DRN-3944194

The complaint

Mr and Mrs S complain about HMCA Insurance Ltd's decision to limit the amount paid towards claims made under their private medical insurance policy.

What happened

Mr and Mrs S took out the policy which started on 1 June 2021. Mr S is named as the main member, and Mrs S is also insured under the policy.

In 2022, Mrs S needed a pacemaker. HMCA authorised the surgery, but said it would only pay £865 towards it as this was Mrs S's remaining benefit limit for day-case treatment.

Mr and Mrs S complained about HMCA's decision to limit the amount paid towards the claim to £865. Meanwhile, Mrs S went ahead and paid for the pacemaker to be fitted. A few months later, Mrs S had further treatment which HMCA refused to pay towards.

HMCA said it had paid the benefit in line with the policy limit. Unhappy with HMCA's response, Mr and Mrs S brought a complaint to this service.

Our investigator didn't recommend the complaint be upheld. He thought HMCA's payment of £865 towards the claim was correct, as this was Mrs S's remaining benefit amount under the policy for day-case treatment.

I issued a provisional decision on 20 January 2023. Here's what I said:

"The policy had a benefit limit of £2,500 for day-case treatment for the 2021-22 policy year.

Mrs S did not stay in hospital overnight when she had her pacemaker fitted in May 2022. I'm therefore satisfied that it was appropriate for HMCA to deal with the claim as day-case treatment, and apply the above benefit limit. As Mrs S only had £865 remaining for that policy year at the time, it was appropriate for HMCA to limit the payment to this amount.

Mr and Mrs S say HMCA did not put them on notice that there may be a significant shortfall due to Mrs S having the surgery as a day-case patient. However, I understand Mr and Mrs S first contacted HMCA in April 2022 about the claim. I see that HMCA emailed Mr S on 6 April 2022 and confirmed that if the operation went ahead as a day-case, then Mrs S had a maximum remaining benefit of £865 towards it. I'm therefore satisfied that HMCA did make Mr and Mrs S aware of the remaining benefit before Mrs S had the surgery.

Later conversations between the parties also made clear the day-case remaining limit. HMCA did not know for certain if Mrs S was going to have the surgery as a day-case or an overnight stay, and so it discussed both options. I think that was reasonable.

Whilst I appreciate HMCA would have likely paid a greater amount towards the surgery had Mrs S stayed overnight in a hospital, I wouldn't have expected HMCA to have given Mrs S any advice about this or suggested that she have her treatment elsewhere. It was Mrs S's

decision where to have her treatment, and her doctor's decision over whether this could be performed without an overnight stay in hospital.

After the policy renewed on 1 June 2022, Mrs S had further treatment in July 2022 (a check-up, as well as ablation of atrio-ventricular junction). Mr and Mrs S say they paid a total of £7,350 for this treatment. HMCA refused to pay for this treatment because it said Mrs S had received the maximum benefit available for the year in which the claim form was issued.

The policy includes the following term:

> *"3.26 The benefits payable towards a claim are those applicable to your certificate at the time the claim form is issued. Therefore benefits from 2 separate membership years cannot be applied to the same claim."*

Private medical insurance policies, like this one, are annually renewable. Usually, if a benefit limit applies, then the limit will 're-start' at each renewal. That means that if treatment takes place across more than one membership year, the insured can claim up to the benefit limit each year.

I therefore find the above term to be highly unusual, and for HMCA to be able to rely on it, I would need to be satisfied that it was brought to Mr S's attention at the time of sale.

The policy was sold on a non-advised basis. In other words, HMCA did not offer Mr S any advice as to the suitability of the cover. Nonetheless, HMCA was still required to provide Mr S with sufficient information about the policy, and make him aware of any significant terms or exclusions.

I've listened to the available calls between HMCA and Mr S before the policy was taken out, but the above term was not brought to Mr S's attention. I've also read the welcome letter, Insurance Product Information Document (IPID), and policy terms. The IPID lists the main policy terms and limitations, but does not include the above. The term itself in the policy document is written in small print and is included amongst over 20 other terms. I find this was not clear or prominent enough.

Overall, I don't think HMCA did enough to bring this unusual term to Mr S's attention when the policy was sold. In the circumstances, I think a fair and reasonable outcome here would be for HMCA to deal with Mrs S's claim for treatment in the 2022-23 policy year, without relying on term 3.26."

I asked both parties for any comments they wished to make.

HMCA did not provide any further comments before the deadline.

Mr and Mrs S responded to say they understood the reasoning behind my provisional findings, though they said they still do not understand the policy.

What I've decided – and why

I've considered all the available evidence and arguments to decide what's fair and reasonable in the circumstances of this complaint.

Mr and Mrs S say they don't understand the policy, because the timing of a procedure may mean it is carried out as day-case treatment rather than in-patient stay. Whilst I can

understand their frustration with the situation, it's up to an insurer what they decide to cover in a policy. HMCA has chosen to limit cover for day-case treatment to £2,500 (which isn't unusual for these policies), and so I can't interfere with that decision.

As neither party has provided any further comments for me to consider in respect of my findings relating to term 3.26, I remain satisfied that it wouldn't be fair for HMCA to rely on this term as it wasn't brought to Mr S's attention at the time of sale.

My final decision

My final decision is that I partly uphold this complaint.

I require HMCA Insurance Ltd to deal with Mrs S's claim for treatment after the policy renewed in June 2022 in line with the policy terms, but without relying on term 3.26.

As Mrs S has already paid for the treatment herself, any payment made should be reimbursed to Mrs S directly. Interest* should be added at 8% simple per annum from the date she paid for the treatment to the date of settlement.

*If HMCA considers that it's required by HM Revenue & Customs to take off income tax from that interest, it should tell Mrs S how much it's taken off. It should also give Mrs S a certificate showing this if she asks for one, so she can reclaim the tax from HM Revenue & Customs if appropriate.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr S and Mrs S to accept or reject my decision before 3 March 2023.

Chantelle Hurn-Ryan
Ombudsman