An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

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| **Decision Ref:** | 2019-0170 |
| **Sector:** | Insurance |
| **Product / Service:** | Private Health Insurance |
| **Conduct(s) complained of:** | Rejection of claim<br>Dissatisfaction with customer service |
| **Outcome:** | Rejected |

## LEGALLY BINDING DECISION
## OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

### Background

The Complainants hold health insurance with the Provider pursuant to a policy incepted on **30 April 2015**. The First Complainant fell and injured her ribs around **13 February 2017**. On that date, the Complainants' daughter called the Provider to enquire about the facilities that the First Complainant was covered to attend, under the policy. Their daughter was informed that her mother was covered to attend three facilities in her county.

On **15 February 2017**, she called again enquiring about the facilities the policy applied to and was told the same three facilities were covered. Ultimately, that day, her mother attended a private facility that was not covered by her policy. Notwithstanding the fact that the clinic was not covered by the Complainants' policy, on **15 March 2017** the Provider discharged the cost of the First Complainant's treatment there. This led the Complainants to believe that they were covered for treatment in this clinic.

The First Complainant took ill again and attended at the clinic on **24 March 2018**. She did so in the belief that she was entitled to claim the costs of doing so under her policy due to the previous payment. By Final Response Letter dated **28 March 2018**, the Provider informed the Complainants' daughter that her mother was not covered for treatment in the clinic and that the Complainants would have to bear the costs for the treatment on **24 March 2018**.

This complaint concerns the Provider's actions which the Complainants say led them to believe they were covered for treatment in the clinic. They believe that the Provider should bear the costs of the treatment there, as a result.

**The Complainants' Case**

The Complainants say that the Provider informed them on the telephone in **February 2017** that certain scans in private hospitals were covered by their policy. They say that when the First Complainant attended the clinic on **15 February 2017**, and the Provider discharged the costs, this further confirmed their belief that they were covered for treatment there.

The Complainants say that they were surprised when the Provider refused to pay the First Complainant's costs for a scan in the facility on **24 March 2018**. The First Complainant paid the sum of €600 in cash on the day of treatment, in the belief that the Provider would reimburse her for that payment. She is out of pocket as a result.

They note that the Provider says that it mistakenly paid out for the treatment in the clinic on **15 March 2017**. The Complainants were never told that this was a payment in error, prior to subsequently attending at the clinic the following year. The Complainants say that they followed the exact same procedure the second time they attended the clinic as they did the first time, in the expectation that the costs would be paid. They say they cannot afford to bear the cost of the scan.

They also say that the customer service provided throughout, was below the standard to be expected.

The Complainants want the Provider to reimburse them for the €600 they paid.

**The Provider's Case**

The Provider says that on numerous occasions the Complainants were provided with documentation that sets out the cover afforded to them under their policy, including on **28 March 2016**, and **29 March 2017**. It says that treatment in the clinic is specifically excluded from the cover of the policy.

The Provider says that at no stage did it inform the Complainants, whether by telephone or otherwise, that they were covered for treatment in the clinic. It says that the payment made for the First Complainant's treatment on **15 March 2017**, was an error. It is not seeking repayment of this sum from the Complainants. The Provider accepts that it did not explain its mistaken payment to the clinic, prior to the First Complainant attending on the second occasion.

The Provider says that the fact that the First Complainant moved from the clinic to one of the covered facilities subsequent to telephone conversations between her daughter and the Provider on **15 February 2017**, demonstrates the Complainants' understanding that they

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were not covered for treatment in clinic. The Provider says that it treated the Complainants with the utmost respect and with a high standard of customer care. It says that its Final Response Letter, which issued on **28 March 2018**, in response to the complaint that was lodged on **27 March 2018**, was a prompt resolution of the dispute.

The Provider confirmed that the Complainants are entitled to €86.70 for out-patient benefits for radiology and pathology and it has made an offer of €295 to cover the CT scan performed on **24 March 2018**, in light of the confusion the previous payment may have caused. In addition, the Provider is willing to make an *ex gratia* payment of €50 (cumulatively "the offer").

**The Complaints for Adjudication**

1. The Provider misled the Complainants to believe that treatment in the clinic was covered under their policy.

2. The Provider wrongly declined the claim for the cost of treatment in the clinic.

**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 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 27 May 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.

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In the absence of additional submissions from the parties, the final determination of this office is set out below.

Section 2.2 of the policy terms and conditions states:

> "*You can find the level of cover available for your hospital costs in a public hospital, private hospital and high-tech hospital in your Table of Cover.*
>
> …
>
> *We will not cover your hospital costs in a medical facility which is not covered in your List of Medical Facilities.*"

Section 3 provides:

> "*We do not cover the following (subject to compliance with the Minimum Benefit Regulations): Any costs that are not covered under a benefit listed on your Table of Cover; any costs incurred in a medical facility that is not covered under your plan.*"

Section 12 indicates, by way of a table, that the clinic at issue is not covered by the Complainants' plan.

The Complainants were not, therefore, entitled to recover the costs for attending the clinic, under their policy terms. The only thing that could, arguably, have entitled the First Complainant to be reimbursed for her attendance at the clinic was if the Provider informed her that she could attend the clinic. Having listened to the audio recordings furnished in evidence to this Office, I do not believe that the Provider said any such thing.

I can appreciate, however, that the Complainants may have been confused by the payment by the Provider, of the treatment charges incurred during the first visit to the clinic. In those circumstances, given that the Provider did not make it clear to the Complainants that the payment in question had been made in error, I believe that the Provider has a case to answer to the Complainants. The Provider should have notified the Complainants of the error made, as soon as this came to light. Be that as it may, I take the view that the offer which has been made to the Complainants by the Provider representing the out-patient benefit entitlement, the offer of €295 and the additional ex gratia payment of €50, represents an appropriate acknowledgment and redress by the Provider of its error in failing to make it clear to the Complainants that the payment previously made, was in fact a mistake. In those circumstances, on the basis that the offer is still available to the Complainants for acceptance, I take the view that it is not appropriate or necessary to uphold this complaint. Instead, if the Complainants wish to accept the proposal which is currently available to them, they should make contact with the Provider in the short-term in order to accept that monetary payment, with a view to bringing this matter to a conclusion. In that event, they should make contact in the short-term, as the Provider cannot be expected to hold that offer open indefinitely.

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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**

19 June 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.**