Decision Ref: 2021-0380

Sector: Insurance

Product / Service: Private Health Insurance

Conduct(s) complained of: Rejection of claim - late notification

Outcome: Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint arises out of a health insurance policy covering the Complainants, a husband and wife. The policy was first incepted in **January 2014** and was subsequently renewed for the years **2015, 2016, 2017** and **2018.**

The Complainants' Case

The Complainants state that in **March 2020** they submitted receipts for outpatient medical expenses to the Provider in respect of various treatments dated in **2014, 2015, 2016, 2017 and 2018.** The Complainants state that these receipts have been deemed inadmissible by the Provider. They submit that although the Provider states that the claims should be made within a specific timeframe, the Complainants had continuously renewed their insurance policy over a five year period and the Provider failed to specifically draw their attention to this information upon each renewal.

The Complainants are seeking reimbursement under the policy for the claims submitted in **March 2020** in respect of invoice receipts dated in **2014, 2015, 2016, 2017** and **2018**.

The Provider's Case

The Provider submits that the receipts for the claimed treatments are more than 12 months older than the policy renewal date of **01 April 2019** and that outpatient claims must be made within 12 months of the treatment date confirmed on the receipt.

The Provider submits that the Complainants never previously submitted any everyday medical expenses, otherwise known as outpatient expenses, to the Provider. It states that the Complainants did not notify the Provider when claimed expenses were incurred that they were presenting for outpatient treatment.

The Provider states that the ruling in respect of everyday medical expenses was advised to the Complainants upon the inception of their policy on **22 January 2014** via their rules brochure. The Provider submits that this brochure was issued to the Complainants as part of its Welcome Pack via post on **16 January 2014**. The Provider refers to the relevant section of the rules booklet in respect of making a claim, which is set out in the '*Evidence'* section.

The Provider submits that it is incumbent upon all members to review their policy documents and rules booklets to ensure that they are fully aware of the extent of the cover provided by the policy. The Provider notes that when the strict enforcement of the '*already existing rule*' 12 month rule took place in **2018**, the Complainants were specifically notified of this via renewal documentation issued to them via email on **24 November 2017**, in advance of their upcoming **1 January 2018** renewal date**.** The Provider refers to the relevant page of the Renewal Flyer enclosed in the documentation, which is set out below under '*Evidence'*.

The Provider submits that although renewal documentation furnished to the Complainants on **11 November 2014** and **20 November 2015** did not contain a rules brochure, it is submitted by the Provider that this was because the Complainants' level of cover remained unchanged and therefore, the **January 2014** version remained in force. The Provider also states that it contacts its members in advance of their renewals each year, and therefore, the Complainants would have been contacted in **November 2016, November 2017, November 2018** and **November 2019.**

The Provider submits that in 2017, "*in an effort to act honestly, fairly and professionally in the best interests of its customers*", it provided the Complainants with a grace period of 12 months to submit any previous years' everyday medical expenses before the full implementation of the rule. It states that the Complainants did not make use of the grace period.

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The Complaint for Adjudication

The complaint is that the Provider wrongfully and/or unfairly failed to process the Complainants' claim for outpatient medical expenses that were incurred in **2014, 2015, 2016, 2017** and **2018** which it deemed to be admissible due to a time limitation under the policy. The Complainants say that the Provider failed to specifically inform them of this condition.

Decision

During the investigation of this complaint by this Office, the Provider was requested to supply its written response to the complaint and to supply all relevant documents and information. The Provider responded in writing to the complaint and supplied a number of items in evidence. The Complainants were given the opportunity to see the Provider's response and the evidence supplied by the Provider. A full exchange of documentation and evidence took place between the parties.

In arriving at my Legally Binding Decision I have carefully considered the evidence and submissions put forward by the parties to the complaint. Having reviewed and considered the submissions made by the parties to this complaint, I am satisfied that the submissions and evidence furnished did not disclose a conflict of fact such as would require the holding of an Oral Hearing to resolve any such conflict. I am also satisfied that the submissions and evidence furnished were sufficient to enable a Legally Binding Decision to be made in this complaint without the necessity for holding an Oral Hearing.

A Preliminary Decision was issued to the parties on **6 October 2021**, outlining the preliminary determination of this office in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter. In the absence of additional submissions from the parties, within the period permitted, the final determination of this office is set out below.

Chronology of Events

- **16 January 2014:** Provider Welcome Pack, including rules booklet is issued to Complainants via post
- **22 January 2014:** Inception of the Complainants' policy with the Provider
- **11 November 2014:** Renewal documentation issued to Complainants. Rules booklet not furnished as cover remains unchanged.
- **20 November 2015:** Renewal documentation issued to Complainants. Rules booklet not furnished as cover remains unchanged.

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- **21 November 2016:** Renewal documentation issued to Complainants. Rules booklet not furnished as cover remains unchanged.
- **18 January 2017:** First Complainant has conversation with Provider's agent where she receives information about claiming everyday medical expenses. Agent states: "*No, you can go back as far as you need to go back". *First Complainant acknowledges she has not submitted two years' worth of claims and enquires as to "*the situation with it". *(See below, under '*Audio Evidence*').
- **24 November 2017:** Provider emails renewal documentation to the Complainants, which includes specific reference to the '*strict enforcement*' of the '*already existing*' 12 month timeframe within which to claim for everyday medical expenses. A grace period of 12 months is also provided for
- **27th November 2018:** Renewal documentation issued to Complainants. Rules booklet not furnished as cover remains unchanged.
- **26th February 2020:** First Complainant phones Provider to ensure receipt of her claims for '4 years' worth of everyday medical expenses, stating that the claim was 'overlooked'.
- **16th March 2020:** First Complainant phones Provider upon receipt of rejection letter from the Provider in respect of the claims for everyday medical expenses
- **18th March 2020:** First Complainant receives a call back from the Provider who discusses the complaint and available options,
- **30th March 2020:** Submission of complaint to this Office.

Evidence

(i) The Provider's Rules Booklet

This Rules Booklet applies to the policy cover in place between the Provider and the Complainants and was furnished to the Complainants at the inception of the policy on **26 January 2014**.

Under the section entitled '*Making a Claim'* the booklet states as follows*:*

> *"9. (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 out-patient treatment and six months of 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.*

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*(ii) Renewal Flyer emailed to Complainants on **24 November 2017.***

The Provider refers to page 3 of a Renewal Flyer enclosed in the documentation it sent to the Complainants on **24 November 2017** via email in advance of their **1st January 2018** renewal date. The relevant extract of the flyer states:

> "*Claiming has never been easier with our new* [Provider] *Member App. You can now submit your claims for everyday medical expenses through the app at any point during the year – 24 hours a day, 7 days a week. From your renewal, we will be implementing an existing rule which states that out-patient claims should be submitted within 12 months of the treatment date on your receipt. In order to help you with this transition, we will pay out-patient benefits for any receipts that you have not previously submitted if you send them to us within the next 12 months."*

*(iii) SMS 'Claims App' campaign text sent by Provider to Complainant on **9th January 2018***

The Provider's log history evidence in respect of the Complainant, that was provided to facilitate the investigation of this complaint, shows an SMS text message was sent to the First Complainant on ***9th January 2018*** at 00.00. It states as follows:

> *"Hi* [name], *did you know that claiming on your health insurance is now easier than ever with our new* [Provider] *Claims App. Simply download the app on your phone, take a photo of your receipt and submit it through our app 24 hours a day, 7 days a week. Your claims will be paid directly into your bank account in a matter of days. Watch this video to see for yourself or go to* [Provider's web address]"

*(vi) Email from First Complainant dated **13th January 2020***

The Complainants cancelled their policy with the Provider in **January 2020,** confirmation of which was sent by the Provider to the First Complainant on **13th January 2020.** The First Complainant responded to this confirmation email, on the same date, as follows:

> "*Thanks for your reply* [name] *and glad all is sorted now.*
> *I have never make a claim with you. I have receipts from GPs dentists etc going back a few years. Can I sent them in to you. They were over looked"* [sic].

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(v) Audio Evidence

Audio evidence of telephone calls that took place between the Complainant and Provider was submitted to this Office. I have listened to the audio evidence and note the following exchanges:

On **18 January 2017**, the Complainant spoke to the Provider's agent, who explained the availability of a benefit under certain policies offered by the Provider where the policyholder could claim back between 50 to 70 percent on the cost of outpatient expenses.

First Complainant: Oh, that's a big difference. I didn't know that existed.

[…]

First Complainant: …*What kind of stuff comes under that?*

Agent: *Consultant visit, GP visit, routine dental, optical, any scans, X-rays or ultrasounds you may need done. They all fall under that, outpatient. You know when you claim back on your receipts at the end of the year? That's outpatient.*

First Complainant: *Right. I haven't claimed back with you for the last two years and I have receipts and all that. Can I send them in straight away or what's the situation with it?*

Agent: *You can send them in straight away in relation to it, no problem at all.*

First Complainant: *I haven't claimed in the last two years*

Agent: *You can still claim for them now*

First Complainant: *Is there a limit on how many years you can go back or anything?*

Agent: *No. You can go back as far as you need to go back. You were on a policy that you could claim back on. It's your entitlement, you've paid for that policy, you can still claim for that year.*

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On **26th February 2020**, the First Complainant spoke with the Provider's agent to enquire about the claims she had submitted for everyday medical expenses.

Agent:	*It was for four years?*
First Complainant:	*Yeah, it was overlooked*
Agent:	*There is a 12 month rule that you can only claim for receipts that are within 12 months.*
First Complainant:	*I know, but this was a claim that was overlooked. We didn't know that we were entitled to claim for GP and all that kind of stuff, and dental stuff as well.*
Agent:	*What I will say to you is, we will look at it for you but the rule has been there for quite a while so it may be that anything over the 12 months will not be assessed.*
	[…]
First Complainant:	*What can we do about it? Surely the fact that it was overlooked for that length?...*
Agent:	*Overlooked by yourself?*
First Complainant:	*Yes, by ourselves, yes*
Agent:	*Unfortunately, there is nothing we can do about that. If we don't have the receipts in at the right time, then that is something that we can't do anything…It may mean that you're not eligible to claim for anything.*
First Complainant:	*We were eligible*
Agent:	*You were eligible but they weren't into ourselves within the right time frame.*
First Complainant:	*I didn't, we didn't know anything about that at the time. I didn't even know we were eligible to apply for the stuff at the time.*

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[…]

Agent:	**…***if we've sent it* [the policy documentation] *out and you just failed to say read the documentation, we have no grounds to pay it. If there is some other reasoning behind it, then we might look at it.*
First Complainant:	*What kind of reason?*
Agent:	*Well, I don't know* […] *I can only advise you that the rule is there*
First Complainant:	*I know the rule is there, yeah*

On **16th March 2020**, the First Complainant spoke with the Provider's agent to enquire about the claims she had submitted for everyday medical expenses, the rejection of which she had received that day via the post:

First Complainant:	*Can I appeal this to anybody?*
Agent:	*There wouldn't be any appeal, no. It would have to be submitted to ourselves within 12 months of the treatment date*
First Complainant:	*Yeah, but this was overlooked. We're in our sixties and we need this money, or the refund at this stage. We didn't know it was part of our healthcare at the time when we took out this claim, when we took out this membership*
Agent:	*It would be in your policy* […]
First Complainant:	*…we've paid you, I think, €25,000 over the last I don't know how many years. It's only when we decided to change to the other company that we were made aware of this…surely…*

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This statement is repeated by the First Complainant in her subsequent conversation with the Provider's agent on **18th March 2020:**

Agent:	*It is an industry wide rule, it's across the board with* [Insurers]. *The claim forms have it on there as well, at the top of all the claim forms, it will say, in order for this receipt…*
First Complainant:	*Yes, but our problem was that we didn't have any claims. We didn't put in any claims for those years because we weren't aware that we were entitled to those at the time* […] *It was only when we want to change from* [Provider] *to the other that we were made aware of it* […] *These are genuine expenses that we had…they're everyday and the reason we were paying a very high premium at the time and we didn't know that the reason that we were paying it was because of the amount of cover*

Analysis

I am satisfied that the Provider took appropriate steps to inform the Complainants that they were entitled to submit claims in respect of their everyday medical expenses. This benefit was included as part of the initial policy documentation furnished to the Complainants when they joined the Provider. It is also apparent that the stipulation that such claims must be made within 12 months of the date of the relevant receipt, was also clearly included as part of this documentation.

I note that when it was decided by the Provider that the 12-month rule was going to be '*strictly enforced'* from **2018** onwards, the Provider took steps to inform its policyholders of this development, providing a grace period within which to submit any outstanding receipts that fell outside the 12-month permissible timeframe. I am satisfied that these actions discharged the Provider of its consumer protection obligations, as it provided at least one month's notice of this new approach, and indeed made a 12 month grace period available.

The telephone conversation that took place on **18th January 2017** is, however, noteworthy. When asked if there was a limit on how many years the Complainants could go back for, in respect of claiming everyday medical expenses, the Provider's agent explicitly stated that the Complainants could go back "*as far as you need to go back*".

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This statement is somewhat at odds with the Provider's suggestion that the 12-month rule was '*already existing'* prior to its 'strict enforcement' in 2018. The Provider should ensure that its agents, particularly those selling its products, are sufficiently well-versed on the details of its policies to facilitate the discharge of its obligations to consumers.

However, I am satisfied that this conversation did not alter the Complainants' position with regard to their submission of receipts for everyday medical expenses. The Complainants were specifically notified 10 months later, within the renewal documentation that issued to them via email on **24th November 2017,** of the pending strict implementation of "*an existing rule*" in respect of everyday medical expenses.

At the time of the exchange on **18th January 2017,** the Complainants had not yet submitted any receipts. The agent told the First Complainant that she could send the receipts in straight away; however, the next time an enquiry was made by the Complainants about claiming everyday medical expenses was almost three years later, upon their departure from the Provider in **December 2019**, almost three years later. Furthermore, the basis of the present complaint is not that the Complainants were led to believe they could "*go back as far as they liked"*, but rather, that the Provider failed to specifically inform the Complainants of the existence of the 12-month condition. In my opinion, that contention is not borne out by the evidence.

Furthermore, I am not satisfied by the Complainants' repeated statements that it was only when they sought to move their insurance cover from the Provider to another insurer that they were made aware of their ability to claim for everyday medical expenses. No evidence of this suggestion has been put forward and it is clear from the documentary evidence furnished and the audio evidence of the conversation between agents of the Provider and the First Complainant on **18th January 2017,** that this was not simply the case.

Having considered the matter, I am satisfied that the Provider's conduct in refusing to cover the claims was reasonable, based upon all the evidence available and details of which are outlined above. I am satisfied that the Provider acted in accordance with the terms and conditions of the policy in declining the Complainants' claims for reimbursement of everyday medical expenses, and accordingly I take the view that there is no reasonable basis upon which this complaint can be upheld.

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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 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

29 October 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.