An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0393
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Rejection of claim - pre-existing condition Claim handling delays or issues
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint arises from the Provider's decision to decline to make payment in respect of a claim made by the Complainant's wife (the "Insured") who is insured on the health insurance policy the Complainant holds with the Provider. The claim relates to two procedures that the Insured underwent on **22nd May 2017** and **12th June 2017** respectively, which the Provider refused to cover under the policy in place.

The Complainant's Case

The Complainant says that he has held health insurance with the Provider for approximately ten years. In his submissions, he sets out the history of the Insured's cover with the Provider as follows:

- 2013 – 2016: Private/public hospitals covered.
- 2016 – 2017: Public hospitals cover only.
- 2017 – To Date: Private/public hospitals covered.

The Complainant's submissions, including copies of correspondence with the Provider show that the Insured's level of cover under the policy held by the Complainant was increased, as set out above, effective from **1st February 2017**. The Complainant does not query the policy provisions in respect of waiting period for pre-existing conditions *per se,* which is two years in the case of the policy concerned. The Complainant's complaint is based on his belief that the Insured's condition, according to her General Practitioner and Consultant, is not a pre-existing condition, within the meaning of the policy.

In this regard, the Complainant refers to the fact that the Insured suffered from varicose eczema during an earlier pregnancy. He refers also to two statements by the Insured's General Practitioner.

The General Practitioner's letter dated **12 July 2018** states:

> *"*[The Insured] *would have been unaware of any predisposition to venous thrombosis based on her history of mild varicose eczema".*

The General Practitioner's letter dated **3 October 2018**, supporting the Insured's claim states:

> "*My notes do not mention varicose veins until her referral to* [the Consultant] *in March 2017".*

The Complainant also refers to the Consultant's letter dated **13 April 2018**, which he says noted:

> "*stable varicose eczema which was treated topically with Elocon cream".*

The Complainant argues that prior to the Insured seeing her Consultant for the first time on **9 May 2017** and again, prior to her attending the hospital to undergo the procedures in May and June 2017, the Complainant contacted the Provider by phone to seek "*guidance and direction".* The Complainant states in his submissions dated **18 December 2019** that;

> "*There was a lot of information delivered on both calls regarding procedure codes, consultant names on the register, excesses, terms and conditions, cover changes and pre-existing rules. During these exchanges I was informed that 'If the onset date is after 1st February that's fine i.e. We would be covered in the private hospital".*

The Complainant says that, on the basis of this information given to him by the Provider, the Insured underwent two procedures, under the care of a Consultant in a private hospital.

The Complainant argues that, with the benefit of all the medical information available to the Provider, "*as a professional medical insurer",* it had an obligation to advise him that it would not cover the procedures as planned. The Complainant states:

> "*…as we do not have a medical background, when we engaged* [the Provider] *we wanted them to arm us with the most relevant information to make an informed decision".*

The Complainant goes on to explain that if they had understood the issue, the Insured could have either gone ahead with the procedures either by seeking a private consultant in a public hospital or by deciding to bear the cost herself.

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By letter to the Provider dated **7 August 2018**, the Insured stated that:

> *"If I had any doubt this was a pre-existing condition I could have went to a consultant in a public hospital which was covered under my old policy. Again, I proceeded with the understanding this would be covered from the information provided".*

The Complainant says that before the Insured saw a private Consultant and before she attended a private hospital to undergo the procedures, both she and the Complainant made every effort to ascertain that she was covered for the procedures. The Complainant is adamant that he was not properly informed by the Provider. The Complainant has maintained this argument throughout his correspondence with the Provider. The Complainant also says that the condition was not a pre-existing condition, given the information made available by the Insured's General Practitioner and the Insured's Consultant.

The Provider's Case

The Provider has set out its response to the complaint in its Final Response Letter dated **2 January 2018.** The Provider relies on the terms and conditions of the policy that relate to upgrading cover, and waiting periods for cover for pre-existing conditions.

The Provider maintains that, although the Insured may not have been aware of the extent of the condition that necessitated the procedures, symptoms of the condition did exist in the six months prior to the upgrade of cover on **1 February 2017**. The Provider maintains its decision to decline payment of the claim.

In its Final Response letter dated **1 November 2018**, the Provider has stated, amongst other things, that:

> *"Based on the medical information we have received to date the condition for* [which] *you were treated was present before you upgraded your cover on the 1st February 2017 and the claim has been correctly assessed on your previous level of cover …*

The Complaint for Adjudication

The complaint is that the Provider has, wrongfully or unreasonably, declined to pay the claim made by the Insured on the policy, relating to two procedures that the Insured underwent in May and June 2017.

The Complainant wants the Provider to pay the outstanding bills for the procedures carried out on **22 May 2017** and **12 June 2017**.

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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 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.

A Preliminary Decision was issued to the parties on **9 October 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.

Chronology of Events

- **January 2017:** The Complainant sought an upgrade on the policy with the Provider.

- **1 February 2017:** The Complainant's upgraded level of cover came into effect.

- **20 April 2017: The** Complainant telephoned the Provider and informed the Provider that his wife was to undergo a procedure and sought to know if she was covered for the procedure or not.

- **21 April 2017:** The Provider telephoned the Complainant and discussed cover. The Provider's Agent explained the upgrade rule and what a pre-existing condition was.

- **24 April 2017:** The Complainant telephoned the Provider to clarify the cover for his wife's procedure. The Provider's Agent informed the Complainant that there is a two- year waiting period for pre-existing conditions. The Complainant was told that the Consultant would complete details on the Complainant's claim form in relation to the onset, and if it was deemed that it was a pre-existing condition, the available cover would be on [Policy A] being the level of cover before the upgrade, and if cover was available to the Complainant's wife it would be on [Policy B], the upgraded level of cover.

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- **25 April 2017:** The Complainant called the Provider and queried the cover for the private hospital. The Provider's Agent informed the Complainant of the pre-existing two-year upgrade rule and continued that if the condition was present prior to the Complainant upgrading his policy on 1 February 2017, the new policy would not cover the procedure, instead it would be covered under the level offered by the old policy.

- **12 May 2017:** The Provider received the Complainant's claim for his wife's procedure at the private hospital. The Provider paid for this, as there was no evidence to suggest that the Complainant's wife had a pre-existing condition.

- **19 May 2017:** The Complainant called the Provider to query cover in relation to a procedure his wife would be undertaking. The Provider's Agent informed the Complainant of the upgrade rule that applied and if the onset of the condition was prior to 1 February 2017, no cover would be available, under the new upgraded policy.

- **20 June 2017:** The Provider issued a letter to the Complainant advising that his wife's admission to hospital on 22 May 2017 was not eligible for benefit.

- **3 July 2017:** The Provider issued a letter to the Complainant and advised that his wife's admission to hospital on 12 June 2017 was not eligible for benefit.

- **1 November 2018:** The Provider issued its Final Response Letter to the Complainant advising that it was unable to change its decision in relation to the Complainant's wife's admission on 22 May 2017.

- **2 January 2019:** The Provider issued its Final Response Letter to the Complainant advising that it would be not be covering the Complainant's wife's admission to the private hospital on 12 June 2017.

- **9 September 2019:** The Provider received a notification that the Complainant had referred the matter to the Financial Services and Pensions Ombudsman.

Policy Terms and Conditions

The Complainant and his wife are covered for healthcare, by a policy held with the Provider. The extent of the cover available is laid down by the relevant terms and conditions of that policy. In the introductory pages of the policy terms and conditions I note the following:

> ***"2) Joining Us***
> *c)If a customer has an accident after he/she is included, we will pay benefits for the treatment needed. However, for other treatment, we will pay benefits if it is carried out after the customer has been insured continuously for a minimum period of time, called a waiting period."*

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I further note the following on the same page:

> ***"When determining whether a medical condition is pre-existing, it is important to note that what is considered is whether on the basis of medical advice signs or symptoms consistent with the definition of a pre-existing condition existed rather than the date upon which the customer becomes aware of the condition or the condition is diagnosed.***
>
> ***Whether a medical condition is a pre-existing condition will be determined by the opinion of our Medical Director"***

On the next page I note the following:

> ***"Renewing the policy***
> *b) You can change your plan at your renewal date. If you upgrade your plan (i.e. subscribe for additional benefits), the payment of additional benefits will be subject to the following waiting periods:*

Waiting periods and pre-existing conditions					
Age at the time of change	***Accident or injury***	***Pre-existing conditions***	***Maternity & Fertility Programme***	***Out-patient medical expenses***	***Day-to-day medical expenses (incl. Lifestyle benefits)****
Under 50 years	*None*	*2 years*	*52 weeks*	*None*	*None*
50-54 years	*None*	*2 years*	*52 weeks*	*None*	*26 weeks*
55-64 years	*None*	*2 years*	*52 weeks*	*None*	*26 weeks*
65+ years	*None*	*2 years*	*52 weeks*	*None*	*26 weeks"*

[My underlining above added for emphasis]

I note that "Pre-existing Conditions" is a term defined in the Glossary of Terms as:

> ***"Pre-existing Conditions***
> *Pre-existing condition means an ailment, illness or condition, where, on the basis of medical advice, the signs or* ***symptoms of that ailment, or condition existed at any time in the period of 6 months*** *ending on the day on which the person became insured under the contract".*

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Analysis

The Complainant upgraded his policy with the Provider in **January 2017**, with the policy upgrade taking effect from the **1 February 2017**. As a result, there was a two-year waiting period before the upgraded level of cover would take effect, for pre-existing conditions.

In the Complainants' submissions to this Office, the Insured has stated that:

> "*They are refusing to pay for a claim for 2 operations carried out on each of my legs on the 22/05/17 and the 12/05/17. Both my GP and consultant have confirmed this was not a pre-existing condition as* [the Provider] *are claiming".*

I note that in its Final Response letter dated **1 November 2018**, the Provider has stated that:

> *"Based on the medical information we have received to date the condition for* [which] *you were treated was present before you upgraded your cover on the 1st February 2017 and the claim has been correctly assessed on your previous level of cover* [policy A].
>
> *We have now received medical notes from Dr* [name]. *The notes mention in October 2016, February 2017 and November 2017 that you had varicose eczema, varicose eczema is caused by varicose veins. There is also a note on the 5th March 2016 that records slightly "red around varicosities". Therefore on 5th March 2016 you had varicose veins which were diagnosed by Dr* [name].

Furthermore, in its Final Response Letter dated **2 January 2018**, the Provider stated that:

> "*As previously stated, you presented to your GP in March 2016 with varicosities in the right leg for which you were already using compression stockings. Varicose eczema is reported to be present in both legs in November 2016, approximately 3 months prior to your upgrade in coverage. This worsened throughout time and on 30 March 2017, you were referred to Mr* [name] *with a diagnosis of Varicose veins. In addition we have received confirmation from Mr* [name] *that you presented to consultation with decompensation of her venous disease which was confirmed by the leg duplex scan performed by Mr* [name] *which revealed severe incompetence reported in multiple veins. Unfortunately, the degree of the incompetence which was described requires more than a 6 month period to develop".*

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 applying the terms and conditions to this complaint, I note that a "pre-existing condition" is not when the Customer becomes aware of the condition but it is based on when the Insured had medical signs and symptoms. Furthermore, it is specifically stated that whether a condition is pre-existing or not, will be determined by the Medical Director.

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I note the contents of the Assistant Medical Officer's Decision dated **10 December 2018**:

> "*I note the member's dissatisfaction towards* [the Provider's] *decision to consider her condition of varicose veins as pre-existing to her upgrade in her policy's level of cover. In her letter dated 5 November 2018 the member states that she was "not diagnosed with varicose veins prior to the change on cover". However she also confirms that she presented to her GP in the 6 month period prior to upgrading her policy's level of coverage with "varicose eczema".*
>
> *I also note the member's GP's letter dated 3 October 2018. In her letter Dr* [name] *confirms that her notes mention*
>
> > *"varicose eczema in October 2016, February 2017 and November 2017. My notes do not mention varicose veins until her referral to Mr* [name] *in March 2017".*
>
> *Despite noting that the first reference to "varicose veins" was made on 30 March 2017, note that multiple references had been made to varicose eczema, which as previously stated is a sign of the condition varicose veins. As such, signs of the condition were present in the 6 month period prior to [when] the member upgraded her level of coverage*
> *.....*
> *This was also reviewed by the medical officer and medical director".*

I am satisfied that the terms and conditions make clear that if a policyholder changes plan level, at the renewal date, any upgrade of cover under the plan will be subject to waiting periods for the additional benefits available. The additional waiting periods are also stated in clear terms, as quoted above.

I further note in the Glossary of Terms that a Pre-existing condition is defined as:

> ***"****an ailment, illness or condition, where, on the basis of medical advice, the signs or* ***symptoms of that ailment, or condition existed at any time in the period of 6 months*** *ending on the day on which the person became insured under the contract".*

As a result, I am satisfied that it was reasonable for the Assistant Medical Officer, the Medical Officer and the Medical Director to conclude from the documentary evidence before it, that the Insured's condition pre-existed the upgrade on the level of cover from **1 February 2017**, given that she attended her General Practitioner with "*varicose eczema*" in October 2016, February 2017 and November 2017. Furthermore, reference was made to "*varicose veins*" on 30 March 2017 and consequently, there were signs of the condition present in the six month period, before the Complainant upgraded the level of cover.

Accordingly, I am satisfied that the Provider acted in accordance with the terms and conditions of the Complainant's policy when it assessed the Insured's claim against the level of cover held **prior to** the 1 February 2017 upgrade in cover.

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Having listened to the audio files submitted to this Office, I am satisfied that the Provider's agent was professional and fair with the Complainant. The Provider's agent explained to the Complainant that there was an additional waiting period for his wife, during a call on **27 January 2017**:

> "*If anyone changes plans, and you're going onto a plan that has higher cover than the plan you're currently on, so for* [Complainant's wife] *going from* [Plan A] *to* [Plan B], *there is for any pre-existing, a two year waiting period for any additional benefits, 52 weeks for any higher maternity benefits and 26 weeks if over the age of 50 for day to day to day benefits"*

The Provider's agent further explained to the Complainant:

> *"You will get your documents online in the next day or two, have a look through everything and if you're happy enough with the changes you don't have to ring us at all, if you do want to do anything else, give us a call and we can go over it again".*

During a subsequent call between the Complainant and the Provider on **21 April 2017**, the Complainant enquired if his wife was covered for a procedure at the private hospital. The Provider explained to the Complainant that when a plan changes, if the condition requiring treatment is deemed to be a pre-existing condition, there was a two-year waiting period for the changed level of cover. The Complainant explained that his wife was having symptoms in March 2017. The Provider's agent explained to the Complainant that if his wife had any onset symptoms prior to the policy upgrade on **1 February 2017,** she would not be covered in the private hospital, however if the onset was after the **1 February 2017**, the Complainant's wife would be covered. The Provider also advised the Complainant that his wife would be covered anyway under the old policy in a public hospital, if she was not covered in the private hospital.

The following month, on **17 May 2017**, the Complainant telephoned the Provider enquiring again if his wife was covered for a procedure. The Provider's agent explained again to the Complainant that he had upgraded his policy this year, and therefore if the onset of symptoms arose after the 1 February 2017, the Complainant's wife would be covered, however if that onset arose before the 1 February 2017, his wife would not be covered in the private hospital, under the upgraded level of cover. The Provider's agent explained to the Complainant that **it's not diagnosis, it's the onset date** and this would be based on the medical information and the policy terms and conditions. The Provider also explained to the Complainant that his wife would be covered in a public hospital under the old policy, in any event.

For the reasons outlined above, I am satisfied that the Provider properly advised the Complainant as to his level of cover at the time of upgrading and also on each of the occasions when he asked the Provider whether the procedure would be covered.

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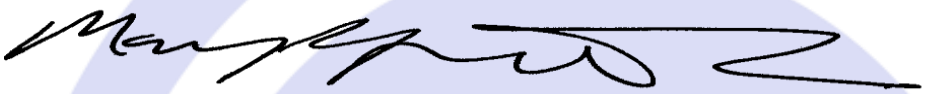
Having considered the matter, I am satisfied that the Provider's conduct in refusing to admit the claim was reasonable, based upon the evidence available, details of which are outlined above. I am satisfied that the Provider acted in accordance with the terms and conditions of the policy, in declining the claim for the Insured's treatment, and accordingly I take the view that there is no reasonable basis upon which this complaint can 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

3 November 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.