An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0066
Sector:	Insurance
Product / Service:	Personal Accident
Conduct(s) complained of:	Rejection of claim Claim handling delays or issues
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainants hold a health insurance policy with the Provider. Two of their daughters underwent operations in **2018** and **2019**. The Complainants attempted to recover the costs of these operations under their policy. The Complainants' claims were declined by the Provider.

The Complainants' Case

In their Complaint Form, the Complainants explain that their first daughter underwent an eye operation in the first half of **May 2018** in Hospital 1 at the request of her doctor at a cost of almost €4,000. The Complainants advise that the Provider declined cover under the policy because the hospital was not covered by the policy even though the doctor and procedure were covered.

In respect of the Complainants' second daughter, they explain that she had an ear operation in the first half of **May 2019** in Hospital 2 and the Provider declined cover because their daughter was not on the policy even though the hospital, doctor and procedure were covered under the policy.

In an email to this office dated **7 May 2020**, the First Complainant submits this is a situation where the Provider's default position was to seek to avoid cover rather than finding a way of ensuring cover which the First Complainant submits is not consistent with the spirit of the policy or *"… indeed offering the benefit of any doubt to the insured …."*

The First Complainant submits that the Provider should not be permitted to avoid cover on the basis of a technicality, stating that *"[i]t is an unfair procedure and an unfair decision to seek out an error in one part of the entire process and to rely upon that one issue to void an entire cover."*

The First Complainant states that someone within the Provider should take *a good look* at their case and similar cases *"… with a view to giving effect to not just the technical wording of a policy but the spirit of that policy and to consider not just the codes for surgery or the hospital address but to consider the infant patients in these cases …."*

The Provider's Case

The Provider advises that the Complainants joined it as a new business customer through a broker. The Provider states that it supplied the Complainants with the relevant policy terms and conditions when their policy went live.

The Provider states it recommends that all members contact it prior to undergoing any treatment or procedure. When a member wishes to confirm cover, the Provider explains, the member must provide the procedure code, consultant name and medical facility they wish to attend. The Provider states that its agent would then check a member's policy and advise whether or not cover is available.

The Provider states it has no record of the relevant consultant or hospital contacting it to confirm cover prior to the procedures taking place. The First Complainant contacted the Provider regarding the first procedure on the day of the procedure in **2018**. The First Complainant advised the Provider that on arrival at Hospital 1, the Complainants were told that cover was not available under their policy. The Provider says the First Complainant advised its agent that the procedure went ahead as planned and he was calling to retrospectively check cover for the procedure.

The Provider explains that where a hospital is not covered under a member's plan, the Provider will not cover any of the costs associated with that admission. The Provider states that where a code or consultant is *active*, this means the procedure is an active and recognised procedure and that the consultant is registered with the Provider to receive direct payment. The Provider says advising that a procedure or consultant is active is not a confirmation of cover.

On inception and at each renewal, the Provider states that members are provided with the documents that comprise their contract: Membership Handbook, Membership Certificate, Table of Cover and List of Medical Facilities, and Schedule of Benefits.

The Provider says the Table of Cover sets out the benefits that are available under a plan which states: *'The hospitals and treatment centres covered on this plan are set out in List 1 in Part 12 of your Health Plans membership handbook.'*

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The Provider states the Complainants' plan provides cover for medical facilities noted on List 1 in the Membership Handbook.

The Provider explains hospitals are divided into three categories: Private, Public and High-tech. The Provider advises that Hospital 1 is classed as a high-tech hospital. The Provider refers to the Table of Cover and the cover offered in respect of high-tech hospitals which is only offered in respect of Hospital 2, and Hospital 1 is not covered. The Provider also refers to section 2.2 and section 3 of the Membership Handbook. The Provider advises that cover is not provided where a member attends a medical facility which is not covered under their plan.

In terms of adding an infant to a policy, the Provider explains that once a policyholder contacts it to add an infant to a policy it will act on this instruction. Once an infant is added, the Provider states it will issue updated documents confirming this.

Addressing the Complainants' letter of **12 November 2018** requesting to add one of their children to their policy, the Provider says it has no record of receiving this letter. The Provider also states that it has no record of a telephone conversation taking place on or around **12 November 2018**. The Provider states this letter is addressed to a claims handling agent who did not take calls.

The Complaint for Adjudication

The complaint is that the Provider wrongfully or unreasonably declined two claims under the policy.

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.

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A Preliminary Decision was issued to the parties on 16 February 2021, outlining my preliminary determination 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, I set out below my final determination.

The First Request for Cover

The First Complainant wrote to the Provider on **23 May 2018** explaining that his daughter underwent an eye operation in Hospital 1 a number of weeks earlier:

> *"… As you will be aware [the Provider] took over our [previous provider] policy some time in the last 15 months or thereabouts and we assumed that we would have the same or at least equivalent cover in place under our [Provider] Policy.*
>
> *In any event, we were advised by our Doctor that the procedure was covered under our policy, the details of which were furnished well in advance of the operation and we arrived for our little girls operation at 7 am on [date].*
>
> *We were very surprised and taken aback that our policy did not cover the hospital and were advised that we had to pay privately on the day. …"*

By letter dated **31 May 2018**, the Provider advised the First Complainant that:

> *"… I note you joined [the Provider] on the 15th December 2016 having migrated from [the previous provider]. I also note that your policy was set through a broker at the time … and that documents were issued to you by them.*
>
> *I can confirm that the broker set up the policy …. It is important to note that this plan covers a full list of hospitals, excluding [Hospital 1] and [another named hospital]. I refer to the calls that you had with our representatives on 1st and 16th of May where it was stated that this hospital would not be covered for procedure code 2870. Unfortunately, if the hospital is not covered on the plan then no costs associated with that hospital will be covered. …"*

This was followed by a series of correspondence between the parties where the First Complainant requested that the Provider cover the costs of his daughter's operation.

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The Policy

The Complainants incepted a health insurance policy with the Provider in **December 2016** which was confirmed by the Provider by letter dated **14 December 2016**.

In advance of the policy renewal date, the Provider wrote to the First Complainant on **12 November 2017**. This letter stated:

> *"… We recommend that you take the time to read your table of cover enclosed. …*
>
> *… A full list of medical facilities covered on your plan is available in your Membership Handbook. …"*

The enclosed Table of Cover explained that:

> *"This table of cover must be read in conjunction with your member certificate and health plans membership handbook. The hospitals and treatment centres covered on this plan are set out in List 1 in Part 12 of your health plans membership handbook."*

The table beneath this passage states that in-patient hospital cover in respect of high-tech hospitals was only offered in respect of Hospital 2.

By letter dated **13 December 2017**, the Provider confirmed the renewal of the policy. This letter stated as follows:

> *"… We have enclosed some important information which makes up your policy contract. Included is your:*
>
> - *Membership Certificate - your policy and premium details*
> - *Table of Cover - the benefits covered on your plan*
> - *Membership handbook - the terms and conditions of your policy*
> - *…*
>
> *Please read these documents carefully, paying close attention to the benefits and hospitals listed, to ensure that your needs are covered. …"*

Membership Handbook

The Membership Handbook dated **December 2017** sets out the benefits under the policy. In the context of this complaint, section 2.2 deals with *In-Patient Benefits*:

> *"In-patient Benefits typically cover the fees charged by **your** hospital, treatment centre and **health care provider** whilst **you** are admitted to a hospital or treatment centre covered under **your plan** as an **in-patient** or **day case** patient.*

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…

***We** will not cover **your hospital costs** in a **medical facility** which is not covered in **your** List of Medical Facilities. …"*

A number of exclusions are set out at section 3:

*"**We** do not cover the following (subject to compliance with the **Minimum Benefit Regulations**):*

*Any costs that are not covered under a **benefit** listed on **your** Table of Cover;*
…

*Any costs incurred in a **medical facility** that is not covered under **your plan**; …"*

The *Lists of Medical Facilities* are listed in a table at section 12 of the Handbook. As can be seen, Hospital 1 is listed as a *High-tech hospital* with direct settlement. However, the policyholder is directed to the *Table of Cover* (referred to above) for an explanation of the level of cover/benefits offered in respect of this hospital.

Analysis

The Complainants' daughter underwent an in-patient procedure in Hospital 1. On the day of the procedure, the Complainants were informed by Hospital 1 that the procedure was not covered under their policy of insurance.

Following this, the First Complainant telephoned the Provider on that same day and advised the Provider's agent that he was told by his daughter's treating doctor that the procedure was covered under the policy. The Provider's agent informed the First Complainant that the procedure was not covered. During a telephone call with the Provider on **16 May 2018**, the First Complainant explained to the Provider's agent that he assumed the procedure was covered but he did not contact the Provider to confirm this. A further telephone conversation took place on **30 May 2018**, where the First Complainant stated that he assumed the procedure was covered as it was covered under a policy held with a previous provider. In the course of this conversation, the First Complainant told the Provider's agent that the consultant and the Provider told him that the procedure was covered a month before it took place. Finally, during a telephone conversation on **26 June 2018**, the First Complainant told the Provider's agent that the consultant who carried out the procedure advised him that the procedure was covered but *she didn't specially say* Hospital 1.

The cover offered under the policy is clearly set out in the policy documents outlined above. Hospital 1 is classed as a *high-tech hospital* and the Complainants' policy does not offer cover in respect of Hospital 1.

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Having considered the evidence, I accept that the Complainants did not contact the Provider in advance of the procedure to confirm if the procedure was covered under the policy. Further, it would appear that the Complainants did not consult or attempt to consult their policy documents to confirm whether the procedure was covered.

What appears to have occurred is that the doctor/consultant advised the Complainant that the *procedure* was covered under the policy. However, it is not clear whether the doctor/consultant told the Complainants that the procedure, if carried out in Hospital 1, was covered under the policy. The evidence also shows that the First Complainant assumed the procedure was covered as it was covered under a previous policy. Again, it is not clear if the procedure in Hospital 1 was covered. In any event, I do not accept that either of these circumstances means that the procedure was covered under the policy in place in **May 2018** nor does it oblige the Provider to cover the costs of the procedure.

Accordingly, I accept that the Provider was entitled to decline the Complainants' claim in respect of this procedure in accordance with the terms and conditions of the policy.

The Second Request for Cover

The Provider wrote to the First Complainant on **12 November 2018** in respect of the renewal of the policy. It is evident from this correspondence, the second of the Complainants' daughters mentioned above was not covered under the policy at this point in time. This is also clear from the Membership Certificate.

Referring to a recent telephone conversation with the Provider, by letter dated **12 November 2018**, the First Complainant wrote to the Provider seeking to have the second of his daughters added to the policy:

> *"… As discussed the only other change I am aware of which may not yet be noted is the addition of my new baby daughter … to the Policy. As discussed I enclose herewith a copy of her birth certificate and ask that same be placed with her policy details on file. …"*

During a call on **14 December 2018**, the First Complainant telephoned the Provider in respect of a renewal email from the Provider advising that he had renewed the policy. The First Complainant advised that he had not renewed the policy but wanted to query if the policy renewed by default. During this call, the First Complainant stated that he was thinking of moving to another provider and that while he hoped to stay with the Provider, he was not going to stay unless the Provider did something about his previous claim. The First Complainant stated that *"I was hoping not to renew"* as he was trying to change policy.

The Second Complainant contacted the Provider by telephone on **22 May 2019** explaining that one of her daughters was scheduled for a procedure in Hospital 2, but the hospital advised that this child was not covered under the policy. In response this, the Provider's agent confirmed that this child was not listed on the policy.

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The Provider's agent asked when this child was to be added to the policy and the Second Complainant answered **2017** and that this child was born in **September 2017**. The Provider's agent asked if the Complainants telephoned the Provider to add this child to the policy. The Second Complainant explained that she did not add this child to the policy and that the First Complainant handled renewals which was generally around November time. The Second Complainant was unable to confirm to the Provider's agent if or when this child was added to the policy.

The First Complainant spoke with the Provider on **22 May 2019** regarding the inclusion of his daughter on the policy. The First Complainant explained that he sent a letter to the Provider in **November 2018** requesting to add this child to the policy. During this call, the First Complainant referred to a telephone conversation he had with one of the Provider's agents in its Claims Support Department regarding changes to the policy, and the First Complainant explained that he told this agent about the birth of his daughter. The First Complainant says he was advised to send details of the birth of this child to the Provider. However, the First Complainant did not specify the date this conversation took place. The First Complainant gave the name of the agent he spoke with and indicated that it may have been the same day as his November letter or the day before, but he could not recall the precise date of the conversation.

In the course of a second conversation with the First Complainant on **22 May 2019**, the First Complainant mentioned that he had an *electronic record* of the November letter being sent. Later in the conversation, the First Complainant stated that the letter was sent to a PO box address. The First Complainant advised that he would have spoken to the relevant agent within a couple of days of the letter being sent. A complaint was logged on foot this call and the Complainants' daughter was also added to the policy.

The Provider issued a Final Response letter on **1 July 2019** advising that following a review of the Complainants' file, the Provider did not receive the First Complainant's letter and the instruction to add his daughter to the policy was not actioned.

A number of submissions have been made by the parties following the Provider's Formal Response. In particular, I note the following passage from the Complainants' submission dated **18 September 2020**:

> *"In the second instance again the default position of [the Provider] is to refuse cover entirely again as a result of one part of the claim not being in order ([the Complainants' daughter's procedure), in this case the consultant was approved, the Hospital was approved but [our daughter] hadn't been formally added to the family policy because although [number] other children at the time had and it was a family policy and but for a missed call or a missed form or however she has not added all cover would apparently been allowed but again because of a technicality, which I am sure is buried somewhere in the 200 pages of general conditions, it allows [the Provider] to decline cover."*

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In a submission dated **25 September 2020**, the Complainants state that:

> *"**Reply 8 and 9** simply is simply a denial by [the Provider] that they were aware or made aware of our [number] daughter … being added to the policy. They have furnished selected phone calls in this regard which neither prove or disprove any point here. It is the case that there is absolutely no benefit to us in not adding our daughter to the policy as we have added all of the others including our most recent child. The Premium is not affected and it is a simple procedure. Again, we would not have gone to the trouble of arranging and paying for consultants fees in relation to [our daughter's] operation, arranging again for it to take place, at [Hospital 2] this time, as arranged by our consultant again on foot of our policy and going through with a costly operation without having a genuine belief that we had cover in place for our daughter …. If for one second we had a doubt in this regard, we could have added [our daughter] at any time prior to the operation or indeed put the operation off but we believed she was covered under the policy at that time.*
>
> *[The Provider] confirmed that the Procedure … was covered, the Hospital was covered, the consultant was covered so all three ingredients in place but this time [the Provider] can void cover because they have no record of [our daughter] being added on their system. Again I ask [the Provider] to exercise discretion … where a typographical error may have led to the omission of a childs name."*

Analysis

The Provider states that it did not receive the November letter and that it has no record of any telephone conversation from around this time which would support the Complainants' position. The First Complainant has not been able to identify the date on which the relevant telephone conversation took place nor has he been able to produce a telephone record showing that any telephone call took place in or around **12 November 2018**. Further to this, there is no evidence to confirm any telephone calls took place during **November 2018**.

There appears to be a conflict in the evidence in respect of the means by which the letter was sent. During the telephone conversation on **22 May 2019**, the First Complainant stated that he had an electronic record of the letter being sent, but later in the conversation he states that it was sent to a postal address. I note that the Complainants have not provided a copy of this electronic record.

In terms of the call recordings furnished by the Provider, the closest point of contact to the November letter appears to be a telephone conversation with the First Complainant on **14 December 2018**. During the **22 May 2019** conversation, the First Complainant stated that he did not receive a receipt or acknowledgment from the Provider in respect of his November letter. However, he did not mention the November letter during the December call nor did he mention the fact this was not acknowledged by the Provider.

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Further to this, if it was the case that the Complainants were considering switching provider and the First Complainant indicated not only that he had not renewed the policy but that he was hoping not to renew; the addition of his daughter to the policy a month prior to this would appear somewhat inconsistent with the First Complainant's position at the time of the December call.

Therefore, having considered the evidence, I have no evidence that any telephone conversations took place between the Complainants and the Provider during **November 2018** regarding the addition of their daughter to the policy nor have I any evidence that the **November 2018** letter was sent to or received by the Provider. As I have no evidence that the Provider received an instruction to add the Complainants' daughter to the policy, I accept that the Provider was entitled to decline the Complainants' claim in respect of the procedure relating to this daughter as she was not covered under the policy at the time the procedure took place.

For the reasons outlined in this Decision, I do not uphold this complaint.

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.

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

11 March 2021

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,

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(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.