Group Hospitalization and Surgical Expense Benefit

Frequently Asked Questions (FAQs)

1. What are the features of Group Hospitalization and Surgical Expense Benefit?

Group Hospitalization and Surgical Expense Benefit (GHSEB) provides coverage for treatment of both emergency and non–emergency cases. If availed within the Sun Life Grepa Health partner hospitals, there is no need for cashout if the aggregate incurred covered expenses is within the maximum coverage limit.

2. Who is eligible to enroll in GHSEB?

All SBF Members who are:

a. currently hold or have previously held a loan with SB Finance;
b. 18 to 64 years old; and
c. in good health and Actively-At-Work.

3. What does Actively-At-Work mean?

Actively-At-Work means individual is actively performing the normal chores of life.

4. What are the available GHSEB products for SBF Members?

We have two options for SBF Members.

Option 1. Group Hospitalization and Surgical Expense Benefit (50,000 MBL)
Pays the charges when an insured individual comes to the hospital for hospitalization treatment, up to the maximum benefit limit. Any and all charges incurred after order for admission has been given will no longer be payable.

Option 2. Group Hospitalization and Surgical Expense Benefit (10,000 MBL)
Pays the charges when an insured individual comes to the hospital for hospitalization treatment, up to the maximum benefit limit. Any and all charges incurred after order for admission has been given will no longer be payable.

5. What are the coverages under GHSEB?

a. Room and Board

Pays for the charges for the number of days (maximum of 31 days) the insured individual is confined in the hospital, subject to maximum benefit limit as defined below (see item no. 7).

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b. Special Hospital Services

Pays for the charges made by the hospital in connection with the hospital confinement of any one continuous period of Sickness and Injury, and which include the following:

- Routine laboratory tests, x-rays and similar necessary diagnostic services;
- Drug, medicines and other medications prescribed and taken during hospital confinement only;
- Whole blood and human blood products transfusions and intravenous fluids, including blood screening and cross matching;
- Oxygen and its administration;
- Anesthesia and its administration
- Dressing, types of casts (plaster of paris) and sutures;
- Admission Kit & ID tag for Option 2 only);
- Registration/Admission Fee;
- Use of operating rooms/theatre& recovery
- Indicated use of ICU, CCU, and other special units;
- Emergency room fees;
- Allergy Testing/Screening (up to Php 2,500 per year); and
- Casting Materials (up to Php 5,000 per year).

Emergency Cases

Pays the charges when an insured individual comes to a hospital's emergency room for immediate treatment but will not lead to hospital confinement.

The emergency cases covered are limited to the following:

- Loss of consciousness (syncope/heart problems/seizure disorder);
- Accident body injury that will not lead to hospital confinement (fractures that need immediate operation/casting/broken bones, dislocated joints or other injuries that immobilize the patient);
- Open wounds that need immediate suturing and treatment (deep lacerations and cuts, and 2nd degree burn);
- Difficulty in breathing (extreme asthma attacks/heart problems);
- Vomiting with danger of dehydration (diarrhea/acute gastroenteritis);
- Animal bites within 24 hours after the time of accident (dog/cat/rate/snake bites); and
- Poisoning or suspected poisoning.

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Diagnostic Procedures

Pays for the charges made by the hospital for the following diagnostic procedures in connection with the hospital confinement of any one continuous period of sickness or injury.

- 24- Hour Holter Monitoring;
- 2D Echo with Doppler;
- Adrenocortical Function (e.g. Primary Aldosteronism, Cushing's Disease);
- Anti-Nuclear antibody (ANA), C-Reactive protein (Rheumatic and its complications), Lupus cell exam;
- Bone Densitometry Scan (Dexascan);
- CT Scan;
- Electrocardiogram (ECG);
- Electromyography/Nerve Conduction Studies;
- Fluorescein Angiogram;
- Genetic Immunologic Studies;
- Magnetic Resonance Imaging (MRI);
- Mammography (Breast Cancer) and Sonomammography;
- Myelogram;
- Neuroscan;
- Orthopedic Arthroscopy;
- Plasma Urinary Cortisol, Plasma Aldosterone;
- Pulmonary Perfusion Scan;
- Sleep Study;
- Stereotactic Brain Biopsy;
- Thallium Scintigraphy;
- Treadmill Stress test, and
- X-Ray (Conventional/Digital).

c. Surgical Benefits

d. Anesthesiologist's Fee

e. Physician's Visit

f. Specialist's Fee

g. Ambulance Fee

NOTE: *The benefits indicated herein are just product highlights and are subject to the terms, definitions and exclusions indicated in the policy contract. In case of discrepancy, the provisions of the policy contract will prevail.*

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6. What are the benefit amounts that can be availed of?

Here are the benefit amounts that are available for SBF Members.

Schedule of Benefits	Benefit A	Benefit B
Maximum Benefit Limit (MBL)	50,000	10,000
Room and Board per day, max of 31 days	2,500	1,000
Special Hospital Services	As Charged	As Charged
Surgical Benefits		
Anesthesiologist's Fee, 50% of Surgical Benefits		
Physician's Visit per day max of 31 days		
Specialist's Fee per day max of 7 days		
Ambulance Fee	2,500.00	2,500.00

7. What is meant by Maximum Benefit Limit (MBL)?

The Maximum Benefit Limit means the highest amount of benefit available to the insured individual within the coverage period under the policy.

8. Are pre-existing conditions covered by GHSEB?

No benefit will be payable within one (1) year from the effective date or reinstatement of the insured individual's benefit if consultation and procedures are due to any pre-existing conditions unless the insured individual is free of medical advice or treatment for three (3) consecutive months immediately preceding the day of first consultation or procedures for which the claim is being made.

Once the pre-existing condition is covered, such condition will be treated as covered sickness already, unless the insured individual's benefit has lapsed.

Pre-existing condition refers to injury or sickness which existed or was existing, or where the insured individual had knowledge, signs or symptoms of the injury or sickness, or where medical advice or treatment or any laboratory test or investigation showed the presence of the injury or sickness, within two (2) years prior to the effective date or date of last reinstatement of the insured individual's benefit, whichever is later.

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9. How long is the coverage term of GHSEB?

One (1) Year.

10. What does restoration period mean?

In any policy year, the schedule of benefits and MBL will be restored/reset 45 days from date of discharge from last hospital confinement for insured individual. The insured individual must have fully recovered from their sickness or injury after 45 days.

a. Restoration of Benefits applies only to recoverable illness. (e.g dengue, viral illnesses, and accidents)
b. Restoration of Benefits does not apply to irrecoverable illness. (e.g diabetes, hypertension, and heart ailments)

- Repeat confinement for DIFFERENT recoverable illness within 45 days from date of discharge > considered as new confinement, reset to zero (max of 31 days)
- Confinement for DIFFERENT and SAME recoverable illness after 45 days from date of discharge > considered as new confinement, reset to zero (max of 31 days)
- Repeat confinement for SAME recoverable illness within 45 days from date of discharge > treated as continuation of 31-day max period

c. In this scenario, the restoration of benefits would not apply, and both confinements would be considered as one continuous confinement. This is because the subsequent confinement is due to a complication directly related to the initial diagnosis.

- Initial confinement: Member is diagnosed with diabetes.
- Subsequent confinement: Member is confined again within 30 days due to kidney complications related to diabetes.

The restoration period does not apply to chronic diseases . <Refer to list>

11. Does the product cover out-patient treatment?

No. GHSEB does not cover out-patient treatment except for emergency cases under item 5b.

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12. What are the implications if an insured individual's actual hospital bill exceeds the MBL?

The insured individual pays for the amount in excess of the MBL. To avoid this situation, it is recommended to opt for higher coverage level.

13. Can an insured individual with an existing HMO plan still utilize GHSEB?

The insured individual can still avail of GHSEB to supplement his existing HMO. See below sample scenarios.

Scenario 1:

Hospital expense: Php 20,000
SBF Member has an existing HMO with Php 20,000 coverage
SBF Member has GHSEB with MBL of Php 10,000

Hospital expense: Php 20,000
Less: HMO: Php 20,000
Balance: Php 0
No need to use GHSEB.

Scenario 2:

Hospital expense: Php 20,000
SBF Member has an existing HMO with Php 10,000 coverage
SBF Member has GHSEB with MBL of Php 10,000

Hospital expense: Php 20,000
Less: HMO: Php 10,000
GHSEB: Php 10,000
Balance: Php 0

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14. How can the premium be paid?

The premium through SB Finance Official Bank Account:

- Bank Name: [Insert Bank Name]
- Account Name: SB Finance, Inc.
- Account Number: [Insert Account Number]
- Amount: PHPXXX [depending on your chosen benefit].

15. Where can the SBF Member check the status of his enrollment and verify if he can already avail of the benefits?

The SBF Member may contact the following:

SB Finance's Customer Service Hotline at (02) 8887-9188 from 8:30am to 5:30pm Mondays to Fridays.

Email Address: zuki@sbfinance.com.ph.

16. When will my coverage start?

The coverage starts upon successful payment of premium.

The Proof of Cover is to be sent to the email address of the insured individual. Additionally, a network card will be sent to the billing address within 30 working days upon receipt of the enrollment file from SB Finance on the 10th day of the current month covering previous month's transactions. The member may present this card at the hospital to avail of the benefit, and If network card is still unavailable and member needs to avail of the benefit (see item no. 18).

17. When will the coverage end?

The coverage will end at the earliest of any of the following:

- The date the policy terminates;
- The end of the coverage period; or
- The end of the coverage period following insured individual's attainment of age 65; or
- The day the maximum benefit limit is used up.

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18. How to avail of the benefits?

The insured individual should present his network card to the accredited hospital of Sun Life Grepa.

If the insured individual does not have his network card yet, he may contact the following 24/7 Client Care Hotline:

- Phone: (02) 8 88-SLGFI (75434) / 0917-8459524 / 0998-5932754
- Email SLGFIContactCenter@sunlifegrepa.com to arrange your hospital admission and your Letter of Admission (LOA).

19. Can the insured individual cancel his coverage after successful enrollment?

No. Cancellation of coverage is not permitted once enrollment has been processed.

20. What are the accredited hospitals of Sun Life Grepa?

Sun Life Grepa has partners with over 413 accredited hospitals nationwide, ensuring you have access to quality healthcare wherever you are. Learn more at https://www.sunlifegrepa.com under Healthcare Providers.

21. Are there any hospitals excluded from the GHSEB

The following hospitals are excluded from GHSEB:

- St. Luke's Medical Center BGC
- St. Luke's Medical Center QC
- Makati Medical Center
- The Medical City
- Asian Hospital & Medical Center

22. Is the insured individual eligible to file a claim for reimbursement if hospitalization is availed of at accredited hospitals of Sun Life Grepa?

Yes. The insured individual can opt to settle the hospitalization expenses at the accredited hospital and file a claim for reimbursement with Sun Life Grepa, subject to the pre-agreed rates.

23. What if the insured individual lost the network card? Is he still eligible to avail of the hospitalization benefit at accredited hospitals of Sun Life Grepa without the network card?

Yes. They can ask the accredited hospital to call the 24/7 Client Care Hotline (see item no. 18).

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Frequently Asked Questions (FAQs)

24. Is the insured individual eligible to file a claim for reimbursement if hospitalization is availed of at non-accredited hospitals of Sun Life Grepa?

Yes. The insured individual can opt to settle the hospitalization expenses at non-accredited hospital and file a claim for reimbursement with Sun Life Grepa, subject to the pre-agreed rates.

25. Are there any exclusions under GHSEB?

Hospital confinement arising from any of the following is not covered:

1. Functional disorders of the mind/psychiatric illness such as but not limited to anxiety and depression;
2. Non-surgical care for tuberculosis/rest cures/PTB medicines;
3. Congenital anomalies;
4. Hospitalization related to medical exam or check-ups not required in connection with the treatment of Sickness or Injury, e.g., sleep apnea test;
5. Examination of the eyes for the glasses;
6. Dental examination, extractions, fillings, and general dental attention;
7. Drug addiction or alcoholism;
8. Treatment for communicable disease in epidemic proportions (to be determined by the Department of Health) requiring isolation or quarantine, e.g., smallpox, severe acute respiratory syndrome and any form of venereal disease;
9. Injuries due to insanity;
10. Injuries resulting from committing or attempting to commit any illegal act;
11. Self-inflicted Injuries whether sane or insane;
12. Special nursing care/physician care;
13. Hospital Related Benefits not in accordance with the diagnosis and treatment of the conditions for which hospital confinement is required;
14. Radium/X-ray/Chemotherapy, radium and isotopes;
15. Plastic surgery for any condition existing on the effective date of this benefit; except if due to accident to restore to normal function;
16. Cosmetic surgery for purposes of beautification except treatment of Injury sustained in an accident while covered;

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17. Any services or supplies for which no payment is required on account of the insured individual receiving them;
18. Circumcision, sex transformation, diagnosis and treatment of fertility or infertility (i.e., IVF), such as oral contraceptives, artificial insemination, sterilization or reversal of such;
19. Injuries due to war (declared or undeclared) insurrection, riots, rebellion, civil commotion or hostile action of armed forces;
20. Injuries due to any aviation or marine activities except while the insured individual is riding as a fare paying passenger in an air or marine device operated by a duly licensed commercial airline or shipping line on a scheduled passenger trip over its established passenger route, or scheduled air service over an established route;
21. Immunizations, (cost of vaccine, allergens and determination of susceptibility);
22. Laser treatment for the purpose of corrective eye refraction;
23. Purchase or lease of durable medical equipment, and oxygen dispensing equipment;
24. Expenses for any kind of the following:
    a. extra bed or pillow;
    b. extra tray or food;
    c. rental of any entertainment equipment or facility, including televisions sets, radios, and audio players;
    d. charges for copies of hospital records;
    e. newspaper;
    f. telephone calls/cellular phone calls/other electronic gadgets/ Wi-Fi (except if free);
    g. acete de mansanilla, efficascent oil, valda pastilles, sebo de macho, soap for skin disease and the like;
    h. other similar charges not related to the direct medical treatment of the patient.
25. Medical or surgical procedures which are experimental in nature or not generally accepted as standard medical treatment by the medical profession, which may include but is not limited to chiropractic services, chelation therapy, herbal treatment and acupuncture;
26. All expenses incurred by the insured individual in the process of organ donation and transplantation, unless the insured individual is the recipient of such donation or transplantation;

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27. Routine physical examinations required in school, insurance and government licensing, physical examination related to pre-employment, visa application and the like; or
28. Expenses in connection with pregnancy resulting in childbirth, miscarriage (abortion) or caesarean section, pre-natal or post-natal care or/and services and supplies performed or prescribed on account of the following complications or pregnancy:

    a. Toxemia of pregnancy
    b. Eclampsia of pregnancy
    c. Extra-uterine pregnancy
    d. Hyperemesia gravidarum
    e. Hydatidiform Mole
    f. Ectopic Pregnancy
    g. Disseminated Intravascular Coagulation (D.I.C.).

26. Are family members of SBF members allowed to avail of GHSEB?

No. Family members cannot avail themselves of GHSEB because they are not members of SB Finance.

27. What number can an SBF Member call if he has additional inquiries not covered by this FAQs?

The SBF Member can contact the following for additional inquiries:

Allan Louise Valentin or Jayzelle Clarish Pangilinan
Department: Affinity Marketing Customer Service
Phone: (02) 8866-6360 to 61

28. What is Teleconsultation?

This is a specially designed Clinic Management Program developed by Grepa Medical and Diagnostic Center (GMDC) exclusively for the Sun Life Grepa Financial Inc. (SLGFI) client, SB Finance.

29. Which clinic facilitates the Teleconsultation?

GMDC, a clinic operated by SLGFI, facilitates this program. The clinic is located at the Mezzanine Tower 2, RCBC Plaza, 6819 Ayala Avenue, Makati City.

30. Who can avail of Teleconsultation?

SBF Members who have availed of the GHSEB.

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31. What is the advantage of Teleconsultation?

Teleconsultation allows the insured individual to access healthcare at the comfort of their home or office.

32. What are the requirements to avail of the Teleconsultation?

The insured individual should have the following:

- Network Card number
- Internet connection
- Mobile phone or desktop computer
- Zoom application
- Email address
- Phone number

33. How many Teleconsultation calls an insured individual is entitled to make?

Up to 10 teleconsultations per year.

34. Is the Teleconsultation provided by GMDC free of charge?

Yes.

35. What is the schedule of Teleconsultation?

Starting Monday to Sunday: 8:00am to 5:00pm.

36. How can the insured individual schedule a Teleconsultation?

The insured individual should call the 24/7 Client Care Hotline (see item no. 18) and provide the following information:

Company/Account Name:
Patient Name:
Network Card Number:
Date of Birth:
Mobile Number:
Email Address:
Reason for Consultation:
Preferred Date & Time for Teleconsultation:

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37. How will the insured individual be notified of their teleconsultation schedule?

The GMDC coordinator will email the details of the schedule and the Zoom link.

38. What steps are involved in initiating the Teleconsultation?

Click the meeting invitation Zoom link. Then enable audio and video.

39. What will happen if the insured individual encounters difficulties accessing the Zoom link?

GMDC coordinator will give a 5-minute grace period for the insured individual to get online. Otherwise, consultation will be cancelled and rescheduled to avoid disrupting the schedule of other teleconsultations in the queue.

40. How will the doctors provide prescriptions, request diagnostic tests or issue medical certificate through Teleconsultation?

The doctor will send the prescription for medicines or diagnostic tests and/or medical certificate through email.

41. What action should an insured individual take upon completion of teleconsultation?

The insured individual should end the Zoom meeting.

42. Is insured individual permitted to cancel his appointment?

Yes.

43. Can an insured individual request to reschedule their appointment if needed?

Yes, request for rescheduling should go through the same process (see item no. 36).

44. Is it possible for an insured individual to request an immediate Teleconsultation appointment?

Yes, as long as the doctor is available.

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Frequently Asked Questions (FAQs)

45. What key terms and conditions should insured individual be aware of when using the Teleconsultation?

- Insured individual requiring immediate medical attention should be taken to a hospital.
- Online consultations follow the first-come, first-served basis policy.
- Each consultation will last for 15 minutes.
- Insured individual must be transparent about their medical history during the teleconsultation.
- Doctor-insured individual confidentiality is respected.

LIST OF CHRONIC DISEASES

CHRONIC DISEASE may have one or more of the following characteristics: they are permanent, or leave residual disability and are caused by nonreversible pathological alteration and require special training of the patient for rehabilitation or may be expected to require a long period of supervision.

LIST OF CHRONIC DISEASES (But not limited to the following)

1. Cerebrovascular disease (cerebrovascular accident or stroke, meningitis, encephalitis, seizure disorder)
2. Cardiovascular disease (ischemic heart disease, cardiomyopathy, heart failure, valvular heart disease,coronary artery disease, myocardial infarction)
3. Poliomyelitis
4. Diabetes Mellitus
5. Malignancies/Cancer
6. Cirrhosis of the Liver/Chronic Liver Failure
7. Hepatitis B
8. Chronic urological/Nephrological disease/Chronic kidney disease/Renal failure
9. Chronic obstructive pulmonary disease
10. Leukemia
11. Chronic osteoartricular diseases (like rheumatoid arthritis or osteoarthritis)
12. Osteoporosis
13. Injuries from accidents
14. Asthma Glaucoma
15. Hypertension/Hyperlipidaemia
16. Hypothyroidism/Hyperthyroidism
17. Multiple sclerosis
18. Bronchiectasis
19. Systemic Lupus Erythematosus
20. Ulcerative Colitis
21. Cystic Fibrosis
22. Guillain-Barre Syndrome
23. Alzheimer's Disease
24. Coma
25. Major Organ Transplant
26. Aplastic Anemia
27. Bacterial Meningitis