An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0144
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Rejection of claim
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The First Complainant renewed his health insurance policy with the Provider on **8 April 2017**. The Second Complainant, his wife, is listed as an insured person on this policy.

The Complainants' Case

The First Complainant states, *"In early 2013,* [the Second Complainant] *suffered a virus which affected her hearing. Thankfully the hearing came back after a few days but it left a legacy of Tinnitus"*. As a result, the Second Complainant later had specialist hearing aids fitted at the Tinnitus Clinic, Harley Street, London in February 2015.

The First Complainant notes that two years later these *"hearing aids were due for renewal and upgrading"* and following research on the matter, the Second Complainant purchased hearing aids *"specific to alleviating tinnitus"* on 7 March 2018 from a named supplier in Ireland. The Second Complainant confirms that *"she gets relief from the tinnitus when she wears the hearing aids"*.

The Provider, however, declined the Complainants' ensuing claim relating to this purchase as it advised that the terms and conditions of the First Complainant's health insurance policy specifically state that there is no cover in respect of the cost of hearing aids.

The First Complainant submits that *"tinnitus is an unpleasant long term disability and should be treated as such by the* [Provider]*"* and notes that the Provider previously *"settled a claim for €5,000 in 2016 in relation to services provided for* [the Second Complainant] *by the*

Tinnitus Clinic in Harley Street, London. The €5,000 covered approximately 50% of the overall costs incurred at the time".
The Complainants note that the hearing aids purchased on 7 March 2018 cost €5,800, and that they received a €1,000 grant from the Department of Social Protection, as well as a €960 tax refund. In this regard, the First Complainant advises that *"a 50% refund of net cost* [of €3,840] *would be acceptable.* [The Provider] *has refused this based on its rules. We take out insurance to cover the unexpected and* [the Second Complainant's] *case fits that category"*.

The Provider's Case

Provider records indicate that the First Complainant renewed his health insurance policy with the Provider on 8 April 2017. The Second Complainant, his wife, who is listed as an insured person on the policy, purchased hearing aids on **7 March 2018** at a cost of €5,800. The Provider is satisfied that it correctly declined the resultant claim in respect of this purchase as the First Complainant's policy provides no cover in respect of the cost of hearing aids. In this regard, Rule 7, 'Exclusions', of the applicable Policy Terms and Conditions provides:

> *"In addition to cover limitations mentioned elsewhere, we will not pay benefits for any of the following:*
> *(e) Hearing and sight tests, hearing aids, spectacles, contact lenses (except those specified in your Table of Benefits), dentures, or orthodontic appliances (such as braces)"*.

The Provider notes that the Complainants did not contact it immediately prior to purchasing the hearing aids to query cover. However, the Provider did previously confirm to the First Complainant by telephone in **February 2016** at the time of another dispute that hearing aids were not eligible for benefit.

In that regard, with respect to the previous payment of €5,000 that it made in relation to the Second Complainant's therapeutic procedure at the Tinnitus Clinic, Harley Street, London in February 2015, which involved the insertion of a neurostimulator, the Provider clarifies that its contribution on that occasion was on a once off ex-gratia basis, based on the specific circumstances of the case at that time, which related to a treatment abroad claim and has no connection with the current dispute. The Provider is satisfied that the Complainants were aware that this was a once off ex-gratia payment and that it was made clear to them that the treatment obtained abroad in February 2015 was not eligible for benefit under the terms of cover and also that the hearing aid/device purchased at that time was also excluded from benefit.

The First Complainant's health insurance contract renews annually and the terms and conditions at the time of the claim apply. The Provider is satisfied that the Complainants were aware that hearing aids are specifically excluded under the terms of cover and that no expectation of cover was created as the settlement reached in 2016 was made on an exceptional basis. As the hearing aids purchased by the Second Complainant on 7 March

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2018 were ineligible for benefit, in accordance with the policy terms and conditions applicable from 8 April 2017 to 7 April 2018, the Provider is satisfied that it correctly declined the Complainants' claim.

The Complaint for Adjudication

The Complainants' complaint is that the Provider wrongly and unfairly declined the Complainants' health insurance claim in respect of the Second Complainant's hearing aids.

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 26 March 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.

The First Complainant renewed his health insurance policy with the Provider on 8 April 2017. The Second Complainant, his wife, who is listed as an insured person on the policy, purchased hearing aids in Ireland on 7 March 2018 at a cost of €5,800. The Provider declined the resultant claim in respect of this purchase as it concluded that the First Complainant's policy provides no cover in respect of the cost of hearing aids. In this regard, the Complainants' complaint is that the Provider wrongly and unfairly declined their health insurance claim in respect of the Second Complainant's hearing aids.

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Health insurance policies, like all insurance policies, do not provide cover for every eventuality; rather the cover will be subject to the terms, conditions, endorsements and exclusions set out in the policy documentation. Rule 7, '**Exclusions**', of the Policy Terms and Conditions applicable at the time the Second Complainant purchased her hearing aids on 7 March 2018 provides, *inter alia*, at pg. 16, as follows:

> *"In addition to cover limitations mentioned elsewhere, we will not pay benefits for any of the following: …*
>
> *(e) Hearing and sight tests, **hearing aids**, spectacles, contact lenses (except those specified in your Table of Benefits), dentures, or orthodontic appliances (such as braces)"*.
>
> [My emphasis]

I am therefore satisfied that the Provider declined the claim in respect of the Second Complainant's hearing aids in accordance with the terms and conditions of the First Complainant's health insurance policy.

The Complainants note that the Provider previously *"settled a claim for €5,000 in 2016 in relation to services provided for* [the Second Complainant] *by the Tinnitus Clinic in Harley Street, London. The €5,000 covered approximately 50% of the overall costs incurred at the time"*. In this regard, the Provider has advised that this payment was made on a once off ex-gratia basis, based on the specific circumstances of the case at that time, which related to a treatment abroad claim and has no connection with the current dispute.

I note from the documentary evidence before me that in its email to the First Complainant at 14:34 on **11 February 2016**, the Provider advised:

> *"As discussed, in an effort to resolve this matter to* [the Complainants'] *satisfaction given the circumstances and in light of your loyal membership,* [the Provider] *is pleased to be in a position to offer you a once off ex-gratia payment of* [€]*5,000 in full and final settlement of this dispute"*.
>
> [My emphasis]

Having listened to the recordings of the telephone calls between the First Complainant and the Provider on 6 February and 7 February 2016 in relation to this previous dispute, I am satisfied that the Provider made it clear to the First Complainant that the payment offered and made was a *"once off ex-gratia"* payment and was made *"without precedent"*.

In addition, I note that this previous dispute concerned hearing-related treatment that the Second Complainant obtained and hearing-related devices that she purchased in London in February 2015. I am satisfied from the evidence before me that the Complainants' claim at that time and the Provider's later once off ex-gratia contribution, were made under the treatment abroad element of the Complainants' policy cover, and therefore that earlier payment is not directly relevant to the complaint at hand relating to the Second Complainant's purchase of hearing aids in Ireland. In this regard, I am satisfied that the terms

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and conditions of the Complainants' policy quoted above, clearly exclude cover in respect of hearing aids.

Furthermore, it was always open to the Complainants to telephone the Provider prior to purchasing hearing aids in Ireland to confirm what cover, if any, was available in respect of such aids and I am of the opinion, particularly in light of the circumstances of their previous claim regarding the hearing treatment the Second Complainant obtained and hearing devices she purchased abroad in February 2015, that it would have been reasonable and prudent of them to have done so.

It is my Decision therefore, on the evidence before me, that this complaint cannot 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
DEPUTY FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

24 April 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.