GROUP MEDICLAIM POLICIES FOR SBI RETIREES
CLARIFICATIONS

1	Who can apply for Policy-A? Whether any form is required to be submitted for becoming member of Policy-A?

Clarification:

- **No individual retiree can apply for Policy-A.**
- **This policy is meant for the existing members of REMBS only.**
- **The existing members of REMBS will be shifted to Policy-A on 01.04.2016 automatically.**
- **There is no need to submit any application or option for Policy-A.**

2	Whether existing members of REMBS having balance in their REMBS Account can join Policy-B ?

Clarification:

Existing members of REMBS can concurrently join Policy-B, irrespective of balance in their REMBS accounts (this has been clarified vide e-Circular No. CDO/P&HRD-PPFG/84/2015-16 dated 08.01.2016).

3	Where a member of REMBS wants an additional cover under Policy 'B' also, whether such people should exercise their option before 31.03.2016 or anytime thereafter.

Clarification:

- **Existing members of REMBS can join Policy-B concurrently, irrespective of balance in their REMBS accounts.**

- **However, they can also join the Policy-B at a later date when the balance in their REMBS account is fully exhausted by paying the full annual premium (provision for joining Policy-B by paying pro-rata premium is applicable to new retirees only).**

4	Is Policy 'A' which is being offered in place of REMBS scheme is on the same lines as that of policy 'B'?

Clarification :

Benefits available under Policy-A and Policy-B are the same. Only difference is the Basic Sum Insured, details of which are as under:

(i) Under Policy-A, all the existing members of SBIREMBS will be covered in the policy with five (5) Basic Annual Sum Insured of Rs. 1 lac, 2 lac, 3 lac, 4 lac and Rs. 5 lac.

(ii) Under Policy-B, there are eight Basic Sum Insured of Rs. 3 lac, 4 lac, 5 lac, 7.50 lac, 10 lac, 15 lac, 20 lac, and Rs. 25 lac.

(iii)Reimbursement of Domiciliary treatment will be based on Basic Sum Insured.

5	In Policy A, the insured sum is Rs. 4 lacs for me, and Rs. 11 lac is available from the buffer, therefore it is subject to conditions, including availability of funds and TPA decision. Isn't that a deterioration of the scheme as it existed when one joined.

Clarification:

- **Under Policy 'A' the residual medical Benefit limit under existing SBIREMBS will always remain fully protected and be met out by the Bank. Corporate Buffer system is an internal arrangement.**

- **While arranging Cashless Treatment at midnight or settling reimbursement claims the TPA will take decision to use the member's portion of Corporate Buffer without referring the same to the Bank or without waiting for advice from the Bank.**

6	In section 6 of the circular, the last bullet point under Example A says that existing retirees will have the option to join a separate group mediclaim policy. Is this the same as Policy B?

Clarification:
Yes, the separate Group Mediclaim policy referred to in the e-Circular is the Policy-B. However, the member of REMBS can become member of Policy-B concurrently. This has been clarified vide e-Circular dated 07.01.2016.

7	Example B shows that when claims are lodged under Policy A, the Corporate Buffer is dipped into first? Is that so? It means the buffer will be used up fast, leaving us with nothing but the insured amount.

Clarification: The correct position is as under:

- **While settling Cashless Treatment / Reimbursement claims basic sum insured will be used first and if the same is found to be inadequate, the amount available to the members from Corporate Buffer will be used.**

- **Benefit of Corporate Buffer will be available to all the members subject to member's remaining balance in the REMBS account.**

- **Under Policy A. the Insurance Company is committed to provide the medical benefits to all the members to the extent of the remaining balance in their REMBS account and the REMB Trust will continue to pay the annual premium for such members till the remaining balance in their REMBS account is fully exhausted, subject to sufficiency of the corpus.**

8	The scheme says that no claim will be rejected without approval by a committee. But the more usual response by the Insurance Companies is not rejection, but arbitrary and heavy reduction of claim amount. Do we have any way of protecting members from that?

Clarification:

- **Claims may be rejected only in the event of misrepresentation, mis-description or non-disclosure of any material fact. In case of rejection of claims it would go through a Committee set up of the Bank [CM (HR) at ZOs], TPA and the concerned Insurance Company unless rejected by the committee in real time the claim should not be rejected.**

- **The TPA is committed to settle claims, keeping in mind the Standard Exclusions as per IRDA guidelines.**

9	Under REMBS the diseases covered are far less than what is under Policy (B). if Policy 'B' is also taken concurrently and the claim is for the disease which is not covered under REMBS or Policy 'A', but is covered by policy 'B' , can the claim be lodged under policy B?

Clarification:

- **When all the existing members of SBIREMBS will be shifted to Policy-A (i,e. on 01.04.2016), the restriction of 20 diseases eligible for hospitalization under REMBS will go automatically.**

- **For getting treatment / reimbursement under Policy-A, date of hospitalization / prescription should be after the commencement of policy i,e. on or after 01.04.2016.**

- **Existing members of REMBS who join Policy-B will have the choice to get treatment / reimbursement from either of the two policies.**

10	Claim under Policy B can be lodged only after the balance available under REMBS or Policy 'A' gets exhausted. However, this anomaly may get clarified after the Bank specifies terms of Policy 'A'.

Clarification:

- **Existing members of REMBS who join Policy-B will have the choice to get treatment / reimbursement from either of the two policies.**

- **For getting treatment / reimbursement from either of the two policies, date of hospitalization / prescription should be after the commencement of policy or the date of joining the policy, whichever is later.**

11	Is there any age limit for dependent disabled child to be covered under the policy ?
Clarification: No.	
12	If both the parents of a dependent disabled child have died, can the disabled child still have cover, if premium is being paid?
Clarification: Yes	
13	Are there any caps on amount of claim for various diseases?
Clarification: ➢ **For Hospitalization under both the policies : there is no cap.** ➢ **For reimbursement of Domiciliary Treatment for 63 listed ailments: there is no cap as of now. However, some cap may be put to ensure viability of the scheme and to avoid abnormal loading on premium at renewal.**	
14	What do you mean by "non-disclosure" in para – xi on page 10 as reason for rejection of claim ,since there is no column for its declaration on the application form for joining the group policy B ?
Clarification: ➢ **'Non-disclosure of material facts' is the standard phrase for any mediclaim policy.** ➢ **All pre-existing diseases are covered under both the policies. There is no need for any disclosure of pre existing diseases.**	
15	The discount or loading of the premium is on the individual claim basis or the total premium paid on the policy? If the loading is on the total premium paid, the retirees who have not claimed also will have to pay higher premium on renewal, which is unfair. Hence the loading / discount should be on the individual claim basis.
Clarification: ➢ **Both the policies 'A' & 'B' are Group Mediclaim Policies. The discount or loading will be on total claims settled over the total premium paid by the group during the currency of the policy.** ➢ **Therefore, there is no question of loading / discount on the individual claim ratio.**	
16	On what basis the discount / loading is calculated? Is it on the premium paid or on sum insured?
Clarification: **Discount / loading will be calculated on the basis of claim ratio (Total claim settled divided by total premium paid by the group).**	

17	If a retiree incurs expenditure on a foreign soil during his / her temporary visit, whether the claim would be entertained under policy A / B?
Clarification: **Overseas Medical Treatments will not be covered under both the policies.**	
18	Insurance premium in Policy 'B' is far higher than Policy 'A'. (For 7 lacs in policy 'A' it is Rs. 9926/- whereas in Policy 'B' for Rs. 7 lacs it is Rs. 12677/-). People who retire after 01.01.2016 will have to pay for higher premium.
Clarification: ➢ **Annual Premium is fixed on Basic Sum Insured.** ➢ **Under policy 'A' there is no Basic Sum Insured of Rs. 7 lacs.** ➢ **To cover REMBS limit of Rs. 7 lacs there will be Basic sum insured of Rs. 3 lac and Rs. 4 lac from Corporate Buffer.** ➢ **Domiciliary treatment benefits will be decided on Basic Sum Insured only.** ➢ **Under Policy 'B' there is no Corporate Buffer and the entire amount of Rs. 7 lac will be the sum insured on which domiciliary treatment will be decided.** ➢ **That is why premium under Policy 'B' for Rs. 7 lacs appears to be higher than that under Policy 'A'**	
19	For long duration ailments under domiciliary treatment the validity of the prescription should be 1 year instead of 30 days.
Clarification: ➢ **The existing provision is the same as that of IBA approved Mediclaim Policy for employees of PSBs.** ➢ **Stipulation is as per IRDA guidelines.**	
20	Both the policies will cover dental root canal surgery for a limit of Rs. 7500/-. This should also include other dental treatments like extraction, filling and capping of the tooth etc.
Clarification: **As per IRDA prescribed Standard Exclusion clause, Dental treatment or surgery of any kind which are done in a dental clinic and those that are cosmetic in nature are excluded.**	
21	The period of 30 days stipulation for submission of claims should be increased to atleast 90 days.
Clarification: ➢ **The existing provision is the same as that of IBA approved Mediclaim Policy for employees of PSBs.** ➢ **Stipulation is as per IRDA guidelines.**	

22	Both the policies provide that the member shall submit all original documents like bills, receipts, prescriptions etc. for getting reimbursement of claims. In stray and many complicated cases the originals are required by the patients for further follow-up/post operative care and continued treatment. In such cases members may be permitted to retain the original documents and submit attested copies thereof.

Clarification:

- **In such extreme cases, members should submit the original documents as well as scanned copy of the same to the TPA and place a request (at the time of submission) that after the settlement of claims the originals may be returned for the above purposes.**

- **The TPA will arrange for returning the originals after settlement of the claims in such cases.**