An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0139
Sector:	Insurance
Product / Service:	Dental Expenses Insurance
Conduct(s) complained of:	Rejection of claim - waiting periods apply
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant holds a dental insurance policy with the Provider and claims in respect of this policy are handled by its claims handler.

The Complainant's complaint relates to a claim made by him under the policy, which the Provider has refused.

The Complainant's Case

The Complainant took out a dental insurance policy with the Provider which was incepted on **1 January 2016**.

The Complainant states that in **November 2016**, while eating, one of his front teeth broke in half and a second tooth was fractured. The Complainant attended his dentist who recommended that two new crowns be fitted. The Complainant agreed to this course of treatment and the procedure was carried out by his dentist on **7th November 2016**.

The Complainant states that he submitted a claim under his dental insurance policy on **24 November 2016** for 50% of the cost of the treatment. The Complainant states that the claim was rejected by the Provider because treatment for crowns was excluded for the first 12

months of the policy. The Complainant acknowledges that, having reviewed the policy, this is correct.

The Complainant states that while reviewing his policy he discovered that emergency treatments are covered for up to 100% of the cost of the treatment. He states that he explained this to the Provider but he was informed that crowns were not covered for the first 12 months. The Complainant states that he acknowledged that the crowns were not covered but that the immediate and prompt repair of his teeth was an emergency as the tooth was broken in half and was jagged with sharp edges.
The Complainant states that he acknowledges that his initial claim was incorrect in seeking 50% of the costs of the treatment and he further states that that perhaps the correct treatment was something less expensive which should be covered to the 100% level as emergency treatment.

The Complainant states that the question he is seeking an answer to is: *"Does a broken tooth constitute an emergency or not?"* The Complainant states that he fails to see how this could not constitute an emergency. He states the next question is what the correct remediation treatment is, and what is the approximate cost of this treatment?

The Complainant states that whatever the correct treatment is, it should be covered to the 100% level and the fact that the treatment he received and claimed for was in respect of crowns should be irrelevant. The Complainant states that if a basic repair (filling/extraction) on his damaged teeth were to cost €300, (the Complainant acknowledges this price is a guess), it is his assertion that, as an emergency, the repair should be covered up to 100%. The Complainant states that the Provider is unwilling to see reason or compromise in this regard.

The Complainant states that the professional opinion of a dentist should be given priority over the Provider's claims assessor and that a dentist should determine if his situation was an emergency and what reasonable remediation treatment would be for this emergency.

The Complainant states that his dentist has provided all dental records, photos and x-rays to the Provider and is completely baffled by the Provider's assessment. He states that it is his dentist's opinion that no dentist would argue with the treatment that was required and provided.

The Provider's Case

The Provider states that the Complainant submitted a claim for crowns on two teeth. Its assessor contacted the Complainant's dental practice by phone on **1 December 2016**, to clarify the clinical reasons for the crowns and it was confirmed that it was necessary due to fractures. The Provider states that fractures are covered under the policy however, the Complainant had only taken out the policy on **1 January 2016**, and a waiting period of 12 months applied in respect of this treatment.

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The Provider states that its assessor contacted the Complainant by phone to advise him of this. On being informed of this, the Provider states that the Complainant requested the information in relation to the declinature of the claim be e-mailed to him and that the claim be reviewed. The Provider states that the Complainant was still unhappy with the claim being declined and requested that a complaint be logged. The Provider states that the Complainant wanted his claim settled under the emergency treatment section of the policy.

The Provider states that the claim was clearly outside the waiting periods contained in section 4 of the policy which related to crowns.

In respect of the Complainant's claim that the repair came under the "Emergency Treatment" section of the policy, the Provider states that Emergency Treatment is covered under the policy;

> "*Once per 12 month period for the immediate, temporary relief of severe pain, trauma, swelling or bleeding. This does not include Treatments or rehabilitation or treatments already covered on the policy.*"

The Provider states the claim was referred to its clinical officer for review. The Provider states the following observations were made:

> *"There is no evidence or indication of any emergency work carried out and no claim for any emergency treatment. The clinical notes do not state that there was any severe pain, trauma, swelling or bleeding associated with the fractured UR2. Also a crown is not a treatment that would be generally used for the immediate, temporary relief of severe pain, trauma, swelling or bleeding. A crown is also a treatment already covered on the policy and therefore according to the above definition of emergency treatment in the terms and conditions is not classified as an emergency treatment in the* [Provider's] *policy."*

The Provider states that four crowns were fitted and only the front two were claimed under the policy. It states that the UR2 (to the left of the front tooth in the pictures furnished in evidence) looks as if it did not break but the notes show no evidence of any filling or temporary work being conducted, only that crowns were fitted.

The Provider states that its internal complaints procedure dealt with the issue as raised by the Complainant and the complaint was not upheld as the Provider states that there was no evidence of any emergency treatment being carried out. The Provider further asserts that when the Complainant sought cover under the basis of emergency treatment, this was considered but declined, as the policy treatments already covered under the policy, such as crowns, are not covered under this section.

The Provider states that if any emergency treatment was carried out this would have been considered, however, the crowns were correctly declined because they were outside the waiting periods for such treatment and did not amount to emergency treatment.

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The Complaint for Adjudication

The complaint is that the Provider refused to categorise the Complainant's claim as one for emergency treatment and therefore declined to pay out on and portion of the claim.

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 5 April 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.

Recordings of telephone conversations have been furnished in evidence. I have considered the content of each of these calls.

The Complainant had a dental plan with the Provider covering the period 1 January 2016 to 31 December 2016. In November 2016, the Complainant sustained damage to his teeth. Following this he attended his dentist where he received crown replacements to the damaged teeth. The Complainant then completed a claim form dated **24 November 2016**, in respect of the treatment he had received. Having reviewed the claim form, I note that the Complainant claimed the sum of €700. In the *Total claimed* box in Section A, the Complainant wrote: *"€700 (50% of cost)."*

Section B of the claim form must be filled out by a dentist or other authorised member of practice. In this instance, Section B appears to have been filled out by a dentist. I note that

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no treatment was recorded as having been carried out under the sections headed *Emergency Treatment (Out of hours)*; *Basic Treatment: Fillings & Sealants*; *Basic Treatment: Extractions*; or *Basic Treatment: Crowns*. Instead, the treatment carried out is set out under *Major Treatments: Crowns, Inlays and Onlays.* This section records that porcelain crowns were fitted to teeth numbers 12, 11, 21 and 22 at a cost of €1,400. The claim form has been signed and stamped by the Complainant's dentist. In a receipt dated 17 November 2016, issued by the dentist to the Complainant it acknowledges receipt of payment in the sum of €1,400 in respect two teeth: *"Porcelain bonded crowns 21/12"*.

On **1 December 2016**, the Provider called the Complainant's dentist's office to confirm the clinical reasons for the crowns and I note from the recordings of these calls that the Provider was informed by the dentist's office that the teeth in question were fractured. On the same day, the Provider called the Complainant to inform him that his claim was declined as the treatment was rendered before the expiry of the waiting periods applicable to the treatment received, as prescribed by the policy. By email dated **1 December 2016**, the Provider wrote to the Complainant stating:

> *"Further to our telephone conversation I unfortunately must advise you that after assessing your claim for crowns on the 21 and 22 we have declined same for the following reason:*
>
> *Under section 4 of the Table of Benefits there is a waiting period of 12 months for all major treatments. …"*

By email dated **5 December 2016**, the Complainant accepted that his claim was excluded by the waiting period clause, but he requested that his claim be settled under a different section of the policy, the emergency treatment section. The email states:

> *"Perhaps the reason for the rejection of this claim lies with me and the paperwork claim submitted, as you have rightly noted that Crowns are only permitted after 12 months & at a rate of 50% of the costs.*
>
> *I would note that Emergency Cover is covered to the rate of 100% from the start of the policy, and feel that my situation was an emergency, which I think will be supported by my dentist.*
>
> *What actually happened was one of my teeth actually broke in half, and the neighbouring tooth, cracked, whilst eating. … on [my dentist's] advice, I proceeded with the crowns as the remedial course of action, and hence the claim was for crowns.*
>
> *I believe you have already spoken with the dental practice asking why the crowns were necessary, and were told that my teeth were 'fractured'.*
>
> *Perhaps, there was a cheaper, alternative course of action, that may have been covered as an emergency cover. But this emergency course of action should be covered to 100% of cost, as opposed to a 50% of the cost of crowns.*

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Perhaps the crowns were the only course of action and I should be seeking the full cost of €1400 as it was an emergency, which is covered under my policy.

I'm not a dentist, so I don't know that answer to the above, but do know that my claim was made in good faith, acting reasonably. …"

A notice dated **6 December 2016**, from the Provider to the Complainant set out the reason why the claim was declined and states: *"No benefit, Treatment was rendered during policy waiting period."* Further to this, following a review of the Complainant's claim, by letter dated **28 December 2016**, the Provider wrote to the Complainant stating:

"A full review of your claim has been completed and we confirm that your claim was correctly assessed in line with the terms and conditions of your policy:

Please see below extracts taken from your [policy]*:*

Section 4 – Major Treatments- 12 months waiting period applies

Emergency Treatment

- *Once per 12 month period for the immediate, temporary relief of severe pain, trauma, swelling or bleeding. This does not include treatments for rehabilitation or treatments already covered on the policy.*

In view of the above, we are regrettably unable to make any payment on this occasion. If you would like to confirm the crown reasoning with you dentist together with a radiograph we can re-open the appeal.

We appreciate that this response will come as a disappointment; however, we can only pay claims that fall within the scope of your policy."

In a Final Response letter dated **26 January 2017**, the Provider wrote to the Complainant informing him that his claim had been correctly assessed, and declined on the basis that the treatment took place during the policy's waiting period for such treatment. With respect to the Complainant's request that his treatment be considered under the emergency treatment section of the policy, the Provider stated:

"This new information was given consideration and the claim was re-assessed under the emergency treatment section of the policy.

If I could please refer you to the policy documents and the definition of what the emergency treatment covers.

Dental Treatment and/or Emergency Treatment subject to the terms and conditions of the Policy.

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Emergency Treatment

- *Once per 12 month period for the immediate, temporary relief of severe pain, trauma, swelling or bleeding. This does not include treatments for rehabilitation or treatments already covered on the policy.*

The emergency treatment does not include treatment for any rehabilitation or treatments already covered on the policy. I have to conclude that your claim was correctly declined under this section of your policy."

POLICY TERMS

I set out below a number of relevant terms of the policy document.

In part *1) Definitions*;

Cover is defined as *"Dental treatment and/or Emergency Treatment subject to the terms and conditions of the Policy."*

Emergency Treatment is defined as *"Dental Treatment required for the immediate relief of severe pain, trauma, swelling or bleeding by their Dentist."*

Table of Benefits is defined as *"The table attaching to and forming part of this Policy which sets out the benefits together with their corresponding financial limits that are applicable to Your Cover."*

Treatment is defined as *"Dental Services or supplies described in this document which are clinically necessary for the maintenance and/or restoration of the oral health of an Insured Person."*

Finally, Waiting Period is defined as *"The period that must be completed from the Commencement Dater of the Policy before the specified benefits become eligible."*

In part *2) Benefits*; the dental services covered under the policy are set out.

In *Section 3 – Basic Treatments*, I note the following:

*"**Emergency Treatment***

- *Once per 12 month period for the immediate, temporary relief of severe pain, trauma, swelling or bleeding. This does not include treatments for rehabilitation or treatments already covered on the policy."*

In part *3) Benefit Rules*, section 9 states:

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> *"**Waiting Period***
> *Where a waiting period applies to a benefit section of Your Policy, you will not be able to claim for the costs of any Dental Services or Treatments under this Policy which happens before the Waiting Period has been satisfied. Please see Your Table of Benefits for details of any applicable Waiting Periods."*

In the Table of Benefits, which is to be read in conjunction with the policy, I note that following:

> *"Section 4 – Major Treatments- 12 months waiting period applies*
> *…*
> ***Crowns, inlays and onlays***
>
> - ***Permanent crowns, inlays and onlays** …"*

ANALYSIS

In considering this complaint, I have also had regard to the Consumer Protection Code 2012 (the **Code**) in particular, I note the following provisions:

> *"7.6 A regulated entity must endeavour to verify the validity of a claim received from a claimant prior to making a decision on its outcome.*
>
> *7.7 … d) the regulated entity must offer to assist in the process of making a claim, including, where relevant, alerting the claimant to policy terms and conditions that may be of benefit to the claimant;*
>
> *e) a record must be maintained of all conversations with the claimant in relation to the claim; …*
>
> *7.19 If the regulated entity decides to decline the claim, the reasons for that decision must be provided to the claimant on paper or on another durable medium.*
>
> *7.20 A regulated entity must provide a claimant with written details of any internal appeals mechanisms available to the claimant."*

Having reviewed the evidence and considered the parties' submissions, I note that the Complainant's policy commenced on **1 January 2016**, he sustained fractures to his teeth in **November 2016** and subsequently received treatment in respect of this. The Complainant then submitted a claim under his policy in respect of the cost of the treatment. This was declined because the Complainant was still subject to the policy's waiting period. The Complainant does not dispute this. I accept that the Provider was entitled to decline the claim on those grounds. The treatment the Complainant received fell within section 4 of the Table of Benefits and was therefore, subject to a 12 month waiting period.

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Following the decision to decline the claim, the Complainant then requested that his claim be considered under the *Emergency Treatment* section of the policy. The term emergency treatment and what it entails is clearly defined in the policy. It relates to dental treatment for immediate and/or temporary relief for severe pain, trauma, swelling or bleeding. I note that the Provider has referred to the findings of its clinical officer to the effect that there was no evidence of emergency treatment.

I note that the Complainant has not furnished any evidence or made any submission which demonstrates that he required and/or received any dental treatment that would bring him within this definition. It is simply his belief that his treatment constituted emergency treatment and *"… which I think will be supported by my dentist."* I note that the Complainant's dentist completed the relevant section of the claim form; however, there is no indication from the form that emergency treatment was required. The Complainant has not made available any evidence directly from his dentist or from any other expert to support his position. The policy and the terms and definitions contained in the policy, define what is and what is not covered; and what does and does not constitute emergency treatment.

The policy further states that emergency treatment does not include treatments for rehabilitation or treatments already covered by the policy. It is clear that the treatment received by the Complainant was already covered by the policy as per section 4 of the Table of Benefits. As outlined above, the Complainant was prevented from claiming for his treatment under the other provisions of the policy due to the waiting period. Therefore, I accept that the Complainant did not receive emergency treatment within the meaning of the policy definition.

I note from the Complainant's submissions that he wishes to claim for what he believes to be the correct treatment or the treatment he could or should have received. The Complainant further states that he possibly should have claimed for emergency treatment in his initial claim. This office was furnished with recordings of calls between the Provider and the Complainant and I note that during a call which took place on **6 January 2017** the Complainant commented during the conversation that it was his belief that his treatment was an emergency and that he possibly should have made a claim for 100% of the cost of the treatment because it was emergency treatment. The Complainant further suggested that a crown may not have been the right course of action or that it may have been an excessive repair and that if he had opted for a basic repair this would be covered as emergency treatment. This view was also expressed by the Complainant in a previous telephone conversation with the Provider which took place on **15 December 2016**.

However, I find that these submissions are not centrally relevant to the issues to be determined in this complaint. The Complainant opted for the treatment recommended by his dentist and this was the treatment that was provided and claimed for. Simply because the Complainant believes that more basic treatment might have been provided as an alternative, does not make his current claim one for emergency treatment.

In the context of the policy, it is not determinative that the Complainant considers the situation he was in, an emergency. What is determinative is whether the treatment received

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by the Complainant constituted "emergency treatment" within the terms of the policy which he entered into with the Provider. In my opinion, the Complainant has not established that he required and/or received emergency treatment within the definition of the policy. The Provider is not obliged to settle a claim in respect of alternative treatment that could or should have been provided. The Provider is only obliged to consider and assess claims in respect of the treatment actually received.
Therefore, I find that the treatment claimed for did not constitute emergency treatment within the meaning of the policy and the Provider was entitled to refuse to accept the claim for payment under this heading. For the avoidance of doubt, I note that the Complainant accepts that the Provider was entitled to decline the original claim for crowns as such treatment fell within the relevant waiting period which had not yet expired, and therefore no benefit was payable under the policy.

For the reasons set out above, I do not consider it reasonable to 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

1 May 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.