An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0074
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Complaint handling (Consumer Protection Code)
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The First Complainant has a health insurance policy with the Provider. On **3 April 2018** the First Complainant attended the Emergency Department of a private hospital in Dublin and was admitted for 11 nights. The First Complainant believed that the cost for her admission was covered by her policy. The First Complainant subsequently received a bill for €11,000 from the hospital in respect of her 11 night stay and was advised by the Provider that this was not covered by her policy.

The Complainants' Case

The First Complainant states that she was admitted to a private hospital in Dublin on **3 April 2018** for 11 nights. The First Complainant states that on check-in she was informed in the Emergency Department that she would have to pay €180 plus €680 for any subsequent tests. She states that there was an issue with her details not being available on the hospital's computer system and the hospital then contacted the Provider by phone to confirm she was on the policy. The First Complainant further states that when she was driving to the Emergency Department *"… I checked on my phone that my plan (sic) covered on the [Provider's] website it said I was."* The First Complainant states that on **20 April 2018** she received an invoice from the hospital for €11,000. She then contacted the Provider and was informed *"… I was not covered until my renewal date in September 2018."* In resolution of this complaint, the First Complainant wants the Provider to discharge her hospital bill.

The Provider's Case

The Provider states that as at **3 April 2018** the First Complainant was insured under the policy.

The Table of Cover which issued at renewal on **13 September 2017** shows, at that point in time, the policy provided inpatient cover for high-tech hospitals in one hospital. This was not the hospital attended by the First Complainant. The Provider states that the only cover for high-tech hospitals, like the one attended by the First Complainant, was for day cases and listed cardiac/special procedures.

In respect of the telephone conversation that took place between the hospital and the Provider on **3 April 2018**, the Provider states that *"[d]espite our agent offering to provide further information to the [Hospital], there was no discussion of the cover available under [the First Complainant's] plan. Only plan type and information on waiting periods was sought by the hospital."* The Provider further submits that *"[i]t is important to note that the information provided to the [Hospital] was correct in that [the First Complainant] was covered on the [policy] and was not serving any waiting periods. We offered to provide more information but they did not ask for anything further."* The Provider points out that it did not have any details of the treatment that the First Complainant received during her admission as a claim was not submitted by the hospital nor did the First Complainant contact it to confirm cover. The Provider states that the only details of the treatment the First Complainant received were provided verbally during a telephone conversation on **23 April 2018**.

The Provider submits that if the First Complainant was unsure as to the type of cover for the hospital she attended, a full list of the hospitals covered by the policy was available in its Membership Handbook. This handbook clearly shows that the hospital attended by the First Complainant was a high-tech hospital. Addressing the First Complainant's point that she checked her policy on the Provider's website on her way to the hospital, the Provider states that the First Complainant would have had access to the most recent version of its Table of Cover which would have shown that there was 50% cover for inpatient stays in the hospital attended by the First Complainant. The Provider submits that the webpage also clearly states that existing members should check their own Table of Cover that is located in the online members' area in order to confirm cover. Referring to the telephone conversation that took place between the First Complainant and the Provider on **23 April 2018**, the Provider states that the First Complainant made the following comment: *"… now I never checked this 'til I was just on hold there with you and it says that the plan, you know on the website, … that 50% cover for semi and private rooms in [Hospital] …"* The Provider submits that this would indicate that the First Complainant did not visit its website to check her cover while she was on her way to hospital on **3 April 2018**.

The Provider states that when a member is admitted as an inpatient to a hospital which is covered under its private health insurance policy the bill is settled by direct settlement. The Provider refers to page 10 of its **June 2017** handbook which sets out how inpatient benefits are claimed.

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The Provider states that the hospital did not submit a bill to it in respect of the First Complainant's admission therefore, it did not issue any claims correspondence. The Provider states that the accommodation costs were sent directly to the First Complainant by the hospital.

The Provider states that on **23 April 2018**, the First Complainant contacted it to query what reimbursement could be claimed under the policy. The Provider states that the First Complainant was advised that there could be no reimbursement as inpatient stays in that hospital were not covered under her policy.

The Provider submits that the contract between it and the First Complainant is based on a number of documents (the Membership Handbook, the Membership Certificate and the Table of Cover). These documents are issued to each policyholder at inception and each renewal. The documentation issued to the First Complainant following renewal in **September 2017** shows that there was no cover included on her policy for inpatient treatment at the hospital she attended with the exception of day cases and listed cardiac/special procedures.

On **1 November 2017**, the Provider advises that it made changes to 14 of its policies. One of the changes was to include *"some cover"* for inpatient stays in private and semi-private rooms in the hospital attended by the First Complainant. The Provider states that this additional cover was only available to new and renewing members. For the First Complainant, this meant that when her policy renewed in **September 2018**, she would be entitled to the increased benefits.

Prior to the First Complainant's admission to hospital on **3 April 2018**, the Provider states that it did not have any contact with her to discuss the cover available under her policy. During the telephone conversation that took place between the Provider and the First Complainant on **23 April 2018**, the Provider states that she was advised her benefits under the policy had been updated since her last renewal in **September 2017** and that these benefits would be available to her on her next renewal. The Provider states that the contract entered into with the First Complainant in **September 2017** did not provide cover for inpatient stays at the hospital. The First Complainant entered into a new contract with the Provider in **September 2018** which provided 50% cover for inpatient stays in private and semi-private rooms in the hospital attended by the First Complainant.

The Complaint for Adjudication

The complaint is that the Provider wrongly and/or unreasonably refused to reimburse the First Complainant for inpatient costs incurred in respect of an 11 night stay in a private hospital.

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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 16 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, I set out below my final determination.

Policy Renewal

The Second Complainant received a policy renewal letter on **11 September 2017** which states:

> *"Thank you for renewing your health insurance policy. …*
>
> *We have enclosed some important information which makes up your policy contract. Included is your:*
>
> - *Membership Certificate – your policy and premium details*
> - *Table of Cover – the benefits covered on your plan*
> - *Membership handbook – the terms and conditions of your policy*

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- *Product suitability statement – outlining why this plan is considered to be most appropriate for you*

Please read these documents, paying close attention to the benefits and hospitals listed, to ensure that your needs are covered. …"

Membership Certificate

On the policy's Membership Certificate, it states that the First Complainant's cover under the policy runs from **13 September 2017** to **12 September 2018**.

Table of Cover

The Table of Cover enclosed in the renewal letter states as follows:

*"**Table of Cover effective from September 13th 2017***

This table of cover must be read in conjunction with your member certificate and Health Plans membership handbook effective from June 2017.

The hospitals and treatment centres covered on this plan are set out in List 1 in Part 12 of your Health Plans membership handbook.

In Patient Benefits

Hospital Cover

…

High Tech Hospitals

Semi Private Room	*Covered in [Hospital] only …*
Private Room	*Covered in [Hospital] only …*
Day Case	*Covered subject to €75 excess per claim*
Listed Cardiac Procedures[(1)]	*…*
Listed Special Procedures[(1)]	*…"*

Membership Handbook

Section 1 of the Handbook states:

"Your contract with us is made up of the following:

> Your Membership Handbook

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> …

> Your Membership Certificate, which sets out your plan, your membership number, your commencement date and your next renewal date

> Your Table of Cover, which outlines the benefits in your plan and which List of Medical Facilities applies to your plan

> The Schedule of Benefits, which sets out the treatments and procedures we cover …

Understanding Your Cover

…

In fact we always advise you to check your cover with us before undergoing any procedure or treatment or being admitted to a medical facility."

Section 1 also deals with policy changes and states on page 4:

"1. Changes to you plan on renewal

From time to time we alter the benefits available under our plans. If we alter the plan that you are on, the changes will not affect you during your policy year but will apply if you purchase that plan for your next policy year. Therefore, it is important to remember that where you renew on the same plan the benefits may not be the same as they were in your previous policy year."

Section 12 of the Handbook contains the Lists of Medical Facilities. The hospital attended by the First Complainant is listed as a high-tech hospital.

While the policy renewal letter of **11 September 2017**, referred to above, was addressed to the Second Complainant, the First Complainant, who resides at the same address, has furnished these documents to this Office in support of her complaint. I further note that the First Named Complainant does not dispute having received these documents.

Analysis

The First Complainant attended hospital on **3 April 2018**. The First Complainant was admitted to this hospital for 11 nights. During her admission the First Complainant spent 2 nights in a semi-private room and 9 nights in a private room. The First Complainant received an invoice dated **19 April 2018** for €11,000 in respect of her 11 night stay.

Prior to her admission to hospital, the First Complainant did not contact the Provider to ascertain whether or not her policy covered inpatient care at that hospital. Furthermore, the evidence in this complaint suggests that the First Complainant did not refer to or consult her specific policy documentation prior to attending hospital.

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Recordings of telephone conversations between the First Complainant and the Provider have been provided in evidence, I have considered he content of these calls. During a telephone call to the Provider which took place on **23 April 2018**, the First Complainant states:

> *"I didn't realise that my plan didn't cover me towards any of the costs. I looked this up ya know and it does say the [Hospital] is listed on my plan as one of the hospitals … I'm just reading here on the website and for my plan, now I never checked this til I was just on hold there with you and it says that the plan … 50% cover for private and semi-private rooms in the [Hospital] …"*

During this call, the First Complainant recounts that she was advised on **3 April 2018** by a member of staff in the hospital as to the charges that she would be responsible for and in the event that she was admitted she would be covered by her policy but subject to a €600 excess. This was not the cover offered by the First Complainant's policy.

The Provider received a telephone call from this hospital on **3 April 2018**. During this call the Provider's agent advised the hospital's representative of the name of the First Complainant's plan. The Provider's agent then enquired as to whether details of the First Complainant's cover were required but was advised that the hospital's representative could check this information. The principal enquiry from the hospital was whether the First Complainant was subject to any waiting periods under the policy.

The First Complainant's policy covered the period of **13 September 2017** to **12 September 2018**. The hospital attended by the First Complainant was a high-tech hospital within the meaning of the policy. Referring to the Table of Cover, at the time of the First Complainant's admission to hospital, the inpatient benefits associated with her policy did not cover her for private and semi-private rooms.

The benefits offered by the First Complainant's policy changed during her period of cover to provide increased benefits in respect of the hospital attended by her in **April 2018**. However, as the First Complainant's policy makes clear, any changes to the policy do not take effect until the next policy renewal. The First Complainant's policy was not renewed prior to her admission to hospital, therefore, she was not entitled to the increased benefits offered by the Provider's new policy until her renewal date in **September 2018**.

While I understand that this is a difficult situation for the Complainant, I cannot hold the Provider responsible, given the clarity of the policy. It is most unfortunate that neither the Complainant nor the hospital checked with the Provider as to whether the Complainant's policy covered her for the hospital concerned.

Given that, at the time the First Complainant was admitted to hospital, her policy did not cover her for the costs of private and semi-private rooms in that hospital, I do not uphold this complaint.

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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.

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

7 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.