

GROUP MEDICLAIM INSURANCE

FORMING PART AND PARCEL POLICY NO. _____

1. INSURANCE:

1.1 WHEREAS THE **POLICYHOLDER** designated in the Schedule hereto has by a Proposal and declaration dated as stated in the Schedule which shall be the basis of this Contract and is deemed to be incorporated herein has applied to HDFC Chubb General Insurance Company Limited (hereinafter called the Company) for the insurance hereinafter set forth in respect of the **INSURED PERSONS** and has paid premium as consideration for such Insurance.

1.2 NOW THIS POLICY WITNESSETH that subject to the terms, conditions, exclusions and definitions contained herein, or endorsed or otherwise expressed hereon, the Company undertakes that if during the period stated in the Schedule, or during the continuance of this policy by renewal, any **INSURED PERSON** shall contract any **DISEASE** or sustain any **INJURY** and if such **DISEASE** or **INJURY** shall require any such **INSURED PERSON**, upon the advice of a duly qualified **MEDICAL PRACTITIONER** to incur hospitalisation or **DOMICILIARY HOSPITALISATION EXPENSES** for medical/surgical treatment at any **HOSPITAL** in India as an inpatient, the Company will pay the amount of such expenses as would fall under different heads mentioned below, and as are reasonably and necessarily incurred thereof by or on behalf of such **INSURED PERSON** but not exceeding the sum insured for the person in any one period of insurance as mentioned in the scheduled hereto.

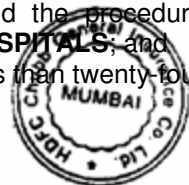
- a) Room, Boarding Expenses as provided by the **HOSPITAL**;
- b) Nursing Expenses;
- c) Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialist Fees;
- d) Anaesthesia, Blood, Oxygen, Operation theatre Charges, Surgical Appliances, Medicines and Drugs, Diagnostic Materials and X-Ray, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, artificial Limbs and similar expenses.

NOTE: The above benefits are available for only for Allopathic Mode of Treatments. The Limit for any other alternative mode of recognised treatment such as Homoeopathy, Ayurvedic and similar other recognised treatments requiring hospitalisation shall be restricted to 20% of the **ANY ONE YEAR LIMIT** subject to a maximum of Rs.25,000.

1.3 Expenses on hospitalisation are admissible only if hospitalisation is for a minimum period of twenty-four (24) hours. However, this time limit will not apply to specific treatments i.e. Dialysis, Chemotherapy, Radiotherapy, Eye Surgery, Dental Surgery, Lithotripsy (Kidney Stone removal), D&C, Tonsillectomy, taken in **HOSPITAL** where **INSURED PERSON** is discharged on the same day. Such treatment will be considered to be taken under Hospitalisation Benefit.

This condition will also not apply in case of stay in **HOSPITAL** of less than twenty-four (24) hours provided:

- a) the treatment is such that it necessitates hospitalisation and the procedure involves specialised infrastructural facilities available only in **HOSPITALS**; and
- b) due to technological advances hospitalisation is required for less than twenty-four (24) hours.



1.4 Any one illness will be deemed to mean continuous period of illness and it includes relapse within 105 days from date of discharge from the **HOSPITAL** where treatment was taken. Occurrence of same illness after a lapse of 105 days as stated above will be considered as fresh illness for the purpose of this policy provided the policy has been renewed with the Company.

1.5 It is further clarified that the Policy shall reimburse only those expenses which are for hospitalisation commencing from a date within the policy period. Even if the hospitalisation spreads beyond the expiry date of the policy, the total benefit will not exceed the sum insured of the policy during which the **INSURED PERSON** was admitted to the **HOSPITAL / NURSING HOME**.

1.6 Pre-Hospitalisation: Relevant medical expenses incurred during period up to thirty (30) days prior to hospitalisation for **DISEASE** or **INJURY** sustained will be considered as part of claim mentioned under item 1.2 above.

1.7 Post Hospitalisation: Relevant medical expenses incurred during period up to sixty (60) days after Hospitalisation for **DISEASE** or **INJURY** sustained will be considered as part of claim as mentioned under item 1.2 above.

1.8 DOMICILIARY HOSPITALISATION EXPENSES means medical treatment for a period exceeding three days for such **DISEASE** or **INJURY** which in the normal course would, require care and treatment at the **HOSPITAL** but actually taken whilst confined at home in India under any of the following circumstances namely

- i). The condition of the **INSURED PERSON** is such that he/she cannot be removed to the **HOSPITAL**; or
- ii) The **INSURED PERSON** cannot be removed to **HOSPITAL** for the lack of accommodation therein;

subject however that **DOMICILIARY HOSPITALISATION EXPENSES** shall not cover:

- i) Expenses incurred for pre and post **HOSPITAL** treatment; and
- ii) Expenses incurred for treatment for any of the following **DISEASES**:
 - 1) Asthma;
 - 2) Bronchitis;
 - 3) Chronic Nephritis and Nephrotic Syndrome;
 - 4) Diarrhoea and all type of Dysenteries including Gastro-enterities;
 - 5) Diabetes Mellitus Insipidus;
 - 6) Epilepsy;
 - 7) Hypertension;
 - 8) Influenza, Cough and cold;
 - 9) All Psychiatric or Psychosomatic Disorders;
 - 10) Pyrexia of unknown origin for less than 10 days;
 - 11) Tonsillitis and Upper Respiratory Tract Infection including Laryngitis and Pharyngitis
 - 12) Arthritis, Gout and Rheumatism

The Annual Limit for **DOMICILIARY HOSPITALISATION EXPENSE** under the policy shall be restricted to 15% of the **ANY ONE YEAR LIMIT** stated in the Annexure of the Schedule subject to the maximum of Rs.50,000/-.

NOTE: The **DOMICILIARY HOSPITALISATION EXPENSE** cover shall be available to treatments taken only under the Allopathic Mode Of Treatment subject to the above conditions.



1.9 **MATERNITY EXPENSES BENEFIT** is an optional benefit available on payment of additional premium. When **MATERNITY EXPENSES BENEFIT** is added in the policy, exclusion 3.14 of the policy stands deleted.

2. DEFINITIONS:

2.1 **ACCIDENT** or **ACCIDENTAL** means a sudden, unforeseen and unexpected event happening by chance.

2.2 **ANY ONE YEAR LIMIT** means Sum Insured which shall be the amount stated in the Policy Schedule as such or limited to the specific insurance details in any Section of this Policy. The **ANY ONE YEAR LIMIT** shall be subject at all times to the terms and conditions of the Policy, including but not limited to the exclusions and any additional limitations and / or **PER OCCURRENCE LIMIT** noted in this Policy and Schedule.

2.3 **DEPENDENT CHILD** means an unmarried dependent child ordinarily residing with the **INSURED PERSON** between the ages of three (3) months and up to and including the age of eighteen (18) years, or up to and including the age of twenty-five (25) years if in full time education at an accredited tertiary institution including legally adopted children and children from a previous marriage, of an **INSURED PERSON** or the **SPOUSE** of an **INSURED PERSON**.

2.4 **DISEASE** means a pathological condition of a part, organ, or system resulting from various causes, such as infection, pathological process, or environmental stress, and characterized by an identifiable group of signs or symptoms.

2.5 **HOSPITAL / NURSING HOME** means an establishment which:

- a) is registered as such with a local authority and is under the supervision of a registered and qualified Medical Practitioner; and operates for the reception, care and treatment of sick ailing or injured persons as in-patients; and
- b) provides organised facilities for diagnosis and medical and surgical treatment at all times; and

is not primarily a day clinic, rest or convalescent home or similar establishment and is not, other than incidentally, a place for the treatment of alcoholics or drug addicts, rehabilitation center;

OR

- a) has a fully equipped operation theatre of its own wherever surgical operations are carried out; and
- b) provides nursing care and has a Physician or a staff of Physicians actually on the premises at all times; and
- c) has at least 10 in-patient beds at all times.

2.6 **INJURY** or **INJURIES** means any physical, external, **ACCIDENTAL** bodily **INJURY** occurring suddenly in time and resulting solely and independently of any other cause or any physical defect or infirmity existing before the Period of Insurance.

2.7 **INSURED PERSON** means anyone over the age of three (3) months and aged sixty five(65) years old or younger, except when the COMPANY, at its sole discretion, accepts anyone over sixty five(65) years old, for whom premium has been paid and who is identified in the



Schedule as an **INSURED PERSON**. **INSURED PERSON** will include any one or more of the following:

- a) Spouse who permanently resides with the **INSURED PERSON**
- b) Dependent Children of an **INSURED PERSON** who
 - Are financially dependent on the **INSURED PERSON**
 - Permanently reside with the **INSURED PERSON**
- c) Dependent Parents of the **INSURED PERSON** not exceeding sixty-five (65) years of age.

2.8 **MATERNITY EXPENSES BENEFIT** means treatment taken in **HOSPITAL** arising from or traceable to pregnancy, childbirth including normal Caesarean section. This is an optional benefit available on payment of additional premium. When **MATERNITY EXPENSES BENEFIT** is opted for in the policy, exclusion 3.14 of the policy stands deleted.

2.9 **MEDICAL PRACTITIONER** means a person currently legally licensed and registered by the Medical Council of the Respective State of India to practice medicine in the jurisdiction of loss. The term **MEDICAL PRACTITIONER** includes qualified physicians, specialists and surgeons other than:

- a) an **INSURED PERSON** under this policy;
- b) an **INSURED PERSON'S** employer or business partner;
- c) an employee of the **POLICYHOLDER**; or
- d) an **IMMEDIATE FAMILY MEMBER** of the **INSURED PERSON**. For purposes of this definition only, the term **IMMEDIATE FAMILY MEMBER** shall not be limited to natural persons resident in the same country as the **INSURED PERSON**. **IMMEDIATE FAMILY MEMBER** means an **INSURED PERSON'S** Spouse; children; children-in-law; siblings; siblings-in-law; parents; parents-in-law; grandparents; grandchildren; legal guardian, ward; step or adopted children; step-parents; aunts, uncles; nieces, and nephews, who reside in the same country as the **INSURED PERSON**.

2.10 **PER OCCURRENCE LIMIT** means maximum amount that can be reimbursed for **ANY ONE ILLNESS** covered under the scope of the policy.

2.11 **POLICYHOLDER** means the entity or person named as such in the Schedule.

2.12 **PRE-EXISTING CONDITION** means any **DISEASE** or **INJURY** for which medical advice, diagnosis, care or treatment:

- a) was received by;
- b) was recommended to; or
- c) would have been sought by a reasonably prudent person,

prior to becoming insured. Complications arising from a **PRE-EXISTING CONDITION** will be considered part of that **PRE-EXISTING CONDITION**. **PRE-EXISTING CONDITION** may be included for an additional charge.

2.13 **QUALIFIED NURSE** means a person who holds a certificate of a recognized nursing council and who is employed on the recommendations of an attending medical practitioner.

2.14 **SURGICAL OPERATION** means manual and / or operative procedures for correction of deformities and defects, repair of injuries, diagnosis and cure of diseases, relief of suffering and prolongation of life.



2.15 **TPA** means a Third Party Administrator as mentioned in the Schedule who is licensed by the Insurance Regulatory & Development Authority (IRDA) and is engaged for a fee or remuneration by whatever name called as may be specified in the agreement with the Company for providing Health Services to the **INSURED PERSON**.

3. EXCLUSIONS:

The Company shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any **INSURED PERSON** in connection with or in respect to:

3.1. All **DISEASES** or **INJURIES** which are a **PRE-EXISTING CONDITION** when the cover incepts for the first time..For the purpose of applying this condition, the date of inception of the initial mediclaim policy taken from any of the Indian Insurance Companies shall be taken provided the renewals have been continuous and without any break

3.2. Any **DISEASE** other than those stated in clause 3.3, contracted by the **INSURED PERSON** during the first thirty (30) days from the commencement date of the policy. This condition 3.2 shall not however, apply in case of the **INSURED PERSON** having been covered under this policy or Group Insurance Scheme with any one of the Indian Insurance Companies for a continuous preceding twelve (12) months without any break.

Note : These exclusions 3.1 and 3.2 shall not however apply if:

- a) in the opinion of a panel of **MEDICAL PRACTITIONERS** constituted by the Company for the purpose, the **INSURED PERSON** could not have known of the existence of the **DISEASE** or any symptoms or complaints thereof at the time of making the proposal for insurance to the Company; and
- b) the **INSURED PERSON** had not taken any consultation, treatment or medication, in respect of the hospitalisation for which claim has been lodged under the policy, prior to taking the insurance.

3.3 During the first year of the operation of the insurance cover, the expenses for treatment of **DISEASES** such as cataract, benign prostatic hyperthrophy, hysterectomy for menorrhagia or fibromyoma, hernia, hydrocele, congenital internal **DISEASE** / defects, fistula in anus, piles, Sinusitis and related disorders are not payable. If these **DISEASES** (other than congenital internal **DISEASE** / defects) are a **PRE-EXISTING CONDITION** at the time of proposal, they will not be covered even during subsequent period of renewal. If the **INSURED PERSON** is aware for the existence of congenital internal **DISEASE** / defects before inception of policy, the same will be treated as a **PRE-EXISTING CONDITION**.

3.4 Claims arising from, as a consequence of or involving investigations, operations or treatment of a purely cosmetic nature; or for obesity; or undertaken to facilitate pregnancy or to cure impotence or to improve potency.

3.5 **INJURY** or **DISEASE** directly or indirectly caused by or arising from or attributable to War, Invasion, Act of Foreign Enemy, Warlike operations (whether war be declared or not).

3.6 Circumcision unless necessary for treatment of a **DISEASE** not excluded hereunder or as may be necessitated due to an **ACCIDENT**, vaccination or inoculation or change of life; or cosmetic or aesthetic treatment of any description, plastic surgery other than as may be necessitated due to an **ACCIDENT** or as a part of any illness.

3.7 The cost of spectacles and contact lenses, hearing aids, dental treatment or surgery of any kind unless requiring hospitalisation.



3.8 Convalescence, general debility, run-down condition or rest cure; congenital external **DISEASE** or congenital internal defects or anomalies for example Congenital heart anomalies like ASD, VSD, Tetralogy of Fallot etc.; sterility, venereal **DISEASE**, intentional self **INJURY** and use of intoxicating drugs/alcohol.

3.9 All expenses arising out of any condition directly or indirectly caused to or associated with Human T-cell Lymphographic Virus Type 111 (HTLB-111) or Lymphadenopathy Associated Virus (LAV) or the Mutants Derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind commonly referred to as AIDS.

3.10 Charges incurred at **HOSPITAL** primarily for diagnostic, x-ray or laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any **DISEASE** or **INJURY**, for which confinement is required at a Hospital or at Home under Domiciliary Hospitalisation as defined.

3.11 Expenses on vitamins and tonics unless forming part of treatment for **INJURY** or **DISEASES** as certified by the attending **MEDICAL PRACTITIONER**.

3.12 **INJURY** or **DISEASE** directly or indirectly caused by or contributed to by nuclear weapons/materials.

3.13 Loss, damage, cost or expense of whatsoever nature directly or indirectly caused by, resulting from or in connection with any action taken in controlling, preventing, suppressing or in any way relating to any act of terrorism.

3.14 Treatment arising from or traceable to pregnancy and childbirth (including voluntary termination of pregnancy) and childbirth, (including caesarean section) unless included as an add-on cover for which additional premium shall have to be paid. Baby's expenditure is not covered under any circumstances unless it is a baby of 3 months or above as mentioned in clause 2.7

3.15 Naturopathy treatment

4.0 **CONDITIONS & CLAIMS PROCEDURE:**

Part I – Conditions:

1) Every notice or communication to be given or made under this policy **other than claim** shall be delivered in writing at the address of the policy issuing office as shown in the Schedule. The claim shall be referred to the TPA appointed for providing health care services.

2) The premium payable under this policy shall be paid in advance. No receipt for premium shall be valid except on the official form of the Company signed by a duly authorised official of the Company. The due payment of premium and the observance and fulfillment of the terms, provisions, conditions and endorsements of this policy by the **INSURED PERSON**, insofar as they relate to anything to be done or complied with by the **INSURED PERSON**, shall be a condition precluding to any liability of the Company to make any payment under this policy. No waiver of any terms, provisions, conditions and endorsements of this policy shall be valid unless made in writing and signed by an authorised official of the Company.



3) Upon the happening of any event which may give rise to a claim under this policy notice with full particulars shall be sent to the TPA within seven (7) days from the date of Hospitalisation.

4) All supporting documents relating to the claim must be field within thirty (30) days from the date of discharge from the hospital with the TPA. In case of post hospitalisation treatment (limited to sixty (60) days), all claim documents should be submitted within seven (7) days after completion of such treatment to the TPA.

5) The **INSURED PERSON** shall obtain and furnish to the TPA with all original bills, receipts and other documents upon which a claim is based and shall also give the Company such additional information and assistance as the TPA may require in dealing with claim.

6) 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 when and so often as the same may reasonably be required on behalf of the Company.

7) The Company shall not be liable to make any payment under this policy in respect of any claim if such claim be in any manner fraudulent or supported by any fraudulent means or device whether by the **INSURED PERSON** or by any other person acting on his behalf.

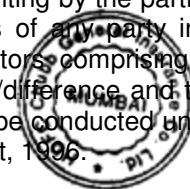
8) If, at the time when any claim arises under this policy, there is in existence any other insurance (other than Cancer Insurance Policy in collaboration with Indian Cancer Society) whether it be effected by or on behalf of any **INSURED PERSON** in respect of whom the claim may have risen covering the same loss, liability, compensation, costs or expenses, the Company shall not be liable to pay or contribute more than its rateable proportion of any loss, liability, compensation, costs or expenses. The benefits under this policy shall be in excess of the benefits available under Cancer Insurance Policy.

9) The Company may, at any time, cancel this policy by sending the **POLICYHOLDER** thirty (30) days notice by registered letter at the **POLICYHOLDER'S** last known address and in such event Company shall refund to the **POLICYHOLDER** a pro-rata premium for unexperienced Period of Insurance. The Company shall, however, remain liable for any claim, which arose prior to the date of cancellation. The **POLICYHOLDER** may at any time cancel the policy and in such event the Company shall allow refund of premium at Company's short period rate only (Table give here below) provided no claim has occurred up to the date of cancellation.

PERIOD ON RISK RATE OF PREMIUM TO BE CHARGED

Upto one month	1/4 of the annual rate
Upto three months	1/2 of the annual rate
Upto six months	3/4 th of the annual rate
Exceeding six months	Full annual rate

10) If any dispute or difference shall arise as to the quantum to be paid under the policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to be the decision of a sole arbitrator to be appointed in writing by the parties to or if they cannot agree upon a single arbitrator within thirty (30) days of any party involving arbitration, the same shall be referred to a panel of three arbitrators comprising of 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.



It is clearly agreed and understood that no difference or dispute shall be referable to arbitration as herein before provided if the Company has disputed or not accepted liability under or in respect of this policy.

It is thereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this policy that award by such arbitrator/arbitrators of the amount of the loss or damage shall be first obtained.

11) If the Company shall disclaim liability to the **INSURED PERSON** for any claim hereunder and if the **INSURED PERSON** shall not within twelve (12) calendar months from the date of receipt of the notice of such disclaimer notify the Company in writing that it does not accept such disclaimer and intends to recover its 'claim from the Company then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

12) **The company shall be under no obligation to renew the policy on expiring terms. The company reserves the right to offer revised rates terms and conditions at renewal based on loss experience.**

13) All medical/surgical treatments under this policy shall have to be taken in India and admissible claims thereof shall be payable in Indian currency.

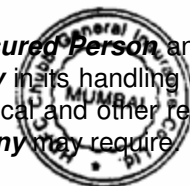
PART II – TPA Claims Procedures:

1) Treatment taken in a Network Hospital means treatment given by a provider of health care services, this means a provider that has a participation agreement in effect with us or with our affiliate (directly or through one or more other organizations) to provide Covered Health Services to Covered Persons. TPA (THIRD PARTY ADMINISTRATOR) is a service provider that has been selected by HDFC Chubb General Insurance Company to provide Third Party Administration services to its policyholders.

2) Treatment taken in a Non-Network hospital means treatment given in any hospital out of the Network mentioned above. For more details please refer to the 'Membership Guide' which will be provided for your reference at the time of being covered under the plan.

TPA Role:

- a) It is a condition precedent to the Company's Liability under this policy that in the event of any disease / illness/ accidental bodily injury that may give rise to a claim, the insured person or the insured person's representative contact and intimates to the TPA who has been appointed under the policy to provide claim services.
- b) All certificates, information and evidence required by the **Company** shall be furnished at no expense to the **Company** and shall be in such form and of such nature as the **Company** may prescribe. When required by the **Company**, at its own expense, the **Insured Person** shall submit to medical examination in respect of any alleged claim that may give rise to a benefit being paid.
- c) No sum payable under this Policy shall carry interest.
- d) In the event of a claim under this Policy, the **Policyholder**, the **Insured Person**, and the **Beneficiary**, if applicable, must fully co-operate with the **Company** in its handling of the claim including, but not limited to, the timely submission of all medical and other reports, and full co-operation with all physical examinations that the **Company** may require.



- e) Medical advice of a Physician shall be sought and followed promptly on the occurrence of any Bodily Injury or Sickness and the Company shall not be liable for any part of any claim which in the opinion of a Physician appointed by the Company arises from the unreasonable or willful neglect or failure of an Insured Person to seek and remain under the care of a Physician.
- f) Treatment taken in a Non-Network hospital means treatment given in any hospital out of the Network mentioned in the 'Membership Guide' which is provided for your reference at the time of enrolment under the policy.
- g) Treatment taken in a Network Hospital means treatment given by a provider of health care services, this means a provider that has a participation agreement in effect with our TPA (directly or through one or more other organizations) to provide Covered Health Services to Covered Persons. TPA as mentioned in the Schedule is a service provider selected by HDFC Chubb General Insurance Company to provide Third Party Administration services to its policyholders. Any changes in the network will be informed to the policyholders by TPA.
- h) The claims eligibility protocol shall be as follows:
- All hospitalization events need to be pre-authorized by TPA.
 - Reimbursement of claims for hospitalizations that have not been pre-authorized will be processed by the TPA at the discretion of the insurer
 - Pre-authorization needs to be done at least 48 hours prior to a planned hospitalization
 - For emergency hospitalizations, **pre-authorization should be done within 24 hours of admission**
 - The insured person may choose to seek hospitalization either at a network or non-network hospital
 - For network hospitalizations, the insured will be eligible for credit facilities subject to fulfilling the eligibility criteria as per the policy
 - In the event of complications during hospitalization or a change in course of treatment, the insured should notify TPA accordingly.
 - In the event of non-notification, the insured's claim for the unauthorized treatment is liable to be rejected by the insurer.
 - For credit hospitalizations, all expenses that are excluded from the benefits are payable by the insured at discharge.
 - For credit hospitalizations, the bills/supporting documents will be forwarded to TPA by the hospital/nursing home.
 - Pre and post hospitalization bills will be forwarded by the insured to TPA
 - For non-credit hospitalizations, the bills will be settled by the insured and sent along with supporting documents to TPA
 - All original documents will be supported by a claim form
 - Reimbursement is subject to receiving all relevant documents and a completed claim form
 - For non-network hospitalizations, there would be a co-payment of 10 percent of admissible claim amount. The co-payment shall be deducted from the claims reimbursable and the balance shall be issued to the insured.
- i) Pre-Authorization means Review of "need" for inpatient care or other care before admission. This refers to a decision made by the payer, TPA or insurance company prior to admission. The payer determines whether or not the payer will pay for the service.



5.0 MATERNITY EXPENSES BENEFIT EXTENSION (Wherever applicable)

5.1 This is an optional cover which can be obtained for an additional premium for all the **INSURED PERSONS** under the policy.

5.2 Option for **MATERNITY EXPENSES BENEFITS** has to be exercised at the inception of the policy period and no refund is allowable in case of **INSURED PERSON'S** cancellation of this option during currency of the policy.

5.3 The maximum benefit allowable under this clause will be up to Rs.50,000 or the sum insured shown in the Schedule, whichever is lower.

5.4 Special conditions applicable to **MATERNITY EXPENSES BENEFITS** Extension:

1. These Benefits are admissible only if the expenses are incurred in **HOSPITAL** as an inpatient in India.
2. A waiting period of nine (9) months is applicable for payment of any claim relating to normal delivery or caesarean section or abdominal operation for extra uterine pregnancy. The waiting period may be relaxed only in case of delivery, mis-carriage or abortion induced by **ACCIDENT** or other medical emergency.
3. Claim in respect of delivery for only first two (2) children and/or operations associated therewith will be considered in respect of any one **INSURED PERSON** covered under the policy or any renewal thereof. Those **INSURED PERSONS** who are already having two (2) or more living children will not be eligible for this benefit.
4. Expenses incurred in connection with voluntary medical termination of pregnancy during the first twelve (12) weeks from the date of conception are not covered.
5. Pre-natal and post-natal expenses are not covered unless admitted in **HOSPITAL** and treatment is taken there.

5.5 When this policy is extended to include Maternity Expenses benefit, the exclusion 3.14 of the policy stands deleted.

