An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0062
Sector:	Insurance
Product / Service:	Dental Expenses Insurance
Conduct(s) complained of:	Rejection of claim Claim handling delays or issues Delayed or inadequate communication Dissatisfaction with customer service
Outcome:	Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

This complaint concerns the Provider's repudiation of a claim made by the Complainant on her dental insurance policy and her dissatisfaction with the Provider's handling of her complaint.

The Complainant's Case

The Complainant held a dental insurance policy with the Provider from **8 July 2013.** She also held a separate health insurance policy.

The Complainant submitted a claim to the Provider on **13 September 2017** for expenses she had incurred for dental and sinus surgery. The Complainant states that the initial procedure failed and she required a further operation to rectify this. There was no charge for the remedial procedure.

The Complainant's claim form states that the Complainant was claiming under the policy for a *"sinus lift"*. The Complainant states that she did not know what the exact nature of this operation was and that she believed she would be covered under her policy as it related to dental surgery. Furthermore, the Complainant states that there is no reference to the eligibility or non-eligibility of a sinus lift in the dental insurance policy. She submits that there was no definitive confirmation in the Provider's terms and conditions that a sinus lift was excluded and therefore she considers her claim to be one which should have been paid.

The Complainant further states that failing the sinus lift itself being covered, then she should be covered on the basis that she met the criteria for emergency treatment under the policy, namely she had a *"need for immediate relief of severe pain, trauma and swelling"*.

Further to a letter dated **6 November 2017** received from the Provider's administrator (referred to in this Decision also as the Provider) the Complainant wrote to the Provider on **4 December 2017** wishing to further appeal the decision to refuse her claim. She also sought a typed copy of the transcript of calls, as the CD recordings she had been furnished with were *"totally inaudible, unintelligible and totally unfit for purpose"*. The Complainant wrote to the Provider on **24 January 2018** and **11 February 2018** seeking a follow up to this letter and received a response on **23 February 2018**.

The Complainant wrote to the Provider on **8 March 2018** referring to her previous correspondence and also raising several points arising out of the letter dated **23 February 2018**. In particular, the Complainant stated that the Provider's statement that *"the list of exclusions on a policy is often exhaustive"* is not only totally confusing but also totally unfair to clients. The Complainant submits that something can only be exhaustive or not exhaustive, it cannot be *"often exhaustive"*. She states that the onus for listing exclusions should rest with the Provider and not be based on a principle of "default". The Complainant also states that the Provider has failed to review her claim, on the basis that she should be covered by the emergency treatment provision of her policy, despite this being raised by her in her previous correspondence. Finally the Complainant again makes complaints about the manner in which her claim was handled.

On **9 December 2018**, the Complainant responded to the summary of the complaint prepared by this Office and the submissions from the Provider in reply, stating that she noted the response from the Provider and *"their admission in section 10 that they acknowledge that aspects of the complaint were not handled with a view to 'good customer services'"*. She went on to state that she was *"happy to leave the outcome of* [her] *complaint to* [this Office's] *impartial judgment"* and expresses a hope that the Provider may acknowledge *"some form of goodwill acknowledge* (sic) *under the circumstances of the case."* This prompted an email from the Provider asking if the *"Complainant would avert the full decision if offered some recompense for the poor customer service handling"*. This led to a further letter from the Complainant dated **11 December 2018** enquiring as to whether a goodwill payment was suggested for poor customer service if she withdrew her complaint. The Provider responded on **3 January 2019** stating that it wished the file to progress to adjudication.

On **9 January 2019**, the Complainant wrote to this Office stating that she had now listened to the two CDs of conversation recordings with the Provider's call centre staff and wished to make the following observations namely that:

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- There are obviously other calls to and from the Provider not recorded on the CDs
- In the sales recordings and review recordings contained, she states that she is clearly confused about the details of her cover. She notes in her first call with a representative of the Provider that she was told that she was covered for "gum disease", however there is no mention of this in the second follow up call with a different representative of the Provider. The Complainant points out that a sinus lift is a treatment needed for gum disease.
- The Complainant queries how it is possible to seek prior approval for a dental procedure if one does not know what the procedure the dentist is going to carry out will be, until the day she attends.
- The Complainant states that her cover seems more extensive in her conversation with the second representative of the Provider, as opposed to her conversation with the first representative.
- The Complainant states that the transfer of her case from the Provider's dental team to the Provider's medical team does not seem to have been properly undertaken and she has no recollection of the outcome of any review of her claim by the Provider's medical team or the return of her original receipts for her dental procedure so she could make a medical claim independently. The Complainant states that her understanding of the recorded conversation was that the Provider's dental team would refer her claim to be assessed under her health insurance policy.

The Complainant complains that the Provider referred her claim to *"a plethora of other agencies which used delaying and confusion tactics to frustrate* [her] *efforts"*. The Complainant states that the manner of handling her complaint correspondence was *"totally unacceptable and disrespectful"*.

The Complainant cancelled her dental insurance policy with the Provider on **25 July 2018**.

Ultimately, the Complainant wants the Provider to reimburse her for the dental surgery fees incurred by her in the sum of €1,500 with additional compensation for the inconvenience, stress and frustration she has suffered.

The Provider's Case

By way of letter dated **26 September 2017** the Provider stated that it was declining the Complainant's claim as the sinus lift was not covered under her policy. The evidence submitted by the Provider states that the Complainant called the Provider on **27 September 2017** querying this declinature and was informed by the Provider that it does not cover surgical procedures. The Provider states that at this point, the Complainant informed the Provider's representative that she had been advised by a medical staff member of the Provider that she would be covered for her sinus lift.

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Following on from the above, the Provider states that it called the Complainant on **27 September** and advised her that it would not be covering her claim, as it fell outside the scope of her cover. It also advised the Complainant that it had listened to the call between the Complainant and the Provider on **18 July 2017** and that she had not been told in that call that she would be covered for graphing but that she could get pre-authorisation for dental claims. The Provider states that the Complainant wanted to appeal the declinature which is something it cannot do pursuant to her policy. The Provider also stated in this phone call that there may be some cover for the Complainant under her separate health insurance policy and a request was sent to the healthcare team to contact the Complainant.

The Provider states that the healthcare team attempted to contact the Complainant unsuccessfully over the phone before issuing a letter to her on **2 October 2017** inviting her to contact them to discuss the matter further. This was responded to by letter from the Complainant dated **13 October 2017** stating that she wished to officially initiate the appeals/complaints procedure relating to the decision and requesting transcripts of telephone conversations with the Provider's staff. The Provider states that a member of its healthcare team responded to the Complainant on **27 October 2017**, outlining that an agent would be replying on its behalf.

The Provider (via its agent) contacted the Complainant on **24 October 2017** noting that it was handling the complaint and that it would be conducting a thorough investigation into the Complainant's concerns.

On **6 November 2017** the Provider wrote to the Complainant stating that on review, the initial assessor of the claim *"had declined the claim correctly as the sinus lift is not covered under the policy and I therefore cannot uphold your complaint"*. The letter also states that *"there is no evidence to suggest you were advised this treatment would be covered under the* [Provider] *dental policy and I therefore cannot uphold this element of your complaint"*. The letter also enclosed a CD containing a copy of the call recordings on **18 July 2017** and **27 September 2017**.

On **23 February 2018**, the Provider wrote to the Complainant stating that as part of the investigation into her formal complaint, a full review of the claim and an appeal were considered and that *"there will be no change to the decision to decline your appeal, as the treatment is not covered under the* [Provider's] *dental policy"*. This letter also stated that *"the list of exclusions on a policy is often exhaustive however if something is not mentioned in what is covered and not mentioned in the exclusions, it is not covered by the policy"*.

The Provider wrote to the Complainant again by letter dated **15 March 2018** stating its position again that *"there is no cover for this treatment under the* [Provider] *dental cover"* and referring to the terms and conditions of the Provider's dental plan including the identity of the administrator of the Provider's dental policy.

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On **23 November 2018**, the Provider submitted its formal response to this Office. It stated that

> *"… it is important to outline that policies of insurance contain various terms and conditions and specified treatments as outlined in the table of benefits and policy documentation. Policies cannot be expected to cover every eventuality, since to do so would make the level of cover prohibitively expensive. The sinus lift is not outlined in the table of benefits and therefore is not covered as per the general exclusions."*

The Provider went on to cite the general exclusions in the policy, which state:

> *"**5. General Exclusions***
> *Cover is not provided for the following:*
>
> *…*
>
> *3. Services or supplies which are not described in the benefits schedule of this Policy or which are specifically excluded under the Exclusions or General Exclusions;*
>
> *…*
>
> *23. Any Treatment not listed on the Table of Benefit"*

The Provider states that its chief dental officer has outlined that *"a sinus lift is usually done to place an implant in the upper posterior region where bone loss has occurred creating reduce* (sic) *bone height between the mouth and the floor of the maxillary sinus"*. The Provider then goes on to state that this is excluded for cover by reason of the fact that it comes within a definition of a prosthetic service and is not one of the stipulated prosthetic services which are covered under the policy.

The Provider also states that the sinus lift is one step in many, for rehabilitation treatment and would not be considered as per the policy definition in the emergency section of the policy. The Provider addresses the Complainant's complaint about the handling of the claim by stating that

> *"… there is no evidence of a deliberate effort to delay or add confusion…it is unfortunate that having received the final response letter into the appeal or* (sic) *her claim the complainant continued to pursue the matter. We have identified that the correspondence on the **04 December 2017** was not flagged correctly on the complaint system and as a result was not responded to until a further letter… However as the final response letter had been issued on the **06 November** clearly outlining the decision and next steps we are unclear why the complainant did not refer the matter to the Financial Services Ombudsman as the next step."*

The Provider also addresses the statement made in its letter dated **23 February 2018** that *"the list of exclusions on a policy is often exhaustive"* and sates that this was a typing error and should have read: "The list of exclusions on a policy is not exhaustive". The Provider states that the *"onus for listing exclusions does not rely on the principle of 'default' and this is clarified in section 3 and 23 of the exclusion section on the policy. The approach was to be more customer friendly rather than relying on quoting the stricter policy terms and conditions"*.

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The Provider states that it has *"no role in the complainant's health insurance cover"* and any questions in relation to same should be directed to the Complainant's health insurance provider. The Provider states that the evidence shows that the Provider's healthcare team wrote to the Complainant via letter dated **2 October 2017**, indicating its attempts to contact her and since then no further contact has been received by the healthcare team, from the Complainant.

The Provider also states that it is

> *"unsure why the complainant experienced difficulties in reviewing the calls as they were tested for clarity before being forwarded and were fully audible. Perhaps it may pertain to the relevant software available on the complainant's chosen device to play."*

The submission by the Complainant dated **9 January 2019**, resulted in the Provider ultimately confirming on **24 April 2019** that it did not wish to make any further submissions in the matter.

The Complaint for Adjudication

The primary complaint is that the Provider wrongfully failed to indemnify the Complainant's dental claim under her dental insurance policy, including failing to consider the emergency nature of the treatment and review the claim on this basis. There is a secondary complaint concerning the manner in which the Provider handled the complaint.

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.

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A Preliminary Decision was issued to the parties on 30 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 of that nature from the parties, within the period permitted, the final determination of this office is set out below.

I have carefully considered the terms and conditions of the Complainant's policy that are applicable to the assessment and payment of the claim in question. In particular I note section 3 which deals with emergency treatment:

> *"… for the immediate/temporary relief of severe pain, trauma, swelling or bleeding, prescriptions or protective restoration. Please note that this does not include treatments for rehabilitation or treatments already covered on this policy."*

Section 4 of the policy deals with major treatments and stipulates the types of prosthetic services which are and also are not covered. I also note general terms and conditions of the policy which state:

> *"**5. General Exclusions***
> *Cover is not provided for the following:*
>
> *…*
>
> *3. Services or supplies which are not described in the benefits schedule of this Policy or which are specifically excluded under the Exclusions or General Exclusions;*
>
> *…*
>
> *23. Any Treatment not listed on the Table of Benefit"*

I further note that the Provider states that its chief dental officer has outlined that

> *"a sinus lift is usually done to place an implant in the upper posterior region where bone loss has occurred creating reduce* (sic) *bone height between the mouth and the floor of the maxillary sinus"*.

The Provider then goes on to state that this is excluded for cover, by reason of the fact that it comes within a definition of a prosthetic service and is not one of the stipulated prosthetic services which are covered under the policy.

Taking all of the above terms of the policy into account, and on the basis of the Complainant's own description of her treatment, I accept that the Complainant's sinus lift operation did not constitute emergency treatment, given that it was part of an ongoing problem suffered by the Complainant and could fairly be said to be a part of a rehabilitation process. I also accept that the treatment was not described in the benefits schedule of the policy or listed on the table of benefit and therefore was not covered by the policy.

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I understand and appreciate the Complainant's point, that there is no definitive confirmation in the Provider's terms and conditions, that a sinus lift is excluded, however, I accept that it is neither reasonable nor possible for the Provider to have stated every single type of dental procedure within its policy and, furthermore, I note that the terms and conditions clearly state that if a procedure is not detailed on the schedule of benefits/the benefits table, then it will not be covered.

I appreciate that it was not convenient for the Complainant to have sought clarity from her dentist about the nature of the sinus lift procedure, given the nature and time pressures of the treatment required, but she would have been best advised to have contacted the Provider in advance of the procedure, to check whether the procedure would be covered under the terms of her insurance in place.

Accordingly, while I understand that the Complainant will be very disappointed with this position, I must accept that the Provider was entitled, under the terms and conditions of the Policy, to refuse to indemnify the Complainant for the cost of the sinus lift procedure.

The Complainant has raised a secondary complaint concerning the manner in which the Provider handled the complaint. In this regard, I note that the Provider has acknowledged, through its administrator, that there was *"poor customer service handling"* and that the correspondence from the Complainant received on **6 December 2017** was not flagged correctly on its system. I note that this letter (dated **4 December 2017)** was not responded to until **23 February 2018** despite follow up letters being sent on **24 January 2018** and **11 February 2018**. This is very disappointing.

I further note that the Provider's administrator caused great confusion in its handling of this complaint by stating in its letter dated **23 February 2018** that *"the list of exclusions on a policy is often exhaustive"*. This was not acknowledged as a typographical error until its submissions to this Office were furnished.

In a similar vein, it is disappointing that the Provider's response to the complaint contains clear inconsistencies suggestive of a lack of care in the preparation of the response. By way of example, on numerous occasions in its submissions to this Office, the Provider states that calls were made and letters were sent on dates in **2018,** when the hard copy evidence and documentation submitted to this Office clearly records that these communications occurred in **2017**.

It is unclear from the documents submitted to this Office whether the Complainant's claim was ever assessed under her separate health insurance policy. There was certainly a suggestion by representatives for the Provider that this could be a viable avenue for recompense for the Complainant. The Provider made it clear to the Complainant however that it has *"no role in the complainant's health insurance cover"* and any questions in relation to same should be directed to the complainant's health insurance provider. This is correct, though it is entirely understandable that the Complainant may have not immediately understood this, given the common use by both providers of the same element of recognisable branding.

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I note the Provider's administrator's enquiry whether the *"Complainant would avert the full decision if offered some recompense for the poor customer service handling"* in its letter dated **9 December 2018.** This was followed by an absence of clarity as to what it meant by this statement, when such clarity was requested by the Complainant, which served only to delay the adjudication process. Similarly, the administrator's response to the submission by the Complainant dated **9 January 2019** that it needed to refer back to the Provider in respect of the telephone conversations, before finally confirming on **24 April 2019** that it did not wish to make any further submissions in the matter, served only to delay the progress of the matter. This is disappointing, given the difficulties encountered by both the Complainant and this office, with the original audio evidence which was in fact utterly inaudible and which required full replacement during 2018.

I take the view that the Provider acted in breach of provision 2.1 of the Consumer Protection Code 2012 (as amended) ('the CPC') by not acting *"professionally in the best interest of its customers and the integrity of the market"* due to the various errors in how it dealt with the Complainant's complaint through its administrator. The Provider also breached provisions 2.2 of the CPC by failing to act with *"due skill, care and diligence in the best interests"* of the Complainant. Furthermore, the Provider has breached provision 2.8 of the CPC by failing to correct the typographical error in respect of the letter of **23 February 2018** *"speedily"* and provision 4.1 of the CPC by failing to ensure that the information it provided to the Complainant was *"clear, accurate and up to date"*.

Having regard to the particular circumstances of this case, in particular the failings on the part of the Provider in its handling of the Complainant's claim and subsequent complaint, consider it appropriate to partially uphold this complaint and to direct the Provider to make a compensatory payment of €750 (seven hundred and fifty euro) 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/s in the sum of €750, 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.***

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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

21 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.