Decision Ref:	2021-0312
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Failure to provide correct information Claim handling delays or issues
Outcome:	Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainant holds a health insurance policy with the Provider. The policy period in which this complaint falls, is from 1 January to 31 December 2019.

The Complainant's Case

The Complainant sets out her complaint in the Complaint Form she completed in November 2019, as follows:

> *"I went for a procedure* [on] *19/9/19 in* [Regional Hospital] *– approx. 3-4 weeks before I attended, I rang* [the Provider] *to check if I was covered under* [my health insurance policy]*, the telephone recording I gained since then is what I based my decision on to proceed with the procedure. Since then I have received a letter* [from the Provider] *stating* [my policy] *does not cover this procedure …*
>
> *I wish to be apologised to for incorrect information been relayed to me. The total cost is €824.50".*

The Complainant seeks for the Provider to admit and pay her health insurance claim in the amount of €824.50.

The Complainant's complaint is that the Provider wrongfully or unfairly declined her claim for the cost of treatment under her health insurance policy, in circumstances where the Provider had previously confirmed to the Complainant that her policy would cover the treatment.

The Provider's Case

Provider records indicate that the Complainant incepted her current level of cover health insurance policy with the Provider effective from **1 January 2004**, and it renewed automatically each year. The Complainant was issued with the policy documentation at the time she purchased the policy, and each year thereafter to her Provider online account, in advance of the policy renewal.

The Provider says that these documents outline the policy benefits and terms and conditions. In addition, each renewal notice suggested that the Complainant review the policy details in order to ensure that the policy was suited to her needs and it invited her to contact the Provider with any queries she had regarding the policy.

The Complainant has been insured under the same level of cover policy since 2004, which provides benefit for the public hospital statutory government levy only. In this regard, **Rule 5, 'Your healthcare benefits'**, of the applicable Rules - Terms and Conditions of Membership policy booklet states at pg. 2:

> *"Please read this section carefully to make sure You understand Your cover and that it is sufficient for Your needs. It will also indicate the extent of the benefits under Your contract.*
>
> *Hospital In-patient benefits*
>
> *5.1 Your healthcare plan provides benefit for the statutory daily public ward charge in public hospitals, subject to a maximum of ten days in any twelve month period"*.

The Provider received a claim from the Complainant through a Hospital Claim Form on **4 October 2019**, in respect of a day case admission to [Regional Hospital] on 19 September 2019. The Claim Form stated that the Provider was being billed for Procedure Code 2249 – Hysteroscopy with complete endometrial resection or ablation for menorrhagia (I.P.). It also stated that the Complainant had been treated as a private patient, and included her signature consenting to her being treated as a private patient.

The Provider says that on **24 October 2019**, following the assessment of her claim, a courtesy telephone call was made to the Complainant to advise that the claim was due to be rejected, as she did not hold cover on her policy to be treated as a private patient. The Complainant said she felt she had been advised by the Provider by telephone on **21 August 2019** that her procedure would be covered and she asked for that telephone call to be checked. The recording of the call that took place on 21 August 2019 was checked and a subsequent call was made to the Complainant later on 24 October 2019 to confirm that she had been provided with correct advice and that the claim would be rejected, in accordance with the policy terms and conditions.

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The Provider then wrote to the Complainant on 24 October 2019 confirming the claim declinature, as the procedure she had undergone in [Regional Hospital] on 19 September 2019 fell outside the remit of the terms and conditions of her health insurance policy, whereby the policy provides cover for the statutory daily public ward charge in public hospitals, and that charges for any private medical services are not covered.

The Provider says that by letter dated **31 October 2019**, the Complainant requested a recording of her telephone calls with the Provider that she had made in advance of her claim. The Provider posted these recordings to the Complainant on 8 November 2019.

The Provider notes that the Complainant had telephoned the Provider on 21 August 2019 to check cover for her forthcoming day case procedure on 19 September 2019. The Agent gathered the information at the start of this call and confirmed to the Complainant to *"go in as a public patient"*, to which the Complainant responded *"Ok"*, indicating that she understood the information she had been told. The Agent repeated that the Complainant must attend as a public patient and that the Provider would be billed directly for the government levy and that the claim would be assessed on the medical information received and the policy terms and conditions. This telephone call ended with the Agent asking the Complainant if she needed the Agent to *"run back over anything"*. The Complainant declined this offer, indicating that she understood the information she had just been told.

The Provider confirms that it has robust procedures in place to ensure that it communicates with its customers in a clear and transparent manner. All employees receive in-house induction training in order to fully prepare them to handle customer queries. Training is refreshed on an ongoing basis in the form of written communication to staff, team meetings and dedicated training days. This process and expectation is monitored in the form of a weekly service observe for all customer-facing staff.

The Provider is satisfied that the Complainant was given correct information and advice throughout her telephone call with the Provider on 21 August 2019, when she was clearly advised that she would have cover for her forthcoming procedure once she attended as a public patient, and the Provider could then be billed directly for the government levy. In addition, the Provider is also satisfied that the Complainant's claim was correctly assessed in accordance with the terms and conditions of her current level of cover health insurance policy, which she had held with the Provider since 2004.

The Complaint for Adjudication

The complaint is that in October 2019, the Provider wrongfully or unfairly declined the Complainant's claim for treatment under her health insurance policy, although the Provider had previously confirmed to the Complainant that her policy would cover the treatment.

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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 **29 July 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. Following the consideration of additional submissions from the parties, the final determination of this office is set out below.

The Complainant holds her current level of health insurance cover, by way of a policy she has held with the Provider since **1 January 2004**. The policy period in which this complaint falls, is from 1 January to 31 December 2019.

I note that on **19 September 2019**, the Complainant attended hospital for a one day procedure, and she was admitted as a private patient. On **24 October 2019**, the Provider declined the ensuing claim in respect of this procedure, on the basis that it fell outside the scope of the terms and conditions of the Complainant's health insurance policy, which provides cover only for the statutory daily public ward charge in public hospitals. Charges for any private medical services are not covered by the Complainant's policy.

The Complainant says that she had telephoned the Provider on **21 August 2019** and that the Agent confirmed to her during that call, that her procedure would be covered by her health insurance policy.

Having listened to a recording of the telephone call that took place on 21 August 2019 when the Complainant telephoned the Provider to query cover for her then impending procedure, I note the following exchange:

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Agent: *So you're going for a D&C 17th September in [Regional Hospital] there* [Complainant]*?*

Complainant: *Yeah*

Agent: *Ok, we'll have a quick look for you here. You're on Plan P. Two seconds there* [Complainant]*, just want to double check this here for you, one moment –*

…
Hiya [Complainant]*, thanks for holding there. Yes, that should be perfect* ***once you make sure to go in on the public patient there, ok?***

Complainant: *Ok –*

Agent: *Yeah, bring along your policy number and you'll sign the form, they'll bill* [the Provider] *directly then for the €80 Government levy.*

[underlining added for emphasis]

In addition, towards the end of this telephone call, I note the following exchange:

Agent: ***If you go in as a public patient****, they'll bill* [the Provider] *directly for the government levy, so just make sure to bring your policy number with you, ok?*

Complainant: *Yeah*

Agent: *They'll bill* [the Provider]*, and as always* [Complainant]*, with all claims that are sent to* [the Provider]*, they're always assessed based on the medical information that's attached and then the terms and conditions of the policy.*

Complainant: *Ok. Ok.*

Agent: *Is that ok? Want me to run back over anything there* [Complainant] *or –*

Complainant: *No, no. That's fine.*

[underlining added for emphasis]

I am satisfied that the Agent advised the Complainant twice during this telephone call that her procedure would be covered if she was admitted to the hospital as a public patient.

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I note that the Hospital Claim Form submitted to the Provider sets out at Section 3, the '**History of illness – for completion by the Patient'**, and this includes the following question and answer, with the box below completed, not in handwriting, but rather by way of a printed "x" within the box:

> *"3.11 Did you elect to be a private patient of the admitting consultant?*
>
> *Yes ☒ No ☐ "*

This Hospital Claim Form also contained the following Declaration:

> *"I declare that the information completed above at the time of signing this declaration is true in every respect … Charges which are not eligible for benefit will remain my responsibility to settle directly with the treatment facility/medical practitioner"*.

I note that the Complainant signed directly beneath this Declaration on **19 September 2019**, indicating that she had elected to be a private patient of the admitting consultant.

The Complainant's health insurance policy, like all insurance policies, does not provide cover for every eventuality; rather the cover was subject to the terms, conditions, endorsements and exclusions set out in the policy documentation, as well as the level of cover provided by the policy itself.

In this regard, **Rule 5, 'Your healthcare benefits',** of the applicable Rules - Terms and Conditions of Membership policy booklet states at pg. 2:

> *"Please read this section carefully to make sure You understand Your cover and that it is sufficient for Your needs. It will also indicate the extent of the benefits under Your contract.*
>
> *Hospital In-patient benefits*
>
> *5.1 Your healthcare plan provides benefit for the statutory daily public ward charge in public hospitals, subject to a maximum of ten days in any twelve month period"*.

As the Complainant consented to be admitted to hospital on 19 September 2019 as a private patient, I am satisfied that the Provider was entitled to decline her claim, in accordance with the terms and conditions of her health insurance policy, because her policy does not provide cover to her for private treatment.

I am not however convinced that, as a result of the telephone call in August 2019, the Complainant understood her position, or that the information that the Provider's agent imparted to her at that time, made her position adequately clear to her.

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In particular I am conscious that the Provider's agent explained that she should make sure to bring her policy number and that she would have to "*sign the form*". I note that on more than one occasion the Complainant was told that she should "*go in as a public patient*", but I believe it would have been helpful if the Provider's agent had specified to the Complainant that she had no cover under her policy for private treatment. It would also have been helpful if the provider had made clear to her that if she elected to have treatment as a private patient, she would not be covered by her policy.

A warning of some nature as to the consequences of not "*going in as a public patient",* would in my opinion have assisted the Complainant in better understanding. Whilst I appreciate that the Provider's agent was very friendly, and offered to go back over the information again with the Complainant, and the Complainant declined indicating that she understood, it seems likely to me that the Complainant did not in fact understand that her private medical health insurance policy, did not cover her for private treatment, and would cover her only for the Government Levy payable for admission to the public ward.

I note from Section 3 of the Hospital Claim Form, that the Complainant was offered no option to elect to be dealt with as a "*public patient*". It is unclear in those circumstances as to what opportunity the Complainant had, if any, to "go in as a "*public patient*", once the Complainant got details of the "procedure code" as she had asked for, and the appointment was then arranged at the hospital.

I take the view that the Provider ought to have provided clearer information to the Complainant at the time when she made the call so that she would understand the very strict limits of the cover which her policy offered. I note indeed that the Provider's agent gave the Complainant a procedure code for her intended treatment, but the discussions did not include the reason why the Complainant was asking for this code. Neither did the Provider enquire as to the identity of the treating physician performing the procedure, which might have alerted the Provider, as the expert in this area, to the issue which ultimately arose.

In those circumstances, I take the view that the Provider has a case to answer to the Complainant for the manner in which it managed its communications with her, during the telephone conversation in August 2019, as a result of which the Complainant believed herself to be covered for the procedure and ultimately "signed the form" as the Provider had advised, which facilitated her in being treated as a private patient.

Accordingly, whilst I am satisfied that the Complainant's policy did not provide cover for the cost of the treatment which she underwent in September 2019, I take the view that the Provider has a case to answer to her for the manner in which it made information available to her, at a time when she was seeking clarity as to whether or not she would be covered for a certain procedure.

Accordingly, I consider it appropriate on the evidence before me to partially uphold the complaint and in recognition of the provider's poor communication with the Complainant, I consider it appropriate to direct the Provider to make a compensatory payment to her in the sum of €500.

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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).***

- 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 €500, 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.

MARYROSE MCGOVERN
Deputy Financial Services and Pensions Ombudsman

10 September 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.