An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

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| **Decision Ref:** | 2022-0055 |
| **Sector:** | Insurance |
| **Product / Service:** | Travel |
| **Conduct(s) complained of:** | Rejection of claim - late notification<br>Advice given by medical-assist line |
| **Outcome:** | Rejected |

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

This complaint relates to a claim for the cost of medical treatment the Complainant received whilst abroad. The claim was made by the Complainant under her health insurance policy with the Provider which she incepted in 2008.

## The Complainant's Case

The Complainant was travelling abroad for a holiday in **August 2019**. Whilst on holiday, the Complainant "*collapsed in the street*".

In an email to this office of **21 February 2021**, the Complainant submitted that she was rendered "*completely incapacitated and unfit to make any decisions in relation to my emergency care*."

The Complainant was hospitalised and received medical treatment. In an email to this office of **21 March 2021**, the Complainant stated that she was not in a position to contact the Provider during this period, as she was unwell and undergoing consecutive medical testing. Following treatment, the Complainant asked a nurse to check with the hospital's accounts department regarding payment of her expenses. The Complainant was informed that the accounts department would liaise with her insurer to deal with the matter.

The Complainant paid a bill to the accounts department for the expense of an ambulance, as she was advised that this was not covered by her insurance. She subsequently held the understanding that the remainder of the medical bill had been covered by the Provider.
In response to the Provider's submission that the claim was not properly made, as the Complainant was required to seek pre-approval of this medical treatment, the Complainant submitted that the Provider's policy states, under the section 'How to claim', that:

> *"you <u>should</u> call their international assistance number while abroad but not that you <u>must</u>"*

The Provider made an offer to the Complainant of €300 (three hundred Euro) in acknowledgement of its delay in dealing with the complaint. This was rejected on the basis that it was insufficient to cover the Complainant's medical bills of €22,000 (twenty-two thousand Euro).

On the Complaint Form at the time when the Complainant made her complaint to this Office, she advised that the Provider had refused "*to pay for medical assistance/hospitalisation while abroad on holiday because I didn't make a phonecall to their overseas office at the time".*

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

In the Provider's response to the formal investigation of this Office dated **3 February 2021**, the Provider submitted that the Complainant's claim was denied on the basis that the terms and conditions of the policy were not met.

It noted that consumers must receive authorisation from the Provider, prior to seeking treatment. It relies on the 'A&E Abroad' section of its **Membership Handbook** in this respect. The Complainant did not contact, or seek to contact, the Provider in advance of receiving medical treatment.

The Provider submitted that it reviewed the Complainant's case "*retrospectively as a goodwill gesture as the Complainant advised she was unconscious when brought to hospital*". The Provider stated that, on receipt of the Complainant's medical notes, the claim did not meet the terms and conditions of the policy.

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The Provider submitted:

> *"Our A&E abroad benefit… does not provide cover for conditions that existed prior to travel, or, where a member might expect they would require medical assistance whilst abroad."*

The Provider states that the Complainant had been suffering from a medical condition (which it says was the subject of the treatment abroad, for which this claim was made by the Complainant), and that she had been suffering from that condition for three months prior to the treatment in question. As a result, the Complainant's claim remained declined. At the request by this Office in November 2021, the Provider supplied the relevant medical documentation which it says bears out its position.

This Office asked the Provider to respond to the Complainant's submission that the policy wording should state 'must' instead of 'should'. It asked the Provider to refer to Provision 4.1 of the ***Consumer Protection Code 2012*** (CPC) in its answer.

The Provider responded that this section of the **Membership Handbook** stated that preauthorisation was a requirement for making a claim. In order to receive the pre-authorisation, the Provider would have to be contacted by the Complainant. The term 'should' related to how the Provider was to be contacted, and did not relate to the requirements for the claim. The Provider submitted that it was happy that these terms and conditions are clear and accurate, and in line with Provision 4.1. The Provider noted that there was a delay in dealing with the Complainant's complaint, and made an offer of €300 (three hundred Euro) in this regard.

## The Complaint for Adjudication

The complaint is that the Provider wrongfully refused the Complainant's claim for the cost of hospital in-patient treatment while on holiday abroad in August 2019. The Complainant wants the Provider to pay her claim in full, at a cost in the order of €22,000.

## Decision

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

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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 **20 January 2022**, 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.

**Evidence**

I note that on page 18 of the **Membership Handbook**, the following is stated:

| **A&E Abroad** | |
|---|---|
| **Benefit** | **Description/Criteria** |
| Hospital bill for in-patient treatment | Under this benefit we will cover your medical costs for emergency care in a medical facility abroad where:<br><br>➢ The emergency care is medically necessary ;<br>➢ The emergency care is pre-authorised and arranged by [Provider];<br>➢ You began your emergency care abroad within 31 days of your departure from Ireland;<br>➢ You receive the emergency care in an internationally recognised hospital;<br>➢ You have not travelled against medical advice;<br>➢ You were not suffering from a terminal illness when you left Ireland; and<br>➢ You did not suspect when you left Ireland that you might require any medical care when you were abroad and a reasonable person in your position would not have suspected that you would require any medical care when you were abroad.<br>… |

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|---|---|
| | We will not cover:<br><br>➢ Non-medical expenses;<br>➢ Medical care that has not been pre-authorised and arranged by us;<br>➢ Elective treatments or procedures or follow on care, regardless of whether this is related to your emergency care;<br>➢ Medical care that could be delayed until your return to Ireland. |

[My underlining for emphasis]

I note that immediately below these details, the following is included in the policy document:-

| **How to claim** |
|---|
| You should call our international assistance number… in advance of receiving your emergency care to have your medical care pre-authorised and arranged by us. You must provide us with details of your travel insurance and your European Health Insurance Card. <u>If you are unable to contact our international assistance number, a third party may do so on your behalf.</u> |

[My underlining for emphasis]

On page 20 of the **Membership Handbook**, there is a comparable section under the title of 'Elective Overseas Referral':

| **Elective Overseas Referral** | |
|---|---|
| **Benefit** | **Description/Criteria** |
| [First option] | … |
| [Second option] | … |
| **How to claim** | |
| If you wish to claim either of these benefits, you must have all your medical care abroad pre-authorised by us. To obtain pre-authorisation you will need to complete the [Provider] Form which is available on our website… | |

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**Analysis**

The Provider submits that the Complainant is not entitled to have this claim accepted, in circumstances where the policy states that medical treatment abroad, must be pre-approved and arranged with the Provider. It submits that this policy is worded clearly, and complies with Provision 4.1 of the Consumer Protection Code ("CPC").

The Complainant argues that the use of the term "*should*" in the Provider's policy indicates that this is not a requirement, and she is therefore entitled to have the claim accepted.

Provision 4.1 of the CPC reads as follows:

> *"GENERAL REQUIREMENTS*
>
> *4.1 A regulated entity must ensure that all information it provides to a consumer is clear, accurate, up to date, and written in plain English. Key information must be brought to the attention of the consumer. The method of presentation must not disguise, diminish or obscure important information."*

I consider that the Provider's policy is initially clear in the 'Description/Criteria' subsection and, in particular, the following is stated:

> *"We will not cover:*
> - *…*
> - *Medical care that has not been pre-authorised and arranged by us;"*

I am satisfied that this provides clarity that contact with the Provider for pre-authorised medical care abroad is a requirement. This section of the **Membership Handbook** does not refer to situations in which emergency treatment is required, if the Complainant is incapacitated or otherwise unable to contact the Provider, due to a medical condition, but this is made clear immediately below, on the very same page, where it specifies that:-

> "*If you are unable to contact our international assistance number, a third party may do so on your behalf*."

The Provider suggests in its submissions that the criterion of pre-authorisation is absolute and, as a result, there would never be a situation in which the Provider would accept a claim without pre-authorisation of the medical treatment abroad.

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However, I accept that the terminology of "*should*" in the '**How to claim'** section somewhat undermines this argument. I do not accept the Provider's explanation that the requirement is set down in the '**Description/Criteria'** section, and the '**How to claim'** simply provides an explanation of how the criterion can be met. In my opinion, the use of the word "should" has the potential to confuse, if what the Provider means is in fact that the policyholder "must" make contact with the Provider, either themselves or through a third party.

The section on '**A&E Abroad'** can be compared to the section entitled '**Elective Overseas Referral'** section on page 20 of the **Membership Handbook.** In the latter section, the term "*must*" and the phrase "*need to*" are used when instructing consumers on how to claim with pre-authorised expenses.

The term "*must*" is mandatory. It directs a certain course to be taken. In contrast, that term "*should*" is more permissive. It recommends that consumers follow a certain course. In my opinion, the Provider has used mandatory language in explaining how to claim for elective overseas expenses, and permissive language in explaining how to claim for emergency overseas expenses. Further, this permissive language is used in a section with an absence of information on the key issue of whether a claim can be made in any circumstances when pre-authorisation is not possible from the Provider.

I accept that the Provider was entitled to reject the Complainant's claim on the basis that she did not seek pre-approval of the treatment. Taking the policy rules as a whole, I believe it is clear that no cover will be available for Accident and Emergency treatment abroad, in the absence of contact being made and pre-approval sought for the cost of such treatment. The Complainant was incapacitated, and was unable to make contact with the Provider and it seems that no other person did so on her behalf. I accept that the more permissive language of the '**How to claim'** section may have caused the Complainant confusion, and thereby caused her inconvenience, owing to her belief that pre-approval was not an absolute or inflexible requirement, because of the use of the language directing a policyholder that they "should" make contact. The use of the word "should" does not fully align with the additional provision, which makes clear that if the insured person is incapable of making contact, a third party may do so on their behalf.

The Provider further submits that the Complainant's claim did not meet the terms and conditions, because its policy does not cover conditions that existed prior to travel, nor does it apply to situations where medical assistance might be expected whilst abroad.

I note that the Complainant travelled abroad on 28 July 2019 and on Sunday 4 August 2019, she moved from one country to another, prior to her scheduled departure on 11 August 2019, to return to Ireland.

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Given the position adopted by the Provider, I wrote to the Provider on **4 November 2021**, asking for details of the medical documentation and seeking confirmation as to whether it was the position of the Provider that the Complainant or indeed a reasonable person in the Complainant's position, would have suspected when she travelled abroad that she was likely to require medical treatment for the condition from which she had been suffering over the previous 3 months.

When the Provider responded, it explained that the Complainant presented to the Emergency Department of a hospital abroad on 6 August 2019 with "*diarrhoea , fainting episode*" and she was admitted and stayed in hospital between the 6th and 8th August 2019. The Provider says that the medical notes record that the Complainant had been experiencing symptoms of her condition for approximately 3 months, prior to her admission to the hospital abroad. I note in that regard that on 7 August 2019 the hospital noted that the Complainant had reported:

> "*that she has had persistent loose watery diarrhoea for the past 3 months – 4 – 5 episodes daily. Symptoms initially began – 3 months after a trip to the U.K. when she ate a poached egg. Symptoms for the first month included nausea and emesis but transitioned to diarrhoea for the following 2 months, through the present time she went to see her PCP in Ireland, at which time stool studies were negative for infection. She was recommended a colonoscopy which is scheduled on 8/23/2019 in Ireland. In the meantime she has attempted to remain well – hydrated. However, ever since she came on her current trip to [location redacted] since Sunday July 28, her fluid intake has been limited to – 1.5 bottles of water daily due to limited ability of water bottles and restrooms while travelling. She has continued to take her anti-htn meds and have diarrhoea in the meantime. Yesterday she was walking from her hotel to a steakhouse in downtown and felt somewhat weaker than usual so she handed her backpack to her partner and leaned against the wall of a building…*"

I note that within the details of cover within the Membership Handbook, it is specified that cover for medical costs for emergency care in a medical facility abroad will be covered where…

> "*you did not suspect when you left Ireland that you might require any medical care when you were abroad and a reasonable person in your position would not have suspected that you would require any medical care when you were abroad*."

In those circumstances, I do not accept that the Complainant is correct when she says that the Provider declined to cover her hospital expenses because she did not telephone the Provider's overseas office when she was ill.

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It is clear that the Complainant or her partner "should" have telephoned the Provider when she became ill. If they had done so, it would have given her the opportunity to explore the level of cover, if any, which might be available to her to undergo medical treatment abroad. I am satisfied however, from the medical reports which have been made available, that if she had telephoned at that time and if her medical history had been shared with the Provider, the Provider would have been entitled to advise her that no cover would be available to her, owing to the provisions of the rules of membership, as quoted above.

I note in that regard, that as a gesture of goodwill to the Complainant the Provider undertook a retrospective assessment of her claim, even though she had not telephoned when she ought to have. I note that at that point, the Provider formed the opinion that on the basis of the Complainant's medical history, the claim did not meet the terms and conditions of the policy. I am satisfied in that regard, that the Provider was entitled to reasonably form this opinion, based on the medical records which had been made available.

Accordingly, I do not accept that the Provider acted wrongfully when it declined the Complainant's claim for the cost of hospital in-patient treatment in August 2019 and for the reasons outlined above, I take the view that it would not be reasonable to uphold this complaint.

I note that the Provider made an offer to the Complainant of €300 (three hundred Euro) in acknowledgement of its delay in dealing with the complaint. If the Complainant wishes to accept that offer, it will be a matter for her to communicate directly with the Provider, in that regard.

**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**
**Financial Services and Pensions Ombudsman (Acting)**

11 February 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.**