An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0550
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Rejection of claim - pre-existing condition Dissatisfaction with customer service
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The First Complainant is covered by a health insurance policy which was incepted by the Second Complainant with the Provider.

The Complainants' Case

The First Complainant's family health insurance policy began with the Provider on **1 July 2003** and was renewed annually thereafter. The first Complainant suffered from pelvic pain and irritable bowel issues between 2014 and 2015.

The Complainants upgraded their policy from **1 June 2015**, in order to provide increased cover and increased benefits and on the same date, the First Complainant initiated her health insurance cover which included those improved benefits (the "**New Health Insurance Package**").

The First Complainant underwent a laparoscopy procedure on the **12 September 2016** and was subsequently diagnosed with Endometriosis. The First Complainant submits that the Provider has since "*refused to cover any of my medical expenses*." The First Complainant further submits that the Provider found that it was not medically necessary for her to stay in hospital during a separate admission on the **16 June 2016**.

The Complainants submit three additional complaints relating to what they assert is a missing telephone call and a suggested data breach caused by the Provider and separately the First Complainant complains regarding the release of medical information held by the Provider.

By email dated **9 January 2018** and addressed to the Provider, the Complainants submit as follows:

> *"[Consultant Gastrointestinal Surgeon] wrote a report on 31st May 2016 stating my medical condition at the time of being admitted to the [Private Hospital A] accident and emergency department and the reason why I required treatment. I then received keyhole surgery in September 2016 following tests that were carried out whilst I was admitted to the [Private Hospital A] accident and emergency department in June 2016.*
>
> *[The Provider] deemed this report as not containing substantial evidence to pay claim. I contacted [The Provider] further on this issue and I was told that the claim will not be paid as I showed symptoms of Endometriosis before starting my new medical cover in June 2016. This is untrue as I was being treated for IBS and at no stage was an Endometriosis diagnosis made until September 2016. I was receiving IBS medication (Colofac) and as it was proving benefical (decrease in pain). Because of this, my symptoms were seen as completely gastro related.*
>
> *I was admitted to Accident and Emergency dept on the 12th June 2016 with severe lower abdominal pain. There were numerous tests carried out on my abdomen during my admittance to [Private Hospital A]. As all tests came back clear and I was still suffering from abdominal pain, [Consultant Gastrointestinal Surgeon] referred me to [Consultant Gynaecologist]. This was the first time I had seen a gynecological consultant in [Private Hospital A].*
>
> *I had received previous ultrasounds to rule out ovarian cysts in [Private Hospital B] by gynecological consultants however all tests confirmed clear results. As these test results came back clear on all occasions, there were no symptoms of Endometriosis previous to September 2016 when a laparoscopy was undertaken by [Consultant Gynaecologist]. It was then and only then that an Endometriosis diagnosis was confirmed. Until I met with [Consultant Gynaecologist] on the 13th June 2016, my symptoms were referred to as abdominal and in no way were they referred to as gynecological.*
>
> *I refer to your letter dated 12th July 2016, 'It appears from the information received on this claim that symptoms of this condition existed before the scheme benefits were increased.' This statement is untrue and I dismiss this as a reason not to pay this claim. For this reason, I will not pay this claim. I am covered for the services I received for the following reasons:*
>
> > *Endometriosis was not examined for/ spoken about until 13th June 2016 with [Consultant Gynaecologist] after being referred by gastroenterology consultant [Consultant Gastrointestinal Surgeon].*
> >
> > *A diagnosis of Endometriosis was not confirmed until a laparoscopy was carried out in September 2016."*

/Cont'd…

By submission dated **9 September 2019**, the First Complainant says:

> *"I was diagnosed with Endometriosis in September 2016. However, there are limitations to this diagnosis as medical professionals and [the Provider] are unable to determine if Endometriosis was causing my ill-health since a young age. I responded very well to Colofac medication for severe IBS and it cannot be ruled out as the main cause of my ill-health. Medical professionals and [the Provider] are unable to determine the start date of Endometriosis."*

By submission dated **9 September 2019**, the First Complainant says:

> *"When we joined [the Provider] in 2003, I was 9 years of age. I was pre-menstrual. I was unable to advise of any pre-existing illness."*

In relation to a separate hospital admission on the night of the **16 June 2016**, the First Complainant says:

> *"When I received the first correspondence from [the Provider], I called them for a further explanation. I was advised that it was 'not medically necessary' for me to stay in the [Private Hospital A] on 15th- 16th June 2016 and therefore they would not settle the bill. This conversation was recorded (as all calls are with [the Provider]). This was never put in writing, but proof can be provided from the call history recordings I requested from [the Provider])… Naturally, I advised that I would've been happier being discharged if it was not medically necessary in hospital."*

The First Complainant asserts that:

> *"I strongly believe [the Provider] is dismissing my case on an unfair and unsupported basis."*

The First Complainant also contends that:

> *"I feel [the Provider] are discriminating against me. We have been loyal customers from 2003 and they have provided mis-matched excuses to avoid settling the accounts with the [Private hospital A] and their consultants."*

By letter dated **30 September 2019**, the First Complainant submits that "*this matter has caused additional agony for me*."

The First Complaint separately complains of a missing phone call and contends that:

> "*I requested my phone call history recordings from [the Provider]. When I met with [Consultant Gynaecologist] in August 2016, she gave me a procedure code. I called [the Provider] with this procedure code and was advised I was covered for the surgery that took place in September 2016. This phone call is missing from the phone recordings received from [the Provider].*

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In relation to the Complainant's request for her medical information from the Provider, the First Complainant wrote to the Provider by email dated **25 January 2018** saying as follows:

> *"I understand information was gathered by [The Provider] regarding my medical history previous to the above date. I would like to request the information received from the various sources at the time as I did not give consent to the [GP] or [Consultant Gastroenterologist] to release this information."*

Additionally, the First Complainant submits that the Provider has:

> *"mistakenly posted my private information regarding my diagnosis to my mother. This matter is being taken up with the GDPR Ombudsman."*

The First Complainant contends that the Provider is incorrect in assessing her Endometriosis as pre-existing the date of renewal of her health insurance policy on **1 June 2015**. The First Complainant says that the Endometriosis was first diagnosed in **September 2016** by way of laparoscopy which is subsequent to the date of renewal of her health insurance policy on **1 June 2015**. The First Complainant submits that the Provider is incorrect in failing to cover her hospital admission on **16 June 2016**. The First Complainant further complains that a telephone call conducted with the Provider is missing. The First Complainant also complains about the release of her medical records to the Provider. Finally, the First Complaint says that the Provider has incorrectly handled her data. In resolution of the complaint, the first Complainant sets out that "*all medical care received in [a private hospital] should be covered and paid in full*."

<u>The Provider's Case</u>

The Provider says that it relies on its terms and conditions which say that after upgrading a health insurance policy, no pre-existing condition will be covered for a period of 2 years for that new higher level of cover or benefit, which results from the upgrade (the "**Upgrade Rule**"). The 2 year Upgrade Rule that began on **1 June 2015** was ultimately served on **1 June 2017** and the Provider submits that during this time the First Complainant was not covered for any higher level of benefit or cover that arose under her New Health Insurance Package.

This complaint relates to an admission on **16 June 2016** and a procedure on **12 September 2016** both of which occurred in a private hospital ("**Private Hospital A**") in circumstances where Private Hospital A required the higher level of cover under the First Complainant's New Health Insurance Package, initiated on **1 June 2015***.*

The Provider submits that the **12 September 2016** admission related to Endometriosis and that the First Complainant's symptoms of Endometriosis pre-dated the renewal and upgrade of the First Complainant's health insurance policy on **1 June 2015** and was therefore *a pre-existing condition*.

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The Provider asserts that because the First Complainant availed of private hospital cover for her **12 September 2016** procedure, she has fallen foul of the Upgrade Rule. The Provider refused cover on this basis.

Additionally, the Provider relies on its terms and conditions to refuse cover for the First Complainant's admission to Private Hospital A on **16 June 2016** as it asserts that this admission was not medically necessary**.**

Furthermore, the Provider has contacted the Data Protection Commission regarding the First Complainant's objection to its use of her data. The Provider submits that it has submitted all telephone evidence relating to the First Complainant, that it was authorised to obtain the First Complainant's medical history in consideration of her claim and that it issued the First Complainant's medical information to her.

The Provider acts as an agent for healthcare products for a principal company (the "**Underwriter Company**"). In this regard, the Provider submits that:

> *"[the Provider] is authorised under our Managing General Agency Agreement with [Underwriter Company] to handle complaints from policyholders in accordance with applicable law and [the Provider] complaints handling process. Therefore, [Underwriter Company], the underwriter, was not involved in this case, as it was processed under the internal [the Provider's] healthcare assessment process."*

In relation to the **12 September 2016** hospital admission, the Provider submits by letter dated **3 April 2018,** and addressed to the First Complainant, that:

> *"This claim was declined for benefit as the clinical information provided with your claim documented that the pelvic pain, which prompted your referral to [Consultant Gynaecologist] for investigation, was ongoing prior to you increasing your benefits, and acquiring cover for the [Private Hospital A] on 01 June 2015*."

In relation to whether or not Endometriosis was a condition pre-existing the Upgrade Rule's start date of **1 June 2015**, the Provider submits that:

> *"A pre-existing condition is defined as one where the symptoms began before a membership started, and it is not the date on when a diagnosis was made. In this case, the Complainants increased membership began on 1 June 2015. As per the previous questions, both her GP and her Consultants, document the Complainants symptoms, as having started prior to this date….it is evident from the clinical documentation received that the symptoms of Endometriosis were present since 2011. These symptoms continued to persist and progress through to September 2014. In September 2014, an ultrasound was requested for menorrhagia, dysmenorrhea and dyspareunia, it is these ongoing symptoms that led to the subsequent diagnosis of Endometriosis. While it is not part of [the Provider's] role, nor part of the assessment process to determine an exact onset of symptoms these symptoms were documented by her GP, at least as far back as 2014."*

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By letter dated **3 April 2018**, the Provider wrote to the First Complainant and said:

> *"Following receipt of your appeal our Medical Advisors have further reviewed your claim, along with additional information provided by your GP, [Consultant Gynaecologist] and [Consultant Gastroenterologist]. …..Based on the above our Medical Advisors have concluded that the pelvic pain which prompted your investigations on 12 September 2016, was consistent and ongoing prior to you upgrading your cover from the [Original Health Insurance Package] to the [New Health Insurance Package] and acquiring cover for the [Private Hospital A]. Therefore, as your symptoms were present prior to you increasing your benefits we are unable to consider the above claim for benefit in line with the upgrade waiting period."*

The Provider submits that:

> *"Following a peer-to-peer review, our Medical Advisors would agree that a laparoscopy is considered the gold standard testing for the diagnosis of Endometriosis. Notwithstanding the above, [the Provider] would like to point out that there is a difference between the onset of symptoms, on which a claim is either rejected or paid, and a diagnosis of Endometriosis, which a laparoscopy is used to determine. There is a large amount of documented evidence that the symptoms of Endometriosis were present as far back as 2014."*

The Provider also submits that:

> *"[the Provider] assess claims based on the clinical information received from the medical practitioners involved in a case. This information is recorded in real time as per the* **Guide to Professional Conduct and Ethics for Registered Medical Practitioners 2019**, *as compiled by the Medical Council. Practitioners have a duty of care to ensure that their records are accurate and up to date (see the relevant section below). Therefore, it is reasonable for [the Provider] to be able to rely on these records during the claim assessment process."*

In relation to the First Complainant's **16 June 2016** stay at Private Hospital A, the Provider submits that the claim was rejected "*as the medical necessity for an overnight stay was not established*."

The Provider rejects the **12 September 2016** claim on the basis that the symptoms of endometriosis are evidenced in the First Complainant's medical records from 2014, and it says that these symptoms pre-date the start date of the Upgrade Rule which was **1 June 2015**. The Provider declined cover for the **16 June 2016** hospital admission on the basis that an overnight stay was not medically justified.

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The Complaint for Adjudication

The complaint is that the Provider wrongfully determined the First Complainant's condition to be pre-existing an upgrade in cover, and wrongfully repudiated the First Complainant's claim, refusing to cover the cost of treatment incurred by the First Complainant in relation to her condition in 2016.

The Complainants also say that the Provider misled them to whether or not the First Complainant's private hospital procedures would be covered by the Provider, and provided inconsistent reasons for declining the First Complainant's claim.

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 **29 November 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.

Overall, the Complainants' complaint relates to two claims against the Provider which amount in total to a cost of **€3,420.00** (three thousand four hundred and twenty euros):

1. Claim xxxxx29 for the [Private Hospital A], [Location] from **16 June 2016** to **17 June 2016** €1,181.00 (one thousand, one hundred and eighty one euros); and

2. Claim xxxxx86 for the [Private Hospital A], [Location] for **12 September 2016** €2,239.00 (two thousand two hundred and thirty nine euros).

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The Provider relies on a number of sections in its terms and conditions housed in the **General Rules Policy Booklet,** dated **15 January 2015**, including Sections 2, 7, 8 and 13.

I note that Section 2, page 4-5, defines "***pre-existing condition***" as follows:

> *"Any disease, illness or injury that a person has which began, or the symptoms of which began, before that person started his or her current continuous period of membership of the scheme. Note that an illness or injury may be present for some time before giving rise to symptoms or being diagnosed. So, when deciding if a disease, illness or injury began before membership started, it is the date when it began that counts not the date when a person became aware of having the disease, illness or injury, or its symptoms."*
>
> [My underlining for emphasis]

Section 7, page 8-9, is entitled "***What is Covered Under the Scheme***" and says as follows:

> *"*
> *(i) We do not have to pay benefits for in-patient treatment provided by a hospital if we are of the reasonable opinion, based on appropriate medical advice, that the treatment could have been received as day-case treatment or out-patient treatment. We also do not have to pay benefits for day-case treatment if we are of the reasonable opinion, based on appropriate medical advice, that the treatment could have been received as out-patient treatment. However, we will pay benefits for such treatment as follows:*
>
> - *if you receive in-patient treatment and we determine that the treatment could have been received as day-case treatment, we may treat such treatment as day-case treatment for the purpose of paying benefits.*
> - *if you receive in-patient treatment or day-case treatment and we determine that the treatment could have been received as out-patient treatment, we may treat such treatment as out-patient treatment for the purpose of paying benefits."*

Section 8, page 10 of the **General Rules Policy Booklet,** is entitled "***What is not Covered under the Scheme***" and says:

> *"we will not pay benefits for the following:*
>
> *(a) Treatment which a person requires during any waiting period that may apply to the treatment under their scheme. All waiting periods commence on a person's membership and upgrade start date and,*
> *except for the maternity waiting period, the length of a waiting period is determined by a person's age on their membership start date."*

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Page 29, is entitled "***Important Information to Note*"** and says:

> *"In addition, if you're upgrading your level of cover/benefits the following waiting periods will apply regardless of how long you have been insured:"*
>
> *"You have health Insurance and want to get a higher level of cover/benefits, how long before you can avail of the better cover/benefits for any disease, Illness or injury which began or the symptoms of which began before you upgraded?*
>
> *2 years for all age groups."*

The Section entitled "***Everyday Medical Expenses – also Referred to as Out-Patient Expenses,"*** page 24 of the **General Rules Policy Booklet**, says:

> *"These are fees and charges for hospitals and consultants for non surgical treatment (other than radiotherapy and chemotherapy out-patient treatment). Annual Out-Patient Excess: Where a member makes a claim for everyday medical expenses [the Provider] will pay valid claims for fees and charges less the amount shown as the out-patient excess. Where two amounts are shown, the first amount refers to a policy where there is only member on the policy and the second amount refers to where you have dependents on your policy. If you and your dependents are on different policies it is the family amount from your scheme that is applicable."*

Section 13 is entitled "***Making a Complaint**,"* at page 17 of the **General Rules Policy Booklet**, and says:

> *"We aim to provide a first-class service to our members at all times. However, if you are in any way dissatisfied, please phone or write to: The Head of Customer Service [details provided]. If you remain dissatisfied you may appeal to the Managing Director by writing to him at the same address. If you are not satisfied with our decision or if we haven't given you a decision after 40 business days, you have the right to refer your complaint to the Insurance Ombudsman at: The Financial Services Ombudsman Bureau, 3rd Floor, Lincoln House, Lincoln Place, Dublin 2. Phone: 1890 882090."*

The Provider also refers to the **Consumer Protection Code 2012 (as amended) ("CPC"**) and cites in particular provision 7.16 which reads as follows:

> *"A regulated entity must, within ten business days of making a decision in respect of a claim, inform the claimant, on paper or on another durable medium, of the outcome of the investigation explaining the terms of any offer of settlement."*

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Provision 2.1 of CPC is also relevant and says that a Provider must *"acts honestly, fairly and professionally in the best interests of its **customers** and the integrity of the market."*

Provision 2.3 of CPC says that the Provider must not *"recklessly, negligently or deliberately mislead a customer as to the real or perceived advantages or disadvantages of any product or service."* Provision 2.8 says that the Provider must ensure it *"corrects errors and handles **complaints** speedily, efficiently and fairly;"*

Provision 7.20 of CPC says that *"a regulated entity must provide a claimant with written details of any internal appeals mechanisms available to the claimant."*

The Provider seeks to rely on Section 33 of the **Guide to Professional Conduct and Ethics for Registered Medical Practitioners 2019,** which is entitled "*Medical Records*" and reads as follows:

> *"33.1 Medical records consist of relevant information learned from or about patients. They include visual and audio recordings and information provided by third parties, such as relatives.*
> *33.2 You must keep accurate and up-to-date patient records either on paper or in electronic form. Records must be legible and clear and include the author, date and, where appropriate, the time of the entry, using the 24-hour clock.*
> *33.3 If you are working in out-of-hours services, or telemedicine, you should make every effort to ensure that any notes you make about a patient are placed in the patient's medical record with their general practitioner as soon as possible."*

The Provider also cites Regulation 6(1) of the **Health Insurance Act, 1994 (Minimum Benefit) Regulations, 1996** which says:

> *"6. (1) A registered undertaking shall not be required to make the prescribed minimum payments specified in sub-paragraphs (1), (2), (3) or (6) of paragraph 1 of Schedule A in respect of in-patient services if, on receipt of appropriate medical advice, the undertaking determines that the health services provided to the insured person could have been provided as day-patient services or out-patient services rather than in-patient services."*

Recordings of telephone calls have been furnished in evidence and have been considered. During a telephone call on **8 June 2015** between Provider Agent 1 and the Second Complainant, it was confirmed that the First Complainant had been put on the New Health Insurance Package cover, and I note that the following discussion ensued regarding the implication of this move:

> Provider Agent 1: *"for any new hospitals that she has gained, if she had a pre-existing condition, there may be an upgrade rule of 2 years, but say if there's not anything pre-existing or no... you know, nothing ongoing for [the First Complainant], from the date we make the change which is the 1st June, you're covered for anything new. So that means she would have full access to the new hospitals."*

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Provider Agent 1*: "does she have anything ongoing do you think?"*

Second Complainant: *"No I can't see that, but it's just that she did attend [Private Hospital 2] and everything is grand now… I mean I cannot see anything..*

Provider Agent 1*: She has access to the hospitals she would have always had, but you know with in adding in the new hospitals, If there was anything pre-existing that is when that rules applies."*

In relation to the above telephone call, the Provider submits that:

"[the Provider] considers the explanation of the 2-year upgrade rule was adequately advised during the call on the 8 June 2015. The Customer Service Representative highlighted that if there are any pre-existing conditions then an upgrade rule of 2 years will apply, and they would not be covered in the new hospitals added to the policy. In conjunction with this call, the complainants also received a rules booklet issued on the 9 June 2015."

During a separate telephone call on the **9 September 2016** between Provider Agent 2 and the Second Complainant, the Second Complainant lists the procedure code for a gynaecological laparoscopy and asks if the First Complainant is covered in Private Hospital A for her Gynaecological Consultant. The telephone conversation went as follows:

Provider Agent 2: …."*is this for a new condition that she is going for this procedure or is it something that is ongoing*?"

Second Complainant: "*ehm... well it's a new procedure really because they are going to go in and have a look."*

Provider Agent 2: "*no problem. so the.. so if it is new to when she upgraded her cover on the first of June 2015, then the way she is covered in [the Private Hospital A] for that day case is she is covered with a once off €300 excess, that's on the policy, so/but if the excess has been paid since June of this year, then it wouldn't 't apply again for her, but if it hasn't been paid then it would be payable to the hospital*."
….

Provider Agent 2: "*there's a €300 euro excess under(/on) her policy that's payable."*

Second Complainant: "Sorry.. whe - sorry she 's covered anyway."

Provider Agent 2: "*you'd have to pay the first €300*."

Second Complainant: "Yes"

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Provider Agent 2: "*and then anything after that is covered*."

Second Complainant: "*oh yes, that's grand that's ok*.."

Provider Agent 2: "*alright?*"

Second Complainant: "*so she is covered yeah that's lovely, and we pay the excess to the hospital?*"

Provider Agent 2: "*Exactly*."

The Provider submits in relation to the **9 September 2016** telephone call that:

> " *At no point did the second Complainant reference any symptoms or illnesses that the first Complainant was suffering from*."

The Provider also submits in relation to its obligations pursuant to provision 2.3 of CPC that:

> "*as there was no reference made on this call to any pre-existing conditions that the first Complainant was suffering from, [the Provider] believe that the Customer Service Representative advised correctly based on the information they had received and therefore did not act recklessly, negligently or mislead the Complainant in any way*."

By letter dated **8 June 2015**, the Provider updated the Second Complainant, advising of the family's policy change. This letter advises that the First Complainant had a start date of **1 June 2015** for New Health Insurance Package. This letter notes that "*this scheme will give you cover up to a semi-private room in public & selected private hospitals*" and *"full cover for in-patient Consultant fees."*

This letter also says *"this product suitability statement is for your guidance only and should be read subject to the rules and table of benefits of the scheme. Terms and conditions apply."* The Provider's **Benefit Table** provides for €300 (three hundred euros) excess per policy per year for private hospital cover under the First Complainant's New Health Insurance Package. The Provider also submits that on **9 June 2015** it

> "*issued the second Complainant an amended pack via post: this pack contained a Rules Booklet, which also outlined pre-existing conditions and the 2-year upgrade rule.*"

I am satisfied that the First Complainant was furnished in June 2015 with the General Rules Policy booklet and was on notice of the two year upgrade rule as outlined to her in the Provider's **General Rules Policy Booklet,** dated **15 January 2015** at page 29, where the specifics of the upgrade rule are laid and where it says that it is "*2 years for all age groups*."

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Section 8, page 10 also says that "*we will not pay benefits for the following: treatment which a person requires during any waiting period that may apply to the treatment under their scheme."*

Additionally, I note that on the basis of the **8 June 2015** telephone call that the Second Complainant also had the two year upgrade rule and its implications for the policy upgrade from **1 June 2015** explained verbally to her. In relation to the **9 September 2016** call it may have been prudent for Provider Agent 2 to recite that a pre-existing condition includes any *symptoms* of a condition.

Nevertheless, the specific question from Provider Agent 2 was, "*is this for a new condition that she is going for this procedure or is it something that is ongoing*?" and the answer given by the Second Complainant was "*it's a new procedure really because they are going to go in and have a look"*. No reference was made by the Second Complainant to why the test was required, notwithstanding that the specific question asked, had requested information as to whether it was for an issue that was ongoing.

Overall, I accept that the Second Complainant was advised of the Upgrade Rule and I am satisfied that the Provider agents did not mislead the Second Complainant or act unreasonably in the course of offering guidance regarding cover under the policy.

In relation to the question of whether Endometriosis was a condition with symptoms that pre-existed **1 June 2015**, I have thoroughly considered the medical records of the First Complainant. I note that the GP medical records on **12 September 2014** read as follows:

> *"P/C: abdominal cramps, heartburn, bloating and alternating diarrhoea/constipation. no bleeding or weight loss. no relevant family hx. dysmenorrhoea and menorrhagia. dysparunia, no discharge."*

On **18 September 2014,** the GP medical records say: "*bloods done incl Coeliac screen, coag, hormone profile*."

I note that the GP medical records dated **29 September 2014** cite panic attacks:

> *"having worsening panic attacks - approx 2-3/day. chest tightness, difficulty bleeding and tremor. Has had panic attacks since age 13, worse in last 3 months……. still having pains, crampy in nature. relieved by passing stool, bloating, alternating diarrhoea/constipation. family hx IBS. Hpylori neg. US neg. No vaginal discharge, periods can be heavy. No recent UPSI*."

I also note that the next GP visit occurred on the **9 February 2015**, when the First Complainant was referred for an OGD/ Colonoscopy and the notes say

> "*stomach still sore, nausea and vomiting. constipation. no weight loss or temps, bloods and coeliac screen nad, US was normal also taking Nexium*."

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On **9 March 2015**, the medical notes say:

> "*has hiatus hernia and spasmodic bowel. Still having stomach pains and cramps with flatulence/bloating*."

The medical notes says on the **10 March 2015** that the

> "*Colonscopy and OGD 2015 - biopsies normal*" and "*as advised by [Consultant Gastroenterologist], can try antispasmodic. trial of meberevine*."

By letter dated **24 May 2016**, the Consultant Gastroenterologist wrote to the GP and said "*I gather that in the past she had been investigated regarding menorrhagia*," and suggested a "*repeat gynaecology review to outrule endometriosis*." This letter also notes that "*as you may recall last year I did an upper & lower GI endoscopy which was essentially fine and the possibility was of severe irritable bowel. She does say that her pain gets worse during her periods*." Referring to this letter, the Provider submits that:

> "*another symptom of Endometriosis is pain that worsens during periods which were documented in a letter from [Consultant Gastroenterologist] to [GP] on 24 May 2016…. these ongoing un-resolving symptoms of pain in the lower tummy or back (pelvic pain), constipation and diarrhoea are all symptoms of Endometriosis. It was these ongoing and worsening symptoms, which lead to the cover upgrade on 1 June 2015 with claim 3186686 taking place on 12 September 2016. As this was during the two-year upgrade waiting period, this claim was correctly rejected*."

An Emergency Consultant, by letter dated **16 June 2016** and addressed to the GP, says as follows:

> "*I saw this very pleasant [age]-year-old who was referred to the emergency department this morning by [Consultant Gastroenterologst]. She has been a patient of his for some time with irritable bowel. She has been on colofac about a year and this has improved her symptoms…… She frequently gets exacerbation of crampy abdominal pain over the lower abdomen going to the right loin especially associated with her periods. She has tried the oral contraceptive pill but this Is not really helped…..typically symptoms are worse for the first 3 days of her periods*""

By letter dated **13 July 2016**, the Consultant Gastroenterologist wrote to GP and said that "*her pain usually starts during her menstrual cycle and gradually get worse*."

By letter dated **17 June 2016**, the Consultant Gynaecologist wrote to Consultant Gastroenterologist and said:

> "*[First Complainant] has only started to experience dysmenorrhoea in the last few years, but in the last 8 to 12 weeks it has become quite significant…… "of note, [First Complainant] came to your attention with quite severe GIT symptoms. She had a lot of abdominal bloating and constipation…*

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… she underwent colonoscopy and OGD last year with you in [Private Hospital B], and was diagnosed as having a hiatus hernia as well as IBS. She started taking Colofac and her symptoms improved but again they tend to worsen with the onset of a period. With this history I think it's likely that [First Complainant] has underlying endometriosis. IBS is a common bedfellow of this condition."

I note that by letter dated **27 October 2016**, the Consultant Gynaecologist wrote to the GP and said:

"[First Complainant] recovered well from the surgery, and I showed her the photos that were taken. We discussed the findings in detail and the great news is that she feels "fantastic." Since the procedure, all of her symptoms have in fact resolved. She's had no further cramping, no nausea, and no bloating. She doesn't need to use Colofac anymore, and is absolutely thrilled with the outcome of the surgery."

By letter dated **14 November 2017**, Consultant Gynaecologist wrote to the Provider and said:

"She wasn't aware of the diagnosis or potential diagnosis of endometriosis until after our first meeting, which was on the 17th of June, 2016. [First Complainant] has experienced considerable bowel symptoms for a couple of years at least and had undergone investigations with [Consultant Gastroenterologist]. Her symptoms seemed to be worsening rather than getting better, and it was for this reason she felt she had to increase her cover. It was after an admission with acute pain here at the [Private Hospital A] that [First Complainant] was referred on to me, and it was at that stage that we discussed the possibility of underlying endometriosis. The diagnosis was confirmed in September 2016 when [First Complainant] underwent hysteroscopy and laparoscopy. She was found to have stage 1 disease."

By submission dated **9 September 2019,** the First Complainant submits the follow timeline:

"23rd May 2016 - Met with [Consultant Gastrointestinal Surgeon] in [Private Hospital B] as I was in excessive pain - I felt, and it was documented that this was due to constipation which was worse during my menstrual cycle…

16th June 2016 - Admitted to A&E of [Private Hospital A] following [Consultant Gastrointestinal Surgeon's] advice. I had severe abdominal pain and I was checked out by [Emergency Consultant] …. Following further examinations by [Consultant Gastrointestinal Surgeon], they referred to [Consultant Gynaecologist] and I had a consultation on the following day (17th June 2016)….

The first mention of Endometriosis was when I was referred to [Consultant Gynaecologist]. Until the 15th June 2016, my pain was treated as a gastroenterology issue and I was not advised Endometriosis was a possibility. Had I known this, I would've demanded to see a Gynaecologist in 2014 and not have suffered in pain until September 2016.

/Cont'd…

…
Endometriosis can only be confirmed by laparoscopy. No ultrasound. MRI or any other, test can prove the existence of Endometriosis.

12th September 2016 - I underwent a hysteroscopy, D&C and also a laparoscopy. From this procedure, [Consultant Gynaecologist] confirmed Stage I Endometriosis was evident within the pelvis. It was at this stage and only this stage that a medical professional could confirm that I had Endometriosis. [Consultant Gynaecologist] was unable to confirm the start date of Endometriosis from this laparoscopy."

The Provider submits that:

> *"The Complainants symptoms were ongoing for a number of years prior to her diagnosis in **September 2016** and it was as a result of these worsening symptoms that the Complainant choose to upgrade her cover."*

The Provider also points to the cover of the **Claim Form** received from Private Hospital A for **12 September 2016**, which the First Complainant has signed. The **Claim Form**, under Section 7, says: "*nature of presenting symptoms: pelvic pain*" and "*date you first saw patient with symptoms: 17 June 2016*" and "*duration of symptoms prior to this: 12 months*." The description of the procedure is "*laparoscopy with or without biopsy and one or more of the follows procedures: excision of lesions of ovary (ies).*" It also notes "*primary diagnosis: endometriosis*."

This Claim Form is signed by the Consultant Gynaecologist on the **12 September 2016.** The eClaim viewer for this form also notes "*when did you first visit your doctor for this condition: 15-03-2015.*" It also says "*how long have these symptoms been present: 1 years*." I note that the First Complainant signed this form on **12 September 2016.** In particular, I note that the First Complainant confirmed **15 March 2015,** two months prior to the cover upgrade on **1 June 2015**, as the date of her first visit to her Doctor for *this condition.*

The Provider sought an **Expert Clinical Advisor Report,** dated **25 September 2020**, which reviewed the First Complainant's medical records and the Provider submits the contents of this report as follows:

> *"14/04/2011: Acne, dysmenorrhea .Start with Dianete.*
> *12/09/2014 Abdominal cramps. Menorrhagia, dysmenorrhea and dyspareunia*
> *29/09/2014 IBS. Trial Colpermin.*
> *17.6.16 Medication: Colofonc. Diagnosis severe IBS*
> *Dysmenorrhea 2: last few years*
> *Presenting problem: Dysmenorrea 2*
> *Umbilical pain*
> *Constipation Pain*
> *Diagnosis: Probable endometriosis*
> *Plan: Zoley and laparoscopy Sep*

/Cont'd…

13.07.2016 Severe crampy abdominal discomfort.
Her pain usually starts during her menstrual cycle and gradually gets worst.
[Consultant Gastroenterologist] suggest severe kind of irritable bowel or possibly endometriosis
18/8/16.Review Plan laparoscopy

12/09/2016 Laparoscopy. Procedure code 2489 (12/09/2016)
Diagnosis: Stage I endometriosis superficial and patent tubes. There was superficial powder burn lesions on the surface ovaries, Douglas and rectum. Endometrios treated with ablation and excision. Only lesion that couldn't be treated on the surface of the rectum.
27/10/16 Review after surgery.
Diagnosis: Stage I endometriosis
Discus findings
Small residual lesion on bowel
Continue with Zoley. She doesn't need to use Colofac anymore. She feels ""fantastic"" Annual review
….
"1. Based on the provided documentation, when is the earliest date on which the patient presented with signs and/or symptoms of Endometriosis?

14/04/2011:GP First mention of the symptom: dysmenorrhea. In treatment with Dianete (Pag 26)

In Sep 2014 she had 3 suspicious symptoms : abdominal cramps , dysmenorrhea and dyspareunia

Suspect endometriosis in women (including young women aged 17 and under) presenting with 1 or more of the following symptoms or signs:

Chronic pelvic pain
Period-related pain (dysmenorrhoea) affecting daily activities and quality of life (This case)
Deep pain during or after sexual intercourse
Period-related or cyclical gastrointestinal symptoms, in particular, painful bowel movements (This case)
Period-related or cyclical urinary symptoms, in particular, blood in the urine or pain passing urine
Infertility in association with 1 or more of the above.
…

After reading the entire file, she probably experimented symptoms since the first mention of dysmenorrhea by the GP in April 2011. The patient was taking combined oral contraceptive pill, which probably made the condition progress more slowly. In 2014 she clearly had symptoms
….

/Cont'd…

Laparoscopy is the "gold standard" for the diagnosis of endometriosis. It certifies the presence of the disease and its extension. By means of tissue biopsies and its pathological analysis, the aggressiveness of the lesions can be determined. The NICE recommends consider laparoscopy to diagnose endometriosis in women with suspected endometriosis, even if the ultrasound was normal.

….

With all the information, the patient had symptoms of endometriosis since 2014. In: 27/10/16: Review after surgery. Dr wrote: She doesn't need to use Colofac anymore. She feels "fantastic". According to this information, after the removal of the endometriosis, the intestinal symptoms seems have disappeared and the patient does not even need Colofac anymore. This can indicate that the previous symptoms could be attributable to endometriosis

…

I think the first symptoms of endometriosis was present since 2011 (page 26) and progressing until September 2014. In September 2014, an ultrasound was requested for menorrhagia, dysmenorrhea and dispaureunia, all of them suspect of endometriosis"

….

After the surgery the patient stopped the treatment with Colofac. This does not make any sense if the pain was only due to the diagnosis of IBS. If after surgery she don't need it anymore the Colofac, it seems that abdominal pain has a direct relationship with endometriosis. It cannot be ruled out that part of the abdominal pain was due to IBS, but the patient also had other symptoms of suspected endometriosis. The patient received treatment with contraceptive pills, which could improve the condition or delay the progression of endometriosis. Both treatments were used and they could overlap its effect."

The Provider submits that:

"It is evident, from the clinical documentation received, that the symptoms of Endometriosis were present since 2011. These symptoms continued to persist and progress through to September 2014. In September 2014, an ultrasound was requested for menorrhagia, dysmenorrhea and dyspareunia, it is these ongoing symptoms that led to the subsequent diagnosis of Endometriosis. To conclude, in 2011 through to 2014 the member presented with symptoms which led to the subsequent diagnosis of Endometriosis which is also in line and consistent with recognised International guidelines."

I note that the Provider's letter of **3 April 2018** to the First Complainant says that on **12 September 2014** she presented to her GP with "*abdominal cramps, heartburn, bloating and alternating diarrhoea / constipation ... dysmenorrhea and menorrhagia*." However, the medical notes say "*no bleeding or weight loss, no relevant family hx. dysmenorrhoea and menorrhagia. dysparunia, no discharge*."

/Cont'd…

I am satisfied that the meaning of this medical record is not clear as it could mean that there is ***no relevant family history*** of *dysmenorrhoea and menorrhagia or dyspareunia* or it could mean *no relevant family history* of something else but a *presence* of *dysmenorrhoea and menorrhagia and dyspareunia.*

However, I note that a letter dated **12 September 2014** from the GP to the radiology department is instructive in this regard and says:

> *"I would appreciate if you could arrange anultrasound abdomen and pelvis for [First Complainant] she is experiencing symptoms of menorrhagia, dysmenorrhoea and dysparunia. She is also having upper abdominal cramps and bloating."*

It is clear that the GP was concerned at this time about the First Complainant's menorrhagia, dysmenorrhoea and dyspareunia to the extent that the GP ordered an ultrasound on **12 September 2014**. I am satisfied that this occurred more than 8 months before the First Complainant's upgrade to the New Heath Insurance Package on **1 June 2015.** I also note that on **14 April 2011** the **GP Medical Records** state "*has dysmennorrhea also, for dianette.*" On **12 September 2014**, the medical records say "*P/C: abdominal cramps*." I note that the medical records dated **29 September 2014** say "*periods can be heavy*." I note that the **Expert Clinical Advisor Report** says that "*in Sep 2014 she had 3 suspicious symptoms: abdominal cramps, dysmenorrhea and dyspareunia*."

I accept that the Provider is correct in its submission in the **Expert Clinical Advisor Report**, that *dysmenorrhea* and *period-related or cyclical gastrointestinal symptoms* and *painful bowel movements* were present as symptoms in advance of **1 June 2015.** I note that the NICE guidelines say that one more of these features is required to be indicative of Endometriosis.

The Provider's **General Rules Policy Booklet,** dated **15 January 2015,** Section 2, page 4-5, defines "pre-existing condition" as "*any disease, illness or injury that a person has which began , or the symptoms of which began, before that person started his or her current continuous period of membership of the scheme*." In particular, I note the **14 November 2017** letter from the Consultant Gynaecologist who said "*[First Complainant] has experienced considerable bowel symptoms for a couple of years at least and had undergone investigations with [Consultant Gastroenterologist]. Her symptoms seemed to be worsening rather than getting better, and it was for this reason she felt she had to increase her cover."* I also note that the First Complainant cites the **15 March 2015**, two months prior to the **1 June 2015**, as the *first visit your doctor for this condition* on the claim form she signed **12 September 2015**.

I am satisfied on an analysis of the medical evidence, that the Provider was entitled to form the opinion that First Complainant was experiencing symptoms of Endometriosis *the symptoms of which began* prior to **1 June 2015.** I am also satisfied that the Provider was entitled to rely on its terms and conditions in the **General Rules Policy Booklet** to decline to cover the claim associated with the Endometriosis on **12 September 2016**.

/Cont'd…

It is important in that regard to note that the definition of a "pre-existing medical condition" as defined within the policy documentation, does not require the Complainant to have been aware of the condition in question, or indeed does not require that particular condition to have been in any way named or diagnosed.

Rather, the policy makes clear that if the symptoms of a condition are present prior to policy membership or policy upgrade, whether or not that condition has been given a name or has been diagnosed, the relevant waiting period will have to be served.

Accordingly, as the medical treatment in respect of which the Complainant's claim was made, was treatment which was undergone by the Complainant before she had served the 2 year upgrade rule, I am satisfied that the Provider was entitled to decline the claim on the basis that the upgrade period to be covered for any pre-existing condition had not been served and, accordingly, no cover was available to the Complainant under the policy.

Regarding the **16 June 2016** claim for an overnight stay as Private Hospital A, the Provider relies on Section 7, page 8-9 of the **General Rules Policy Booklet,** entitled "*What is Covered Under the Scheme*" which says that

> "*we do not have to pay benefits for in-patient treatment provided by a hospital if we are of the reasonable opinion, based on appropriate medical advice, that the treatment could have been received as day-case treatment or out-patient treatment*."

The Provider also cites, Regulation 6(1) of the **Health Insurance Act, 1994 (Minimum Benefit) Regulations, 1996** which is similar to Section 7. The Provider submits that:

> *"In this case, the first claim, 3118629 was for an overnight admission into the [Private Hospital A] from 16 June 2016 to 17 June 2017. When the Claim form and invoices in the Schedule of Evidence, were reviewed by our medical advisors no medical necessity was found for an overnight admission as the bloods, ultrasound and gynaecological review were conducted in the emergency department. These charges fall into the category of Everyday Medical Expenses and are not sufficient to justify an overnight admission."*

The Provider also submits that:

> *"It should be noted, that following this rejection on **12 December 2016**, [the Provider] reached out to the consultant and the patient accounts department in the [Private Hospital A]…asking them if they wished to submit further information in support of the overnight stay but nothing further was received and so the claim has remained rejected."*

/Cont'd…

I note that the Provider has submitted evidence of a letter they issued to the Consultant Gastroenterologist saying:

> *"If however you feel we have omitted any relevant clinical information that would alter our conclusion please submit this for further review."*

I note that during a telephone call on **9 February 2017** between Provider Agent 3 and the First Complainant, referring to the **16 June 2016** admission, the following was said:

> Provider Agent 3: "*we did receive a claim from [Private Hospital A] and it wasn't covered by ourselves because there was no medical necessity for yourself to be admitted for what took place so what so basically what we were claimed was one thousand one hundred and eighty one, now you don't have to pay that because the hospital are aware, we contacted them, and they are aware that we would regard it as not medical necessity and they haven't fought it so it would suggest that they would agree as well*."

During a telephone recording, dated **15 March 2017,** between Provider Agent 4 and the First Complainant in relation to the **16 June 2016** admission it was said as follows:

> Provider Agent 4: "*the amount you owe is zero, so as far as I can see you are not liable for it….so because they kept you right and it wasn't medically necessary for to keep you we are not going to pay the claim but that doesn't mean that you are liable for any costs either*."

During a telephone recording dated **4 August 2017** between Provider Agent 5 and the First Complainant's father, Provider Agent 5 says "*there is actually two claims there for [Private Hospital A], there was one for June 2016 that also hasn't been paid out on, that's due to the onset date as well.*"

I note that the Provider Agent 5's explanation on **4 August 2017** that the **16 June 2016** claim was rejected due to the onset date is not correct, but I am satisfied that generally the First Complainant was made aware of the reason, by the Provider, for the rejection of this claim - that it was not deemed *medically necessary.* The First Complainant has referred to this a number of times in her own submissions.

I also note that in the telephone calls of **9 February 2017** and **15 March 2017** the Provider suggested that the First Complainant may not be liable for the **16 June 2016** costs, as she was admitted by the hospital when it was not *medically necessary.* Whether or not that is correct, I am satisfied that the Provider was entitled to refuse to cover the **16 June 2016** admission to Private Hospital A on the basis of Section 7, page 8-9 of the **General Rules Policy Booklet** and in accordance with Regulation 6(1) of the **Health Insurance Act, 1994 (Minimum Benefit) Regulations, 1996.**

/Cont'd…

I accept that the Provider was entitled pursuant to Section 7 to judge the information submitted in the claim form and refuse cover on the basis that

> "*the Complainant had bloods, an ultrasound and a consultation in the A and E department and there was no necessity as per the clinical information received, for the following overnight admission.*"

In relation to the First Complainant's complaint regarding a suggested data breach, I am satisfied that the FSPO has no role to play regarding a complaint of that nature. The appropriate body for a complaint of that nature is the Data Protection Commission and I note indeed that the Provider has been in contact with the DPC with which the First Complainant may continue to engage, if she remains dissatisfied.

In relation to the First Complainant's request for her medical information from the Provider, the First Complainant wrote to the Provider by email dated **25 January 2018** and said as follows:

> *"I understand information was gathered by [The Provider] regarding my medical history previous to the above date. I would like to request the information received from the various sources at the time as I did not give consent to the [GP] or [Consultant Gastroenterologist] to release this information."*

The Provider wrote to the Complainant by email on **26 January 2018** and says:

> "*A 'Declaration and Consent' form was signed by yourself in the [Private Hospital A] on the 12/09/16 which allows for the release of medical information. We can forward a copy if you wish."*

The Provider also notes on **28 March 2019** that**:**

> *"the Complainant was not happy that both claims had been rejected and requested all information in relation to these claims. This claim information was sent 4 April 2019 with the An Post tracking number of *** ."*

If the First Complainant has any concerns regarding the nature of the consent relied upon by the Provider in the Declaration and Consent Form which she signed in June and September 2016, this is a matter which she should raise directly with the Data Protection Commission which is the appropriate body for complaints of that nature.

Finally, I note that Provision 7.20 of CPC says that the Provider must "*provide a **claimant** with written details of any internal appeals mechanisms available to the claimant.*" I am satisfied that Section 13 entitled "*Making a Complaint*", page 17, of the **General Rules Policy Booklet**, dated **15 January 2015** provides the consumer with the relevant complaints information.

/Cont'd…

Furthermore, the Provider submits in relation to the **12 September 2016** claim that:

> *"Two appeals were conducted on this claim, one as requested by [Consultant Gynaecologist] ... and another appeal as requested by one of the Complainants on 3 December 2019. Please note that the team who conduct appeals is independent of the assessment team. This is completed to ensure a fair and equitable outcome for members. Again, based on the clinical information available, from more than one clinician, the appeals team noted that these symptoms, which were ongoing prior to the Complainant changing her level of cover on 1 June 2015, constituted a pre-existing condition and therefore rejected the claim."*

I am satisfied that the Provider handling of the appeals mentioned above was reasonable. Additionally, the Provider submits that it contacted the Complainant within 10 business days as required by Provision 7.16 of CPC, which says:

> "*The first claim, xxxxx29 was rejected on 12 December 2016 and the Statement of Claim was posted internally in [the Provider] on 14 December 2016. The second claim was rejected on 11 July 2017 and the Statement of Claim was prepared and posted by a third party on [the Provider's] behalf on 17 July 2017*."

The First Complainant also submits that:

> *"when I met with [Consultant Gynaecologist] in August 2016, she gave me a procedure code. I called [the Provider] with this procedure code and was advised I was covered for the surgery that took place in September 2016. This phone call is missing from the phone recordings received from [the Provider]."*

By email dated **28 March 2019**, the First Complainant also notes by email to the Provider that *"I have listened to the previously attached sound recording however a phone call to [Provider] on in September 2016 is missing from this list."*

The Provider submits that:

> *"[The Provider] have no record of a call from August 2016. [The Provider], used the contact numbers provided under the second complaints policy and carried out a search of their calls received from 1 June 2016 - 30 September 2016. The only call that the second Complainant made to [The Provider] from these numbers, was on the 9 September 2016….[The Provider] also completed a search using a mobile number that the first Complainant used to contact [The Provider] however, no calls were returned during this timeframe."*

It is of course open to the First Complainant to make details of any additional telephone number available to the Provider if she believes that this may assist the Provider in locating the telephone call which she believes has not been supplied. She may also of course pursue a complaint to the Data Protection Commission if she believes that an issue arises with the Provider's processing of her data.

/Cont'd…

For the reasons outlined in detail above, I am satisfied on the basis of the evidence made available, that it is not appropriate to uphold the Complainant's complaint against the Provider that it wrongfully determined her condition to pre-exist the upgrade in her cover in June 2015, and wrongfully repudiated her claims for the cost of treatment.

Neither am I satisfied that the Provider offered inconsistent reasons to the Complainant as to why the claims were being declined.

Accordingly, I take the view that there is no reasonable basis upon which it would be appropriate to uphold this complaint.

Conclusion

My Decision, pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is rejected.

The above Decision is legally binding on the parties, subject only to an appeal to the High Court not later than 35 days after the date of notification of this Decision.

MARYROSE MCGOVERN
Deputy Financial Services and Pensions Ombudsman

21 December 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.