Decision Ref:	2021-0034
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Rejection of claim - pre-existing condition
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainants' son is insured on the health insurance policy which they hold with the Provider. This complaint arises from the Provider's decision to decline to admit and pay a claim made for the cost of treatment which the child underwent on **21 August 2018.**

The Complainants' Case

The Complainants say that on **28 September 2017** the Second Complainant incepted a health insurance policy with the Provider, for their son, who was then a year old. The Complainants say that their son was referred to an Ear, Nose and Throat specialist in **January 2018** for treatment for an ear condition and the medical opinion of the specialist at that time was that his ear pain, was due to teething and that surgical intervention was not necessary.

The Complainants contend that their son presented again to the same specialist in **July 2018** for treatment of his ear pain and during the consultation, it was recommended that he undergo surgery for the insertion of grommets. They say that he had surgery to his ear for the insertion of grommets and they made a claim to the Provider for the expenses related to the surgery. The Complainants say that the claim was repudiated by the Provider because it was deemed to arise from a "pre-existing condition", under the terms of the policy.

The Complainants contend that their son's ear condition was not pre-existing when the policy was incepted, and that his General Practitioner (GP) has written a letter in support of the claim. The Complainants say that their son's GP has stated within this supporting letter, dated **22 August 2018,** that he reviewed the relevant medical notes which document that their son presented with an ear infection in **February 2017** and again between **February** and **November 2017,** for various conditions including gastroenteritis, tonsillitis and upper respiratory infection.

The GP says that a specific diagnosis of otitis media "*was not mentioned again in the notes until 30th of November 2017"* and that the medical visits between February and November 2017, although more frequent that what would be deemed to be average, were part of "*normal childhood illness".* They submit that it is the GP's medical opinion that the need to insert grommets was not as a result of a pre-existing condition.

<u>The Provider's Case</u>

The Provider, in its Final Response Letter dated **22 November 2018**, contends that:

> *"The claim was declined as the information provided on the claim form indicated that the recurrent episodes of acute otitis media, which prompted [the child]'s admission, were present prior to [the child] commencing cover with [the Provider] on 28 September 2017.*
>
> *Therefore, in line with the pre-existing condition waiting period [the child]'s claim was not eligible for benefit".*

The Provider goes on to say that its Medical Advisors had further reviewed the Insured's claim and says that:

> *"Therefore, based on the recommendations of our Medical Advisors, we are unable to consider the above claim for benefit in accordance with the pre-existing condition waiting period.*
>
> *Going forward please note that we will be unable to consider future treatment related to the above symptoms for benefit until the pre-existing condition waiting period has been served. The pre-existing waiting period will be served on 28 September 2022.*
> *….*
> *The pre-existing waiting period applies upon joining all health insurers in Ireland, when you take out health insurance for the first time. Once you have served your 5-year pre-existing waiting period you will not have to serve it again if you switch to another insurer, as long as you haven't had a break in cover of more than 13 weeks."*

/Cont'd…

The Complaint for Adjudication

The complaint is that the Provider wrongfully declined the Complainants' claim.

The Complainants want the Provider to admit the claim and reimburse them for the cost of the surgery which gave rise to the claim.

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 **19 January 2021**, 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

- **25 August 2017:** The Second Complainant telephoned the Provider to get a quote for health insurance. The Provider's agent took the Complainants' details. The Provider's agent advised her of waiting periods for any pre-existing conditions and told her there was a 5-year waiting period to be covered for any pre-existing conditions. The Provider's agent told her that he would email out the quote.

- **11 September 2017:** The Second Complainant telephoned the Provider about a quote she received by email "*a few weeks ago*". She told the Provider's agent that she wanted to go ahead with the quote she received by email.

/Cont'd…

The Provider's agent told the Second Complainant that this quote was no longer available and gave her a new quote. The Provider's agent told her that the reason the new quote was higher, was because it was covering a longer period. The Second Complainant agreed, but did not want the policy to start until 28 September 2017 as she was able to avail of the lower quote. The Provider's agent set up the health insurance policy with a commencement date of **28 September 2017**. The Provider's agent advised her again of waiting periods and told her to read the policy documentation to make sure she was happy with the policy.

- **12 September 2017:** The Provider issued the policy documentation.

- **28 September 2017:** The policy commenced with the Provider covering both the Complainants and their infant son.

- **2 July 2018:** The Provider's agent returned the Second Complainant's call. She wanted to know if her son would be covered for a procedure in a Private Hospital. She gave the Provider's agent the procedure code. The Provider's agent put her on hold to check if her son would be covered under the policy.

  The Provider's agent told the Second Complainant that if the symptoms that required the procedure, started on or after 28 September 2017, her son would be covered with an excess of €125. If symptoms occurred before 28 September 2017, her son would be subject to a 5-year waiting period and would not be covered. The Provider's agent told the Complainant that the onset date on the claim form would be the determining factor along with the opinion of her son's Consultant.

- **16 July 2018:** The Second Complainant renewed the health insurance policy with the Provider.

- **23 July 2018:** The Provider emailed to advise that the renewal pack was available in the member area.

- **9 August 2018:** The Complainant telephoned the Provider to check if their son was covered for a procedure. The Provider's agent took the procedure code and the Consultant's name to check. The Provider's agent asked if the child had any symptoms prior to the inception of the policy on 28 September 2017 and the Complainant said that he did not. The Provider's agent put the Complainant on hold to check if there was cover under the policy, and then advised that based on the information given, the child would be covered for the procedure with an excess of €125. The Provider's agent told the First Complainant that, if there were any symptoms before 28 September 2017, the child would be serving a 5-year waiting period for a pre-existing condition and would not be covered. The Provider's agent told the First Complainant that the child's Consultant and GP would be the best persons with whom to query when the symptoms first occurred.

- **10 October 2018:** The Provider rejected the Complainants' claim.

/Cont'd…

- **16 October 2018:** The Complainants appealed the Provider's rejection of the claim.

- **17 October 2018:** The Provider sent the Second Complainant a letter acknowledging her enquiry in relation to the claim being rejected and told her that it would contact her shortly with an update.

- **23 October 2018:** The Provider sent a letter to the child's GP requesting his medical notes.

- **15 November 2018:** The Provider send the Second Complainant an update in relation to the claim and told her it was gathering more information *"in order to make a fair and equitable decision on this appeal".*

- **22 November 2018:** The Provider sent the Complainants its Final Response Letter declining the claim, on the basis that their son had suffered from a pre-existing condition and was therefore subject to a 5-year waiting period to be covered for treatment.

- **8 April 2019:** The Provider sent the Complainants the policy documentation for another child who was added to their policy.

- **17 July 2019:** The Complainants renewed their health insurance policy with the Provider.

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

> *"It's a good idea to call [telephone number] and let us know about any upcoming treatment. Don't forget to tell us which hospital you're going to and the name of your consultant, so we can confirm cover".*

I note that "*Pre-existing condition*" is a term defined in the Policy Documentation as:

> ***"Pre-existing condition***
> *Pre-existing condition: An ailment, illness or condition, where, on the basis of medical advice, the signs or symptoms of that ailment, illness or conditions existed at any time in the period of 6 months immediately preceding:*
>
> *a) the day you took out a Health insurance contract for the first time; or*
>
> *b) the day you took out a Health insurance contract again after your previous Health insurance contract had lapsed for 13 weeks or more.*

> ***Please note that our medical advisors will determine whether a condition is a Pre-Existing condition. Their decision is final.***

I further note the additional information under "*What is not covered under the scheme*":

> ***"9. What is not covered under the scheme***
> *(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 start date or the date of the change to their policy/schemes.*
>
> ***There are three waiting periods that apply under the scheme***

….

- *the pre-existing condition waiting period – this only applies to treatment which a person requires for a pre-existing condition".*

On the same page I note the following:

> ***"The pre-existing condition waiting period is***

- *the first five years of membership"*

The Second Complainant incepted a policy with the Provider on **12 September 2017**, with the policy taking effect from **28 September 2017.** As a result, there was a five-year waiting period before cover would take effect, for treatment for any pre-existing conditions.

In the Complainants' submissions to this Office, they have stated that:

> *"…We have subsequently been informed by our health insurance provider [Provider's name] that because our son had a pre-existing condition i.e. Ear infections prior to us taking [out a health] insurance policy, that we would have to incur cost of surgery as it would not be settled by [the] insurance company. Following discussion with our son's GP Dr [name], he reviewed [the child]'s medical notes and concluded that it was not pre-existing, but normal childhood illness, above average but still normal…"*

I note that in its Final Response letter dated **22 November 2018**, the Provider has stated that:

> *"This claim was declined as the information provided on the claim form indicated that the "recurrent episodes of acute otitis media", which prompted [the child]'s admission, were present prior to [the child] commencing cover with [the Provider] on 28 September 2017.*
>
> *Therefore, in line with the pre-existing condition waiting period [the Complainants'] claim was not eligible for benefit".*

The additional content of the Provider's Final Response Letter is also quoted above on Page 2 of this Decision.

/Cont'd…

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 examining the policy terms and conditions for the investigation of this complaint, I note that a "*pre-existing condition*" is not when the customer becomes aware of the condition. Rather, its existence is established by reference to whether the insured had medical signs and symptoms of the condition, before the policy inception date. In that regard, the policy specifically states that whether a condition is pre-existing or not, will be determined by the Provider's Medical Advisors and their decision is final.

I note the comments of the Provider's Medical Advisors, which include the following:

- *"On 12 March 2017 [the child] attended [the out of hours doctor]. The report forwarded to [the child]'s GP documented that [the child]'s symptoms are "ear infection two weeks ago – had cleared up complaining of same symptoms – right ear Pulling at ear, awake every night crying in pain"*

- *On 23 August 2017 [the child] attended his GP and the consultation notes document the following "ENT – red right TM, throat ok"*

- *On 14 September 2017 [the child] attended [the out of hours doctor]. The [out of hours doctor] report sent to [the child]'s GP documented that [the child] had been treated for an ear infection a few weeks previously.*

- *On 28 September 2017 [the child] commenced cover with [the Provider]. On joining [the child] was subject to a 5-year pre-existing condition waiting period in respect of pre-existing conditions and/or any signs or symptoms of that condition.*

- *On the 4 October 2017, 6 October 2017, 30 November 2017, 22 December 2017 and 20 February 2018 [the child] attended his GP in relation to his ongoing ear symptoms.*

- *On 22 December 2017 [the child] was referred to [Consultant name], Consultant ENT Head and Neck Surgeon. The referral letter documents the following "I would be grateful if you could see this child. He has recurrent wheeze and severe bulging tympanic membranes. He has had well over 8 trips here with the same. I wonder does he need grommets".*

- *On 11 January 2018 [the child] consulted with [the Consultant ENT Head and Neck Surgeon] The written consultation notes document that [the child] presented with recurrent right acute otitis media on eight occasions over the past six months. The clinic letter to [the child]'s GP documented the following "he has a history of recurrent right acute otitis media over the past six months having had four courses of antibiotics". [The Consultant] also wrote that he planned to manage [the child]'s symptoms conservatively however if the symptoms persist he would book [the child] for grommets.*

/Cont'd…

- *On 23 August 2018 [the child] underwent bilateral insertion of grommets for recurrent episodes of acute otitis media with glue ear in [the private hospital].*

- *Based on the information provided for review our Medical Advisors have concluded that the recurrent otitis media, which prompted the requirement for grommet insertion on 21 August 2018, were consistent and ongoing prior to [the child] commencing cover with [the Provider] on 28 September 2017."*

I am satisfied that the terms and conditions make clear that if a policyholder suffers from a pre-existing condition, before they incept a health insurance policy, they will be subject to waiting periods for the cover available. The waiting periods are 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, illness or conditions existed at any time in the period of 6 months*** *immediately preceding: a) the day you took out a Health insurance contract for the first time".*

As a result, I accept that it was reasonable for the Provider, through its Medical Advisors to conclude from the documentary evidence before it, that the Complainants' son's condition pre-existed the policy inception on **28 September 2017**, given that he had attended his General Practitioner on 9 March 2017 with an ear infection and on 12 March 2017, the GP notes documented "*Ear infection 2 weeks ago – had cleared up. Complaining of same symptoms – right ear, Pulling at ear, awake every night crying in pain".*

*In addition, t*he child attended the out of hours doctor on 14 September 2017 and it was noted that he had been treated "*a few weeks ago for an ear infection".* On the 23 August 2017 I also note the GP notes stated "*ENT- red right TM, throat Ok".*

Accordingly, I am satisfied that the Provider acted in accordance with the terms and conditions of the Complainants' policy when it assessed the claim for treatment undergone by the Complainants' son, taking into account the 5-year waiting period for pre-existing conditions.

I am also satisfied from the audio files submitted in evidence to this Office, that the Provider's agent was professional and fair with the Complainants. The Provider's agent explained waiting periods during a call on **25 August 2017,** when the Second Complainant telephoned the Provider to get a quote for health insurance. On **2 July 2018,** the Provider's agent told the Second Complainant that if the symptoms that required the procedure started on or after 28 September 2017, her son would be covered with an excess of €125 but if symptoms occurred before 28 September 2017, he would be subject to a 5-year waiting period and would not be covered. The Provider's agent told the Complainant that the onset date on the condition giving rise to the claim would be the determining factor along with the opinion of the child's Consultant.

/Cont'd…

During a subsequent call between the First Complainant and the Provider on **9 August 2018,** the First Complainant telephoned the Provider to check if their son was covered for a procedure. The Provider's agent took the procedure code and the Consultant's name to check and asked if the child had any symptoms prior to the inception of the policy on 28 September 2017 and was told that he did not.

I note that the Provider's agent put the First Complainant on hold to check if there was cover under the policy and advised that based on the information given, the child would be covered for the procedure with an excess of €125. I also note that the Provider's agent told the First Complainant that if there were any symptoms before 28 September 2017, the child would be serving a 5-year waiting period for a pre-existing condition and would not be covered. The Provider's agent him that the child's Consultant and GP would be the best persons to ask when the symptoms first occurred.

For the reasons outlined above, I am satisfied that the Provider properly and consistently advised the Complainants in relation to the 5-year waiting period for cover for any pre-existing conditions at the time of the purchase of the policy and also on each of the occasions when the First and Second Complainants asked the Provider whether the procedure would be covered.

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 Complainants' son'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

10 February 2021

/Cont'd…

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.