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| **Decision Ref:** | 2021-0224 |
| **Sector:** | Insurance |
| **Product / Service:** | Private Health Insurance |
| **Conduct(s) complained of:** | Rejection of claim - pre-existing condition<br>Rejection of claim - waiting periods apply |
| **Outcome:** | Partially upheld |

## LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

### Background

This complaint concerns a private Health Insurance Policy

The Complainant submits that she underwent gynaecological procedures in hospital on **01 July 2019** and **07 October 2019** and further submits that the Provider has refused to pay the resulting claims under the policy.

The complaint is that the Provider has wrongfully repudiated the Complainant's claims for her treatment under the policy.

### The Complainant's Case

The Complainant states she asked the Provider, twice, by email and Webchat, if she was covered for the surgery. The Complainant states that on both occasions the Provider confirmed that she was covered and confirmed that she could go ahead with the surgery.

The Complainant submits that the Provider was aware on **28 June 2019** that the Provider would not be paying her claim but only informed her of this in their letter dated **12 November 2019.**

The Complainant states that her doctor incorrectly put down that her symptoms were present for *"years"* on her referral letter. The Complainant states that this reference to *"years"* is incorrect and says she does not know why her doctor said that in the referral letter.

The Complainant states that the doctor has since retired from her GP surgery so she is unable to dispute this with her.

The Complainant wants the Provider to pay for the claims, as she says the Provider led her to believe she was covered and let her go ahead with the surgery.

**The Provider's Case**

The Provider in its Final Response Letter dated **3 December 2019** states:

> *"Based on the information provided for review our Medical Advisors have concluded that the symptoms, which prompted your referral and surgery were present for "years" thus prior to the commencement of your [Provider] policy on 23 January 2019".*

And:

> *"Consequently, 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".*

The Provider's position is that the linked claim could also not be paid.

**The Complaint for Adjudication**

The complaint is that the Provider wrongfully repudiated the Complainant's 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 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

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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 **24 May 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.

Submissions dated **11 June 2021** from the Provider, and a submission from the Complainant dated **16 June 2021** advising she had no further comment, were received by this office after I issued my Preliminary Decision to the parties. These submissions were exchanged between the parties and an opportunity was made available to both parties for any additional observations arising from those additional submissions.

The Provider states that the Complainant joined the plan online on **23/01/2019**. The Provider says that when requesting to "Get a Quote" from the website, the following disclaimer advises:

> ***"Waiting periods:*** *If you have held private health insurance within the past 13 weeks and the level of cover was higher or is the same as that of your new policy with us, then you are covered immediately with no waiting periods. If you are still serving your 5 year *pre-existing waiting period (for ailments, illnesses or conditions where the signs or symptoms existed at any time in the period of 6 months prior to the insurance commencing) you may serve the balance with [the Provider]. Should you require additional cover or benefits a 2 year waiting period must be served before you can avail of the higher level of cover for any disease, illness or injury of which the symptoms began before you changed your level of cover. When taking out health insurance for the first time or if it has been 13 weeks since you last held private health insurance with an Irish health insurer, the five year *pre-existing waiting period for illnesses applies. When taking out health insurance for the first time or if it has been 13 weeks since you last held private health insurance with an Irish health insurer a 52 week maternity waiting period also applies. Find out more about our waiting periods here [link to data base]"*

The Provider states that on **24/01/2019** the Complainant used the Provider's webchat service and the customer service advisor advised:

> *"If you are taking out health insurance for the first time or it has been 13 weeks since you last had private health insurance with an Irish health insurer, the following waiting periods may apply.*

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*A 5 year wait for pre-existing conditions to be covered.*
*(The definition of a pre-existing condition will be an ailment, illness or condition where the signs or symptoms existed at any time in the period of 6 months prior to the insurance commencing)"*

On **24/01/2019**, the Provider e-mailed the Complainant to advise that her Welcome Pack was available to view online on the secure Member Area. This Welcome Pack was also posted to the Complainant on **25/01/2019**, at her request. Included in this pack was a General Rules booklet.

Page 5 of the General Rules booklet under Section 2 "Policy Definitions" states:

## 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 condition 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.**

Page 12, Section 9, set out "What is not covered under the policy"

## The pre-existing condition waiting period is

- the first five years of membership

Page 36, states: "Important information to note – Waiting periods"

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| How long before **you** can claim for any disease, illness or injury which began or the symptoms of which began before membership started? | 5 years for all age groups |

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On **28/03/2019** the Complainant had a consultation with her GP. On this date the Complainant was referred by her GP, to the Hospital. The referral letter stated, *"she has always had a problem with …. but in recent years, this has been giving a lot of trouble, …".*

The Provider states that this referral letter clearly states that signs were always present, given that the Complainant has *"always*" had a problem with .., and symptoms were present for *"years".* It is the Provider's position that these statements make this a pre-existing condition and therefore, the Complainant was subject to the pre-existing condition waiting period of 5 years.

The Provider submits that the claim was rejected in its entirety on the basis of the referral letter as the information contained therein established that the condition was present prior to the Complainant incepting the policy of health insurance and the claim was consequently ineligible for benefit per the Scheme Rules.

The Provider states that the linked claim was rejected in its entirety as that too was determined to be related to the same pre-existing condition that was present prior to joining.

The Provider explains that it received the claim electronically from the Hospital on **10/07/2019**. The Provider says as the Complainant joined on **23/01/2019** and the consultant, Dr X, had listed the onset date of symptoms as March 2019 on the claim form, the claim was then added to the claims pended list to request further clarification of the onset date of symptoms. The Provider states that standard protocol from a claims assessment point of view would be to request the referral letter for the onset date of symptoms as the symptoms were stated to have begun very close to the original joining date with the Provider. The Provider states that in statements from its claims department to the Hospital it was outlined that this claim would be pended awaiting the referral letter for the procedure. The Provider states that a statement was issued to the Hospital in August, September and October 2019.

On **07/10/2019** Dr X's secretary contacted the Provider querying the claim. The Provider states that it advised it required the referral letter and had requested the letter from the Hospital. The Consultant's secretary then forwarded the GP referral letter to the Provider on **09/10/2019**. The Provider says it was forwarded to the claims assessor on **21/10/2019** and it was set for rejection on **22/10/2019** as the information in the referral stated the Complainant has *"always had a problem"* and therefore this was a pre-existing condition.

The Provider says it pays in-patient claims around the 11th-15th of each month, and as this claim was set for rejection after the October payment run it was then rejected in the November payment run on **12/11/2019**. The cost of this claim was €1,352.

The linked claim was for a day-case procedure on **04/11/2019** with Dr X in the Hospital.

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The total cost of claim was €2,442.80. The Provider says that this claim was rejected in its entirety as it was related to the first claim and therefore also subject to the pre-existing condition waiting period.

The Provider states that it received the linked claim electronically from the Hospital on **05/12/2019**. The Provider says it was then added to the claims pended list. This was done as the initial claim had been rejected due to the pre-existing condition waiting period. The Provider states that its medical team reviewed the linked claim to establish if it was related to the initial claim.

The Provider submit that requests were sent on **13/01/2020** to the Hospital for admission notes, including the procedure booking form and medical notes. The claim remained on the pended list throughout January and February as these notes were not received. Provider statements were issued to the Hospital in January and February 2020 advising the claim was pended awaiting a Medical Practice review. The Hospital admission notes were received on **02/03/2020**. The Provider says these notes established that the symptoms were the same presenting symptoms as stated on the initial claim, and the same referral letter was used, therefore, the linked claim was assessed and set for rejection on 06/03/2020 and rejected on **11/03/2020**.

On **21/11/2019** the Complainant requested to open an appeal on the initial claim. This appeal was closed and rejected on **03/12/2019**.

The Provider states that its protocol is to advise of all waiting periods in its member's documents and to advise of "both scenarios" if a member checks cover for a procedure with the Provider. The Provider submits that what this means is, should a member contact its customer service team to check cover, its customer service team will advise a member of their cover if their symptoms were present prior to joining the Provider, and will also advise of their cover if their symptoms were new since joining the Provider. The Provider says that this was done in this case. The Provider says the onset date of symptoms is determined by its medical advisors based on the clinical information available to the Provider and as such both scenarios are advised on all occasions where a member checks cover with the Provider unless there is evidence of 5 years of uninterrupted health insurance cover.

- On **28/03/2019** the Complainant emailed the Provider and advised:
  *"I was at the doctor today for a gynaecological issue, she has referred me to a specialist in the [Hospital] and she thinks that im going to need an operation."*

- On **03/04/2019** a customer service advisor responded to this email and advised the Complainant to contact the Provider again when she had more details and:
  *"Please note if your symptoms were present before your joining date of 23/01/2019 your procedure will not be covered."*

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- On **17/05/2019** the Complainant e-mailed [the Provider] advising the following:
  *"The name of your consultant – "Dr X"*
  *The hospital you will be admitted to - "X Hospital"*
  *The date symptoms of your condition first occurred – "14 Mar 2019"*
  *The name of the procedure you will be having or the procedure code – "xxxx"*

- On **20/05/2019** a customer service advisor responded to this email and advised:
  *"Based on the information you have provided you are covered for procedure … in the .. Hospital under [Dr X]. An excess of €175 is payable by you on admission. Please note if the onset date of your symptoms are before your joining date of 23/01/2019 the procedure will not be covered."*

The Provider therefore, says that the Complainant was advised on the appropriate cover based on the information she furnished to the Provider. The Provider states the Complainant was also advised there would be no cover if her symptoms were pre-existing to her joining date, and that both scenarios were explained to the Complainant.
The Provider states that on **28/06/2019** the Hospital called the Provider to check the Complainant's previous insurance details and waiting periods. The Provider says that this would be normal practice from hospitals to check if a patient had continuous cover to establish if waiting periods are served. A customer service advisor advised the Hospital that the Provider had no previous health insurance details for the Complainant. The Provider says it advises hospitals on the level of cover available, the Provider do not advise on whether a procedure should take place or not. The Provider says this is a decision to be taken by the member and their consultant, and this decision is outside of the scope of its involvement.

The Provider states that on **07/10/2019** the Complainant checked cover for her second procedure, via webchat. The Provider says the customer service advisor advised:

"*Provided your symptoms have started after joining [the Provider] you will be covered in the [Hospital] with an excess to pay on the day of €175"*.

The Provider submits that during the assessment of the claim, the Provider requested a GP referral letter from the Complainant's Consultant, Dr X, which advised symptoms were present for *"years"*. The Provider says this was at variance to the Complainant's statement that symptoms began after joining. The Provider therefore says the claim was rejected based on the pre-existing condition waiting period.

The Provider says it assess claims based on the clinical information available to it. This information is recorded in real time by the medical practitioners involved in the case as per the guide to Professional Conduct and Ethics for Registered Medical Practitioners 2019, as compiled by the Medical Council. The Provider states that practitioners have a duty of care to ensure that their records are accurate and up to date. The Provider therefore, says it is reasonable for it to be able to rely on these records when assessing claims.

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On **12/11/2019** the Provider issued a Statement of Claim, for the initial claim, by email to the Complainant. The Provider states it advised the Complainant of her cover prior to the procedure on the basis of the information she furnished. The Provider states that the information the Complainant furnished was that her symptoms were new since her joining date of **23/01/2019**. The Provider states that the clinical information received stated her symptoms were *"always"* an issue and were exacerbated in *"recent years"* therefore the claim was rejected due to the pre-existing condition waiting period.

As regards whether the Provider accepts that it could have informed the Complainant of its position prior to her surgeries, the Provider states that it informed the Complainant of its position prior to surgery on the basis of the information she provided in respect of the onset date of symptoms. The Provider states however, the referral letter contradicted the information provided by the Complainant and so both claims were rejected due to the 5 year pre-existing condition waiting period.

The Provider says it is compliant with the Consumer Protection Code provision:
*7.6 A **regulated entity** must endeavour to verify the validity of a claim received from a **claimant** prior to making a decision on its outcome*.

The Provider says it verified the validity of the claim prior to making a decision by contacting the Hospital and the Consultant to request the GP referral letter. The Provider say this was done in order to establish the onset date of symptoms so that the Provider could make a decision on the eligibility of the claim. The Provider submits that once this information was received, the initial claim was rejected on **12/11/2019** as the symptoms were deemed to be pre-existing based on the information contained in the referral letter. The linked claim was rejected on **11/03/2020** as the Provider claims department contacted the Hospital for hospital admission notes. The Hospital forwarded the same referral letter as a part of these notes and therefore, that claim was also rejected due to the 5 year pre-existing waiting period.

The Provider was asked by this office where there is an indeterminate time frame given *"years"* does the Provider not clarify the actual time period with the doctor.

The Provider's response is that where the time frame for the onset date of symptoms is listed as "years", the protocol of the Provider claims assessors is to apply a minimum of one year as the onset date. This the Provider says is in the interest of fairness to its members.

The Provider says it was completely honest with the Complainant when she checked cover via both email and webchat. The Provider states that the Complainant was advised of her cover if her symptoms were new since her joining date of **23/01/2019**. It was also made clear to the Complainant that her claim would be rejected and there would be no cover if her symptoms were present prior to joining the Provider.

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The Provider submits that it acted with due skill, care and diligence by fact checking the information provided by the consultant on the claim form. The Provider says that the onset date on the claim form was so close to the Complainant's joining date with the Provider, its claims department sought additional clinical information from the Hospital to confirm the onset date of symptoms. A request for the GP referral letter was sent to the Hospital and the secretary of Dr X. The Provider says that the GP referral letter stated symptoms had "*always*" been present and were exacerbated *"in recent years".* It is the Provider's position that in the interest of fairness to the Complainant, its claims assessor applied an onset date of one year minimum from the date of the referral letter. The Provider says however, even with an onset date of one year prior to the referral date of **28/03/2019** this still meant the Complainant's symptoms were present prior to joining the Provider on **23/01/2019**.

The Provider says it also acted diligently in the review of the claims as four independent teams conducted a review of both claims. Firstly the Provider's inpatient claims team reviewed the initial claim and made requests for the GP referral letter. The Provider says this referral letter confirmed the symptoms were pre-existing for *"years"* and this claim was determined to be ineligible for benefit. Secondly, the claims appeal team then reviewed the claim and also confirmed based on the clinical information available, this claim was ineligible due to the 5 year pre-existing condition waiting period. Thirdly, after the appeal was closed for the claim, the Provider received the linked claim which was reviewed by the Provider's Utilisation Review (UR) team. The Provider explains that the UR team is comprised of a team of nurses. This team sought additional clinical information from the Hospital to confirm if both claims were related. The Provider says that on receipt of the hospital admission notes it was found both claims were related and the linked claim was also found to be ineligible for benefit. Finally, the Provider's external medical advisors, also conducted a review of both claims and advised the following:

1. *Based on the provided documentation, when is the earliest date on which the patient presented with signs and/or symptoms of ….?*
   *The discomfort has been present for years ….*
   *… is a birth defect ...*
2. *Please provide an approximate time frame during which it is likely the patient would have first experienced symptoms related to …?*
   *…. is a birth defect … .*
   *Discomforts are described ..“but in recent years, this has been giving a lot of trouble ..” Therefore, we can assume that the discomfort has been present for years.*
3. *The second claim for November 2019 has a diagnosis of painful … lesion. We requested the referral for this claim and were sent a copy of the initial referral we got dated 28/03/2019. Based on the procedure notes for this claim, can you advise if these 2 claims for this patient are linked?* ***Yes*** *The second surgery seems related to be related to the first. It's the same area (right side) mentioned in the report provided by the GP and is a typical complication (cyst) associated with this kind of surgery".*

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The Provider's position is that based on all the above, the pre-existing condition waiting period of 5 years applies to both to the initial claim and linked claim. The Provider states that when assessing claims, it treats all members equally by applying waiting periods rigorously across all members and schemes. This is to ensure market integrity.

The Provider states that it was very clear from the beginning of the Complainant's membership with it and throughout all communications with her. The Provider says that the key information, that a 5 year waiting period had to be served for pre-existing conditions, was brought to the Complainant's attention on numerous occasions. The Provider says the Complainant was advised that she would only have cover if her symptoms were new since her joining date of **23/01/2019**.

As regards whether the Provider was satisfied that it had met its obligations under the relevant General Principles of the Consumer Protection Code 2012 (As amended) regarding its interactions with the Complainant throughout, the Provider's position is that its claims process was outlined in the General Rules booklet which was issued to the Complainant by email on **24/01/2019** and by post on **25/01/2019**.
Page 14, Section 10 "Making a claim":

(a) When possible, **you** should tell us about any **treatment you** are going to have. This gives us the chance to tell **you** if **you** can claim for **benefits**. We may ask **your consultant** or other registered medical practitioner to provide us with full written details of the **treatment**.

(c) **You** should send **your** claims to us as soon as possible. We will only pay **benefits** if we receive all of the following:

- any proof we reasonably need to help us to decide if **you** are entitled to **benefits**.

This can include:

- any medical reports and other information to do with the **treatment** for which **you** are making a claim

(e) In order to process a claim we require a fully completed claim form. If information required to process the claim is incomplete or ambiguous on the claim form, our claims department will follow up with the necessary party to obtain this information.

The Provider states that when assessing claims, it treats all members equally by applying waiting periods rigorously across all members and schemes. This is to ensure market integrity.

The Provider says that due skill, care and diligence was portrayed by fact checking the information provided by the Consultant on the claim form and requesting the GP referral letter for clarification on the onset date of symptoms. The Provider states that diligence of the team was also proven as four independent teams conducted reviews on the eligibility of the Complainant's claims and all four teams confirmed the medical evidence, written in real time, stated that the Complainant's symptoms were present for *"years"* prior to the referral date of **28/03/2019** and therefore subject to the pre-existing conditions waiting period of 5 years.

In the Complainant's submission of **25 September 2020**, the Complainant states that the Provider's position is that it only received information from the treating hospital on the **10/07/2019**. The Complainant however says, the evidence shows that the hospital called the Provider on the **28/06/2019** and the Provider relayed to the hospital that the Complainant's condition had a 5 year waiting period. The Complainant states that this indicated that she was not to be covered. The Complainant states that this was before her surgery – and she says hence the Provider knew that it was not going to cover the claim, but still let her go ahead with the surgery.

The Complainant says that the Provider's position is that it received the claim on the **10/07/2019** – the Complainant says, yet her claim was not accessed until months later and rejected on the **12/11/2019**. The Complainant submits that in October she contacted the Provider for her second surgery and was told that she was covered, even though as per the Provider notes her claim was set for rejection on the **22/10/2019** which was before her second surgery which was on the **04/11/2019**. In this regard, the Complainant questions why the Provider did not inform her that she was not to be covered despite the Provider knowing the position before both surgeries.

The Complainant states that the Provider says it informs all their clients of "both scenarios". The Complainant says that this does not make any sense.

The Complainant submits that the Provider told her she was covered on all occasions when she contacted the Provider about both surgeries, then it mentions at the end of the correspondence that if the condition is pre-existing you are not covered. The Complainant's position is that when reading these responses from the Provider as her condition is not pre-existing it confirmed to her that she was covered, so she went ahead with the surgeries.

The Complainant says she believes that the Provider purposely informs clients of "both scenarios" so the Provider can access the claims many months after the surgery, as the Provider does not have the resources or manpower to access claims before a surgery.

The Complainant submits that using this "both scenarios" method is falsely giving the client the belief that they are covered, and it is deliberately ambiguous to "trick" the client

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into believing that they are covered for a surgery when in fact the Provider's customer service agent does not know if the client is covered or not at all.

The Complainant argues that this "both scenario" method is dishonest, misleading and unethical.

The Complainant states that the evidence shows that the Hospital called to advise the Provider that she had a 5-year waiting period on the **28/06/2019** before her surgery, yet the Provider did not contact her to advise of this 5-year waiting period.

> *Provider's note*
> *"On 28/06/2019 the .. Hospital called the [Provider] healthcare to check the Complainant's previous insurance details and waiting periods. This would be normal practice from hospitals to check if a patient had continuous cover to establish if waiting periods are served. A customer service advisor advised the …Hospital that we had no previous health insurance details for the Complainant. [The Provider] healthcare advise hospitals on the level of cover available, [the Provider] healthcare do not advise on whether a procedure should take place or not. This is a decision to be taken by the member and their consultant. This decision is outside of the scope of our involvement".*

The Complainant states that the Provider says that it will only acknowledge clinical information that is in "real time", yet her consultant on her medical form for the Hospital said that her onset date of symptoms was 3 months, hence her symptoms only started in March 2019. The Complainant says this form was completed in "real time" by the consultant. The Complainant says this statement by the Provider, that they will only acknowledge clinical information in "real time" contradicts the Provider's note, which is from an "Expert Clinical Advisor Report" dated **28/08/2020**. The Complainant states that this information is over 1 year after her surgeries and is not in "real time" and that she rejects this information.

> *"[The Provider] healthcare assess claims based on the clinical information available to them. This information is recorded in real time by the medical practitioners involved in the case as per the guide to Professional Conduct and Ethics for Registered Medical Practitioners 2019, as compiled by the Medical Council".*

The Complainant refers to the Provider saying that both claims were rejected due to 5 year waiting period, and she says yet the Provider states it was aware about 5 year waiting period from the Hospital before her surgery.

The Complainant submits that the Provider has not been compliant, as it did not inform her of the decision of her claim before her surgeries, but gave its "both scenario" method that falsely led her to believe that she was covered when in fact the cover had not been accessed properly.

The Complainant states that she does not believe that the Provider has acted in compliance with General Principles 2.1 and 2.2 of the Consumer Protection Code 2012, as

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its *"both scenario"* method is dishonest and deliberately framed to "trick" a consumer into believing that they are covered.

The Complainant says she does not believe that the Provider is compliant with 4.1 of the Consumer Protection Code 2012 as there "both scenario "method is not clear, accurate or in plain English and deliberately framed to "trick" a consumer into believing that they are covered.

It is the Complainant's position that the Provider was aware that it was deeming her condition pre-existing from **28/06/2019** before both surgeries and did not inform her of this.

The Complainant refers to the Provider's quote below:

> *[The Provider] informed the Complainant of its* ***position*** *prior to surgery on the basis of the information she provided in respect of the onset date of symptoms.*

The Complainant notes the Provider uses the singular "position "and not "positions" – as she says the Provider uses a "both scenario" method to cover, and she questions how this statement can be accurate.

The Complainant states that the Policy states that the Provider will tell a customer before treatment if the customer can claim for benefits and the Provider may ask for further documentation to determine this. The Complainant submits that through the Provider's "both scenario" method she was led to falsely believe she was covered, yet the Provider's statement refers clearly that it will be a *yes or no* answer about a claim before surgery. The Complainant questions how can the Provider's "both scenario" method be a clear yes or no answer. The Complainant says she believes that the Provider is not complying with its own terms and condition by not giving a clear yes or no answer to cover.

Page 14 of Policy, Section 10 "Making a claim":

> *"10. Making a Claim*
> *(a) When possible, you should tell us about any treatment you are going to have. This gives us the chance to tell you if you can claim for benefits. We may ask your consultant or other registered medical practitioner to provide us with full written details of the treatment".*

The Complainant states that in the above regard:

- The Provider was aware it was not going to cover the surgeries before both surgeries and did not inform her of this. That the Provider did not comply with its own terms and conditions by not informing her of cover before both surgeries, hence if she had known she was not to be covered, she could have (a) been given a chance to argue this and

present documentation to show her condition was not pre-existing (b) gone public for the surgery if the Provider was not going to cover her.

- The Complainant says the Provider's "Both Scenario" method as mentioned above is dishonest, misleading and unethical.

The Complainant states that she is not an insurance expert, however says she does know through claims with her house insurance and car insurance that, each time she was informed that she was to be covered or not before work on her car or house proceeded. The Complainant says additionally, she is now with another health insurance provider and underwent surgery, this provider was able to inform her before the surgery if she was covered or not.

The Complainant states that she believes that she has been treated very unfairly and unjustly in this issue, and it has caused her a lot of stress and anxiety during a time when she was completing her college thesis, and when pregnant, caused her stress and anxiety.

On **30/09/2020** the Provider issued its response to the above submission from the Complainant.

In its response the Provider states that it determines the onset date of a member's condition based on the clinical information received from the clinicians involved in a case. The Provider states that this information is received after the procedure has taken place. The Provider says that prior to receiving this information, it is impossible for the Provider to determine the exact onset date of symptoms.

The Provider says therefore the Customer service advisors advise on a member's level of cover based on the information being supplied by the member in advance of any procedure. The Provider states that it advises on both scenarios prior to the member's procedures so if there is any issue around waiting periods being served, the member can discuss these waiting periods with the medical practitioners involved. The Provider submits that it is incumbent on it as insurers to advise on all possible scenarios in advance of a procedure, as was done in this case. The Provider says therefore, it apologises if the Complainant feels the Provider is "dishonest, misleading and unethical" but, it asserts that the exact opposite is the case. The Provider states it must, in the interest of being fair to members, advise on all possible scenarios on checking cover calls, when it does not have any clinical information to hand.

The Provider submits that its medical advisors determine the onset of symptoms of a condition by reviewing the clinical notes and letters, which accompany a claim. The Provider states that the onset date written on the claim form is only one element of the clinical information it received. The Provider says that the onset date written on the claim form was at variance to the other clinical information it received, including the referral letter, which stated "*she has always had a problem with …. but in recent years, this has been giving a lot of trouble, ….*". The Provider states that as well as being reviewed

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internally at the Provider, all of the clinical information available was reviewed externally by a Third Party specialist, who also concluded this was a pre-existing condition.

The Provider states that it did not advise the Hospital that the Complainant's condition was pre-existing on a call on **28/06/2019**. The Provider says that the Hospital called the Provider to check the Complainant's previous insurance details and waiting periods in general. The Provider states that it advises hospitals on the level of cover available and if waiting periods are served, and do not advise on whether a procedure should take place or not. The Provider submits that the member in conjunction with her consultant makes this decision. The Provider says in this case, the Complainant and the hospital were aware as per the checking cover call, emails and webchats, that waiting periods were not served.

The Provider explains that it received the initial claim on **10/07/2019**. That additional clinical information was required, namely the referral letter, to determine the onset date of symptoms. The Provider states that this was requested from the Hospital in August, September and October. The Provider states that this referral letter was not provided by the hospital, but subsequently provided by the consultant's secretary. The Provider says that this was received on **09/10/2019** and the initial claim was set for rejection on **22/10/2019**. The Provider submits that the Complainant contacted its customer service team via webchat on **07/10/2019** to check cover for her second procedure. The Provider therefore says, it would have been impossible for the customer service advisor to advise the Complainant on the status of the first claim, as this was still under assessment until after this webchat conversation had taken place.

**Analysis**

On the evidence submitted I accept that the Provider could not have come to an alternative conclusion, other than that the Complainant's medical condition was a pre-existing medical condition subject to the policy's 5 year waiting period.

I am satisfied that the Provider did not have the referral letter, to say whether the condition was pre-existing prior to the initial operation. I accept that the Provider was merely setting out for the Hospital when asked on **28/06/2019** the extent of the cover the Complainant had, and the maximum pre-existing waiting period that could apply. The Provider was not communicating that the pre-existing waiting actually applied in respect of the proposed treatment, as it did not have all the information at that time, to come to that conclusion.

That said, I do consider that the Provider could reasonably have done more to clarify the position regarding cover from the outset with the Complainant verbally and in writing.

The Complainant disputes the information contained in the referral letter and states that the doctor who wrote that letter is no longer practicing.

The Complainant submitted a clarifying letter dated **25 November 2019** from the medical practice she attended (where the retired referring GP practiced), advising that:

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*"Prior to March 2019, there is no previous mention or visits documented in the patient's Medical Records regarding the symptoms which led to this referral".*

The treating Consultant also confirmed that the Complainant's symptoms were recent in origin. In his letter of **13 May 2020** the Consultant stated:

*"The pain was of relatively recent onset only within about 4-6 weeks and I performed surgery to correct it on 01/07/2019. She required further surgery on the 04/11/2019 to complete correction".*

When making her initial enquiry to the Provider as to whether she was covered for the procedure, the Complainant was asked by the Provider as to whether the onset of her symptoms predated the setup of the policy. I believe it was not unreasonable for the Complainant to interpret *"symptoms"* as meaning the complaint (ache or pain for example) that she had or was experiencing and that was the reason that caused her to attend her doctor. A symptom can therefore be said to be subjective. The objective evidence (the "signs") of the disease or illness is completely different and will be identified and given a time frame by the medical practitioner.

Furthermore, I believe the Provider's use of the word "onset" of the symptoms was not clear. I also believe it was not unreasonable for the Complainant to interpret the "onset" to be when she first noted a change in her usual health status, for example when she began to experience pain or discomfort to a degree that required her to attend her doctor.

In the above regard I note that while the Provider used the phrase "onset of symptoms" in its communication with the Complainant, those words are not actually used in the policy documentation. The Policy refers to *"signs or symptoms"* and not *"onset date of your symptoms"* or *"The date symptoms of your condition first occurred"*. All those words have distinct meanings (medically and in their ordinary use). I consider that the Provider should ideally use the wording contained in the policy provisions in its communications with policyholders. Furthermore, it would be helpful for its customers, and in particular, the Complainant, if it provided the definitions for those words in the policy. The Provider's policy provisions do not define what it means by *"onset" "signs"* or *"symptoms".*

From the evidence before me and the lack of clarity ion the Provider's communications, I consider that the Complainant reasonably considered she was giving the Provider the correct information it sought from her.

I consider that a simple question to the Complainant as to what diagnosis was given by the treating doctor could have assisted both parties to establish if the procedure was covered. Advice should also have been reasonably given by the Provider so that the Complainant could have submitted any additional information to assist the Provider in giving accurate information as to the availability of cover under the policy.

I consider that the Provider should have made further, and earlier, enquiries from the Complainant or her medical practitioner, so as to better inform her as to whether the

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medical treatment would be covered by the Provider. It is clear that the policy provisions do allow for such enquiries to be made by the Provider. The Policy specifically states at 10(a):

> *"When possible, you should tell us about any treatment you are going to have. This gives us the chance to tell you if you can claim for benefits. We may ask your consultant or other registered medical practitioner to provide us with full written details of the treatment".*

I consider that in the circumstances where the treatment being claimed for, related to a medical procedure which is provided for a birth defect, or any long-term medical condition, the Provider should have made those further enquiries, particularly as the Complainant had recently joined the Provider.

I note that the Provider sent an e-mail to the Complainant on **29 March 2019** stating:

> *"To advise fully on how your procedure will be covered we would need to know the following by return email:*
>
> *The name of your consultant*
> *The hospital you will be admitted to*
> *The date symptoms of your condition first occurred*
> *The name of the procedure you will be having or the procedure code"*

The Complainant supplied this information when requested. I consider that it would have been reasonable for the Complainant to expect that when she provided the above information, that was specifically requested by the Provider, that the Provider was going to do what it said it would do, that is, ***"To advise fully on how your procedure will be covered"***.

On **17/05/2019** the Complainant e-mailed the Provider advising of the following information:

> *"The name of your consultant" –* ***"Dr X "***
> *"The hospital you will be admitted to" -* ***"X Hospital"***
> *"The date symptoms of your condition first occurred" –* ***"14 Mar 2019"***
> *"The name of the procedure you will be having or the procedure code" –* ***"xxxx"***

The Complainant set out for the Provider, the Consultant's name, the Hospital and the Provider's procedure code for the medical procedure she was going to have done.

On **20/05/2019** the Provider's customer service advisor responded to the above information, and advised:

> *"Based on the information you have provided you are covered for procedure … in the .. Hospital under [Dr X]. An excess of €175 is payable by you on admission. Please note if the onset date of your symptoms are before your joining date of*

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*23/01/2019 the procedure will not be covered."*

I note that again that the policy wording of *"signs or symptoms"* is not used in this communication, but the more subjective wording *"onset date of your symptoms"* is used by the Provider.

It is clear that the Complainant made a considerable effort to establish if she was covered for the procedure before going ahead with it. I consider that it was reasonable of the Complainant to believe that she was receiving the fullest information from the Provider, on the basis of the information she had been asked for by the Provider, and which she had submitted to the Provider.

With this claim, I consider the Provider could have reasonably made further enquiries of the Complainant, or her medical attendant, or reasonably have had the Complainant seek, and submit, a copy of the referral letter from her doctor, before the Provider carried through on its undertaking: *"To advise fully on how your procedure will be covered".* I consider that such further enquiries by the Provider were reasonably required as the medical procedure claimed for by the Complainant was a medical procedure that appears to be related to a treatment for a medical condition that could have an onset date going back as far as birth. Knowing this information and knowing that the Complainant had only recently joined the Provider, the Provider should have made the further enquires at an early stage, and more accurately advised the Complainant as to cover under the policy. I consider that it is only after making those additional early enquiries that the Provider could reasonably say it had fulfilled its undertaken: "*To advise fully on how your procedure will be covered"*

I note there appears to have been some subsequent enquiry from the Provider with the Consultant as to the procedure code used by the Consultant. However, I do not consider that a claimant should be inconvenienced by any disagreement these parties may have in that regard.

I accept that the Complainant, endeavoured to establish in advance of the procedure whether or not she was covered so that she could have made alternative arrangements had she known earlier, that she would not be covered by the Provider under her health plan. I believe better and clearer communication by the Provider could have established if she was covered before she undertook the procedure.

With regard to the provision of information to a consumer a Provider must ensure that all information it provides is clear and comprehensible, and that key items are brought to the attention of the claimant. The method of presentation must not disguise, diminish or obscure important information.

In its post Preliminary Decision submission, of **16 June 2021** the Provider disputes that the Provider's communications with the Complainant on **20/05/2019** and **07/10/2019** lacked clarity and that the Complainant reasonably considered she was giving the Provider the correct information it sought from her. The Provider states that it considers that the

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advice it gave to the Complainant was in fact quite clear, on the basis of the information the Complainant supplied to the Provider.

The Provider states it considers it absolutely critical to highlight that the date of symptoms that the Complainant gave to the Provider (being **14/03/2019**) and the date of symptoms the Complainant provided to her GP (during her GP consultation held on or around **28/03/2019**) were significantly at variance. The Provider states it advised the Complainant of cover on the basis that her symptoms commenced on **14/03/2019** as per the information advised to it in her email of **17/05/2019**. The Provider submits that the Complainant failed to disclose to the Provider that, as stated in the GP referral letter dated **28/03/2019**, she had in fact "always had a problem" with this gynaecological issue and she further failed to disclose to the Provider the duration of the symptoms that she had described to her GP, namely that she had been having a lot of trouble, especially after participating in her sport in "recent years".

The Provider states that the Complainant clearly advised the Provider that the date symptoms of the condition first occurred was **14/03/2019**, despite her GP describing the issue as having been exacerbated in "recent years" in the referral letter dated **28/03/2019**. The Provider states that while the term "onset date of symptoms" is not used in the policy documentation, the Provider does not accept that this term, in its ordinary meaning, could mean anything other than the date the symptoms (the ache or pain) first occurred, being in "recent years" as stated to the GP's referral letter, as opposed to the date that the Complainant finally decided to attend her doctor. The Provider argues that accepting that the Complainant took the interpretation of "onset" as that suggested by the FSPO, she did not disclose the same "onset" to the Provider as she disclosed to her GP, as evidenced by the referral letter dated **28/03/2019**.

The Provider states it took the definition of 'pre-existing condition' directly from the Health Insurance Act 1994 (Open Enrolment) Regulations 2015 (S.I. No. 79/2015) as being '*an ailment, illness or condition, where, on the basis of medical advice, the signs or symptoms of that ailment, illness 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*.' The Provider says the legislation itself does not define or give any further guidance on the meaning of "*signs" or "symptoms*".

The Provider states that it notes the view in my Preliminary Decision that the Complainant endeavoured to establish cover in advance of the procedure, but says it believes it to be an error of fact not to find that this endeavour was based on misleading information given to the Provider and it says it does not accept that the information it provided in response was unclear or ambiguous nor does it accept that any attempt was made to disguise, diminish or obscure any important information. The Provider submits that the advice provided was clear based on the information the Complainant furnished to the Provider.

The Provider then goes on to state, in its post Preliminary Decision submission, that there are fundamental principles of law underpinning insurance contracts including the doctrine of utmost good faith and the duty of disclosure of material facts. The Provider states it considers that the Complainant failed to disclose to the Provider that the gynaecological

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matter in question, was a pre-existing condition which had become more symptomatic in "recent years", as stated in the GP's referral letter. The Provider states that the Complainant did not provide the same material facts regarding symptoms to the Provider as she provided to her GP. It states that, had she done so, the Provider would have been in an informed position to advise her that she would not have been covered for the proposed procedure. The Provider states that in particular, it would reiterate that the date of symptoms that the Complainant provided to the Provider (being **14/03/2019**) and date of symptoms the Complainant provided to her GP (during her GP consultation held on **28/03/2019**) were significantly at variance, a fact which was material to the claim.

The Provider submits that the Complainant led the Provider to believe that her symptoms were not pre-existing and, even if that was a mistaken belief of the Complainant herself (despite the relevant dates given to her GP), the Provider's advice regarding waiting periods for pre-existing conditions should have prompted the Complainant to give the Provider the same details as she had given to the GP. The Provider says on this basis it submits that an error of fact has been made in my Preliminary Decision in respect of the non-disclosure by the Complainant of a material fact and any assertion that the Provider's communications on the matter lacked clarity could only be founded on this error of fact.

The Provider states it fundamentally disagrees with and rejects the Complainant's assertion that the Provider's dealings with the Complainant were dishonest and deliberately framed to "trick" her into believing that she was covered. The Provider says there could be absolutely no benefit for the Provider, whether financial or otherwise, in "tricking" a member into believing that he/she is covered for a procedure that is not in fact covered by his/her policy of insurance. The Provider says it believe that setting out "both scenarios" is the prudent approach to take in circumstances where, even though the information presented by a member would lead the Provider to believe that no pre-existing condition exists (as the Provider says was its belief in the case of the Complainant, based on the information she provided), there could nevertheless be a risk that a member may be under the mistaken belief that they are covered for a pre-existing condition.

The Provider states it disagrees that it should have requested further medical information from the Complainant prior to a procedure being performed in this case. The Provider states that its customer service operators provide advice in good faith based on the information given to them by its members, information which the customer service operators take at face value. The Provider states in respect of the particular procedure for example, it can be performed to alleviate a condition which is either present from birth or can develop as a result of external factors, for example, radiotherapy. The Provider says that accordingly it relies on the corresponding duty of its members to advise the Provider in good faith regarding whether a condition is pre-existing or not, and in doing so they should derive supporting knowledge from any consultations they may have with their GPs. The Provider states that in this case such supporting knowledge was withheld, as is evidenced in the GP's referral letter dated **28/03/2019**.

In its post Preliminary Decision submission, the Provider totally fails to acknowledge that the Complainant disputes the content of the GP letter of **28 March 2019**. The Provider

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also appears to incorrectly assume that the Complainant had sight of the GP letter prior to Complainant's e-mail to the Provider on **17 May 2019**.

While I accept that the Health Insurance Act 1994 (Open Enrolment) Regulations 2015 (S.I. No. 79/2015) does not define "Signs" or "Symptoms", this does not mean that a Provider cannot include a definition of these words in its policy documentation.

The Provider also contends that it did not have to specifically consider the medical procedure code that was quoted by the Insured, before giving advise as to whether the procedure could be covered, upon a specific enquiry from an Insured. In support of its contention, the Provider furnishes as an example another medical condition that the procedure code also applies to. The Provider states that the procedure code can also be for conditions developing as a result of external factors, and it gives the example, radiotherapy. I do not accept that this example from the Provider, would change my position that the Provider should have known or further questioned the pre-existing nature of the Complainant's medical condition.

In the Provider's Post Preliminary decision submission of **11 June 2021** it inappropriately introduced an assertion / ground for denial of the claim, which had not previously been raised. In its submission the Provider introduces the assertion of non disclosure by the Complainant and alludes to her as not acting in good faith in the claim. This was a wholly inappropriate as it was not raised by the Provider at claim stage.

It is also unnecessary and irrelevant in circumstances where my Preliminary Decision specifically recognised that the Complainant's medical condition was a pre-existing medical condition and not covered under the policy.

I remain of the view that the Provider could have engaged and communicated better with the Complainant in advance of the procedure to establish cover and allow her to make an informed decision. However, I do not accept the Complainant's assertion that the Provider attempted to "trick" her into believing that she was covered for a procedure that was not covered by her policy.

For the reasons set out in this decision, I am partially upholding this complaint and I direct the Provider to make a compensatory payment to the Complainant of €2,000 (two thousand euro).

## Conclusion

- My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is partially upheld, on the grounds prescribed in ***Section 60(2)(g)*** as its conduct was improper.

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- Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to make a compensatory payment to the Complainant in the sum of €2,000, to an account of the Complainant's choosing, within a period of 35 days of the nomination of account details by the Complainant to the Provider. I also direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, if the amount is not paid to the said account, within that period.

- The Provider is also required to comply with ***Section 60(8)(b)*** of the ***Financial Services and Pensions Ombudsman Act 2017.***

**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**

29 June 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.**