BHUBANESWAR

Over Seas Mediclaim

BHUBANESWAR OMBUDSMAN CENTER

Complaint No.11-003-0689

Smt Uma Saha
Vrs
National Insurance Co. Ltd., Rourkella DO

Award dated 21 Sept 2010

Complainant had taken an Over Seas Mediclaim Policy with National Insurance Company Ltd for trvelling to USA. While in USA, she was admitted to a hospital. Diagnosis revealed a 3rd degree A V Block and pace maker was implanted. She filed a claim. Insurance company repudiated the claim on the ground that the ailment was pre existing.

Hon'ble Ombudsman heard the case on 20.09.2010., where both sides were present. Complainant pleaded that the policy is useless, if pre existing diseases are not covered. The insurer falling on policy conditions stated that the contract does not allow coverage of pre existing diseases. Hon'ble Ombudsman after hearing both sides and on perusing documents including policy conditions, opined that pre existing disease is an exclusion and hence the decision of repudiation by insurer is right.

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HYDERABAD

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.14.251.2010-11

Sri H. Seetharama Swamy Umadevi Vs. Cholamandalam Ms. Gen. Ins. Co. Ltd

Award No:G-115/12.10.2010

Smt H.S.S. Uma Devi took short term Travel Insurance Cover on 23.3.09 and went to United States & Canada along with her daughter. The period of cover under the policy was from 25.3.09 to 20.9.09. She preferred a claim on the policy for

'Acupuncture' treatment which she underwent from 19.8.09 to 12.9.09 in Canada and on her return to India she submitted bills for treatment expenses of $ 525. The claim was denied by insurer stating that out patient treatment taken by her did not fall under clause 23 of the policy. She stated that she made representation for consideration of claim to the insurer and it was also rejected. Aggrieved, Smt. H.S.Uma Devi filed complaint for redressal.

The complainant stated that she was suffering so much from pain in her left arm that she could not lift her arm to pick up even a glass of water. The consulting doctor diagnosed the condition as 'Bicipatal Tendonitis'. She preferred 'Acupuncture' treatment as she was allergic to many allopathic medicines and she was apprehensive that the new allopathic doctor might not address her problem adequately. She informed to the insurer on the toll free number specified in the policy before start of her acupuncture treatment. She stated that no communication was received from the insurer or their overseas administrator. She took 'acupuncture' treatment from 19.8.09 to 12.9.09 and it costed her Canadian $ 525. On return to India, she preferred the claim. She stated that the policy given to her did not exclude 'acupuncture' treatment. After a long lapse of time, the insurer informed that the treatment was not covered under the policy.

The insurer contended that the expenses incurred by the complainant for 'acupuncture' treatment did not fall under policy coverage. They stated that it fell under policy exclusion C, Sec. B and Cover I – Medical Expenses which read as under:

> *"The insurer shall not be liable for any claim under this cover that is caused by, attributable to, arises out of: - Any treatment which could in the opinion of the overseas administrator and attending doctor be or have been delayed until the insured's return to India".*

It was also further stated by them that the claim could not even be entertained under Clause 23 of the definition of the policy wordings. As per the said clause, OPD treatment was covered only when the condition was critical and could not be deferred till the insured's return to India.

They state their rejection was justified as per policy terms and conditions.

O R D E R

The contention of complainant was that she complied with the policy condition of informing the insurer / overseas administrator about the problem and the proposed treatment but there was no response from the insurer. The insurer's representative raised an objection to this and stated that the request was not made since otherwise the request would have been registered by their overseas administrator. Whether the complainant registered the claim abroad or not is not crucial because in any case the policy provides for submission of smaller amounts without overseas registration of the claim.

The policy does not exclude acupuncture treatment. The complainant underwent acupuncture treatment and explained the reasons for such treatment. Opinion of overseas administrator or the attending doctor is *sine qua non* for applying exclusion C under the policy. The insurer has not obtained any such opinion. The complainant also has produced a certificate from the doctor stating that her condition was critical and that she required treatment immediately.

In view of the above, It was held that the insurer repudiated the claim for specious reasons. Consequently, the insurer is directed to admit the claim for Canadian $ 425/- [after deduction of $100/- as per the policy] and pay the same to the complainant. The complainant also sought expenses and interest, which are not allowed in this award.

In the result, the complaint is allowed in part as above.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.12.305.2010-11

Shri K M Krishna Mohan V/s ICICI Lombard Gen. Co. Ltd.

Award No:G-136/16.11.2010

Sri M. Krishna Mohan and his wife took travel insurance policies with the insurer. Sri M. Krishna Mohan's wife was k/c/o "Diabetic" and under control. That she was a diabetic was declared while taking the policy and the policy also was issued by the insurer stating it as pre-existing ailment. While in the US, due to climatic changes, her sugar levels shot up and she underwent treatment for the same. The claim preferred by

them was rejected by the insurer stating it as pre-existing ailment. Aggrieved, Sri M. Krishna Mohan filed this complaint.

Pursuant to the notice given by this office, the complainant and the insurer's representative attended hearing on 28-10-2010.

In the hearing, the complainant stated that his wife suffered extensive blood sugar fluctuations due to the extreme cold weather conditions and owing to the altitude of the place where they stayed. Before leaving India, her blood sugar levels were normal for the past 6 months and the aggravation in the US occurred only due to the climatic conditions. He stated that the blood sugar levels shot up to 360 to 390 for fasting and 480 to 520 post lunch. The medicine that his wife took in India did not prove helpful at all in controlling the blood sugar levels and when the sugar levels touched alarming levels, they had to seek medical assistance there. The insurer's representative stated that the insured person took treatment for diabetes, which was a pre-existing condition. The policy did not cover pre-existing disease or illness and, therefore, the claim was correctly denied under the policy.

It is not in dispute that the insured person was a diabetic. She took the policy after declaring her ailment. As per the customer information sheet supplied by the insurer to the insured person, it is mentioned that pre-existing disease or illness is excluded except in life saving unforeseen emergency and/ or acute painful conditions. The policy, therefore, undoubtedly excluded PED. Exception to this, however, is life saving or emergency treatment. Blood sugar levels beyond 480 post lunch can be life threatening and the person has to seek medical attention on emergency basis.

In view of the above, it was convinced that the insured person was presented with a life threatening situation and she had to seek medical intervention immediately. The policy issued to the insured person covers treatment in such circumstances.

In the light of the aforesaid, it was held that the insurer erroneously rejected the claim of the insured person. The insurer is directed the insurer to settle the claim at US $ 395 ($495 less $ 100 deductible).

In the result, the complaint is allowed in part for US $ 395.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.12.453.2010-11

Award No:G-177/6.1.2011

Sri M.S.Suryanarayana Murthy **V/s** ICICI Lombard Gen. Ins. Co. Ltd

Sri M.S.Suryanarayana Murthy took the insurer's Overseas Individual Travel Insurance Policy to cover his overseas travel to the USA and stay of 180 days there from 3.03.2010 to 29.8.2010. Due to acute abdominal pain he was hospitalized on 2.5.2010 in emergency condition and was treated for kidney stones. Adhering to the doctor's instructions he had follow up medical attention for the next 6 weeks. All the bills raised by the hospital and other service providers were submitted to the insurer and lodged the claim on prescribed format after completion of treatment on 20.5.2010. He also filed his final claim for reimbursement of expenses on 17.8.2010. The Insurer dodged to pay the claim and the hospital handed over the bill collection to recovery agents in the US and they initiated steps against him to recover the bill amount. All his efforts by sending 85 e-mails and around 182 telephone calls made from the US and also from India at considerable expense failed to elicit any response from the insurer. Aggrieved, Sri M.S. Suryanaryana Murthy filed this complaint.

The complainant stated that non-payment of bills by the insurer hospital and other service agency classified his unpaid bills as 'delinquent' which classification would have an adverse effect on his credit rating for no fault of his. He requested to take up the matter with the insurer for payment of his legitimate claim and for payment of suitable compensation for mental agony.

He further informed that after lodging the complaint with this office and initiation of our proceedings, the insurer's TPA sent a cheque for Rs.3096/- detailing their settlement. He replied to the insurer immediately for the amounts and deductions he agreed as per the policy and stated

that he did not agree for deduction of US $ 176.55 which were deducted by the TPA towards treatment charges for blood pressure since expenses related to PED. He replied to them that he had neither hypertension [blood pressure] nor was he treated for it in the hospital. He stated that he was treated in the hospital for kidney stones only. He demanded for payment of US$ 176.55 without any deduction as per the policy. He also wanted to know the status of 'cashless' part of the claim.

The insurer sent their brief note stating that an amount of US $ 2289.98 had already been paid to the hospital by their TPA and reimbursement claim of the insured person was settled as per policy terms and conditions. They stated that they had already discharged their liability under the policy and requested to treat the matter as closed.

O R D E R

The policy covers (i) hospital room (ii) ICU charges (iii) surgical treatment (iv) anesthetist services (v) physician's visits (vi) diagnostic and pre-admission testing and (vii) ambulance services. In respect of the claim in question, only expenses in respect of items (v) and (vi) ate in dispute in addition to the cost of medicines purchased.

The limit for physician's visits as per the policy is $75 per visit. Treatment of the complainant involved 4 visits of the physician. The insurer stated that it paid $300 under this head covering four visits @ US $ 75 per visit. The complainant stated that the insurer paid less than this amount under this head. The insurer is directed to verify the payment and ensure that shortfall, if any, on this score is made good forthwith.

Under the head 'diagnostic and pre-admission testing', the insurer paid $750 which is the maximum amount payable under the head. The complainant stated that radiology expenses should not be part of this head. This cannot be accepted since there is no other head, out of the heads mentioned supra, where radiology expenses could be covered. All diagnostic expenses including radiological treatment, therefore, are subject to a ceiling of $750 even though the bill under this head was for $3933. The insurer has paid $750 under this head. Consequently, nothing more is payable under this head.

Hypertension is a pre-existing condition under the policy issued to the complainant. Therefore, any expenses relating thereto cannot be allowed. But

Tamsulosin, Promethazine, Hydrocodone and Ciprofloxacin capsules / tablets are not used in treatment of hypertension. Therefore, the insurer erred in disallowing the claim in relation to the cost of these medicines. The insurer is directed to examine the claim and allow the same without associating the expense with any pre-existing condition.

In the result, the complaint is partly allowed.

KOLKATA

Kolkata Ombudsman Centre
Case No. 501/11/012/NL/12/2009-10
Shri Madan Lal Agarwal
Vs.
ICICI Lombard General Insurance Company Ltd.

Order Dated : 31.01.2011
Facts & Submissions:

This complaint is filed against partial repudiation of a claim under Overseas Individual Travel Insurance Policy issued by ICICI Lombard General Insurance Company Ltd.

The complainant Shri Madan Lal Agarwal stated that he met with a road accident during his trip to Orlando (USA) and he was hospitalized at Orlando Regional Medical Centre (USA) from 22.05.2007 to 23.05.2007. The treatment was carried out on a cashless basis after receiving the requisite approval from the authorized overseas representatives of the insurance company. Subsequently he was informed by M/s OVAG International AG that the insurance company had only made an ad-hoc payment of $3,425 against the hospital's total bill amount of $23,685.Thereafter, he had been receiving constant reminders and demands for payments from M/s OVAG International AG for payment of the balance amount. He followed the matter with the insurance company and M/s International SOS Services (I) Pvt. Ltd. and has approached them umpteen times through personal visits at their office and written communication requesting them to settle the claim in his favour but all his efforts have proved futile and seem to have fallen on deaf ears. He had not received any communication from them either verbal or written. As a final reminder he represented to the insurance company on 18.05.2009 requesting the insurance company to review and settle his balance claim. His representation was not considered by them. Being aggrieved, the complainant approached this forum for redressal of his grievance seeking monetary relief of Rs.13 lakhs.

DECISION:

We find that insurer has not yet taken any decision in this case. Therefore, there is no cause of action for us to intervene at this stage. The jurisdiction under Redressal of Public Grievances rules is applied only when a final decision has been taken by the insurer and the same has been communicated to the complainant. Since the claim is pending for more than a year, the insurer is directed to complete their investigation and take a final decision to admit/ repudiate the claim and communicate the same to the complainant within 30 days.

MUMBAI
10th day of January, 2011

BEFORE THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)
MUMBAI

Complaint No. GI 472 of 2010-2011
Award No. IO/MUM/A/ 447/2010-2011
Complainant: Shri Raman Narayan
V/s
Respondent: Oriental Insurance Co. Limited

Shri Raman Narayan took a Traweltag Policy bearing No. 121800/48/2009/10244/WR/WAI/BR/6/HRM/1220633 valid from 4/7/2009 to 20/11/2009 issued by Oriental Insurance Company Limited from his travel agent covering his study trip to France and USA . After around 40 days of his overseas trip, whilst in Michigan, he developed acute back pain and problems of evacuation. He sought medical assistance from the University of Michigan Hospitals for the above referred physical discomforts. He was referred to various Specialists and underwent all sorts of procedures and diagnostic test as per US practices commencing from 24/8/2009 to 1/10/2009.

During his treatment, he kept in touch with Coris Miami for prior approvals for the treatment which was apparently not given and later the TPA, Heritage-Mumbai gave their repudiation letter dated 9th October,2009 rejecting the claim on the grounds that complaints had started 1-2 months back. His representations made to the Insurance Company did not evoke any response for which he approached the Insurance Ombudsman praying for release of payment to University of Michigan Hospitals, aggregating to US $ 9385 towards diagnostic expenses and US$ 3813 for professional charges as also release of medical expenses incurred by him in India for treatment. On going through the various medical records produced to the Forum it is observed that the complainant was presented to the Michigan University Hospital on 24/8/2009 and he was diagnosed to be suffering from severe spinal stenosis with internal and external haemorrhoids and atypical lipoma versus low grade liposarcoma. In the case papers there is a mention of the insured's past history of the ailments of approx. 1-2 months duration.

The scrutiny of the medical records coupled with the investigation reports and treatments recommended throws light to the fact that all the 3 ailment were suggestive to be of a longer duration than between 1-3 months as recorded in the case papers. This view emerges from the impression of the MRI report of the Spine done giving the findings as 'Spine Stenosis'/'advanced degeneration' and revelations of multiple polyps and external and internal haemorrhoids from the Cystoscopy done and the size of the mass in the left thigh which are no doubt a progressive process over a period of time. It is also noted that the complainant was aware that the problems were existing, although not diagnosed, prior to taking the Insurance Policy, since he narrated his past complaints precisely to the consultants which were duly recorded in hospital case papers. Hence to

that extent it was not only within the knowledge of the Insured but also a pre-existing condition.

The nature of coverage of the policy, makes it necessary to incur the medical expenses for a sudden and unexpected sickness or accident arising when the Insured Person is outside the Republic of India. The claim also attracts our attention on the pre-existing exclusion and condition.

Strictly as per the policy conditions, the Insurance Company's standpoint that the ailment was pre-existing is acceptable, however, the whole issue being a borderline case with symptoms occurring for 1-2 months as recorded in the hospital papers, would be just before the policy was taken coupled with the fact that the ailment was not identified or diagnosed before and there being no past surgical history or medications taken except a haemorrhoid steroid cream for painful bowel movement as per records, the case deserves some consideration and therefore, 50% of the admissible expenses should be reimbursed in respect of two ailments denied by the Insurance Company for which he availed treatment abroad.

As regards, the complainant's plea for reimbursement of medical expenses incurred in India for Spine surgery under the said policy, Specific condition No. 7 of the Policy is clear to mention that "no claim shall be paid under the policy in respect of medical treatment and related services obtained within the republic of India except as stated."

Dated at Mumbai, this 10th day of January, 2011.

9.3.2011 Overseas Mediclaim

Complaint No. GI- 742 of 2010-2011
Award No. IO/MUM/A/534 /2010-2011-9.3.2011
Complainant : Shri. Tarun Rai
Respondent : The Oriental Insurance Co. Ltd.

Shri. Tarun Rai availed Overseas Mediclaim Insurance Policy through M/s Travel Tag. The said policy was issued by The Oriental Insurance Co. Ltd covering his mother Late Smt. Satya Mehta Rai during the period 4.4.2009 to 30.9.2009 with Certificate Exclusions of "Medical Expenses section restricted upto US$10000 including Hospitalization due to an accident. Hypertension." The claim arose under the Policy when Smt. Rai during her stay abroad was admitted to South Warwickshire General Hospital NHS Trust from 10.7.2009 to 21.7.2009 where she was diagnosed a case of Biventricular failure with global poor RV and LV and the secondary diagnosis and co-morbidities were mentioned as "Asthma, Ovarian Ca, Hypertension". Smt. Satya Rai succumbed to her illness and expired on 6th September, 2009 at Warwickshire. When complainant lodged a claim of UK pounds 6889 towards the expenses incurred on medical expenses, hospitalization expenses and funeral cost, the same was denied by M/s Heritage Health TPA Pvt. Ltd., TPA of the Insurance Company by stating that the

ailment suffered by the insured is a direct complication of past medical history of hypertension, which is excluded from the scope of policy coverage. Being aggrieved complainant approached this Forum. The parties to the dispute were heard during the personal hearing. Complainant contested that in the opinion of the doctors the ailment suffered by his mother was not the result of pre-existing condition of hypertension.

Observations : The analysis of the case revealed that the coverage under Medical Expenses cover was intended for use by the person insured under the Policy in the event of sudden and unexpected sickness or accident arising when he/she is outside the Republic of India, which included expenses for physician services, hospital and medical services. In the instant case it was observed that Smt. Rai was suffering from Hypertension and was on medication for the same, prior to taking an OMP Policy. No doubt, it is well established fact in Medical Science that Hypertension is one of the major risk factors for Cardiac diseases. In the instant case however, Smt. Rai was hospitalized & treated in the hospital for severe impairment of the left and right ventricular function. The coronary angiography report indicated – "Clinical scenarion suggests presented with myocarditis". The treating doctor ruled out the possibility of the role of hypertension or coronary disease to cause the present ailment and was of the view that the presentation fitted best with an acute inflammatory or infected insult of heart muscle giving rise to a myocarditis.

It was observed that for denial of claim, Insurance Company/TPA chose to take the cause of death mentioned in the death certificate as an ailment suffered by her and linked the same to the condition of hypertension. even though it was a fact that the death of Smt. Rai took place after nearly two months from the date of hospitalization. It was further noted that the doctor to whom the file was referred for his opinion asked the TPA to call for ECG, Angiography report, complete set of indoor medical records and any test reports showing evidence of myocarditis. However, Insurance Company/TPA had not even bother to examine the indoor case papers of the hospital before rejecting the claim neither had they taken cognizance of the Angiography Report. The Oriental had merely taken the contention of the TPA and supported their view based on the cause of death mentioned in the Death Certificate without taking into account the contents of Angiography Report and views expressed by the Treating doctor. Insurance Company did not challenge the views expressed by the Consultant Cardiologist by referring the case to an independent Cardiologist of the repute and an opinion was just sought from the M.S. doctor. Also, the advices given by this doctor to call for further papers & reports were simply ignored and the decision of the TPA was upheld. Considering these facts, it was observed that the decision of the Insurance Company to reject the claim on the ground that the ailment suffered by Smt. Rai was a complication of hypertension was not conclusively established and hence was not accepted.

The complainant was also awarded reimbursement of Funeral expenses except the Air Ticket charges and the decision of the Insurance Company to restrict the coverage for Medical Expenses section up to US$10,000 was held as not acceptable in view of the fact that the complainant had submitted medical documents at the time of taking the Policy.. The expenses incurred on consultation for low back pain and the corresponding

X-ray report were considered as not payable since the same were not falling under the scope of the Policy.