QBE Group Medical Prestige

Plans specially tailored for SME

Introducing QBE Group Medical Prestige

Behind the success of most organisations is a dedicated, productive and efficient workforce. Thus, it is very important to provide good employee benefits to encourage healthy staff retention and create a supportive culture.

QBE Group Medical Prestige is specifically designed to provide your company with affordable medical insurance and your staff comprehensive healthcare protection. Simply put, QBE helps protect your interests against the unexpected while you focus on growing your business.

The product

Why QBE Group Medical Prestige?

- Wide range of Room and Board options – including six variations of ward types from Private to Restructured hospitals.
- Comprehensive coverage – basic Hospital and Surgery includes kidney dialysis, cancer treatment and supplementary Major Medical benefits.
- Pre-existing conditions covered – after a 12-month waiting period, pre-existing conditions will be covered, with some exceptions due to underwriting decisions.
- Minimal eligibility requirements – you can enrol and start coverage with 5 employees in your company.
- Simple and cost-effective Plan – premiums are fixed and based on age-bands, enabling you to manage your budget upon enrolment, plus selecting covers is simple and straightforward.
- Lowering premiums – you can also opt for deductibles to reduce the premium by as much as 30%.
- Wide choice of covers – riders can be included into your main inpatient coverage.
- Dependant coverage – there is an option to include spouses and children into the coverage.
- 24-hour comprehensive worldwide cover.

To qualify, companies must meet the following criteria:

- Group size – minimum of 5 to maximum 50 employees
- Core benefit – minimum compulsory cover under this Policy is the Group Basic Hospital and Surgical Benefit.
- Eligibility of employees – compulsory cover for ALL your full-time active at work employees OR employees under a pre-defined catergory.
- Eligibility of employees' dependants – compulsory cover for eligible dependants of ALL employees or employees of the pre-defined category.
- Age limits for adults – the maximum entry age is 70 and renewable until the age of 80, subject to compulsory health declaration upon age 70.
- Age limit for children – entry age is 15 days to 18 years old, or up to 25 years old as long as the child is a full-time student at a recognised education institution.
- Residence – for Insured persons who reside or travel to any country outside Singapore for more than 90 days during the policy period, there is no cover unless QBE has been informed and additional premium (if any) has been paid.
- Occupational class – any job involving heavy hazards and a dangerous occupation is subject to underwriting approval, for example: operators of agricultural machinery, electrical engineers, professional athletes, onboard vessel operators, or any job involving explosives, the military or another similar occupation.

Choose your coverage (currency in SGD)

Group H&S Benefit

BENEFITS/PLANS	PLAN 1	PLAN 2	PLAN 3
HOSPITAL TYPE		ALL HOSPITALS	
Room & Board (R&B)	4 bedded	2 bedded	1 bedded
Intensive Care Unit (ICU)	3x R&B	3x R&B	3x R&B
Surgery Charges	As charged		
Theatre Fee			
Anaesthetist Fee			
Misc Services			
Specialist Consultation			
Post Hospitalisation Treatment			
Ambulance Fee			
In Hospital Physician Visits			
Overall Maximum Limit	25,000	30,000	35,000
Emergency Dental Treatment	500	600	800
Emergency Outpatient Treatment	2,000	2,300	2,500
Special Grant	10,000	10,000	10,000
Organ Transplant	15,000	18,000	22,000
Miscarriage	1,000	1,000	1,000
Kidney Dialysis & Chemotherapy/Radiotherapy (Limit per policy year) 20% – Coinsurance for Treatment in Singapore 50% – Coinsurance for Treatment Overseas	10,000	15,000	20,000
Medical Report Fee	100	100	100
Supplementary Major Medical 20% – Coinsurance	60,000	80,000	100,000

Subjected to per disability per confinement (except for Kidney Dialysis & Chemotherapy/Radiotherapy – per policy year).

Supplementary Major Medical pays if eligible expenses in excess of the Group Basic H&S Benefit.

Admission to higher ward or hospital that differs from plan entitlement. If the insured member is admitted to a ward or hospital higher than what he/she is entitled to under the policy, we will pay 60% of the eligible medical expenses subject to the maximum limit stated in the policy schedule.

1-bedder is applicable only for Standard Rooms.

Expenses incurred overseas will be based on the equivalent Room & Board charges in Singapore General Hospital.

Outpatient GP Panel Benefit

BENEFITS (1 VISIT PER DAY)	PLAN 1	PLAN 2
Panel GP Clinics (Covers Basic Diagnostic Tests)	As Charged	As Charged
Panel TCM (Covers Consultation Fees only)	As Charged	As Charged
Non-Panel GP Clinics (Covers Basic Diagnostic Tests)#	30	30
Non-Panel GP Clinics Overseas (Covers Basic Diagnostic Tests)#	25	25
Polyclinics	As Charged	As Charged
Accident & Emergency#	100	100
Co-payment (SGD)	Nil	5
Annual Limit	3,000	1,500

Outpatient Specialist Benefit

BENEFITS/PLANS (REFERRAL BY PANEL GP REQUIRED)	PLAN 1	PLAN 2
Specialist Consultation (Limit per policy year)	1,000	500
Includes Diagnostic Tests (X-Ray and Laboratory Tests), MRI/CT/PET Scans	Yes	Yes

Dental Benefit

BENEFITS/PLANS		DE5	DE7	DE10
D1*	Basic Treatments	600	750	1000
D2*	Gum Treatments	150	150	200
D3*	Preventive Treatments (2 visit)	50	75	75
D4	Complex Treatments	300	375	500
D5	Dentures	700	900	1000
D6	Restorative Treatments	300	375	500
	Annual Overall Limit	1800	2250	3000

Notes:
Minimum group size of 5 Members (excluding Dependents) is applicable for all riders.
Co-payment applicable to items indicated with #
All employees and eligible dependants will have to take up the same plan.
Dental benefit for minimum age of 3 and maximum 65.
* Only benefits D1, D2, D3 are subject to 20% deductible on each claim payable.

Annual premium rates (to add prevailing GST to total premium)

Group H&S Benefit

	ALL HOSPITALS		
	ANNUAL PREMIUM PER EMPLOYEE/SPOUSE		
AVERAGE AGE OF EMPLOYEES	PLAN 1	PLAN 2	PLAN 3
0-25	247	423	481
26-30	260	445	507
31-35	281	481	550
36-40	306	523	597
41-45	329	562	644
46-50	459	780	896
51-55	566	969	1,105
56-60	704	1,203	1,373
61-65	917	1,568	1,792
66-70	1,222	2,091	2,390
71-72	1,681	2,876	3,286

30% discount applicable for Government/Restructured Hospital option.

	SINGAPORE GOVERNMENT/ RESTRUCTURED HOSPITALS		
	ANNUAL PREMIUM PER EMPLOYEE/SPOUSE		
AVERAGE AGE OF EMPLOYEES	PLAN 4	PLAN 5	PLAN 6
0-25	172	296	337
26-30	182	312	355
31-35	197	336	385
36-40	214	366	418
41-45	230	393	450
46-50	321	546	627
51-55	396	678	774
56-60	493	842	961
61-65	642	1,097	1,254
66-70	855	1,463	1,673
71-72	1,176	2,013	2,300

Premium per child is 60% of the employee's (parental relationship) premium.

Deductible option for group basic H&S benefit (exclude rider)

DEDUCTIBLE	PLAN 1	PLAN 2	PLAN 3	PLAN 4	PLAN 5
S$500	-15%	-10%	-10%	-10%	-10%
S$1,000	-30%	-25%	-20%	-20%	-15%

Outpatient GP panel and specialist benefit (rider to group basic medical)

BENEFITS/PLANS	PLAN 1	PLAN 2
Outpatient GP Panel* (Minimum group size of 5)	372	300
Outpatient Specialist* (Minimum group size of 5)	276	168

* Maximum coverage age is up to age 65.

Dental benefit (rider to group basic medical)

AVERAGE AGE OF GROUP/PLANS	DE5	DE7	DE10
Age 3 to 65	171	271	339

The Total Distribution Cost of this product is between 15% to 20% of the premium. Such costs include cash payments in the form of commission, costs of benefits and services paid to the distribution channel. We assure you the Total Distribution Cost is not an additional cost to you, as it was already accounted in the calculation of your premium.

Description of cover

Group basic H&S benefits

Room and Board – Reimburses the daily charges for room and board accommodation, general nursing services and meals for each day of hospital confinement as a registered bed-paying patient in a hospital for up to a maximum of 120 days.

Intensive Care Unit – Reimburses charges for an intensive care unit, provided it is certified medically necessary by the attending physician or surgeon, up to the daily maximum as per schedule for a period not exceeding 30 days (inclusive in the maximum 120 days under Room and Board benefit).

Surgery Charges, Theatre Fee and Anaesthetist Fee – Reimburses fees charged by the surgeon including Anaesthetist fee and Theatre fee for the operation up to Overall Maximum Limit. This includes all normal post-surgical care up to 90 days after operation. Surgeon fees shall also include fees charged by a second physician or surgeon who may be consulted prior to hospitalisation of the insured for a surgical operation.

Miscellaneous Services – Reimburses charges for pre-hospitalisation diagnostic tests within 90 days preceding confinement and when pertaining to the disability on account of which confinement was required and for charges incurred during a hospital confinement for medically necessary hospital supplies and services. This includes prescribed medicines, dressing, rental of appliances, implants, treatment fees, therapy fees, laboratory fees, X-rays, blood transfusions, oxygen and its administration.

Specialist Consultation Fees – Reimburses consultation fees charged by a specialist in connection with a disability requiring confinement in a hospital within 90 days provided such consultation has been recommended in writing by the attending physician.

Post-Hospitalisation Treatment – Reimburses expenses incurred for follow-up treatment by the same physician up to a period of 90 days immediately following a discharge.

Ambulance Fee – Reimburses charges made by a hospital or organisation providing ambulance services for transporting the Insured to a hospital when medically necessary.

In-hospital physician's visit – Reimburses fees charged by a physician for visiting a bed-paying patient up to maximum 120 days.

Emergency Dental Treatment – Reimburses expenses incurred as a result of an accidental injury occurring to wholly sound natural teeth, provided treatment takes place within 60 days of the accident causing the injury and in a legally registered dental clinic or hospital.

Emergency Outpatient Treatment – Reimburses expenses incurred as a result of an accidental injury for treatment as an outpatient at any registered clinic or hospital within 60 days of the accident causing the injury. If the injury is treated by a registered Chinese bone-setter, charges up to maximum of S$250 are covered.

Special Grant – Pay the policyholder or legal representative, the stated sum in the event of death of the Insured person in connection with a claim resulting from:

a) an injury.
b) a sickness during or after treatment for such sickness at the hospital or in a day surgery ward.

Organ Transplant – Reimburses the cost of surgery for the transplantation of kidneys, lungs, heart, liver, bone marrow or corneas. This does not cover the costs relating to the acquisition of organs or expenses incurred by donor.

Miscarriage – Reimburses the expenses incurred for miscarriage and ectopic pregnancy. Termination of pregnancy requested by insured person will not be payable.

Outpatient Kidney Dialysis and Cancer Treatment Benefit – Reimburses charges for kidney dialysis at a registered dialysis centre or unit and cancer treatment (chemotherapy and radiotherapy) at an outpatient department of a hospital or registered cancer treatment centre on recommendation of a registered medical practitioner.

Medical Report Fee – Reimburses the cost of obtaining any medical report required by QBE up to the amount stated in the Policy Schedule. This benefit is payable together with any other benefit.

Supplementary Major Medical Benefit – The Supplementary Major Medical Benefits pays eighty percent (80%) of the aggregate of the total Covered Eligible Expenses incurred in excess of the benefits payable under the Room & Board, ICU and As-Charged benefits under the Policy per Disability subject to the Maximum Hospitalization Limit as per benefit schedule.

Group outpatient benefits
This benefit is available for minimum group size of 5 Members (excluding Dependents) and above.

a) Panel of Appointed Physicians/Clinics
If the Insured receives consultation at our Panel of Appointed Physicians, then the consultation, treatment and medicine prescribed will be on cash-free basis except if there is a co-payment or capping imposed. The maximum amount payable shall not exceed the daily maximum indicated in the Benefits Table.

Non-Panel Appointed Physicians/Clinics
If the Insured receives consultation from any Physicians who are not in the QBE's Panel of Appointed Physicians, QBE will repay the reasonable and customary charges for the consultation, treatment and medicine prescribed up to the daily maximum limit as stated in the Benefit Table.

b) Polyclinic GP Consultation and Medication
If the Insured receives consultation at Polyclinics then the consultation, treatment and medicine prescribed will be reimbursed up to the overall annual limit as stated in the Benefits Table. Consultation, treatment and medicine prescribed will be on reimbursement and subject to any co-payment imposed.

c) Limits for Specialist Outpatient
The maximum benefit amounts and the deductible (if any) as shown in the Benefits Table are for each Insured in one Policy Year.

d) Panel of TCM Clinics
If the Insured receives consultation at our Panel of Appointed Physicians, then the consultation (treatment/medicines are not covered) will be on cash-free basis. The maximum amount payable will not exceed the maximum limit indicated in the Benefits Table.

e) Emergency Treatment at A&E
If the Insured receives treatment at A&E departments of registered Hospitals in Singapore, the treatment will be reimbursed up to the number of visits per policy year as specified, regardless of doctor referral or on volunteer basis.

GP benefit claims procedure
Panel of appointed physicians

i) Download appointed medical app for E-Card and clinic locator. Present E-Card and NRIC for outpatient panel visits.

ii) Complete the Clinic Utilisation Form at point of Registration. You will be asked to provide the following information:

- Dependant's Name, NRIC Number and Date of Birth
- Time in
- Sign the Form

iii) Payment is required, if due to co-payment, surcharges or exceeding the coverage limit, to the Clinic. GST imposed on the co-payment, surcharges or exceeding the coverage limit will be payable by the insured.

Dental benefit
The amount payable will not exceed the actual cost of medically necessary services provided by a dentist and the maximum liability of the company will not exceed the limit of cover less any deductible for the account of the insured.

D1. Basic Treatments – Reimburses charges for basic treatments, which will include X-rays required prior to the performance of dental services; treatment of abscesses, anterior or amalgam fillings, gold pins for cusp restoration, extractions; and root canal filling up to the maximum per policy year.

D2. Gum Treatments – Reimburses charges for gum treatments, including curettage up to the coverage limits.

D3. Preventive Treatments – Reimburses charges for scaling, polishing and prophylaxis up to a maximum of two visits per policy year.

D4. Complex Treatments – Reimburses charges for complex treatments, which include periodontal surgery, apicectomy (molars and premolars), and the surgical extraction of wisdom teeth up to a maximum per tooth.

D5. Dentures – Reimburses charges for dentures required due to loss of sound natural teeth, previously covered under this Policy up to the maximum per set.

D6. Restorative Treatments – Reimburses charges for restorative treatments to sound natural teeth, which include gold inlays, capping, crowns and bridges in plastic or porcelain fused to gold up to a maximum per tooth.

Major policy conditions

Age Limits – For Insured whose entry age is 70 years old and below, cover will be renewable until the Insured reaches the age of 80, subject to compulsory health declaration upon age 70. The benefit limit for Insured Person age 75 Years and above will be automatically reduced to 50% of the original sum insured.

Cover for children commences from the age of 15 days to 18 years old, or up to the age of 25 years as long as the child is registered as a full-time student at a recognised educational institute.

Cancellation – Policyholder may cancel the policy at any time by notifying QBE by issuing an official letter, specifying the effective date of cancellation of the said policy. Provided no claims have been paid or are payable under the said policy, the policyholder will be entitled to a refund of any premium paid by him/her after the deduction of a proportionate part of the policy year for which the policy has been inforce, less administration charges based on short rate table.

Eligibility – All full time employees will be eligible to join the plan.

If an employee is not actively at work on the date he/she would otherwise be eligible in accordance with the above, the eligibility date will be deferred to the first working day of active employment.

If a dependant is confined to a hospital on the date he/she is eligible for the coverage under this plan, the eligibility date will be deferred to the date the dependant is discharged from hospital.

Late Notification – New employees and dependants (if applicable) must make applications to the company within 30 days of the eligibility date the Insurer may, at its discretion, accept late applications, subject to satisfactory evidence of health.

Other Insurance – The Plan will indemnify on a proportionate basis if the application has any other insurance in force for the same injury, sickness, disease or illness.

Pre-existing condition – A condition existing before the date the Insured is covered under this plan and for which the Insured:

(A) received treatment during the preceding three years and
(B) showed symptoms of the condition or is reasonably aware of the condition.

Non-guaranteed premium – Premium payable for this cover is not guaranteed and may be adjusted on the policy renewal date, at the discretion of the company.

Reasonable and Customary charges – Benefits payable are limited to reasonable and customary charges for the treatment provided and to the limits of the covered plan.

Premium and Payment Warranty – The plan is subjected to a premium payment warranty clause, which requires the premium due to be paid in full within 60 days from inception date of the coverage or the effective date of each endorsement – failing which QBE will not be liable under the policy.

Where terms of the policy cannot be finalised by the 21st day from the commencement of the policy due to the absence of or inadequate policy information, QBE will proceed to issue a provisional policy based on expiring terms or terms quoted.

The plan applied for had not been in whole or in part terminated by another insurer due to non-payment of the premium in the last 12 months.

Policy exclusions

1. Pre-existing conditions and specified illnesses will be covered under the Policy for the Insured, who is a GROUP MEMBER, provided the Insured has been covered continuously for 12 months under this Policy.

2. Known congenital or neo-natal physical abnormalities developing within six months of birth.

3. Specified illnesses including hypertension or cardiovascular disease, cataracts, all internal tumours/cysts/nodules/polyps of any kind, breast lumps, haemorrhoid and endometriosis during the first year of an insured person's cover.

4. Treatment pertaining to sexually transmitted diseases or AIDS.

5. Preventive treatment or medicines and routine examinations and health checks.

6. Cosmetic treatments, eyeglasses or refraction and hearing aids except as necessitated by injuries.

7. Treatment for obesity, weight reduction or improvement regardless of whether caused directly or indirectly by a medical condition; study and treatment of sleep apnoea.

8. Services provided by hospitals that are non-medical in nature.

9. Dental treatments except as necessitated by injuries to sound natural teeth (unless the dental benefit has been included in the Policy).

10. Psychotic, mental or nervous disorders.

11. Care or treatment covered under a Workman's Compensation Insurance Contract.

12. Pregnancy (except ectopic pregnancy), childbirth, abortion, pre-natal or post natal care and surgical, mechanical or chemical contraceptive methods of birth control or any resulting complication or treatment/tests pertaining to varicocele, infertility or impotency.

13. Treatment that arises from or is any way attributed to sex reassignment.

14. Experimental drugs and chemotherapeutic agents not of proven value.

15. Asbestos, in whatever form or quality, whether causes, contributed or aggravated by asbestos directly or indirectly.

16. Professional fees charged by a member of the Insured's immediate family or by a person normally residing in the household of the Insured or under his/her employment.

Outpatient GP and Specialist
We will not pay for charges for the following:

1. Any surcharge incurred due to visits outside the normal operating hours of the clinic.

2. More than one outpatient visit per day.

3. Prescription of drugs obtained without consultation.

4. Chiropractic treatment and any type of therapy including physiotherapy.

5. Kidney dialysis and cancer treatment.

6. Routine physical examinations, health check-ups or any other tests where there is no objective indication of impairment of normal health or any treatment of a preventive nature including vaccinations, acupuncture, or any treatment which is not medically necessary.

7. Treatment arising from any geriatric, psycho geriatric or psychiatric conditions.

8. Medical appliances and prosthetic devices.

9. The use or any treatment arising from any drugs not licensed by an official governmental control agency of the country in which the drug is given, or drugs used in any circumstances other than in accordance with their licensed indications as well as drugs not listed in the Singapore Index Medical Supplies (SIMS).

10. Any treatment directed towards development delay and/or learning disabilities in children.

11. Specialised investigations not specified in the Schedule/Benefits Table.

12. Any expenses incurred in relation to psychological, emotional, mental or behavioural conditions.

13. Any expenses incurred in relation to birth control measures, pregnancy, infertility, post-delivery confinement, miscarriage, ligation or abortion.

14. Any expenses incurred in relation to cosmetic nature including but not limited to plastic surgery, acne, skin peeling or treatment for hair loss, and sex change operation.

15. Any expenses incurred in relation to illness or disablement arising from self-inflicted injuries, any unlawful act, misuse of drugs or alcohol.

16. Any expenses incurred in relation to counselling sessions, health food, supplements, weight management, alternative treatments, non-prescribed medication.

17. Any expenses incurred in relation to congenital anomalies, physical defects or hereditary conditions and disorders.

18. Any expenses incurred in relation to illness or disablement arising from venereal disease, HIV infection, AIDS or any illness caused by the misconduct or negligence of the Insured.

19. Any expenses incurred in relation to procurement or use of special braces, equipments, prosthetic devices or appliances including but not limited to spectacles, contact lens or artificial limbs due to medical, surgical, dental or optical reasons.

20. Any expenses, including investigations, incurred in relation to illness and disablement during or in the course of employment which constitutes a valid claim under the Workmen's Compensation Act, Singapore.

Important Note: Please refer to the Policy Contract for the full Terms and Conditions.

Policy Owners' Protection Scheme

This policy is protected under the Policy Owners' Protection Scheme which is administered by the Singapore Deposit Insurance Corporation (SDIC). Coverage for your policy is automatic and no further action is required from you. For more information on the types of benefits that are covered under the scheme as well as the limits of coverage, where applicable, please contact your insurer or visit the GIA/LIA or SDIC websites (www.gia.org.sg or www.lia.org.sg or www.sdic.org.sg).

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