An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0183
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Rejection of claim - waiting periods apply Mis-selling
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainants incepted a health insurance policy with the Provider on **1 March 2014** via its website, in order to avail of an online discount, which they then renewed in March 2015 and March 2016 (having previously held a different health insurance policy with the Provider from 1 March 2006 through to 1 March 2014). The Complainants upgraded their level of cover with the Provider mid-contract by telephone on **4 January 2017**, so as to include cover for private hospitals, and later renewed this by telephone in March 2017.

The Complainants' Case

The First Complainant was admitted to [Clinic A] a private hospital, for one night on 18 December 2017 for a surgical procedure on his left shoulder.

The Provider declined the Complainants' ensuing health insurance claim in respect of the First Complainant's shoulder surgery, advising in its correspondence dated 12 July 2018, as follows:

> *"This claim was declined as the information provided with your claim indicated that the left shoulder pain, which prompted your referral to* [Mr R. Consultant Orthopaedic Surgeon] *and your subsequent surgery, was present prior to you increasing your benefits on 4 January 2017 and acquiring private hospital cover.*

> *Therefore, as you were serving a two-year additional cover waiting period your claim was assessed in accordance with your previous scheme…*[Your previous scheme] *does not provide cover for the* [Clinic A] *therefore your claim was not eligible for benefit"*.

The First Complainant, however, states *"I was pre-approved by* [the Provider] *for tendon surgery in my shoulder. After the fact, the* [Provider] *are now saying they won't cover it"*.

In this regard, the First Complainant sets out the Complainants' complaint, as follows:

> *"In 2017, I had to have 2 knee replacements – our* [health insurance] *cover did not extend to these surgeries, we took out a loan and went private. I was told I would be in a wheelchair if we didn't have these surgeries. Subsequently we increased our coverage with* [the Provider] *because the knee surgeon…said I might need a new hip in the future.*
>
> *While recovering from my knee surgeries, I was doing physio and yoga. My yoga teacher noticed that movement in my shoulder was limited. He said 'you should get it checked out'. I went to my GP and he referred me on to* [Mr R. Consultant Orthopaedic Surgeon] *at the* [Clinic A]*. An MRI was taken and the doctor said I had a torn tendon and it needed surgery.* [The Provider] *contends this was a pre-existing condition and do not want to pay the bill. Both the doctor and the hospital feel* [the Provider] *should have paid.*
>
> *Due to the nature of my work – delivering* [xxx] *and now store work. Shoulder, knee and ankle pains would not be unusual. I have never missed work or complained of any injury. If this condition was pre-existing I would not have been able to work"*.

In addition, in his correspondence dated 20 March 2018, the First Complainant's GP, Dr M. advises, as follows:

> *"This is to certify that* [the First Complainant] *attended me on 9/10/2017 with a discomfort in his Left shoulder with a number of years.* [The First Complainant] *had not attended the practice before in relation to his shoulder nor had* [he] *any formal diagnosis in relation to his shoulder.*
>
> [The First Complainant] *had an MRI undertaken on 13/10/2017 and subsequently was seen by* [Mr R. Consultant Orthopaedic Surgeon] *and required surgery for same on 18/12/2017.*
>
> [The First Complainant] *was not aware of any potential surgery on his shoulder on renewal of his insurance early in 2017"*.

The First Complainant considers that *"*[the Provider] *is trying to find a loophole not to pay"* the health insurance claim and that *"the financial strain of paying for this surgery on top of the increase in insurance coverage would put a severe strain on the family"*. As a result, the

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Complainants seek that *"the bill for the surgery will be paid as promised by* [the Provider]*"*, in the amount of €6,013.

The Provider's Case

Provider records indicate that the Complainants incepted a health insurance policy with the Provider on **1 March 2014** via its website, in order to avail of an online discount, which they then renewed in March 2015 and March 2016 (having previously held a different health insurance policy with the Provider from 1 March 2006 through to 1 March 2014). The Complainants upgraded their level of cover with the Provider mid-contract by telephone on **4 January 2017**, so as to include cover for private hospitals, and later renewed this by telephone in March 2017.

The Second Complainant telephoned the Provider on 4 January 2017 and upgraded the Complainants' level of cover to include access to private hospitals up to a semi-private room. This upgrade provided cover in private hospitals, subject to the applicable excesses, once the signs or symptoms of the condition being treated began, after the date of the upgrade. For pre-existing conditions, the Complainants' cover would for two years revert to the public hospital cover (up to a semi-private room) that they had held prior to the upgrade. The Provider is satisfied that this upgrade rule was clearly explained to the Second Complainant during the telephone call on 4 January 2017. In addition, the applicable Policy Booklet sent to the Complainants following their upgrade in cover stipulated that additional cover waiting periods apply to pre-existing conditions.

The First Complainant was admitted to [Clinic A] a private hospital, on 18 December 2017 for one night for a surgical procedure on his left shoulder. Mr R. Consultant Orthopaedic Surgeon, noted on the Claim Form that the First Complainant had attended on 4 December 2017 as he was suffering with *"left shoulder pain"* and that the duration of his symptoms prior to this was 1 year. The total cost of the claim as billed to the Provider was €6,013.

The First Complainant states, *"I was pre-approved by* [the Provider] *for tendon surgery in my shoulder. After the fact, the* [Provider] *are now saying they won't cover it"*. In this regard, the Provider notes that the Complainants did not contact the Provider to confirm cover for the surgical procedure on the First Complainant's left shoulder and thus it did not pre-approve cover, as contended. The Second Complainant telephoned the Provider on 4 January 2017 to upgrade the Complainants' level of cover to include cover for private hospitals and during this telephone call she was clearly advised and indicated that she understood, that the Complainants would not be able to avail of the private hospital cover for existing symptoms for a period of two years.

The Second Complainant telephoned the Provider on 18 January 2017 to query cover for the First Complainant's knee replacement procedure in a private hospital, [Clinic B] and was again advised during this telephone call that an additional cover waiting period applied for pre-existing symptoms. Similarly, on 6 April 2017, the Second Complainant telephoned the Provider to query cover for the First Complainant's other knee replacement procedure. It was again explained to her during this telephone call that if the symptoms were present

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prior to upgrading the level of policy cover, then the procedure would not be covered in private hospitals for a period of two years from the date of upgrading.

In this regard, the Second Complainant contacted the Provider to query cover for the First Complainant's two knee procedures, however, despite the Complainants' knowledge of the importance of calling the Provider to confirm cover in advance, the Provider notes that the Complainants did not contact it prior to the surgical procedure on the First Complainant's left shoulder in December 2017.

The Provider notes that it appears that the hospital may have verified cover for the Complainants. In this regard, the hospital has at its disposal a verification tool that it can use for its own reference when admitting patients. The Provider does not endorse or authorise the hospital to confirm cover on its behalf. The Member Verification System is not in place for the purpose of replacing the policyholders' responsibility to contact the Provider to confirm cover nor is it in place for the purpose of a hospital confirming cover on behalf of the Provider. It is a tool for hospitals to use as a guide when admitting patients which outlines applicable excesses, shortfalls etc. Therefore, if the hospital confirmed cover or gave the Complainants the impression that it was confirming cover, on behalf of the Provider, the hospital was acting on its own accord in doing so and without the Provider's authority . In any event, the Provider is satisfied that it is the responsibility of the policyholder to contact the Provider to verify cover in advance of a procedure.

The Provider notes that in correspondence dated 20 March 2018, the First Complainant's GP, Dr M. states, *"*[the First Complainant] *had not attended the practice before in relation to his shoulder nor had* [he] *any formal diagnosis in relation to his shoulder …* [He] *was not aware of any potential surgery on his shoulder on renewal of his insurance early in 2017"*.

In this regard, however, the existence of a pre-existing condition is not the date that the First Complainant first presented to his GP with the condition or when the condition was first diagnosed. Rather it is based on the date that the signs or symptoms of the condition first began.

The Provider notes from the medical documentation before it that the First Complainant was referred by his GP, Dr M. to Mr R. Consultant Orthopaedic Surgeon on 19 October 2017 in relation to *"L shoulder discomfort for a couple of years"*. The First Complainant consulted with Mr R. on 4 December 2017 and the letter he sent to the First Complainant's GP, Dr M. dated 4 December 2017 stated *"*[the First Complainant] *has had left shoulder trouble for about a year"*. The First Complainant then underwent a surgical repair to his left shoulder on 18 December 2017. As a result, the Provider concluded that the symptoms were present prior to the Complainants' upgrading their health insurance cover on 4 January 2017. In addition, in his correspondence dated 20 March 2018, the First Complainant's GP, Dr M. states that the First Complainant had had a *"discomfort in his Left shoulder with a number of years"*.

In accordance with the policy terms and conditions, the additional cover waiting period outlines that a two year waiting period will apply for *"any disease, illness or injury which began or the symptoms of which began before you changed your level of cover"*, therefore

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there does not need to be a diagnosis nor does there need to be an awareness of potential surgery in order for it to be considered a pre-existing condition. Thus, the Provider's medical advisors are fully satisfied that the claim at issue was correctly declined on the basis that the symptoms of the First Complainant's condition were present prior to the upgrading of his health insurance cover on 4 January 2017.

The First Complainant submits that *"due to the nature of my work – delivering* [xxx] *and now store work. Shoulder, knee and ankle pains would not be unusual. If this condition was pre-existing, I would not have been able to work"*. It is not for the Provider to speculate on the First Complainant's capacity to work as a result of his condition, however, as stated, the Provider's medical advisors are fully satisfied from the documentation submitted by the First Complainant's treating doctors that the symptoms of his condition were present prior to the upgrading of his health insurance cover on 4 January 2017.

The Provider is satisfied that the upgrade rule, where waiting periods apply to pre-existing conditions, was clearly explained to the Second Complainant during the telephone call on 4 January 2017 when she chose to upgrade the Complainants' cover and during her subsequent telephone calls to the Provider on 18 January and 6 April 2017 when she was checking cover for other procedures. These three telephone calls all took place prior to the surgical procedure the First Complainant underwent on his left shoulder on 18 December 2017. In addition, the Provider is also satisfied that the applicable Policy Booklet sent to the Complainants following their upgrade in cover in January 2017 clearly stipulated that additional cover waiting periods apply to pre-existing conditions. As a result, the Provider is satisfied that it correctly declined the Complainants' health insurance claim in respect of the First Complainant's shoulder surgery, in accordance with the terms and conditions of their policy.

The Complaint for Adjudication

The Complainants' complaint is that the Provider wrongly or unfairly declined the Complainants' health insurance claim in respect of the First Complainant's shoulder surgery.

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 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.

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

The complaint at hand is that the Provider wrongly or unfairly declined the Complainants' health insurance claim in respect of the First Complainant's shoulder surgery. In this regard, the Complainants incepted a health insurance policy with the Provider on 1 March 2014 via its website, in order to avail of an online discount, which they then renewed in March 2015 and March 2016 (having previously held a different health insurance policy with the Provider from 1 March 2006 through to 1 March 2014). The Complainants upgraded their level of cover with the Provider mid-contract by telephone on 4 January 2017, so as to include cover for private hospitals, and later renewed this by telephone in March 2017.

The First Complainant was admitted to [Clinic A] a private hospital, on 18 December 2017 for one night for a surgical procedure on his left shoulder. Mr R. Consultant Orthopaedic Surgeon, noted on the Claim Form to the Provider that the First Complainant attended on 4 December 2017 as he was suffering with *"left shoulder pain"* and that the duration of his symptoms prior to this was 1 year. The total cost of the claim as billed to the Provider was €6,013. The Provider declined this claim, advising in its correspondence dated 12 July 2018, as follows:

> *"This claim was declined as the information provided with your claim indicated that the left shoulder pain, which prompted your referral to* [Mr R. Consultant Orthopaedic Surgeon] *and your subsequent surgery, was present prior to you increasing your benefits on 4 January 2017 and acquiring private hospital cover.*
>
> *Therefore, as you were serving a two-year additional cover waiting period your claim was assessed in accordance with your previous scheme…*[Your previous scheme] *does not provide cover for* [Clinic A] *therefore your claim was not eligible for benefit"*.

In this regard, the Complainants' health insurance policy, like all insurance policies, does not provide cover for every eventuality; rather the cover with be subject to the terms, conditions, endorsements and exclusions set out in the policy documentation.

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I note that the '**Important Information to note'** section of the applicable Policy Booklet provides, *inter alia*, at pg. 44, as follows:

> *"**If you're changing your level of cover/benefits the following waiting periods will apply regardless of how long you have been insured:***
>
> *You have health insurance and want to get an additional level of cover/benefits, how long before you can avail of the better cover/benefits for any disease, illness or injury which began or the symptoms of which began before you changed your level of cover?*
>
> *2 years for all age groups"*.

Section 9, 'What is not covered under the scheme', of this Policy Booklet provides, *inter alia,* at pg. 11, as follows:

> *"**We will not pay 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 start date or the date of the change to their policy/schemes"*.

Section 2, 'Policy Definitions', of the Policy Booklet provides, *inter alia*, at pg. 5, as follows:

> *"**Pre-existing condition***
>
> *Pre-existing condition: An ailment, illness or condition, where, on the basis of medical advice, the signs or symptoms of that ailment, illness or condition existed at any time in the period of 6 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 advisors will determine whether a condition is a Pre-Existing condition. Their decision is final**"*.

I am thus satisfied that the terms and conditions of the Complainants' policy state that they cannot avail of the upgraded level of cover for a condition where the signs or symptoms of that condition were present during the 6 months prior to them upgrading their cover on 4 January 2017, for a period of two years, that is, until after 4 January 2019.

I note from the documentary evidence before me that in his correspondence dated 19 October 2017, the First Complainant's GP, Dr M. referred the First Complainant to Mr R. Consultant Orthopaedic Surgeon, as follows:

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> *"Many thanks for seeing* [the First Complainant].
>
> *L shoulder discomfort with a couple of years. no major injury"*.

In addition, in his correspondence to the Complainant's GP, Dr M. dated 4 December 2017, Mr R. Consultant Orthopaedic Surgeon advised, *inter alia*, as follows:

> *"Thank you for referring* [the First Complainant] *who works as a stores man. He has had left shoulder trouble for about a year"*.

Furthermore, in his correspondence dated 20 March 2018, the First Complainant's GP, Dr M. advises, *inter alia*, as follows:

> *"This is to certify that the* [First Complainant] *attended on 9/10/2017 with a discomfort in his Left shoulder with a number of years.* [He] *had not attended the practice before in relation to his shoulder nor had* [he] *any formal diagnosis in relation to his shoulder"*.

I am thus satisfied that it was reasonable for the Provider to conclude from the documentary evidence before it that the symptoms of the First Complainant's condition were present prior to the upgrading of his health insurance cover on 4 January 2017. As a result, I am satisfied that the Provider declined the Complainants' health insurance claim in respect of the First Complainant's shoulder surgery in accordance with the terms and conditions of their health insurance policy.

In addition, I have listened to a recording of the telephone call the Second Complainant made to the Provider on 4 January 2017 and note the following exchange:

> Second Complainant: [First Complainant] *has to have a knee replacement and he wants to go private, now I know our insurance doesn't cover it.*
>
> Agent: *Ok.*
>
> Second Complainant: *The policy we have, can he, can we up our insurance and wait 6 months? …*
>
> Agent: *Ok, the scheme covers a semi-private room in a public hospital, now if he wants to upgrade the plan to get private hospitals included, just to make you aware, there is a two year upgrade rule involved so that means there wouldn't be any cover in private hospitals for this particular procedure for two years …*
>
> Second Complainant: *… so he has to wait two years? Even though, you know, we never had a claim at all, ever …*
>
> Agent: *Yeah, well that is just the standard rule across all health insurance in Ireland….when any benefits are being upgraded*

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on a plan it does take an additional two years to get cover on the higher level of cover.

Second Complainant: *Ok.*

I have also listened to a recording of the telephone call the Second Complainant made to the Provider on 18 January 2017 and note the following exchange:

Agent: *So if the condition is, em, if the onset date was pre the 4th January this year that it wouldn't be covered …*

Second Complainant: *Yeah but it's not, we don't know yet the date –*

Agent: *Ok, but, if it's a new onset, em, and it's after the 4th January this year, then we will fully cover it in the* [Clinic B]*, with no excess or shortfalls, but we go by the onset date that the consultant puts down, so, em, prior to your level of cover change you wouldn't have had it on your previous level of cover and there would be the two year waiting period …*

So if the consultant, if he said that the onset date of this symptom or condition is before the 4th of January than we won't cover the procedure.

Second Complainant: *But if he says the onset is after?*

Agent: *Yeah, then it will be covered.*

Second Complainant: *Ok. Ok. Ok.*

Furthermore, having listened to a recording of the telephone call the Second Complainant made to the Provider on 6 April 2017, I note the following exchange:

Agent: *So, em,* [Clinic B] *is a private hospital and* [First Complainant] *has only had cover in* [Clinic B] *since 1 March so that means that if he had any symptoms before the 1st March it wouldn't be covered at all …*

Second Complainant: *So that means that it was something that he had symptoms of prior to the 1st March which means that it wouldn't be covered in* [Clinic B]*, so whenever you, em, add on additional inpatient cover on to your policy there's always a two year wait to use that additional cover, em, which means he would be covered to have it done in a public hospital but not in a private hospital.*

I am thus satisfied that the Provider clearly explained to the Second Complainant by telephone on 4 January, 18 January and 6 April 2017, the two-year additional cover waiting

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period for pre-existing conditions and that she indicated that she understood this policy condition.

As a result, I am satisfied that the Provider advised the Complainants both in writing, by way of the Policy Booklet, and verbally, during three different telephone calls with the Second Complainant, of the two-year additional cover waiting period for pre-existing conditions.

Whilst the First Complainant states *"I was pre-approved by* [the Provider] *for tendon surgery in my shoulder"*, I note that there is no evidence before me indicating that the Provider pre-approved cover for this surgery to either of the Complainants, either in writing or by telephone. I note that the Second Complainant had telephoned the Provider previously on 18 January and again on 6 April 2017 to check cover for other procedures. It would have been prudent to have contacted the Provider directly again, to verify cover in advance of the First Complainant's hospital admission on 18 December 2017 for a surgical procedure on his left shoulder. In this regard, I note that the 'How to make a claim' section of the applicable Policy Booklet provides, *inter alia*, at pg. 2, as follows:

> *"It's a good idea to call us on 1890 *** *** and let us know about any upcoming treatment. Don't forget to tell us which hospital you're going to and the name of the consultant, so we can confirm your cover"*.

In addition, Section 10, 'Making a Claim', of this Policy Booklet provides, *inter alia*, at pg. 13, as follows:

> *"(a) When possible, you should tell us about any treatment you are going to have. This gives us the chance to tell you if you can claim for benefits. We may ask your consultant or other registered medical practitioner to provide us with full written details of the treatment"*.

Accordingly, based on the evidence available, I take the view that the Provider acted within its entitlements when it decided to decline the claim. It is therefore my Decision that this complaint cannot be upheld.

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Conclusion

My Decision is that this complaint is rejected, pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***.

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.