An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0437
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Rejection of claim - pre-existing condition Delayed or inadequate communication Dissatisfaction with customer service Failure to process instructions in a timely manner Disagreement regarding Medical evidence submitted
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint concerns a private health insurance policy which the Complainant upgraded in **February 2019**.

The Complainant's Case

The Complainant submits that he underwent treatment in hospital from **[month redacted] 2019** to **[month redacted] 2019**, and further submits that the Provider has refused to pay the resulting claim he made under his policy.

The Complainant's Consultant's report dated **31 October 2019** details:

> *"*[The Complainant] *is under my care for a diagnosis of [illness redacted]. I first met with* [the Complainant] *on [month redacted] 2019 at which point he presented with new onset headaches and jaw claudication and a 6lb weight loss. He had also recently had visual changes which have since resolved".*

The Complainant submits that the hospital confirmed his diagnosis on **[month redacted] 2019**, which was *"well after the date"* when he updated his cover. The Complainant contends that the Provider should pay his medical bills as he believed he was covered.

The Provider's Case

The Provider says that in telephone conversations with the Complainant on **26 February 2019**, **4 March 2019** and **21 March 2019**, it advised the Complainant that he would not be covered under the updated Policy dated **26 February 2019** for any hospital procedure relating to a pre-existing condition and would only be covered under the level available from his previous policy cover for such conditions.

The Provider states that the Complainant's claim was declined as the information furnished with the claim indicated that the symptoms which prompted the Complainant's admission to hospital were present prior to him upgrading his cover from **26 February 2019**.

The Provider sets out in detail in its Final Response Letter dated **28 November 2019** that:

> *"This claim was declined as the information provided in your claim indicated that the symptoms which prompted the above admission, were present prior to your increasing your benefits to include cover for the* [hospital].

The Final Response Letter goes on to say that the evaluation conducted by a neurologist via the Provider's external Medical Advisory Board determined that:

> *"Patient upgraded policy on 26 January* 2019 and there is evidence of headache and raised inflammatory markers on 28 January 2019 as per GP summary letter; and again, on clinical exam on 25 February 2019 it was noted a persistent headache and bitemporal pain. So I believe that member's symptoms were milder on 28 January 2019, however they were already present in some degree".*
>
> **The correct date of the Policy upgrade is 26 February 2019.*

The Complaint for Adjudication

The complaint is that the Provider has wrongfully declined the Complainant's claim for the cost of his treatment under the policy.

The Complainant wants the Provider to pay "*All medical bills from the hospital totalling €4027.04".*

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

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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 November 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 chronology of relevant dates and details below is included to assist in determining this complaint.

Chronology

- **14 March 2013:** The Complainant first incepted health insurance with the Provider.
- **1 April 2014:** The Complainant purchased [Policy A] from the Provider.
- **25 February 2019:** The Complainant was referred by his G.P. to Consultant for review in relation to

  > *"ASAP-PERSISTENT HEADACHE-? FROM CHRONIC SINUSITIS …has been unwell since mid dec – initially chesty cough-seen by dr* [name] *7th jan… no better by phone 21 jan… NEW SYMPT = ADDITIONAL DRENCING SWEATS FPR 1/52, PERSISTENT COUGH AND HEADACHE …but reported ongoing headache if didn't take neurofen…today 25 feb – reports persistent headache – bitemporal and into cheeks."*

- **26 February 2019:** The Complainant upgraded his policy to [Policy B] with the Provider to include cover for private hospitals.
- **27 February 2019:** The Complainant was sent his new policy documentation.

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- **20 March 2019:** The Complainant was referred to a Neurologist for further investigations in relation to ongoing symptoms.

- **[month redacted] 2019 – [month redacted] 2019:** The Complainant was admitted to private hospital. I note from the claim documentation the hospital Consultant's notes as follows:-

  > "*This patient was admitted to [Hospital] on [month redacted] 2019 suffering from severe bifrontal headaches with night sweats, fever, lethargy, phonophobia and scalp tenderness. Investigations included Biochemistry, Histopathology, Microbiology, Haematology, X-ray, CT-scan. The patient condition of possible [illness redacted] was treated over 3 days. The patient was treated with IV medication/fluids. The patient was discharged from my care on 05/04/2019.*"

- **31 October 2019**: The Complainant's Consultant reported "*a diagnosis of [illness redacted]. I first met with* [the Complainant] *on [month redacted] 2019 at which point he presented with a new onset headaches and jaw claudication and a 6lb weight loss. He has also recently had visual changes which have since resolved".*

- **26 November 2019:** The Provider sent its Final Response Letter to the Complainant.

Policy Terms and Conditions

I note the following information which is made clear in the Policy Booklet under the heading:-

> ***"Important information to note:***
> *Waiting periods*

In addition, if you're changing your level of cover/benefits the following waiting periods will apply regardless of how long you have been insured:	
You have health insurance and want to get an additional level of cover/benefits, how long before you can avail of the better cover/benefits for any disease, illness or injury which began or the symptoms of which began before you changed your level of cover?	*2 years for all age groups"*

At the beginning of the policy booklet under the heading

"**What is not covered under the Scheme**"

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I note that the following is made clear:-

"*We will not pay benefits for the following:*

(a) Treatment which a person requires during any waiting period that may apply to the treatment under their Scheme. All waiting periods commence on a person's membership and upgrade start date and except for the maternity waiting period, the length of a waiting period is determined by a person's age on their membership start date…."

On page 5 of the General Rules Policy Booklet, I noted the following:

"Please note that our medical advisors will determine whether a condition is a pre-existing condition. Their decision is final.

There are additional clear warnings in the Provider's Messaging Flyer, in which I note the following:

"Additional Cover Waiting Period
If you want to get an additional level of cover or benefits, that's no problem, we can find a scheme to suit you. It's important to remember that it will be two years before you can avail of the better cover or benefits for any disease, illness or injury which began, or the symptoms of which began, before you changed your level of cover.

Please note; where we refer to the additional cover waiting period in relation to a change in your cover or benefits this also includes any scheme excess and shortfall".

Furthermore, on page 8 of the Renewal Flyer I noted the following:

"Changes to your Rules since your last renewal
Rule Clarification
Clarification of the Additional Cover Waiting Period *If you want to get an additional level of cover or benefits, it will be two years before you can avail of the better cover or benefits for any disease, illness or injury which began, or the symptoms of which began, before you changed your level of cover.* *Please note; where we refer to the additional cover waiting period in relation to a change in your cover or benefits this also includes any scheme excess and shortfall".*

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Analysis

The Complainant has held health insurance with the Provider since the **14 March 2013**. He upgraded his cover with the Provider from [Policy A] to [Policy B] on **26 February 2019** and then underwent treatment in the private hospital from **[month redacted] 2019** to **[month redacted] 2019**.

The Complainant submits that:

> *"My claim was rejected as the information provided indicated that the symptoms were present prior to me increasing my benefits to include cover for the* [Private Hospital]. *I upgraded my cover on the 26th February 2019 to include cover in the* [private hospital]. *My Consultant* […], *in a letter of 31/10/19 stated that the hospital confirmed my diagnosis on 05/4/19. This is well after the date of the 26/2/19 when I updated my cover.*

In its Final Response Letter dated **28 November 2019,** the Provider stated that:

> "*The claim was declined as the information provided with your claim indicated that the symptoms, which prompted the above admission, were present prior to you increasing your benefits to include cover for the* [private hospital]
>
> *Therefore, as you were serving a two-year additional cover waiting period your claim was assessed in accordance with your previous scheme,* [Policy A]. *The* [Policy A] *scheme does not provide cover for the* [private hospital] *therefore your claim was not eligible for benefit.*
> *….*
> *We are unable to consider further treatment related to these symptoms for benefit in the hospitals for which you gained increased benefits, until the additional cover waiting period applicable when you switched from* [Policy A] *to* [Policy B] *will be served on 26 February 2021".*

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 considering this complaint, I note the following on page 5 of the General Rules Policy Booklet:

> *"Please note that our medical advisors will determine whether a condition is a pre-existing condition. Their decision is final.*

I note that in its correspondence to the Complainant dated **28 November 2019**, the Provider stated, as follows:

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"*Based on the information provided for review our Medical Advisors have concluded that the symptoms, which prompted your referrals and subsequent admission on [month redacted] 2019, were consistent and ongoing prior to you increasing your benefits on 26 February 2019 and gaining cover for the* [private hospital]

Additionally in order to provide a fair and equitable decision concerning your appeal, our external Medical Advisory Board independently assessed your claim. The information provided for review has been evaluated by a Neurologist who has determined the following:

The confounding factor here is the chest respiratory infection and cough that started in December 2018; however there is evidence of improving in respiratory symptoms, and in parallel the headache symptoms were progressing. So, there is an overlapping of respiratory and headache symptoms.

Patient upgraded policy on 26 January 2019 and there is evidence of headache and raised inflammatory markers on 28th January 2019 as per GP summary letter; and again, on clinical exam on 25th February 2019 it was noted a persistent headache and bitemporal pain.*

So I believe that member's symptoms were milder on 28th January 2019, however they were already present in some degree".

**The correct date of the Policy upgrade is 26 February 2019.*

Therefore based on the recommendations of both our Medical Advisors and Medical Advisory Board, as outlined above, we are unable to consider your claim for benefit in line with additional cover waiting period".

I note that the Complainant was referred to a Consultant for review on 25 February 2019, in relation to:

"*ASAP-PERSISTENT HEADACHE-? FROM CHRONIC SINUSITIS …has been unwell since mid dec – initially chesty cough-seen by dr* [name] *7th jan… no better by phone 21 jan… NEW SYMPT = ADDITIONAL DRENCING SWEATS FPR 1/52, PERSISTENT COUGH AND HEADACHE …but reported ongoing headache if didn't take neurofen…today 25 feb – reports persistent headache – bitemporal and into cheeks".*

I am satisfied from the evidence that the Provider was entitled to form the opinion that it was these same symptoms that gave rise to the Complainant's admission to hospital for treatment in [month redacted] 2019. As a result, I am satisfied that the Provider was entitled to assess the Complainant's claim against the level of cover he held prior to the 26 February 2019, that is, under [Policy A] as those symptoms were present before the upgrade in cover.

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Having listened to the audio files submitted to this Office, I am satisfied that during February and March 2019, the Provider's Agents were professional and fair to the Complainant. They clearly explained to the Complainant that there was an additional waiting period for him to be covered for admission to the private hospital. Furthermore, the Provider referred the Complainant's case to its external medical advisors, in order to review the apparent onset date of the Complainant's symptoms.
The evidence from the audio files and the webchat screenshots submitted to this Office confirm that the Provider's Agents repeated details of the pre-existing waiting period, to ensure that the Complainant understood fully.

I am satisfied that the Provider advised the Complainant of the two-year waiting period to be covered for pre-existing conditions on the upgraded level and I note that this was also disclosed in the Rules Booklet when the Complainant first purchased the health insurance policy from the Provider, and when the policy documentation was sent to him at the time of his policy upgrade.

Furthermore, when the Complainant updated his cover on the 26 February 2019, the Provider's Agent advised through webchat that the Complainant had public hospital cover only and did not have private hospital cover. Subsequently when the Complainant upgraded his policy cover that day, the Provider's Agent advised the Complainant that there was a two-year upgrade rule to be covered for pre-existing conditions.

For the reasons outlined above, I am satisfied that the Provider has met its obligations to the Complainant and on the basis of the evidence made available by the parties, I am satisfied that the Provider's refusal to admit the claim was a reasonable one 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 forming the opinion that cover in the particular hospital was not available to the Complainant, because the condition giving rise to his hospital admission was pre-existing his upgrade in cover level in February 2019. Accordingly, 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 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

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1 December 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—

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

(a) ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.