An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0043
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Rejection of claim - pre-existing condition
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

This complaint arises out of a health insurance policy and relates to the Provider's refusal to indemnify the Complainant under his policy.

The Complainants' Case

The Complainant states that he took out a health insurance policy with the Provider on **2 April 2016.**

The Complainant states that she has suffered from Polycystic Ovary Syndrome (PCOS) since she was a teenager and this has led to an irregular and infrequent menstrual cycle. She further explains that in **August 2015**, she visited her GP with fertility related concerns. She was referred for an ultrasound on that occasion.

The Complainant acknowledges and does not dispute that when she took out the policy with the Provider in April 2016, she was fully aware that pre-existing conditions, including the PCOS, were subject to a 5 year waiting period to be eligible for benefit for treatments. The Complainant was referred for a pelvic ultrasound on **22 April 2016** which revealed an abnormality in the right ovary. Consequently, the plaintiff was referred to a consultant gynaecologist and obstetrician, Dr Q. The Complainant states that she had never previously been referred to a consultant after an ultrasound for her PCOS condition.

The Complainant states that Dr Q. made a diagnosis of a dermoid cyst and advised the Complainant that it was a new diagnosis, independent of the PCOS and that it was not a long-standing abnormality. The Complainant was advised that the cyst had a high risk of torsion and that the Complainant could lose the ovary if surgery was not carried out. The Complainant states that following this consultation, she contacted the Provider by phone and presented the findings and diagnosis she had received from Dr Q. The Complainant states that she was told by the Provider, based on the information she had verbally presented to it, that she would be covered if it was a new diagnosis.

Thus on **12 July 2016**, the Complainant underwent a laparoscopic right ovarian cystectomy. Subsequent to this, the Provider has declined to cover the Complainant for the surgery on the basis that her symptoms which prompted a referral for an ultrasound, existed in the period of six months immediately preceding the day she took out cover with the Provider.

The Complainant says that the Provider has wrongfully, unreasonably and through a mistake of law or fact refused to provide cover to the Complainant for the medical costs incurred for her surgery.

The Provider's Case

The Provider explains that the Complainant's claim under her policy was declined based on the clinical information provided to it. It says that the symptoms that led to her admission were deemed to have existed and been present prior to the Complainant taking out her policy with the Provider on 2 April 2016. The Provider explains that therefore, as the symptoms were present prior to the Complainant joining the Provider, the pre-existing condition waiting period was applicable and the claim was therefore ineligible for benefits in line with the rules and table of benefits applicable to the Complainants' policy.

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.

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

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Binding Decision to be made in this complaint without the necessity for holding an Oral Hearing.

A Preliminary Decision was issued to the parties 5 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.

The Complainant holds a [Named] health insurance policy with the Provider.

The Complainant states that she was fully aware that pre-existing conditions, including her PCOS, were subject to a 5 year waiting period to be covered for benefits for treatment. I have been furnished with a copy of the general rules policy booklet issued by the Provider and effective from 1 March 2016.

A pre-existing condition is defined in the following way:

> *"Pre-existing condition: an ailment, illness or condition, where, on the basis of medical advice, signs or symptoms of that ailment, illness or condition existed at any time in the period of six months immediately preceding:*
>
> *a) The day **you** took out a health insurance contract for the first time; or*
> *b) The day **you** took out a health insurance contract again after **your** previous health insurance contract had lapsed for 13 weeks or more.*
>
> ***Please note that our medical advisers will determine whether a condition is a pre-existing condition. Their decision is final."***

In addition, Clause 9 of the same policy booklet deals with "**What is not covered under the scheme**" and that clause provides as follows:

> *"We will not pay for benefits for the following*
>
> ***a)*** ***Treatment** which a person requires during any waiting period that may apply to the **treatment** under their **scheme**. All waiting periods commence on a person's **membership** and upgrade **start date.***
>
> *There are three waiting periods that apply under the scheme*
>
> - *The initial waiting period – this applies to any **treatment** that a person may require*

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- *The pre-existing condition waiting periods – this only applies to **treatment** which a person requires for a **pre-existing condition***
- *The maternity waiting periods – this only applies to **treatment** that a person requires for pregnancy or childbirth."*

The policy goes on to stipulate that the "*pre-existing condition waiting period*." is "*the first five years of membership*".

Therefore, cover for the surgery carried out to treat the Plaintiff's condition will not be provided if, under the above terms, the Complainant had signs or symptoms of the condition that existed at any time in the period of six months immediately prior to taking out the policy.

The Provider in its letter of final response to the Complainant dated 30 May 20017, states that as the Complainant was experiencing symptoms which prompted her referral for further investigations and management, prior to joining the Provider, it was unable to consider her claim for benefit. According to the Provider's letter of final response, the relevant symptoms being relied upon are "*irregular, infrequent menses x years*". The Provider states that in August 2015, the Complainant was referred for an ultrasound arising out of these symptoms. The Provider then refers to a GP referral letter dated 3 May 2016 to Dr Q. which outlines, amongst other things, that the Complainant had recently undergone a pelvic ultrasound due to "*irregular menses".*

The Complainant's relevant medical records have been made available. I have carefully read and considered the referral letter from the Complainant's GP to Dr Q. dated 3 May 2016. That letter refers to the ultrasound that had been performed recently. It states that the ultrasound had been carried out "*due to irregular menses*". The letter goes on to explain that the Complainant "*has a history of irregular menses*" and that "*more recently*" the Complainant experienced "*approximately three menses per year*".

On 2 August 2016, Dr Q. wrote to the Complainant's GP following the surgery on 12 July 2016. That letter explained that during surgery, the cyst that had been identified in the ultrasound and that was suspected to be a dermoid cyst, was not present. Dr Q. in her letter to the Provider of 16 December 2016, explained that when the laparoscopy was carried out, no dermoid cyst was identified and only a functional ovarian cyst was found. However, she explained that due to the description of the mass detected in the ultrasound as a dermoid cyst, the ovarian cystectomy was deemed to be necessary and Dr Q. stated that it was not a long-standing abnormality.

I have listened to the audio recording of the telephone call made by the Complainant to the Provider on 11 July 2016. The Complainant advised that she was due to go in for surgery and was calling to find out if she was insured for the procedure. She didn't have the procedure code but she explained that it was a laparoscopy and that the consultant carrying out the procedure was Dr Q. and that it would be carried out in [identified] Hospital in [town].

The Complainant was asked how long she had symptoms and she responded that she didn't have any symptoms but that she had a scan at the end of April and got referred to a consultant straightaway because they thought it was a benign tumour. The Complainant was

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then asked what symptoms she had in order for her to be referred to have a scan in the first place. The Complainant explained that it was a checkup and she was asked what kind of a checkup and the Complainant responded that it was an ovarian ultrasound and that she had had one in her early 20s and her GP referred her to have a more up to date one.

The Complainant was asked again whether she had symptoms and she responded that she did not and that apparently symptoms are uncommon with this type of tumour. The Complainant was then advised that her medical notes would determine what the onset date was and if it was after she took out the policy, she would be covered. The Complainant was also advised that if it was deemed that the onset date was prior to taking out the policy, she would not be covered. The Complainant explained that she did have previous cover but it had lapsed for more than 13 weeks and she was then told that there is a five year waiting period if it's an onset date that predates the policy.

The Provider states that it is not the diagnosis of the dermoid cyst that led to the claim being rejected in this instance, but rather, the Provider's medical advisers concluded and advised with certainty, that the symptoms of "irregular menses" which prompted the Complainant's referral for an ultrasound in April 2016 and which subsequently led to her referral to Dr Q. for further management, were present prior to joining the Provider on 2 April 2016.

In light of all of the foregoing circumstances, where the Complainant had experienced irregular menses over a long period of time and which, according the medical notes, was ongoing in the 6 months prior to taking out cover and directly led to the April 2016 ultrasound and the consequent referral and surgery, I am satisfied that the Provider was entitled, under the terms and conditions of the Policy to form the reasonable opinion, based on the determination of its medical advisors that the surgery was for a pre-existing condition and therefore the Provider was entitled to decline the claim.

As the evidence does not disclose any wrongful conduct on the part of the Provider, I take the view that it would not be reasonable 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 INVESTIGATION, ADJUDICATION AND LEGAL SERVICES

27 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.