An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0216
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 incepted a health insurance policy with the Company on **8 March 1993**. Her partner and son were later added to the policy as insured persons.

The Complainant's Case

The Complainant renewed her health insurance policy with the Company with effect from **8 May 2016.**

The Complainant had an eye test at the Wellington Eye Clinic on 16 July 2016 where she was diagnosed with narrow-angled glaucoma and advised that she *"had a 50% chance of going blind within 12 months and that this could happen overnight"*. In this regard, the Complainant submits, as follows:

> *"I was given two treatment options by the clinic. One option was a laser type treatment which would reduce my chance to 2% and the other was clear lens extraction which involved removing my lens and replacing them with plastic lens and this would sort my problem. I opted for option 2 clear lens extraction. My problem is* [the Company] *will cover the laser option* [that is, option 1] *but won't cover the extraction* [that is, option 2]*. However they will cover this if I had a different complaint …I went ahead with the procedure* [that is, option 2] *as I couldn't take the risk"*.

The Complainant underwent a refractive lens exchange on her right eye on 12 October 2016 and one on her left eye on 19 October 2016, where the natural crystalline lens was removed and replaced with a new intraocular lens.

The Complainant was advised by the Company in advance of her undergoing this procedure that her policy did not cover the clear lens extraction procedure when it was carried out for the treatment of glaucoma. In this regard, the Complainant notes that *"I am covered for Glaucoma and I'm covered for the clear extraction but not clear extraction for Glaucoma"* and she seeks for the Company *"to refund me"* for the cost of the procedure.

The Complainant's complaint is that the Company wrongly or unfairly declined to provide her with benefit under her health insurance policy in respect of the two clear lens extraction procedures she underwent in October 2016.

The Company's Case

Company records indicate that the Complainant renewed her health insurance policy with the Company with effect from 8 May 2016.

The Company notes that the Complainant was diagnosed with narrow angle glaucoma in July 2016 and subsequently sought benefit in respect of a clear lens extraction, that is, procedure code 2795, for the treatment of this condition. This treatment is, however, specifically excluded from benefit under the terms and conditions of the Complainant's health insurance policy, as it is not considered by the Company to be a proven form of treatment.

The Company is satisfied that the Complainant was informed of this by email on 22 July 2016 and again on 17 August 2016, prior to her proceeding with the treatment in October 2016. In addition, the Company notes that the Complainant's treating Consultant would also have been aware that the Company does not cover this particular treatment, as its exclusion is also listed in the Schedule of Benefits for Professional Fees which each consultant has received a copy of. The Company notes that there are other proven treatments available for the prevention of acute angle glaucoma and it does provide benefit for these.

The Company is satisfied that the terms and conditions of the Complainant's health insurance policy clearly excludes benefit in respect of the clear lens extraction procedure when it carried out for the treatment of narrow angle glaucoma. In addition, the Company is also satisfied that it advised the Complainant by email on 22 July 2016 and again on 17 August 2016, prior to her proceeding with the treatment in October 2016, of this policy exclusion.

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

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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 23 November 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 complaint at hand is that the Company wrongly or unfairly declined to provide the Complainant with benefit under her health insurance policy, in respect of the cost of two clear lens extraction procedures she underwent in October 2016.

In this regard, the Complainant holds a health insurance policy with the Company. She was diagnosed with narrow-angled glaucoma in July 2016 and advised that she *"had a 50% chance of going blind within 12 months and that this could happen overnight"*. The Complainant underwent a refractive lens exchange on her right eye on 12 October 2016 and one on her left eye on 19 October 2016, where the natural crystalline lens was removed and replaced with a new intraocular lens.

The Complainant was advised by the Company in advance of her undergoing this procedure that her policy did not cover the clear lens extraction procedure when it was carried out for the treatment of glaucoma. In this regard, the Complainant complains that *"I am covered for Glaucoma and I'm covered for the clear extraction but not clear extraction for Glaucoma"* and she seeks for the Company *"to refund me"* for the cost of the two procedures.

However, the Company notes that a clear lens extraction, that is, procedure code 2795, for the treatment of glaucoma is specifically excluded from benefit under the terms and conditions of the Complainant's health insurance policy as it is not considered by the Company to be a proven form of treatment. The Company is satisfied that the Complainant was informed of this by email on 22 July 2016 and again on 17 August 2016, prior to her opting to proceed with the treatment in October 2016. In addition, the Company notes that the Complainant's treating Consultant would also have been aware that the Company does

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not cover this particular treatment as its exclusion is also listed in the Schedule of Benefits for Professional Fees, which each consultant has received a copy of.

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. In this regard, Section 7, 'Exclusions', of the applicable health insurance policy document provides, *inter alia*, at pg. 14, as follows:

> *"In addition to cover limitations mentioned elsewhere, we will not pay benefits for any of the following: …*
>
> > *t) Ophthalmic procedures for correction of short-sightedness, long-sightedness or astigmatism and lens extractions for prevention of glaucoma"*.

In addition, the Company will only provide cover for the procedure codes listed in its Schedule of Benefits for Professional Fees. In this regard, in respect of procedure code 2795, 'lens extraction', pg. 178 in the applicable Schedule of Benefits for Professional Fees sets out that *"benefit is not payable for lens extraction for prevention or treatment of glaucoma"*.

As a result, whilst the Company does provide cover for clear lens extraction in certain circumstances, I note that it does not provide benefit for clear lens extraction when it is for the prevention or treatment of glaucoma. In this regard, Section 1, 'Contract', of the applicable health insurance policy document provides, *inter alia*, at pg. 1, as follows:

> *"d) Certain procedure codes listed in the Schedules have clinical indications and/or conditions of payment and/or payment indications attached to them. Benefit for these procedure codes is payable only when, in the opinion of our Medical Director, the relevant clinical indications and/or conditions of payment and/or payment indicators have been satisfied in full"*.

A health insurance policy is a contract like any other, it is based on the legal principles of offer, acceptance, and consideration. Each year, a Company may offer terms which can be accepted by those seeking insurance, who then elect to pay the premium requested, which represents the consideration aspect of the contract. I am satisfied that it is a matter for the Company, as part of the terms it is offering, to set out what procedures it is willing to cover. In this regard, I am satisfied that the terms and conditions of the Complainant's health insurance policy clearly excludes benefit in respect of the clear lens extraction procedure, when it is carried out for the treatment of glaucoma.

In addition, the Complainant telephoned the Company on 18 July 2016 to query cover. Having listened to a recording of this telephone call, I note that the Complainant did not have at hand the exact name or procedure code for the treatments she was querying. The Agent did attempt unsuccessfully to find a procedure that matched the one that the Complainant was describing, and in this regard I note the following exchange:

> Agent: *It's hard to find one…there's so many, when I put in eye there's so many different procedures.*

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Complainant: *Ok, well look, I'll find out from them.*

In addition, I note that the Agent also advised the Complainant, just before the telephone call ended, as follows:

> *"Just to make you aware, all claims are assessed based on the medical information and terms and conditions of the policy"*.

I note from the documentary evidence before me that the Complainant then emailed the Company on 21 July 2016 with the procedure codes to query cover. In this regard, the Company advised the Complainant by email the following day, 22 July 2016 that *"benefit is not payable for lens extraction for prevention or treatment of glaucoma…As you have indicated that your procedure is required for the condition of glaucoma, we will be unable to allow benefits for procedure 2795"*.

In addition, in response to a further query, the Company also advised the Complainant by email on 17 August 2016, as follows:

> *"I can confirm that benefit is <u>not payable</u> for procedure code 2795 lens extraction for prevention or treatment of glaucoma.*
>
> *This means that if you are having this procedure carried out for the prevention or treatment of glaucoma,* [the Company] *will not be in a position to assist you with the cost of this procedure"*.

I am therefore satisfied that the Company provided the Complainant with notice in advance of her proceeding with the treatment, that her policy did not provide cover in respect of a clear lens extraction procedure when it carried out for the treatment of glaucoma.

In the event, the Complainant elected to proceed with the 2 lens extraction procedures, in the knowledge that her policy did not provide benefits for the cost of the procedures in the circumstances in question.

Whilst the Complainant maintains that the Company should be directed to make payment of benefit to her in circumstances where she is covered by her policy for the procedure in question in other circumstances which did not arise during the relevant period, I am satisfied that the Company was entitled to decline benefit in accordance with the terms & conditions of the health insurance policy which the Complainant held and there is no evidence before me of any wrongdoing on the part of the Company in that regard.

It is my Decision therefore, on the evidence before me that this complaint is rejected.

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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 INVESTIGATION, ADJUDICATION
AND LEGAL SERVICES

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