An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0010
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Failure to advise on key product/service features
Outcome:	Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The complaint concerns a health insurance policy held by the Complainants.

The Complainants' Case

The first Complainant was admitted to a private hospital on the 16th May 2016 and the 9 June 2016 and underwent procedures for a cardiac problem. The Provider paid for the first procedure in the sum of €3,150.08 under Medical Codes 5090 and 5091. The Provider has refused to pay for the second admittance in June 2016 under Medical Codes 5091 and 5108.

The Complainants submit that as *"we were covered on the first admittance for the same procedure we also should be covered on the second admission for the same cardiac problem"*. They state that *"no one explained to us that our fair assumption was wrong… If we'd have known we would have made alternative arrangements as we cannot afford these payments"*.

The complaint is that the Provider wrongfully failed to pay benefits under the policy. The Complainants are looking for the Provider to pay the sum of approximately €14,000.00 in respect of medical expenses.

The Provider's Case

The Provider states that it did "*not receive a claim for (the first Complainant's) admission to the (Private Hospital) on 9th June 2016*". It states that the first Complainant was "*covered for*

a fixed price procedure … however she was not covered for an admission to the (Private hospital) that did not involved a Fixed Price Procedure… in accordance with Section 1b) of the Table for Benefits which form part of the health insurance contract".

The Provider states that the "*limitations on cover do apply in Private 4 Hospitals*" as stated in the Complainants' Table of Benefits. It states that the terms and conditions of the plan state that "*If you are in any doubt about the level of cover payable in respect of any procedure or treatment we recommend that you contact us prior to admission*". It states that the Complainants did not contact it prior to admission. The Provider states that it was not billed for the procedure "*as the hospital would know from its patient verification system that no cover would be available*".

The Provider states that the Complainants were made aware of the benefits available "*when they renewed their policy on 1st March 2016".*

Decision

During the investigation of this complaint by this Office, the Provider was requested to supply its written response to the complaint and to supply all relevant documents and information. The Provider responded in writing to the complaint and supplied a number of items in evidence. The Complainants were given the opportunity to see the Provider's response and the evidence supplied by the Provider. A full exchange of documentation and evidence took place between the parties.

In arriving at my Legally Binding Decision I have carefully considered the evidence and submissions put forward by the parties to the complaint.

Having reviewed and considered the submissions made by the parties to this complaint, I am satisfied that the submissions and evidence furnished did not disclose a conflict of fact such as would require the holding of an Oral Hearing to resolve any such conflict. I am also satisfied that the submissions and evidence furnished were sufficient to enable a Legally Binding Decision to be made in this complaint without the necessity for holding an Oral Hearing.

A Preliminary Decision was issued to the parties on 10 January 2018 outlining the preliminary determination of this office in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter.

In the absence of additional submissions from the parties, the final determination of this office is set out below.

/Cont'd…

Sequence of Events:

- On the **16 May 2016** the first Complainant was admitted to a private hospital for treatment for a cardiac compliant. The Provider paid benefits for this admission.

- On the **8 June 2016** the second Complainant telephoned the Provider to enquire whether the first Complainant's attendance as an out-patient for an ECG in a private hospital the following day would be covered under his policy. The Provider informed him that he would have to pay for the ECG himself but could claim for a certain amount of the outlay pursuant to the out-patients section of his policy, subject to an excess of €125.

- On the **9 June 2016** the first Complainant was admitted to a private hospital for 13 days with a cardiac problem.

- On the **30 June 2016** the hospital invoiced the Complainants for the June 2016 admittance.

- On the **7 July 2016** the Provider explained to the Complainants' daughter that Codes 5108 and 5091 were not covered under the Complainants' policy and that this included the fees charged by Consultants seen by the second Complainant in the hospital at that time.

- On the **17 October 2016** the second Complainant telephoned the Provider to query why the initial admittance in May 2016 was covered and the subsequent admittance was not covered. The second Complainant informed the Provider that the medical Codes used for the May admittance were 5090 and 5091 and that Codes 5091 and 5108 were the relevant Codes for the June admittance. He explained that the first Complainant was admitted as an emergency in the evening of the 9th June.

  The Provider explained that in the May admittance Code 5090 was the main procedure claimed for under the policy and that this Code is covered under the policy. The Provider stated that Code 5091 is not covered but as the first Complainant was admitted to have a procedure under Code 5090 that the whole claim was paid pursuant to the 5090 Code. The Provider stated that during the first Complainant's admittance in June 2016 that neither of the procedures she underwent were cardiac fixed price procedures and accordingly were not covered. The Provider sympathised with the second Complainant and informed him that "*absolutely I wouldn't expect you to know*".

- On the **18 October 2016** the Provider wrote to the Complainants as follows:-
  "*Thank you for your recent communication with our Customer Services Department. I wish to confirm the policy you hold Company Plan has full cover for Day care & in-patient cardiac FPP's Level 1 in the (Private Hospital). There is no cover on this plan for the (Private Hospital)…I wish to advise that we can only determine eligibility of a claim at the time of assessment*".

/Cont'd…

- On the **20 October 2016** the second Complainant wrote to the Provider as follows:- "*…my wife … was admitted on the 16 May with cardiac problems this procedure was covered and paid …. On the 9th June 2016 my wife was admitted with the same cardiac problems and was in for 13 days. On the 30 June we received a bill from the (Private Hospital) for €13,020.68 + pathology fee72.45 + radiology fee + Consultants fee €820. As we were covered on the first admit we also should be covered on the same cardiac problem… we have been in (the Provider) for all our married life(52 years) we feel very grieved and very troubled to be treated in this way*".

- On the **27 October 2016** the Provider confirmed in writing to the Complainants that "*we did not receive a claim for (the first Complainant's) admission to the (Private Hospital) on 9th June 2016".*

- On the **29 October 2016** the Complainants wrote to the (Private Hospital) as follows:- "*… As we were covered on the first admittance we also should be covered on the same cardiac problem on the second admission. On contacting (the Provider) about this invoice they informed us that they did not receive a claims form from you for my wife's second admission …. And my company plan covers some of the procedures like code 5091 which was covered on the first claim…*
On my wife's first admittance we were told by… your Finance Dept we were covered and on her second admittance which was eleven o clock at night the Finance Dept was closed. We therefore felt that my wife was covered the first time she would be covered the second time and no one from your Finance Dept informed us otherwise…we have paid so far €4,722.72 off this Bill we will not be paying any further instalments…".

- On the **1 November 2016** the Complainants state that they received a telephone call from the (Private Hospital) "*stating that (the Provider) would not have received a claim form for the 9th June as it was not covered*".

Policy Terms and Conditions

The Complainants' "*Company Plan*" policy with the Provider renewed on the 1 March 2016. I have been furnished with a copy of the Complainants' "*Table of Benefits - Company Plan*" which includes the following:

"…
This Table of Benefits must be read in conjunction with your Company Plan Terms and Conditions and the directories of approved facilities. Facilities may change from time to time, so log onto (the Provider's website) *or phone us on …. if you are planning treatment.*

Benefit Provision ***Benefit***
Section 1-Hospital charges
…

/Cont'd…

B *Private Hospitals and treatment centres*

…

Private 4 Hospitals (other than for certain investigations & treatments referred to in Section 1c & 1d)

- *Day care, side room, semi-private & private accommodation* *0%*

…

C *Certain investigations and treatments – herein referred to as Fixed Price Procedures (FPPs) (contact us for details)*

Private 3 & 4 hospitals

- *Day care & in-patient cardiac FPPs Level 1* *Full cover*
- *Day care & in-patient non-cardiac FPPs Level 1 …* *0%*
- *In-patient cardiac FPPs Level 2 …* *0%*
- *Hospital Excess …* *€75*

…

D *…*

Section 2 – Consultants' fees….

A *In-patient treatment, …*

- *Participating consultant …* *Full cover…*
- *Non Participating consultant* *Standard*

benefit".

The terms and conditions of the policy include the following:-

"5)Benefits

…

13)Fixed Price Procedures (FPP) We will provide the ***benefit set out in Section 1 of your Table of Benefits for Fixed Price Procedures available in the Directory of Hospitals (and Treatment Centres) included in the Fixed Price Procedure Hospital List. Please note that the level of cover may vary depending on the type of Fixed Price Procedure…If you are in any doubt about the level of cover payable in respect of any procedure of treatment we recommend that you contact us prior to admission****…* *….*

Glossary

…

Directories

The Directories which form part of your policy are made up of the following and where any of the following are referenced in your policy, they are taken to have the meaning as set out here:

The Directory of Hospitals (and Treatment Centres)

In the Directories of Hospitals (and Treatment Centres) we list the hospitals and treatment centres covered under your plan.

…

Procedures

/Cont'd…

The following definitions apply…
Fixed Price Procedure
Fixed Price Procedure (FPP) is a term we use to describe a variety of specified major complex procedures (e.g. cardiac and neurosurgery)
…
Schedules
The Schedules which form part of your policy are made up of the following and where each of the following are referenced in your policy, they are taken to have the meaning as set out here:
The Schedule of Benefits for Private Hospital Services
The Schedule of Benefits for Professional Fees
…
The Schedule of Benefits for Medical Screening".

[my emphasis]

The Complainants were sent the following letter at policy renewal on the 1 March 2016:-
"*… your current benefits and any changes to benefits since your last renewal are included on the enclosed Table of Benefits. Please take time to read it …".*

The Complainants have made submissions regarding the conduct of the hospital which provided the treatment to the first Complainant. It is important for the Complainants to be aware that this office investigates complaints against providers of financial services only. While the hospital may well have a case to answer in relation to how it dealt with this matter the conduct of the hospital cannot be investigated by this office nor can I make any decision with regard to the hospital's conduct.

The agreement between the Provider and the Complainant is based on the Table of Benefits, the terms and conditions of the Complainants' policy and the directories of approved facilities; these do not promise benefits for admittance to the Private Hospital in question except for certain investigations and treatments including Fixed Price Procedures (FPPs). On balance, having examined in detail and carefully considered, the complex terms and conditions that apply to this policy, I must accept that the Provider was not obliged to provide benefits for the first Complainant's treatment in the hospital in June 2016. Consequently, I accept that on the basis of the evidence before me, the substantive complaint against the Provider cannot be upheld.

I am of the view, however, that there were shortcomings in the information that was made available to the Complainants by the Provider. I accept that the Provider asks customers to contact it prior to hospital treatment "*so we may discuss cover available*" and I note that the "*Table of Benefits*" also states it is necessary to contact the Provider for details on the fixed price procedures. The Provider's website, however, states that its telephone lines are open *"Monday to Friday 8am to 7pm Saturday 9am to 3pm".* The Provider's website also states that a 24 hour *"World Assistance Alarm Centre*" is available for policy holders "*when you're abroad*" but there is no suggestion that such a facility is offered to policy holders with an "*out of hours*" query regarding the benefits available on their policy in Ireland, particularly in circumstances, as in this case, where a person is being admitted to hospital, "*out of hours"*

/Cont'd…

as a medical emergency. I note that the first Complainant was admitted to hospital on an emergency basis late on a Thursday evening and accordingly would have been unable to obtain information from the Provider as to her benefits prior to admittance as its telephone service was closed; this was unsatisfactory.

I am also of the view that there are deficiencies in the description of the benefits available in the "*Table of Benefits*" furnished to the Complainants at policy renewal, particularly in light of provision 4.1 of the Consumer Protection Code. I note that, according to the "*Table*" the Complainants need to consult the Provider's "*directory of approved facilities*" and the policy terms and conditions to obtain the classification of their specific hospital. The "*Directory of Hospitals (and Treatment Centres)*" is available online. A "*Facility Finder*" is also available online to assist policy holders in obtaining the classification of the hospital in question. While this information is online and I note that the Table of Benefits states that policyholders should contact the Provider for information regarding whether their specific treatment was covered, I am of the view that it would have been good practice for the Provider to have furnished the Complainants with clear information regarding the hospitals and treatments covered under the Complainants' plan, without the Complainants having to make online searches or contact the Provider, particularly in the context of a medical emergency. I am also of the view that the Provider's practice of admitting Code 5091 as part of a fixed price procedure and then subsequently not allowing a claim for a procedure under the same Code caused confusion.

Furthermore, I note that the Table of Benefits refers to "*Section 1c & 1d*", however, the Sections are actually referenced as *"C"* and "*D"*. I also note that during the telephone conversation on the 7 July 2016 the Complainants were informed that their policy did not provide benefits for the fees charged by the first Complainant's Consultant in June 2016. While Section 1 of the "*Table*" states that the policy does not pay "*hospital charges*" for Private 4 hospitals, I note that Section 2 states that "*participating consultant*" fees are covered for "*in-patient treatment*". I accept that the policy terms and conditions state that "*If the treatment is not covered by your plan or is carried out in a hospital which is not covered by your plan, benefit for consultant …. fees will not be payable*", however, I am of the view that setting out the information in this fashion in the "*Table"* could easily cause misunderstanding and confusion. Accordingly, I do not accept that the information regarding benefits is as clearly set out in the Table of Benefits, as the Provider believes it to be.

I note that the Provider was "*not contacted by the patient prior to admission*" and while I appreciate that the first Complainant was clearly very sick at the time of her evening admittance and as stated above the Provider's telephone services was not available, it is disappointing that the second Complainant failed to make enquiries regarding the benefits available with the Provider the following day or at some time during her period in hospital.

I believe the best solution to this situation would have been for some form of agreed resolution between the various parties involved in this complaint. However, as that has not happened it falls to this office to decide on the dispute between the Complainants and the Provider. In the particular circumstances, I believe that an element of fault lies with the Provider in this instance. Having considered the matter at length, I take the view that in

/Cont'd…

order to do justice between the parties this complaint should be partially upheld and I direct the Provider to make a compensatory payment to the Complainants in the sum of €4,000.00.

For the reasons outlined above my Decision is that the complaint is partially upheld.

Conclusion

- My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is partially upheld on the grounds prescribed in ***Section 60(2)(g).***

  Pursuant to ***Section 60(4)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct that the Respondent Provider make a compensatory payment to the Complainants in the sum of €4,000.00. The compensatory payment should be by way of payment to an account of the Complainants' choosing, within a period of 35 days from the date of notification to the Provider of details of that account.

- Pursuant to ***Section 60(6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, where the amount is not paid within a period of 35 days of the Complainant's notification of account details to the Provider.

- Pursuant to ***Section 60(8)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** the Respondent Provider is now required, not later than 14 days after the period specified above to notify this office in writing of the action taken or proposed to be taken in consequence of the said direction outlined above.

The above Decision is legally binding on the parties, subject only to an appeal to the High Court not later than 35 days after the date of notification of this Decision.

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

6 February 2018

Pursuant to *Section 62* of the *Financial Services and Pensions Ombudsman Act 2017*, the Financial Services and Pensions Ombudsman will publish legally binding decisions in relation to complaints concerning financial service providers in such a manner that—

(a) ensures that—

(i) a complainant shall not be identified by name, address or otherwise,

(ii) a provider shall not be identified by name or address,

and

(b) in accordance with the Data Protection Acts 1988 and 2003.