An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0032
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Claim handling delays or issues
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant has a health insurance policy with the Provider, which commenced on **22 October 2013** and runs from 22 October to 23 October each year.

The Complainant was diagnosed with an auto-immune skin condition which required a minor surgical procedure. The Complainant underwent a biopsy and excision in a Dermatology & Surgery Clinic on **12 August 2016**. The Complainant subsequently made claims for the medical expenses incurred. The Provider settled four out of the five claims made by the Complainant under the policy.

The first claim was in relation to the cost of a minor surgical procedure. A letter of settlement dated 23 September 2016 was sent to the Complainant.

The Complainant's second claim was for the cost of a consultation and medication. A letter of settlement dated 14 October 2016 was sent to the Complainant. The first two claims fell under policy year 2015/2016.

On 23 October 2016, the Complainant's policy renewed, and consequently, he was entitled to a potential €500 out-patient benefit for 2016/2017. The third and fourth claims were for the cost of a consultation and medication respectively. These claims were settled, and

letters of settlement dated 27 December 2016 and 26 January 2017 respectively, were sent to the Complainant.

The Complainant's fifth claim on 03 March 2017 was declined by the Provider on the grounds that the Complainant had reached the benefit limit of €500 for out-patient treatment.

The Complainant's Case

The Complainant states that the Provider initially considered that the consultations and medication to treat his condition were covered under the policy. The Complainant relies on the email of 23 June 2017 which states;

> *"I can see from your claims history on your policy, you had (procedure) in (clinic) on 12 August 2016. This was assessed correctly as a minor surgical procedure and settled on that basis. You then had a consultation and received medication on 26 August 2016, this was assessed correctly under your out patients benefit. Our claims department received invoices for your consultation on 25 November 2016 and medication on 10 January 2017. These were assessed under post-hospitalisation benefit in error and should have come from your out patients benefit. The Claims Department further assessed the consultation and medication claim on 3 March 2017 under your out -patient benefit as the benefit limit of €500 for out-patient treatment had been reached the claim was denied"*

The Complainant is aggrieved that the Provider having settled the first four claims decided that his (*condition)* is no longer considered to be *"post hospital benefit"* and now is considered *"out-patient benefit".* As per his policy, the Complainant has a limit of €500 per policy year on out-patient benefit. Out-patient benefit is defined in the policy as;

> *"Medical treatment provided to the Insured person by or on the recommendation of a Physician which does not involve an admission to Hospital either on an In-Patient or Day-Care basis"*

The Complainant states that the Provider is attempting to misuse the definition of day care under the policy. Day care is defined in the policy as:

> *"Medical treatment provided in a hospital where an insured person is formally admitted but is not required out of medical necessity to stay overnight"*

The Complainant accepts that his treatment occurred on an out-patient basis following his (*procedure)* however he states that out-patient benefits are not limited to a €500 cap. The Complainant states that for more serious conditions such as cancer, there is no cap for out-patient benefit and that the out-patient cap is intended to be used for routine GP visits and medical care.

The Complainant refers to the Provider's promotional literature and states that this message implies that if you have a serious illness, your treatment will be covered. The Complainant

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states that the Provider's obligation to treat his serious illness has not been honoured under his policy.

The Complainant seeks for the Provider to reverse its decision of 23 June 2017 and allow for ongoing treatment of his condition to be covered until it has been cured. The Complainant also seeks for the Provider to pay the benefit related to all of his claims to date.

The Provider's Case

The Provider states that the issue in dispute is whether the annual €500 out-patient limit, as detailed on the Table of Benefits has been applied correctly to the costs claimed under the Complainant's policy.

The Provider states that the Complainant had a biopsy and excision under local anaesthetic in a Dermatology and Surgery Clinic on 12 August 2016. It says that this procedure was assessed correctly as a minor surgical procedure, as per Section 2 (j) of his policy and was settled on that basis. The Provider states that the Complainant subsequently had a consultation and received medication on 26 August 2016. This cost was assessed correctly under the out-patients benefit. The Provider states that its Claims Department also received invoices for a consultation on 25 November 2016 and medication on 10 January 2017. The Provider states that these invoices were assessed in error under post-hospitalisation benefit, as they should in fact have come from the out-patient benefit. The Provider states that the Claims Department therefore further assessed the additional consultation and medication claim on 3 March 2017 under the out-patient benefit and as the benefit limit of €500 for out-patient treatment had been reached, the claim was declined.

The Provider states that out-patient benefit covers all visits of this kind, regardless of the condition and based on the Complaint's level of care under his policy, the limit for this out-patient benefit is €500 per policy year.

The Provider states that the Complainant was not admitted to hospital and therefore its decision to apply the benefit limit of €500 was correct. The Provider states that the Complainant believes that given the seriousness of his condition, that any treatment should be reviewed separately and should not be confined to a benefit limit. It disagrees however.

The Provider notes that a telephone conversation took place between the Complainant and the Provider on the 11 May 2017, the Provider explained to the Complainant that from the documentation submitted to the Provider, the procedure was minor surgical and had been carried out in a clinic and not a hospital. The Complainant advised the Provider that he requires treatment for his condition and that the treatment was carried out in a hospital. The Provider states that the Complainant was advised that his claim could be reviewed if the Provider received a medical report confirming the treatment was carried out as a day patient in a hospital.

The Provider denies that the out-patient limit has been intentionally misused. The Provider states that the Complainant agrees that the treatment received was on an out-patient basis.

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The Provider states that the Complainant was not diagnosed with cancer and therefore that section of the policy concerning cancer, does not apply to the Complainant.

The Provider accepts that the Complainant was previously overpaid in error however, the Provider says that this does not imply that the Complainant should be paid more than the policy limit going forward.

The Provider states that its obligation to the Complainant is to pay claims in accordance with his policy cover as detailed in the policy wording.

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 22 January 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.

Following the consideration of an additional submission from the Complainant, the final determination of this office is set out below.

The issue which has to be resolved in this instance is whether the Complainant's policy's out-patient benefit with a limit of €500 per policy year, was applied correctly under the Complainant's policy. The Complainant accepts that the treatment occurred on an out-patient basis. His complaint is that out-patient benefits for more serious conditions (including his) should not be capped at €500 and that it is a misuse of the out-patient benefit limit to apply this €500 limit to all outpatient events. I note from the documentary evidence before me that the Complainant says as follows:

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> *"I now risk having to bear the significant costs of ongoing consultations and treatments for an indefinite amount of time when it is clearly ongoing treatment associated with a very serious condition that should be covered by the insurance policy."*
> and
> *"Including … treatment under "Out-Patient Benefit" unfairly uses up my annual out-patient allowance of €500 which should be rightfully allocated to minor medical consultations such as GP visits that I am entitled to under the terms of the insurance policy".*

The Provider's policy provides definitions of the words used in the policy. I note that per the Complainant's policy the words set out below should be taken to have the following meaning:

> *"Day Care – Medical treatment provided in a Hospital where an Insured Person is formally admitted but not required, out of medical necessity, to stay overnight"*

> *"In-Patient – Medical Treatment provided in a Hospital where an Insured Person is admitted and, out of medical necessity, occupies a bed for one or more nights but not exceeding 12 months in total for any one Medical Condition"*

> *"Out-patient – Medical treatment provided to the Insured Person by or on the recommendation of a Physician which does not involve an admission to Hospital either on an In-Patient or Day-Care basis"*

I see that per the Complainant's policy under the heading "What is covered?" Section 2(g) provides that;

> *"Post-hospitalisation costs – During the 3 months period immediately following an Insured Person's discharge from a period of In-Patient or Day-Care treatment, we will pay for post-hospitalisation consultations and treatment where received on an Out-Patient basis provided the Insured Person remains under the control and supervision of the original treating Physician"*

I note that the Complainant received treatment on an out-patient basis. He did not receive in-patient or Day-Care treatment, and therefore, post-hospitalisation costs are not applicable in the circumstances.

The Complainant's policy covers out-patient costs as set out at 2(i);

> *"Out-patient costs – We will pay medically necessary consultation fees for the services of a General Practitioner, Specialist, Physician, Physiotherapist, diagnostic tests and investigations including ECGs, X-rays, pathology, histology, MRI/CT/PET scans, radiotherapy, prescribed drugs and medicines and the hire or purchase of crutches, walkers, wheelchairs and basic orthopaedic prostheses and equipment*

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> ***Please Note:*** *A Co-insurance will be applied to the cost of all out-patient prescribed drugs and medicines covered under this Section of the Policy, as stated on Your Table of Benefits. An excess also applies to this benefit for (level number) and (level number), as stated on Your Table of Benefits"*

I note that Section 2(j) provides that the Complainant's policy will cover;

> *"Out-Patient Minor Surgical Procedures requiring local anaesthesia undertaken in a GP/Specialist's consulting room"*

There is no documentary evidence before me to show that the Complainant was treated on either a day-care or in-patient basis. I therefore accept, per the definitions of the Complainant's policy (set out above), that the Complainant's procedure was correctly assessed as a minor surgical procedure on an out-patient basis, rather than as Day-Care treatment.

The documentary evidence before me also confirms that the Complainant's fifth claim was assessed on an out-patient basis. The Provider states that this was claim was correctly assessed and as the Table of Benefits provides a limit of €500 on out-patient costs, per policy year, the Complainant's claim was rejected as he has reached his limit of €500 for the policy year.

Furthermore, I note from the Claim Timeline submitted by the Provider that it maintains that:-

> *"…*
> *received nurses review back and when processed it shows the out-patient benefit has been reached for this year, (client had a claim for another condition under this policy year) therefore claim is declined"*

While I accept that the error made by the Provider in settling the Complainant's claims of 25 November 2016 and 10 January 2017 was unfortunate and I understand the Complainant's subsequent disappointment on learning that the benefit limit of €500 had already been reached, and indeed overpaid, I do not believe that the conduct of the Provider in declining the March 2017 claim, was unreasonable in the circumstances.

In this regard, the Complainant's policy at Section 2(i) clearly sets out the out-patient costs which will be covered and further that a co-insurance will apply to the costs of all prescribed drugs and medicines as stated in the table of benefits. The Complainant's out-patient benefit has a limit of €500 per policy year. Whilst no doubt the Complainant considers his condition to be serious, it does not fall for assessment under the policy provisions which apply to "cancer".

The Complainant has indicated that this benefit limitation of €500, in his opinion is "*a nasty little contractual technicality, on a contract I had no right to negotiate, and which is completely contrary to the spirit of the agreement*". He has also suggested that the Provider's practice of "*excluding reasonable treatment costs*" is nefarious, in circumstances where the Provider, he believes, has a moral obligation to support him in this treatment. I

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do not accept this. The Complainant's health insurance policy, like all insurance policies, does not provide cover for every eventuality. Rather, the level of cover which the Complainant elected to put in place, is subject to the terms, conditions, limitations and exclusions as set out within the policy documentation.

For the reasons set out above, I do not consider that the Provider's conduct has been wrongful such that it would be appropriate to uphold this complaint. Indeed, the Provider has indicated a willingness to review the matter, if a report is made available confirming that the procedure undergone by the Complainant was in fact carried out on a day-care basis, rather than as an out-patient. The Complainant has not however made any such evidence available and consequently, I take the view on the evidence before me that the Provider has correctly applied the payment of benefit to the Complainant, on foot of his out-patient benefit claims, in accordance with the level of cover he holds. Accordingly, I cannot uphold this complaint.

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

15 February 2019

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.**