, with/without air tamponade	100.00	75.00
destruction, localised lesion, retina or choroid	70.00	-
CONJUNCTIVA: incision and drainage cyst, stye	3.00	-
LACRIMAL SYSTEM: incision and drainage lacrimal gland	11.00	-
lacrimal sac	8.00	-
excision of lacrimal sac or gland – total or partial	67.00	-
Fractures		
ANKLE: single malleolus, closed, manipulative reduction	23.00	-
closed or open, open reduction with skeletal fixation	60.00	-
closed or open reduction with/without skeletal fixation	73.00	-
closed or open, open reduction with skeletal fixation posterior lip (malleolus)	100.00	-
CLAVICLE: closed, manipulative reduction closed or open, reduction with/without skeletal fixation	60.00	-
ELBOW: comminuted, closed, manipulative reduction	53.00	-
closed or open, or open reduction,with/without skeletal fixation	100.00	5.00
FEMUR:shaft, closed,manipulative reduction age 12 and over	53.00	-
closed or open, reduction, with/without skeletal fixation over 12	100.00	25.00
FIBULA: proximal end, open, uncomplicated soft-tissue closure, manipulative	25.00	-
closed or open, open reduction with skeletal fixation	53.00	-
FINGERS: metacarpal, single, closed, manipulative reduction	16.00	-
closed/open: open reduction with/without skeletal fixation	42.00	-
phalangeal, closed, manipulative reduction	11.00	-
closed/open: open reduction with/without skeletal fixation	27.00	-
FOOT: Tarsal, closed, manipulative	13.00	-
Metatarsal, closed, manipulative	15.00	-
HUMERUS: shaft, closed manipulative	33.00	-
reduction closed/open reduction, with/without skeletal fixation	72.00	-
Supracondylar, radical or lateral, closed, manipulative reduction	27.00	-
closed/open, open reduction, with/without skeletal fixation	67.00	-
JAW: mandibular, closed, manipulative reduction with interdental fixation	53.00	-
open reduction with interdental fixation	100.00	10.00
KNEE CAP: open reduction	27.00	-
RADIUS: shaft, closed, manipulative reduction-age 12 and over	29.00	-
closed/open, open reduction, with skeletal fixation, age 12 and over	67.00	-
RIBS: simple, 1 lib	10.00	-
SCAPULA: closed manipulative reduction	19.00	-
close/open: juxta-articular, open reduction with/without skeletal fixation	80.00	-
SPINE: vertebral process, one/more, manipulative reduction with anaesthesia cervical open reduction and fusion, posterior, approach, with local	100.00	85.00
anterior approach with iliac or other bone graft	100.00	100.00
TIBIA and FIBULA: shafts closed, manipulative with/without external pinning	58.00	-
Closed/open, open reduction, with/without skeletal fixation, age 12 and over	97.00	-
ULNA & RADIUS: shaft, closed, manipulative reduction age 12 and over	40.00	-
closed/open, open reduction, with skeletal fixation: age 12 and over	100.00	-
WRIST: Colles and Smith type: closed manipulative reduction age 12 and over	27.00	-
Closed, complex, with external skeletal fixation/ percutaneous pinning	50.00	-
Genital Systems		
Male		
PENIS, biopsy, cutaneous	4.00	-
deep	8.50	-
excision penile plaque	47.00	-
amputation, partial	58.00	-
radical	100.00	65.00
circumcision, office	6.00	-
hospital	12.00	-
TESTIS: biopsy, needle	2.50	-
incisional, bilateral	23.00	-
excision, local lesion	35.00	-
orchiectomy, simple, unilateral	35.00	-
radical	53.00	-
PROSTATE: biopsy, needle or punch	10.00	-
incisional	47.00	-
prostatectomy, external drainage of abscess complicated	80.00	-
prostatectomy, sub-total or total	100.00	15.00
radical	100.00	50.00
Female		
PERINEUM: abscess, incision and drainage, or biopsy	3.50	-
VULVA and INTROITUS: Bartholin's cyst, incision and drainage	6.00	-
marsupialisation	22.00	-
Vulvectomy, complete, bilateral	92.00	-
Radical, excluding skin graft	100.00	10.00
Excision, Bartholin's cyst tumor or cyst	28.00	-
VAGINA: Colpotomy with exploration	25.00	-
biopsy, vaginal mucosa	4.00	-
Colpectomy, complete obliteration	69.00	-
Anterior colporrhaphy, repair cystocele, with/without repair of urethrocele	47.00	-
Posterior colporrhaphy, repair of rectocele	37.00	-
CERVIX UTERI: biopsy or local excision of lesion, or cauterisation	4.00	-
trachelectomy, cervicectomy, amputation of cervix	35.00	-
CORPUSUTERI: endometrial biopsy, suction	4.50	-
dilation and curettage (non-obstetrical)	27.00	-
Myomectomy, single or multiple, abdominal approach	87.00	-

	Basic Schedule Per 100 of Benefit (%)	Bonus On Basic Schedule in % (%)
Hysterectomy, total abdominal approach	100.00	-
OVIDUCT: transection fallopian tube, unilateral/bilateral		
independent	56.00	-
Salpingo-oophorectomy, complete/partial, unilateral/		
bilateral	71.00	-
OVARY: drainage of cyst(s), vaginal approach,		
unilateral/bilateral	27.00	-
abdominal approach	75.00	-
oophorectomy, with total omentectomy	83.00	-
Hemic And Lymphatic Systems		
SPLEEN: splenectomy	100.00	-
Heart And Circulatory Systems		
PERICARDIUM: Pericardiotomy for removal clot/foreign		
body	100.00	-
partial resection for chronic construction pericarditis,		
with bypass	100.00	150.00
HEART: intracardiac tumor, resection with bypass	100.00	120.00
pacemaker, insertion with epicardial, electrode	80.00	-
repair, cardiac wound, with bypass	100.00	75.00
cardiotomy and removal foreign body, with bypass	100.00	100.00
AORTA and GREAT VESSELS: suture repair, with		
bypass	100.00	75.00
Myocardial Resection	100.00	150.00
Repair post infarction ventricular septal defect	100.00	200.00
VALVES Aortic: commissurotomy		
with bypass	100.00	100.00
valvuloplasty, with bypass	100.00	100.00
Mitral, commissurotomy, open, with bypass	100.00	120.00
Tricuspid, commissurotomy, open, with bypass	100.00	120.00
valvuloplasty or valvectomy, with bypass	100.00	120.00
Pulmonary, commissurotomy, with bypass	100.00	100.00
Replacement, single valve	100.00	190.00
double valve with commissurotomy/valvuloplasty		
one valve	100.00	230.00
triple valve	100.00	300.00
CORONARY ARTERY: anomalous ligation	100.00	25.00
with bypass	100.00	150.00
PULMONARY ARTERY: embolectomy, with bypass	100.00	120.00
ARTERIES AND VEINS: Arterial embolectomy carotid	83.00	-
renal	100.00	35.00
Venous thrombectomy, iliac-femoral, unilateral	67.00	-
bilateral	100.00	-
Varicose, ligation/division/stripping, long saphenous		
complete, unilateral	38.00	-
bilateral	60.00	-
short and lesser saphenous unilateral	35.00	-
bilateral	54.00	-
Angiogram	30.00	-
Angioplasty	80.00	-
Maternity		
Hysterotomy, abdominal, for removal hydatidiform mole	83.00	-
Hydatidiform Mole, evacuation by dilation and curettage	37.00	-
Ectopic Pregnancy, tubal abdominal/vaginal approach	83.00	-
Ovarian Pregnancy	83.00	-
Interstitial, hysterectomy for uterine pregnancy, total/sub		
total	100.00	-
Dilation & Curettage, postpartum haemorrhage, same		
admission as delivery	25.00	-
Vaginal Deliver: with/without forceps	61.00	-
Caesarean Section: low cervicalor classic	70.00	-
Abortion, completed by dilation and curettage	58.00	-
induced by dilation and curettage	37.00	-
Respiratory System		
LUNGS & Pleura: thoracostomy, tube		
with waterseal	12.00	-
with rib resection for empyema	54.00	-
thoracotomy, limited, with biopsy lung/pleura	55.00	-
major, with exploration and biopsy	71.00	-
with excision-plication bullae, with/without pleural		
procedure	100.00	20.00
pneumonostomy, with open drainage abscess/cyst	85.00	-
decortication, pulmonary	100.00	30.00
pleurectomy, parietal	100.00	20.00
pneumonectomy, total	100.00	80.00
lobectomy, total or segmental	100.00	55.00
with bronchoplasty or decortication	100.00	80.00
wedge resection/enucleation of lesion, single or		
multiple	100.00	25.00
enucleation of empyema cavity, extra pleural	100.00	25.00
with lobectomy	100.00	80.00
thoracoplasty, extrapleural resection		
ribs,		
first stage	87.00	-
second stage	52.00	-
NOSE: excision polyps(s), simple	10.00	-
requiring hospitalisation	27.00	-
submucous, resection, turbinate partial/complete	48.00	-
removal foreign body, intranasal, requiring general		
anaesthesia	24.00	-
SINUSES: lavage by cannulation (antrum puncture or		
natural ostium) each	2.50	-
sphenoid sinus	5.50	-
sinusotomy maxillary, intranasal, unilateral	26.00	-
radical, (Caldwell-Luc) unilateral	77.00	-
combined, three or more sinuses	100.00	15.00
LARYNX: laryngotomy, with removal/tumor/laryngocele,		
cordectomy	100.00	5.00
laryngectomy, total, without radical neck dissection	100.00	70.00
with radical neck dissection	100.00	160.00
TRACHEA and BRONCHI: tracheotomy	31.00	-
bronchoscopy, diagnostic	24.00	-
Maxillary sinus endoscopy surgical with removal of		
foreign body	32.00	-
Skin, Integumentary, Breast		
ABSCESS: carbuncle or furuncle, incision and		
drainage/puncture aspiration	2.50	-
complicated	5.00	-
ACNE: marsupialisation or removal multiple milia,		
comedones, cyst, pustules	2.00	-
BENIGN LESIONS: skin tags excision, including		
anaesthesia, up to 15cm	3.00	-
each additional 10cm	11.00	-
other, up to 0.5cm diameter	4.00	-
0.5cm to 1cm	5.00	-
paring or curettement, with/without cauterisation	2.50	-
MALIGNANT LESIONS: up to 0.5cm	11.00	-
0.5cm to 1cm	16.00	-
1cm to 2cm	23.00	-
Biopsy, skin or subcutaneous tissue, including closure,		
first	4.00	-
CYST: infected or non-infected, incision and drainage,		
first lesion	2.50	-
second lesion	1.50	-
excision with removal sac and treatment of cavity	4.50	-
PILONIDAL SINUS or CYST: incision and drainage		
excision, sample	13.00	-
NAILS: avulsion, nail plate, partial or complete, first	2.50	-
second	2.00	-
excision, nail and matrix, partial or complete	14.00	-
REPAIRS, simple, sum of length of repairs;		
up to 2.5cm	5.50	-
2.5cm to 7.5cm	7.50	-
7.5cm to 12.5cm	11.00	-
intermediate		
up to 2.5cm	8.00	-
2.5cm to 7.5cm	10.00	-
7.5cm to 12.5cm	14.00	-
Complex		
1cm to 2.5cm	20.00	-
2.5cm to 7.5cm	35.00	-
Tissue Transfer or Rearrangement		
Trunk, up to 10sq.cm	26.00	-

	Basic Schedule Per 100 of Benefit (%)	Bonus On Basic Schedule in % (%)
10sq.cm to 30sq.cm	39.00	-
Scalp, arms, legs, up to 10sq.cm	39.00	-
Forehead, cheeks, chin, mouth, neck,		
axillae, genitalia, hands or feet		
up to 10sq.cm	52.00	-
10sq.cm to 30sq.cm	67.00	-
Eyelids, nose, ears, or lips up to		
10sq.cm	67.00	-
FREE SKIN GRAFTS, pinch, single or multiple	8.00	-
Split skin, trunk, scalp, arms, legs, hand, feet		
up to 100sq.cm	33.00	-
each additional 100sq.cm	8.50	-
Full thickness: free, including closure donor site;		
Trunk up to 20sq.cm	27.00	-
each additional 20sq.cm	13.00	-
Scalp, arms, legs up to 20sq.cm	39.00	-
Forehead, cheeks, chin, mouth, genitalia, neck, axillae		
hands, feet up to 20sq.cm	53.00	-
each additional 20sq.cm	26.00	-
Eyelids, nose, ears, and lips		
up to 20sq.cm	67.00	-
each additional 20sq.cm	32.00	-
PEDICLE FLAPS: skin and deep tissue tube pedicle		
without transfer or major 'delay' of large flap	45.00	-
primary attachment, open/tubed flap to recipient site	58.00	-
Forehead, cheek, chin, mouth, neck, axillae, genitalia,		
eyelids, nose, hands or feet	100.00	5.00
BREAST: puncture aspiration of cyst,		
single	3.00	-
Mastotomy, with exploration/drainage of deep abscess	17.00	-
biopsy, needle	4.00	-
incisional	23.00	-
excisional, cyst/fibro-adenoma/benign tumor/aberrant		
tissue/duct lesion/nipple lesion; male or female, 1 or		
more, unilateral	29.00	-
mastectomy, complete, unilateral	52.00	-
bilateral	65.00	-
partial, unilateral	39.00	-
radical, incl. breast, pectoral muscle, axillary and		
lymph nodes	100.00	20.00
Urinary System		
KIDNEY: exploration	100.00	-
drainage perirenal or renal abscess	83.00	-
Nephrostomy, nephrotomy with drainage	100.00	15.00
large staghorn calculus	100.00	50.00
biopsy, percutaneous	16.00	-
by surgical exposure	47.00	-
Nephrectomy, including partial ureterectomy	100.00	15.00
radical, with regional lymphadenectomy	100.00	50.00
Cysts, excision of	100.00	5.00
Nephropexy, fixation or suspension of kidney	92.00	-
URETER: ureterotomy, with exploration or drainage	100.00	5.00
ureterlithotomy, upper one third of ureter	100.00	15.00
BLADDER: aspiration by needle	1.50	-
by trochar or inter catheter	2.50	-
by insertion suprapubic catheter	9.00	-
Cystotomy with insertion ureteral catheter	63.00	-