An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0235
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Disagreement regarding Settlement amount offered
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainants hold a health insurance policy with the Provider.

The Complainants' Case

In his letter to this Office dated **15 May 2019**, the First Complainant sets out the complaint, as follows:

> *"I wrote to the* [Provider] *29th of August 2018 advising that I had been diagnosed as needing a full hip replacement.* [The Provider] *replied* [by email] *on 7th of September 2018 and informed me that* [Mr D.]*, Consultant Orthopaedic Surgeon is fully participating with* [the Provider] *and his fees are covered in full.*
>
> *In addition,* [the Provider] *stated that "we have a direct payment facility with* [named] *Hospital" and "hospital and professional charges will be billed directly to* [the Provider]*".*
>
> *I presumed from the above that as* [Mr D.] *and* [named] *Hospital are participating with* [the Provider]*, that the entire procedure including consultant and hospital charges would be covered in full by* [the Provider]*.*
>
> *If I had thought that there was any doubt as to whether I wasn't covered in full by my…policy I would have made further enquiries with both* [the Provider] *and/or* [named] *Hospital as to the likely charges.*

Furthermore if I was in any doubt that I wasn't fully covered I could have made enquiries if I could have had the procedure carried out in the [Hospital B] *or with some other medical institution …*

The procedure was carried out on the 14th of November 2018 ...

On the 17th of April 2019 I was shocked and dismayed to receive a bill from [named] *Hospital seeking €3,846.57 (a 40% shortfall of the cost of the hospital bill). This was the first I heard of any shortfall from* [the Provider] *…*

On the 23rd April 2019 I contacted [the Provider] *to clarify the position and their response to me (24th April 2019) was extremely unclear. Following further communication with* [the Provider] *it was confirmed to me on the 25th of April that I wold be liable for the above mentioned shortfall.*

Under the circumstances given the [Provider's] *correspondence was extremely unclear and led me to believe that the benefit under my…policy would be accepted as full settlement for the procedure at the* [named] *Hospital under* [Mr D.]*, I requested (30th April 2019) that* [the Provider] *would cover the outstanding charges.*

[The Provider] *responded to me on the 8th May 2019 advising that* [it] *is not in a position to allow any further benefit towards the shortfall to* [named] *Hospital.*

As well as not being in a financial potion to discharge this debt/shortfall…I am extremely annoyed with how [the Provider] *have dealt with this while situation"*.

As a result, the First Complainant is *"seeking* [the Provider] *to make full payment of fees due to* [named] *Hospital,* [location]*"*.

The Provider's Case

Provider records indicate that on **7 September 2018**, the First Complainant advised by email that his proposed hip replacement procedure (code 3660) was to be performed by Consultant Orthopaedic Surgeon Mr D. at the [named] Hospital. The Provider's email reply of 7 September 2018 confirmed that procedure code 3660 is a listed inpatient procedure and that the Complainants' health insurance policy provides 60% cover for this procedure in the [named] Hospital.

In addition, it was noted in this email that Consultant Mr D. is fully participating with the Provider, meaning that he has agreed to accept Provider benefit as full settlement of his fees for carrying out the procedure. It was also outlined that the Provider has a direct payment facility with the [named] Hospital, and that the First Complainant would be required to sign a claim form on admission and the hospital and professional charges would be billed directly to the Provider.

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The Provider later received a claim in respect of the First Complainant's admission to the [named] Hospital, from 14 November to 17 November 2018. This claim was assessed on 29 November 2018, in accordance with the benefit available under the Complainants' policy.

In accordance with Section 1(D) of the Table of Benefits, the hospital charges were allowed at 60%, whilst the professional fees were allowed in full as per Section 2(A) of this Table of Benefits. As a result, the First Complainant is liable for the 40% shortfall in respect of the hospital charges.

Accordingly, the Provider is satisfied that its email of 7 September 2018 was clear as to the level of cover available in respect of the First Complainant's proposed hospitalisation and procedure and that it correctly assessed the resultant claim in accordance with the terms and conditions of the Complainants' health insurance policy.

The Complaint for Adjudication

The complaint is that the Provider failed to fully admit the First Complainant's claim in respect of his hospital admission in November 2018, in circumstances where he had understood from the Provider's email of 7 September 2018 that the Complainants' health insurance policy would provide him with full cover in respect of all charges in relation to this admission.

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 18 June 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.

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In the absence of additional submissions from the parties, within the period permitted, the final determination of this office is set out below.

The complaint at hand is that the Provider only paid part of the First Complainant's claim in respect of his hospital admission in November 2018, in circumstances where he had understood from the Provider's email of 7 September 2018 that the Complainants' health insurance policy would provide him with full cover in respect of all charges in relation to this admission.

The First Complainant was admitted to the [named] Hospital, from 14 November to 17 November 2018 under the care of Consultant Orthopaedic Surgeon Mr D., where he underwent a hip replacement. I note that the Provider paid benefit in the amount of €2,086.75 in respect of the consultant fees, representing 100% of this charge, and €5,994.85 in respect of the hospital charges, representing 60% of this charge. As a result, the First Complainant later received an invoice from the [named] Hospital, dated 17 April 2019 in the amount of €3,846.57.

I note that the First Complainant confirmed by email to the Provider on 7 September 2018 that he was intending to undergo a hip replacement procedure, code 3660, under the care of Consultant Orthopaedic Surgeon Dr D. at the [named] Hospital. In this regard, I note that the Provider replied to the First Complainant by email at 11:35 on 7 September 2018, as follows:

> *"Thank you for contacting* [the Provider].
>
> *I wish to confirm that procedure code 3660 is a listed inpatient procedure with* [the Provider]. *Your…policy provides 60% cover for this procedure in the* [named] *Hospital,* [location].
>
> [My emphasis]
>
> [Mr D.] *is fully participating with* [the Provider]. *This means that he has agreed to accept our benefit as full settlement of his fees for carrying out the procedure.*
>
> *We have a direct payment facility with the* [named] *Hospital,* [location]. *You will be required to sign a claim form on admission and the hospital and professional charges will be billed directly to* [the Provider].
>
> *Following the assessment of your claim, we will issue a benefit statement to you. This document outlines the services that were paid for on your behalf to the hospital and doctors involved with your procedure. Should you notice any discrepancies with this document, we would ask that you contact us directly so that we can report any issues to our Special Investigation Unit.*
>
> *All claims are assessed in accordance with the Terms and Conditions of the policy for the renewal period you are claiming for and based on the medical information provided. A copy of the Terms and Conditions is available on the following link:*

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[LINK INSERTED]

… If you need any further information, you can reply to this email or alternatively please call us …"

I note that the First Complainant says that he understood from this email, that the Complainants' health insurance policy would provide him with full cover in respect of all charges in relation to this admission.

In this regard, in his email to this Office at 11:25 on 9 March 2020, the First Complainant submits, *inter alia*, as follows:

"I presumed…that as [Mr D.] *and* [named] *Hospital are participating with* [the Provider]*, that the entire procedure including consultant and hospital charges would be covered in full by* [the Provider]*.*

If I had any doubt in my mind that I would be responsible for 40% of the procedure I would have made enquires on having the operation/procedure at another hospital e.g. [Hospital B].

In the circumstances I think that the initial reply from [the Provider] (that is, the above email of 7 September 2018) *was unclear at best and also misleading. I certainly interpreted that the Consultant and hospital fees would be covered in full"*.

In this regard, having read the Provider's email of 7 September 2018, I note that the opening paragraph clearly states that the Complainants' health insurance policy provides 60% cover for the First Complainant's procedure in the [named] Hospital,

"Your…policy provides ***60% cover for this procedure*** *in the* [named] *Hospital,* [location]*"* .

[emphasis added]

This email then states that as a participating consultant, Dr D.

"has agreed to accept our benefit ***as full settlement of his fees*** *for carrying out the procedure".*

[emphasis added]

I am satisfied that the reference to *"full settlement"* is clearly only in relation to *"his fees"*, that is, the consultant's fees for carrying out the hip replacement procedure, which is separate to the hospital charges, for which the Complainants' policy provides only 60% cover, as clearly stated in the opening paragraph.

In addition, I note that the applicable Table of Benefits provides, *inter alia*, as follows:

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*'**Section 1 – Hospital charges** …*

D *Specified hip, knee & shoulder joint replacement procedures (herein referred to as Orthopaedic procedures) & specified Ophthalmic procedures – contact us for details of these*

Private 1, 2 & 3 hospitals

- *Day care, side room, semi-private & private accommodation* ***Benefit*** *60%*

…

Section 2 – Consultants' fees/GP procedures

A *In-patient treatment, day-care/side room/out-patient & GP procedures*

- *Participating consultant/GP* ***Benefit*** *Full cover*
- *Non-participating consultant/GP* ***Benefit*** *Standard benefit".*

It is my opinion that the Provider correctly advised the First Complainant in its email of 7 September 2018 as to the level of cover that would apply to his then pending hip replacement procedure. I also accept that it then correctly assessed the claim in respect of this procedure, in accordance with the terms and conditions of the Complainants' health insurance policy and paid 60% of the hospital bill.

Accordingly, I take the view on the evidence before me that the Provider acted correctly, and it is my Decision therefore, 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

10 July 2020

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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.