An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0063
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Rejection of claim - treatment abroad
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The complaint is that the Provider has acted wrongfully in declining the Complainant's claim, under her medical expenses insurance policy, for the costs incurred in obtaining inpatient medical treatment in a hospital in the United Kingdom in September 2016.

The Complainant argues that the procedure she underwent in the United Kingdom was not available to her in Ireland and that, in these circumstances, her insurance policy should cover the costs incurred.

The Complainant's Case

The Complainant states that in September 2016, when six months pregnant, she discovered that her unborn baby suffered from a rare medical condition, and that it was unlikely that the baby would survive birth.

The Complainant made arrangements to travel to a hospital in the United Kingdom, where she was subsequently induced and gave birth to a stillborn baby girl.

The Complainant submits that it was not possible, due to Irish legislative and constitutional restraints, for her to have this procedure carried out in Ireland.

The Complainant submits that, upon her return to Ireland, she sought to claim the costs of the in-patient medical procedure she had received in the United Kingdom, under her

medical expenses policy. The Complainant states that she was advised by the Provider that her policy would not cover the cost of the medical expenses incurred.

The Complainant argues that the procedure she had undergone in the United Kingdom had not been available to her in Ireland and that, in these circumstances, her insurance policy should cover the costs incurred in obtaining this treatment in the United Kingdom.

The Complainant seeks the reimbursement of her inpatient costs in the sum €2,100.00.

The Provider's Case

The Provider states that the Complainant, upon returning from the United Kingdom, contacted the Provider's customer service team on 16 September 2016 and enquired whether her hospital stay in the United Kingdom was covered under her policy.

The Provider states that it reviewed the Complainant's policy terms and found that, in order for treatment to be covered under the Complainant's in-patient benefits, the treatment received must be carried out in a hospital on the approved list of hospitals for the Complainant's plan. The Provider states that the hospital in the United Kingdom which the Complainant attended is not one of the approved hospitals and that, accordingly, no cover applies to medical treatment received in this hospital.

The Provider submits that, in addition, there are no benefits for overseas treatment under the Complainant's enhanced maternity cover.

The Provider states that the benefits made available under the policy's additional health and travel cover, which allows for international travel, requires pre-approval for any medical treatments received overseas. The Provider submits that, in this instance, the Complainant did not seek pre-approval from the Provider before travelling to the United Kingdom to receive treatment.

The Provider acknowledges that the treatment received by the Complainant in the United Kingdom was not a treatment available to her in Ireland, but submits that this is due to constitutional constraints within the State.

It is the Provider's position that it has acted in accordance with the pertinent Irish constitutional and legislative framework, and in compliance with its own policy terms and conditions.

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 26 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 circumstances giving rise to this complaint are that the Complainant travelled to a hospital in the United Kingdom in September 2016, when she was six months pregnant, to undergo a medical procedure which she was unable to have carried out in Ireland. The Complainant subsequently, upon her return to Ireland, sought to recover the cost of this inpatient medical treatment under her medical expenses insurance policy, which is underwritten by the Provider.

The complaint is that the Provider has acted wrongfully in declining the Complainant's claim, under her medical expenses insurance policy, for the costs incurred in obtaining this inpatient medical treatment. The Complainant argues that the treatment she received in the United Kingdom in September 2016 had not been available to her in Ireland and that, in these circumstances, her insurance policy should cover the costs incurred in obtaining this treatment abroad.

Having considered the policy documentation submitted, I note that the Complainant was covered under a policy of medical expenses insurance, underwritten by the Provider, from 11 May 2016 until renewal on 11 May 2017. The Complainant's medical expenses policy included additional benefits under an enhanced maternity package, and under an international health and travel package.

The Provider has based its response to the Complainant's complaint on a number of grounds. The Provider states that the hospital in which the Complainant underwent treatment in the United Kingdom, was not on the approved list of hospitals for the Complainant's healthcare plan; that the Complainant had not sought pre-approval for the treatment, as required by her policy for any medical treatment overseas; and that the

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Provider *"must operate its benefits within the legal constraints of the jurisdiction and cannot cover benefits that are not deemed legal or constitutional within the State".*

Not an Approved Hospital

The Provider has submitted that, in order for treatment to be covered for in-patient benefits under the Complainant's Hospital Cover, the treatment received must be carried out in a hospital on the approved list of hospitals for the Complainant's plan. The Provider states that the hospital in the United Kingdom which the Complainant attended is not one of the approved hospitals for her chosen plan and that, accordingly, no cover applies.

With reference to the provisions of the Complainant's policy, I note that Section 6 of the policy booklet, entitled "Your Plan Explained", sets out (at page 35) the terms and conditions which apply when settling any claim under the policy, including the following:

> ***"What is not Covered Under Your Plan:***
> *…*
> - *Any treatment received in a hospital not covered within the hospital network selected…"*

Section 3 of the policy booklet, entitled "Tailoring Your Cover – Hospital Cover", explains the term "Hospital Networks" as follows (at page 12):

> ***"Hospital Networks***
>
> [The Provider's] *plans are based on hospital networks. A network is a list of selected hospitals where you may receive treatment.*
>
> *This means that you get great cover in the hospital network you have selected but you will not be covered for hospitals that are not listed as being a part of your chosen network. You can view the list of hospitals covered in your chosen network on the documents page in the members' section of our website.*
>
> *This list may change during the year, so please check with us before going into hospital to confirm your level of cover and that that hospital is still listed in your chosen network".*

It is clear, therefore, that the Complainant's plan covers her for in-patient benefit in hospitals which are listed as being part of her chosen hospital network, but that it does not cover her for in-patient treatment in hospitals which are not in her chosen network. I accept that the policy booklet clearly advises of the situation in this regard, and recommends that the insured checks, before going into hospital for in-patient treatment, to confirm whether or not the hospital is listed in the insured's chosen network.

I note that the list of hospitals covered in the Complainant's chosen network may be viewed on the documents page in the members' section of the Provider's website. It was

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also included in the information pack which issued to the Complainant on 5 May 2016, along with her Membership Schedule and Table of Benefits.

Neither the Provider nor the Complainant have identified the name of the hospital which the Complainant attended in September 2016, other than its location in Liverpool. However, upon reviewing the network of hospitals relevant to the Complainant's plan, it is evident that all of the hospitals within the Complainant's network are located within Ireland, and that the list does not contain the names of any hospitals located in the United Kingdom. Consequently, I accept that the hospital to which the Complainant travelled in the United Kingdom is not one of the list of approved hospitals within the Complainant's network.

In summary, I accept that the policy requires that the hospital be in the Complainant's chosen network in order for Hospital Cover to apply. I accept that the hospital in the United Kingdom, to which the Complainant travelled in September 2016 to obtain treatment, was not within the Complainant's hospital network and that, accordingly, Hospital Cover did not apply in this instance.

Pre-Approval for Treatment

The Provider has submitted that the Complainant's additional health and travel cover, which allows for international travel, requires pre-approval for any medical treatments received overseas.

This additional cover provides an additional level of medical expenses cover while the Complainant is abroad. I note that Section 4 of the policy booklet, entitled "Tailoring Your Cover – Personalised Packages", sets out (at page 21) the following exclusion to the Complainant's international health and travel cover:

> *"**What You Are Not Covered For While Abroad:***
>
> *Any claims arising directly or indirectly in respect of:*
>
> *a) Hospital expenses for in-patient treatment in a hospital abroad where* [the Provider] *has not arranged all services…"*

Furthermore, Section 4 sets out (at page 23) the following provisions which are applicable to the circumstances of this complaint:

> *"**Travelling Abroad For Treatment***
>
> *In some cases you will be covered for treatment overseas but it is essential that you speak to us first.* [The Provider] *will have to pre-approve any procedures carried out outside of Ireland before you travel abroad for treatment..."*

The policy then sets out four clear steps which the insured is required to follow if he or she wishes to apply for approval for treatment abroad. I note that these steps include

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obtaining a referral by a participating consultant in Ireland, obtaining written approval from the Provider in advance of the treatment, obtaining a report from the treating consultant overseas, and finally, obtaining confirmation from the Provider that the treatment is covered and the maximum amount payable by the Provider for the treatment.

The requirement of pre-approval for treatment abroad under the Complainant's international health and travel cover is also set out in the Table of Benefits attached to the Policy Schedule for the Complainant's plan, as follows:

International Health and Travel

Benefits	***Level of Cover***
…	…
Treatment abroad up to the amount that would have been paid in Ireland	*Covered – subject to pre-approval.*
…	

It is clear, therefore, that the cover made available to the Complainant under her additional international health and travel cover, which forms part of her medical expenses policy and which allows for international travel, requires pre-approval from the Provider for any medical treatments received overseas. This is clearly set out within the terms of the Complainant's policy.

In this complaint, while I acknowledge the distressing circumstances in which the Complainant came to the decision to travel outside Ireland to undergo the medical procedure in question, I accept, and indeed it is not disputed, that the Complainant did not contact the Provider in advance of the procedure to obtain the required pre-approval and confirmation of cover. It is evident that it was upon the Complainant's return to Ireland, having received the treatment in question in a hospital in the United Kingdom, that she first contacted the Provider to inquire whether she was covered under her policy for the hospital costs incurred.

In these circumstances, I accept that the Complainant did not meet the requirements of the procedures set out in the terms and conditions of her medical expenses policy in respect of cover for treatment abroad, and that the Provider was accordingly entitled to decline cover under the terms of the policy for the medical procedure in question.

Legislative and Constitutional Framework

The Provider has acknowledged the Complainant's contention that the procedure she had undergone in the United Kingdom had not been available to her in Ireland and that, in these circumstances, her insurance policy should cover the costs incurred in obtaining this treatment abroad.

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I note that the Bank's response, referring to the constitutional and legislative framework which exists in Ireland, did not constitute one of the grounds upon which the Complainant was initially advised by the Provider in relation to her potential claim.

In its Final Response Letter to the Complainant dated 30 January 2017, the Provider grounded its position in respect of the Complainant's claim on the basis that the hospital in the United Kingdom was not included within the Complainant's hospital network, and on the basis that the Complainant had not obtained pre-approval from the Provider for the treatment obtained.

It would appear that the third ground to which the Provider has subsequently referred, in its submission to this office dated 1 August 2017, in response to the specific issue raised by the Complainant in relation to the non-availability of the procedure in Ireland, raises significant issues of constitutional complexity which, in all likelihood, are not a matter for the Financial Services and Pensions Ombudsman.

However, in circumstances where I consider that the Provider was entitled to decline the Complainant's claim on the grounds that the medical procedure in question did not take place in an approved hospital, and on the grounds that the Complainant did not obtain the required pre-approval from the Provider for treatment abroad, I take the view that it is not necessary in those circumstances for this office to consider arguments raised in relation to the laws and constitution of this jurisdiction.

In conclusion, and for the reasons set out above, it is my Legally Binding Decision that this complaint is not 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 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.

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.