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SBI HEALTH ASSIST (POLICY – B) :: ANNUAL PAYMENT PLAN
FREQUENTLY ASKED QUESTIONS

1. **What is SBI Health Assist (Policy-B)?**

SBI Health Assist (Policy-B) is an Annual Health Plan, which is voluntary, wherein those eligible can get insurance cover every year on payment of the premium from their own sources.

2. **Who are all covered under SBI Health Assist (Policy-B)?**

The policy covers retiree or family pensioner, spouse of retiree and disabled child/ children (if any) as declared to the Bank.

3. **Who are all eligible for Membership in SBI HEALTH Assist (Policy-B)?**

Existing members, all members of SBI REMBS, left out retirees/ spouses of left out retirees & e-AB retirees/ spouses of e-AB retirees (who are not members of IBA Mediclaim Policy), Employees who retire during the year, Spouse of deceased employees.

4. **What is the time-limit to join the policy?**

Employees who retire during the year - Within 90 days from the date of retirement.
Spouse of deceased employees - Within 120 days from the date of death of the employee.

5. **Whether Pro-rata Premium would be applicable in the case of employees who retire during the year/spouse of deceased employees?**

Yes - May join by paying Pro-rata Premium

6. **Who are not eligible to apply for membership?**

Employees who are/ were discharged / dismissed / removed/ compulsorily retired / terminated from service and Officers in whose case Rule 19(3) are/ were invoked on attaining the age of retirement and they are/ were subsequently discharged / dismissed / removed/ compulsorily retired from service.

Note: Those who joined the Health Assist Policy for the year 2023-24 and do not renew their policy in the Policy year 2024-25, **will not be eligible** to apply for membership under Policy Year 2025-26.

7. **What are all the plans covered under the Policy?**

Basic Sum Insured (Rs)	**Super Top-up Sum Insured (Rs)**	**Additional Super Top-up Sum Insured (Rs)**	**Total cover (Rs)**
3.00 lacs	6.00 lacs	11.00 lacs	20.00 lacs
		16.00 lacs	25.00 lacs
5.00 lacs	6.00 lacs	14.00 lacs	25.00 lacs
		19.00 lacs	30.00 lacs

8. **Is there any waiting period?**

Yes - There will be a waiting period of 30 days from the date of their joining or date of inception of policy, whichever is later.

9. **What is Super Top-up Cover?**

Super Top-up cover for Rs. 6.00 lacs will be available to all members as additional health cover along with the Base Plans. **The cost of premium for Super Top-up cover will be borne by the Bank**. Premium amount for Super Top-up cover (including GST) will be debited to member's account and then will again be re-credited in the member's account. This exercise will be done to enable the members to claim tax benefits for the premium amount paid for Super Top-up plan. This activity will be done in batches in the succeeding month of receipt of enrolment data and details of this transaction will also reflect in pension slip.

10. **What are the norms relating Additional Super Top-up Cover?**

a) Additional Super Top-up Cover can be taken only in conjunction with Base Plan and not on standalone basis.

b) Any eligible retiree can opt for Basic sum Insured of Rs. 3.00 lacs or Rs. 5.00 lacs **with or without Additional Super Top-up Cover**.

c) Members who did not apply for Additional Super Top-up Cover in the Policy year 2023-24, will not be eligible to opt for Additional Super Top-up Cover in Policy Year 2024-25 and 2025-26.

d) Those who opt for any of the Additional Super Top-up cover in the Policy year 2023-24 can renew their policy with any options of additional Super Top-up Cover against the Base Plan opted in Policy Year 2024-25.

e) Members who do not renew their Additional Super Top-up Cover in Policy Year 2024-25, will not be eligible to opt for Additional Super Top-up Cover in Policy year 2025-26.

11. **Whether any subsidy is provided by the Bank?**

Yes - 50% subsidy on Base Premium of Rs. 3.00 lacs is available to all Family Pensioners (irrespective of age) and to retires with 70 years of completed age and above on the date of renewal. GST or other taxes / surcharges, if any, on premium will be borne by the member.

Note: Members would be required to make payment of premium in full. After completion of renewal process, member wise list of eligible retirees and Family pensioners will be prepared by Corporate Centre for reimbursement of subsidy to eligible members. Reimbursement of subsidy will be done along with pension of the succeeding month

after receipt of premium for enrolment and it will be included in the pension slip.

12. **What are the coverage provisions in case a member is deceased?**

a) Coverage of deceased member will cease automatically from the date of death.

b) There will be no refund of premium irrespective of a claim having been preferred or not.

c) The cover will be extended to the other eligible family members of the deceased covered in the policy till the end of the policy period so long as the sum insured is not exhausted in Base policy plus Super Top-up plus additional covers (if any).

13. **Whether Critical Illness Cover is available?**

Yes- The policy covers **Critical Illness for14 (Fourteen) ailments** for a Sum Insured of Rs. 5.00 lacs.

14. **What are the terms and conditions for Critical Illness Cover?**

- The cover for Critical Illness Plan is optional in nature and can be opted only inconjunction with Base Plan and not separately on standalone basis.

- Members should have completed age below 65 years, to opt for Critical Illness Plan. Those who are already the members of Critical Illness Plan in the policy year can continue to renew their Critical Illness Plan even beyond the age of 65 years.

- Pre-existing diseases will not be covered.

- If the member or eligible dependents of his/her family is diagnosed with any of the 14 listed ailments and he/she survives

for 30 days after first detection of the disease, the whole amount under the critical illness plan will become admissible.

- The critical illness cover is available to the entire family (Retiree/ Family pensioner and other eligible dependents) on floater basis.

- The Insurance company shall pay the insured person only once in respect of any one of the covered illnesses under the policy. The critical illness cover ceases after admission of any claim of the member and no further claim are admissible under the said cover during the policy year.

15. **What is e-Pharmacy Scheme?**

a) e-Pharmacy scheme was launched with an objective of allowing members for online purchase of medicines as a domiciliary facility up to Rs. 18,000/- (with member's contribution up to Rs. 6,000/- and Bank's contribution up to Rs. 12,000/-) during the policy year.

b) Members can purchase medicine even beyond Rs. 18,000/- during the policy year from their own sources and discount will continue to be available to them as per the agreed arrangement with e-Pharmacy.

c) Members joining midway during the policy year are eligible for pro-rata amount of 'self' and 'Bank's' contribution based on residual period of their joining the policy.

16. **What is the Claim Procedure?**

a) All Policy Holders should opt for cashless treatment from the Network Hospitals of TPA (Third Party Administrator).

b) In Case of Planned Hospitalization, the insured can obtain pre-authorization from TPA, 4 days in advance. This shall enable

him to just walk in with the authorization to the hospital for hassle-free admission.

c) Some Hospitals may ask for Security Deposit at the time of admission. Care has to be taken that Deposit amount is adjusted at the time of final discharge.

d) In cases of Reimbursement, all claim documents in ORIGINAL need to be submitted to the pension paying branch OR to the serving TPA Desk at the AOs.

e) The Insured should also furnish the original of latest cancelled cheque or the Pension Paying Branch, attested photo copy of Aadhaar Card, PAN card along with all the original documents.

17. **What is the Time period for claim Intimation and submission of claim documents?**

a) The communication regarding hospitalization must be given within 7 days from the time of hospitalization or before discharge whichever is earlier.

b) Claim documents must be submitted within 30 days of date of discharge.

c) Post hospitalization claims to be submitted within 30 days of the completion of treatment or within 30 days after post hospitalization period of 90 days, whichever is earlier.

Note: In no case, the time period for submission of documents should exceed 3 months from the date of discharge or completion of treatment or completion of 90 days of post hospitalization period, whichever is applicable.

18. **Whether Pre & Post hospitalisation expenses are admissible?**

Yes – Pre-hospitalization expenses admissible for 30 days and post-hospitalisation expenses for 90 days subject to maximum of actual expenses or 10% of Base Sum insured for each Hospitalization whichever is less.

19. **Whether Day Care expenses are admissible?**

Yes–For specific treatments/investigations. **Please note that Day Care expenses are not admissible if treatment is taken on O.P.D. Basis.**

20. **Whether pre-existing Diseases/Ailments are covered?**

Yes – All Pre-existing diseases and ailments are covered under the scheme.

21. **Whether Alternative Treatment is covered?**

Yes – Reimbursement of Expenses for Hospitalisation & Domiciliary Treatment (Applicable for SBI Health Care Policy Members) under the recognised system of medicines viz., Ayurvedic, Unani, Siddha, Homeopathy is covered provided such treatment is taken in a Hospital / Nursing Home / Clinic registered with the Central/State Government.

IMPORTANT NOTE

Expenses incurred on Platelet Rich Plasma Therapy are not reimbursable.