THE ORIENTAL INSURANCE COMPANY LIMITED
HEAD OFFICE, NEW DELHI

CIRCULAR

Deptt: Personnel **25.09.2020**

Ref: HO/Pers/Staff GMC policy/2020/41/CR-8367

To: All HO Departments, ROs, OSTC-Faridabad & Chennai

Re: Staff Group Mediclaim Policy w.e.f. 01.04.2020 – Coverages, Exclusions, Terms and Conditions for Modern Treatment procedures and Mental illness

We refer to our circular CR-8336 dated 16.03.2020 regarding Staff Group mediclaim policy 2020-21.

As approved by the Competent Authority, we are now enclosing Annexure-I containing definition, terms and conditions, exclusions, sub-limits, etc. effective from 01.04.2020 in respect of the following, under our Staff Group Mediclaim policy:-

a) Treatment of Mental illness
b) Treatment by modern methods and advanced surgeries like Robotic Surgeries, etc.

All other terms and conditions of Staff Group Mediclaim policy remain unaltered.

This may be brought to the notice of all concerned and a copy of the Circular may be displayed on the Company's Notice Board for their information.

(Girish Joshi)
Chief Manager

Annexure-I

STAFF GMC EFFECTIVE FROM 1.4.2020

COVERAGE,SUB LIMITS,EXCLUSIONS,TERMS AND CONDITIONS PERTAINING TO MODERN TREATMENT METHODS/ADVANCEMENT IN TECHNOLOGIES AND MENTAL ILLNESS, STRESS OR PSYCHOLOGICAL DISORDERS AND NEURODEGENERATIVE DISORDERS

1. COVERAGE & SUBLIMITS:

DETAILS MENTIONED HEREUNDER ARE SPECIFIC TO MODERN TREATMENT MENTHODS/ADVANCEMENT IN TECHNOLOGIES AND MENTAL ILLNESS/ NEURODEGENERATIVE DISORDERS.ALL OTHER TERMS & CONDITIONS ARE AS PER EXPIRING POLICY OR REVISION ADOPTED BY GIPSA, IF ANY.

A. MODERN TREATMENT METHODS/ADVANCEMENT IN TECHNOLOGIES

All the following procedures will be covered in the policy, if treated as In-Patient care or as a part of domiciliary hospitalization or as day care treatment in the hospital, within the sub-limits in the complete policy period which is as defined below:

Sr. No.	Treatment Methods & Advancement in Technology	Sub Limit
A	Uterine Artery Embolization & High Intensity Focused Ultrasound (HIFU)	Upto 20% of Sum Insured subject to a maximum of Rs. 2 Lacs per policy period for claims involving Uterine Artery Embolization & HIFU
B	Balloon Sinuplasty	Upto 10% of Sum Insured subject to a maximum of Rs. 1 Lac per policy period for claims involving Balloon Sinuplasty
C	Deep Brain Stimulation	Upto 50% of Sum Insured per policy period for claims involving Deep Brain Stimulation subject to a maximum of Rs. 10 Lacs
D	Oral Chemotherapy	Upto 20% of Sum Insured subject to a maximum of Rs. 5 Lacs per policy period for claims involving Oral Chemotherapy
E	Immunotherapy- Monoclonal Antibody to be given as injection	Upto 20% of Sum Insured subject to a maximum of Rs. 5 Lacs per policy period
F	Intra vitreal Injections	Upto 10% of Sum Insured subject to a maximum of Rs. 1 Lac per policy period
G	Robotic Surgeries (including Robotic Assisted Surgeries)	Upto 75% of Sum Insured subject to a maximum of Rs. 10 Lacs per policy period for claims involving Robotic Surgeries for (i) the treatment of any disease involving Central Nervous System irrespective of aetiology; (ii) Malignancies Upto 30% of Sum Insured subject to a maximum of Rs. 5 Lacs per policy period for claims involving Robotic Surgeries for other diseases
H	Stereotactic Radio Surgeries	Upto 30% of Sum Insured subject to a maximum of Rs. 5 Lacs per policy period for claims involving Stereotactic Radio Surgeries

I	Bronchial Thermoplasty	Upto 20% of Sum Insured subject to a maximum of Rs. 3 Lacs per policy period for claims involving Bronchial Thermoplasty
J	Vaporisation of the Prostate (Green laser treatment or holmium laser treatment)	Upto 20% of Sum Insured subject to a maximum of Rs. 2 Lacs per policy period
K	Intra Operative Neuro Monitoring (IONM)	Upto 15% of Sum Insured subject to a maximum of Rs. 1 Lacs per policy period for claims involving Intra Operative Neuro Monitoring
L	Stem Cell Therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered only	Upto 50% of Sum Insured per policy period subject to a maximum of Rs. 10 Lacs

B. MENTAL ILLNESS,STRESS OR PSYCHOLOGICAL DISORDERS AND NEURODEGENERATIVE DISORDERS :

Mental Illness Cover

The Company shall indemnify the Hospital or the Insured the Medical Expenses (including Pre and Post Hospitalization Expenses) related to Mental Illnesses, provided the treatment shall be undertaken at a Hospital with a specific department for Mental Illness, under a Medical Practitioner qualified as Psychiatrist (as defined in Definition 7.42) or a professional having a post-graduate degree (Ayurveda) in Mano Vigyan Avum Manas Roga or a post-graduate degree (Homoeopathy) in Psychiatry.

Exclusions

Any kind of Psychological counseling, cognitive/ family/ group/ behavior/ palliative therapy or other kinds of psychotherapy for which Hospitalization is not necessary shall not be covered.

Relevant Definitions are -

Mental Illness means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterized by sub-normality of intelligence.

Psychiatrist means a Medical Practitioner possessing a post-graduate degree or diploma in psychiatry awarded by an university recognized by the University Grants Commission established under the University Grants Commission Act, 1956, or awarded or recognized by the National Board of Examinations and included in the First Schedule to the Indian Medical Council Act, 1956, or recognized by the Medical Council of India, constituted under the Indian Medical Council Act, 1956, and includes, in relation to any State, any medical officer who having regard to his knowledge and experience in psychiatry, has been declared by the Government of that State to be a psychiatrist.

2. EXCLUSIONS:

A. GENERAL EXCLUSIONS:

The company shall not be liable to make any payment under the policy, in respect of any expenses incurred in connection with or in respect of:

I) Investigation & Evaluation – Code –Excl04

a). Expenses related to any admission primarily for diagnostics and evaluation purposes only.

b). Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment.

II) Rest Cure, rehabilitation, and respite care – Code - Excl05

Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

a) Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such a bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

b) Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

III) Obesity/Weight Control: Code- Excl06

Expenses related to the surgical treatment of obesity that does not fulfill all the below conditions:

a) Surgery to be conducted is upon the advice of the Doctor.

b) The surgery /Procedure conducted should be supported by clinical protocols.

c) The member has to be 18 years of age or older and

d) Body Mass Index (BMI):

- greater than or equal to 40 or

- greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failures of less invasive methods of weight loss:

i). Obesity – related cardiomyopathy

ii). Coronary heart diseases

iii). Severe Sleep Apnea.

iv). Uncontrolled Type 2 Diabetes.

IV) Change of Gender Treatments: Code –Excl07

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

V) Cosmetic or Plastic Surgery- Code- Excl08

Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an accident, burns(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical practitioner.

VI) **Hazardous or Adventure sports- Code- Excl09**

Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

VII) **Breach of law – Code –Excl10**

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

VIII) **Excluded Providers- Code –Excl11**

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website /notified to the policy holders are not admissible. However, in case of life-threatening situations following an accident, expenses upto the stage of stabilization is payable but not complete claim.

IX) Treatment for, Alcoholic drug or substance abuse or any addictive condition and consequences thereof. – **Code- Excl12**

X) Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons.- **Code- Excl13**

XI) Dietary supplements and substances that can be purchased without prescription, including but not limited to vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure.-**Code- Excl14**

XII) **Refractive Error- Code- Excl15**

Expenses related to the treatment for correction of eyesight due to refractive error less than 7.5 diopters.

XIII) **Unproven Treatments- Code –Excl16**

Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

XIV) **Sterility and Infertility- Code- Excl17**

Expenses related to sterility and infertility. This includes:

i). Any type of contraception, sterilization.

ii). Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI.

Iii). Gestation Surrogacy.

iv). Reversal of sterilization.

XV) **Maternity- Code- ExcI18**

i). Medical treatment expenses traceable to childbirth (including complicated deliveries and cesarean sections incurred during hospitalization) except ectopic pregnancy.

ii). Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

B. **EXCLUSIONS SPECIFIC TO MENTAL ILLNESS,STRESS OR PSYCHOLOGICAL DISORDERS AND NEURODEGENERATIVE DISORDERS:**

1. Any treatment undertaken as Outpatientis not covered.
2. Any treatment undertaken as domiciliary hospitalization is not covered.
3. Any kind of Psychological counseling, cognitive/ family/ group/ behavior/ palliative therapy, or other kinds of psychotherapy for which hospitalization is not necessary is not covered.
4. Any treatment for mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterized by sub normality of intelligence.
5. Any Treatment for Mental Illness/ disorder/ stress due to alcoholism/ drugs/ substance abuse.

3. CONDITIONS:

It is a condition precedent that the expenses incurred in respect of medically necessary treatment, are reasonable and customary; and in any case the liability of the Company, in respect of one or all the Insured Persons stated in the schedule, shall be upto the limit specified in the Policy and/or schedule of the Policy, but not exceeding the Sum Insured as stated in the schedule, for all claims arising during the Policy Period mentioned in the schedule.

GENERAL TERMS & CONDITIONS

3.1 Disclosure of Information

The Policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, Mis-description or non-disclosure of any material fact.

3.2 Condition Precedent to Admission of Liability

The due observance and fulfillment of the terms and conditions of the policy, by the insured person, shall be a condition precedent to any liability of the Company to make any payment for claim(s) arising under the policy.

3.3 Material Change

The Insured shall notify the Company in writing of any material change in the risk in relation to the declaration made in the proposal form or medical examination report at each Renewal and the Company may, adjust the scope of cover and / or premium, if necessary, accordingly.

3.4 Records to be maintained

The Insured Person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representatives to inspect such records. The Policyholder or Insured Person shall furnish such information as the Company

may require for settlement of any claim under the Policy, within reasonable time limit and within the time limit specified in thePolicy.

3.5 Complete Discharge

Any payment to the Insured Person or his/her nominees or his/her legal representative or to the Hospital/Nursing Home or Assignee, as the case may be, for any benefit under the Policy shall in all cases be a full, valid and an effectual discharge towards payment of claim by the Company to the extent of that amount for the particularclaim

3.6 Notice & Communication

a. Any notice, direction, instruction, or any other communication related to the Policy should be made in writing.
b. Such communication shall be sent to the address of the Company or through any other electronic modes specified in the PolicySchedule.
c. The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in theschedule.

3.7 Physical examination: Any medical practitioner authorised by the company shall be allowed to examine the insured person in case of any alleged injury or disease requiring hospitalisation as and when the same may reasonably be required on behalf of the company.

3.8 Claim procedure

Notification of Claim: In case of a claim, the insured person/insured person's representative shall intimate the TPA (if claim is processed by TPA)/company (if claim is processed by the company) in writing by letter, e-mail, fax providing all relevant information relating to claim including plan of treatment, policy number etc. within the prescribed time limit.

Claim notification in case of cashless facility	**TPA must be informed:**
In case of planned hospitalization	At least 72 hours prior to the insured person's admission to network provider/PPN
In case of emergency hospitalization	Within 24 hours of the insured person's admission to network provider/PPN

Claim notification in case of reimbursement	**Company/TPA must be informed:**
In case of planned hospitalization	At least 72 hours prior to the insured person's admission to hospital
In case of emergency hospitalization	Within 24 hours of the insured person's admission to hospital

3.8.1 Procedure for cashless claims:

1. Treatment may be taken in a network provider/PPN and is subject to preauthorization by the TPA.
2. Cashless request form available with the network provider/PPN and TPA shall be completed and sent to the TPA for authorization.
3. The TPA upon getting cashless request form and related medical information from the insured person/ network provider/PPN will issue pre-authorization letter to the hospital after verification.
4. At the time of discharge, the insured person must verify and sign the discharge papers, pay for non-medical and inadmissible expenses.
5. The TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details.
6. In case of denial of cashless access, the insured person may obtain the treatment as per treating doctor's advice and submit the claim documents to the TPA for reimbursement.

3.8.2 Procedure for reimbursement of claims:

For reimbursement of claims the insured person may submit the necessary documents to TPA/company within the prescribed time limit.

3.8.3 Documents:

The claim is to be supported with the following documents and submitted within the prescribed time limit:

1. Completed claim form
2. Original bills, payment receipts, medical history of the patient recorded, discharge certificate/ summary from the hospital etc.
3. Original cash-memo from the hospital(s)/chemist(s) supported by proper prescription
4. Original payment receipt, investigation test reports etc. supported by the prescription from attending medical practitioner
5. Attending medical practitioner's certificate regarding diagnosis arid bill receipts etc. ,
6. Surgeon's original certificate stating diagnosis and nature of operation performed along with bills/receipts etc.
7. Any other document required by company/TPA

Note: In the event of a claim lodged as per contribution clause of the policy and the original documents having been submitted to the other insurer, the company may accept the documents listed as above and claim settlement advice duly certified by the other insurer subject to satisfaction of the company.

Type of claim	**Time limit for submission of documents to company/TPA**
Reimbursement of hospitalisation and pre hospitalisation expenses	Within 15 days of date of discharge from hospital
Reimbursement of post hospitalisation expenses	Within-15 days from completion of post hospitalisation treatment

3.9 Claim settlement:

1. On receipt of the final document(s) or investigation report (if any), as the case may be, the company shall within a period of 30 days offer a settlement of the claim to the insured person.
2. If the company, for any reasons, decides to reject a claim under the policy, shall

communicate to the insured person in writing and within a period of 30 days from the receipt of the final document(s) or investigation report (if any), as the case may be.

3. Upon acceptance of an offer of settlement as stated above by the insured person, the payment of the amount due shall be made within 7 days from the date of acceptance of the offer by the company.
4. In the cases of delay in the payment, the company shall pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is paid

3.10 Services offered by a TPA

The TPA shall render health care services covered under the policy like issuance of ID cards & guide book, hospitalization & preauthorization services, call centre, acceptance of claim related documents, claim processing and other related services The services offered by a TPA shall not include

1. Claim settlement and rejection with respect to the policy. However, TPA may handle admission of claims and recommend to the company on the settlement of the claim.
2. Any service directly to the insured person or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered with the company.

3.11 Waiver:

Time limit for claim notification and submission of documents may be waived in cases where it is proved to the satisfaction of the company, that the circumstances under which insured person was placed, it was not possible to intimate the claim/submit the documents within the prescribed time limit.

3.12 Payment of claim:

All claims under the policy, shall be payable in Indian currency through NEFT/ RTGS only.

3.13 TerritorialLimit

All medical treatment for the purpose of this insurance will have to be taken in India only.

3.14 Multiple Policies

a. Incase of multiple policies taken by an insured during a period from the same or one or more insurers to indemnify treatment costs, the policy holder shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer if chosen by the policy holder shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosenpolicy.
b. Policyholder having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies, even if the sum insured is not exhausted. Then the Insurer(s) shall independently settle the claim subject to the terms and conditions of thispolicy.
c. If the amount to be claimed exceeds the sum insured under a single policy after, the policy holder shall have the right to choose insurers from whom he/she wants to claim the balance amount.
d. Where an insured has policies from more than one insurer to cover the same risk on indemnity basis, the insured shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the chosen policy.

3.15 Fraud

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy shall beforfeited.

Any amount already paid against claims which are found fraudulent later under this policy shall be repaid by all person(s) named in the policy schedule, who shall be jointly and severally liable for such repayment.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent, with intent to deceive the insurer or to induce the insurer to issue an insurance Policy:—

a. The suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true.
b. The active concealment of a fact by the Insured Person having knowledge or belief of the fact.
c. Any other act fitted to deceive; and
d. Any such act or omission as the law specially declares to befraudulent

The company shall not repudiate the policy on the ground of fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of material fact are within the knowledge of the insurer. Onus of disproving is upon the policyholder, if alive, or beneficiaries.

3.16 Cancellation

The company may at any time cancel the policy (on grounds of fraud, moral hazard or misrepresentation or noncooperation) by sending the insured 30 (thirty) days' notice by registered letter at insured's last known address and in such event the company will not allow any refund.

The insured person may at any time cancel the policy and in such an event the company shall allow refund of premium after charging premium at company's short period rate mentioned below provided no claim occurred up to the date of cancellation.

Period of risk	Rate of premium to be charged
Up to 1month	1/4 of the annual rate
Up to 3 months.	1/2 of the annual rate
Up to 6 months	3/4 of the annual rate
Exceeding 6 months	Full annual rate

3.17 Territorial Jurisdiction

All disputes or differences under or in relation to the interpretation of the terms, conditions, validity, construct, limitations and/or exclusions contained in the Policy shall be determined by the Indian court and according to Indian law.

3.18 Arbitration

a. If any dispute or difference shall arise as to the quantum to be paid by the Policy, (liability being otherwise admitted) such difference shall independently of all other questions, be referred to the decision of a sole arbitrator to be appointed in writing by the parties hereto or if they cannot agree upon a single arbitrator within thirty days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act 1996,as amended by Arbitration and Conciliation (Amendment) Act, 2015 (No. 3 of 2016).
b. It is clearly agreed and understood that no difference or dispute shall be preferable to arbitration as herein before provided if the Company has disputed or not accepted liability under or in respect of thepolicy.
c. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon the policy that award by such arbitrator/arbitrators of the amount of expenses shall be first obtained.

3.19 Disclaimer:

If the company shall disclaim liability to the insured person for any claim hereunder and if the insured person shall not within 12 calendar months from the date of receipt of the notice of such disclaimer notify the company in writing that he does not accept such disclaimer and intends to recover his claim from the company, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

3.20 Migration:

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the company as per extant Guidelines related to Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, as per Guidelines on migration, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as perbelow:

a. The waiting periods specified above shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.
b. Migration benefit will be offered to the extent of sum of previous sum insured and accrued bonus/multiplier benefit (as part of the base sum insured), migration benefit shall not apply to any other additional increased Sum Insured.

For Detailed Guidelines on Migration

https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3987&flag=1

3.21 Renewal of Policy

The policy may be renewed by mutual consent. The company is not bound to give notice that it is due for renewal. Renewal of the policy cannot be denied other than on grounds of fraud, moral hazard, misrepresentation, or noncooperation.

In the event of delay in renewal of the Policy, a grace period of 30 days is allowed. However, no coverage shall be available during the grace period and any disease/Injury contracted during the break period shall not be covered and shall be treated as Pre-existing disease.

If not renewed within Grace Period after due renewal date, the Policy shallterminate.

3.22 Low Claim Ratio Discount (Bonus):

Low claim ratio discount at the following scale will be allowed on the total premium at renewal only depending upon the incurred claims ratio for the entire group insured under the Group Mediclaim Policy for the preceding three completed years excluding the year immediately preceding the date of renewal. Where the Group Mediclaim Policy has not been in force for three completed years, such shorter period of completed years excluding the year immediately preceding the date of renewal will be taken into account.

Incurred Claims ratio under the Group Mediclaim Policy	Discount %
Not exceeding 60%	5
Not exceeding 50%	15
Not exceeding 40%	25
Not exceeding 30%	30
Not exceeding 25%	30

3.23 Withdrawal of product:

In case the policy is withdrawn in future, the company will provide the option to the insured person to switch over to a similar policy at terms and premium applicable to the new policy.

3.24 Revision of terms of the policy including the premium rates:

The company, in future, may revise or modify the terms of the policy including the premium rates based on experience after following the due procedure as laid down by IRDAI. The insured person will be notified three months before the changes are affected.

3.25 Redressal of grievance:

In case of any grievance relating to servicing of the policy, the insured person may submit in writing to the policy issuing office or regional office for redressal. If the grievance remains unaddressed, insured person may contact Customer Relationship Management Dept., ...NAME OF THE INSURANCE COMPANY

If the insured person is not satisfied. the grievance may be referred to "Health Insurance Management Dept.", NAME OF THE INSURANCE COMPANY. The insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance. •

3.26 Add on cover:
Whereas the insured designated in the schedule hereto has by a proposal, dated as stated in the schedule which shall be the basis of this contract and is deemed to be incorporated herein, has applied to NAME OF THE INSURANCE COMPANY (herein after called the company) for the insurance herein after set forth and has paid the premium as consideration for such insurance in respect of the insured person as mentioned in the schedule.

3.26 Maternity Expenses Cover:

Subject otherwise to the terms, definitions, and conditions of the policy, the exclusion 4.7 stands deleted, and subject to the terms, definitions, exclusions, and conditions contained herein, it is hereby understood and agreed that the company shall pay up to the limit, as stated in the schedule with respect of delivery or termination up to first two deliveries or terminations-of pregnancy, during the lifetime of the insured person, if covered under the policy, as described below.

A. Cover:
1. Medical expense for delivery (normal or caesarean).
2. Medical expense for lawful medical termination of pregnancy.
3. Pre-natal and post-natal hospitalisation expenses per delivery or lawful medical termination of pregnancy.

B. Exclusions:
The company shall not be liable to make any payment under the cover in respect of any expenses incurred in connection with or in respect of:
1. Delivery or termination within a waiting period of 9 months. However, the waiting period may be waived only in the case of delivery, miscarriage or abortion induced by accident or other medical emergency.
2. Delivery or termination after first two deliveries or terminations during the lifetime of the insured person.
3. Surrogate or vicarious pregnancy
4. Ectopic pregnancy as it is already covered under base cover
5. Pre and post hospitalisation expenses.

3.27 Condition:

In the event of cancellation of the cover by the insured or the company during the policy period, premium will not be refunded.

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