An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0051
Sector:	Insurance
Product / Service:	Hospital Cash Plan
Conduct(s) complained of:	Rejection of claim
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

On **28 April 2015,** the Complainants took out a family health insurance policy with the Provider.

On **28 December 2017**, the First Complainant attended the emergency department at hospital ('**1st hospital**') with a history of right sided renal colic. The First Complainant was diagnosed with a kidney stone on her right side. She underwent a ureteroscopy and the insertion of a stent and was discharged on **30 December 2017**.

As a follow up treatment, the Complainant underwent two further smaller procedures under the same consultant. On **9 February 2018**, she underwent a rigid cystoscopy and the removal of the original stent with the replacement of a different stent at a different hospital ('**the 2nd hospital**'). On **26 February 2018**, the Complainant underwent the removal of the stent at a different hospital ('**the 3rd hospital.**').

The Complainants made a claim to the Provider in respect of all of the treatment that the First Complainant received. On **10 July 2018**, the Provider wrote confirming its final decision that the treatment received by the First Complainant at the 2nd and 3rd hospitals would not be covered, on the basis that the particular insurance policy did not cover these two hospitals.

The Complainants' Case

The Complainants say that the First Complainant underwent emergency medical treatment at the 1st hospital having been admitted after attending the Emergency Department. The First Complainant states that she did not decide to have the follow up treatment at the 2nd and 3rd hospitals. She says that due to the minor nature of the subsequent procedures, she was told to have the procedures at these locations. The First Complainant notes that the procedures had to be done, and that she did not have any discretion in this regard. The First Complainant notes that the same consultant performed the procedures in question. She submits a letter from the consultant dated **6 June 2018**, which explains why the procedures were carried out at the 2nd and 3rd hospitals. The consultant notes that the 2nd and 3rd hospitals are a part of the group of hospitals connected to the 1st hospital.

The Complainants seek to have the claims in respect of the treatment at the 2nd and 3rd hospitals admitted and paid for by the Provider. These claims are valued in the sum of €2,980.

The Provider's Case

The Provider's case is set out in the formal response and the associated documentation submitted with the response.

Firstly, the Provider refers to various sections of the policy documentation. In the membership handbook, the Provider notes that there are multiple references to the fact that certain medical facilities are not covered. In that regard, in the renewal letter dated **26 April 2017**, the Provider requested that the insured pay close attention to the benefits and hospitals which were covered by the policy in question. The Provider says that the 2nd and 3rd hospitals were not included in the policy documentation and, therefore, it has no obligation to pay these claims.

Secondly, the Provider notes that the Complainants called in relation to other coverage issues before the treatment the subject matter of this complaint, occurred. On **29 November 2016**, there is a note of the Complainants calling to query whether a certain hospital was covered or not. On **31 July 2017**, the First Complainant called querying whether her son would be covered in a separate hospital or whether different coverage was required. During the First Complainant's treatment at the 1st hospital, the Second Complainant contacted the Provider in order to obtain the First Complainant's policy number, but did not query whether the treatments would be covered.

Thirdly, the Provider states that the First Complainant was treated as a public patient in the 1st hospital and was billed €80 per night, which was discharged by the Provider. The Provider notes that the First Complainant elected to be treated as a private patient for the treatments at the 2nd and 3rd hospitals. In this regard, the Provider says that the First Complainant signed a private patient waiver form, which contains a warning to the effect that if the insured's policy does not cover the treatment, then the insured will be personally liable for the cost of treatment.

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The Complaint for Adjudication

The complaint is that the Provider acted wrongfully in declining the First Complainant's claim in respect of the cost of the treatment received at the 2nd and 3rd hospitals.

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 28 January 2020, 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.

It is necessary to firstly set out the relevant policy terms.

In the membership booklet, under the heading '*what to look for*' it is stated that an insured should consult to table of cover to determine '*which list of medical facilities applies to you.*'

In relation to '*medical facilities covered under your plan'* it states that:

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> '*The medical facilities covered under your plan are shown in your List of Medical Facilities. There are four of these lists but only one will apply to your plan. You can see which one applies to you in your Table of Cover. All the Lists of Medical Facilities are contained in the tables of medical facilities in section 12 of this Membership Handbook.'*

In relation to '*medical facilities not covered under your plan*' it states that:

> '*We will not cover your hospital costs in a medical facility which is not covered in your list of Medical Facilities.'*

In relation to '*exclusions from your cover*' it states that:

> '*We do not cover the following:*
>
> *Any costs incurred in a Medical Facility that is not covered under your plan.'*

At section 12 of the Membership Handbook, the relevant Medical Facilities are set out. The 2nd and 3rd hospitals are not contained within the List of Medical Facilities. Furthermore, in the letter dated **26 April 2017** for renewal of coverage, it was expressly stated that the insured should pay close attention to the hospitals that were covered by the particular policy in question.

On the clear wording of the policy, the treatment received by the First Complainant at the 2nd and 3rd hospitals was not covered by her policy, owing to section 12 identifying the List of Medical Facilities covered. I note that the attention of the insured was drawn to the covered hospitals at the time of renewal and the terms of the policy were written in plain and ordinary English. Similarly I note from the previous telephone queries referred to above, that the Complainants were aware that the policy contained limitations in cover depending on which hospital was attended for treatment.

It is understandable that the First Complainant adopted the approach that she did. It is apparent from the letter from the treating consultant that the procedures were done because they were necessary. Furthermore, the 2nd and 3rd hospitals were chosen because the treatments required at that stage were minor and were, therefore, more suitably done at those locations. It is also uncontested that the 2nd and 3rd hospitals form a part of the hospital group which the 1st hospital is a part of. The same consultant performed all of the relevant procedures.

The crux of the matter, however, is that 2nd and 3rd hospitals were not listed in section 12 identifying the List of Medical Facilities for the Complainants' policy. The First Complainant elected to admit herself to the 2nd and 3rd hospitals as a private patient on the mistaken belief that the policy would cover her treatment. Unfortunately, this was not correct, but the Complainant raised no query with the Provider regarding her forthcoming treatment, and I do not believe that the position which the First Complainant now finds herself in, was caused in any way by the Provider.

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Whilst the phone call of **3 April 2018** between the Provider's representative and the First Complainant included a discussion concerning which hospitals were covered by the policy, this discussion occurred after the relevant treatments, and therefore it did not form part of the First Complainant's decision making process, when deciding whether and on what basis to admit herself to the 2nd and 3rd hospitals. Accordingly, I take the view that the evidence discloses no wrongdoing on the part of the Provider. Consequently, this complaint cannot reasonably be upheld.

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 February 2020

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.