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| **Decision Ref:** | 2020-0347 |
| **Sector:** | Insurance |
| **Product / Service:** | Private Health Insurance |
| **Conduct(s) complained of:** | Rejection of claim<br>Claim handling delays or issues |
| **Outcome:** | Rejected |

## LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint concerns the declinature of the Complainant's claim under a health insurance policy held with the Provider.

### The Complainant's Case

The Complainant was scheduled for a medical procedure at a private hospital (Hospital B) on **29 January 2019**. The Complainant states that the private hospital was chosen by his surgeon due to the facilities complementing the necessary procedure. The Complainant notes that, because a similar surgery in another hospital *“was fully covered by my health insurance nobody doubted that I was fully insured”*. The Complainant submits that he was informed four days before the procedure that he was not insured.

The Complainant states that the surgery was urgent and being admitted to another hospital where he was insured for the procedure would take time. The Complainant therefore chose to attend the private hospital as scheduled and paid €19,510 in cash for the surgery, noting that the private hospital has since *“issued a revised invoice seeking a further €3,290”*.

The Complainant states that *“I now understand that [private hospital] is deemed High Tec* (sic) *and I was not covered there”*, but he asks that the Provider pay the price of a prosthesis, as the Complainant contends that this would have been a cost that would have been claimable if the Complainant had attended a hospital covered by this policy. The Complainant says that *“I am being victimised”* because his surgeon or the staff of the private hospital had not “*checked my insurance status until it was too late”.*

The Complainant wants the Provider to cover the amount that would have been covered if he had attended a hospital that was available under his policy, or the average cost of same.

**The Provider's Case**

The Provider states that the procedure took place in a hospital that is not covered under the terms of the policy. It notes that the policy documentation clearly sets out the hospitals that are covered. It further notes that in **March 2017** the Complainant had already been advised that this particular hospital was not covered under his policy, in the context of another procedure.

The Provider noted that the private hospital contacted it on **22 January 2019** to verify the Complainant's membership and policy type. The Provider states that the Complainant contacted it on **25 January 2019**, informing it that the private hospital had contacted the Complainant to advise that he would not be covered for the procedure.

The Provider notes that its representative *"confirmed with you that the [private hospital] was correct, that your current plan does not provide cover in this hospital".*

The Provider contends that this representative also confirmed that the Complainant's surgeon worked out of an alternative hospital that the Complainant would be covered for, but the Complainant nevertheless went ahead with the surgery in the hospital where his cover did not apply.

The Provider states that it received the claim on **13 March 2019**, and *"upon immediate review of the claim our claims processors noted that you do not have cover for the [private hospital]"* and *"the claim was declined in full on the 21st March 2019, and letters confirming same were issued to you and the hospital".*

The Provider's position is that it has correctly declined the claim as the procedure was not covered under the policy in the hospital where it took place.

**The Complaint for Adjudication**

The complaint is that the Provider is wrongfully failing to make a partial payment towards the medical costs incurred by the Complainant in January 2019.

**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.

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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 **16 September 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 Complainant has held a health insurance policy with the Provider since **2007**. Policy documentation provided to him on renewal each year, sets out the level of cover held.

**During 2017** the Complainant underwent knee replacement surgery at Hospital A, for which he benefitted from full cover (subject to an excess). I note that prior to the 2017 surgery, the Complainant was advised by the Provider that his policy did not provide cover to him for Hospital B**.**

His treatment bills for Hospital A were covered by the Provider without, it appears, any issues. **During 2018** the Complainant had to undergo further knee surgery at Hospital A. Again, his treatment bills were covered by the Provider without any issues.

However, the surgery itself was not a success and the Complainant came under the care of another surgeon who advised that he required further surgery. This surgery was scheduled for **29 January 2019** at Hospital B.

On **22 January 2019** Hospital B contacted the Provider to verify that his policy would cover the proposed treatment. The Provider advised the hospital and the hospital in turn, informed the Complainant that he would not be covered by the Provider for this treatment in Hospital B.

On **25 January 2019** the Complainant contacted the Provider and the Provider confirmed to him that he would not be covered for the proposed treatment at Hospital B, that was scheduled to take place a few days later. The Complainant was advised that the surgeon in question also operated out of another hospital, Hospital C, and his policy would cover him for treatment if it took place there.

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On **28 January 2019** the Complainant's surgeon confirmed to him by letter that an appointment was available for him at Hospital C for 10 April 2019 (and that he would be on a waiting list for any cancellations in the intervening period).

The Complainant was in considerable pain. It appears that the 2018 procedure was only a stopgap measure and further treatment was needed urgently. Accordingly, the Complainant chose to go ahead with the surgery in Hospital B on 29 January 2019, as planned.

I note that the policy terms in force at the time of the procedure in January 2019 are not materially different from the terms that were in force since February 2017, when he had begun this particular policy through a broker.
Policy terms were provided to the Complainant each year at the end of January/beginning of February in a renewal pack, which includes: a membership certificate; a table of cover; a membership handbook; and a product suitability statement.

The table of cover for 2018 and for 2019 both contain the following statement:

> ***"This table of cover must be read in conjunction with your member certificate and Health Plans membership handbook effective from January 2019. The hospitals and treatment centres covered on this plan are set out in List 3 in Part 12 of your Health Plans membership handbook"***.

The membership handbooks for 2018 and 2019 both contain the following statement, under the heading *"**UNDERSTANDING YOUR COVER**"*:

> *"Health insurance can be difficult to understand so to help you check your cover we have set out a checklist below. We understand that it may be difficult for you to figure out whether you are covered yourself so if you're in any way unsure, please call us on [number] and we'll walk you through it. In fact we would always advise you to check your cover with us before undergoing any procedure or treatment or being admitted to a medical facility. When checking your cover with us you will need to tell us where you intend to have the procedure or treatment performed; the name of your health care provider and the procedure/treatment code. You can get this information from your health care provider."*

The checklist referred to contains the following item:

| ***What to look for*** | ***Where to check*** |
|---|---|
| *If you are being admitted to a medical facility, is it included in the Lists of Medical Facilities covered under your plan?* | *Your membership handbook* |

On the same page, under the heading "MEMBERSHIP HANDBOOK", the following information is set out:

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> *"Section 12 of this Membership Handbook contains tables which show the medical facilities that are covered under our plans."*

Under the heading "EXCLUSIONS FROM YOUR COVER", the following is set out:

> *"We do not cover the following...*
>
> *... Any costs incurred in a medical facility that is not covered under your plan."*

A list of medical facilities is set out at section 12 of the Membership Handbook. There are 4 lists, numbered 1, 2, 3 and 4. As outlined in the table of cover, List 3 is the applicable list for the Complainant's level of cover. I note that Hospitals A and C are "Covered" but Hospital B (where the Complainant underwent his surgery in January 2019) is not covered.

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. In this regard, the policy documentation provides detailed information about what is and what is not covered under the policy. It also advises customers to contact the Provider if they are in any doubt about their cover.

In this case, the Complainant's hospital and the Complainant himself contacted the Provider in advance of the procedure and the Provider advised that the surgery at Hospital B would not be covered. There can be no confusion about this, and the Complainant has indeed accepted that he received this information.

The Complainant submits that, since he was covered for treatment at Hospital A, which he describes as *"5 star"* or the *"creme de la creme"* of all private hospitals, it was reasonable for him to assume that he would be covered in any other, older, hospitals. His position is that, whilst accepting that his policy did not cover treatment at Hospital B and accepting that he was told this in advance of undergoing the surgery, the Provider ought nevertheless to pay out the level of cover that it would have had to pay, if he had undergone the treatment at a hospital for which the policy did in fact provide cover.

Although the Complainant also blames staff at hospital B for not checking his insurance status until it was *"too late"*, such matters are not within the jurisdiction of this Office. Whilst I fully appreciate the Complainant's circumstances, in that he felt that he was in need of urgent intervention, he received accurate advice about the limits of his cover, and he chose to go ahead with the surgery anyway instead of waiting until April to have the procedure in a facility where he was covered. A policy of insurance however, does not permit a policyholder to claim benefits other than in accordance with the terms of the policy. This is a fundamental principle of insurance.

I note that in 2017 the Complainant had previously been advised that he had no cover for Hospital B. In 2019, having been told in clear terms (in addition to it being set out clearly in the policy documentation) that he was not covered, he elected to go ahead with the surgery anyway.

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The Complainant is not however entitled to require that the Provider pay out funds equivalent to what he would have been covered for, had he received treatment in a facility covered by his policy.

The Complainant has taken issue with the font size of the policy documentation. I am satisfied that the policy is legible in the format provided, and I note that if a customer cannot read it in the format provided, the documentation is also available online where a zoom function is available.

Although the Complainant's claim for the surgery was declined, I note that the Provider paid out €5,548.68 for home care to a third party provider for one week of home care in February 2019. The Provider has clarified that this was paid out in error, as the policy only covers home care after treatment at a medical facility which is covered under the policy. However, the Provider has confirmed that this bill will remain paid by it. The Complainant believes that this strengthens his contention that the Provider ought to pay for the January surgery and treatment too. I do not however accept this. The Complainant has incorrectly received over €5,000.00 in benefits that he was not entitled to under the policy and the Provider is not seeking to reclaim those monies. This does not however extend the Complainant's cover to Hospital B, which is not one of the hospitals covered by his policy.

I am satisfied on the evidence before me, that the Provider gave the Complainant notice in advance of his proceeding with the treatment, that his policy did not provide cover for the procedure in Hospital B. In the event, the Complainant elected to proceed with the procedure in the knowledge that his policy did not cover it. Whilst the Complainant maintains that the Provider should be directed to make payment of benefit to him in circumstances where he is covered by his policy for the procedure in other hospitals, I am satisfied that the Provider was entitled to decline to pay any such benefit, in accordance with the terms and conditions of the health insurance policy which the Complainant held and there is no evidence before me of any wrongdoing on the part of the Provider in that regard.

**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**

8 October 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.**