An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0043
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Rejection of claim
Outcome:	Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant incepted a policy of health insurance with the Provider on 22nd June 1979, which policy was in place at all times relevant to the within complaint.

The Complainant's complaint is that the Provider has wrongfully and/or unreasonably refused to provide benefit in respect of any future mammogram procedures, due to the fact that she is over 70 years of age.

The Complainant's Case

The Complainant submits that there is a history of breast cancer within her family. She submits that as a long term member with the Provider, paying a high yearly premium, she is very unhappy with the Provider's decision not to provide benefit for the cost of a routine mammogram every two years, on the basis of her age, specifically because she is over 70 years of age.

She submits that this is particularly unreasonable in circumstances where the Provider issued her with documentation, which clearly states that she has "*full cover*" for *"mammogram in an approved mammogram centre*".

The Complainant submits that it is a reasonable request to have this procedure covered by her health insurance policy, particularly in light of the fact that there is a significant history of breast cancer in her family.

The Complainant submits that, in all of her years as a member with the Provider, she has never had cause to make a claim, save as regard health screenings.

The Complainant submits that in all of the circumstances, the Provider has acted wrongfully and unreasonably in refusing to pay benefit in respect of this procedure due to her age.

The Provider's Case

The Provider submits that in order to determine the eligibility of its customers for a mammogram, it follows the National Breast Check criteria. The Provider submits that these criteria recognise that breast cancer occurs infrequently in women under 40 and above 70 and that, based on this information, it allows benefit for customers who are aged between 40 - 49 and 65 - 69. It submits that benefit is not payable for members aged between 50 and 64, as they are eligible for the National Breast Screening programme.

The Provider submits that it cannot provide benefit in respect of any future screening mammograms which the Complainant may require, in accordance with Rule 5 Benefits, Section 18, of its Rules, Terms and Conditions of Membership.

The Provider submits that while the Table of Benefits applicable to the Complainant's level of cover confirms that it allows benefit for a mammogram, this is qualified by a note asking its customers to contact it for details, as follows:

Health Screening — in each 24 month period, covered in accordance with our rules contact us for details	
• *Health Check in a [Provider] Medical Centre* • *Cancer Check in a [Provider] Medical Centre* • *Lifestage screening programme in a [Provider] Medical Centre* • *Dexa scans in an approved dexa scan centre* • *Mammograms in an approved mammogram centre*	*Full Cover* *Full Cover* *€450 per screen* *Full Cover* *Full Cover*

The Provider states that it agreed to cover the cost of the mammogram, which the Complainant had carried out in May 2016, on a one off, ex-gratia basis, but confirms that it cannot provide benefit in respect of any future screening mammograms which the Complainant may require, in accordance with its Rules.

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.

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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 21 May 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 Policy of Health Insurance

The Complainant has been a member of the Provider's health insurance scheme since 1979. By letter dated **07th February 2016**, the Provider wrote to the Complainant in relation to her policy renewal, enclosing policy documentation, for the period **08th March 2016** to **07th March 2017**. The total cost of the policy for the year was stated to be €3,385.50.

Following receipt of this documentation, and in advance of renewing the policy, the Complainant contacted the Provider by telephone, on **22nd February 2016,** to discuss the cover available under the policy in respect of certain procedures.

(It is somewhat disappointing, given their relevance to the complaint, that whilst certain audio recordings were furnished by the Provider, in response to the formal investigation of the complaint, it was necessary, subsequently for this office to specifically request the call recordings of the **22nd and 23rd February 2016** in the course of adjudicating upon the within complaint).

By way of telephone call, on the **22nd February 2016**, the Complainant spoke to a member of the Provider's "review team", about the policy review. The Complainant drew the Agent's attention to page 5 of the Table of Benefits document, and specifically section 9, subsection "L", as follows:

C: Down to L – do you see there – heart check, is that free?

A: It is for you on this policy. Just to point out there…We have a screening centre…in every 2 year period now, you are fully covered, there, fully covered, for a screening

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heart check and you are fully covered for a screening cancer check. In every two year period"

C: Although, that is up in April, to my knowledge.

A: Okay.

C: I just wondered there– where it says then, down at the heart check, cancer check - "lifestage screening" - €450, what is that?

A: What that means is that, apart from the heart check, and apart from the cancer check, we have a number of other screening programmes, that people can do there. You would get €450 off the cost of those screening programmes. So, for certain programmes you may have to pay a little amount yourself there. Now..,

C: *When you say "little", [Agent's name], what are you telling me?*

A: *I don't work in that Department, what I can do…we have got two options there , I can transfer you straight across to my colleagues who work in the screening dept. there, or else I can get you out a brochure there , but I wouldn't know the figures myself, I'm afraid…*

Then, a little later on in the conversation, the following exchange occurred:

C: What you are telling me is the heart check is free, the cancer check is free, the dexa and the mammogram.

A: Now there's criteria. There is criteria, for what we call a screening dexa scan and a screening mammogram.

C: I had this done before, actually [Agent's name] under my cover…

A: Ok. Now again, in relation to the specific criteria I am aware that the GPs and the hospital consultants are aware of that. But it would be my colleagues in the benefits team to go through that with you. These are more benefits outside of the actual hospital itself there, so again for those specific questions, I may have to transfer you to the experts.

C: Oh, well, if there is an expert available, may I just speak to them please?

A: Which one would you like to speak with first, may I ask?

C: Well, I just want to see what am I covered for and how much will it cost me.

A: Ok, Well what I will do first of all, I will send you straight across there to my colleagues who work in the screening department. Now [Complainant's name] in the meantime, the Policy comes up for renewal there, on the 08th March.

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C: That's right.

A: We have sent you on the renewal documentation …

C: I have it in front of me.

A: Now, in essence I think it has gone up by about €35.00 for this year. So you can see there that the overall quote is coming in at €3,385.50. This is your time to go through the terms, the table of benefits, familiarise yourself with what you are covered for and where there may be shortfalls. And, of course, if at any stage you are going in for any procedures always contact us in advance, my colleagues who work in the payments side can verify your cover…Is there any aspect of the hospital cover you want me to go through on the call today or is it just specifically the screening …

C: Oh no, it was purely on that particular one, the health screening, you know, the 24 months. …

…

A: Now unfortunately [C's name], all of my colleagues in the screening dept, they are all on calls on the moments so what I can do there is I can get a member of that team to call you back there inside of 24 hours. We can call you and my colleague can go through that in some detail.

C: I would appreciate that actually, if it is possible…

The following day, the **23rd February 2016**, the Complainant received a call from an agent in the Provider's medical screening department.

The Complainant enquired with the Agent about making an appointment for a heart screening, a dexa scan and a mammogram.

The Complainant was told that the Provider did not offer the dexa screening and the mammogram services at its centres and that this Agent would not be able to assist her with that, as it was a separate issue. The Complainant sounded slightly surprised and said she usually had it done at a particular hospital. The Agent advised that she could not assist her with such a query but could transfer her to the benefits team, who, she recommended would be better able to advise the Complainant in that regard. The Complainant advised that she had been "*getting it done there*" [at a specific hospital] and said, "*I don't think anything has changed, that I am aware of now, with a letter from the doctor, of course."*

The Agent responded that, "*my colleagues on the benefits team would be better equipped to give you the advice on that, because what I deal with is booking appointments in our Clinics in [locations] So that would be the heart check, or the cancer check, or the life stage screening."*

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The Complainant went on to enquire about the life stage screening and the cost of same. The Complainant was told that it would cost her €40 under her plan. The Complainant was advised that she was eligible to make an appointment in May.

She then asked, "*Must I also wait to have the Dexa scan and the Mammogram done, then, in May*?" The Agent replied that they were separate and that she would not be able to advise her in that regard. The Complainant says that she is "*just wondering about having the cover for it*". The Agent advised her that she would have to speak with her colleagues in the benefits department and told the Complainant she would transfer her over. The Agent proceeded to arrange an appointment for the Complainant in respect of the life stage screening procedure. Having gone through the details of the procedure with the Complainant, and made the appointment, I note that the conversation ended without the Complainant being transferred to the benefits team for assistance with her query.

The Complainant renewed her Policy, with effect from the **08th March 2016,** and the next contact which she had with the Provider was on **21st April 2016**. The Complainant had been referred for a mammogram, on this date, and had travelled quite a distance, to attend a particular hospital and undergo same. However, upon arrival at the hospital, she was informed that she would have to pay €200 for the procedure, as it would not be covered under her policy of health insurance.
The Complainant rang the Provider, to query this. The Provider confirmed to her that she was not eligible to have this procedure covered by her insurance due to the fact that she was over 70 years of age and did not meet the Provider's policy criteria for screening mammograms.

The Complainant was very unhappy with this and wrote to the Provider, by letter dated **03rd May 2016**, regarding its failure to provide benefit in respect of the mammogram. She stated that:

> *"In April 2014, aged 70 years and 2 months, I had a similar appointment and my [Provider] cover meant I did not have to pay for the mammogram. However, this time I was told the mammogram would cost me €200. I found this inexplicable and having had a conversation by phone with one of your representatives was told the payment was due as I was "over 70" and did not have to pay. In any event, on principle, I did not have the mammogram done that day, despite my worries since two of my sisters have had breast cancer diagnosed."*

The Complainant subsequently attended at the Provider's Medical Centre on the **09th May 2016** for a health assessment. A letter issued that day, from a GP at the Centre, to the Complainant's GP, stating that:

> *"the Complainant attended…for a health assessment.*
>
> *A full written report will follow in the coming weeks. However prior to this I have some concerns regarding her breast exam. Her right breast has some definite asymmetrical nodularity in the lower inner quadrant.*

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Of note she has had a mammogram < 2 years ago.
She has a very strong family history of breast cancer, both her sisters have had breast cancer. One diagnosed age 40 and another age 50.

Given the strong family history am anxious that she is seen urgently regarding this."

By letter dated **10th May 2016**, issued in response to the Complainant's letter of the **03rd May 2016**, the Provider advised that its criteria for screening mammograms are drawn up in line with the National Breast Check criteria. The letter advised that, according to this, breast cancer occurs infrequently in women under 40 years and above 70 years of age. It stated as follows:

Screening Mammograms are eligible for benefit once certain criteria has been met. This is in accordance with Rule 5) Benefits, section 18) of the Rules, Terms and Conditions of your policy, which states.

We will pay the benefit listed in your Table of Benefits towards the cost of a mammogram, subject to the following criteria:

(i) The customer is referred for a mammogram by a general practitioner or consultant to an approved mammogram centre listed in the Directory of Hospitals (and Treatment Centres); and

(ii) The customer meets the eligibility criteria and one of the clinical indications as specified in the Schedule of Benefits for Medical Screening.

As you outlined in your letter we do allow benefit for this procedure under your policy, however the Table of Benefits includes a note asking our customers to contact us for details, see below:

Benefit Provision	*Benefit*
L Health screening - in each 24 month period, covered in accordance with our rules (contact us for details)	
Mammograms in an approved mammogram centre	*Full cover*

In order to determine the eligibility of our customers for this procedure [the Provider] follows the National Breast Check criteria. This states that Breast Cancer occurs infrequently in women under 40 years and above 70 years and based on this information, benefit is provided for customers who are aged between 40 and 49 years and between 65 and 69 years.
Additional criteria for this procedure include the following:

1. Benefit is not payable if a mammogram was performed within the last 12 months for women between 40 and 49 years or the last 24 months for women between 65 and 69 years.
2. The patient must be referred by a gp or a consultant.

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3. *Specific medical criteria must be satisfied.*
4. *Procedure must be performed in an approved centre.*

Regrettably, no benefit is eligible in your case as the criteria for the procedure has not been satisfied

I note that we have previously allowed benefit for a Screening Mammogram on 22nd April 2014 when you were 70 years. I have reviewed your claim and unfortunately this benefit was provided in error, however we will not be seeking a refund in this instance

By letter dated **18th May 2016** the Complainant wrote to the Provider and expressed her frustration at the Provider's criteria regarding benefit for mammograms. She advised the Provider that she had been referred for an urgent mammogram, to be carried out on **20th May 2016**.

On **13th June 2016**, the Provider issued a letter to the Complainant advising her that it would cover the cost of her May mammogram, on a one off ex-gratia basis, but that no further screening mammograms would covered, "*in accordance with the terms of your contract with us as outlined in our letter dated 10th May*".

The Complainant responded by letter dated **27th June 2016**, confirming that she had the mammogram carried out under the public hospital system and therefore did not incur any costs. She advised the Provider that:

"the nub of the issue is not about money but the principle. Anyone I have spoked to about this fails to understand, as I do, how health insurance cover ceases at age 70 for me in a specific area where my family has a serious medical history as I have indicated to you."

I will turn now to examine the policy information, which was provided to the Complainant at the time of her renewing her policy with the Provider.

The Policy of Insurance

The "*Hospital Plans, Rules – Terms and Conditions*", at Rule 5, "*Benefits*" section 18, "*Mammograms*", provides that:

We will pay the benefit listed in your Table of Benefits towards the cost of a mammogram, subject to the following criteria:

(i) The customer is referred for a mammogram by a general practitioner or consultant to an approved mammogram centre listed in the Directory of Hospitals (and Treatment Centres); and
(ii) The customer meets the eligibility criteria and one of the clinical indications as specified in the Schedule of Benefits for Medical Screening.

Section 9, of the Table of Benefits, "*Out-patient medical expenses*", at subsection *'L'*, states:

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L	*Health Screening — in each 24 month period, covered in accordance with our rules (contact us for details)*	
	• *Heart Check in a [Provider] Medical Centre* • *Cancer Check in a [Provider] Medical Centre* • *Lifestage screening programme in a [Provider] Medical Centre* • *Dexa scans in an approved dexa scan centre* • *Mammograms in an approved mammogram centre*	*Full Cover* *Full Cover* *€450per screen* *Full Cover* *Full Cover*

The section advises policyholders to "*contact us for details*". I note that the Complainant did so contact the Provider in this regard and made specific reference to the "*Health Screening*" section, as being the reason for her call. She explained that she was seeking to check what cover she had in respect of the screening programmes. In fact she spoke with two different departments in trying to get an answer to her query.

I note that the first Agent, within the "review" department, advised that it could not answer the Complainant's specific queries in respect of cover and he advised her that he would arrange a call back for her from *"an expert*", within 24 hours. The Complainant confirmed that this was something she would appreciate and, indeed, she received a call back from an Agent, in the Screening Department, the following day, the **23rd February 2016**. However, as set out above, when the Complainant enquired about insurance cover in respect of mammograms, the Agent explained that it was not her area and that she could transfer the Complainant to a different department (which ultimately did not occur). I accept that, as per the note in the section, to *"contact us for details",* the Complainant had taken reasonable steps toward contacting the Provider for these details.

When the Complainant called the Provider, on the **27th April 2016**, following her attendance at hospital where she was informed that no cover was available to her in respect of the mammogram procedure, she was somewhat distressed and explained that her recollection of the telephone conversation of the **23rd February 2016** was that she had been advised that she would be covered for a mammogram. Whilst, I note from having listened to the call recordings, this was not so advised, the Complainant did raise it as a query but the call ended without the Complainant's query having been addressed conclusively, and that this may have caused some confusion.

I note that during the course of the telephone conversation of the **23rd February 2016**, with the Screening Dept., the Complainant specifically mentioned that she had previously been covered by her Policy for the mammogram procedure, and advised the Agent, "*I don't think anything has changed, that I am aware of now, with a letter from the doctor, of course."* In fact, something had changed – upon the Complainant turning 70, she no longer fell within the Provider's criteria to have benefit payable in respect of a mammogram. However, as far as the Complainant was aware, she had benefitted from "*full cover*" in respect of that particular procedure on the last occasion when she had it performed, in 2014, at a time when she was already 70 years of age. The Provider has acknowledged that this occurred

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due to an error on its part and that this should not have occurred. However, the Complainant was not on notice of this fact.

I note the Provider's explanation that, in determining the eligibility of its customers for a mammogram, it follows the National Breast Check criteria and that, based on this information, it allows benefit for customers who are aged between 40 - 49 and 65 - 69.

The Provider has furnished this Office with a document entitled, "*Determining Member's Medical Appropriateness For Breast Screening Mammogram*", which I have reproduced in part, below:

> ***DETERMINING MEMBER'S MEDICAL APPROPRIATENESS FOR BREAST SCREENING MAMMOGRAM***
>
> ***1. <u>Exclusion Criteria</u>***
>
> *Members are considered medically inappropriate for screening mammogram benefit if any of the following criteria are met:*
>
> *1.1 The member is less than 40 years of age*
> *1.2 The member is 70 years of age or over*
> *1.3 The member has had a mammogram performed in the last 12 months, if aged 40 to 49 years, or in the last 24 months if aged 65 to 69 years*
> *1.4 The member is pregnant*
> *1.5 The member has been diagnosed with Breast Disease and is currently under the care of a breast specialist for Breast Disease*
>
> *Members are also excluded if they are eligible for the National Breast Screening programme i.e. aged between 50 and 64.*
>
> ***2. <u>Members Eligible for Screening Mammogram Benefit</u>***
>
> *Members who are not excluded by the above criteria can be divided into two age-groups.*
>
> ***2.1. Members aged 65-69***
>
> *Members aged 65-69 (and not excluded by the criteria above) are eligible for the screening mammogram benefit.*
>
> ***2.2. Members aged 40-49***
>
> *Members aged 40-49 (and not excluded by the criteria above) may be medically appropriate for screening mammogram benefit depending on the member's family history. These members are eligible for screening mammogram benefit if any one of the following additional criteria is met…*

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The Provider's position, as communicated to the Complainant, is that no benefit was payable in respect of the mammogram due to have taken place on the 21st April 2016, because she was over 70 years of age. I believe that, given that this is its position, it would be reasonable for the Provider to set out more transparently within subsection L, the particular age restrictions which impact upon the "*Full Cover",* available to policyholders. Not to do so, in my opinion, is unhelpful to the policyholder.

I appreciate the Complainant's frustration with the fact that, whilst these criteria have been based on general statistics, that she herself is a person with a strong family history of breast cancer and, as such, may be in a more vulnerable position in this regard than other persons of her age. Indeed this is evidenced by the letter which issued from the Provider's Medical Centre, on the **09th May 2016**, which expressed "*concerns regarding her breast exam"* and which recommended that the Complainant be *"seen urgently regarding this*."

As a matter of general course, however, I accept that the limitations of cover made available by the Provider, under its Plans are matters which are at the commercial discretion of the Provider and the rules in place are for all policyholders, whatever the family history. Resultantly, I am satisfied that it remains a matter for the Provider to determine the extent of the cover it offers. While I do not consider it therefore, appropriate to uphold that element of the Complainant's complaint, nevertheless, having examined all of the evidence before me, I am not satisfied that the Provider has acted reasonably or transparently, in its dealings with the Complainant. Nor do I believe that the information with which she was furnished, including by way of telephone conversations, prior to her renewal of her Policy, was sufficient.

I am also of the opinion that the mistake, which I note, the Provider has acknowledged, whereby it paid benefit in respect of a mammogram procedure at a time when the Complainant was already over 70 years of age, but which was not identified until the current issue arose, may have contributed to the Complainant's misapprehension as to the situation, as she had no reason to understand that she was ineligible for cover, due to her being over 70 years of age.

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 of €500.00 to an account of the Complainant's choosing within a period of 35 days of the Complainant's notification of account details to the Provider.

  I also direct the Provider to give consideration to including an appropriate warning as to age restrictions within the relevant section of the Schedule of Benefits.

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- 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 within a period of 35 days of the Complainants' 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 for the implementation of the directions pursuant to Section 60(4), to notify this office in writing of the action taken or proposed to be taken in consequence of the said directions 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.

MARYROSE MCGOVERN
DIRECTOR OF INVESTIGATION, ADJUDICATION AND LEGAL SERVICES

19 June 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.