An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0032
Sector:	Insurance
Product / Service:	Critical & Serious Illness
Conduct(s) complained of:	Failure to provide correct information Claim handling delays or issues
Outcome:	Substantially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

This complaint relates to a request for cover in respect of a medical procedure under a Health Insurance Plan.

The Complainant contacted the Company in relation to the procedure she wished to claim for, while the procedure is covered, it only extends to certain hospitals.

The Complainant is unhappy that the Company will not cover her in a hospital of her surgeon's choice.

The Complainant's complaint is that the Company provided incorrect information regarding cover for her procedure, and that it will not cover the procedure in a named hospital which she understood to be part of another hospital, which would be covered under her plan.

The Complainant's Case

The Complainant states that she was referred by her local GP to a specialist. The consultant she was referred to was MR L. The Complainant says that before she went for her first appointment she telephoned the Company to see if Mr L was on its list of approved specialists. The Complainant says that she established that he was on the Company's list. The Complainant states that she paid the fee in full on the day of the appointment, and received €50 back from the Company under her policy. The Complainant explains that she then had to go for a second appointment to see MR L and again received 50 euro back from the Company.

The Complainant states that Mr L said he would like to make an appointment for surgery in a named private hospital. The Complainant stated that Mr L gave her a code for the procedure. The Complainant's positon is that she telephoned the Company and was advised that the procedure and the doctor were covered, but the hospital was not covered, as it was a private hospital. The Complainant states that she got back in touch with Mr L who said he could do the procedure in a named public hospital (said to be part of a coverable hospital) instead. The Complainant got in touch with the Company and the Company initially said it would not be covered in that public hospital, but then after the representative checked with a supervisor said it would be covered if Mr L wrote a letter saying this is the only other place he could do the procedure. The Complainant states that Mr L provided the letter, but the Company advised it would not cover the procedure and that incorrect information had been given by its representative. The Complainant says that she was advised that the Company would only cover the procedure if it was done in a public hospital on the list. The hospital in question was not on the list. The Complainant submits that Mr L had told her that the hospital was part of a hospital that was covered, but the Company still said it would not be covered. The Complainant states that Mr L had advised that the named hospital was the only place he would carry out the procedure.

It is the Complainant's position that as the Company would not cover the place of her procedure she had to go public and she is still waiting for an appointment for her first consultation visit again. The Complainant states that she could be waiting up to two years for surgery. The Complainant submits that it makes no sense that the consultant is approved, the procedure is approved, but the hospital even though it is public and even though it is part of an approved hospital, is not approved.

The Complainant states that she considers that the Company should have covered the place of her procedure, as the named hospital is part of a covered hospital. The Complainant states that it should also be noted that the Company gave her the incorrect information. The Complainant's position is that as a result this led to her thinking the procedure would take place and it was a huge disappointment to be told she had received the incorrect information and it would not be covered. The Complainant states that it wasted a lot of her time, and was also embarrassing to have to keep going back to her consultant and it wasted her consultant's time.

The Complainant says that she is very disappointed that she now has to go public when she has health insurance and she could be waiting for up to two years for a procedure that could have been done sooner.

The remedy that the Complainant is seeking is to have the procedure covered by the Company in the named hospital.

The Provider's Case

The Company states that the Complainant is looking to have her procedure covered in the named hospital. It is the Company's position that this is not possible; however the Company

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believe it has provided adequate assistance to the Complainant despite the misinformation provided on 12th July 2016. The Company advised it would cover the cost of a visit to an alternative consultant, one who could carry out the procedure in a hospital covered on the Complainant's health insurance plan. It is the Company's position that if the Complainant wanted to stay under the care of her medical specialist Mr L, it provided details of the hospitals where she would have cover.

The Company states that the Complainant's plan provides cover in a select hospital network, and the hospital in question is not covered on this plan. It is the Company's position that it must treat all customers fairly, and as other Company members have purchased the same plan, with the same select hospital network it cannot allow any deviation to the cover. The Company states that although it cannot allow deviation from the plan, it has outlined to the Complainant the hospitals covered on her plan from which her medical specialist Mr L works in. The Company says that cover is available to the Complainant to have the procedure carried out in any of these facilities, subject to the terms and conditions of her plan and subject to all waiting periods being served. The Company states that as is normal process, all claims will be assessed on receipt.

As regards the Complainant's query as to why the procedure cannot be carried out in the named hospital, the Company states that the hospital is not covered under the Complainant's plan. The Company state that the Complainant was advised of this at policy inception and again at her renewal.

It is the Company's position that its agents were always courteous and patient with the Complainant and did their upmost to explain to her that she could have this procedure done in any other of the hospitals she had cover for under her plan.

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 Complainant was 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.

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A Preliminary Decision was issued to the parties on 26th February 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.

The issue for investigation and adjudication is whether the Company correctly communicated with the Complainant when advising her of the cover that is available under her plan.

Analysis

The evidence shows that the Complainant contacted the Company on the 8th July 2016 making enquires about a medical procedure. The Complainant had seen her medical specialist Mr L who proposed that she could attend a named Clinic to undergo the required medical procedure. The Company advised the Complainant that Mr L is a fully participating consultant with the Company and according to its records he is registered to work out of Public and Private Hospitals. The Company explained to the Complainant that her plan did not cover her at the named Clinic, but she did have cover for alternative Clinics / Hospitals.

On 12th July 2016, the Complainant contacted the Company again to confirm cover for the medical procedure. The Complainant advised that her consultant advised her he could do the procedure in an alternative hospital to that of the originally requested Clinic. The Company representative explained that this second hospital was not covered under the Complainant's plan. During the course of the conversation the Company representative provided incorrect information to the Complainant regarding her cover for the requested hospital, under the care of Mr L. During the call the Company representative informed the Complainant that it would cover treatment if her consultant sent in "pre-approval" and once it was pre-approved the procedure would be covered in the requested hospital. The Company corrected this information with the Complainant on the 25th July 2016, when the Company received correspondence from Mr L and realised its error. There was no cover on her plan for the requested alternative hospital. The fact that the medical procedure was available in other hospitals covered by the plan, meant that prior approval would not address the particular situation. The Company acknowledge that the Complainant was obviously disappointed and a complaint was immediately logged. The Company's position is that the correct information was reiterated on 2nd August 2016 and it then offered to cover the cost of a visit to an alternative consultant if the Complainant chose to do so. The Company states that it believes it offered the Complainant a fair and proportionate solution to the misinformation she was provided with; however she has chosen to decline this offer.

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The following section of the policy deals with the situation that arose. Section 2.2 deals with In-Patient Benefits in the Membership Handbook and under the heading *"Medical facilities not covered on your plan"* states that:

> *"We will not cover your hospital costs in a medical facility which is not covered in your List of Medical Facilities.*
>
> *We have made every effort to ensure that all health services that are listed in the Minimum Benefit Regulations ("Prescribed Health Services") are available through at least one of the medical facilities covered in your List of Medical Facilities. In the unlikely event that a Prescribed Health Service is not available in one of those medical facilities, we will cover the Prescribed Health Service in a medical facility that is not covered in your List of Medical Facilities as if it was covered under your plan (i.e. to the level of cover available under your In-patient Benefits). However, you must notify us in advance that you wish to receive such medical services in a medical facility that is not covered under your plan. Please note that we will not cover you if you receive health services (other than emergency care), which are not listed in the Minimum Benefit Regulations, in a medical facility which is not covered under your plan."*

This means that where a procedure can only be carried out in an unapproved hospital, that the Company would consider paying for the procedure in such circumstances.

The Company accept that its representative incorrectly advised the Complainant that pre-approval provision could be used in the situation where her consultant stated that he could only do the procedure in a particular uncovered hospital. However, the procedure in question is a procedure that can be carried out in a number of hospitals covered under the Complainant's plan.

As regards the Complainant's position that the alternative hospital (a hospital not specifically covered by her plan) was a hospital managed by another named hospital (which is covered under her plan), I accept that the hospital in question is outlined in the Membership Handbook as a separate hospital as distinct from any other entity, and is clearly set out as not being covered under the list of facilities applying to the Complainant's plan.
I also accept that the other hospital mentioned as being the alternative hospital to carry out the procedure (the hospital said to manage the uncovered hospital) is separately listed on the Complainant's plan.

The Company submit that both hospitals are registered as two separate hospitals and are billed separately. I accept that this is the situation.
As regards any advice that Mr L may have given the Complainant about the cover that would be provided for that hospital, the Company states that this is something the Complainant needs to take up with Mr L.

To conclude, I cannot uphold the Complainant's claim for the procedure to be carried out in the named uncovered hospital, however, I do consider that there could have been greater and better communication from the Company to the Complainant about the plan cover.

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As regards the provision of information to a customer, the General Requirements of the Consumer Protection Codes state that:

> *"A Regulated entity must ensure that all information it provides to a consumer is clear, accurate, up to date, and written in plain English. Key information must be brought to the attention of the consumer. The method of presentation must not disguise, diminish or obscure important information".*

Here the Company accepts that it gave inaccurate information to the Complainant regarding the need for her to formally get prior approval for the procedure to be carried out, and that the Company would consider such a request if sought in that manner.

The Company also communicated to the Complainant that a hospital which is stated to be an unapproved hospital, but managed by an approved hospital would not be considered eligible on that basis for cover for the procedure in question. While I accept that this is the position (as the hospitals are specifically named separately and billed separately by the Company), I do consider that customers, and consultants dealing with the Company would expect greater clarity on such a matter in the policy documentation. It would have been helpful here for the Company to specifically state in the plan documentation that although a named hospital may be managed by another named hospital, for the purpose of the benefits provided under the plan, they are separate entities and may have separate contractual conditions and exclusions applying in respect of the benefits being sought under the plan. On reading the policy provisions a customer would not be aware that such hospitals are registered and billed separately by the Company.

While I accept that the Company did reasonably make an offer to pay for a consultation that would lead to the procedure being carried out in an approved hospital, but do not seem to appreciate the inconvenience that the Complainant would have had to go through, that is, to return to her GP for a new referral to a consultant who would carry out the procedure in a covered hospital, the additional time waiting for appointments etc.

Having regard to all of the above I consider that in addition to the Company's offer, a substantial customer service payment is merited. Therefore, it is my Legally Binding Decision that the complaint is substantially upheld and the Company is to (in addition to its offer of paying for an alternative consultation leading to a referral to hospital that is covered) pay the Complainant €2,000 (two thousand euro). I direct the Company accordingly.

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Conclusion

- My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is substantially 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 to pay for an alternative consultation and pay the Complainant €2,000 (two thousand euro)

- 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 by the expiry of the 35 day appeal period.

- 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 expiry of the 35 day appeal period to notify this office in writing of the action taken or proposed to be taken in consequence of the said direction/s 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

26th March 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.