InternationalExclusive

Product Disclosure Sheet

Important Note

1. **Read this Product Disclosure Sheet before you decide to take out the International Exclusive Insurance Policy. Be sure to also read through the general terms and conditions.**

2. **You should satisfy yourself that this policy will best serve your needs. You should read and understand the insurance policy and discuss with the agent or contact the insurance company directly for more information.**

3. **Pursuant to Paragraph 5 of Schedule 9 of the Financial Services Act 2013, if you are applying for this Insurance wholly for purposes unrelated to your trade, business or profession, you have a duty to take reasonable care not to make a misrepresentation in answering the questions in the Proposal Form (or when you apply for this insurance). You must answer the 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 contract of insurance.

   The above duty of disclosure shall continue until the time your contract of insurance is entered into, varied or renewed with us.

   In addition to answering the questions in the Proposal Form (or when you apply for this insurance), you are required to disclose any other matter that you know to be relevant to our decision in accepting the risks and determining the rates and terms to be applied.

   You also have a duty to tell us immediately if at any time after your contract of insurance has been entered into, varied or renewed with us any of the information given in the Proposal Form (or when you applied for this insurance) is inaccurate or has changed.

1. What is this product about?

InternationalExclusive is a comprehensive medical expense annual insurance plan that covers eligible inpatient and outpatient expenses as a result of an illness or accident, subject to the limits set out in the Benefit Schedule shown below. Plan 1 also includes health screening, pregnancy and delivery benefits, routine dental care and routine optical care. In addition, you will be able to enjoy other benefits e.g. International Emergency Medical Assistance, 24-hour claims enquiry, Health at Hand, pre-existing and non-pre-existing chronic conditions cover.

2. What are the covers / benefits provided?

BENEFITS				
Please note: benefit values are per person each year unless otherwise specified and are reduced each time you claim only by the net amount (less any deductible or co-insurance) we have actually paid. Please refer to the policy wordings on full terms applying to these benefits.				
Plan	Plan 1	Plan 2	Plan 3	Plan 4 (In-patient plan)
Yearly maximum up to	RM9,000,000	RM7,000,000	RM3,000,000	RM3,000,000
Area of cover	1. Worldwide 2. Worldwide excluding USA Δ 3. Asia #	1. Worldwide 2. Worldwide excluding USA Δ 3. Asia #	1. Worldwide 2. Worldwide excluding USA Δ 3. Asia #	1. Worldwide 2. Worldwide excluding USA Δ 3. Asia #
Outside area of cover	Emergency treatment only	Emergency treatment only	Emergency treatment only	Emergency treatment only
Level of Reimbursement	Reasonable and customary (R&C) charges	Reasonable and customary (R&C) charges	Reasonable and customary (R&C) charges	Reasonable and customary (R&C) charges
In-patient and daycare treatment (including surgery, consultations, consumables etc.)				
Daily accommodation charges	Standard single room	Standard single room	Standard single room	Standard single room
Parent Accommodation up to	RM500 per night	RM500 per night	RM500 per night	RM500 per night
Cash benefit	RM700 per night	RM500 per night	RM500 per night	RM500 per night

Pre-Hospitalisation treatment	Included within the 'General Practitioner and Specialist Consultation Charges' benefit. Subject to the terms and conditions applied for 'General Practitioner and Specialist Consultation Charges' benefit.			Included for one consultation, prescribed investigations and essential medications received as an out-patient within 60 days prior to a hospitalisation.
Post-Hospitalisation treatment	Included within the 'General Practitioner and Specialist Consultation Charges' benefit. Subject to the terms and conditions applied for 'General Practitioner and Specialist Consultation Charges' benefit.			Included for follow-up out-patient consultation and treatment received within 90 days following the discharge from the hospital.
Out-patient treatment (including diagnostics, prescribed drugs, dressings etc)				
General Practitioner and Specialist Consultation Charges	Included	Included	Included	Included if it is part of pre-hospitalisation treatment or post-hospitalisation treatment. Subject to the limitations applied for 'Pre-hospitalisation treatment' or 'Post-hospitalisation treatment' benefits.
Courses of chiropractic treatment, acupuncture, homeopathy and osteopathy up to	RM3,600	RM3,600	RM3,600	No benefit
Traditional Chinese Medicine up to	RM180 per visit up to 20 visits per year	RM180 per visit up to 20 visits per year	RM180 per visit up to 20 visits per year	No benefit
Courses of physiotherapy	Included	Included	Included	Included if it is part of post-hospitalisation treatment and subject to the limitations applied for 'Post-hospitalisation treatment' benefit.
Other Benefits				
Health screen up to	RM3,000 - available only after 12 months membership	No benefit	No benefit	No benefit
Pre-existing conditions up to	Years 1 & 2: RM7,000 Available only after 9 months membership Subsequent years: RM14,000	Years 1 & 2: RM7,000 Available only after 9 months membership Subsequent years: RM14,000	RM3,500 Available only after 12 months membership	RM3,500 Available only after 12 months membership
Maintenance of non-pre-existing chronic conditions	Included	Included	Included	No benefit
Oral and maxillofacial surgery	Included	Included	Included	Included
Ambulance transport	Included	Included	Included	Included
International Emergency Medical Assistance	Included	Included	Included	Included
Psychiatric treatment up to	RM24,000	RM14,000	RM14,000	No benefit

Accidental damage to teeth	Included	Included	Included	Included
Pre and post natal complications	Included - available only after 12 months membership	Included - available only after 12 months membership	Included - available only after 12 months membership	No benefit
Pregnancy and delivery up to	RM43,000 - available only after 12 months membership	No benefit	No benefit	No benefit
Vaccination up to	RM4,800	RM3,800	RM1,300	No benefit
Routine dental care up to	80% of eligible expenses incurred up to RM3,800	No benefit	No benefit	No benefit
Routine optical care up to	RM900	No benefit	No benefit	No benefit
Hospice and palliative care up to	RM120,000 in a member's lifetime Available only after 12 months membership	RM95,000 in a member's lifetime Available only after 12 months membership	RM95,000 in a member's lifetime Available only after 12 months membership	RM60,000 in a member's lifetime Available only after 12 months membership

Duration of cover is for one year. You need to renew your insurance cover annually.

 # We define Asia as
Afghanistan, Bangladesh, Bhutan, Brunei, Cambodia, China, Hong Kong, India, Indonesia, Japan, Kazakhstan, Kyrgyzstan, Laos, Macau, Malaysia, Maldives, Mongolia, Myanmar, Nepal, North Korea, Pakistan, Philippines, Singapore, South Korea, Sri Lanka, Taiwan, Tajikistan, Thailand, Timor-Leste, Turkmenistan, Uzbekistan, Vietnam

Δ We define Worldwide excluding USA as
Worldwide excluding USA and US Minor Outlying Islands

3. Does this policy cover Daycare Procedures?

Yes, this policy provides coverage for Daycare Procedures. Daycare Surgical Procedures are performed as an outpatient without confinement in hospital. No minimum hour of stay is required for eligibility for a claim. Daycare Surgical Procedures should include minor operations such as but not limited to: simple excision of pilonodal cyst, cataract removal, colonoscopy that is commonly performed safely on an Outpatient basis. Any Daycare Surgical Procedures done for investigative and diagnostic purposes not related to treatment for any specified disabilities is not covered.

4. How much premium do I have to pay?

The total premium that you need to pay depends on your country of residence, choice of plan, area of cover and your age. This may further vary depending on our underwriting requirements. The premiums are paid annually. Please refer to the Premium Table booklet for complete premium rate table.

Below is an illustration of **International**Exclusive premium rates for customers with standard risks and are residing in Malaysia.

Annual Premium (RM)												
Age	Plan 1			Plan 2			Plan 3			Plan 4		
	Asia	Worldwide ex USA	Worldwide	Asia	Worldwide ex USA	Worldwide	Asia	Worldwide ex USA	Worldwide	Asia	Worldwide ex USA	Worldwide
10	7,045	7,825	14,088	4,040	4,490	8,084	3,509	3,899	7,018	1,974	2,193	3,948
20	10,140	11,267	20,280	5,035	5,596	10,074	4,373	4,859	8,746	2,460	2,734	4,920
30	16,200	17,999	32,395	7,819	8,692	15,643	6,792	7,547	13,584	3,821	4,245	7,641
40	20,443	22,714	40,886	12,148	13,496	24,292	10,548	11,720	21,096	5,933	6,593	11,866
50	26,480	29,425	52,963	17,805	19,783	35,611	15,463	17,181	30,925	8,698	9,664	17,395
60	39,264	43,628	78,525	27,907	31,006	55,812	24,233	26,926	48,466	13,631	15,146	27,262

Premium rates are not guaranteed and the premium payable at renewal shall be determined at each renewal based on the attained age of each member, the premium rates then in effect, and any other factors which may materially affect the risks insured. Premium loading may also be imposed for non-standard risks.

5. What are the fees and charges I have to pay?

What you have to pay in addition to the premium

i. Stamp Duty – RM10.00
ii. Service Tax - 6% of premium (for Corporate policy)

What is included in the premium

i. Commissions paid to insurance intermediaries (for Individual policy) - 15% of premium
ii. Commissions paid to insurance intermediaries (for Corporate policy) - 10% of premium

6. What are some of the key terms and conditions that I should be aware of?

Eligibility

Members eligible to be covered under this policy must be aged eighty (80) years or less at the time of application. By members we mean you and any family member included in your policy.

"Family member" means your partner and your unmarried children (or those of your partner) living with you when you take out the policy or when it is renewed. By partner we mean your husband or wife with whom you live permanently. Children cannot stay on your policy after the renewal date following their 21st birthday.

This policy may provide cover for members residing outside of Malaysia; however, in most cases we cannot cover you if you are a national of your resident country (other than Malaysia). In addition, country specific regulations may impact your eligibility.

Policy Renewal/ Renewal Premium

(i) This is a yearly renewable policy. Unless renewed, the coverage will cease on expiry date and the insurance company shall strictly not be liable for any expenses that take place after the expiry date. On or before the expiry of your policy, and subject to our acceptance, you may renew this policy by paying the premium applicable at the time of renewal. This shall not apply in the event that the policy expires, or is terminated or cancelled in accordance with the terms of this policy and you should subsequently wish to reapply for insurance cover under this policy.
(ii) Premium rates are not guaranteed and the premium payable at renewal shall be determined at each renewal based on the attained age of each member, the premium rates then in effect, and any other factors which may materially affect the risks insured.
(iii) We have the right to cancel or change all or any part of your policy from any renewal date by giving you at least thirty (30) days written notice prior to the renewal date. We will not change the terms of your policy alone simply as a result of your personal claims. However, we will make changes only to reflect any past or foreseeable changes in medical practice or procedures and the claims experience. The purpose of such changes will be to seek, as far as possible, to maintain substantially the same level and type of cover in place while ensuring that the plan remains affordable.

Free look Period

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

Reasonable & Customary Charges

The benefits payable under this plan shall be the lower of the actual charge incurred or the reasonable and customary (R&C) charges. Where we consider any charge not to be reasonable and customary (R&C), we will only pay the amount which is, in our experience, customarily charged and you will have to pay the rest. We will base that calculation on a combination of our global experience, statistical information provided by local health authoritative body and information collected from medical specialists and surgeons practicing in the country or area where the treatment is received.

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

Changes in principal country of residence

If you are a planning to change your principal country of residence (where you live for most of the year), you must tell us as this may affect your eligibility. If you don't tell us we can refuse to pay benefits.

International Exclusive is also available from AXA in several other Asian Countries and AXA PPP healthcare also offers similar plans both in the UK and elsewhere. Where appropriate, we may be able to transfer you to another AXA plan, with no additional medical underwriting exclusions.

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

Importance of Disclosure
- You must disclose all material facts such as personal particulars and any medical condition which you already had when you apply for the policy. This includes any medical condition or symptoms whether or not being treated and any previous medical condition which recurs or which you should reasonably have known about even if you have not consulted a medical practitioner. If you are in any doubt you should disclose the medical condition.
- Failure to notify AXA of all material facts and medical condition may result in claims being refused or cover withdrawn.

Cash Before Cover
- It is fundamental and an absolute special condition of this insurance that the premium due must be paid and received by us before cover commences. This insurance policy is automatically null and void if this condition is not complied.

Waiting Periods & Co-insurance
(i) Our In-patient and Daycare Treatment, Out-patient Treatment, Routine Optical Care, Psychiatric Treatment & Vaccination benefits will be covered from the date of commencement of cover.
(ii) The following benefits will not be payable during the specified waiting periods:

Benefits	Waiting Period (from date of commencement of cover
Health Screen, Pre and Post-natal Complications, Pregnancy and Delivery, Hospice and Palliative Care	12 months
Pre-existing conditions	9 months (Plan 1 and 2)
	12 months (Plan 3 and 4)

(iii) A 20% co-insurance is applicable to routine dental benefit available under Plan 1. No other co-insurance/deductible is applied to any other benefits.

Claim Procedures
- All insured members will be given a membership card. With this card, you have access to numerous hospitals worldwide which are listed in our international directory of hospitals. Prior to admission or receiving treatment you must identify yourself and your eligibility for discounts by showing your membership card together with a recognized official form of identification (such as passport) to any network provider as evidence that you are an insured member of an AXA **International**Exclusive policy.
- Before receiving any planned in-patient or daycare treatment recommended by your medical practitioner, you or the treating hospital must contact us to obtain authorization for your proposed treatment. We will confirm, in writing, to you and/or the hospital the extent of your cover for the proposed treatment and the amount we are prepared to pay for it.
- Failure to obtain pre-authorization as required may prevent us from settling all or part of any claim. In the event that we are obliged to pay for any item not covered by our confirmation we will recover that amount from you. In any event any cost that is not directly related to treatment will be borne by the member.
- For outpatient claims and claims which are from outside our international directory of hospitals, settlement of claims will be done on a reimbursement basis. In other words, insured person will pay the bills first and will be compensated later.
- For claims done on a reimbursement basis, you must take a claim form with you and make sure it is filled in and signed by yourself and the medical practitioner treating you and sent back to us as quickly as possible, giving us all the information we request.
- Only original receipted invoices can be accepted with your claim. A fully completed claim form will ensure that your claim will be processed promptly. An incomplete or unsigned claim form may delay settlement of your claim and in some cases may lead to the claim form being returned to you for completion.
- It may be necessary for us to obtain a medical report from the attending medical practitioner. If the medical practitioner does not respond quickly to such a request your claim may be delayed. We do not pay for medical reports.
- Please note that, for reimbursement claims, we will only consider claims made within 90 days of treatment being received.

Note: This list is non-exhaustive. Please refer to the policy contract for the terms and conditions under this policy.

7. What are the major exclusions under this policy?
Generally, the policy does not cover
- treatment of any medical condition which the member already had when he or she joined and which you should have told us about but did not tell us at all or did not tell us everything unless we had agreed otherwise in writing that there

was no need for you to tell us. This includes any medical condition or symptoms whether or not being treated and any previous medical condition which recurs or which the member should reasonably have known about even if he or she has not consulted a medical practitioner

- any treatment which only offers temporary relief of symptoms rather than dealing, when it is reasonable to do so, with the underlying medical condition
- pregnancy or childbirth (delivery) unless this is specifically included in your benefits. We will not pay for treatment of any medical condition that arises during pregnancy or childbirth (delivery) if the pregnancy was a result of assisted means or any form of assisted conception or if the child is through surrogacy
- treatment begun, or for which the need had arisen, during the first 90 days after birth for any child conceived by artificial means or any form of assisted conception including artificial insemination or if the child is through surrogacy
- investigations into and treatment of infertility, contraception, assisted reproduction, sterilization (or its reversal) or any consequence of any of them or of any treatment for them
- treatment of impotence or any consequence of it
- treatment of sexually transmitted diseases
- sex change including treatment which arises from or is directly or indirectly made necessary by a sex change
- treatment of any medical condition which arises in any way from HIV infection
- treatment of obesity (Body Mass Index or BMI equal to 30 and above) or any medical condition which arises from, or is related to, obesity in any way including but not limited to the use of gastric banding or stapling, the removal of fat or surplus tissue from any part of the body whether or not it is needed for medical or psychological reasons
- the costs of collecting donor organs for transplant surgery or any administration costs involved even if such transplants are allowed by the terms of this plan
- treatment which arises from or is directly or indirectly caused by a deliberately self-inflicted injury or an attempt at suicide
- treatment which arises from or is in any way connected with alcohol or drug or substance abuse; all types of classes/courses/programs such as but not limited to cessation of alcohol, smoking/nicotine, drugs, substance
- any treatment to correct refractive defects of the eyes such as long or short-sightedness or astigmatism unless allowed for by your plan
- treatment directed towards developmental delay in children whether physical or psychological or learning difficulties
- preventive (i.e. prophylactic) treatment
- treatment to relieve symptoms commonly associated with any bodily change arising from any physiological or natural cause such as ageing, menopause or puberty and which is not due to any underlying disease, illness or injury
- the costs of providing or fitting any external prosthesis or orthosis or appliance or medical aids or durable medical equipment
- claims in respect of treatment received outside the area of cover or if the member travelled against medical advice even inside the area of cover
- Treatment of injuries sustained from playing professional sport or from base jumping, cliff diving, flying in an unlicensed aircraft or as a learner, martial arts, free climbing, mountaineering with or without ropes, scuba diving to a depth of more than 10 metres, trekking to a height of over 2,500 metres, bungee jumping, canyoning, hang-gliding, paragliding or microlighting, parachuting, potholing, skiing off piste or any other winter sports activity carried out off piste
- any charges which are incurred for social or domestic reasons or for reasons which are not directly connected with treatment
- any charges from health hydros, spas, nature cure clinics (or practitioners) or any similar place, even if it is registered as a hospital
- any claim or part of a claim in respect of which you have to pay an excess (or deductible or co-insurance). In this case we will only pay the balance of the claim after we have deducted the excess (or deductible or co-insurance) amount
- in-patient charges for any hospital which are not reasonable and customary (R&C). We will pay only for the reasonable cost of the lowest cost standard single room associated with the treatment given
- any charges for treatment related to and/or the correction of congenital conditions and/or deformities whether or not manifest and/or diagnosed or known about at birth
- any administrative costs or reports of any kind (unless otherwise advised by us) or any other charges of a non-medical nature in connection with the provision and/or performance of medical supplies and/or services
- all bank or credit charges
- vitamins or supplements whether prescribed or not
- treatment for all types of sleep disorder including snoring
- treatment which has not been established as being effective or which is experimental. However we will pay if, before the treatment begins, it is established that the treatment is recognised as appropriate by an authoritative medical body and we have agreed in writing, with the medical practitioner, what the fees will be
- benefits for more than 100 days in total in any member's lifetime for in-patient treatment of psychiatric illness
- any treatment, or for International Emergency Medical Assistance, if they are needed as a result of nuclear contamination, biological contamination or chemical contamination, whilst engaging in or taking part in war, act of foreign enemy, invasion, civil war, riot, rebellion, insurrection, revolution, overthrow of a legally constituted government, explosions of war weapons or any event similar to one of those listed
- benefits for any treatment needed as a result of work related accident or injury where the cost of such treatment is recoverable under a Workman's Compensation policy or similar cover required by Government Act prevailing in the country where the work related accident or injury took place or elsewhere at the time of injury or accident

Note: This list is non-exhaustive. Please refer to the policy contract for the full list of exclusions under this policy.

8. What is Pre-Existing Conditions?

Pre-existing Conditions mean medical conditions/disabilities that the Insured Person has reasonable knowledge of. An Insured Person may be considered to have reasonable knowledge of a pre-existing condition where the condition is one for which:

(a) the Insured Person had received or is receiving treatment; or
(b) medical advice, diagnosis, care or treatment has been recommended; or
(c) clear and distinct symptoms are or were evident; or its existence would have been apparent to a reasonable person in the circumstances.

9. Can I cancel my Policy?

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

Termination of cover

We have the right to cancel your policy from any renewal date by giving you no less than 30 days in writing. We will refund you premiums on a pro-rata basis from the end of Gregorian calendar month in which cancellation takes effect provided you have returned to us the policy documents including the membership card(s). We will not refund premiums if any claim, however small, has been made in the current policy year.

10. What are the disadvantages on switching policy from one insurer to another?

One of the main disadvantages is if your current health status is less favourable to the new insurer, new terms may be imposed to exclude such illness. To ensure continuous cover is provided, you are advised to check with us on the accepting terms prior to your policy expiry date.

11. What do I need to do if there are changes to my contact details?

It is important that you inform us of any change in your contact details to ensure that all correspondences reach you in a timely manner.

12. Where can I get further information/ a group quotation?

Should you require additional information about our Group Hospitalization and Surgical Insurance, please contact us or any of our branches nationwide or your insurance intermediary or visit our website at www.axa.com.my

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