AXA 安盛

AxtraCare Employee Benefits
Insurance Package Plan

A smart choice for employee care

Product brochure

Medical insurance is an important element of an employee benefits package, playing a vital role in helping businesses retain their valued staff and attract new talents.

The **AxtraCare Employee Benefits Insurance Package Plan** (**"AxtraCare"**) is tailored for small and medium-sized enterprises (SMEs) seeking reliable medical protection with medical coverage, affordable premiums, secure network and a simple setup for both employers and employees.

Enhance your employee benefits with **AxtraCare**.

Plan features

Supporting businesses to care better

Cost-effective protection tailored to your team

AxtraCare provides your employees with practical medical protection through four plans of hospital benefits aligned with different staff levels, offering up to 100% reimbursement with full cover[1] per disability per year. It also includes one standard clinical benefits for all with affordable co-payments up to HKD100 per visit. This structure allows your company to align benefits with workforce needs while maintaining predictable medical costs and ensuring fair access to essential services.

Easy administration and a hassle-free application procedure

Enrolment is straightforward, with no health declaration required for groups of 6 employees or more. This simplifies onboarding, reduces administrative workload, and helps HR teams manage staff updates and renewals more efficiently.

Reliable network[2, 3] with quality care

AXA's appointed network[2,3] offers predictable co-payments with no unexpected charges through pre-approval[4], helping employers maintain transparency in medical expenses. Consistent service standards across the network[2,3] ensure employees receive dependable and professional care whenever they seek treatment.

Supporting employees to live healthier

Guided support from consultation to recovery

Your employees can rely on AXA's trusted network[2,3] to seek consultations and more specialised follow-up care. Clear instructions when they seek consultation through network[2,3], helps them understand where to seek treatment, while timely referral if required, pre-approval[4] and cashless arrangement[5] with paperless claims reduces uncertainty and administrative steps. This support enables a smoother and more reassuring experience throughout their care journey and helps your employees manage medical expenses with confidence.

Continuous health support and additional worldwide support[6]

Pre-existing conditions are covered when the insured person has been insured under **AxtraCare** continuously after 12 consecutive months of protection.

With AXA Emergency Assistance[6] as additional worldwide support service, insured have access to a 24-hour worldwide designated hotline for emergency assistance services. Also including China Health Network[6] gives insured further peace of mind while in Mainland China.

Smart care journey by network through Emma by AXA

AxtraCare gives your employees and their dependants convenient access to the network[2,3], simply by presenting their AXA eHealth Card[7] on Emma by AXA during visits. Emma by AXA also provides easy access to policy management and a variety of health and wellness services, ensuring comprehensive support for their workforce's health needs.

AxtraCare at a glance

Eligibility	Policyholder must be a Hong Kong registered company with a minimum of 3 employees
Issue age	■ Employee: Age 69 or below ■ Dependant: - Spouse: Age 69 or below - Unmarried child(ren): 14 days old to age 18 (or up to age 22 if still a full-time student)
Protection up to age	■ Employee: Up to age 70# ■ Dependant: - Spouse: Up to age 70# - Unmarried child (ren): Up to age 19# (or up to age 23# if still a full-time student)
Medical underwriting	■ 3 - 5 employees: Required ■ 6 employees or above: Not required
Class set up	Policyholder can divide eligible full-time employees into different classes by grade, contract type or years of services. You may set a maximum of 3 classes with designated plan levels depending on the number of employees as shown below: ■ 3 employees – 1 class available ■ 4 to 9 employees – 2 classes available ■ 10 to 50 employees – 3 classes available
Premium△	Yearly renewable and premium rates are not guaranteed
Policy currency	HKD
Payment mode	Annual

Subject to the respective termination clause for insured person and for insured dependant(s) as stated in the policy provisions. The protection in respect of employees and their spouse can be extended to age 80, subject to satisfactory result of individual underwriting and loading.

△ Please refer to **"Premium adjustment and revision of terms and conditions"** section under Important information for details.

Benefit schedule

Hospital Benefits[1]				
Plan	**Plan 1**	**Plan 2**	**Plan 3**	**Plan 4**
Benefit level	Ward		Semi-private room	
Overall maximum (HKD) For items 1-10	$150,000		$330,000	
	Per disability per year			
Reimbursement %	80%	100%	80%	100%
Medical service providers	Network[2][3] only			
Maximum benefit (HKD) [4]				
1. Room and board[7] Maximum 180 days per disability per year	Full cover[5][6]			
2. Doctor's visit[7] Maximum 180 days per disability per year				
3. Hospital expenses[7][8] Per disability per year	$15,000		$33,000	
4. Surgeon's fee[9] Per disability per year	Full cover[5][6]			
5. Anaesthetist's fee[9] Per disability per year				
6. Operating theatre[9] Per disability per year				
7. Specialist consultation[7] Per disability per year				
8. Intensive care[7] Maximum 10 days per disability per year				
9. Pre-hospitalisation doctor's visit[3]				
10. Post-hospitalisation doctor's visits [3] Per disability per year, including 1 (the latest) pre-admission network doctor's or network specialist's visit and medicine before hospitalisation in a network hospital or day case surgery and up to 3 follow-up network doctor's or network specialist's visits, medicine, dressing and off stitches within 2 months after discharge from network hospital or day case surgery				

Clinical Benefits	
Plan	**C1**
Overall maximum (HKD)	Maximum 20 visits overall for item 1 - 4 per year
Medical service providers	Network[2] only
Reimbursement %	100% for item 1-4
Maximum benefit (HKD) [4]	
1. Consultation at doctor's office Including consultation fee and up to 3 days of basic medication which are medically necessary per visit	Full cover[5][6] with co-payment $50 per visit Maximum 20 visits per year
2. Specialist consultation Including consultation fee and up to 5 days of basic medication which are medically necessary per visit (Subject to a written referral[10][11] from a network doctor)	Full cover[5][6] with co-payment $100 per visit Maximum 10 visits per year
3. Physiotherapist Including consultation fee and cost of medicine (Subject to a written referral[10] from a network doctor or a network specialist)	Full cover[5][6] with co-payment: $50 per visit Maximum 5 visits per year
4. Chinese medicine practitioner Including consultation fee and up to 2 packs of medically necessary Chinese medicine per visit	Full cover[5][6] with co-payment $50 per visit Maximum 5 visits per year
5. X-ray and lab tests Including laboratory examinations, X-ray examinations, electrocardiograms and basal metabolism tests (Subject to a written referral[10][12] from a Network Doctor or a Network Specialist)	80% reimbursement subject to $1,000 per year

Remarks

(1) Day case surgery is covered under hospital benefits. Day case surgery payable under hospital benefits of the policy must be performed by a network doctor or network specialist and carried out in a network hospital or network healthcare facility. Pre-approval must be obtained for day case surgery exceeding HKD4,000 under the hospital benefits. For further details on benefits coverage and pre-approval, please refer to below remark (5) and (6).

(2) Network means a network of healthcare facility(ies), hospital(s), doctor(s), specialist(s), physiotherapist(s) or Chinese medicine practitioner(s) which/who has entered into and is covered by a valid written agreement with the Company to provide specified medical services to the insured.

a. The network hospitals are as follows:

- Canossa Hospital
- St. Paul's Hospital
- St. Teresa's Hospital
- Hong Kong Baptist Hospital
- Evangel Hospital
- Precious Blood Hospital
- Union Hospital
- CUHK Medical Centre
- Hong Kong Adventist Hospital – Tsuen Wan

b. The lists of network service providers, that is, network doctor(s), network specialist(s), network physiotherapist(s), network Chinese medicine practitioner(s), network hospital(s) and network healthcare facility(ies) are subject to change from time to time at AXA's sole discretion without prior notice. For the current directory of the network service providers, please check Emma by AXA or call AXA's customer service hotline at (852) 2519 1166.

(3) AXA credit facility up to the pre-approval limit shall be available provided that the insured shall comply with all of the applicable requirements under remark (5), with the exception that for:

a. pre-hospitalisation doctor's visits and post-hospitalisation doctor's visits under hospital benefits; and

b. any medical services from non-network service provider arising out of the context of an emergency under hospital benefits; and

c. any medical services by specialist from public hospital under the administration of the Hospital Authority in Hong Kong or non-network hospital in Hong Kong incurred during hospital confinement or day case surgery under hospital benefits when there is no relevant specialist available in network for treating the insured's disability, AXA credit facility will not be available.

(4) Subject to the terms and conditions of the policy, the hospital benefits and clinical benefits covered under the policy are payable up to maximum benefit, which can be either (i) an itemised benefit limit; or (ii) full coverage, and subject further to the overall maximum and co-payment requirement; or (iii) partial coverage, subject to the reimbursement %. In order to become eligible to receive hospital benefits and/or clinical benefits, the insured has to fulfil the applicable requirements. If any of the applicable requirements is not fulfilled, the insured will not be entitled any benefits under the policy. For the definition of "maximum benefit(s)", please refer to the policy provision.

(5) Unless otherwise specified in the Policy, all the benefits payable are to cover reasonable and customary charges actually incurred for eligible hospital confinement, treatment, surgical procedure, supplies or other medical services that are specified in the benefit schedule under the policy which are medically necessary and are subject to the overall maximum, maximum benefits, and other limits (if any) as stated in the terms and conditions of the Policy, including those benefits which indicate "Full Cover".

Subject to the terms and conditions of the policy, benefits shall only be payable provided that the insured shall comply with all of the following applicable requirements:

a. For hospital benefits and clinical benefits:

i. Hospital confinement, treatment, consultation, surgical procedure, supplies or other medical services under hospital benefits must be performed by a network doctor or a network specialist, and carried out in a network hospital where the Insured is confined according to the benefit level or below as specified in the benefit schedule; and/or

ii. Day case surgery payable under hospital benefits must be performed by a network doctor or a network specialist, and carried out in a network hospital or network healthcare facility; and/or

iii. Treatment, consultation, or medical services (including cost of medicine) under clinical benefits must be performed by a network doctor, a network specialist, a network physiotherapist or a network Chinese medicine practitioner and carried out in a network healthcare facility. For the avoidance of doubt, a co-payment may be required subject to reimbursement % and/or maximum benefit(s) and/or overall maximum of relevant benefits as specified in the benefit schedule; and/or

iv. X-ray and lab tests, advanced diagnostic imaging and physiotherapy by a physiotherapist or treatment by chiropractor under

hospital benefits must be referred in writing by a network doctor or a network specialist. X-ray and lab tests under clinical benefits must be referred in writing by a network doctor or a network specialist and carried out in a network healthcare facility;

b. the applicable pre-approval and subsequent approval requirements as specified in remark (6) must be complied with; and

c. the medical expenses must be settled by the AXA eHealth Card or AXA letter of guarantee which must be presented to the network hospital or network healthcare facility (as the case may be) upon registration.

If any of the applicable requirements under this remark (5) is not fulfilled, the insured will not be entitled to any benefit. Without prejudice to any other terms and conditions in the policy contract (including but not limited to the policyholder's obligation to reimburse the Company of any shortfall as a result of the use of AXA credit facility and the Company's right to recover outstanding shortfall from the policyholder, to withhold payment of any claims, to deduct shortfall from any monies payable under the policy and to suspend usage of AXA credit facility), payment of benefits shall be deemed to have been made by AXA to the policyholder where AXA pays the relevant network hospital or network healthcare facility (as the case may be) for the settlement of the medical expenses incurred by the insured. For the avoidance of doubt, notwithstanding satisfying the applicable requirements as mentioned in this remark (5) above, benefit shall not be payable when it is indicated in the benefit schedule as being excluded by the policy.

(6) Subject to remark (3) above and such terms and conditions in relation to the issue and use of AXA eHealth Card as set out in the policy provision, the Company shall not be liable to pay any benefit unless written approval ("pre-approval") of the Company is obtained before any of the following services is rendered:

a. Hospital confinement, treatment, consultation, surgical procedure, supplies and/or other medical services hospital benefits; and/ or

b. day case surgery exceeding HKD4,000 under hospital benefits; and/or

c. advanced diagnostic imaging under hospital benefits.

If there is any variation to the extent, nature or costs of the pre-approved items, the Company's prior written approval of such change must be obtained.

For medical services from non-network service providers arising out of the context of an emergency, pre-approval/ prior written approval as stated above under this remark (6) will not be required and AXA credit facility will not be applicable. Instead, the insured has to settle any medical expenses incurred with the non-network service provider and submit the claim(s) to the Company in accordance with the terms and conditions of the policy. Subject to the terms and conditions of the policy, including but not limited to the maximum benefits and overall maximum, we will cover eligible expenses in any public hospital under the administration of the Hospital Authority in Hong Kong or non-network hospital in Hong Kong incurred during hospital confinement or day case surgery under hospital benefits, provided that there is no relevant specialist available in the network for treating the insured's disability under hospital benefits and clinical benefits and that the pre-approval of the Company is obtained. AXA credit facility will not be applicable. Instead, the insured has to settle the claim(s) to the Company in accordance with the terms and conditions of the policy.

(7) If multiple disabilities are treated during one period of hospital confinement, such multiple disabilities shall be deemed as one disability and the aggregate benefits payable shall be capped at the maximum benefit(s) as specified in the schedule.

(8) X-ray and lab tests, advanced diagnostic imaging and physiotherapy by a physiotherapist or treatment by a chiropractor under hospital benefits must be referred in writing by a network doctor or a network specialist.

(9) If more than one operation or surgical procedure is performed either:

- during any one period of hospital confinement and/or day case surgery and any successive periods of hospital confinement and/or day case surgery for the same or related disability; or
- through a single incision but in respect of unrelated disabilities, then the aggregate amount payable shall be capped at the maximum benefit(s) as specified in the benefit schedule of the policy for one disability.

(10) Referral letter from a network doctor or a network specialist is valid for six (6) months from the date the written referral was made. A new referral letter is required if no further treatment for the referred disability has been carried out within nine (9) months from the last treatment or consultation date, whichever is later.

(11) Specialist consultation in the following specialty do not require a written referral from a network doctor: Dermatology, Ophthalmology (ENT), Pediatrics (for child below age 19), Orthopedics and Traumatology, Gynecology, Medical or Clinical Oncology.

(12) X-ray and lab tests under clinical benefits must be referred in writing by a network doctor or a network specialist and carried out in a network healthcare facility.

Kickstarting your smart care journey

AxtraCare allows insured to access network[2,3] of doctors, specialists, physiotherapists and Chinese medicine practitioners, as well as well-equipped healthcare facilities or hospitals in Hong Kong. The medical service must be performed by a network[2,3] doctor, a network specialist, a network physiotherapist, a network Chinese medicine practitioner and carried out in a network hospital or network healthcare facility.

	Example 1 Required hospital confinement after consultation	Example 2 No hospital confinement after consultation*
1 Make an appointment	Search your preferred network[2,3] doctor and make an appointment.	
2 Medical Consultation	Present your personal identification document with AXA eHealth Card[7] upon registration at the network[2,3] healthcare facility and pay the relevant co-payment.	
3 Pre-approval	AXA shall receive the pre-approval[4] application form completed by network[2,3] doctor and you will be notified of the pre-approval[4] result prior to treatment or hospital admission.	N/A
4 Receive medical treatment during confinement in hospital	Present your AXA eHealth Card[7] upon admission, use it to settle the eligible medical expenses and enjoy cashless arrangement up to the pre-approval[4] limit.	N/A

* Same step for seeking consultation of Chinese medicine practitioner. If after your first consultation with network doctor, the network doctor considers it medically necessary for you to see a specialist, physiotherapist, or to conduct X-ray and lab tests, the network doctor will provide you with a written referral. The process will be the same as your initial steps in step 1 and 2.

Important information

Participation guideline

- Employees must be actively at work at your company on the commencement date of insurance of the employees and their eligible dependants.
- Except the top class in your company (for example, if you set class 1 for directors as the top class which can have less than 3 full-time employees), all classes must have at least 3 full-time employees.
- Policyholder must select the same plan level for employees belonging to the same class.
- If the class includes coverage for employees' dependants, their eligible dependants must also be enrolled in the same class as the respective employees.

Grace period

A grace period of thirty-one (31) days following the due date shall be allowed to the policyholder for the payment of each premium after the first. If any premium with respect to the insured in any class is not paid before the expiration of the grace period, the policy shall automatically discontinue with respect to all persons in such class at the expiration of the grace period, except that if the policyholder shall have given the Company written notice of discontinuance before the expiration of the grace period, cover under the policy shall discontinue with respect to all persons in such class as of such earlier date. As to each class, the policyholder shall be liable to the Company for all unpaid premiums with respect to the insured in such class for the period (including a pro rata premium for the grace period or fraction thereof) during which the policy was in force with respect to such insured.

Termination

Termination of an insured person's insurance

An insured person (that is, an employee) shall cease to be an insured person at the earliest of the times indicated below:

(a) at the end of the period for which the insured person shall have made to the policyholder any contribution required hereunder towards any premium for his or her insurance if the insured person fails to make any such contribution when due; or

(b) on the date the insured person retires voluntarily or as a result of dismissal ceases to actively perform full-time duties in his or her usual occupation; or

(c) on the day on which the insured person's relationship with the policyholder (as specified in the application) shall cease, as evidenced to the Company by the policyholder, whether by notification or by cessation of premium payment on account of such insured person's insurance under the policy; or

(d) on the anniversary date (as specified in the application or any endorsement) on or next following the insured person's 70th birthday or such later birthday as may be agreed by the Company in writing; or

(e) on the date of discontinuance of the policy; or

(f) on the date of discontinuance of cover under the policy with respect to the class of persons of which he or she is a member.

Termination of insurance for insured dependants

The insurance in respect of each insured dependant shall terminate at the earlier of the times indicated below:

(a) on the day the insured person ceases to be an insured person under the policy; or

(b) on the day the insured dependant ceases to be a dependant of the insured person; or

(c) on the anniversary date (as specified in the application or any endorsement) on or following the spouse of an insured person's 70th birthday or such later birthday as may be agreed by the Company in writing.

Benefit limits

Any benefit payable under the policy in respect of an insured is the lesser of:

(a) the benefit as specified in the benefit schedule under the policy; and

(b) any maximum amount specified in writing by the Company after consideration of such medical evidence as the Company may require.

Notwithstanding any other terms and conditions in the policy, if the insured is covered for less than a full policy year, the maximum number of visits per policy year and the maximum benefit limit per policy year under clinical benefits for which benefit shall be made available to the insured and/or for which reimbursements shall be made in such period, shall be daily pro-rated to the portion of the full policy year of which the insured is covered.

Adjustments of an insured person's or insured dependant's benefit

If the amount of any benefit as specified in the benefit schedule of the policy is contingent upon the classification of an insured person or insured dependant as the case may be, and if at any time the insured person's or insured dependant's classification warrants an amount of

benefit different than that for which he or she is then insured, the amount of benefit for the insured person or the insured dependant shall be changed on the date shown on the application for making such change, PROVIDED THAT if the insured person is not actively at work on the day prior to the date the insured's benefit would otherwise be changed, the effective date of the change in such insured's benefit shall be deferred until the insured person actually returns to work; PROVIDED FURTHER THAT any such insured person who is not at work because he or she is on holiday or it is his or her regular day off work shall, for the purposes of this condition, be deemed to be at work if he or she was actually at work on his or her last scheduled working day prior to such holiday or day off work.

Pre-existing conditions

No benefit shall be payable in respect of injuries or sickness sustained prior to the date the insured becomes insured under the policy if because of which such person shall have received medical or surgical care or treatment within the three consecutive months immediately preceding such date. If, however, during any consecutive three-month period after such date, the insured does not undergo any medical or surgical care or treatment in respect of such injuries or sickness, then benefits will subsequently be payable, subject to the terms and conditions of the policy, in respect of such injuries or sickness.

Notwithstanding the above, pre-existing conditions shall be covered when the insured has been insured under the policy continuously for twelve (12) consecutive months.

No benefit shall be payable if prior to the date the insured becomes insured, such person was infected with any Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or any HIV or AIDS related diseases.

Change of benefits

In the event of any subsequent change in benefit coverage due to a change in classification of an insured or change in benefit coverage at the choice of the Policyholder, the Benefit payable under the Policy shall be in accordance with the new benefit coverage applicable after such change, EXCEPT THAT if the new benefit coverage is higher than the insured's original entitlement before such change ("Upgrade"), the hospital benefits payable in respect of any disability which was sustained prior to the date of the Upgrade shall be limited to the original benefit coverage applicable before such Upgrade.

Notwithstanding the above, the benefit coverage for any disability which was sustained prior to the date of the Upgrade shall subsequently be subject to the new upgraded benefit coverage when the Insured has not undergone any medical or surgical care or treatment in respect of such disability for a continuous period of ninety (90) days, or when the Insured has been insured under this new Benefit coverage continuously for twelve (12) consecutive months.

For the avoidance of doubt, where the new benefit coverage is lower than the insured's original entitlement before the change ("Downgrade"), all benefits payable under the policy shall be subject to the new downgraded benefit coverage as soon as such Downgrade becomes effective.

Contract-contestability

In the event of fraud, misrepresentation, non-payment of premiums or where any conditions of the policy are not complied with, the Company may at all times contest:

(a) the validity of the policy; and/or

(b) any benefits under the policy; and/or

(c) insurability of the insured,

and may determine that the policy shall be void from inception.

All statements made by the policyholder or any insured shall, in the absence of fraud, be deemed representations and not warranties, and no statements will be used in defence of a claim under the policy unless such statements are in writing.

Misstatement of age

In the event of misstatement of age of any insured, an equitable adjustment of premium shall be made to conform to the correct age; and if the amount of the insured's benefit is dependent on age, the amount of benefit shall be adjusted to conform to the correct age.

Indemnity clause

(a) The policyholder agrees to reimburse the Company of any shortfall in full as shown in a shortfall notice within ninety (90) days of receipt of that notice for charges incurred by the insured through the use of AXA credit facility:

  (i) that exceeds any maximum benefit and/ or overall maximum to which the insured is entitled to as specified in the benefit schedule under the policy;

  (ii) for hospital confinement, treatment, consultation, surgical procedure, supplies or other medical services that is not specified in the benefit schedule under the policy;

  (iii) after the insured person leaves the policyholder's employment or after the insured's insurance under the policy is terminated for whatever reason;

(iv) on and after the due date of the required premium if the policyholder fails to pay the required premium within the grace period; or

(v) after the policy is terminated or lapsed for any reason.

(b) The Company has the right to

(i) recover the outstanding shortfall from the policyholder, withhold payment of all incoming claims incurred by the insured, adjust any premium refundable to the policyholder, deduct the outstanding shortfall from any monies payable by the Company under the policy and take any further action as the Company deemed appropriate and necessary against any outstanding shortfall arising from any of the insureds; and

(ii) suspend the usage of AXA credit facility in case of any outstanding shortfall in the policy.

Premium adjustment and revision of terms and conditions

Premium rates are not guaranteed and terms and conditions of the policy may also change upon renewal. AXA reserves the right to review and adjust the premium rates for each policy year. At the beginning of each policy year in respect of each class of insured, AXA shall determine the table of premium rates for that policy year. It shall then compute an aggregate premium which shall be the sum of the individual premiums for the insured of that class, calculated according to the table of premium rates then in effect. The premium rates may be adjusted based on factors including but not limited to the attained age of the insured, medical trend and AXA's claims experience.

Notwithstanding any other terms and conditions in the Policy, if the insured is covered for less than a full policy year, any premium in respect of such insured to be charged in such period shall be daily pro-rated to the portion of the full policy year of which the insured is covered.

The policy may be changed at any time or times by written agreement between the Company and the policyholder, without the consent of any insured person or other person. No change in the policy shall be valid unless approved by the Company and evidenced by endorsement hereon, or by amendment hereto signed by an authorised representative of the Company.

Renewal

On each anniversary date after the effective date, the policy is renewable subject to the consent of the Company for an additional annual period by the payment of the premium, in accordance with the provisions of the policy, at the Company's premium rates in effect at the time of such renewal, provided the number of insured person is:

(a) if insured persons are required to contribute towards the premiums under the policy, not less than three; or

(b) if the policyholder is liable for 100% of the premiums, not less than the greater of three and the total number of those eligible.

Levy on insurance premium

Levy collected by the Insurance Authority through the Company will be imposed on the policy at the applicable rate. Policyholders must pay the levy in order to avoid any legal consequences.

Right of third parties

Any person or entity which is not a party to the policy shall have no rights under the Contracts (Right of Third Parties) Ordinance (Cap 623 of the Laws of Hong Kong) to enforce any terms of the policy.

Reasonable and customary charges and medically necessary

The Company will only reimburse the reasonable and customary charges actually incurred for eligible hospital confinement, treatment, surgical procedure, supplies or other medical services that are specified in the benefit schedule under the policy which are medically necessary. If the charges are higher than the reasonable and customary charges, the Company will only pay the amount which is reasonably and customarily charged.

Notice and proof of claim

Written notice of Injury or sickness on which claim may be based must be given to the Company within ninety (90) days of the date of the commencement of the first loss for which benefits arising out of each such injury or sickness may be claimed, or as soon thereafter as is reasonably possible.

Proof of injury or sickness on which claim may be based must be furnished to the Company within ninety (90) days after the injury or sickness was first treated. If proof was not given within the time specified, it must be shown that proof was given as soon as was reasonably possible, or the Company will not pay a benefit.

Any appeal request for the claims result must be submitted to the Company within ninety (90) days after the issue date of claim settlement letter. We will not accept any appeal request if we do not receive within such timeframe.

Key exclusions

Below are the key exclusions which apply to hospital benefits and clinical benefits of **AxtraCare**:

1. General check-up, convalescence, custodial or rest care, preventive treatments, innoculation or medication; or
2. Any elective treatment or surgical procedure such as but not limited to cosmetic surgery, sterilisation or beautification; or
3. Congenital conditions; or
4. Infertility; or
5. Conditions seeking medical care that is not directly attributed to a disease, such as growth delay or failure to thrive without a medical cause; or
6. Dental treatment or surgery unless necessitated by injury caused by an Accident, provided such treatment or surgery is given by a legally licensed dentist or dental surgeon and incurred within ninety (90) days from the date of an Accident; or
7. Pregnancy, childbirth, miscarriage or abortion; or
8. Unless otherwise covered by hospital benefits or clinical benefits (as the case may be), any physiotherapy treatment or treatment by a chiropractor; or
9. Correction of eye vision or fitting of eye glasses; or
10. Participation in illegal acts (except traffic and pedestrian offences) such as but not limited to robbery, drug abuse or assault; or
11. Declared or undeclared war or any act thereof; or
12. Any injury or sickness for which compensation is payable under any government law or any other health insurance policy except to the extent that such charges are not reimbursed by such laws or other policies; or
13. Unless otherwise covered by hospital benefits, rental or purchase of prosthetic appliances such as but not limited to hearing aids, artificial limbs, glasses or corset.

In addition, medical services provided by doctors, specialists, physiotherapists, chiropractors and Chinese medicine practitioners through "Related Healthcare Facility(ies)" shall be excluded from the policy. "Related Healthcare Facility" shall mean a healthcare facility which the owner, insured and/or beneficiary (if any) owns 10% or more of the ownership interest or is a director thereof, or is a partner thereof (in the case of partnership), or is an employee thereof.

For the latest list of exclusions for **AxtraCare**, please refer to the policy provision.

Notes

1. Subject to the terms and conditions of the policy for hospital benefits and clinical benefits, benefits and full cover shall only be payable provided that the insured shall comply with all of the following applicable requirements:
   a. Hospital confinement, treatment, consultation, surgical procedure, supplies or other medical services under hospital benefits must be performed by a network doctor or a network specialist, and carried out at a network hospital where the insured is confined according to the benefit level or below as specified in the benefit schedule; and/or
   b. Day case surgery payable under hospital benefits must be performed by a network doctor or a network specialist, and carried out in a network hospital or network healthcare facility; and/or
   c. Treatment, consultation, or medical services (including cost of medicine) under clinical benefits must be performed by a network doctor, a network specialist, a network physiotherapist or a network Chinese medicine practitioner, and carried out in a network healthcare facility. For the avoidance of doubt, a co-payment may be required subject to reimbursement % and/or maximum benefit(s) and/or overall maximum of relevant benefits as specified in the benefit schedule; and/or
   d. X-ray and lab tests, advanced diagnostic imaging and physiotherapy by a physiotherapist or treatment by chiropractor under hospital benefits must be referred in writing by a network doctor or network specialist. X -ray and lab tests under clinical benefits must be referred in writing by a network doctor or network specialist and carried out in a network healthcare facility.
   e. The applicable pre-approval and subsequent approval requirements as specified in the policy provision must be complied with; and the medical expenses must be settled by the AXA eHealth Card or AXA letter of guarantee which must be presented to the network hospital or network healthcare facility (as the case may be) upon registration.

   If any of the applicable requirements stated above is not fulfilled, the insured will not be entitled to any benefit. For further details on full cover and the applicable requirements, please refer to the policy provision.

2. The directory of the network is subject to change from time to time at AXA's sole discretion without prior notice. Please login to Emma by AXA or other channels made available by AXA or call AXA Customer Care Hotline for the latest list. Any change shall be deemed as effective on the date of publication irrespective of whether any separate notice is given.

3. Network service providers (including network healthcare facility, network hospital, network doctor, network specialist, network physiotherapist or network Chinese medicine practitioner) are independent third parties and are not agents of AXA. AXA shall (i) not be held responsible for or liable to the policyholder or any of the insureds for anything in relation to any services provided by any of the network service providers; and (ii) not have any obligation or liability whatsoever in relation to any services provided by any of network service providers, and shall not be responsible for or liable to any act or failure to act on the part of any of the network service providers. AXA reserves the right to amend the terms and conditions in relation to the services of the network service providers from time to time without prior notice.

4. The giving of pre-approval and subsequent approval from the Company shall not be deemed as admission of AXA's liability to pay and/ or reimburse the policyholder and/ or the insured under the policy or a waiver of any breach of the terms and conditions of the policy, if any.

5. Cashless arrangement shall mean "AXA Credit Facility" in the policy provisions, please refer to the policy provisions for its definition. Cashless arrangement up to the pre-approval limit shall be available provided that the insured shall comply with all of the applicable requirements as stated in note 1 above, with the exception that for:
   a. Pre-hospitalisation doctor's visits and post-hospitalisation doctor's visits under hospital benefits; and
   b. any medical services from non-network service provider arising out of the context of an emergency under hospital benefits; and
   c. any medical services from by a specialist from public hospital under the administration of the Hospital Authority in Hong Kong or non-network Hospital in Hong Kong incurred during hospital confinement or day case surgery under hospital benefits when there is no relevant specialist available in network for treating the insured's disability, cashless arrangement will not be available. For further details on cashless arrangement, please refer to the policy provisions.

6. The provision of services is subject to the AXA Emergency Assistance terms and conditions, including China Health Network. Service is provided by a third-party service provider. The Company and the third party service provider reserves the right to amend the terms and conditions thereof from time to time without prior notice. The service provider is independent third parties and is not agents of the Company. The Company shall not have any obligation or liability whatsoever in relation to the service provider, and shall not be responsible for any services so provided or any act or failure to act on the part of the third-party service provider.

7. The following conditions apply for the issue and use of AXA eHealth Card:
   a. In the event that the Insured Person leaves the Policyholder's employment, or if the Policy is terminated / lapsed for any reason, the eHealth Card will not be available or active on or after the termination date;
   b. The eHealth Card will cease to be accessible immediately upon the termination of the policy and that no further use or access will be permitted beyond this date.
   c. The Policyholder accepts full responsibility for controlling the use of the eHealth Card and, if relevant, shall deduct any shortfall from the Insured Person's payroll and repay the same to the Company; and
   d. The Company has the right to suspend the usage of eHealth Card in case of any:
      i. unpaid premium payment in the Policy after the expiration of the grace period; and
      ii. outstanding shortfall in the Policy.

Notes:

- Unless otherwise specified, all ages mentioned in this product brochure refer to the age of the insured on his or her last birthday.

AxtraCare Employee Benefits Insurance Package Plan is underwritten by AXA General Insurance Hong Kong Limited ("AXA", the "Company", or "we").

How do I make a claim or enquire about claims?

Simply contact our 24-hour customer service representatives at (852) 2519 1166 or email us at employee.benefits@axa.com.hk for claim submission detail or claims related enquiries. We will provide a response within 2 working days.

The plan is subject to the terms, conditions and exclusions of the relevant policy provisions. AXA reserves the final right to approve any application. This product brochure contains general information only and does not constitute any contract between any parties and AXA. It is not a policy. For detailed terms, conditions and exclusions of the plan, please refer to the relevant policy provisions, which will be made available by the Company upon request.

ABOUT AXA HONG KONG AND MACAU

AXA Hong Kong and Macau is a member of the AXA Group, a leading global insurer with presence in 50 markets and serving 95 million customers worldwide. Our purpose is to act for human progress by protecting what matters.

As one of the most diversified insurers in Hong Kong, we offer integrated solutions across Life, Health and General Insurance. We are the largest General Insurance provider and a major Health and Employee Benefits provider. Our aim is to not only be the insurer to provide comprehensive protection to our customers, but also a holistic partner to the individuals, businesses and community we serve. At the core of our service commitment is continuous product & service innovation and customer experience enrichment, which is achieved through actively listening to our customers' needs and leveraging and investing in technology and digital transformation.

We embrace our responsibility to be a driving force against climate change and a force for good to create shared value for our community. We are proud to be the first to address the importance of mental health through different products and services and thought leading iconic research. Our overall Sustainability Strategy, with emphasis on climate strategy and biodiversity commitment, is developed based on TCFD recommendations. We are committed to integrating environmental, social and governance factors across our business and strive to contribute to a sustainable future through 3 distinct roles - as an investor, an insurer and an exemplary company.

AxtraCare Employee Benefits Insurance Package Plan Product brochure

March 2026

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