An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0158
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Rejection of claim - late notification Delayed or inadequate communication
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint relates to a private health insurance policy and the Provider's refusal to pay a claim made by the Complainant under the policy.

The Complainant's Case

The Complainant submits that she held a private health insurance policy with the Provider from **December 2009** to **November 2016** and during that period she was not made aware of any time limit for claiming outpatient expenses. The Complainant states that in **December 2018**, she submitted a claim for expenses incurred in 2014 and she was informed that she could not proceed with the claim as it was outside of the time limits allowed under the Provider's rules.

The Complainant asserts she was not made aware of any changes to existing timelines, and she believes that she did not receive a copy of any documentation from the Provider, which was referenced in the letter sent to her declining her claim.

The Provider's Case

The Provider states that the time limits have always been in place in accordance with its scheme rules and that outpatient receipts can only be claimed within 12 months of the date of the visit. The Provider states that this rule has been strictly enforced since **2017**, and all of its active members have been advised of it.

The Provider has however stated that it will allow the Complainant's receipts to be assessed on an ex gratia basis under her previous level of cover held, but that the outpatient excess of €440 in respect of these claims would apply in line with the Complainant's plan at the time that the expenses were incurred.

The Provider says that this offer is made without any admission or acknowledgement of any obligation on its part to update former members, of its rule changes or enforcement policies.

The Complaint for Adjudication

The Complaint is that the Provider wrongfully refused to fully indemnify the Complainant for her claim 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 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 **28 April 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.

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In the absence of additional submissions from the parties, within the period permitted, the final determination of this office is set out below.

The Provider submits that on joining in **December 2009**, the Complainant was issued with a rules brochure on 10 December 2009 which contained the following wording on page 15:

> *(c) You should send your claims to us as soon as possible. We will only pay benefits if we receive all of the following:*
>
> - *a written claim within 12 months from the date of any non-surgical outpatient treatment and 6 months from the date of any other treatment (unless this was not reasonably possible). You must make the claim in the way that we reasonably ask you. We may change the procedure for making a claim. If we do change the procedure, we will write and let you know.*

The Provider then explains that on **13 December 2014**, the Complainant changed her level of cover and upon doing so she received an amended pack, which included a rules brochure and within this brochure the following wording was contained on page 13:

> *(c) You should send your claims to us as soon as possible. We will only pay benefits if we receive all of the following:*
>
> - *a written claim within 12 months of the date of any non-surgical outpatient treatment and 6 months of the date of any other treatment (unless this was not reasonably possible). You must make the claim in the way that re-reasonably ask you. We may change the procedure for making a claim. If we do change the procedure, we will write and let you know.*
> - *Any proof we reasonably need to help us to decide if you are entitled to benefits. through the Member App or using an out-patient claim form.*

The Provider has supplied a copy of both of these brochures in evidence, and the contents have been noted.

On **20 December 2016,** the Complainant's daughter emailed the Provider stating she wished to cancel her mother's membership from 1 December 2016. The Provider responded the same day confirming that the Complainant's membership was cancelled with effect from 1 December 2016.

The Provider explains then, that from **August 2017** onwards, it made a decision to strictly enforce the 12 month rule. The Provider explains that before August 2017, while the 12 month rule was outlined in the rules brochure, it was not strictly enforced and, as a gesture to its members, the Provider previously allowed the assessment of outpatient claims made outside of the 12 month rule.

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The Provider also explains that it had previously assessed and made payments on previous outpatient expenses claims submitted by the Complainant which were outside of the applicable 12 month rule, during the course of her membership and before the decision in August 2017, to more strictly enforce the rule regarding 12 months to make a claim.

The Provider says that in **August 2017**, it notified its active members of this policy decision. The Provider submits that it would not be practicable to send updates to all its previous members who are no longer members, in the event of rule updates and policy changes. The Complainant did query the claim over the telephone but was told that any claims outside of the 12 months would not be admissible because of the 12 month rule. This is what gave rise to this complaint.

I note that the terms and conditions of the 2009 and 2014 rules brochure are sufficiently clear that outpatient claims will only be paid on receipt of a written claim within 12 months from the date of the nonsurgical outpatient treatment and 6 months from the date of any other treatment. The terms also expressly state that the Provider may change the procedure for making a claim and if it does, it will write to the policyholder to let them know.

As it happens, before August 2017, the Provider had adopted a more flexible approach and it allowed outpatient claims notwithstanding the fact that they were outside of the 12 month time limit. By August 2017, the Complainant had cancelled her policy approximately 8 months earlier and was no longer a policyholder. By the time the Complainant sought to make her claim, in **December 2018**, the Provider had decided to adopt a less flexible approach and that it would strictly apply the 12 month time limit. The Provider states that in line with the content of the rules brochure, it wrote to its policyholders to inform them of this, but it did not write to the Complainant, because she was no longer a policyholder at the time.

The Provider is entitled to rely on the terms and conditions of the rules in respect of its policyholders and equally it is obliged to comply with those terms and conditions. However, I accept the Provider's submission that it would not be practicable to expect it to write to every former policyholder, to inform them of rule changes or policy changes.

I am satisfied that it is clear under the terms of the rules brochure that applied to the Complainant's policy when it was active, that the Provider was entitled to exercise the 12 month rule. However, at the time, the Provider had chosen to adopt more relaxed approach This changed in August 2017 and the terms of the rule brochure expressly provide that the Provider can change the procedure for making a claim. I am satisfied therefore that the Provider operated within the terms and conditions of the rules brochure and I'm equally satisfied that it did not have an obligation to write to former members to inform them of ongoing policy changes that would apply to members of the health insurance scheme.

I note however the Provider's ex gratia offer to process the claim in line with the previous level of cover held by the Complainant at the time when the outpatient expenses were incurred. I am satisfied that this is a reasonable approach, given that the Provider previously assessed such overdue claims from the Complainant, and it may well be that the Complainant had come to rely upon that practice, before she ceased her membership.

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The Complainant should be aware however, that it is the policy terms and conditions which were in place at the time when the medical expenses were incurred, which will govern the excess deductible and the assessment of any such claim.

I am satisfied that the Provider was entitled to decline the Complainant's claim because the medical expenses incurred were long since overdue to be claimed. I take the view however, that the Provider's approach has been reasonable in the circumstances and on the basis of the evidence before me, and given that the Provider has confirmed that it will now assess the claim, on an *ex-gratia* basis, I do not consider it appropriate or necessary to 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.

MARYROSE MCGOVERN
DEPUTY FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

20 May 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,**
  - **(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.