Decision Ref:	2018-0050
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Rejection of claim - pre-existing condition
Outcome:	Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant took out a medical expenses insurance policy underwritten by the Provider on 1 December 2015, through his employer's group scheme. The Complainant underwent a medical procedure in hospital on 29 February 2016.

On 21 December 2016, the Provider declined the Complainant's claim for the medical costs incurred as a result of this procedure, on the basis that the procedure was in respect of a medical condition that had existed before the Complainant took out his insurance cover on 1 December 2015 and that the Complainant had not yet served the applicable waiting period for pre-existing conditions.

The Complainant disputes that his claim was related to a pre-existing medical condition, and is dissatisfied both with the assessment of his claim, and the length of time taken by the Provider to come to a decision on his claim.

The Complainant is further dissatisfied with the actions of the Provider in communicating to the hospital in question, that he would be settling the related bill himself.

The complaint is that the Provider has wrongfully declined the Complainant's claim, and delayed unreasonably in its assessment.

The Complainant's Case

The Complainant states that he underwent a colonoscopy in hospital on 29 February 2016, as a precautionary measure, taken in light of a family medical history of colon cancer, and not because of any existing medical condition.

The Complainant states that, as part of this pro-active approach to looking after his health, he had engaged with his GP in 2013, and his GP had organised for him to have a colonoscopy as a precautionary measure, in January 2014. The Complainant states that this procedure was carried out, that "*no issues were uncovered*", and that the related costs were covered by his then health insurer. The Complainant states that his specialist at the time recommended a bi-annual check up, and that this was how he came to have a repeat colonoscopy two years later, in February 2016.

The Complainant disputes the Provider's action, on 21 December 2016, in declining his claim for medical expenses on the grounds that it was related to a "pre-existing" condition. The Complainant states that he does not, to his knowledge, have any pre-existing medical condition.

The Complainant states that he spoke on the telephone with a Provider representative on 30 December 2016, during which he set out the reasons for his dissatisfaction with the outcome of his claim. The Complainant states that the Provider representative suggested that a letter from the Complainant's GP regarding his health might assist the Provider in reviewing the matter. The Complainant states that he requested the Provider representative to summarise the content of the telephone conversation in writing, and to email him the details of what was required from his GP as soon as possible. The Complainant states that he had not received a response from the Provider representative by 4 January 2017, and on that date he sent a further email seeking the information he had requested.

The Complainant states that he received an email from the Provider the following day, 5 January 2017, advising as follows:

> *"…your claim was subsequently declined following a medical review, as it was deemed that your treatment was relating to a pre-existing condition based on the onset date of symptoms provided in the hospital claim form, and you do not yet have the applicable waiting periods served for this".*

The Complainant is very disappointed, and does not understand why the Provider failed to mention or to send the email outlining the details required from his GP, as discussed in the telephone conversation which had taken place on 30 December 2016.

The Complainant continues to query the declinature of his claim, and the basis on which the Provider has categorised his claim as relating to a pre-existing medical condition.

The Complainant is also dissatisfied with the length of time taken by the Provider to consider his claim and to make contact with him in respect of its assessment. He submits

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that the procedure took place on 29 February 2016, yet the Provider did not communicate its decision to decline the claim until 21 December 2016. The Complainant comments that he had moved his medical expenses insurance to another health insurer in the meantime, with effect from 1 December 2016, and he wonders whether this was the reason for the Provider's decision at that stage to decline his 10 month old claim. The Complainant states that an explanation from the Provider for the 10 month delay remains outstanding.

The Complainant is further dissatisfied with the actions of the Provider in communicating to the hospital, in which he had undergone the procedure in question, that he would be settling the related bill directly with the hospital, in circumstances where the claim was not covered under the Complainant's policy. The Complainant contends that the Provider wrongfully gave a commitment to the hospital on his behalf, that he would discharge the medical bill himself, without having spoken to or consulted with the Complainant in this regard.

The Complainant wants the Provider to acknowledge its errors and seeks payment of his claim in full.

The Provider's Case

The Provider states that the Complainant took out medical expenses insurance with the Provider with effect from 1 December 2015.

The Provider states that on 22 March 2016 it received a Hospital Claim Form on the Complainant's behalf for a colonoscopy which the Complainant had undergone in hospital on 29 February 2016.

The Provider wishes to point out that the Complainant did not contact the Provider to confirm cover prior to undergoing this procedure.

The Provider submits that, upon assessing the claim, its records indicated that the Complainant had not completed all of the applicable waiting periods which had to be served before he could benefit from inpatient cover.

The Provider states that, as part of the claim adjudication process, it sought confirmation of continuing cover from other health insurance providers, and that it took some time for the other health insurance providers to respond. The Provider states that, when the other health insurance providers reverted with the information requested, there appeared to be a break in health insurance cover prior to the start date of the Complainant's policy with the Provider on 1 December 2015. The Provider states that, upon making a direct inquiry with the Complainant, the Complainant confirmed that he had a break in cover from the end of July 2015 to the start of his policy with the Provider on 1 December 2015. The Provider submits that, consequently, because the Complainant had a break in cover of more than 13 weeks, he was subject to all new member waiting periods when he took out his new policy on 1 December 2015.

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The Provider states that the Complainant's colonoscopy occurred during his initial waiting period and is not therefore covered. The Provider refers to page 25 of the Complainant's membership handbook, where it states that all applicable waiting periods are explained.

On 21 December 2016, the Provider declined the Complainant's claim and issued written notification to this effect to both the Complainant, and to the hospital, on 21 December 2016.

The Provider notes that the Complainant's cover was cancelled in accordance with a request received from his broker on 14 November 2016, effective as of 2 December 2016.

The Provider states that, subsequently, following receipt of the declinature letter, the Complainant telephoned the Provider on 30 December 2016 to express his dissatisfaction with the outcome of his claim. The Provider states that a complaint was immediately logged, and that within 4 working days (on 5 January 2017) a full written response was issued to the Complainant. The Provider states that the Complainant replied on the same day with further queries, and that the Provider telephoned the Complainant on 6 January 2017, addressing his questions, and explaining the application of the waiting period.

In response to the Complainant's complaint that he never received written confirmation from the Provider of the information required from his GP, to be taken into account in a review of his claim, which the Complainant suggests had been promised to him during the telephone conversation which took place on 30 December 2016, the Provider states that it has since explained to the Complainant that, as he had not served his initial waiting period of 26 weeks, there is no further medical information that he could submit from his GP for review by the Provider, as the terms and conditions of his policy were not satisfied at the time of his claim.

The Provider states that, based on the information it holds on file and the applicable terms and conditions relating to waiting periods, its position remains that it has processed the Complainant's claim correctly.

The Provider notes that the Complainant was upset that it had informed the hospital that the Complainant would be settling the bill directly with them, but states that this is its normal procedure for declined claims. The Provider submits that, when a claim is declined, it is obliged to inform all parties concerned of the outcome.

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 23 March 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 Provider has declined the Complainant’s claim, under his policy of medical expenses insurance, for the costs incurred in undergoing a medical procedure in hospital on 29 February 2016, on the basis that the procedure was in respect of a medical condition that had existed before the Complainant had taken out his insurance policy on 1 December 2015. The Provider states that, as of 29 February 2016, the Complainant had not yet served the waiting periods which were applicable to his policy cover and that, consequently, these medical expenses were not covered.

The documentary evidence submitted shows that the Complainant incepted a policy of medical expenses insurance, underwritten by the Provider, on 1 December 2015, through his employer’s group scheme. The policy was put in place through an independent insurance broker. On 8 December 2015 the Complainant was issued with his policy documentation, including his Membership Certificate, his Table of Cover effective from 1 December 2015, his Membership Handbook, Terms of Business, and product suitability statement.

In circumstances where the group scheme’s renewal date was 30 December 2015, for the upcoming policy year, the Complainant’s renewal documents were issued to him on 17 December 2015. The Provider confirmed renewal by letter to the Complainant dated 29 December 2015.

The submissions show that, on 22 March 2016, the Provider received a Hospital Claim Form for the direct payment of medical charges incurred by the Complainant on foot of a medical day procedure carried out in hospital on 29 February 2016.

The Provider declined the Complainant’s claim on 21 December 2016. In its letter of declinature, the Provider informed the Complainant as follows:

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> *"Your claim details that your treatment was for a condition that existed before you had health insurance and so you still have an exclusion period on your policy for treatment of this condition. We regret to advise you that there is no cover for this treatment at the moment on your policy so we can't pay this claim on this occasion."*

The Provider advised the Complainant that "*we've made the hospital aware that you'll be settling directly with them in this case".*

The operation of the Complainant's medical expenses policy is set out within the terms and conditions of his contract, which are contained in the Complainant's Membership Handbook. I note that it is a term of the Complainant's contract (at page 5 of the Membership Handbook) that "*your medical expenses will not be covered until after your waiting periods have expired."*

I note also that certain specific exclusions from cover are set out at page 22 of the Membership Handbook, including the following:

> *"We do not cover the following (subject to compliance with the Minimum Benefit Regulations):*
>
> *…*
>
> - *Any cost incurred whilst a waiting period applies."*

The Provider has pointed to the fact that waiting periods are a fundamental element of the principle of open enrolment in health insurance in this country, consistent with the provisions of the Health Insurance Act 1994 (Open Enrolment) Regulations 1996, as amended by the Health Insurance Act 1994 (Open Enrolment) Regulations 2015, which applied standardised waiting periods for all new customers taking out health **insurance** after 1 May 2015. These maximum periods are 26 weeks for illnesses that commence after joining, five years for pre-existing illnesses, and 2 years for upgrades in cover.

The term "*waiting period*" is explained in Section 6 of the Membership Handbook, at page 25, as follows:

> *"A waiting period is the amount of time that must pass before you will be covered under your plan or before you will be covered to the level of cover available under your plan. There are a number of different types of waiting periods:*
>
> - *Initial waiting periods*
> - *Pre-existing condition waiting periods*
> - *Upgrade waiting periods."*

The term "*initial waiting period*" is defined in the Membership Handbook as follows:

> ***"Initial waiting periods***

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> *Initial waiting periods apply when you take out health insurance for the first time or when you take out health insurance after your health insurance has lapsed for 13 weeks or more. You will not be covered during your initial waiting period.*
>
> *…*
>
> *The table below sets out the initial waiting periods applied by* [the Provider]. *These waiting periods will apply from the date you took out health insurance with* [the Provider] *or another insurer for the first time, or, from the date you took out health insurance with* [the Provider] *or another insurer after your health insurance had lapsed for 13 weeks or more.*

I note that the policy sets out the initial waiting period which applies in the case of different types of benefits. In respect of all in-patient benefits, the applicable initial waiting period is 26 weeks.

The term "*pre-existing condition waiting period*" is defined in the Membership Handbook as follows:

> ***"Pre-existing condition waiting periods***
> *Where you make a claim which relates to a pre-existing condition, a pre-existing condition waiting period will apply. A pre-existing condition is an ailment, illness or condition, the signs or symptoms of which existed at any time in the six months before you took out health insurance for the first time, or before you took out health insurance after your health insurance had lapsed for 13 weeks or more.*
>
> *You will not be covered for a pre-existing condition during your pre-existing condition waiting period. Our medical advisors will decide whether your claim relates to a pre-existing condition. Their decision is final…*
>
> *The table below sets out the pre-existing condition waiting periods applied by* [the Provider]*. These waiting periods will apply from the date you took out health insurance for the first time with* [the Provider] *or another insurer, or from the date you took out health insurance with* [the Provider] *or another insurer after your health insurance had lapsed for 13 weeks or more.*

I note that the policy sets out the pre-existing condition waiting period which applies in the case of different types of benefits. In respect of all in-patient benefits, the applicable pre-existing waiting period is 5 years.

In this complaint, it is not disputed that the Complainant had had a break in health insurance cover from the end of July 2015 to the start of his policy with the Provider on 1 December 2015. Consequently, the Complainant had had a break in cover of more than 13 weeks and, in these circumstances, in accordance with the terms and conditions of his policy with the Provider, he was subject to both the initial waiting period, as defined above, and also the pre-existing condition waiting period, as defined above.

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The Provider has indicated in its submissions to this office that the Complainant's claim was declined on the grounds that the medical procedure in question took place during his initial waiting period, and was not therefore covered.

I note, however, that when the Provider declined the Complainant's claim on 21 December 2016, it was on the grounds that the medical information contained in the Hospital Claim Form indicated that the treatment that the Complainant had received was *"for a condition that existed before you had health insurance and so you still have an exclusion period on your policy for treatment of this condition".*

It is evident, therefore, that when the Complainant's claim was first declined in December 2016, it was on the basis that the claim was related to a pre-existing condition and that the "pre-existing condition waiting period" had not been served. There was no mention of the separate and distinct "initial waiting period" in the letter of declinature.

The Complainant has disputed this basis for declining his claim. He submits that his claim was not related to a "*pre-existing*" condition, and has argued that the procedure in question was undertaken as part of a precautionary and pro-active approach to his health, in light of a family history of colon cancer. He states that the procedure was not related to any pre-existing medical condition, and that *"no issues were uncovered".*

I have considered the Complainant's arguments in this regard. I understand that it was of concern to him that his claim had been declined on the grounds that the procedure was related to a pre-existing condition, in circumstances where the Complainant himself states that he had no knowledge of any pre-existing condition.

The Provider is entitled to assess the claim based on the medical information received during the claims process. In this instance, the Hospital Claim Form is composed of two parts. Part 1 is completed by the patient or policyholder, and Part 2 by the admitting doctor/Consultant/GP.

I note that in the "History of Illness Section" of Part 1 of the Hospital Claim Form (which is completed by the patient or policyholder), in response to the question "*When did you first suffer from these symptoms or illness*?" the response given was "*Jan 2014".* Similarly, in response to the question "*When did you first visit your doctor with these symptoms?"* the response given was *"Jan. 2014".*

It is evident that the Complainant signed this form and, in so doing, he confirmed with his signature that the "*details, answers and information given in this form are true, accurate and complete".*

I note, in addition, that in Part 2 of the Hospital Claim Form (which is completed by the admitting doctor/Consultant/GP), the admitting doctor indicated that this was a planned admission, that the patient had suffered from "*unexplained lower abdominal pain*", the duration of symptoms being since "*2014*", and that the primary reason for admission was "*colon polyps*".

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Having considered the content of the Hospital Claim Form, I accept that, on the basis of the medical information provided by both the Complainant in Part 1, and by the admitting doctor in Part 2 of the Claim Form, the Provider was reasonably entitled to conclude that the procedure in question was in respect of a medical condition from which the Complainant had suffered since January 2014, and which therefore pre-dated the start of the Complainant's insurance policy on 1 December 2015. Consequently, in circumstances where the Complainant was subject to a 5 year pre-existing condition waiting period, which had not yet been served at the date of the medical procedure in question, the Provider was reasonably entitled, based on the information provided in the Hospital Claim Form, to decline the Complainant's claim on the grounds that the procedure in question was not covered by his policy. I cannot find any wrongdoing on the part of the Provider in declining the Complainant's claim on these grounds.

I am aware that the Complainant has referred to a subsequent telephone conversation which took place with a Provider representative on 30 December 2016, during which he expressed his dissatisfaction with the assessment of his claim in a number of respects, including his contention that the treatment was not connected to a pre-existing medical condition. The Complainant has submitted that during this conversation the Provider representative undertook to write to him setting out what would be required from his GP to support his contention that the procedure was not related to a pre-existing condition. The Complainant states that the Provider representative failed to furnish him with these details, and that when he finally received a letter from the Provider dated 5 January 2017, it was to advise him once again that his claim had been declined on the grounds that the procedure in question related to a pre-existing condition.

The Provider has submitted the file notes made by its representative in relation to the content of the telephone call which took place on 30 December 2016, which record that the Complainant *"was not happy with the decline and was not happy with the contents of the letter that was sent to him…he is not happy that claim is deemed as being pre-existing – explained details but he does not accept the pre-existing condition…"* The representative's notes included the following comments: "[The Complainant] *would not accept my explanation and wants an email with the reason why claim was declined and what he needs to do to appeal and wants the Ombudsman details."*

The Provider has also submitted a recording of this telephone conversation, the content of which has been made available to the Complainant, and has been taken into account during the course of this adjudication. I note that during this conversation the Complainant requested the Provider representative to summarise the content of the conversation, and to send it to him by email, setting out what the Provider required from the Complainant's GP, and furnishing the details of the Financial Services Ombudsman. I note that the Provider representative confirmed that she would log the Complainant's dissatisfaction with the outcome of his claim, and that the information he had requested would be sent to him by email. I note that during this call the Complainant advised that he was leaving the country for a period of time, on 7 January 2017, and that he wished to have the matter resolved prior to that date.

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The submissions show that the Provider issued a letter to the Complainant, dated 5 January 2017, on foot of the telephone conversation with the Complainant, setting out the basis for the declinature of the Complainant's claim, and advising that if the Complainant wished to appeal the decision "*we need further medical information from you to support that your treatment was not a result of a pre-existing condition*". The Provider advised the Complainant, among other things, that if he remained dissatisfied with the situation he could refer the complaint to the Financial Services Ombudsman and provided the relevant contact details.

I note the Complainant's dissatisfaction with both the content of this response, and the fact that it took four working days for the Provider representative to revert to him. It may be that the Complainant expected an emailed response by return. However, I accept that the Provider furnished the information sought, or understood to have been sought, by the Complainant, within a reasonable period of time (4 working days), and advised the Complainant to submit further medical information "*to support that your treatment was not a result of a pre-existing condition*" if he wished to appeal the declinature of his claim.

From a review of the correspondence that followed, however, I note that the Complainant was subsequently advised by the Provider in a letter dated 2 February 2017, and again in a letter dated 6 February 2017, that "*although your claim was declined on the grounds that your pre-existing condition waiting period was not served, please note that your 26 week waiting period for new conditions was also not served at the time. Therefore additional medical information would not have been required. Please accept my apologies for this error.*"

The Provider, in its submissions, has explained that it became clear upon further review of the details of the Complainant's claim, that the Complainant had not served his initial waiting period of 26 weeks and that, in these circumstances, the submission of additional medical information would not alter the position in respect of cover, as the Complainant was not covered for any in-patient benefits until the expiry of the initial 26 week waiting period.

Upon review of the documentation, I accept that the Complainant's claim arose within the initial 26 week waiting period to which the Complainant's cover was subject. In these circumstances, even if the Complainant had established that his claim did not arise from a medical condition which pre-dated his insurance policy, I accept that he would not have been covered for the procedure in any event as the medical expenses were excluded from cover until the expiry of the 26 week initial waiting period.

Be that as it may, I consider that the Provider's communications with the Complainant in respect of his claim have been unclear in respect of the two separate and distinct waiting periods to which the Complainant's cover was subject, and their application to the Complainant's claim. No reference was made by the Provider to the application of the initial waiting period in the letter of decline issued to the Complainant on 21 December 2016, or in any subsequent correspondence or communications in relation to the claim, prior to the above-mentioned correspondence from the Provider dated 2 and 7 February 2017. It is disappointing, and indeed not acceptable, that the Complainant was not

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informed of the application of the initial waiting period to his claim, in addition to the pre-existing condition waiting period, until February 2017. This was almost a year after he signed the Hospital Claim Form for the procedure in question, and some six weeks after his claim had been formally declined by the Provider on the basis of the application of the pre-existing waiting period. It is not acceptable that the Complainant was not provided with this information when the Provider invited him, on 5 January 2017, if he wished to appeal the decision to decline, to submit *"further medical information… to support that your treatment was not a result of a pre-existing condition*". The Provider has now made it clear to the Complainant that the submission of additional medical information would not have altered the position in respect of cover, as the Complainant was not covered for any in-patient benefits until the expiry of the initial 26 week waiting period. It is not acceptable that no clear explanation of the two separate and distinct waiting periods to which the Complainant's cover was subject, and their application to the Complainant's claim, was presented to the Complainant in the context of the assessment of his claim, until February 2017. It is important for a provider to set out fully the grounds upon which a claim has been declined, and to afford the claimant the certainty that these grounds will not be departed from, or additional grounds added, at a later date.

I note also that in the Provider's letter to the Complainant, dated 5 January 2017, the Provider referred to the fact that the Complainant's claim had been declined "*following a medical review*". The Complainant has repeatedly, throughout this complaint, inquired of the Provider about this "*medical review*" and sought details in relation to this medical review. In a submission to this office, dated 31 July 2017, the Provider responded that "*the claim was declined as* [the Complainant] *had not served his initial waiting period of 26 weeks. There would have been no medical review carried out as this would not have changed the outcome of the claim*". I would point out, firstly, and as already identified above, that the Complainant's claim was not declined on the basis that the Complainant *"had not served his initial waiting period of 26 weeks".* The Complainant's claim was declined on 21 December 2016 on the basis that the procedure was in respect of a medical condition that had existed before the Complainant took out his insurance cover on 1 December 2015, and the Complainant had not yet served the applicable 5 year waiting period for pre-existing conditions. The Complainant was not informed of the application of the initial waiting period until February 2017. Secondly, it is unclear why the Complainant was informed by the Provider in a letter dated 5 January 2017 that his claim had been declined following a medical review, and then later told by the Provider in July 2017 that, in fact, no such medical review had ever taken place.

It is evident that there has been a lack of clarity in the assessment of the Complainant's claim and, indeed, some confusion in the communications between the parties in respect of the grounds for declining the claim, and I accept that this has been a cause of genuine concern and frustration on the part of the Complainant.

The Complainant was entitled to expect that the assessment of his claim, and all communications in respect of his claim, would be carried out by the Provider with due skill, care and diligence, professionally and in his best interests, as required under the General Principles of the Consumer Protection Code 2012. It is my view that the Provider has failed

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to adhere to this requirement in the circumstances of this complaint, and that a compensatory payment is merited in these circumstances, in favour of the Complainant.

I note that the Complainant has also expressed dissatisfaction with the length of time taken by the Provider to consider his claim and to communicate its decision to him. The submissions show that the Provider received the Hospital Claim Form on 22 March 2016, and communicated its decision to decline the claim to the Complainant on 21 December 2016, some 9 months later. The Complainant contends that the Provider delayed in assessing his claim, and states that an explanation from the Provider for the time involved in finalising his claim remains outstanding.

It is the Provider's position that it was seeking additional information from other health insurance providers regarding the Complainant's previous insurance cover, prior to making a final decision on the claim. While I accept that the Provider is entitled to make such inquiries as part of the claims assessment process, and in order to establish continuity of cover where appropriate, it is regrettable that the Provider waited some six months for this information, before writing directly to the Complainant on 12 September 2016 to request his previous medical insurance details. I note that the Complainant supplied this information on 29 September 2016. Thereafter, it took a further three months before the Provider issued its letter of decline to the Complainant on 21 December 2016. The Provider has submitted no explanation for this timeframe. The claims assessment process was unacceptably long.

No evidence has been submitted to show that there was any connection between the Provider's declinature of the Complainant's claim on 21 December 2016, and the instruction received from the Complainant's broker to cancel the Complainant's cover, with took effect on 1 December 2016.

A further aspect of this complaint is the Complainant's contention that the Provider wrongfully gave a commitment to the hospital on his behalf, following the declinature of his claim, that he would discharge the medical bill himself, without having spoken to or consulted with the Complainant in this regard.

I note that the Provider wrote to the hospital concerned, on 21 December 2016, advising that the Complainant's claim had been declined and would not be paid by the Provider on this occasion, and stating as follows:

> *"…We have advised our member of this and we are returning both hospital and consultant invoices to you so that you can seek payment directly in this case…"*

As detailed on page 10 of the Membership Handbook, under "How In-Patient Benefits are Claimed", and as set out at the head of the Hospital Claim Form, the Provider has a direct payment agreement with "*most hospitals*", including the hospital concerned in this complaint, which allows the policyholder's claim to be settled directly between the hospital and the Provider.

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I note the following, at page 10 of the Membership Handbook, under "*How In-Patient Benefits are Claimed*":

> *"In most cases, we'll pay the amount for which you are covered under your In-Patient Benefits directly to your medical facility and health care providers. They claim the amount for which you are covered from* [the Provider] *on your behalf and we pay this to them directly. This is known as direct settlement. Please note that only the amount for which you are covered will be directly settled with your medical facility and health care provider."*

On signing the Hospital Claim Form, on 29 February 2016, the Complainant signed a consent at the foot of the document in which he accepted that "*charges not covered under the* [Provider] *plan to which I subscribe will remain my responsibility, or that of the named dependent who received the treatment, to settle directly with the doctors, consultant or hospital concerned".*

In circumstances where the Provider had a direct settlement arrangement in place with the hospital, where the hospital had submitted a claim on the Complainant's behalf, and where the claim had been declined, I do not consider it wrong of the Provider to communicate the outcome of the claim to the hospital concerned and, in so doing, to inform the hospital that it was returning the medical invoices to the hospital so that it could seek payment directly from the Complainant.

In conclusion, upon a careful consideration of the documentary evidence and the submissions of both parties to this complaint, I accept that, based on the medical information provided in the Hospital Claim Form, (and I note that no subsequent or additional medical information was furnished), the Provider was entitled to decline the Complainant's claim under his medical expenses policy.

However, for the reasons set out above, I consider that the Provider's standard of claims assessment in this instance, and its related communications with the Complainant in the context of his hospital claim, were unacceptable, and to this extent the complaint is partially upheld. For this reason I consider that a compensatory payment is called for, and I direct the Provider to make a payment of compensation in the sum of €700.00 to an account of the Complainant's choosing within a period of 35 days from the date of this decision.

It is my Legally Binding Decision that this complaint is partially upheld.

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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 partially upheld on the grounds prescribed in ***Section 60(2)(g).***

- Pursuant to ***Section 60(4)(d)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct that the Respondent Provider pay an amount of compensation to the Complainant for his loss, expense or inconvenience sustained as a result of the conduct complained of, in the terms set out above.

- 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 35 days of the date of this decision.

- 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 direction 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 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

19 April 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.