SBI general INSURANCE
SURAKSHA AUR BHAROSA DONO

COVERAGES FAQ

What is covered in Group Mediclaim Policy

• Sum Insured – Rs. 2Lacs per student

• Room, Board & Nursing Charges – At Actuals

• Medical Practitioner and specialists Fees

• Anesthesia, Blood, Oxygen, Operation Theatre charges, Surgical Appliances, Medicines & Drugs, Diagnostic Materials and X-ray, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, prosthesis/ internal implants and any medical expenses incurred which is integral part of the operation

• Pre-hospitalisation Expenses – 30 days

• Post-hospitalisation Expenses – 60 days

• Day Care Expenses

• HIV/AIDS Cover

• Mental Illness Cover

• Genetic Disorders or Diseases

• Internal Congenital Diseases

• Advance Procedures covered wherever Medically Indicated either as in patient or as part of daycare treatment in a hospital up to 50% of Sum Insured for Robotic Surgeries

What are the major Exclusions in Group Mediclaim Policy

• Admission primarily for investigation & evaluation

• Admission primarily for rest Cure, rehabilitation and respite care

• Expenses related to the surgical treatment of obesity that do not fulfill certain conditions

• Change-of-Gender treatments

• Expenses for cosmetic or plastic surgery

• Expenses related to any treatment necessitated due to participation in hazardous or adventure sports

What is covered in Group Personal Accident Policy

- • This policy covers sudden, unforeseen and unexpected event caused by external, violent and visible means and resulting in physical bodily injury.
- • Policy Covered Only students of the institute on Named Basis.
- • 24 Hours World Wide Cover .

Scope of Coverages

- • Sum Insured – Rs. 2Lacs per student
- • Accidental Death
- • Permanent Total Disablement
- • Permanent Partial Disablement
- • Age Limit – Minimum 18 years and maximum 35 years.
- • Terrorism covered for all however terrorism activity arising out of Nuclear, Biological and/or Chemical means is excluded from scope of this policy

Exclusions

- • Suicide, attempted suicide (whether sane or insane) or intentionally self-inflicted injury or illness, or sexually transmitted conditions, mental or nervous disorder, anxiety, stress or depression.
- • Being use/abuse of drugs, alcohol, or other intoxicants or hallucinogens unless properly prescribed by a physician and taken as prescribed;
- • Participation in an actual or attempted felony, riot, crime, misdemeanour, or civil commotion
- • Exposures Pertains to Adventures Sports are Excluded

CLAIMS FAQ

Q 1: What is a TPA?
• "TPA" means a Third Party Administrator who is licensed by the IRDAI, for the purpose of providing services to the “Health Insurance – Policyholders” under an agreement with an insurance company.

Q 2: If there is a change in name of the policyholder, will it affect the policy?
• If there are any alterations in the name, it is to be intimated to your respective insurance company. Endorsement for the change in name needs to be passed by insurance company. This has to be done on priority.

Q 3: How can I get my E-card?
• Insured can download E cards from: https://www.paramounttpa.com/Home/InstantEcard.aspx

Q 4: What is the definition of the hospital with regards to the health insurance policies?
• Hospital means any institution established for in-patient care and day care treatment of illness and/ or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under Schedule of Section 56(1) of the said Act, OR complies with all minimum criteria as under:
1. has qualified nursing staff under its employment round the clock
2. has at least 10 inpatient beds, in those towns having a population of less than 10,00,000 and 15 inpatient beds in all other places;
3. has qualified medical practitioner (s) in charge round the clock;
4. has a fully equipped operation theatre of its own where surgical procedures are carried out
5. Maintains daily records of patients and will make these accessible to the Insurance Company’s authorized personnel.

Hospital shall not include an establishment which is a rest home or convalescent home for the addicted, detoxification centre, sanatorium, home for the aged, mentally disturbed, remodeling clinic or similar institution

Q 5: What is a Network Hospital?
• A Hospital, which has an agreement with a TPA for providing Cashless treatment, is referred to as a 'Network Hospital'. Cashless facility is provided ONLY at the network hospitals. Cash less facility cannot be extended to non Network Hospitals. Please, refer to Network Hospital Section of our Website for updated List. Link https://www.paramounttpa.com/Home/ProviderNetwork.aspx

Q 6: What are the different ways to claim the expenses under the policy?
Expenses can be claimed on cashless or reimbursement basis. **Cashless**: It can be availed only at network hospitals of Paramount Health Services and Insurance TPA Private Limited (Paramount) to the amount of pre-authorisation sanctioned. **Reimbursement**: It is a claim where the member pays all the expenses related to the hospitalization and submits the claim to Paramount for reimbursement of expenses.

Q 7: What is the coverage of a mediclaim policy?
• In general, the Policy covers reimbursement of Hospital / Nursing Home expenses incurred by the insured as an inpatient for treatment of any disease or bodily injury through an accident. The expense incurred in the policy period, covered up to a maximum of the sum insured in aggregate are: Room, Boarding Expenses as provided by the Hospital / Nursing Home, Nursing Expenses, Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialists fees. Anesthesia, Blood, Oxygen, OT Charges, Surgical appliances, Medicine and Drugs, Diagnostic Materials and X-Ray, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, Artificial

Q 8 : What is the procedure for availing cashless facility?
The following procedure should be followed to avail cashless benefits in network hospital:
1. Intimate Paramount about hospitalization via - Toll free number / Website / Mobile App
2. Present your Paramount ID Card along with Photo ID proof at the admission counter of the hospital. In absence of physical ID card, you can log in to Paramount portal and print an instant E-card.
3. Ensure that the hospital sends pre-authorisation request form to Paramount.
4. Paramount sends the approval to the hospital. Enhancement approvals may be sent based on policy terms and conditions.
5. After discharge, hospital will send all original documents to Paramount for the cashless claim.
6. In case the request is denied, you will have to settle full hospital bill and subsequently submit a reimbursement claim to Paramount. (Note: Denial of pre-authorization request must not be construed as denial of treatment or denial of coverage.)

Q 9 : If I avail the cashless facility, will the insurance company pay the entire bill at the hospital?
• No, certain items of the bill will have to be borne by the insured if it consists of the non-payable amounts that are listed by the insurer. (Link to non-payable items Non Payable List). Also, if there is any Co-payment or Capping applicable in the policy, then these charges will be borne by the insured. [ADDENDUM: There is no Co-Pay or Capping of room-rent in our policy]

Q 10: What happens in case of an Emergency hospitalization where Cashless facility is not authorized to me?
• The liability for paying to the hospital will be on the insured. You would have to submit the claim documents to Paramount as mentioned in the checklist for reimbursement (Claim Document Checklist) The Insurance Company will then reimburse the admissible amount to you as per the terms & conditions of the policy.

Q 11: Where should the claim be intimated/submitted, the Insurance company or Paramount?
• The claim should be intimated / submitted preferably with Paramount.

Q 12 : If I have not utilized my permissible eligibility amount in a particular policy period will it get carried forward to the next policy period?
• The amount will not be carried forward to subsequent periods.

Q 13: Whether intimation is necessary for every hospitalization?
• Yes, every hospitalization has to be intimated to the insurance company on its occurrence immediately within 24 hrs or before the timeline mentioned in your policy. Claim intimation means you inform insurance company about your claim, but it does not necessarily mean that your claim will be approved and paid.

Q 14: How do I intimate & submit a reimbursement claim?
1. Immediately intimate Paramount about the claim via Call / email / mobile app / website,
2. Submit the original documents to Paramount within 7 days from the date of discharge or before the eligible submission period mentioned in the policy.

Paramount team processes the claim and sends it to your insurance company. If approved, payment is done through NEFT and if rejected, rejection letter is sent to you by insurance company.

Q 15: What should I do, if I am not able to submit the claim documents within the eligible submission period?
• You may submit the claim documents as per the checklist along with a letter mentioning the reason for delayed submission. These documents will be sent to insurer delay condonation.

Q 16: What are the documents required to be submitted to Paramount for a reimbursement claim?

• Documents that you need to submit for reimbursement claim are:

1. Original completely filled & signed IRDA Claim form
2. Covering letter stating Schedule of Expenses
3. Copy of the PHS ID card or current policy copy and previous years' policy copies (if any)
4. Original Discharge Card/ Summary
5. Original hospital final bill
6. Original numbered receipts for payments made to the hospital
7. Complete detailed breakup of the hospital bill
8. Original bills for investigations done with the respective investigation reports and films
9. Original bills for medicines supported by relevant prescriptions
10. NEFT details of the proposer.
11. Valid Photo Id proof
12. KYC document(details)

You may also refer to Claim Document Checklist. You are advised to keep photo copy of the entire set of claim documents submitted to us.

Q 17: How to send reimbursement claims to Paramount?

• Reimbursement claims can be submitted to us through registered post / courier or handed over at any of our branch offices.

Q 18: What are "Non Admissible Expenses / Non Payable Expenses"?

• Your health insurance policy pays for reasonable and necessary medical expenditure. There are several items that do not classify as medical expenses during hospitalization. These items will not be payable and expenditure towards such items will have to be borne by you. Non Admissible Expenses / Non Payable Expenses are listed in this link for your reference: Non Payable List.

Q 19 : Can I claim medical expenses incurred before and after the hospitalization?

• Yes, you can claim medical expenses incurred 30 days before and 60 days to 90 days after hospitalization (as specified in your policy), provided they are related to the ailment / accident for which you were hospitalized. Such expenses are termed as **pre and post hospitalization**.

Q 20: Can I claim my dentist's bills?

• Usually, it is not covered as per terms and conditions of policy unless arising out of accidental injury.

Q 21: Will medical costs be reimbursed from day one of the insurance cover?

• Typically, there is a waiting period of 30 days, within which the insured cannot claim for any hospitalization expenses except accidental claims. This waiting period may vary from insurer to insurer. [ADDENDUM: There is no waiting period for our policy.]

Q 22: Are there any limitations for claiming under health insurance policy?

• There is no limit to the number of claims per policy period but there is a limit to the amount that you can claim in a year. Usually, the maximum amount that you can claim in a year is limited to the sum insured.

Q 23: Is there any waiting period applicable for ailments under the policy?

• Yes. There is 30 days waiting period for all ailments except accident on the inception of the fresh policy. Pre-existing diseases & certain aliments will have a waiting period from 1 to 4 years depending upon the policy terms and conditions. Refer your policy document for complete list and waiting period. [ADDENDUM: There is no waiting period for our policy.]

Q 24: If I have a health insurance policy in Mumbai, can I make a claim if I am transferred to Delhi?
• Yes, your health insurance policy is valid all over the country. (Some policies have zone wise limitations)

Q 25: Are all the diagnostic tests prescribed by the doctor at a hospital reimbursed under the Health Insurance Plan?
• Expenses incurred at a hospital or a nursing home for diagnostic purposes such as X-rays, blood analysis, ECG, etc. will be reimbursed if they are related to the ailment for which the policy-holder has been hospitalized.

Q 26: If I do not get admitted in a network hospital, am I still eligible to claim the expenses?
• Yes, claims will be reimbursed even if insured is not treated in a network hospital. The hospital should fall under the definition as described in Q4.

Q 27: Is there a minimum time limit for stay within the hospital under the health insurance plan?
• Typically, the insured can claim if he/she is hospitalized for more than 24 hours. However, for certain treatments, such as dialysis, chemotherapy, eye surgery etc. the stay could be less than 24 hours which is treated as day care. (Refer your policy document for complete list of day care procedures)

Q 28: What happens when the limit of insurance is exhausted under a Health Insurance Policy?
• If the insurance limit i.e. the sum insured is exhausted in a particular year, the insurer is not liable to bear/reimburse the insured for any further expenses.
•
• **Q 29 . Who will receive the claim amount if the insured dies at the time of treatment?**
• The claim amount is paid to the registered nominee of the insured mentioned on the policy copy. [ADDENDUM: In case of death of insured member, the immediate family person will become a nominee subject to provide the no objection from other family members on Rs. 100/- stamp paper.]

Q 30 : What is Co-pay?
• Co-pay is the percentage applied on admissible amount which the policy-holder has to bear, as per policy terms and conditions.
[ADDENDUM: There is no Co-pay in our policy.]

Q 31: What is the time limit to submit pre-authorization request to Paramount?
• In case of an emergency or unplanned admission, the hospital must send the pre-authorization request to Paramount within 24 hours from the time of admission. In case of a planned hospitalization, it is prudent to send the pre-authorization request to Paramount at least 72 hours prior to the admission date. This will ensure a hassle-free cashless admission procedure for you at the hospital. Cashless Email Id: al.request@paramounttpa.com

Q 32: When can a claim be rejected?
• The claims are processed as per the Policy Terms, Conditions & Exclusions. A claim may be rejected if it falls under the exclusions mentioned in the policy or due to non- compliance with the policy conditions or discrepancy in the submitted documents.

Q 33: What is Deficiency Letter?
• This is a letter sent for requirement of additional information / non submitted documents to conclude the coverage of claim submitted by insured. These documents should be sent within 7 days from the notification of insufficient documentation. Insured can submit these documents to the nearest Paramount branch.

Q 34: What are the incremental / proportionate charges?

- If there is a sub-limit on rooms and the policyholder occupies a room with a tariff that's more than what he is eligible for, the proportionate deduction on 'associated medical expenses' are the incremental charges which the insured has to pay.

ADDENDUM

1. Please save the following contacts on your mobile. They are your points of contact with the insurance and should be contacted in case of hospitalisation:

(i) Anup Bhat, Contact No: 7028942541, Email ID - anup.bhat@paramounttpa.com

(ii) Siddhartha Shah, Contact No 7410010172, Email ID - siddhartha.shah@paramounttpa.com

(iii) Rajendra Kumbhar, Contact No 9371455858, Email ID - rajendra.kumbhar@paramounttpa.com

2. Please download the app mW!SE developed by the TPA Paramount Health Services. Use your Roll Number and the Group Code **IISR** to log in. From this app you can download your E-healthcard, get the list of network hospitals near you, see the procedure for filing claims at non-network hospitals etc. Your E-healthcards have also been emailed to you.

3. Each student is covered by the health insurance upto Rs 2Lakh. Please get in touch with the TPA points of contact listed in (1) for details.

4. Each student is covered by an Accident insurance policy upto Rs 2Lakh. This is a benefit based cover for accidental death or permanent disability due to an accident and the hospital must file the case as a medico-legal case.

5. All treatment at a Network Hospital is cashless. The TPA must be intimated by sending email/ contacting the numbers given in Point 1. You must carry your E-healthcard and some Government Photo ID (PAN, Aadhaar etc not IISER ID). See attached file for details.

The following hospitals around campus are currently network hospitals (Please check latest list from the app mentioned above)

- Ruby Hall Clinic, Pune
- Deenanath Mangeshkar Hospital, Pune
- Jupiter Hospital, Baner
- Jehangir Hospital, Pune
- Sahyadri Hospitals, Pune
- Aditya Birla Hospital, Thergaon, Pimpri-Chinchwad
- Medipoint Hospital, Pune
- Global Hospital, Pune

The following hospitals around campus are NOT network hospitals:

- AIMS Hospital, Aundh
- Sai Shree Hospital, Pune

6. Treatment at non-network hospitals is on reimbursement basis. For documents that need to be submitted to Paramount and for procedure for reimbursement please see details in attached file. An agent from Paramount will visit IISER Campus once a week to collect claim documents. Please coordinate with Dipali Dalvi for this.

7. Further details were given in the interaction session with SBI. To see a recording of this session go to:

https://youtu.be/LvdGzjo-r0M