An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0029
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Claim handling delays or issues Delayed or inadequate communication Rejection of claim - pre-existing condition
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainants' son was born in Australia in September 2013, where he *"had full health insurance…from birth until* [his] *return to Ireland"* in November 2016. The First Complainant incepted a health insurance policy with the Provider, via a named Broker, on **11 June 2017** and their sons were listed as a named person on the policy.

The Complainants' Case

The First Complainant sets out the Complainants' complaint as follows:

> *"My son saw his GP in May 2017 for hay fever and while there GP also suggested writing referral to urologist to further explore query* [regarding] *tight foreskin on my son's penis. This was a referral requesting an appointment for consultation with an expert in this area of medicine. There was no diagnosis that* [my son] *needed a circumcision. This referral was sent and we awaiting* [appointment] *from specialist. We took out health insurance in June. We saw specialist urologist in July, he suggested that* [my son] *would benefit from a circumcision. This was the first and only time we saw a specialist for* [my son] *in relation to this…*[my son] *has circumcision in September* [2017]*"*.

The Provider declined the ensuing claim in respect of the Complainants' son's medical procedure as it determined that their son's condition pre-existed the inception of the policy.

The Complainants, however, submit that

> *"Appointment for* [Urologist] *in July 2017. This was first & ONLY time* [my son] *saw Doctor re same. Circumcision suggested for tight foreskin. Until this* [appointment] *no person had ever stated this was an issue for* [my son] *& in my mind therefore a NEW diagnosis/condition"*.

In addition, the Complainants note that the Provider initially declined the claim as their son had not yet served the 26 week initial waiting period provided for in the policy terms and conditions; however it *"later agreed they had waived* [this initial waiting period] *at time of taking out policy. They then stated reason for non payment…was pre-existing"*.

In this regard, the Complainants *"do not understand how it was pre-existing as* [my son's] *first consult was July 2017"* and submit *"we would never have had procedure done privately had we known that we were liable for a bill of over €800"*. The Complainants now seek for the Provider to admit the claim in respect of their son's medical procedure, into payment.

The Complainants' complaint is that the Provider wrongly or unfairly declined their health insurance claim in respect of their son's medical procedure.

<u>The Provider's Case</u>

Provider records indicate that the Complainants incepted a health insurance policy with the Provider, via a named Broker, on 11 June 2017 and their son was listed as a named person on the policy.

The Provider notes that the Complainants attended a GP appointment with their son on 11 May 2017, following which a referral letter was sent to a consultant urologist questioning the need for a circumcision. The Complainants then incepted their health insurance policy with the Provider on 11 June 2017, met with the consultant urologist for the first time on 11 July 2017 and their son's circumcision was later performed on 20 September 2017. The Provider declined the Complainants' claim in respect of the cost of this medical procedure as it concluded that their son's condition pre-existed the inception of their policy and thus the pre-existing condition waiting period applied, before benefits were payable.

The Provider notes that for all its health insurance policies, the definition of a pre-existing condition (in line with Health Insurance Regulations) is

> *"Any disease, illness, condition or injury that existed before you started your first health insurance plan with any health insurer. A pre-existing condition is determined from the date the condition commences rather than the date upon which you become aware of the condition. A pre-existing condition may therefore be present before giving rise to any symptoms or being diagnosed by a doctor"*.

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In this regard, the industry-standard waiting period for pre-existing conditions is 5 years from the date that the person takes out private health insurance for the first time, or from the date a person re-joins a private health insurance plan after a break of 13 weeks or more. The Provider Membership Handbook confirms, *"You will not be covered for a pre-existing condition during your pre-existing condition waiting period. Our medical advisers will decide whether your claim relates to a pre-existing condition"*.

The Provider received a Hospital Claim Form from the [Specified] Regional Hospital [location] in respect of the Complainants' son for procedure 683, which was performed on 20 September 2017. Part 1 of this Hospital Claim Form, which was signed by the First Complainant, states that the Complainants' son had been suffering from symptoms since 3 September 2017 and that this was also advised as the date that he first attended his GP, identified as Dr Q., with same. However, the Provider notes that the Complainants' son first presented to a GP, Dr T. with symptoms on 11 May 2017, this being the date that this GP wrote a referral letter to a consultant urologist questioning the need for a circumcision.

In addition, the attending consultant, Mr A., completed Part 2 of this Hospital Claim Form on 29 September 2017, noting that the Complainants' son had first been brought to him with these symptoms on 11 July 2017 and that the symptoms had been present for 1 month prior to the date of the procedure.

The Provider also notes from the claim documentation received that the First Complainant signed the Private Insurance Patient Form on 20 September 2017, waiving her son's right to be treated as a public patient. This document clearly advised, as follows:

> *"****Please be aware that if you are subject to any waiting periods/pre-existing conditions or if you do not have sufficient insurance cover you will be liable for the full cost of your hospital stay (as per the charges above) and treatment by a private consultant****"*.

On 24 October 2017, the Provider Claims Handler noted that *"initial waiting periods were not served, condition is often pre-existing"*. As the attending consultant, Mr A. had advised that he had first met with the Complainants' son on 11 July 2017, one month after the inception date of the policy, that is, 11 June 2017, it was decided that further medical information would be required to fully assess the Complainants' claim as the condition to which procedure 683 relates, is often apparent for more than 1 month prior to the treatment.

The Provider notes that the initial waiting period, when applied to a health insurance policy, is 26 weeks, during which cover is only available for treatment required as a result of an accident or injury. There is no cover for pre-existing conditions, for five years. When the initial waiting period is waived, it does not waive the pre-existing condition waiting period that runs concurrently; instead it allows cover for conditions that are newly occurring within the first 26 weeks of the policy.

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In this instance, the use of the term *"initial waiting periods"* by the Claims Handler on 24 October 2017 was incorrect, as the initial waiting period of 26 weeks had been waived for the Complainants' health insurance policy, however the Claims Handler was correct in questioning the validity of the claim as the 5 year pre-existing condition waiting period, still needed to be served by all insured persons on the policy.

As a result, the Provider wrote to the First Complainant on 1 November 2017 requesting proof of previous health insurance for her son. The First Complainant telephoned on 3 November 2017 to confirm that the family had previous overseas cover, which the Provider notes is not eligible cover, for the purposes of serving waiting periods as this cover had lapsed in November 2016 and the policy with the Provider did not start until June 2017, meaning that there had been a break in cover in excess of 13 weeks, regardless of whether the overseas cover was or was not recognised for this purpose. During this telephone call, the First Complainant advised that the initial waiting periods on the policy had been waived and she forwarded an email from the Complainants' Broker dated 19 June 2017 at 12.20pm to the Provider later that day which stated, *"As agreed with* [K.]*, can you note on this client's policy that the initial 26 weeks waiting period has been waived for this client"*. An email was sent to the First Complainant the next day, 7 November 2017 confirming that the information she had provided had been forwarded to the Claims Handler.

Following this telephone call and email from the First Complainant, the Provider sent a request to the Complainants' son's attending consultant urologist, Mr A. on 6 November 2017 seeking a copy of the GP referral letter that he had received. The Provider received a copy of this GP referral on 20 November 2017, which was written by Dr T. on 11 May 2017 and addressed to Mr D., Consultant Urologist. This referral letter advises that the Complainants' son has a *"*[history] *of balanitis and intermittently complains of penile pain. On examination tight foreskin noted –* ? *need for circumcision"*. It is clear from the stamp on this referral that the letter was received by Mr D.'s offices on 12 May 2017.

The condition for which the Complainants' son received treatment for noted by the consultant as *"phimosis"*, that is, the inability to retract the foreskin covering the glans of the penis, often referred to as a tight foreskin. Common symptoms of this condition include both penile pain and balanitis. Accordingly, based on the GP referral, written on 11 May 2017, prior to the inception date of the Complainants' health insurance policy on 11 June 2017, the Provider maintains that there is medical evidence that there were both signs and symptoms of his condition prior to the Complainants' son having health insurance in Ireland for the first time. As a result, the Provider is satisfied that the Complainants' son's condition pre-existed the inception of the Complainants' health insurance policy and therefore the Provider declined the Complainants' claim in respect of their son's medical procedure, in accordance with the terms and conditions of their health insurance policy.

Provider records indicate that the Complainants' health insurance policy was set up by a Broker, listed as the Intermediary on the Complainants' Health Insurance Membership Certificate, and all information relating to the level of cover, terms and conditions and applicable waiting periods was provided by the Broker.

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In this regard, the Provider notes that Section 10, 'Your Contacts', of the Membership Handbook provides, *inter alia*, at pg. 31,

> *"**COMPLAINTS** ... If you arranged your cover through broker initially then you should direct your complaint to the broker through whom you arranged your cover"*.

The only information the Provider has in relation to the sale of the Complainants' policy is an email from the Complainants' Broker confirming the agreement to waive the initial waiting period of 26 weeks, dated 19 June 2017.

The Provider did not provide any advice to the Complainants, prior to the sale of their health insurance policy nor, indeed, in relation to the claim in question. The policy documentation sent by the Provider to the Complainants on 14 June 2017 confirming cover, clearly defines what a pre-existing condition is and how the pre-existing condition waiting period is applied to the policy. In addition, the earliest record of any telephone contact the Provider had with one of the Complainants is the First Complainant's telephone call on 3 November 2017, when she advised of her son's health insurance history. In this regard, the Complainants did not telephone the Provider with the procedure code, to query cover in advance of their son undergoing his medical procedure on 20 September 2017.

In conclusion, as the GP referred the Complainants' son to a consultant urologist on 11 May 2017 and as the Complainants did not incept their health insurance policy with the Provider until 11 June 2017, the Provider is satisfied that the Complainants' son's condition pre-existed the inception of the policy and therefore it declined the Complainants' claim in respect of their son's medical procedure, in accordance with the terms and conditions of the health insurance cover.

The Complaint for Adjudication

The complaint is that the Provider wrongly or unfairly declined the Complainants' health insurance claim in respect of their son's medical procedure in September 2017.

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 Complainants were 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.

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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 6 February 2019, 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.

In this regard, the Complainants incepted a health insurance policy with the Provider on 11 June 2017 and their son was listed as a named person on the policy. The First Complainant sets out the Complainants' complaint as follows:

> *"My son saw his GP in May 2017 for hay fever and while there GP also suggested writing referral to urologist to further explore query* [regarding] *tight foreskin on my son's penis. This was a referral requesting an appointment for consultation with an expert in this area of medicine. There was no diagnosis that* [my son] *needed a circumcision. This referral was sent and we awaiting* [appointment] *from specialist. We took out health insurance in June. We saw specialist urologist in July, he suggested that* [my son] *would benefit from a circumcision. This was the first and only time we saw a specialist for* [my son] *in relation to this…*[my son] *has circumcision in September* [2017]*"*.

The Provider declined the Complainants' ensuing claim in respect of their son's medical procedure as it determined that their son's condition pre-existed the inception of the policy. The Complainants, however, submit that *"the appointment for* [Urologist] *in July 2017. This was first & ONLY time* [my son] *saw Doctor re same. Circumcision suggested for tight foreskin. Until this* [appointment] *no person had ever stated this was an issue for* [my son] *& in my mind therefore a NEW diagnosis/condition"*.

I note from the documentary evidence before me that the Complainants' son attended a GP**,** Dr T., on 11 May 2017 and that this GP wrote a referral letter on that date to Mr D., Consultant Urologist, as follows:

> *"Please review this young child, who has* [history] *of balanitis and intermittently complains of penile pain. On examination tight foreskin noted – ? need for circumcision"*.

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In this regard, I am satisfied that Part 1 of the Hospital Claim Form that the Provider received from the treating hospital in respect of the Complainants' son for procedure 683, which was signed by the First Complainant, was incorrectly completed, insofar that it erroneously advised that the Complainants' son had been suffering from symptoms since 3 September 2017 and that this was also the date he first attended a GP, identified as Dr Q., with same.

The Complainants *"do not understand how* [their son's condition] *was pre-existing as* [my son's] *first consult was July 2017"*. I am, however, satisfied that it was reasonable for the Provider to conclude from the evidence before it, and in particular from the GP referral letter dated 11 May 2017, that the Complainants' son had presented with symptoms of the condition that resulted in him later undergoing a surgical procedure on 20 September 2017, prior to the Complainants incepting their health insurance policy with the Provider on 11 June 2017 and thus that this condition pre-existed the inception of the policy.

In this regard, the Complainants' health insurance policy, like all insurance policies, does 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. I note that the Provider wrote to the First Complainant on 14 June 2017 to confirm cover and enclosed*, inter alia*, the Membership Handbook, which set out the terms and conditions of the Complainants' health insurance policy. Section 1, 'Your Contract', of the enclosed Membership Handbook provides, *inter alia*, at pg. 3, as follows:

> *"**WAITING PERIODS***
>
> *Your medical expenses will not be covered until after your waiting periods have expired. Waiting periods are explained in section 6 of this Membership Handbook"*.

In this regard, Section 6, 'Waiting Periods', of the Membership Handbook provides, *inter alia*, at pg. 30, as follows:

> *"**WAITING PERIODS***
>
> *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 …*
>
> ***INITIAL WAITING PERIODS***
>
> *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.*
>
> *Initial waiting periods do not apply in the following circumstances:*

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- *To claims made in respect of children who have been added to your policy within 13 weeks of the date of their birth*

- *To claims made in respect of adopted children who have been added to your policy within 13 weeks of the date of their adoption*

- *To claims in respect of emergency care for accidents and injuries.*

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 …*

Initial Waiting Periods		
Benefit	**Under 55 years old**	**55 years and older**
All In-patient Benefits	26 weeks	

…

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 advisers will decide whether your claim relates to a pre-existing condition. Their decision is final.

Pre-existing condition waiting periods do not apply in the following circumstances:

- *To claims made in respect of children who have been added to your policy within 13 weeks of the date of their birth*

- *To claims made in respect of adopted children who have been added to your policy within 13 weeks of the date of their adoption.*

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The following table 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.*

Pre-Existing Condition Waiting Periods		
Benefit	**Under 55 years old**	**55 years and older**
All In-patient Benefits	5 years	

".

In addition, Section 11, 'Definitions', of this Handbook provides, *inter alia*, at pg. 34, as follows:

"PRE-EXISTING CONDITION

Any disease, illness, condition or injury that existed before you started your first health insurance plan with any health insurer. A pre-existing condition is determined from the date the condition commences rather than the date upon which you become aware of the condition. A pre-existing condition may therefore be present before giving rise to any symptoms or being diagnosed by a doctor".

I also note that Section 3, 'Exclusions from Your Cover', of this Handbook provides, *inter alia*, at pg. 27, as follows:

"We do not cover the following (subject to compliance with the Minimum Benefit Regulation): …

- *Any costs incurred whilst a waiting period applies"*.

In addition, Section 1, 'Your Contract', of the Handbook provides, *inter alia*, at pg. 3, as follows:

"UNDERSTANDING YOUR COVER *…*

In fact, we would always advise you to check your cover with us before undergoing any procedure or treatment or being admitted to a medical facility. When checking your cover with us, you will need to tell us where you intend to have the procedure or treatment performed, the name of your health care provider and the procedure/treatment code. You can get this information from your health care provider".

It would have been prudent of the Complainants to have contacted the Provider in advance of their son undergoing his medical procedure on 20 September 2017 to ascertain and confirm cover, as suggested in the policy terms and conditions.

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I note that the Complainants advise that the Provider initially declined the claim, as their son had not yet served the 26 week initial waiting period provided for in the policy terms and conditions; however it *"later agreed they had waived* [this initial waiting period] *at time of taking out policy. They then stated reason for non payment…was pre-existing"*.

In this regard, I note the Provider states that on 24 October 2017 the Claims Handler noted on the Complainants' claim that *"initial waiting periods were not served, condition is often pre-existing"*.

It is accepted by the Provider that the initial waiting period of 26 weeks was waived for the Complainants' policy and thus the use of the term *"initial waiting periods"* by the Claims Handler was incorrect, however I accept the Provider's position that the Claims Handler was correct in questioning the validity of the claim, as the 5 year pre-existing condition waiting period still needed to be served by all insured persons on the policy.

As the GP wrote a referral letter to a consultant urologist on 11 May 2017 in relation to the Complainants' son's symptoms and questioned the need for a circumcision, I am satisfied that it was reasonable for the Provider to conclude that the Complainants' son's condition pre-existed the inception of the Complainants' health insurance policy with the Provider on 11 June 2017 and thus that the pre-existing condition waiting period of 5 years applied. As a result, I am therefore satisfied that the Provider was entitled to decline the Complainants' claim in respect of their son's medical procedure, in accordance with the terms and conditions of their health insurance policy.

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

28 February 2019

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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.