An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2022-0323
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Rejection of claim - depression/mental health illness Failure to process instructions Rejection of claim
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The First Complainant held a **Health Insurance Policy** with the Provider. The Second Complainant, his daughter, is a named person on the Policy. This complaint concerns the Provider's refusal to provide cover for the Second Complainant's treatment for her condition in a specific treatment facility. The Policy term in which this complaint falls, is from **1 February 2020** to **31 January 2021**.

The Complainants' Case

The First Complainant says that the Second Complainant was diagnosed with anorexia nervosa and that following consultation, the family GP recommended that the Second Complainant be admitted into Hospital A for treatment of her condition.

The First Complainant says that the Provider declined to cover any treatment that the Second Complainant may undergo in Hospital A, as it advised that there is no cover under his Policy in respect of this treatment facility.

The First Complainant sets out the Complainants' complaint in the **Complaint Form** he completed in **November 2020**, as follows:

> *"My daughter* [the Second Complainant] *is battling Anorexia. We found this out about 2 months ago. We were referred to numerous different treatment centres by our GP … After meeting with* [the Second Complainant]*,* [our GP] *advised us that the best course of action was to refer* [the Second Complainant] *to* [Hospital A]*, and* [Hospital A] *agreed to help* [her].

> *The finance department in* [Hospital A] *rang* [the Provider] *to check if their facility was covered on our health insurance policy.* [The Provider] *declined the treatment. My policy states that all members are entitled to "up to 100 days inpatient treatment, once the condition is not related to substance abuse". I rang the Provider to question their refusal, and they told me that* [the Second Complainant] *could attend* [Hospital B], [Hospital C] *or* [Hospital D]*. These facilitates do not offer teenage mental health facilities/eating disorder. They are general health facilities. This is not suitable for the treatment my daughter requires.*
>
> [The Provider] *then sent me a letter* [dated **10 November 2020**] *which did not address my concerns and offered no solution to our very serious issue.* [The Provider] *have had no problems taking €256 from my bank account every month for the last number of years, and when we really needed it, they were of no help whatsoever. The description of the 100 days inpatient treatment is not fairly described in my policy conditions in my mind".*

In his email to this Office of **10 June 2021**, the First Complainant also submits that:

> *"*[The Provider's **Formal Response** to the complaint investigation by this Office dated **1 June 2021**] *just seems to be a load of waffle in our minds. And* [the Provider] *still have not provided an answer as to where we are or were supposed to have our daughter* [the Second Complainant] *treated.* [The Provider] *offered 3 alternatives, but as we have already stated, not one of those facilities provide adolescent treatment facilities … This, as we have said all along, is the question we want answered".*

The First Complainant states in the **Complaint Form** that in order to resolve this matter:

> *"I don't want anything except to have my daughter* [the Second Complainant] *treated like a human being with a very real disease. Please assist my family and I in getting her the treatment she deserves".*

In addition, in his email to this Office of **10 June 2021**, the First Complainant submits that:

> *"…we have cancelled our Health Insurance with* [the Provider]*, and have moved to an alternative provider. Despite the fact that I spoke to one of* [the Provider's] *advisors, who informed me that as a result of the dispute over this whole scenario, we would not incur a mid-cancellation penalty, I have received both letters and emails demanding full payment of the penalty. I think that this is despicable on* [the Provider's] *part, and would ask that they be brought to task over this also".*

/Cont'd…

The Provider's Case

The Provider notes that the Complainants' complaint is that the First Complainant's Policy did not provide cover in respect of Hospital A, where the Second Complainant was seeking to be admitted for treatment.

Provider records indicate that on **13 January 2014**, the First Complainant telephoned to obtain a health insurance quote for himself and his family. The Provider says that the First Complainant was taken through a 'fact find' process to establish his needs and to make a product recommendation. The following day, on **14 January 2014**, the First Complainant telephoned back and purchased Policy 1 for himself and his wife and Policy 2 for his three children, both with an inception date of **1 February 2014**. The Provider notes that both Policy 1 and Policy 2 covered in-patient hospital costs and day case procedures in selected Public, Private and Hi-Tech hospitals, subject to certain policy excesses. The Provider says that in relation to Policy 2 for his three children, the hospitals and treatment centres covered were set out in List 2 in Part 6, 'Lists', at pg. 30 of the applicable **Membership Handbook**. The Provider confirms that there was no cover for Hospital A on either Policy 1 or Policy 2.

The Provider further says that on **23 January 2015**, in advance of his **1 February 2015** policy renewal date, it telephoned the First Complainant and completed a health insurance review. The Provider says that during this call, the First Complainant amended the level of cover for himself, his spouse and his three children to Policy 3, hereinafter 'the Policy'. This Provider notes that this Policy covered in-patient hospital costs and day case procedures in selected Public, Private and Hi-Tech hospitals, subject to certain policy excesses and that the Agent advised that the Policy had a select hospital list. The Provider says that the First Complainant renewed this Policy for himself and his family every year thereafter, until he cancelled the policy with effect from **4 March 2021**.

The Provider says that the Policy the First Complainant and his family have been insured on since **1 February 2015** covers hospitals, treatment centres and scan facilities set out in List 3 in Section 12, 'List of Medical Facilities', of the applicable **Membership Handbooks**.
The Provider confirms that while there may have been changes to the different hospital lists over the years since the First Complainant first incepted health insurance cover with it, Hospital A has never been covered on the list relevant to the First Complainant's Policy.

The Provider says that because the First Complainant had opted in **January 2014** to receive all policy documents electronically, it emailed him at inception and each renewal thereafter to notify him that his policy documents were available to view online, namely, the Policy Schedule, the Table of Cover, the Membership Handbook (containing the full list of hospitals and treatment centres covered), the Terms of Business and the Product Suitability Statement. The Provider notes that it also includes an up-to-date hospital list on its website.

/Cont'd…

The Provider notes that when the First Complainant telephoned on **9 November 2020**, he had just been informed by Hospital A that the Second Complainant was not covered under his Policy for admission to this centre. The Provider says its Agent explained to the First Complainant that his Policy only provided cover for those medical facilities on List 3 and that Hospital A is not on List 3 and the Agent named alternative facilities that are covered on List 3. The First Complainant expressed his dissatisfaction in relation to this matter and a complaint was immediately logged. The Provider notes that the First Complainant never formally submitted a claim to it in respect of the treatment sought for the Second Complainant in Hospital A. The Provider says that following its complaint review, it sent the First Complainant its **Final Response** on **10 November 2020**, setting out its position.

In response to the First Complainant's comments that *"the description of the 100 days inpatient treatment is not fairly described in my policy conditions in my mind"*, the Provider says that at each renewal, the First Complainant was supplied with the Table of Cover for his Policy. The Provider notes that this Table of Cover clearly states that it must be read in conjunction with the Membership Handbook and advises that the hospital list associated with the Policy, is List 3.

The Provider says that at his renewal date in **February 2020**, the First Complainant was issued with a Table of Cover wherein the cover for psychiatric treatment was set out as follows:

Psychiatric Treatment	
Not related to substance abuse	100 days (up to the level of Hospital Cover provided under your plan for your listed hospitals)
Related to substance abuse	91 days per 5 years (up to the level of Hospital Cover provided under your plan)

The Provider says that psychiatric cover is covered according to the policyholder's hospital list.

In that regard, the Provider notes that the hospitals, treatment centres and scan facilities covered on the First Complainant's Policy were set out in Section 12, 'List of Medical Facilities', at pg. 33 of the **January 2020 Membership Handbook**. The Provider points out that the hospitals that are not covered are clearly labelled accordingly, and it notes that cover for Hospital A for a List 3 plan, was clearly set out as follows:

A. Hospitals	Hospital type	Direct Settlement	List 1	List 2	List 3	List 4
[Hospital A]	Private hospital	Yes	Covered	Not Covered	Not Covered	Not Covered

/Cont'd…

The Provider says that while it appreciates the First Complainant's dissatisfaction, it must provide health insurance benefit in accordance with the terms and conditions for the level of health insurance cover paid for by the policyholder and it cannot make any exceptions to this process.

In response to the First Complainant's comments that *"*[the Provider] *still have not provided an answer as to where we are or were supposed to have our daughter* [the Second Complainant] *treated"*, the Provider says that if the medical treatment required for the Second Complainant was not available from any of the medical facilities on the First Complainant's Policy hospital list, List 3, then the Second Complainant's treating physician is the most appropriate person to determine the care path suitable and to advise on alternative medical facilities providing the necessary treatment. In that regard, the Provider says that it has no role, and indeed that it would be unethical and inappropriate for it to interfere with patient choice, when it comes to selecting healthcare interventions or providers for treatment. The Provider says it cannot direct members or their families in their medical care decisions, as that is a matter for their treating physicians, be that the GP or treating consultant.

The Provider says that the First Complainant cancelled his Policy effective from **7 March 2021** and that when this cancellation was completed, a mid-term cancellation fee of **€1,532.13 (one thousand five hundred and thirty-two Euro and thirteen Cent)** was applied, in accordance with the Policy terms and conditions. The Provider says that when his bank returned the direct debit for this cancellation fee as unpaid, an automated email issued to the First Complainant notifying him that his payment was in arrears. The Provider notes that the First Complainant responded to this email making it clear that the Policy was to be cancelled and that he was not paying the midterm cancellation fee. The Provider says that, as an exception, it waived the cancellation fee in this instance.

The Provider says it was then quickly identified that as the Policy had been paid by monthly direct debit, premiums had only been paid up to **4 March 2021** and not to the cancellation date of **7 March 2021**, resulting in premium in the amount of **€30.82 (thirty Euro and eighty-two Cent)** outstanding in order to provide cover up to the cancellation date. The Provider notes that when this was brought to the attention of the First Complainant, he made it clear that he would not be paying anything further by way of premium on the Policy, and so the Provider amended his cancellation date back to the 'paid up-to' date of **4 March 2021** and informed him of this. The Provider says that unfortunately, when its Agent completed this change, they did not correctly waive the mid-term cancellation fee as had been done previously, resulting in two reminder letters issuing to the First Complainant seeking payment of the mid-term cancellation fee. In that regard, the Provider apologies for the confusion and reiterates that it waived the mid-term cancellation fee of **€1,532.13** and that there is nothing further due on the First Complainant's Policy.

The Provider says that as part of this complaint review, it has identified one instance where its service fell below its normal expected high standards. In that regard, the Provider notes that during his telephone call with it on **5 January 2018**, the First Complainant requested to change his communication preference from electronic documentation to postal documentation and asked for an email to be sent outlining his cover.

/Cont'd…

The Provider notes that this request was not processed, and it apologises for any inconvenience that this may have caused and it has offered the First Complainant a customer service payment of **€200.00 (two hundred Euro)**. The Provider says that while it acknowledges that this request should have been actioned, it does not believe that this oversight had a material impact on this complaint, as Hospital A had never been covered on the First Complainant's Policy since inception. The Provider also notes from a subsequent telephone call on **24 January 2019** that the First Complainant was still using his online account with the Provider to access his policy documents.

The Complaint for Adjudication

The complaint is that in 2020, the Provider wrongfully or unreasonably declined cover in the medical facility [Hospital A] which the First Complainant says was the only appropriate facility to provide treatment required by the Second Complainant.

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 **30 August 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.

I note that the First Complainant's daughter, the Second Complainant, was diagnosed with anorexia nervosa and he says that following consultation, the family GP recommended that the Second Complainant be admitted into Hospital A for treatment of her condition.

/Cont'd…

The First Complainant says that the Provider declined to cover any treatment that the Second Complainant may undergo in Hospital A because it said that there is no cover under his Policy, in respect of this treatment facility.

It is important to note that health insurance policies, like all insurance policies, do not provide cover for every eventuality; rather the cover will be subject to the terms, conditions, endorsements, and exclusions set out in the policy documentation.

In that regard, health insurance providers offer an array of different policies that provide different levels of cover for its customers.

I note that the Provider emailed the First Complainant on **31 December 2019** to advise that his Policy was due for renewal on **1 February 2020** and that he should log in to his online account with the Provider to access his renewal documents.

I note that the '**What you're covered for – Effective from 1st February 2020**' document stated:

> *"You should read this table of cover along with the Health Plans membership handbook effective from January 2020, which you can find on* [website link redacted]*. The hospitals and treatment centres covered on this plan are set out in List 3 in Part 12 of your Health Plans membership handbook"*.
>
> [my underlining added for emphasis]

I note that this document also set out the cover for psychiatric treatment, as follows:

Psychiatric Treatment	
Not related to substance abuse	100 days (up to the level of Hospital Cover provided under your plan for your listed hospitals)
Related to substance abuse	91 days per 5 years (up to the level of Hospital Cover provided under your plan)

[my underlining added for emphasis]

I am satisfied that this document makes it clear that cover in respect of 100 days of psychiatric treatment not related to substance abuse, is subject to being available in the hospitals listed under the policyholder's particular plan.

I also note that Section 12, 'Lists of Medical Facilities', at pg. 33 of the **January 2020 Membership Handbook** advises:

/Cont'd…

*"Please refer to **your** Table of Cover to check whether list 1, 2, 3 or 4 applies to **your plan**..."*

As noted, the '**What you're covered for – Effective from 1st February 2020**' document confirmed that the First Complainant's Policy provides cover for those hospitals and treatment centres set out in List 3.

In that regard, I note that cover for Hospital A was set out at pg. 33 of the Membership Handbook, as follows:

A. Hospitals	Hospital type	Direct Settlement	List 1	List 2	List 3	List 4
[Hospital A]	Private hospital	Yes	Covered	Not Covered	Not Covered	Not Covered

[my underlining added for emphasis]

I am therefore of the opinion that the First Complainant's policy documentation provided clear and appropriate notice that his health insurance cover did not provide any cover in respect of Hospital A.

I note that recordings of telephone calls have been furnished in evidence. In particular, I note that when he telephoned the Provider on **24 January 2019**, the First Complainant was advised that his Policy is a List 3 plan, in that it only provides cover for those medical facilities listed as covered under Hospital List 3.

As he was having difficulty at the time accessing the Membership Handbook on his online account, I note that the Agent talked the First Complainant through locating Hospital List 3 on the Provider's main website, so that he could then see, in full, the list of medical facilities covered by his Policy.

In confirming to the First Complainant by telephone on **9 November 2020** that his policy did not provide cover for any treatment that the Second Complainant may undergo in Hospital A, I am satisfied that the Provider was acting in accordance with the terms and conditions of the contract of insurance that the First Complainant had in place with the Provider at the time. In that regard, I note from the documentation before me that since the First Complainant first incepted his health insurance cover with the Provider in **February 2014**, Hospital A has never been covered on the list relevant to his policies.

I note that during a telephone call with the Provider on **5 January 2018**, the First Complainant requested to amend his communication preference from e-documents to postal documents. I note that the Provider has acknowledged and apologised for the fact that it failed to action this request, and that it has offered the First Complainant a customer service payment in the amount of **€200.00 (two hundred Euro)**.

/Cont'd…

The First Complainant submits in his email to this Office of **10 June 2021** that:

> *"We also would like to add that it is completely inappropriate for* [the Provider] *to offer €200 for not carrying out my instructions of forwarding the policy documents etc by paper method and not by email. I think that this is a derogatory offer on their part. I actually don't know why they even offered that"*.

Administrative errors are unsatisfactory, as indeed was the Provider's failure to action the First Complainant's request to change his communication preference from electronic documentation to postal documentation.

That said, I am of the view that it would have been open to the First Complainant at the time of his next policy renewal, to have contacted the Provider to advise that his renewal documents had once again been issued to him electronically rather than in paper format, as he has previously requested. I also accept the Provider's position that its oversight, while regrettable, did not have any material impact on this complaint, given that Hospital A has never been covered on the hospital list relevant to the First Complainant's Policy, as set out in his policy documentation.

As a result, I consider the Provider's offer of a customer service payment to the First Complainant in the amount of **€200.00** in respect of its failure to action his request in **January 2018** to amend his communication preferences with it, to be a reasonable and appropriate offer and that it is a matter for the First Complainant to advise the Provider whether he now wishes to accept the offer.

Having regard to all of the above, I am of the opinion that the evidence does not support the complaint that the Provider wrongfully or unreasonably declined in 2020, to make cover available in Hospital A, under the Complainant's policy. I take the view that there has been no wrongdoing by the Provider, such that it would be appropriate for this Office to uphold the complaint made and, consequently, it is my Decision on the evidence before me, that this complaint should not be upheld.

Conclusion

My Preliminary 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)

26 September 2022

/Cont'd…

PUBLICATION

Complaints about the conduct of financial service providers

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.

Complaints about the conduct of pension providers

Pursuant to *Section 62* of the *Financial Services and Pensions Ombudsman Act 2017*, the Financial Services and Pensions Ombudsman will **publish case studies** in relation to complaints concerning pension 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.