An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0265
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Disagreement regarding Settlement amount offered
Outcome:	Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

This complaint concerns a health insurance policy, and relates to the Complainant's claim under the policy for orthotic expenses, namely insoles and boots, for the sum of €554.99, incurred between November 2017 and January 2018.

The complaint is that the Provider has incorrectly applied the outpatient excess to the Complainant's claim in January 2018 resulting in the Complainant not receiving any refund of expenses paid for orthotic insoles and boots, and that it has proffered below-par customer service throughout.

The Complainant's Case

The Complainant purchased orthotic insoles on **7 December 2017** for the sum of €165. She also bought orthotic boots on **20 November 2017** and **4 January 2018** for the sums of €239.99 and €150, respectively, and submitted a claim for these expenses to the Provider in January 2018 with the receipts for same as requested by the Provider.

Following the repudiation of her claim, the Complainant raised a complaint with the Provider in February 2018. She contends that she was aware of an excess on her policy of €200. The Complainant maintains that the maximum benefit she *"can claim for orthotics, under Medical and Surgical Appliances is 50% up to € 200.00"* and that she has *"spent in total €554.99. The excess is €200.00. Surely then [she is] entitled to €200 from the remaining balance of €334.99?"* The Complainant states that not receiving any reimbursement *"makes little sense to [her]"*.

The Complainant submits that the policy documents she received and what the Provider refers to in the Final Response Letter dated **7 February 2018** as its reasoning for the declinature of her claim, contradict each other. She further submits that *"it is misleading to now adopt a different formula to work out any reimbursement that [she is] entitled to than what is set out in the [policy document] and the Medical and Surgical Appliances List"*.

The Provider's Case

The Provider received three receipts on **7 January 2018** via its online membership platform and included:

- A till receipt dated **20 November 2017** for the amount of €239.99;
- A receipt detailing the Complainant's full name and address dated **7 December 2017** for the amount of €165; and
- A till receipt dated **4 January 2018** for the amount of €150.

The Provider states that a letter was issued to the Complainant advising her that only the receipt for €165 was accepted but would not be reimbursed as *"the outpatient excess had not been exceeded"*. The other two receipts for €239.99 and €150 were not accepted as they were till receipts and did not detail the Complainant's name and address. This stipulation, the Provider asserts, is located under the *How to Claim* heading of its policy document and the Complainant, it advises, was made aware of this on 15 January 2018.

It is the Provider's contention that the benefit, which the Complainant is claiming for, is listed under the cover for *'Outpatient Benefits (subject to excess)'* and it advises that the Complainant's excess is noted in the same section as being €200. The Provider explains that *"the excess of €200 per person is the amount deducted from the total benefits for* [the Complainant's] *out-patient benefits including medical and surgical appliances on the plan and not the total amount paid on the receipts"*. It further submits that upon submission of receipts from a customer, it *"will calculate the benefit amount based on the benefit levels of your table of cover and deduct from the total benefit amount the €200.00 excess."* The Provider submits that orthotics, under medical and surgical appliances in the Complainant's policy, is subject to *"50% up to €200".*

Evidence

Provider Membership Handbook: Health Plans (January 2017)

> *"You will need to pay any excess, shortfall or co-payment that applies to a benefit or a group of benefits under your plan"*.
>
> *"Please note that there may be a limit on the total amount that we will pay for Day-to-day Benefits or Out-patient Benefits in a policy year. This limit will apply before the deduction of any applicable policy excess"*.

/Cont'd…

Outpatient Benefits (subject to excess)	
Outpatient excess per person	€200
Maximum amount of outpatient benefits per member per policy year	€5000
Manual Lymph Drainage	€50 x 5 visits
Psycho-oncology Counselling	€40 x 5 visits
Emergency Dental Care	€250
Consultant fees	€60 per visit
Pre/Post natal medical expenses	€400
Public A&E Cover	€60 x 3 visits
Child A&E visit	€60 x 3 visits
Medical and surgical appliances	As per specified list[3]
Home Nursing	€40 x 20 days
MRI Scan: non approved centre	Not covered on this plan
CT Scan: non approved centre	Not covered on this plan
PET-CT Scan: non approved centre	Not covered on this plan

"Cover for orthotics is included under medical and surgical appliances list which is available on our website (relevant section below)".

15	NG Tubes	50% up to €200
16	Orthopaedic splints	50% up to €200
17	Orthotics	50% up to €200
18	Peak Flow meter	50% up to €200
19	Support belts-back	50% up to €200

"…. an excess may apply to the total amount you claim under your Day-to-Day Benefits or Out-patient Benefits in your policy year. So for example where an excess applies to the Out-patient Benefits under your plan, it applies to the total amount you are claiming for all your Out-patient Benefits in your policy year. When you submit your receipts to us we will calculate the total amount due to be refunded to you under all your Out-patient Benefits, subtract the excess and refund you the balance".

/Cont'd…

For example:

	Consultant	GP
Cover shown on Table of Cover	€60 x 4 visits	€25 x 6 visits
Number of times *you* visited *your health care provider* in *your policy year* and how much *you* paid per visit	3 x €150	7 x €60
Total amount that *you* can *claim*	3 x €60 = €180 (3 being the number of times *you* visited a *consultant* and €60 being the maximum amount that can be *claimed* per visit)	6 x €25 = €150 (6 being the maximum number of times *you* can *claim* for a visit to a *GP* and €25 being the maximum amount that can be *claimed* per visit)
Total amount that *you* can *claim* under both *benefits*	€330 (i.e. €180 + €150)	
Less *out-patient excess*	€200	
Money *we* pay *you* back	€130	

Letter from the Provider to the Complainant dated 18 January 2018

Under the heading **'Shortfall Definitions'**, the Provider states that the **'Shortfall Reason'** for the Complainant's claim not being paid is:

> *"Receipt submitted and paid previously. A claim was already paid relating to this receipt".*

Email from the Complainant to the Provider dated 29 January 2018

> *"I made a claim for orthotic boots and insoles which I was told was sent for Review as I had been incorrectly told that the claim had been paid out when it had not been paid out".*
>
> *"I have heard nothing since, despite my two phone calls to [the Provider] taking an hour of my lunchtime. I was cut off the first time I rang and had to wait another twenty minutes to speak to someone".*

Email from the Provider to the Complainant dated 3 February 2018

> *"In relation to your query regarding declined claims for Orthotics under Medical and Surgical Appliances, please be advised that this claim was declined correctly as the member benefit adjudicated went to your policy excess".*
>
> *"According to the terms and conditions for claiming medical and surgical appliances, under the orthotics benefit you can claim a maximum of €200 per policy per year. This benefit is subject to Out-patient excess which has now been met. Therefore, any additional claims you make under this or any other out-patient benefit will now not be subject to excess, and will result in a payment to you".*

/Cont'd…

Emails from the Complaint to the Provider dated 3 February 2018

"I gave up an hour of my lunchtime, three phone calls and two emails…. I have not even been provided with a contact response name and number".

"…. I have not received any reimbursement in relation to my claim, despite being previously incorrectly told by [the Provider] that I had already been paid on a claim for two of the three receipts".

"…… I do not intend to renew my health insurance with [the Provider]. I have been a loyal member of [third party provider] for many years and have never had to deal with such badly handled, though straightforward issue as this".

Final Response Letter from the Provider to the Complainant dated 7 February 2018

"…. The excess of €200 per person is the amount deducted from the total benefits for your out-patient benefits including medical and surgical appliances on the plan and not the total amount paid on the receipts".

"When you submit receipts to [the Provider], we will calculate the benefit amount based on the benefit levels on your table of cover and deduct from the total benefit amount the €200 excess".

"As the orthotics is the only medical and surgical appliance receipt you have submitted the maximum benefit amount noted on the medical surgical appliance list is '50% up to €200'. The orthotic receipts submitted cost €554.99. [Under your plan] the benefit is 50% up to €200, therefore the benefit amount for this medical and surgical appliance is 1 X €200. As noted… the excess of €200 is deducted from the benefit amount. Under [your claim] the benefit is €200 less the excess of €200 meaning nothing would be due back to you for the receipts".

"As the excess of €200 has been reached for the policy year 1st June 2017 to the 31st May 2018 due to the Orthotic benefit amount, if you have other out-patient receipts or receipts for other items besides orthotics on the medical and surgical appliances list you may be entitled to receive something back".

Provider's formal response to FSPO dated 7 September 2018

"We are not disputing that the benefit payable to [the Complainant] for orthotics is the maximum entitlement of €200. The cover for orthotics is 50% up to a maximum amount of €200. It is important to note however that the outpatient excess must be applied to the benefit payable amount and not the receipt amount. As [the Complainant] paid a total amount of €554.99 she was entitled to the maximum benefit payable of €200. However, the outpatient excess of €200 must be reached and exceeded prior to any refund being issued. In this instance, as the benefit payable amount is equal the outpatient excess there is nothing due back to [the Complainant]".

/Cont'd…

"The claims settlement letter reflects the details as they were submitted on the online membership area. It confirms that each receipt submitted was paid in line with the terms & conditions of [the Complainant's] policy:

- *Cover for medical and surgical appliances is included in the outpatient benefits (subject to excess) section of the policy.*
- *The Medical and Surgical Appliances List notes that the contribution per policy year for Orthotics is 50% up to €200.*
- *The document also states that the contribution per policy year is subject to the annual excess (with some exceptions noted). "*

The Provider also refers to the **Health Insurance Authority website – Excess and Outpatient Claims:**

"An out-patient excess is the amount that is deducted from the amount payable to you".

"It could be the case that even though the total of your outpatient expenses is more than the out-patient excess, you might still not be in a position to claim because your total allowable expenses have not yet reached the level of the out-patient excess".

Telephone Calls

Recordings of telephone calls between the Complainants and the Provider were submitted by the Provider as part of its formal response to this Office.

The Complainant telephoned the Provider in November 2017, and during this call the Provider advises the Complainant that her policy's outpatient excess applies to all outpatient benefits payable under the policy and explains that the excess is applied to the total benefits:

"If the addition of those benefits exceeds €200 you will be able to claim back".

The Provider also refers the Complainant to the working example in her membership handbook, and states again that the outpatient benefits, including orthotics, are subject to a total excess of €200 (the outpatient excess). The Complainant at one point during the call apologises, saying:

"Sorry, I'm a bit slow on this".

At the end of this call however, the Complainant states that she understands.

In subsequent phone calls with the Provider, all relating to the claim which is the subject of this dispute, it is apparent that the Complainant did not fully understand the way the Provider had applied the outpatient excess to her benefits under the policy.
Though this was explained during the calls a number of times by the Provider, the Complainant states that she cannot understand why she is not entitled to:

/Cont'd…

"50% once you spend €200; anything that you spend over €200, you get 50% back".

The Complainant refers a number of times to a previous health insurer, stating:

> *"I've done this with [third party insurer] before",* and
>
> *"This is how I've always claimed before".*

During her last call with the Provider on **5 February 2018**, the Complainant logs a complaint about the Provider's *"double threshold"* and states that she will cancel her policy. I would note that during this call, and during a previous call dated **1 November 2017**, Provider staff took time to explain in detail how the outpatient excess operated and made every effort to assist the Complainant's understanding of how it would apply to any claim made for outpatient expenses, including orthotics (medical and surgical appliances).

Aside from the issue of the outpatient excess, the recordings show that the Complainant was very unhappy with the Provider's customer service. She states that she spent *"an inordinate amount of time"* trying to resolve the issue and that *"nobody [was] dealing with it"*. During a call on **22 January 2018**, the Complainant sought clarity on a letter she had received from the Provider advising that the claim *"had been paid out"* and was told by the Provider that the matter would be reviewed. Despite this assurance, the Complainant had to *"follow up again"* herself. I note that the Complainant was put on hold on a number of occasions so that the Provider staff member might consult with another member of staff or a manager. Each of these calls ended with the Provider reassuring the Complainant that she would either receive an update or a call back, and it would appear that she received neither. During a number of calls the Complainant remarked that she did not want to *"shoot the messenger"* before reiterating her dissatisfaction with the Provider's claims handling and customer service.

<u>The Complaint for Adjudication</u>

The complaint is that the Provider incorrectly applied the outpatient excess to the Complainant's claim in January 2018, resulting in the Complainant not receiving any benefit payment for expenses paid for orthotic insoles and boots, and that it has proffered below-par customer service throughout.

<u>Decision</u>

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.

/Cont'd…

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 11 July 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, within the period permitted, the final determination of this office is set out below.

Analysis

The relationship between the parties must be governed by the terms of the agreement between them which, in this case, is contained in the policy document dated June 2017. The Complainant's policy was incepted by renewal on **1 June 2017**. The Provider wrote to the Complainant enclosing the policy documents and product suitability statement on **10 May 2017.** The 'Membership Handbook' refers to *"Day-to Day Benefits and Out-patient Benefits"* and advises on page 4 that an insured will need to pay any excess that applies to a benefit or group of benefits under the plan. It also states on page 8 of the handbook that the Provider, when processing a claim, will calculate the total amount due to be refunded under the out-patient benefits, subtract the excess and refund the balance to the claimant. The handbook presents an example of the aforementioned in table form on page 8. I note the Provider's submission that it is *"not disputing that the benefit payable to [the Complainant] for orthotics is the maximum entitlement of €200"*, but that *"the outpatient excess must be applied to the benefit payable amount"*.

I note that the Provider discussed the subject of the policy excess and its application to out-patient benefits, including orthotics, at length in its phone call with the Complainant on **1 November 2017**, and referred her to the 'Membership Handbook' for a written example. Given the above, I accept that the Provider to some extent explained the application of the out-patient excess under the policy to the Complainant on a number of occasions and that this information was stated in the handbook with an example of how the excess would apply in practice.

In this case, the benefit payable amount was equal to the outpatient excess, and therefore the benefit of €200 was reduced to nil. I accept that the Provider acted in accordance with the terms and conditions of the Complainant's policy in this regard. I also acknowledge that

/Cont'd…

the Provider made reasonable efforts to ensure that the Complainant understood how the out-patient excess would be applied in the event of a claim, both during phone calls and in the 'Members Handbook'. I note that the Complainant makes reference, in phone calls with the Provider, to her experiences with a previous health insurer, but the Provider must process claims according to the current policy's terms and conditions and I accept that it has done so in this case.

I would suggest, however, that the Provider review its policy wording to further clarify the application of the outpatient excess. The Health Insurance Authority defines outpatient excess as:

> *"An out-patient excess is the amount that is deducted from the amount payable to you".*

The inclusion of the above wording in the 'Members Handbook' would serve to further highlight that the outpatient excess is deducted from the benefits payable, rather than the total of receipts submitted. It would also be helpful if the Provider, in addition to the working example which is currently in the member's handbook, (as reproduced above on page 4) also included a comparative working example, showing a scenario where benefit does not fall to be paid. This is perhaps something that the Provider may wish to consider, with a view to helping its members to understand the calculations.

I am not satisfied with the Provider's customer service and communication regarding the Complainant's claim for orthotics under her policy. I note that a letter from the Provider to the Complainant dated **18 January 2018** States:

> *"Receipt submitted and paid previously. A claim was already paid relating to this receipt".*

Somewhat understandably, the Complainant sought clarification regarding the above statements in her phone call to the Provider on **22 January 2018** and her subsequent email to the Provider on **29 January 2018**. Despite being reassured by the Provider that the matter would be reviewed, the Complainant did not receive an update that clarified the Provider's contention that a previously submitted receipt had been *"paid previously"*. While I acknowledge that the Provider's statement: *"Your receipts….. Were assessed and your full benefit was applied"* may have been intended to address the Complainant's query, in my view the meaning was not sufficiently clear. The word *"paid"* implies that there was some tangible benefit to the Complainant, such as a payment, and in this case there was none. The Provider was remiss in not clearly communicating to the Complainant that the receipt submitted had been processed rather than *"paid"* and that the ensuing benefit had been put towards the out-patient excess specified in the policy documents.

Neither am I satisfied with the level of customer service proffered by the Provider when communicating with the Complainant regarding her claim. It appears that the fact that her receipts were submitted more than once (at the Provider's request) may have led to difficulties for Provider staff attempting to assist the Complainant when she telephoned,

/Cont'd…

and this necessitated her being put on hold on a number of occasions so that the staff member could speak with a colleague or manager. On all but one of these occasions, after being on hold, the Complainant was told by the Provider that it would contact her later with an update. The Complainant states in her email dated **3 February 2018** that:

> *"I gave up an hour of my lunchtime, three phone calls and two emails…. I have not even been provided with a contact response name and number".*

Assurances given by the Provider that the Complainant would be contacted with an update on her claim were not followed through, and the Complainant's understandable unhappiness with the Provider's lack of response is evident from the phone call recordings.

Having regard to the particular circumstances of this complaint, in particular the failings that have been noted above, it is my Decision that the complaint is partially upheld and I direct the Provider to make a compensatory payment of €100 to the Complainant.

Conclusion

- My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is partially upheld, on the grounds prescribed in ***Section 60(2) (g).***

- Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to make a compensatory payment to the Complainant in the sum of €100, to an account of the Complainant's choosing, within a period of 35 days of the nomination of account details by the Complainant to the provider. I also direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, if the amount is not paid to the said account, within that period.

- The Provider is also required to comply with ***Section 60(8) (b)*** 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

2 August 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—

/Cont'd…

(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.