IN THE PUNJAB AND HARYANA HIGH COURT AT CHANDIGARH

119

CWP-13225-2023 (O&M).
Date of Decision: 03.07.2023.

The Oriental Insurance Company Limited

.. Petitioner

Versus

Promila Kumari and others

... Respondents

CORAM: HON'BLE MR. JUSTICE VINOD S. BHARDWAJ.

Present: Mr. Ram Avtar, Advocate,
for the petitioner.

VINOD S. BHARDWAJ, J. (ORAL)

Challenge in the present petition is to the Award dated 25.11.2022 (Annexure P-1) passed by the Permanent Lok Adalat (Public Utility Services), S.A.S. Nagar, Mohali, whereby the petitioner-insurance Company has been directed to reimburse the medical expenses incurred by respondent No.1-applicant as per package rates defined under the Insurance Scheme and as per the PGEPHIS admissible rates. Additionally, a compensation of Rs.15,000/- along with litigation expenses of Rs.10,000/- has also been ordered by the Permanent Lok Adalat (Public Utility Services), S.A.S. Nagar, Mohali.

Briefly summarized, the facts of the case are that the respondent No.1-applicant is a retired Govt. employee and had availed medical treatment from MAX Super Specialty Hospital, Mohali for Pancreatitis in the month of November 2016. The petitioner-Insurance

Company had entered into an agreement with the Govt. of Punjab for extending insurance cover for treatment to the employees/retired employees of the Govt. of Punjab for their indoor medical treatment, specified day care and chronic diseases. The respondent No.1-applicant claimed that she was covered under the Cashless Health Insurance Scheme as notified by the State of Punjab on 20.10.2015 for the identified disease including pancreatitis for which she was admitted in the month of November 2016 and discharged on 05.12.2016. Even though cashless scheme was available, however, the same was refused by the respondent-hospital as a result whereof respondent No.1-applicant had to defray all the expenses from her own pocket. A claim was thereafter raised by the respondent No.1-applicant with the petitioner-Insurance Company, however, the same was rejected by the petitioner-Insurance Company vide letter dated 29.03.2017 on the ground that the policy does not entitle her for reimbursement of the medical claims under cashless insurance scheme.

Hence, an application under Section 22-C of the Legal Services Authorities Act, 1987 (hereinafter referred to as 'the Act of 1987') was preferred by the respondent No.1-applicant before the Permanent Lok Adalat (Public Utility Services), S.A.S. Nagar, Mohali. Notice of the said application was issued whereupon the petitioner-Insurance Company filed its written statement. It was averred that the claim of the respondent No.1-applicant was repudiated as the tie-up with the Govt. of Punjab is for a cashless treatment and reimbursement is not permissible for the treatment in Punjab, Chandigarh and Panchkula where cashless scheme is available. Since a request for cashless treatment had not been submitted at the time of admission and in view of the express prohibition contained in the Scheme,

the respondent No.1-applicant cannot seek reimbursement in violation of the terms and conditions of the notification dated 20.10.2015.

Efforts were made by the Permanent Lok Adalat (Public Utility Services), S.A.S. Nagar, Mohali, to amicably resolve the dispute, however, the same failed to yield any result. Consequently, adjudication of the dispute under Section 22-C (8) of the Act of 1987 was initiated by the Permanent Lok Adalat (Public Utility Services), S.A.S. Nagar, Mohali.

After consideration of the respective contentions raised by the parties, the application in question was allowed and the petitioner-Insurance Company was directed to pay the package rates defined under the Cashless Scheme along with compensation and litigation expenses.

Aggrieved thereof, the present writ petition has been filed.

Learned counsel for the petitioner has vehemently argued that the petitioners have processed the claim made by respondent No.1-applicant in terms of the notification dated 20.10.2015 as per which an employee was entitled to take benefit of treatment from any Govt. or empanelled hospital in Punjab, Chandigarh and Panchkula region and that clause IV of the above said notification specifically contemplated that no reimbursement will be available to employees/pensioners in Punjab, Chandigarh, and Panchkula where cashless scheme is available. Reimbursement can be taken by the employee/pensioners for medical treatment taken in any other State in India in exceptional circumstances and reimbursement upto Rs.3 lakhs as per the package rates defined under the Scheme. Since there is a specific embargo in the above said notification hence there was no illegality in the action of the petitioner-Insurance Company not ordering reimbursement.

It was also argued that the respondent No.1-applicant did not inform the Hospital that the facility of cashless treatment was available and that she having not claimed cashless treatment cannot thereafter be permitted to raise the above said claim more-so when the policy stipulated against reimbursement.

Learned counsel for the petitioner-Insurance Company, however, does not dispute the fact that the treatment extended to the respondent No.1-applicant was covered under the above said policy and that the hospital in question is an empanelled hospital under the scheme. He further does not dispute the fact that there is no material available with the petitioner-Insurance Company on the basis whereof it may be held or assumed that the respondent No.1-applicant was never admitted or extended any medical treatment for the above said disease.

A pointed query was also raised to the counsel for the petitioner-Insurance Company as to the object behind incorporation of the above said clause and the prejudice that may be suffered by the petitioner-Insurance Company especially when it was otherwise liable to pay the expenses incurred under the cashless policy. Counsel for the petitioner was also called upon to refer to any regulations notified by the Insurance Regulatory and Development Authority (IRDA) under which a claim, which is otherwise admissible, can be repudiated on the above said account especially when no prejudice has been established. Counsel for the petitioner-Company failed to respond to the above queries or refer to any judgment to support its claim.

I have heard the learned counsel for the petitioner-Insurance Company and have gone through the documents available on record with his able assistance.

It is also seen from the record that respondent-applicant had taken a specific stand before the Permanent Lok Adalat (Public Utility Services) that she had applied for cashless facility as per the Scheme, however, the enlisted hospital refused to provide the said facility. The specific averment raised in the claim application was responded too vaguely and not even dealing with the above allegation. No enquiry was conducted by the petitioner Insurance Company into the allegations levelled by the applicant. There was no occasion as to why the petitioner Insurance Company did not verify the said allegations.

The Permanent Lok Adalat (Public Utility Services), S.A.S. Nagar, Mohali, has considered the disputed contentions in its impugned Award dated 25.11.2022 which is noticed as under:-

> *"14. Whereas the respondents argued that the respondent no. 1 hospital is empanelled hospital of the respondent no. 2 i.e. Insurance company and cashless treatment is available in the said hospital under the cashless health insurance scheme for Pb. Govt. employees/retired employees but the applicant had not claimed the cashless treatment from respondent no.1 when she was admitted in the hospital therefore she is not entitled to reimbursement of the medical expenses incurred by her on her treatment.*
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> *15. As in this case there is no dispute between the parties that the applicant is entitled for Cashless Health Insurance Scheme to cover the indoor medical treatment specified by the Pb. Govt. as per notification dated 20.10.2015. It is also admitted*

case of the parties that the Max Super Specialty Hospital respondent no. 1 is empanelled hospital under this scheme formulated by the Govt. of Pb. of cashless treatment to the Pb. Govt. employees/retired employees. The dispute is that the respondent claimed that applicant has not claimed cashless treatment from respondent no. 1 when she was admitted in the said hospital for her treatment. Therefore, she is not entitled for reimbursement of the medical expenses incurred by her (sic) treatment. However, it is un-natural and un-acceptable that if the applicant is entitled for cashless treatment from respondent no.1 and despite it she paid all expenses from her own pocket amounting Rs. 2,12,512/-. It is unreasonable that applicant has paid her medical expenses in cash to respondent no.1, despite when she can claim cashless treatment from the hospital respondent no. 1. Therefore, this Adalat comes to the conclusion that as claimed by the applicant when she was admitted in the hospital of respondent no.1, the cashless treatment was promised by respondent no. 1 but later on refused by respondent no. 1 and thereafter the applicant had to pay amounting to Rs. 2,12,512/- from her own pocket due to refusal of respondent no.1. Moreover, she was admitted in the hospital when she was suffering from pancreatitis and she remained in the hospital from 23.11.2016 to 05.12.2016. The applicant remained in hospital for about 12 days of the respondent no.1, it shows that she was suffering from some serious disease and due to urgency of her treatment she has to get her admitted in the hospital of respondent no. 1. It is natural that when the patient is in serious condition admitted in the hospital, it was the first priority of the patient to get her medical treatment started immediately despite to raise dispute with regard to the payment of the medical expenses. Hence, after considering all these facts, this Adalat comes to the conclusion that respondent no.1 refused to provide the cashless medical treatment to the applicant when she was admitted in

the hospital on 23.11.2016 and she was compelled to pay all the expenses amounting to Rs. 2,12,512/- from her own pocket.

16. Therefore, respondent no. 2 to 4 are directed to reimburse the medical expenses occurred by the applicant while got medical treatment from respondent no. 1 as per the package rate defined under the scheme and as per PGPHIS admissible rates. The respondents no. 2 to 4 are further directed to pay amount of Rs. 15,000/- as compensation apart from Rs. 10,000/- as litigation expenses. The said amount has to be reimbursed to the applicant along with interest @ 9% from the date of filing of the application till the realization of the said amount. Award is passed accordingly. Copy of award be supplied free of costs to the parties. File be consigned to record."

It is evident that the respondent No.1-applicant was covered under the cashless policy. The justification given by petitioner-Insurance Company for non-reimbursement is that the claim should have been raised for cashless scheme especially when the respondent No.1-applicant had been treated in a hospital in Mohali which is covered under the cashless insurance policy of petitioner-Insurance Company.

The respondent-applicant having levelled specific allegation against the hospital in not providing cashless facility, the Insurance Company cannot be permitted to derive any benefit of its failure to ensure the services and facilities in terms of the notification and also refuse to indemnify the consumers for the inconvenience they had to undergo because of lapses of the Insurance Company. Its failure to ensure availability of standard facilities as per the notified scheme dis-entitles it

from raising defence of other clauses. The situation, such as above, has not been contemplated in the Scheme. Hence, necessary interpretation in furtherance of the object need to be given to the Scheme document so that a beneficiary is not deprived of the benefits of the Scheme. The lacunae need to be filled up by judicial intervention and interpretation. Once the Insurance Company has undertaken upon itself to bear all expenses and the employee has gone to an enlisted hospital, the employee cannot be stated to be in lapse.

The employee infallibly performed its prudence in going to the enlisted hospital for treatment. The condition of the employee cannot at that juncture be presumed to permit her to search hospitals. Being left with no options in that hour of emergency, she had to make the payment.

Counsel for the Insurance Company also failed to refer to any statutory provision or the Regulations under which claim could be denied under the cashless policy where the enlisted hospital of the Insurance Company refuses to provide the facility promised under the Scheme.

The insurance policy/medi-claim policy are for the welfare of the people availing such benefits. The above said policy cannot be literally interpreted to deny legitimate and undisputed claims of the person insured. It must also be kept in mind that clauses which deny the benefit must be specifically brought to the notice of the parties. It has also been a settled position in law that where terms and conditions of a contract of insurance has two possible views, the interpretation in favour of the insured has to be accepted. Under the given circumstances, when two possible interpretations are possible, the one extending favour to the insured needs to be accepted.

The Hon'ble Apex Court in catena of judgments has held that Insured has a right to favorable interpretation in case of ambiguity in Insurance Policy. In the matter of ***Haris Marine Products Vs. Export Credit Guarantee Corporation (ECGC) Limited, reported as 2022 SCC Online SC 509***, the Hon'ble Apex Court has observed as under:-

> *"16. It is entrenched in our jurisprudence that an ambiguous term in an insurance contract is to be construed harmoniously by reading the contract in its entirety. If after that, no clarity emerges, then the term must be interpreted in favour of the insured, i.e., against the drafter of the policy. In deciding the applicability of a cover note on houses swept away by floods, a Constitution Bench of this Court in* ***General Assurance Society Ltd. v. Chandumull Jain, (1966) 3 SCR 500****, para 11 held as follows:*
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> > *"In other respects there is no difference between a contract of insurance and any other contract except that in a contract of insurance there is a requirement of uberrima fides i.e., good faith on the part of the assured and the contract is likely to be construed contra proferentem that is against the company in case of ambiguity or doubt… (I)n interpreting documents relating to a contract of insurance, the duty of the court is to interpret the words in which the contract is expressed by the parties, because it is not for the court to make a new contract, however reasonable, if the parties have not made it themselves".*
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> *(Emphasis supplied)*
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> *While the court ultimately denied insurer's liability, it laid down the manner in which ambiguities were to be interpreted. Since then, a catena of judgments has upheld this approach. In* ***United India Insurance Co. Ltd. v. Pushpalaya Printers, (2004) 3 SCC 694,*** *para 6, a Division Bench of this Court was confronted with interpreting the term 'impact' in an insurance*

policy for protection against damage caused to the insured building. Interpreting the term to include damage caused by strong vibrations by heavy vehicles without 'direct' impact, this Court held:

> *"The only point that arises for consideration is whether the word "impact" contained in clause 5 of the insurance policy covers the damage caused to the building and machinery due to driving of the bulldozer on the road close to the building... (I)t is also settled position in law that if there is any ambiguity or a term is capable of two possible interpretations, one beneficial to the insured should be accepted consistent with the purpose for which the policy is taken, namely, to cover the risk on the happening of certain event... Where the words of a document are ambiguous, they shall be construed against the party who prepared the document. This rule applies to contracts of insurance and clause 5 of the insurance policy even after reading the entire policy in the present case should be construed against the insurer".*
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> *(Emphasis supplied).*

Similarly, in ***Sushilaben Indravadan Gandhi v New India Assurance Company Ltd., (2021) 7 SCC 151****, paras 37-42 this Court charted the evolution of the rule of contra proferentem, and relied inter alia on its explanation as provided under Halsbury's Laws of England:*

> *"Contra proferentem rule.—Where there is ambiguity in the policy the court will apply the contra proferentem rule. Where a policy is produced by the insurers, it is their business to see that precision and clarity are attained and, if they fail to do so, the ambiguity will be resolved by adopting the construction favourable to the insured. Similarly, as regards language which emanates from the insured, such as the language used in answer*

to questions in the proposal or in a slip, a construction favourable to the insurers will prevail if the insured has created any ambiguity. This rule, however, only becomes operative where the words are truly ambiguous; it is a rule for resolving ambiguity and it cannot be invoked with a view to creating a doubt. Therefore, where the words used are free from ambiguity in the sense that, fairly and reasonably construed, they admit of only one meaning, the rule has no application."

The rule of contra proferentem thus protects the insured from the vagaries of an unfavourable interpretation of an ambiguous term to which it did not agree. The rule assumes special significance in standard form insurance policies, called contract d' adhesion or boilerplate contracts, in which the insured has little to no countervailing bargaining power. This consideration is highlighted in the facts of this case, since the risks that ECGC is mandated to cover is its business, and other insurers rarely foray into the field."

Further, the Hon'ble Supreme Court in the matter of ***Texco Marketing Private Limited Vs. Tata AIG General Insurance Company Limited and others, reported as (2023) 1 Supreme Court Cases 428***, has held that insurance contracts are adhesion contract also known as standard form of contract, heavily favour insurers as consumer have little bargaining power, hence, in such contracts full discloser and notice on part of insurer is excepted.

10. Adhesion contracts are otherwise called Standard-Form Contracts. Contracts of Insurance are one such category of contracts. These contracts are prepared by the insurer having a standard format upon which a consumer is made to sign. He

has very little option or choice to negotiate the terms of the contract, except to sign on the dotted lines. The insurer who, being the dominant party dictates its own terms, leaving it upon the consumer, either to take it or leave it. Such contracts are obviously one sided, grossly in favour of the insurer due to the weak bargaining power of the consumer.

11 . The concept of freedom of contract loses some significance in a contract of insurance. Such contracts demand a very high degree of prudence, good faith, disclosure and notice on the part of the insurer, being different facets of the doctrine of fairness. Though, a contract of insurance is a voluntary act on the part of the consumer, the obvious intendment is to cover any contingency that might happen in future. A premium is paid obviously for that purpose, as there is a legitimate expectation of reimbursement when an act of God happens. Therefore, an insurer is expected to keep that objective in mind, and that too from the point of view of the consumer, to cover the risk, as against a plausible repudiation."

The Permanent Lok Adalat (Public Utility Services), are governed by the principles of equity, objectivity, fairness, principles of natural justice and other principles of justice. Having exercised a discretion to award the package rate (the cost whereof had not been paid by the petitioner-Insurance Company and the expenses had to be incurred by respondent No.1-applicant/insured), the Permanent Lok Adalat (Public Utility Services), Mohali, exercised an equitable jurisdiction. The petitioner-Insurance Company cannot take benefit of its own lapses and to claim retention of the monies or deny the admissible dues to the insured. Exercise of such a discretion does not run contrary to any Statute or to be in violation of the object of the mediclaim insurance policy.

In the absence of reference to the provisions of any Statute and/or any document to establish that the disease was either not covered or that the insured was not actually treated by the hospital for the disease and/or that the petitioner-Insurance Company was otherwise not liable to meet the expenses qua the above said treatment, I do not find any error in the discretion exercised by the Permanent Lok Adalat (Public Utility Services), S.A.S. Nagar, Mohali. The present writ petition is accordingly dismissed in *limine* and the Award dated 25.11.2022 (Annexure P-1) passed by the Permanent Lok Adalat (Public Utility Services), S.A.S. Nagar, Mohali, is affirmed.

July 03, 2023 **(VINOD S. BHARDWAJ)**
raj arora **JUDGE**

Whether speaking/reasoned : Yes/No
Whether reportable : Yes/No