An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2022-0013
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Claim handling delays or issues Rejection of claim - pre-existing condition
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The First Complainant held a health insurance policy with the Provider from the **1 March 2018** (the "**Original Health Insurance Policy**").

On **1 March 2019,** he upgraded to an improved health insurance policy with the Provider (the "**New Health Insurance Policy**").

The Complainants' Case

The First Complainant says that some weeks after upgrading his cover, he visited his GP on **29 March 2019** with general "'*all over' stiffness creating great discomfort and soreness in my middle to lower back area*."

Some 2 months later, on **28 May 2019,** X-rays were taken. The First Complainant says that he was informed of "*issues relating to the right knee, right hip & potential wedging of some vertebrae in the back*" and on **26 June 2019** he was referred from his GP to a Consultant/Surgeon, which resulted in a consultation with the Consultant/Surgeon on **19 July 2019,** when surgery was recommended and a date of **2 October 2019** was set for a total right hip replacement.

The Complainant says that four weeks before **2 October 2019**, the hospital chosen by the First Complainant for the procedure, contacted the First Complainant and asked if the surgery was covered by his health insurance provider and it advised that the First Complainant could be personally liable for costs in excess of €10,000 (ten thousand euro) if he did not confirm cover with the Provider.

The Complainants say that in the weeks prior to **2 October 2019** they began contacting the Provider to establish if his hip surgery was covered under the New Health Insurance Policy. The First Complainant, by letter dated **14 December 2020**, submits the following in relation to the conversations with the Provider:

> *"it is very clear we were advised to check with the consultant/GP whether the condition was a pre-existing condition and that the [the Provider] would accept the Consultant's / GP advice to us on this issue. Please note that we were never advised at any time that the [the Provider's] medical advisers would determine when the condition commenced. Neither were we offered the facility to get a decision on the matter from the [the Provider's] medical advisors PRIOR to any surgery going ahead."*

The First Complainant submits that he was aware of the upgrade rule and that **1 March 2019**, the date of the policy upgrade, was the starting point for a two-year waiting period, during which any pre-existing condition that existed prior to the date of the policy upgrade, would not be covered by the upgrade.

The Second Complainant, his wife, had a telephone conversation with Provider Agent 1, on the **26 February 2019** when the upgrade rule was explained using an analogy of an orthopaedic knee surgery. The First Complainant was also aware that he was covered under the Original Health Insurance Policy, held from **1 March 2018**, for orthopaedic procedures in two other public hospitals in the same city as the private hospital that carried out the surgery.

The Complainants place strong reliance on a number of telephone calls and one online conversation which occurred between the Complainants and the Provider in the weeks before **2 October 2019**, the date of the hip surgery. The Complainants submit that during these exchanges with the Provider, misleading information was given to them regarding the criteria of how, and on whose medical advice, the Provider's decision about cover would be made. The First Complainant also submits that:

> *"I was never advised by any of the 3 agents that the [the Provider's] medical advisers would determine when the condition commenced and that their decision was final."*

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On the **25 September 2019**, the First Complainant's GP issued a Medical Certificate that said that the First Complainant

> "*has never attended this surgery with any right hip problems in the past. This was confirmed on full review of his medical notes dating back to 2005.*"

The First Complaint also submits as follow:–

> "*I strongly assert that I had no hip symptoms or signs prior to March 2019 and that I only became aware of its existence in July 2019 when I was first examined by [the Consultant/ Surgeon].*"

The First Complainant also notes that "*[the Second Complainant] contacted [Consultant/Surgeon's] office on the 03/9/19 & 18/9/19. The office confirmed on both occasion that the 'form' would be filled out indicating that June date would be used as first date."*

In a letter dated **25 January 2020,** the Surgeon wrote to the Provider and said

> "*I was unaware as to whether or not [the First Complainant] had any symptoms prior to March 2019, but it will certainly appear that there were not at the level where he was contemplating joint replacement surgery.*"

As a result of these conversations the First Complainant submits that:

> *"during phone conversations with the [the Provider] prior to any surgery I was told to get medical advice from both my GP and Consultant with regard to my condition being pre-existing. I was told by [the Provider] agents that it would on this advice only that [the Provider] would rely on to determine if my condition was pre-existing. My GP issued a Medical Cert. stating that no hip treatment were recorded on my files – I had not been suffering with any hips pains etc. The consultant office was contacted on 3 no. occasion, prior to surgery and they confirmed that there was no issue and that the claim form date would be written as post March 2019 – date mentioned was June 2019."*

By letter dated **25 November 2020** the First Complainant argues that the Provider's conduct was "*unreasonable and unjust*."

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The First Complainant's position is that the Provider wrongly or unfairly declined cover for the cost of his hip surgery and that the Provider's advice in advance of the hip surgery was given wrongly and amounted to misleading advice, regarding the criteria of how, and on whose medical advice, the Provider's decision to cover the claim would be made.

The Provider's Case

The Provider states that the terms and conditions of the upgraded New Health Insurance Policy, which began on **1 March 2019,** excludes cover for the First Complainant's hip surgery because the Provider submits that the hip complaint constituted a pre-existing condition. The Provider outlines in its email dated **20 February 2020** that:

> "*Under rule 3(b) of the rules, terms & conditions of your policy – [New Health Insurance Policy] as the condition being treated was deemed to be present when you upgraded your policy on the 1st March 2019. Where the upgrade rule applies claims are assessed under the previous level of cover. However, under your previous level of cover – [Original Health Insurance Policy] there is no cover for private hospital and therefore, regrettably no benefit is available for this claim. Pre-existing Condition means an ailment, illness or condition, where, on the basis of medical advice, the signs or symptoms of that ailment, illness or condition existed at any time in the period of 6 months ending on the day on which the person became insured under the contract.*"

The Provider relies on the terms and conditions (applicable to new registrations or renewals on/or after 31st December 2018) at section 3 (b) which read as follows:

> "*When determining whether a Medical Condition is Pre-Existing, it is important to to note that what is considered is whether on the basis of medical advice signs or symptoms consistent with the definition of a Pre-existing condition existed rather than the date upon which You became aware of the condition or the condition is diagnosed. Whether a Medical Condition is a Pre-existing condition will be determined by the opinion of Our Medical Director*."

In accordance with section 3 (b) of its terms and conditions, the Provider relies on the evidence submitted to it by the First Complaint's doctors and the Provider's doctor who in his *Assistant Medical Officer Decision*, dated **17 February 2020**, outlined his assessment of the First Complainant's medical evidence as follows:

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> "*According to the information on the claim form, the member's diagnosis was osteoarthritis of the hip and in section 6.5 of the claim form the duration of symptoms/signs was "> 1 year". I also note the member had a previous left hip replacement performed in 2007*."

The Provider refers to the Hospital Claim Form referred to above, which was completed by the First Complainant's Consultant/Surgeon on **2 October 2019**.

In that regard, the medical notes from the First Complainant's GP surgery of **29 March 2019** note that he was:

> "*On Allopurinol & Vimovo x years for ? Gout."*

and

> *"Describes stiffness across lower back and & hands, pain ++ in right hip & knee, had surgery on right knee before. Stiffness usually loosens out if walks for a few minutes but Vimovo really helps*."

The Provider says that its *Assistant Medical Officer* considered this medical evidence and noted that:

> "*The member attended the surgery on 29 March, 2019 i.e. four weeks after the upgrade in cover. According to the notes the member was complaining of stiffness across lower back and hands with pain in right hip and knee but no mention is made of the duration of symptoms but It does mention that the member had been taking the anti-inflammatory Vimovo for 'years.'"*

The Provider says that having reviewed the medical evidence, the Provider's *Assistant Medical Officer* decided that:

> "*The member had significant osteoarthritis affecting his hip and knees which was confirmed on x-ray within three months of joining [the Provider]. This level of arthritis could not have developed in this three month period and therefore the member would have had signs of osteoarthritis in the six months prior to joining [the Provider] had an x-ray actually been performed in this period of time. While the member may not have had symptoms of osteoarthritis the information provided indicates he would have had signs. We have received a letter from [the Consultant/ Surgeon], the member's consultant orthopaedic surgeon, dated 25th of January 2020. According to this letter the member had 'x-rays taken on 28/05/2019, which showed arthritis of his right hip both knees. Radiological evidence of arthritis can be present prior to the onset of symptoms and is not unusual for there to be significant osteoarthritis radiologically long before symptoms develop'.*

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> *[The Consultant/Surgeon] goes on to state that he is unaware as to whether or not [the First Complainant] had any symptoms prior to March 2019. The question however is whether the member had signs or symptoms of the condition in the 6 months prior to the upgrade in cover and not just symptoms alone. From reviewing the information we received, it would appear that the member had signs of osteoarthritis in the 6 months prior to joining [the Provider] even if he may not have had any symptoms*."

By letter dated **21 January 2021**, the Head of Claims at the Provider said that the Provider:

> "*Advised [the First Complainant] that his claim would be assessed based on the medical information submitted by his GP or Consultant and in accordance with the rules, terms and conditions of membership. This was clearly communicated to [the First Complainant] during our telephone interactions. In additional the First Complainant] repeatedly advised [the First Complainant] that if the treatment was found to be pre-existing he would not have cover under his upgraded plan for treatment at the [Name] Hospital in until the upgrade waiting period was satisfied.'*"

In relation to the advice given over the phone and online by the Provider's agents, the Provider submits, by letter dated **3 November 2020**, that:

> "*Our advisers did not specifically state that the Medical Director would make the final decision on a claim. Our advisors confirmed that the claim would be assessed based on the medical information received, terms and conditions of the policy. Our advisers would not be obliged to highlight each rule contained in our Rules – Terms and Conditions of cover. We recommend that our members refer to the terms and conditions for a comprehensive overview of their contract."*

In conclusion, the Provider relies on the contractual obligations attaching to the New Health Insurance Policy as outlined in section 3 (b) of its terms and conditions which says that

> "*what is considered is whether signs or symptoms of the hip complaint condition existed at any time in the period of 6 months ending on 1 March 2019 and that whether a Medical Condition is a Pre-existing condition will be determined by the opinion of the Provider's Medical Director."*

The Provider also considers that it is not "*obliged to highlight each rule contained in its terms and conditions".*

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The Provider submits that the First Complainant's condition pre-existed the inception of the New Health Insurance Policy, and therefore it declined the claim in respect of the cost of the First Complainant's hip surgery, in accordance with the terms and conditions of First Complainant's New Health Insurance Policy.

The Complaint for Adjudication

The Complaint is that the Provider incorrectly or unfairly denied the First Complainant's health insurance claim and gave him 'misleading' guidance with regard to what information would determine a claim outcome, and by whom this decision would be made.

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 **3 September 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.

I note that the Original Health Insurance Policy did not cover the private hospital which carried out the Complainant's hip procedure and therefore, to avail of cover, the First Complainant required the Provider to determine that the hip surgery fell to be covered under the terms and conditions of the New Health Insurance Policy, on the basis that it was not a pre-existing condition subject to a two-year waiting period.

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I am satisfied that the First Complaint was bound by the contractual obligations attaching to the New Health Insurance Policy. It is also clear from the evidence that the First Complainant was aware of the upgrade rule (and indeed he acknowledges that) and that he understood that **1 March 2019**, the date of the policy upgrade, was the starting point for a two-year waiting period, during which any pre-existing condition (that existed prior to the date of the policy upgrade) would not be covered by the upgrade.

I note that the health insurance policy held by the Complainants with the Provider provides that:

> *"**Pre-existing conditions***
>
> *Pre-existing condition means an ailment, illness or condition, where, on the basis of medical advice, the signs or symptoms of ailment, illness or condition existed at any time in the period of 6 months ending on the day on which the person became insured under the contract"*

The Provider's terms and conditions relating to the New Health Insurance Policy say at section 3 (b) that:

> "*When determining whether a Medical Condition is Pre-Existing, it is important to to note that what is considered is whether on the basis of medical advice **signs or symptoms** consistent with the definition of a Pre-existing condition existed rather than the date upon which You became aware of the condition or the condition is diagnosed. Whether a Medical Condition is a Pre-existing condition will be determined by the opinion of Our Medical Director*."
>
> [My underlining for emphasis]

I note that the Consultant/Surgeon wrote to the First Complainant, after the hip surgery, by email on **17 November 2020,** and said as follows:

> "*[The Provider] appear to be declining your claim on the basis that there were 'SIGNS' of arthritis on x-rays which would have been present prior to March 2019. This is an unusual step which I have not seen before as many people would have signs of arthritis or indeed other medical conditions long before any intervention or treatment would be required and the time of onset of 'signs' would be very debatable in many cases*"

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Notwithstanding this opinion from the Consultant, it is the terms and conditions governing the New Health Insurance Policy, which refer to **signs or symptoms,** which are pertinent in this matter. In my opinion, 'Symptoms' suggest a feature or a phenomenon that serves as some form of evidence and indeed I am satisfied that 'signs' is a potentially broader concept, closer in meaning to an *indication* of a medical condition.

I am satisfied that, as a matter of contract, the Provider was entitled to assess whether 'signs' or "symptoms" of the Complainant's medical complaint for which he was claiming the cost of treatment, existed within the 6 months before **1 March 2019.** In that event, the Complainant was entitled to cover, only on the basis of the Original Health Insurance Policy, rather than on the basis of the upgraded level of cover, because the waiting period following the upgrade had not been served.

I am satisfied that this contractual provision entitled the Provider to conclude from an assessment of the medical evidence before it, that the First Complainant's hip complaint "pre-existed" **1 March 2019** within the meaning of the policy provisions. I note that the Provider's medical assessors considered the medical evidence made available to them by the Complainant's treating doctors. I am satisfied that the Provider was entitled to consider the relevance of the noted osteoarthritis of the hip, at Section 6.5 of the Hospital Claim Form completed by the First Complainant's Consultant/Surgeon on **2 October 2019** and also to consider the relevance of the attendance notes from the First Complainant's GP surgery on **29 March 2019**.

This leads me to conclude that the Provider was contractually entitled to determine that, on **1 March 2019,** the First Complainant's hip complaint was a pre-existing condition within the meaning of the policy definition, and that it was therefore entitled to refuse to indemnify him under the New Health Insurance Policy, for the cost of the treatment he underwent, because he was limited to the cover available to him under the Original Health Insurance Policy.

Since the preliminary decision of this Office was issued in **September 2021**, the Complainants' legal representatives have challenged the opinion of this Office as to the entitlement of the Provider to place reliance on the prescribing of *Vimovo,* stating that this:

> "*directly contradicts the evidence of the [name redacted] GP in her certificate of the 14th September 2021(enclosed)*"

I note in that regard that this GP certificate in question, dated some 10 days after the preliminary decision of this Office had been issued, advised:

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> *"Was prescribed Allopurinol on a regular prophylactic basis & Vimovo on an as required basis for the treatment of gout.*
> *On lengthy review of his notes I can again confirm that he did not attend the surgery or receive treatment for the right hip/leg pain or discomfort before March 29th 2019"*

It is clear that the Complainants' legal representatives are correct that this certificate is in conflict with the Provider's opinion at the time when it declined the Complainant's claim, in 2019. I am conscious however that the GP cert dated **14 September 2021**, was not available to the Provider in 2019, at the time when it made its decision on the Complainant's claim, whereas the note taken by the GP on **29 March 2019**, was contemporaneous to the Complainant's surgery visit at that time, when it was recorded that:

> *"Describes stiffness across lower back and & hands, pain ++ in right hip & knee, had surgery on right knee before. Stiffness usually loosens out if walks for a few minutes but Vimovo really helps*."

I am satisfied that in late 2019/early 2020, at the time when the Provider was determining whether or not to admit the Complainant's claim, it could take into account only those medical records that were available to it at that time. In coming to this conclusion, I am satisfied that this approach is in accordance with the views of the High Court in *Baskaran v. FSPO* [2016/149MCA], where the Court confirmed at paragraph 61, that:

> "*In his decision, the respondent gave consideration to the contents of all medical reports at the time that Friends First made its initial decision to terminate benefit, and such medical reports as became available between that date, and the determination of the appeal by Friends First approximately twelve months later. However, the respondent excluded from consideration the four medical reports subsequently provided by the appellant, on the basis that they could not have been considered by Friends First at the time that it made its final decision. It is submitted on behalf of the appellant that the respondent fettered his discretion in excluding these reports from his consideration and therefore erred in law. 30 62. This submission must be rejected for two reasons. Firstly, as a matter of common sense, the approach taken by the respondent was correct. The respondent was engaged in reviewing the decision of Friends First which was based upon the information that it had available to it at that time. Clearly Friends First could not be criticised for failing to take into account reports that were not even in existence at the time that it made its decision, and if the respondent had taken those reports into consideration, he would have erred in doing so."*

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The Court made clear its view, at paragraph 70, that:

> *"The function of the* [Financial Services and Pensions Ombudsman] *in considering the…complaint was, in general terms, to assess whether or not* [the Provider] *acted reasonably, properly and lawfully in declining the claim of the Appellant"*.

In those circumstances, I accept that the Provider was entitled to form the opinion in late 2019/early 2020, on the basis of the medical information available to it at that time, that the First Complainant's hip complaint was a condition that pre-existed the policy upgrade on 1 March 2019, and that as a result he was not covered for the cost of the surgery, because at the time of the surgical treatment, the waiting period of 2 years had not been served to be covered for pre-existing conditions, under his upgraded policy.

Separate from the Provider's determination that the Complainant's treatment was for a pre-existing condition, the Complainants also complain that they received misleading information from the Provider, in and around the month before the First Complainant's surgery. The First Complainant, by letter dated **14 December 2020**, says as follows:

> "*Please note that we were never advised at any time that the [the Provider's] medical advisers would determine when the condition commenced. Neither were we offered the facility to get a decision on the matter from the [the Provider's] medical advisors PRIOR to any surgery going ahead.*"

In my consideration of this matter, the audio evidence supplied has been reviewed thoroughly. I note that on **25 June 2019**, the First Complainant had a telephone conversation with Provider Agent 2 and during the course of this phone call, Provider Agent 2 confirmed with him that a pre-existing condition would be determined by the Consultant/Surgeon who would fill out the claim form.

The Second Complainant, also had a telephone conversation with Provider Agent 3 on **3 September 2019** when Provider Agent 3 said that the test for a pre-existing condition was when the signs and symptoms arose, and said that

> "*claims are always assessed on the medical information received and the terms and conditions of the policy so you need to go back to the Consultant secretary if you are concerned about it because that is where the date is going to come from.*"

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I note that the Second Complainant, had a telephone conversation with Provider Agent 4, on **9 September 2019** when Provider Agent 4 said as follows:

> "*if there was a date on there to say it is a medical condition dating back to his first visit to my office in 2016. You know we don't have access to any information other than what the Doctor or Consultant sends into us in the medical form. We don't go on anything in the past or anything like that other than what's on that medical claim form.*
> [...]
> "*we don't go in and asses any other past claims or Doctor's visits, we don't do any of that, it's just what is on that claim form.*"

The First Complainant, had an online conversation with Provider Agent 5, on **11 September 2019** when Provider Agent 5 said in the context of a discussion about a five year waiting period and pre-existing conditions,

> "*this means that if the treatment you are receiving is in relation to a condition that existed prior to the 01/03/15 this treatment will not be covered. You can check this with the Consultant / GP.*"

The Second Complainant, also had a telephone conversation with Provider Agent 6, on **12 September 2019** as follows:

> **The Provider**: "*If he has had signs or symptoms of it before that date then that would be considered to be pre-existing, so he may have gone to the Doctor, may have pointed it out to somebody, so it would be date and documented if you know what I mean*"
>
> **Second Complainant**: "*So the GP sent the referral letter to the Consultant so it goes back to the first GP's visit which I think the first referral letter was the 22nd of June but it all happened in and around June of this year, so when he first went to the GP, we will just say it was the 20th of June or and he met the consultant on the 2nd, this was when he first went about it basically you know there could be wear and tear on all our joints but it wasn't sore enough to do anything about it, so he didn't go until June now there is a lady in the Consultant's office said that when they are filling out their form for [the Provider] the first record they have at all is the referral letter from the GP on the 22nd of June … that is what we will be using*".
>
> [...]

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The Provider: "*When that comes in, what happens is ... [the Provider] because it is someone pre-existing here, the claims department will automatically go and look for more information through the consultant which will go back through your GP, but it will come from the originator which is your GP, the information will come from that and it will be based on that*."
[...]

Second Complainant: "*Am I right in saying that this is not pre-existing because he only went to seek help in June*.."

The Provider: "*And he didn't seek help with his doctor he never visited his doctor or anything, has he* "

Second Complainant: "*No, he went to the doctor first in June and she referred him*"

The Provider: "*If there is no record and he hasn't any signs or symptoms before that date then it isn't pre-existing so you can be happy about that if that is the case"*
[...]

The Provider: "*Had your husband gone to the doctor and it was documented then that medical information would be put on to us anyway*"
[...]

The Provider: "*Because the upgrade is there, the pre-existing is there, when the claim comes in there is no doubt that the claims department will definitely look for further information because they have to, it's part of your policy, they will look for further information, there is no doubt about that and then it will be decided, based, one will consult with your GP, if he hadn't gone to the GP with any signs, then that is different*.."

Second Complainant: "*The claims department by all means obviously they look for further information, so they go back to the GP, they say oh when did [the First Complainant] come into visit you and she says oh my records say the 1st of June this year*"

Provider: "*Yeah*." [...]

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Second Complainant: "*I am telling you [the First Complainant] didn't do anything about it until the 1st June, 10th of June, I know there was one, the first referral letter is from the 22nd of June from the GP to the Consultant, so that is the only record the GP would have, so are we safe in saying that is when the GP records start with this...*

Provider: "*Well you would know that, you know what I mean, only you would know that, but yeah if that's the first time then …*" [...]

Provider: "*Because it's a hip replacement, you need to talk to your doctor, that's who I would be talking to, your GP, because it's a hip replacement, he has had to have had some kind of symptoms preceding that, he couldn't just have had a pain overnight, he may have had arthritis, he may, have had an infection, he may have gone to them with pain, there has to have been something, if this all starts with your GP, you need to go back to your GP. That's all you can do."*

Second Complainant: "*He didn't have anything, he didn't, not that I can think of anyway. So if the GP has a record of him ever coming up and saying oh my hip is sore what can I have an injection or can I do something, the GP, when did she first see him, basically ...*"

Provider: "*Yeah you need to find that out because that is what is going to go on, like the GP he will have the records there so anything that is there is going to go on the claim form to us when it comes into us and it will be determined on that the determination of the policy*"

Second Complainant: "*I see what you're saying there was wear and tear but there was nothing, like he didn't do anything about it I suppose*."

Provider: "*That is signs and symptoms though [Second Complaint]. That is exactly what that it. So you need to go back in and see when, what date you can get for that, then you will know*."

Second Complainant: "*So you go back to the GP, is it*."

Provider: "*the first day of the signs and symptoms as far as he is concerned. He will have it on record. [inaudible]*"
[...]

Provider: "*So just go back and check with the GP first just so you know in your own head.*"

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Second Complainant: "*so what does the GP have on record as to when he first complained about this and that is the date that is for that"*

Provider: "*whatever date I said, normally, with something like that you would have had signs and symptoms, you may have had signs and symptoms you went to the GP over*".

[All underlining above added for emphasis]

I am satisfied that a review of the audio evidence and online conversation makes it clear that the Complainants repeatedly sought clarification on their position, under the New Health Insurance Policy, in order to fully understand the Provider's assessment process. In my opinion, the Second Complainant's telephone conversation with Provider Agent 6, on **12 September 2019**, is of particular relevance. During this call Provider Agent 6 says that

"*the claims department will automatically go and look for more information through the consultant which will go back through your GP, but it will come from the originator which is your GP, the information will come from that and it will be based on that."*

Provider Agent 6 also says that

"if there is no record and he hasn't any signs or symptoms before that date, then it isn't pre-existing so you can be happy about that if that is the case"

and

"*the first day of the signs and symptoms as far as he is concerned. He will have it on record."*

I am satisfied that the evidence shows however, that the Provider was clear in the information given to the Complainants that the First Complainant's medical records would be examined by the Provider to establish when there were first signs of the issue that gave rise to the hip replacement. Indeed, they were told:

"because it's a hip replacement, he has to have had some kind of symptoms preceding that, he couldn't just have had a pain overnight, he may have had arthritis, he may, have had an infection, he may have gone to them with pain, there has to have been something, if this all starts with your GP, you need to go back to your GP."

[underlining above added for emphasis]

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I note that it was on foot of those GP medical records (together with the treating doctors entries on the claim form) that the Provider ultimately formed the opinion that the First Complainant's condition in relation to his hip, was one which pre-dated the policy upgrade on 1 March 2019, insofar as it was satisfied that the First Complainant had arthritis and "**++**" pain in his right hip on 29 March, and that he had indeed been prescribed *Vimovo*, for a number of years. In my opinion that was a reasonable opinion, on the basis of the medical evidence made available to the Provider.

The First Complainant says that:

> "*The [The Provider] agents advised me over the phone that if the condition was a pre-existing condition that, under the upgraded policy, there would be no cover in the [Name] hospital in [Location].*
> *They outlined what information was required prior to surgery, from whom and what date the consultant office would go on the [Provider] claim form. I was assured that if these boxes were all ticked – then I was covered*."

By email dated **21 December 2020** the Provider's representative said that for

> "*procedures including hip replacements, a prior approval process is not required and the claims are assessed in accordance with the rules, terms and conditions of membership in addition to the medical information submitted on the claim form*."

By letter dated **3 November 2020**, the Provider commented that

> "*our advisers did not specifically state that the Medical Director would make the final decision on a claim. Our advisors confirmed that the claim would be assessed based on the medical information received, terms and conditions of the policy.*
> *Our advisers would not be obliged to highlight each rule contained in our Rules – Terms and Conditions of cover. We recommend that our members refer to the terms and conditions for a comprehensive overview of their contract*."

Although the Provider did not specifically indicate that it was the Medical Director of the Provider who would assess the medical evidence in order to determine whether the claim would be covered, I am satisfied that the audio evidence makes clear that the Complainants were specifically and clearly advised that the Provider's Claims Department would "*definitely look for further information … there is no doubt about that … it will be decided, based, one will consult with your GP …*".

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Although the Complainants on a number of occasions when speaking on the phone, sought to raise additional queries with the Provider, in terms of what the Provider would do, based on certain suggested dates, all of these discussions were in the absence of the specific medical records which the Provider subsequently gained access to.

I also note that the Provider's agent on one occasion pointed out that it was the Complainants themselves who "*would know that" … "only you would know that … if that's the first time then*".

I don't accept the Complainants' suggestion that they were advised by the Provider that it "*would accept the Consultant's / GP advice to us on this issue*" or that they were assured by the Provider *"that if these boxes were all ticked – then I was covered*." I do not accept that the evidence supports that position.

Rather, I am satisfied that the Complainants were clearly placed on notice that in the course of assessing the claim, for treatment of that nature, the Provider would look to examine all relevant historical medical records in order to determine whether or not the treatment undergone by the First Complainant concerned a condition, the signs and symptoms of which had existed before he upgraded his policy cover on 1 March 2019.

Accordingly, I am satisfied that in accordance with the medical evidence made available to the Provider, it was entitled to determine that the First Complainant's condition pre-existed the upgrade in the policy cover. As a result, I accept that it was entitled to determine that the Complainant's cover was limited to the cover under the Original Health Insurance Policy, before the policy upgrade took place, and as a result it was appropriate for the Provider to decline the Complainant's claim. I am also satisfied that the Provider did not give "*misleading*" guidance to the Complainants as to how and by whom the determination as to cover would be made.

I am of the firm opinion that the Provider clarified to the Complainants that additional evidence of relevant medical records would be sought, in order for the Provider's claims department to determine whether the condition was "pre-existing" the policy ugrade.

The Complainants' legal representatives have pointed out that it would have been open to the Complainant to have the named procedure carried out in other conveniently located hospitals, but a decision was made by the Complainant to choose the hospital in question, because he was already a patient of the Consultant in question and had undergone surgery previously with that Consultant. I accept this statement. The Complainants' decision in that regard, however, does not create an entitlement over and above the policy benefits to which he was contractually entitled.

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The Complainants' legal representatives also point out that the Complainant could have chosen to delay the procedure until the waiting period elapsed, or he could have elected to be treated elsewhere by an equally qualified doctor, under the terms of his existing policy. I agree with the Complainants' legal representatives in that regard. He did not however make that choice, and I am satisfied that the Provider made clear information available to the Complainants, and it was the Complainant who elected, on the basis of that information, to proceed with the surgery in a hospital where he would be covered only if the condition requiring surgery was not a pre-existing condition, within the meaning of the policy provisions.

The Complainants' legal representatives have suggested that the Complainant's medical team has offered the view that "*there may have been no symptoms or signs*". I disagree. In my opinion, the Complainant's surgeon did not offer an opinion that "*there may have been no symptoms or signs*". Rather, the surgeon wrote to the Provider on 25 January 2020 to advise that he was "*unaware*" as to whether or not the Complainant had experienced symptoms before March 2019, and he continued by saying that "*it will certainly appear that there (sic) were not at the level where he was contemplating joint replacement surgery".* If indeed the Complainant had experienced symptoms, but those symptoms "*were not at the level where he was contemplating joint replacement surgery*", such symptoms would nevertheless constitute symptoms, whatever their severity.

I do not accept the Complainants' recent submission that the Provider is in some way, seeking to hide behind complex terms and conditions. I am satisfied that the waiting period to be served to be covered for a "*pre-existing*" condition, within the meaning of the policy of health insurance held with the Provider, is an industry-wide standard.

The result of this rule is that individuals who incept health insurance cover, or who upgrade their level of cover, will not be covered for the cost of treatment for a pre-existing condition, or will not benefit from the upgraded level of cover for a pre-existing condition, until such time as the relevant waiting period has been served. In my opinion, there is nothing inherently unfair in such a contractual arrangement and I reject the Complainants' argument that such a condition is unenforceable, owing to the provisions of the Unfair Terms in Consumer Contract Regulations 1995, as amended.

It should also be noted that the entitlement of the Complainant to benefit was not in any way dependent upon his awareness or otherwise, of his need for surgery at the time of the policy upgrade. A pre-existing condition is defined to include a condition, the signs or symptoms of which existed at any time within the period of 6 months prior to the Complainant's policy upgrade.

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The signs or symptoms in question do not require a name or a formal diagnosis, nor does the Provider need to establish that such signs and symptoms were of any particular obviousness or severity. Rather, the policy definition of a pre-existing condition is one which includes any ailment, illness or condition if, on the basis of the objective medical evidence available, the signs or symptoms of the ailment, illness or condition, were in existence during the period of 6 months immediately before the Complainant's policy upgrade. The policy provides in that regard that:

> *"Pre-existing conditions means an ailment, illness or condition, where, on the basis of medical advice, the signs or symptoms of ailment, illness or condition existed at any time in the period of 6 months ending on the day on which the person became insured under the contract"*

I note that in a recent submission, the Complainant has suggested that he was led to believe by his Consultant, that he would be covered for the surgery in question. This Office has no role to play regarding the actions or conduct of a consultant and rather, the complaint before this Office is one made about the conduct of the respondent financial service provider, specifically that it wrongfully declined the Complainant's claim, pursuant to the policy terms and conditions.

I also note the Complainants' recent submission that the decision of this Office is in conflict with another Decision published on the FSPO website, under the reference "***2018-0100***" in a situation described by the Complainants as analogous. It will be noted that the Ombudsman in that published Decision made clear his opinion that:

> *"the Provider's agents…should have made it clearer how the claim would be assessed and informed her that it was the Provider's medical advisors and not her consultant who would determine whether it was a pre-existing condition…."*

Every complaint to this Office is considered upon its own individual merits and I am satisfied that, in this instance, the Provider's agents made it very clear to the Complainants how a claim would be assessed, details of which are set out above, in the audio evidence quoted.

The Provider's recent submission in fact draws attention to the differences between the within complaint and the Published Decision ***2018-0100***, and points out that the fundamental difference, is that within that Published Decision, the Ombudsman noted that:

> "*the Complainant was led to believe that the Consultant would have the final decision on whether it was a pre-existing condition …"*

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Insofar as the complaint in this matter is concerned, I am satisfied with the quality of the information which the Provider's agents made available to the Complainants across a significant number of calls. In this matter, I have not formed the opinion that the Complainant was led to believe that his Consultant would have the final decision on whether or not his condition was a pre-existing condition, for the purpose of his health insurance with the Provider. For that reason, and in the absence of evidence of wrongdoing by the provider, within the meaning of ***Section 60(2)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** as amended, I do not consider it appropriate to uphold this complaint.

I note the Complainant's view that he should have been able to seek prior approval from the Provider, before undertaking the surgery. For this particular type of surgery however, no such pre-approval process is required, and any such processes are a matter for the Provider. In any event, for the reasons outlined above, I take the view that the quality of the information which the Provider made available to the Complainant in the period before he underwent the surgery, was clear and put him firmly on notice that the relevant medical records would be sought from his treating doctors, by the Provider's claims department, for the purpose of the Provider establishing whether the signs or symptoms of his condition predated his policy upgrade in March 2019.

Accordingly, on the basis of the evidence made available, including the audio evidence, I do not accept that it would be reasonable 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

7 January 2022

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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.