An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0060
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Rejection of claim
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant holds a Policy of Health Insurance with the Provider, under which Policy she, her husband and three Children are covered. The Policy was incepted on 08th February 2001. The Complainant's complaint is that the Provider has unfairly refused to provide benefit in respect of the cost of a wig, for her son, who suffers from alopecia.

The Complainant's Case

The Complainant submits that, in June 2015, her young son lost his hair and by October 2015, he was completely bald, as a result of alopecia. (The Complainant submits that he was diagnosed and treated in Crumlin Hospital's Dermatology Dept., as a public patient).

The Complainant submits that she purchased a wig in October 2015, which cost €473.00 and, in July 2016 she purchased another, human hair, wig which cost €2,500.00.

The Complainant submits that at the time she was reviewing her policy, in July 2016, on a telephone call with the Provider, she was informed that the Provider only provides benefit in respect of wigs where the underlying cause of hair loss caused is cancer, and does not offer benefits for the cost of a wig for hair loss due to alopecia.

The Complainant submits that she appealed this decision with the Provider and was informed, by letter dated 23rd September 2016, that this was a business decision and that it maintained its position that no benefit was available.

The Complainant believes that this is unfair. The Complainant is seeking to have the Provider change its policy in this regard and submits that, in her experience, hair loss can be traumatic and painful for the sufferer and that the cause of the hair loss, does not change the impact of this, in a significant way. The Complainant submits that this policy/business decision on the part of the Provider, i.e., to provide benefit for the cost of wigs in the case of cancer sufferers, but not for those suffering from hair loss due to alopecia, is unfair.

The Provider's Case

The Provider submits that, on 25th July 2016 the Complainant called its Customer Service Division to review her cover. During this call she advised the call agent that her son had developed alopecia and would require a wig and asked what benefit would be available for this under her cover. The Provider submits that the call agent advised that benefit is only provided for wigs following chemotherapy or radiotherapy. Benefit is not provided for wigs required due to alopecia.

The Provider notes that the Complainant wanted this policy reviewed.

The Provider submits that, on 27th July 2016 following a review of the case and its rules, a letter was issued to the Complainant, confirming that in order to allow benefit for a wig under the terms and conditions of its contracts, the hair loss must be as a result of chemotherapy or radiotherapy.

The Provider submits that, on 23rd September 2016, the Complainant contacted its Customer Service Division again regarding cover for wigs due to alopecia and that the Provider reiterated its position.

The Provider submits that on a day to day basis it receives various requests to provide cover for new surgical procedures, medical therapies, new technology, outpatient appliances and various non-medical treatments and therapies but that its primary focus as a health insurance company is to provide cover for hospital costs and professional fees arising out of unforeseen illness requiring hospital care.

It submits that, in deciding whether to provide cover for any services, it needs to clinically evaluate the new service, establish the potential need, value and demand for such services and take cognisance of the economic factors. It says that, generally, extensions of cover lead to increases in the overall cost of insurance premiums which have to be shared by all of its members whether or not they avail of the additional services or whether or not they regard such services as essential.

The Provider submits that the list of approved medical and surgical appliances has been frozen in recent years as this is an area of its product offering that is under review. It submits that there are a number of prostheses, machines and therapies that may provide some element of comfort to its customers but says that funding these demands is not always possible if it is to keep subscriptions affordable and that at the present time, it finds its customers are demanding that it contains costs and keeps prices to a minimum.

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The Provider says that it acknowledges that the Complainant requested benefit for a wig for her son, due to alopecia but says that this is not covered under the terms and conditions of her contract with it.
The Provider points to Section 5 of the Table of Benefits applicable to the Complainant's son's contract, which states:

C	[Provider] approved medical & surgical appliances - subject to an excess of €300 per member per year (contact us for details of the eligible appliances)	€1000 per member per year

The Provider submits that while a wig is an "*approved appliance*" it is only so, in respect of hair loss following chemotherapy or radiotherapy. It says that, unfortunately, therefore, under the terms of the Complainant's insurance contract it is not in a position to provide benefit for the costs incurred for the wig.

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 on 23rd 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 Complainant incepted cover on 08th February 2001. The Complainant is the Policyholder and, she, her husband and three children are covered under the Policy.

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Refusal to Provide Benefit

The Provider wrote to the Complainant, following discussions between the Complainant and the Provider's Customer Service Department regarding the unavailability of benefit, on the Complainant's son's Plan, or indeed any Plan offered by the Provider, in respect of wigs, for sufferers of hair loss arising from a cause other than chemotherapy or radiotherapy.

This Final Response Letter of the Provider, which issued to the Complainant on the 27th July 2016, explained that the Provider was, "*unable to accede to your request to provide cover for this under our benefit for medical and surgical appliances."*

It went on to state:

> *"Please note that in order to receive benefit for a Wig, certain medical criteria need to be met. This criteria is "hair loss as a result of chemotherapy or radiotherapy." Please note, all claims are subject to the Terms and Conditions of Membership and the medical information received.*
>
> *I understand my response may come as a disappointment to you. Unfortunately, due to the large number of new and upcoming medical procedures, appliances and treatments; it is not always possible for us to provide cover for each and every treatment or medical appliance available to our members."*

In examining the within complaint, I have also had regard to the Policy Terms and Conditions.

Policy Terms and Conditions

The policy document entitled "*Hospital Plans, Rules – Terms and Conditions*", within section 5, headed, "*Benefits*", states that "*You must consult your Table of Benefits to ensure that a benefit is covered and the appropriate level of cover, if any."*

The Table of Benefits applicable to the Complainant's son's Policy states that benefit is provided in respect of:

> *"[Provider] approved medical and surgical appliances - subject to an excess of €300 per member per year (contact us for details of the eligible appliances)"* up to *"€1,000 per member per year."*

The Provider has furnished its "*Approved List of Medical and Surgical Appliances*" for the relevant period. This document states that:

> "*Only appliances listed on Table 1 are eligible for benefits. At present this list is closed and new applications are not being considered."*

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The last entry on this List of Appliances is, "*Wigs*". The "*Conditions of Payment"* in this respect, are stated as, "*For hair loss following chemotherapy or radiotherapy. Note: Claim must be accompanied by supporting medical documentation*."

Analysis

Health insurance policies, like all insurance policies, do not provide cover for every eventuality; rather the cover will be subject to the terms, conditions, endorsements and exclusions set out in the policy documentation.

Whilst I do have the greatest sympathy for the Complainants, a policy of insurance is not all encompassing in terms of cover provided and there will be events and, in this instance, Appliances, which are not covered by a policy.

I am satisfied from an examination of all of the evidence furnished, that the terms and conditions make it clear that no benefit is available in respect of wigs for hair loss, other than following chemotherapy or radiotherapy.

I appreciate that the Complainant is aware of this, and that her complaint relates to the general unavailability of benefit in respect of wigs other than where the hair loss has been caused by chemotherapy or radiotherapy. Having examined in detail the Complainant's submissions and having listened to the audio recordings furnished by the Complainant, I am also aware that the Complainant, as a member of an alopecia support group is conscious of the suffering and distress caused by this condition and is seeking to have the Provider change its current policy, to include cover for the cost of wigs for alopecia sufferers. Such a change would require a policy decision by the Provider. I would note however, that this Office must examine any complaint about the conduct of a Provider against the background of the parties' contractual relationship, and must consider each individual complaint based on its own individual facts and merits.

I have also taken into account the Provider's submissions that, in deciding whether to provide cover for any particular service, it needs to clinically evaluate the new service, establish the potential need, value and demand for such services and take cognisance of the economic factors. It has submitted that although customers may benefit in certain areas, if it extended cover, funding these demands is not always possible, if it is to keep subscriptions affordable.

I accept that underwriting decisions and the limitations of cover made available under its Plans are, in general, matters which are at the commercial discretion of the Provider and I am satisfied that it is for the Provider to determine the extent of the cover it offers.

Overall, in this instance, I am satisfied that the Provider has acted reasonably, transparently and in accordance with its Policy Terms and Conditions, regarding its decision that no cover is available in respect of wigs, other than for hair loss following chemotherapy or radiotherapy. As the evidence before me discloses no wrongdoing on the part of the Provider, there is no reasonable basis upon which it would be appropriate to uphold this complaint.

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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 rejected.

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 ADJUDICATION AND LEGAL SERVICES

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.