1. CASE OF COL. S L NARULA V/S UNITED INDIA INS. CO. LTD.

(AWARD DATED: 06.12.2017)

Mr. S L Narula, the complainant has stated in his complaint that a mediclaim for treatment of his son had not been settled by the insurance company till date. The complainant stated that his son met with an accident on 24.09.2017 and was admitted in ICU of Kailash Hospital on the same day. The complainant had found a health card (corporate policy purchased by the employer of his son) in the wallet of his son and the same was handed over to the hospital for availing cashless treatment. M/s Med save, the TPA in this case, sanctioned cashless treatment up to Rs. One lakh as sum insured under the policy was Rs. One lakh only. When, the expenses of treatment exceeded the limit of one lakh, the hospital asked the complainant to pay balance amount. At that time, when he again searched documents of his son, he came to know that his son had also purchased another policy (Individual Mediclaim Policy) with sum insured of Rs. 3 lakhs from the same insurer. Accordingly, he handed over health card of the second policy to the hospital. In order to avail cashless benefit under second policy, the hospital discharged the patient on 29.09.2017 at about 7 PM and readmitted him on the same day after two hours. This exercise was done only in records as the patient remained admitted in the ICU during the intervening period of two hours. The Claim papers for Rs. 2, 06,188/- were submitted to the TPA who sanctioned Rs. One lakh only and disallowed balance amount of Rs. 1, 06,188/- in view of sum insured under the policy. Later, another claim of Rs. 94,800 for the hospitalization period from 29.09.2017 to 03.10.2017 was submitted to E-meditek, the TPA of second policy which was approved and paid by them. Since, the insurer was same in both the policies, the complainant approached the insurer several times requesting them to settle the claim for unpaid amount of Rs.1, 06,188/- under the second policy but failed to get any relief. The insurer stated that the TPA of the second policy had advised the complainant to submit original /certified documents for hospitalization which were submitted by him to M/s Med save, the TPA of corporate policy, so as to enable them to process reimbursement of balance amount of Rs. 1,06,188/- but the complainant failed to submit the same, hence his claim could not be settled by the TPA of the second policy (Individual Mediclaim Policy). The complainant stated that he was unable to understand as to why his claim had not been settled till date, when both the policies were issued by the same insurer. The insurer admitted that due to lack of coordination between the two TPAs, the claim for balance amount could not be settled. However, the insurer assured that the claim would be settled within one week from the date of receipt of required documents.

2. CASE OF PRAGATI GUPTA V/S NATIONAL INSURANCE CO. LTD.

(AWARD DATED: 06.12.2017)

The complainant stated that her husband was admitted in the Synergy Hospital Agra for the period from 16.03.2016 to 19.03.2016 for treatment of Acute Pancreatitis. She had incurred an expenditure of approximately Rs. 40,000/- and all the required documents, medical papers and reply to various queries raised by the TPA were submitted to the insurer but her claim had not been settled till date. On going through the documents submitted by the complainant, it is observed that the TPA had raised certain queries vide their letters dated 25.07.2016 and 02.08.2016 which were replied by the insured vide his letter dated 26.08.2016. However, the insured informed vide letter dated 07.10.2016 that on receipt of complaint through this forum, the claim was reviewed and the insurer had agreed to settle the claim for Rs. 22,358/- subject to submission of consent of the complainant. Subsequently, the complainant, vide another mail dated 07.10.2017 has confirmed receipt of claim amount. The complaint, thus, stands closed and disposed off.

3. CASE OF SYED AHMED ALI SHAH V/S ORIENTAL INSURANCE CO. LTD.

(AWARD DATED: 05.12.2017)

The complainant had taken Mediclaim Policy for the period from 27.11.2015 to 26.11.2016 from The Oriental Insurance Co. Ltd. He was hospitalized in Max Super Speciality Hospital, Ghaziabad on 26.08.2016 with acute ischemic stroke and discharged from the hospital on 29.08.2016. The complainant had applied for cashless facility but the same was rejected by the company. Thereafter, the claim was lodged by the complainant with all the relevant documents for re-imbursement but the same was too not settled by the company inspite of various reminders. The company stated that the claim was settled by them on 25.09.2017 after deducting the amount of Rs.20,595/- due to non-availability of MRI films and ECHO reports. The insurer informed that they had confirmed from the hospital that MRI was done and accordingly they were settling the claim. That an amount of Rs.20,595/- was approved by the company for settlement of the claim was later also confirmed by the complainant vide his e-mail dated 08.11.2017.

4. CASE OF MR. RAJEEV KUMAR V/S UNITED INDIA INSURANCE CO. LTD.

(AWARD DATED: 07.12.2017)

Mr. Rajeev Kumar, the complainant has stated that two claims for treatment of his wife had not been settled by the insurance company till date. Aggrieved, he had requested the TPA/insurer including its GRO to reconsider the claims but failed to get any relief. The complainant stated that he had submitted two claims amounting to Rs. 299179 for treatment of his wife to the TPA on 17.01.2017 but in spite of various letters and telephonic calls, his claims had not been settled by the insurance company till date. The complainant informed that after lodging the complaint in this forum, he had received payment of one of the claims but another claim had not been settled by the TPA/insurer till date. The representative of the insurer stated that in spite of his best efforts, status of the pending claims could not be obtained from the policy issuing office. He requested for some time so as to enable him to get details of the claims lodged by the insured. Accordingly, another personal hearing was held on 17.11.2017. The insurer informed that out of the two claims lodged by the complainant, one claim for Rs. 93881/- had been paid and the complainant had been advised to resubmit claim papers of the second claim as the same could not be traced by the TPA/Policy issuing office at Bangalore. The complainant stated that he had already sent the claim papers of the second claim to the TPA; however, he agreed to resubmit the same. The insurer informed vide their mail dated 29.11.2017 that the complainant has resubmitted claim documents of the second claim for Rs. 1.73 lakhs to the TPA and the admissible amount of the claim would be settled shortly. It is observed that although, the complainant had alleged inordinate delay in settlement of the claims, he himself was confused and could not provide specific details of the claims. It appears that the complainant had also not followed up the claims properly with the insurer. However, now that the documents have been re-submitted, the insurer is advised to ensure prompt settlement of pending claim.

5. CASE OF MR. BARUN KUMAR CHANDRA V/S ORIENTAL INSURANCE COMPANY LIMITED.
(AWARD DATED : 05.12.2017)

The complainant had taken Oriental bank Mediclaim Policy for the period from 06/09/2016 to 05/09/2017 with sum insured of Rs 200000/ for himself and his family. The spouse of the complainant had problem of acute cholecystitis and Cholelithiasis, where laparoscopic cholecystomy was conducted on 28.02.2017. The complainant had lodged a claim with the company for re-imbursement but the same was rejected by the company . The complainant stated that the company had rejected the claim of his spouse because of break in insurance due to fault of Bank . He had regularly taken the policy from the company for the last five years . The premium of the policy of Rs.3399/- was debited from his account on 23.08.2016 instead of 26/07/2016 hence the policy period should be effective from 23.08.2016 instead of 05.09.2016; which is less than one month and very much within grace period. The company stated that the policy, on which the claim was reported was renewed after a gap of 41 days **a**nd the previous policy was also renewed after a gap of 16 days, hence the current insurance policy was treated as a fresh policy. As per terms and conditions of the policy there is a waiting period of 2 years for the treatment of cholelithiasis (stone) disease and if continuity of the policy was not maintained then subsequent cover was to be treated as fresh policy, hence the claim of the complainant was rejected by the company under clause 4.2 of the policy, which states that the expenses on treatment of calculus disease for the period of two years is not payable if contracted and/or manifested during the currency of the policy**.** The insured did not appear for personal hearing. From the records, it was noticed that the premium as claimed by the complainant was debited within one month, confirming the break in insurance is within 30 days. Hence the Insurer should settle the claim on merit as agreed by them after condoning the delay, which is less than 30 days. Once this is considered, the treatment of cholelithiasis would not fall within two years. Hence, an award was passed with the direction to the insurance company to provide all the continuity benefits of renewal under the policy to the complainant after condoning the delay.

6. CASE OF MR. ABHISHEK BHARGAVA V/S ORIENTAL INSURANCE COMPANY LIMITED.

(AWARD DATED : 05.12.2017)

The complainant had taken Happy Family Floater Policy for the period from 31.07.2016 to 30.07.2017 from Oriental Insurance Co. Ltd. for himself, his mother and father. The mother of the complainant was admitted twice in Vinayak Nursing Home, Jaipur for the period from 10.12.2016 to 14.12.2016 and from 31.05.2017 to 02.06.2016 for gastroenteritis, dehydration, diabetes and Crohns disease. Two claims were lodged by the complainant with the company for re-imbursement but the same were rejected by the company on the ground of being genetic disease. However earlier two or three claims for gastroenterology had been paid by the company. The claimant submitted a certificate of Dr. Sanjeev Bhargava, treating doctor, stating that Crohns disease is not a genetic disease and sought relief from this forum for re-imbursement of the claim of his mother. The company rejected the claim stating that Crohns disease was genetic, hence the claim was considered as Non-payable as per General Exclusion No.4.15 of the policy, which states that ***"the company shall not be liable to make any payment under the policy in respect of any expense whatsoever incurred by any insured person in connection with or in respect of –genetic disorders and stem cell implantation/surgery".*** The complainant did not appear and requested for decision on the basis of records. From the available records, it is observed that origin of Crohn disease need not necessarily be genetic as it could be also due to deficiency in immune system or environmental factors. The insurer also agreed but insisted that main reason is always genetic. It is thus clear that besides genetic, there may be various other reasons also which may cause Crohns disease. Hence, the decision of insurance company in rejecting the claim is not totally justified**.** An award was passed with the direction to the insurance company to pay the admissible claim amount to the complainant.

7. CASE OF SH. CHANCHAL DWIVEDI V/S STAR HEALTH AND ALLIED INSURANCE CO. LTD.
(AWARD DATED : 14.11.2017)

This complaint is filed by Sh. Ashish Dwivedi against Star Health and Allied Insurance Co. Ltd. relating to P.No. P/231115/01/2016/003358 due to partial and delayed settlement of claim. The complainant stated that he was diagnosed of Chronic Lymphocytic Leukemia (CLL) Stage 4 and had been planned for IBRUTINIB based therapy. The complainant had submitted claim form for an amount of Rs.694545/- to the insurer but the insurer had made claim payment of Rs.112616/- after deduction of an amount of Rs. 581929/- due to non-payable and consumable items. Hearing in the said case was held on 10-10-2017. The complainant stated that he had taken policy in the year 2013 and had kept on renewing the policy till date and the claim had arisen in the 4th year of policy. The insurer stated that the terms and conditions of policy were revised in the year 2016 and as per revised conditions, the company was not liable to make any payment in respect of expenses incurred by the insured in connection with ORAL CHEMOTHERPY. Hence the insurer had made partial payment of claim amount of RS.112616/-only. The complainant stated that in the year 2016 at the time of renewal of policy the insurer had not provided revised terms and conditions of the policy along with the covering letter of the policy document. The complainant pleaded that renewal of policy should be treated as continuous policy since it speaks of 2nd and 3rd year renewal premium which is only used for continuation purpose. In support the complainant submitted a SUPREME COURT JUDGEMENT in the case of Biman Krishna Bose V/S United India Insurance Co. Ltd. dated 02-08-2011 wherein the Hon'ble court have made following observation: "A renewal of an insurance policy means repetition of the original policy. When renewed , the policy is extended and renewed policy in identical terms from a different date of its expiration comes into force. In common parlance, by renewal, the old policy is revived and it is sort of a substitution of obligations under the old policy unless such policy provides otherwise. It may be that on renewal , a new contract comes into being, but the said contract is on the same terms and conditions as that of the original policy". The complainant had also submitted Delhi High Court Judgment in the case of Akshay Kumar Paul and ANR case dated 26-12-2007,which also rely on the observation of the Apex court in the case of Biman Krishna V/S United India Insurance Company Ltd. Lastly , the complainant invited attention of this forum to the IRDA circular dated 31-03-2009(52/15/IRDA/Health/SN/08-09) issued to CEO's of all General Insurance Companies regarding renewability of Health Insurance Policies, which inter alia clearly states that "A prospectus of a health policy shall contain detailed upfront disclosures about the terms of its renewal to enable the consumer to take an informed decision. This will include material information related to the coverage". It also states that, insurer shall intimate such revision(s) to all the policyholders such that the policyholders are so informed at least 3 months prior to the date of renewal of their cover". Relying on above decisions of the courts and circular of IRDA the complainant stated that only treatment available to him was targeted therapy Ibrutinib i.e. Oral Chemotherapy and no Injectible Chemo was possible as clarified by the treating doctor. In view of above mentioned facts amount deducted by the insurer on the ground of ORAL CHEMOTHERAPY and the treatment, is found unfair and unjustified. Hence the insurance company is directed to pay complete oral chemotherapy charges to the insured, towards full and final settlement of the claim.

8. CASE OF MRS. SHEETAL JAIN V/S HDFC ERGO GENERAL INSURANCE CO. LTD.
(AWARD DATED : 30.10.2017)

This complained is filed by Mrs. Sheetal Jain against HDFC Ergo General Insurance Company Limited relating to repudiation of death claim on the life of her husband late Sh. Shaswat Goel. The complainant stated that her husband had taken home loan of Rs. 18,00,000/-from HDFC Ltd. for purchase of flat. An insurance policy was issued by the company as collateral security. Her husband died on 15-06-2017 and cause of death was B/L pneumonia with Acute respiratory distress syndrome with sepsis and septic shock with Multiple organ dysfunction syndrome, Acute Kidney injury and ulcerative colitis. The complainant had submitted all the relevant documents to the insurer for claim payment but the claim had been rejected by the insurer on the ground that the ailment was not covered under the policy. Hearing of the said case was held on 20-09-2017. The complainant submitted a certificate from the treating

doctor and some old prescriptions , which showed that the patient had been suffering from kidney disease in addition to various other diseases. In addition to her argument that kidney failure was major reason behind her husband's death, the complainant stated that it was assured by the company at the time of issuance of policy, that in case of any mis-happening, the company will make repayment of outstanding home loan amount, which was not being honored by the company. The insurer stated that as per Death summary the insured was diagnosed with "Decompensated Cirrhosis, Spontaneous Bacterial Pertinent with multi organ failure". As per Death certificate issued by Max Hospital , the cause of death was Pneumonia with ARDS with Sepsis and Septic Shock Multiple organ dysfunction syndrome, Acute kidney injury and Ulcerative Colitis. Since the said ailments were not covered under the policy, hence claim was rejected by the company. Keeping in view all the facts it was observed that that the insurance company had not sold correct policy to the deceased life assured. Whenever a policy is sold as collateral to the mortgage loan taken from the bank, it is supposed to cover all the eventualities of death. In this case doctors used CRRT as emergency measure and yet could not save the patient, which is covered as per no.2 in the list of critical diseases covered. Thus it is unfair on the part of the insurer to deny the claim under the cover of other ailments.

9. <u>CASE OF RAVI GOYAL V/S UNITED INDIA INS. CO. LTD.</u>
(AWARD DATED : 08.12.2017)

This is a complaint filed by Sh. Ravi Goyal against the decision of United India Insurance Company Ltd. relating to rejection of Medi-claim of his wife on the ground of policy exclusion clause no. 4.1 (pre-existing disease). The complainant stated that his wife Mrs. Richa Goyal was admitted in Sir Ganga Ram Hospital for treatment of Post Cholecystectomy status with Choledocholithiasis (Removal of gall stones from the bile duct in a case in which gall bladder had already been removed). The complainant argued that the insurer had wrongly applied exclusion clause no. 4.1 because the disease of his wife (Removal of gall bladder stones) falls under policy clause no. 4.3 which stipulates that expenses for the treatment of the disease were payable in case the policy was in force for a continuous period of 24 months and his policy was in force since last 7 years. The insurer informed that the claim falls under policy exclusion no. 4.1 which stipulates that the expenses incurred for any pre-existing disease would be payable only after expiry of 48 months of continuous coverage of the patient and the patient was admitted in the hospital on 21.07.2017 for treatment and surgery while, she was under continuous insurance coverage since October 2014 only. The patient had taken the policy for the first time in the year 2009 and not 2014 as claimed by the insurer. Therefore, the insurer had wrongly repudiated the claim as more than four years had already elapsed since inception of the policy, hence, pre-existing disease, even if any, stands covered. The complainant also exhibited the policy, wherein, inception date of first policy was found mentioned as 24.08.2009. The insurer stated that the complainant had taken the policy for the first time in the year 2009 but there was a gap of 37 days in renewal of policy for the year 2014-15, hence, the policy of 2014-15 would be considered as fresh policy. In view of break in the policy, benefit of continuity cannot be granted to the complainant. The complainant countered that in any case, as per policy clause no. 4.3, expenses incurred for removal of gall bladder stones were payable after the continuous coverage of two years. In the subject case, his wife was admitted in the hospital on 21.07.2017, so two years had elapsed even if date of inception is taken as 27.10.2014 as claimed by the insurer. Ongoing through the documents exhibited, it can be presumed that the insurer had waived the so called gap of 37 days while renewing the policy for the year 2014-15 and there was a continuous risk cover since the year 2009. Accordingly, the said pre-existing disease, stands covered after 4 years and it is evident that the disease of stones in the bile duct related to gall bladder stones falls under policy clause no. 4.3, hence, contention of the complainant in this respect is very much relevant and appears to be in order. Therefore, repudiation of the claim by the insurer is not justified and requires to be set aside.

10. CASE OF MR. ANIL SINGH V/S BAJAJ ALLIANZ GENERAL INSURANCE CO. LTD.
(AWARD DATED : 05.12.2017)

This is a complaint filed by Shri Anil Singh against the decision of Bajaj Allianz General Insurance Company relating to rejection of medi-claim on the ground that illness was due to intake of Alcohol. The complainant stated that he was not consuming Alcohol. He had also submitted a certificate of Dr. Ashish Gautam, treating doctor stating that the patient had no history of alcohol intake. The company stated that the claim documents revealed that the claimant was hospitalized for treatment of Acute Pancreatitis; hence the claim was rejected as per Exclusion No.C-15, which states that "the company will not be liable to make any payment for any claim directly or indirectly caused by, based on, arising out of or attributable to any of the following : Ailments requiring treatment due to use or abuse of any substance, drug or alcohol and treatment for de-addiction." The insurer assumed that alcohol consumption is one of the reasons for Pancreatitis. Gall bladder disease is another cause for Pancreatitis, since the complainant did not suffer from gall bladder related ailments, the most probable cause for Pancreatitis was alcohol intake. The Insurer was asked to produce any documentary evidence in support of their allegation that the insured was chronic alcohol drinker, which had led to pancreatitis, but they could not produce any documentary evidence. The complainant denied that he was an alcoholic and relied upon doctor's certificate. Thus the ground on which the claim was rejected by the company has no basis and has to be considered as mere presumption. The decision of the insurance company is thus is unjustified and deserves to be set aside.

11. CASE OF SH. BHUWAN CHANDRA JOSHI V/S STAR HEALTH AND ALLIED INS. CO. LTD.
(AWARD DATED : 14.12.2017)

This complaint is filed by Sh. Bhuwan Chandra Joshi against Star Health and Allied Insurance Company Ltd. relating to repudiation of claim due to non disclosure of pre-existing disease. The complainant stated that he had purchased a policy named Star Comprehensive Insurance Company Ltd. for the period from 25-11-2016 to 24-11-2017.He was diagnosed with heart disease by the doctor on 03-02-2017 after some prescribed medical procedure. After that he had visited four reputed hospitals of the country for confirmation of disease and was finally admitted in Metro Heart Institute, Pandav Nagar, New Delhi due to breathlessness and chest pain . During investigation, echocardiography showed severe calcific aortic stenosis. The complainant submitted all required documents to the insurer but his claim was repudiated by the insurer after denial of cashless treatment in the hospital. The insurer stated that their senior medical panel had reviewed the claim records and observed from the discharge summary of the hospital that the insured patient had undergone treatment OPCAB x AVR # 20 ATS on 15-02-2017. Based on the available medical records, their medical team was of the opinion that the insured patient had history of disease prior to inception of medical insurance policy hence the present admission and treatment of the insured was for the pre-existing disease and as per exclusion no. 1 of the policy document, the company was not liable to make any payment in respect of expenses for treatment of the pre-existing disease/condition, until 48 months of continuous coverage had elapsed, since inception of policy. As the policy was in the first year of running since inception, hence the claim was repudiated. During hearing the insurer was advised to submit some documentary evidence to prove that the disease was pre-existing time of proposal, which they could not. The moot point in the present case was not whether the insured was having this problem prior to proposal or not but whether he was aware of this problem prior to proposal and whether he had consciously concealed material facts from the company. In absence of any evidence, the insurance company was directed to make payment of admissible claim amount.

12. CASE OF SH. HEMANT JOSHI V/S STAR HEALTH AND ALLIED INS. CO. LTD.
(AWARD DATED : 13.12.2017)

This complaint is filed by Sh. Hemant Joshi against Star Health & Allied Insurance Company relating to repudiation of claim due to pre-existing disease. The claimant stated that he had purchased a policy from Star Health and Allied Insurance Company Ltd. and had been paying premium regularly for the last 3 years. His wife developed back pain and they approached Dr. Mukunth Raj Gopalan who after investigations suggested Hip Replacement Surgery. Following the advice she got the replacement of hip joint done in an insurer approved hospital viz Kanishk Hospital in Dehradun and submitted claim to the insurer and kept following up about reimbursement but the claim was rejected by the insurer on the ground of misrepresentation of facts . The insurer stated that it was observed from the submitted medical records including discharge summary of the Kanishk Hospital – Dehradun that the insured patient had complaints of difficulty in walking for last 3 years with pain in right leg and following diagnosis of Ankylosing Spondylitis Hybrid, total hip replacement was performed. Hence as per condition no. 8 of the policy condition, the claim was rejected by insurance company During hearing, the insurer stated that the disease cannot be 3 to 6 month old for hip replacement as claimed by the complainant. But the discharge summary stated that the patient was not having any problem three years back . The complaints of pain in walking was recent. The claim has also arisen in the in the 4thyear of policy. , the insurance company was directed to make payment of admissible claim amount.

13. CASE OF SH. MUKUL KUMAR V/S STAR HEALTH AND ALLIED INS. CO. LTD.
(AWARD DATED : 13.12.2017)

This complaint is filed by Sh. Mukul Kumar against Star Health and Allied Insurance Company Ltd. relating to repudiation of claim under policy no. P/161100/01/2017/020154 due to non -disclosure of pre-existing disease at the time of porting policy to Star Health & Allied Insurance Company Ltd.- The complainant had purchased a policy from Apollo Munich2 years back and in the current year on 26-02-2017, he ported this policy to Star Health & Allied Ins. Co. Ltd. with Senior Citizens Red Carpet plan. His father was diagnosed with CA Esophagus (cancer in food pipe). On 11-04-2017 his father was admitted to Rajiv Gandhi Cancer hospital, Delhi with complaints of difficulty in swallowing and back pain of two month duration for treatment of Carcinoma Esophagus till his discharge on 13-04-2017. The complainant later submitted all related documents to the insurer for claim payment but the insurer rejected the claim on the ground of non-disclosure of disease at the time of porting of policy. Both parties appeared for personal hearing and reiterated their submissions. The insurer informed that they had reviewed the claim and were ready to settle it as per terms and condition of policy. The insurer has informed us vide their mail dated 23-11-2017 that the payment of Rs. 1,15,163/ has been made vide DD NO. 793992 dated 10-11-2017 drawn on HDFC Bank, in full and final settlement of claim.

14. CASE OF MR. RAHUL BANSAL VS ORIENTAL INSURANCE CO. LTD.
(AWARD DATED : 13.12.2017)

Mr. Rahul Bansal had taken PNB-Oriental Royal Mediclaim Policy for the period from 19.07.2016 to 18.07.2017 from The Oriental Insurance Co. Ltd. for himself and his family. The complainant was admitted in Medanta the Medicity for the period from 10.10.2016 to 17.10.2016 , from 21.10.2016 to 21.11.2016 and thereafter in Asian Institute of Gastroenterology for the period from 26.12.2016 to 02.01.2017 for the treatment of acute Necrotizing Pancreatititis (<30%necrosis)—2nd week etiology, Biliary with evolving I/A collection. Total six claims were lodged by the complainant with the company for the same disease out of which only one claim was settled by the company for Rs.29,104/-. The other five claims of the complainant were rejected by the company on the ground of waiting

period of two years. The complainant has sought relief from this forum for re-imbursement of his five claims. The company stated that , the claim was rejected by the company as per Exclusion 4.2 of the policy, which states that ***"the expenses on treatment of following ailment/diseases/surgeries for the specified periods are not payable if contracted and/or manifested during the currency of the policy – xiii) Surgery of gallbladder and bile duct excluding malignancy 2 Years."***. During hearing it was found that after payment of one claim when the Insurer found several other claims following, they just found some excuse to deny them. There are thus not sufficient and conclusive reasons to deny rest of the claims, since pancreatitis is neither excluded nor subject to waiting period. Thus the Insurance Company was not justified in rejecting the claim. , An award was passed with the directions to the insurance company to pay the admissible claim amount to the complainant.

15. CASE OF KUMAR PULKESIN VS ORIENTAL INSURANCE CO. LTD.
(AWARD DATED : 13.11.2017)

Mr. Dilip Sinha, father of the complainant was covered under corporate policy of Bajaj Allianz General Insurance Co. Ltd. and Staff Medi claim Policy No. 124500/48/2016/4249 of Oriental Insurance Co. Ltd. He was admitted in Yashoda Super Speciality Hospitals for the period from 25.06.2016 to 28.06.2016 with the complaint of S/P PTCA (Percutaneous transluminal coronary angioplasty) plus Stenting to Lad(left anterior descending) & Ramus (20.06.2016) in anatomy, a branch of blood vessel or nerves, CAG-Two Vessel Disease (25.06.2016), Intermittent Atrial with k/c/o DM-T2, SHT with complain of exertional chest pain. The cashless claim of Rs.3,00,000/- was settled by the Bajaj Allianz General Insurance Co. Ltd. and the claim for the balance amount was lodged by the complainant with the Oriental Insurance Co. Ltd. The claim was settled by the company after deducting an amount of Rs.5,293/-. The complainant stated that after regular follow-up, the claim was settled by the company after the deduction of Rs.5,293/- without any justification. The complainant has sought relief from this forum for settlement of the balance amount. The insurer did not appear to explain the reason of deduction nor did they submit SCN. On discussion with the complainant, it was found that the deduction of Rs.4063/- was made on account of tax collection at source and Rs.665/- was deducted for lab charges. Apparently, the tax is on total bill and the company is responsible to collect/pay tax on the bills raised by them. The other lab charges appear payable.

16. CASE OF MR. MANISH TEWARI VS NEW INDIA ASSURANCE CO. LTD.
(AWARD DATED : 13.11.2017)

The complainant took Mediclaim Policy No. 3229013416280000008 for the period from 07.09.2016 to 06.09.2017 with sum insured of Rs. 5,00,000/- for himself and his family. He was admitted for the period from 17.03.2017 to 18.03.2017, where laser surgery of left URS was done on 18.03.2017. The complainant had lodged the claim for Rs.67,549/- along with claim documents for re-imbursement of the claim but claim of the complainant was settled by the company for Rs.26,863/- only after deducting the amount of Rs.40,686/-. As per the complainant, this was not justified since he had paid the premium for the sum insured Rs.5,00,000/-, hence he should be reimbursed the full amount of treatment. The complainant has sought relief from this forum for settlement of the differential amount of Rs.Rs.40,686/.Hearing of the said case was held on 16-10-2017.The complainant stated that he had submitted all the documents along with test reports/films etc. On the basis of which around 40% of the claim was sanctioned. However, he was not aware about the basis on which remaining amount was not paid. The insurer has not submitted SCN. He was asked to explain the reasons for short payment but he had neither any document in support nor could explain the reasons why the balance amount had not been paid. Under the circumstances, it has to be construed that the deductions have been made without any valid reason and the complainant is entitled for the remaining amount.

17. CASE OF SH. RAVI KUMAR V/S STAR HEALTH AND ALLIED INS. COMPANY LTD.
(AWARD DATED : 10.11.2017)

This complaint is filed by Sh. Ravi Kumar against Star Health and Allied Insurance Co. Ltd. relating to inadequate settlement of claim under policy no. P/161115/01/2017/000199. The complainant stated that a mediclaim policy was purchased by Sherwood College, Nainital for its employees from the insurer for the period from 05-04-2016 to 04-04-2017 for sum insured of Rs. 3 lakh. The complainant, an employee of Sherwood College had near fatal road accident on 29-06-2017 after which he was taken to IGMC, Shimla from where he was referred to PGI, Chandigarh. He was under treatment at PGI , Chandigarh till his discharge. He was prescribed physiotherapy which was very critical for regaining his physical movements. In the month of March 2017 the complainant had submitted the bills amounting to Rs. 24845/- to the company. The insurer partially settled the claim after deducting Rs. 21239/-which was not justified. The insurer settled maximum amount i.e. Rs.3606/- as per the policy terms and conditions after deducting Rs. 21339/-because as per policy Physiotherapy post hospitalization was not covered(rest cure charges). None appeared for personal hearing. The insurer informed vide their letter dated 12-10-2017 that the claim has been settled vide DD No. 549872 for Rs.15000/- drawn on HDFC bank being the full and final payment of claim. In view of above, the proceedings were not held and the complaint was treated as closed.

18. CASE OF : MR. SHISHIR AGARWAL VS ORIENTAL INSURANCE CO. LTD.
(AWARD DATED : 01.11.2017)

Mrs. Meena Agarwal, mother of the complainant was covered under Mediclaim Policy No. 311100/48/2017/56 with Oriental Insurance Co. Ltd. for the period from 04.04.2016 to 03.04.2017 with sum insured of Rs.1,00,000/-. One more policy was taken by the complainant through his employer with United India Insurance Co. Ltd. for sum insured of Rs.3,00,000/-. The patient was hospitalized in Shri Ram Murti Smarak Institute of Medical Sciences, Bareilly for the period from 17.05.2016 to 19.05.2016 with the complaint of DM + since 4 years, HTN + since 4 years, CAD with Old PTCA + Stenting to LAD. The complainant had lodged a claim for re-imbursement with United India Insurance Co. Ltd. and the same was settled by the company on 22.06.2016 after deducting the amount of Rs.70,160/- due to co-payment clause of 30%. Thereafter, the complainant had lodged the claim for the balance amount of Rs.70,160/- with Oriental Insurance Co. Ltd. but the same was rejected by the company on the ground that co-pay portion deducted by one insurer cannot be claimed with other insurer. The complainant stated that the claim of his mother was rejected by the company on the false ground since there was no condition under the policy, which states that co-payment of one policy of an insurer, cannot be claimed under the policy of another insurer. Further, there was no co-payment clause under the policy of the Oriental Insurance Co. Ltd., hence the contention of the company regarding rejection of claim on the ground of co-payment clause was irrelevant. The complainant has sought relief from this forum for re-imbursement of the claim of his mother. The rejected portion of the original claim was not maintainable as per clause 2.8 of the policy, which states that ***"Co-payment is a cost of sharing requirement under a health insurance policy that provides that the policy holder/insured will bear a specified percentage of the admissible claim amount. A Co-payment does not reduce the sum insured".*** Hearing of the said case was held on 10-10-2017.It was observed that deduction on account of co payment is unjustified. Hence insurance company was directed to pay the copayment to the insured.

19. CASE OF SH. SUSHIL BHATIA V/S STAR HEALTH INSURANCE COMPANY LIMITED.
(AWARD DATED : 10.11.2017)

This complaint is filed by Sh. Sushil Bhatia against Star Health and Allied Insurance Company Limited relating to rejection of his claim on the ground of Pre-existing disease. The complainant stated that he had purchased a health plan from Star Health And Allied Insurance Company Limited for the period from 16-03-2017 to 15-03-2018 for sum insured of Rs. 5 lakh. The complainant was admitted to Medigram Hospital, Saharanpur on 13-06-2017 due to recurrent chest pain radiating to upper arms & upper back for one hour. During investigation he was diagnosed with Coronary artery disease (CAD), acute myocardial infarction(MI), post primary percutaneous transluminal coronary angioplasty(PTCA) stent to left anterior descending(LAD). The complainant was discharged from hospital on 16-06-2017 and he submitted claim documents to the company but his claim was repudiated by the insurer on 24-07-2017 stating that he was suffering from above disease prior to inception of policy. The insurer stated that the complainant had purchased Family Health Optima Insurance plan on 16-03-2017 but had not disclosed any Pre-existing disease at the time of inception of policy. The finding of CAG report dated 13-06-2017 confirmed chronic, longstanding multiple vessel disease with which the patient had been suffering even prior to inception of medical insurance policy. The present admission and treatment of the insured patient was thus for pre-existing disease and as per Exclusion no.1 of the policy, the company was not liable to pay for treatment of the Pre-existing disease/condition, until 48 months of continuous coverage had elapsed, since inception of policy. Hearing of the said case was held on 10-10-2017.The insured did not appear at the personal hearing .The insurer informed that they had settled the claim on 3-10-2017 vide demand draft no.548922 for an amount of Rs.217811/-. In view of above, no arguments were tendered and the complaint is treated as closed.

20. CASE OF MR. ARUP KUMAR NANDI V/S UNITED INDIA INS. CO. LTD.
(AWARD DATED : 01.11.2017)

Mr. Arup Kumar Nandi, the complainant has stated in his complaint that a mediclaim for treatment and surgery of his son was partially settled by the insurance company stating that as per policy terms and conditions, reimbursement of fees/charges paid to visiting doctors was not payable. The complainant stated that his son aged 10 months was admitted in Repose Clinic and Research Centre Kolkata on 28.08.2016 for treatment and surgery of cleft lip and palate. He had incurred an expenditure of Rs.1,44,885/- for the treatment and all the claim papers were submitted to the TPA for reimbursement but the claim was partially paid by the insurance company stating that as per policy terms and conditions, reimbursement of charges paid to visiting doctors (Surgeon and anesthetist) were not payable.The insured argued that both the doctors were not outside doctors. In fact, the hospital calls them for performing surgery and administering anesthesia as per requirement. As advised by the hospital, he had paid Rs. 90,000/- and Rs. 15,000/- directly to the surgeon and to the anaesthetist and they had given payment receipts which were submitted to the TPA along with hospital bills. Hearing of the said case was held on 20-09-2017. The complainant stated that as per verbal advice of the hospital authorities, he had paid fees/charges directly to the surgeon and to the anesthetist and obtained receipts from them. Later, as desired by the TPA, he had also submitted a certificate dated 11.04.2017 wherein, the hospital authorities had confirmed that the insured had made charges directly to the surgeon and to the anaesthetist. The insurer stated that on receipt of complaint through this forum, the claim for cleft lip and palate surgery was reviewed and keeping in view policy condition no. 2.36 which stipulates to pay reasonable and standard charges prevailing in the geographical area for similar services, it was decided to offer Rs. 20,000/- as surgeon fees and Rs. 6000/- as anesthetist fees. The insurer argued that the charges paid by the complainant were on higher side as prevailing rates in Kolkata for similar surgeries in reputed hospitals are much less than the amount paid. In support of their argument, the insurer produced a list of package charges for various surgeries/invasive procedures performed by Indraprastha Apollo Hospital Kolkata, wherein, entitled package charges for surgeries of cleft lip and cleft palate are Rs. 22400 and Rs. 30,500 (Total Rs. 52,900/-) respectively. The insurer further stated that they had already paid Rs. 21300 and Rs. 9492/- (Total Rs. 30792) on account of hospital bill and medicines. If package charges of Apollo

Hospital are taken into consideration, then, they need to pay the balance amount of Rs. 22108/- (Rs. 52,900- Rs. 30792). While, they are offering Rs. 26,000/- as surgeon and anaesthetist charges. Ongoing through the documents exhibited and the oral submissions during the hearing, it is observed that the insurer had wrongly disallowed charges/fees paid by the complainant directly to the visiting doctors. However, contention of the insurer that fees of the visiting doctors was on higher side, appears valid as package charges of Apollo Hospital, a reputed hospital, for the surgeries are much lower than the charges collected by the visiting doctors. Looking at the above factual position, I am of the considered opinion that offer of the insurer to pay an additional sum of Rs. 26,000/- as surgeon and anesthetist fees appears to be reasonable. In addition to above, on going through the policy terms under the head Taxes and other charges, it is observed that the service charges of Rs. 2693/- paid by the complainant were wrongly deducted by the insurer, hence, need to be reimbursed.

21. <u>CASE OF MR. VIRAT TOMER V/S NATIONAL INSURANCE CO. LTD.</u>
(AWARD DATED : 01.11.2017)

Mr. Virat Tomer, the complainant has stated in his complaint that his father was admitted in a hospital on 11.04. 2016 for treatment of Chronic Kidney Disease with HTN but his three supplementary claims pertaining to pre and post hospitalization were wrongly repudiated by the insurance company. The complainant stated that his father was admitted in the Chandra Luxmi Hospital Ghaziabad for the period from 08.04.2016 to 11.04.2016 for treatment of Chronic Kidney Disease with HTN and acute Gastroenteritis. The claim for Hospitalization expenses was settled by the insurer but three supplementary claims for Rs. 4, 68,444/- pertaining to pre and post hospitalization expenses were denied by the insurance company stating that these expenses were incurred for the diseases other than the proximate cause of hospitalization. The complainant further stated that although he had submitted a letter obtained from the attending doctor who confirmed that the claimed amount pertained to the same diseases for which the patient was hospitalized but his claims were not settled by the insurer. The insurer stated that on going through the documents submitted by the complainant, it was observed that the proximate cause of hospitalization was Acute febrile illness with urinary tract infection and chronic kidney disease was a pre-existing co- morbidity and the supplementary claims submitted by the complainant pertained to expenses incurred primarily for Chronic Kidney disease, hence, the same were not relevant to the proximate cause of hospitalization. In view of the above, the supplementary claims were rejected in accordance with policy exclusion clause no. 3.20 and 3.21. Hearing of the said case was held on 10-10-2017.The complainant did not appear for personal hearing. The insurer appeared for personal hearing and informed that the claims were reviewed and all the four claims were settled and paid to the complainant. The complainant also expressed his satisfaction over settlement of the claims over phone. The complaint, therefore, stands closed.

22. <u>CASE OF MR. ABHAY KIMAR GUPTA V/S HDFC ERGO GENERAL INS. CO. LTD.</u>
(AWARD DATED : 16.10.2017)

This complaint is filed by Sh. Abhay Gupta against repudiation of health insurance claim by Hdfc Ergo General Insurance Company. The complainant stated that he was admitted to the Fortis Hospital, Noida on 24-01-2017 for pain in legs. During investigation in the hospital he was diagnosed with T B. and kidney disease and on discharge from hospital on 29-01-2017, he submitted his claim to the company on 7th Feb.2017 which was repudiated by the insurer due to non-disclosure of pre-existing disease. The complainant stated that he was having policy since 2009 and the doctor by mistake had written that he had history of anemia since 5-6 years, though it was detected for the first time during the current investigation as later clarified by the doctor. The insurer stated that the complainant had not disclosed the history of anemia at the time of inception of policy. As per section 10j of policy which states "if any claim is in any manner dishonest or fraudulent, or is supported by any dishonest or fraudulent means or devices, whether by insured person or anyone acting on behalf of an insured person, then this policy shall be void and all

benefits paid under it shall be forfeited". The claim was also denied under Section 9Aiii as the ailment was Pre-existing in nature. The certificate submitted during hearing did not bear the name and stamp of the treating doctor, so the complainant was advised to submit certificate from the treating doctor duly signed and stamped regarding non-existence of any disease prior to the inception of policy. The complainant had then submitted the original certificate of treating doctor duly signed and stamped. The Insurer admitted that they did not have any document to prove that the complainant was having anemia prior to the proposal. Hence, the Insurance Company is directed to settle the claim

23. CASE OF MR. RANGA HARISH V/S UNITED INDIA INSURANCE COMPANY LIMITED.
(AWARD DATED : 05.10.2017)

This is a complaint filed by Shri Ranga Harish against the decision of United India Insurance Company relating to partially rejection of his medi-claim. The complainant stated that his son aged 2 years was admitted in Bayya ENT Hospital Guntur (Andhra Pradesh) on 23.04.2017 for treatment and surgery of Adenoidectomy. He had incurred an expenditure of Rs. 55,000/- for the treatment and all the claim papers were submitted to the TPA for reimbursement but his claim was partially settled by the insurance company stating that reimbursement of expenses of surgery by conventional method only was payable. The surgery of his son was done by an advanced method named as Coblator method which was considered more suitable and safe by the attending doctor in view of tender age of his son. Moreover, there was no condition in the policy prohibiting surgery by an advanced technique. The insurer/TPA stated that in response to request for cashless pre-authorization, they had categorically mentioned that expenses incurred for surgery by conventional method would be payable and accordingly had given authorization for Rs. 20,000/- only but the complainant had opted for advanced method of surgery resulting in additional expenses. The claim was rejected in accordance with policy condition no. 5.29 which stipulates that only reasonable and customary charges would be payable. Ongoing through the documents exhibited and the oral submissions during the hearing, it was observed that surgery by advanced technique was necessary to remove the fluid from the ear; hence, expenses for the same should be reimbursed. Hence, the insurance company is directed to reimburse additional expenses of Rs. 35,000/- incurred by the complainant which were deducted by the insurance company while settling the claim.

24. CASE OF MR. VED PRAKASH SHARNA V/S ORIENTAL INSURANCE COMPANY LIMITED
(AWARD DATED : 26.10.2017)

This is a complaint filed by Shri Ved Prakash Sharma the decision of Oriental Insurance Company relating to inadequate settlement of claim by the Oriental Insurance Company. The complainant stated that he was admitted in Sunetra Eye Centre (P) Ltd., Ghaziabad on 12.07.2017 and 20.07.2017 for micro incision cataract surgery with premium mice lens +FCI (Femto incision) of both eyes. The complainant had incurred expenses of Rs. 60,546/- for right eye and Rs.59,594/- for left eye. The claim was lodged by the complainant with the company for re-imbursement but after various reminders, the company had offered only Rs.24,000/- for each eye. The complainant refused to accept Rs.24,000/- since the expenses incurred by him was much higher for each eye. The complainant stated that eye is an important organ for all human beings hence no compromise was possible with the quality of treatment. The company stated that they were willing to pay in terms of the provision of reasonable and customary charges as per PPN network rates under the policy. They, however, admitted that there was no provision under the policy specifying the limit for the treatment. They also admitted that the expenses were within sum insured. Since, there is no such limiting provision or express exclusion in the policy and sum insured covers the expenditure, the Insurer has no ground to deny the claim. The decision of insurance company to deduct the amount of claim for micro incision cataract surgery with premium

mice lens + FCI (Femto incision) of both eyes is not correct, hence the Insurance Company was directed to reconsider the claim and to pay the admissible claim amount without applying the PPN rates contracted by them with the hospital.

25. CASE OF MR. SURENDER SINGH SIROHI V/S NATIONAL INSURANCE CO. LTD.
(AWARD DATED : 03.10.2017)

The complainant was admitted in the Apollo Hospital Sarita Vihar Delhi on 20.10.2016 for treatment of low grade fever which was running for 15 days and high PSA. He had incurred an expenditure of Rs. 2, 20,577/- and all the required documents and medical papers were submitted but the Insurer/TPA had approved the claim only for Rs. 77774/- after making various deductions including a sum of Rs. 93820/- being cost of three tests namely Whole body PET Scan, CT Chest and Pro-biopsy (urology) stating that the tests were not relevant to the illness/diagnosis, hence, were not required. The insurer/TPA stated that the patient was diagnosed with Hypertension, fever and high PSA. The attending doctor had performed Needle biopsy to rule out cancer which confirmed that the disease was only in benign stage and no malignancy was found but the said three diagnostic tests were still conducted without any need, hence, expenses incurred for these tests were deducted from the claim. Ongoing through the documents exhibited and the oral submissions during the hearing, it is observed that the attending doctor had given in writing vide letter dated 07.04.2017 that all the tests were conducted in accordance with the protocol of diagnosis and treatment of pyrexia (fever) of unknown origin and it is an established fact that an attending doctor is the best judge to decide line of treatment and requirement of various diagnostic tests for a patient and not a TPA. Hence, the Insurance Company is directed to reimburse the expenses incurred by the complainant for the three diagnostic tests namely Whole body PET Scan, CT Chest and Pro-biopsy (urology) within 30 days under intimation to this forum.