An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0047
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Failure to provide correct information Delayed or inadequate communication
Outcome:	Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

This complaint arises out of a private healthcare insurance policy and relates to the Provider's refusal to indemnify the Complainant under her policy.

The Complainant's Case

The Complainant holds a health insurance policy with the Provider.
The Complainant states that in December 2016 she was advised by a consultant cardiologist that she should undergo a cardiac MRI scan. The Complainant points out that the membership card issued to her by the Provider does not specify the plan on it and that she has had health insurance for over 10 years and never had cause to use it up until this point. The Complainant explains that she rang the Provider in early December 2016 and explained what her consultant had said to her and that she needed to have a cardiac MRI carried out before 16 December 2016 when she was scheduled to undergo a separate private medical procedure. The Complainant states that a representative of the Provider informed her that her cardiac MRI scan would be covered under the policy and a few days later she received an approval letter from the Provider.
The Complainant then explains that she rang [a Dublin Clinic] who advised her that she should ring her health insurance Provider. The Complainant states that she rang the Provider and was told that if the Complainant had the scan carried out at [that Clinic], 66% of the cost would be covered under her policy. The Complainant explains that she telephoned the Provider once more about the medical centres that had been specified on

the Provider's approval letter. The Complainant explains that none of those medical centres were able to accommodate the Complainant for a number of months.

The Complainant went ahead and had the MRI carried out at the [Dublin Clinic] and the Provider has declined to reimburse for any of the cost incurred in having the MRI carried out at the Clinic on the basis that it was not an approved cardiac MRI centre specified under the Complainant's health insurance policy.
The Complainant paid €528 to have the MRI scan carried out at the Clinic and is seeking to have this amount refunded on the basis that the Provider has wrongfully, unreasonably and through a mistake of law or fact refused to fully indemnify the Complainant for the cost incurred.

The Provider's Case

The Provider explains that under the Complainant's health insurance policy, she did not have any cover on her plan for a cardiac MRI at the particular Clinic and that no pre-approval was provided to her to have the cardiac MRI carried out at that clinic. The Provider acknowledges that it initially gave the Complainant incorrect information that she would have 66% cover for the MRI scan if it was carried out at the Clinic, where she had the scan undertaken, but points out that this was clarified and corrected later that day.

I note in an e-mail to this Office on 30 November 2017 the Provider advised this Office that it made an offer of €100 to the Complainant which remains available to the Complainant.

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.

A Preliminary Decision was issued to the parties 30 July 2018, outlining the preliminary determination of this office in relation to the complaint. The parties were advised on that

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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, my final determination is set out below.

The policy was taken out by the Complainant and her husband as joint named policyholders at the end of December 2015. The Complainant was on a plan entitled [AS]. Amongst other things, the AS policy document provides a table of cover effective from 31 December 2015.

It states:

"This table of cover must be read in conjunction with your member certificate and Membership Handbook effective from July 2015. The hospitals and treatment centres covered on this plan are set out in List 4 in part 12 of your membership and book."

It would appear from this that in terms of medical facilities, List 4 was the relevant list for the Complainant's policy.

On the following page of this document it is stipulated that if an MRI scan is carried out in a non-approved centre then it is not covered under the plan.

The Membership Handbook, at page 8, states in relation to cardiac MRI scans:

"Under this benefit we will cover or contribute towards the cost of your scan. The amount that is covered and how it is covered will depend on whether you have your scan carried out in a scan facility that is covered in the appropriate table for your scan type in your list of medical facilities (i.e. an approved centre) or in a scan facility that is not included in your list of medical facilities (i.e. a non-approved centre). The maximum amount that can be claimed for non-approved centres in your policy year may be limited. This will be shown in your table of cover.

Cardiac MRI Scans

All cardiac MRI scans must be pre-authorised by us. You must be referred by a consultant. All cardiac MRI scans must be carried out in approved cardiac scan facility (see the tables of MRI and CT facilities in section 12 of this membership Handbook)."

Section 3 of the Membership Handbook commences at page 22. Section 3 is entitled "*Exclusions from Your Cover".* Amongst other things, it is stipulated that any costs incurred in a medical facility that is not covered under the plan are excluded from cover.

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Section 12 of the Membership Handbook commences at page 31, and on pages 33 and 34, the table includes the approved cardiac MRI scan facilities.

This comprises a series of tables that list a series of hospitals and medical facilities. The table includes the name of the facility, the settlement arrangements, the hospital type and whether it is covered by List 1, List 2, List 3 or List 4.

It includes four "*approved cardiac scan facilities"* including the Clinic where the Complainant had her scan performed.

However, where the other three have the word "*covered*" in the cell of the table titled "*List 4",* the Clinic in which the Complainant had her scan performed is blank in this cell, indicating that it was not covered for cardiac scans.

I can understand the Complainant's confusion and difficulty in being clear as to whether or not the scan would be covered in the particular Clinic where she proposed to have it performed.

While I accept that the document provided, including the policy and Members Handbook do contain this detail, they are not easy documents to navigate. However, importantly, the Complainant took the prudent action of telephoning the Provider to check directly if the procedure was covered in the particular Clinic.

I will return to the phone calls shortly.

On 1 December 2016, the Provider wrote to both the Complainant and the Complainant's Consultant Cardiologist in the Clinic in response to a request for pre-approval for a cardiac MRI. The letter confirmed that having reviewed the information received from the Complainant's Consultant Cardiologist, the Provider was approving cover for cardiac MRI based on medical appropriateness. Specifically, the letter went on to say as follows:

"This approval has been granted on the basis that this procedure is carried out in one of our Approved Cardiac MRI Centres and up to her level of cover as follows:

[It named three facilities where the scan would be approved but this did not include the particular Clinic where the Complainant proposed to have the procedure done].

This approval has been based on the Policy Premiums being paid up to date of treatment and her current [redacted] *Plan."*

Copies of both letters have been provided to this office.

Recordings of telephone conversations between the Complainant and the Provider have been provided in evidence. The eleven phone calls provided to this office have been considered by me in arriving at my decision. The relevant calls can be summarised as follows:

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The first call, on 5 December 2016, was a call from Complainant to Provider. She explained that she was due to undergo a scan in the Dublin Clinic but that the Clinic informed her that the Provider has told it that the Complainant's planned scan was not covered under the plan. She asked was it just the Clinic where it was not covered or can it be carried out somewhere else? The Provider's employee stated that customer care was busy and she would let her know as soon as possible.

The second call, also on 5 December 2016, was a call back from the Provider to the Complainant. The Complainant was advised that she would not be covered in the Dublin Clinic.

The Complainant then enquired as to whether a rural hospital would be covered but she was told it was not. The Complained was then advised that three Dublin hospitals would be covered.

The Complainant asked about another rural hospital and was told it was a covered hospital but that she would have to check whether that hospital carried out the procedures in question. The Complainant was then told that the procedure codes she had provided were incorrect.

The third call, on 6 December 2016, was a call from the Complainant to the Provider. The Complainant advised she was waiting on a call back from the Provider and that she had not realised that her policy did not cover certain hospitals. The Complainant explained that it was an urgent procedure and asked for the contact details of the two Dublin hospitals. The contact details were provided as requested. The Complainant then gave the Provider the correct procedure code. The Provider then informed the Complainant that if she had the MRI scan carried out at the Dublin Clinic she had enquired about that she would be covered for 66% of the procedure. This information was incorrect.

The fourth call, also on 6 December 2016, was a call from the Dublin Clinic to the Provider. The Clinic advised that the Complainant had informed it that she was covered for 66% of the cost procedure and wished to clarify this with the Provider. The Clinic stated that the Complainant stated she had received a letter from the Provider to this effect. The Provider was clearly very confused as to whether the Complainant was covered for a cardiac MRI at that Clinic and had initially stated that the Complainant was covered for the Cardiac MRI at the Clinic and then expressed doubt as to whether this was accurate. She advised the representative from the Clinic to contact another employee within the Provider's company to confirm. The Provider, in its response to this office, asserts that its employee confirmed to the Clinic during this phone call that there was no cover for the Cardiac MRI at the Clinic. This description of the phone call is wholly inaccurate, and it was abundantly clear from the contents of this call that there was a high degree of uncertainty on the Provider's part.

The fifth call took place at the same time as the fourth call and was a call from the Complainant to the Provider. The Complainant explained the conflicting information she had received earlier from the Provider and the information she was receiving from the

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Clinic in relation to her cover. It was then confirmed to the Complainant that she would not be covered for the Cardiac MRI scan at the Clinic.

The sixth call, on 22 December 2016, was a call from the Complainant to the Provider in relation to the non-receipt of policy renewal documents.

The seventh call, also on 22 December 2016, was a call from the Complainant to the Provider. The Complainant explained she had the cardiac MRI carried out in the Dublin Clinic at a cost of €528. The Complainant explained that she had tried other approved hospitals but could not get an appointment at a suitable date. She then enquired about claiming back 66% of the cost of the scan carried out. The Complainant then explained that she received a pre-approval letter from the Provider for the Cardiac MRI for the procedure code. The Complainant was advised to send in the bill from the Clinic to the Provider.

The eighth, ninth, tenth and eleventh calls, on 23 December 2016, 29 December 2016 and 30th December 2016 and 10 January 2017 respectively were calls from the Complainant to the Provider in relation to policy renewal and alternative plans.

The Complainant states that it was not clear from her policy whether she was covered or not and that she could not identify her plan from the card issued to her. However, it does not appear to be disputed that the Claimant received the terms and conditions of the policy and the Membership Handbook. Both documents set out what treatments are covered and in what approved medical centres the policy will cover. The policy excludes cover for Cardiac MRI scans carried out at the Dublin Clinic.

However, these documents are not easily navigated and I believe this is evidenced by the confusion among the Provider's agents as to what was covered and what was not covered. In fact, had the Clinic itself not raised the concern that it felt the Complainant's policy did not provide cover for the procedure in its facilities, the information might not have been corrected before the procedure was performed.

That said, the Provider wrote to the Complainant on 1 December 2016 stating that she had pre-approval for her procedure but also stating the approved Cardiac MRI Centres under her policy where she could have the procedure carried out. This did not identify the Dublin Clinic as an approved cardiac MRI centre which would be covered under her policy.

It is a fact that on 6 December 2016, it was erroneously misrepresented to the Complainant by the Provider that 66% of the cost of the procedure would be covered if it was carried out at the Clinic. That representation was incorrect, and it was misleading and had communications between the Complainant and the Provider ceased at that point then it would have been reasonable for the Complainant to expect a refund of 66% of the procedure.

However, the audio recordings are clear and later that same day, the Complainant called back and was told in clear terms by the Provider that the procedure would not be covered under her policy. At that point, the Complainant had been put on notice that if she

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underwent the procedure at the Clinic, it would not be covered under her policy. Notwithstanding the foregoing, the Complainant went ahead with the scan at that Clinic. It appears from a later telephone call, that the Complainant had difficulty in obtaining an appointment at a suitable date at an approved centre and it is therefore understandable why she felt she needed to go ahead with the procedure at the Dublin Clinic. While I accept that the Complainant was on notice that the scan would not be covered under the policy and I also accept that the Provider caused her considerable confusion and unnecessary inconvenience at a time that was already stressful, I acknowledge nonetheless that the Provider has offered €100 in light of these issues. I consider that a sum of €250 is more appropriate in all the circumstances.

Therefore, for the reasons outlined above, I partially uphold this complaint.

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) |(b) and (g).***

Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to make a compensatory payment to the Complainant in the sum of €250, to an account of the Complainant's choosing, within a period of 35 days of the nomination of account details by the Complainant to the provider. I also 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***, if the amount is not paid to the said account, within that period.

The Provider is also required to comply with ***Section 60(8)(b)*** of the ***Financial Services and Pensions Ombudsman Act 2017.***

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.

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FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

10 September 2018

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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) ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.