An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2022-0130
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Rejection of claim Failure to provide product/service information Failure to process instructions
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint concerns a private health insurance policy.

The Complainant's Case

The Complainant submits that on **3 February 2020** he contacted the Provider to check the cover under his policy regarding maternity benefit for his wife for homebirth expenses. The Complainant states that he and his wife arranged for homebirth services through a midwife, hereto referred to as "Ms. M". He states that Ms. M made some visits to his house to prepare for the homebirth while his wife attended the public scheme for her normal pre-natal care. The Complainant maintains that because his wife had medical complications she could not go ahead with the homebirth and was admitted to hospital as a public patient for delivery in **July 2020**.

The Complainant states that the partial expenses for the midwife in providing the homebirth services amounted to €700 which the Complainant submits he paid. The Complainant submits that in **September 2020** he made a claim to the Provider for the midwife expenses using the receipt from the midwife, through the Provider's online app but his claim was rejected by the Provider on **25 September 2020**.

The Complainant states that he queried the Provider's response on **2 October 2020** and again on **7 October 2020**. He submits that on **14 October 2020** he received a response from the Provider enclosing a claim form that he was required to complete to make his claim.

The Complainant maintains that he returned the completed claim form on **19 October 2020** but the claim was again refused. Following an appeal, the Complainant states that he received the Provider's Final Response Letter on **7 November 2020** in which it categorised the cost, relating to his claim, as pre-natal benefits, for which there was no cover on the Complainant's policy. The Complainant states that he again appealed the decision on the basis the Provider had not based its assessment on the completed claim form or the information provided by the Complainant in **February 2020**. The Complainant submits that the claim was again refused by the Provider.

The Complainant states that the Provider is wrong to categorise the costs of the midwife's visits to prepare for the homebirth, as a normal pre-natal claim. He states that the only costs that related to the midwife were the part-payment for the homebirth, that did not go ahead.

The Complainant made further submissions to this Office by way of email dated **21 August 2021**. The Complainant accepts that *"procedurally* [he] *made a mistake in making the claim initially through the* [Provider's] *app. I had thought this would facilitate all claims"*. The Complainant also accepts that he has *"no cover for pre-natal care"*.

The Complainant states that the Provider does not address the correct provision that the Complainant is claiming under, namely the provision which states that *"if a member ends up being admitted to hospital, having planned to have a home birth….there would still be charges from the midwife/GP even if the baby was not physically delivered at home"*. He states that *"common sense would imply that a homebirth must be planned months in advance"*, however, the Provider's response to his claim implies that the expenses covered are for the delay of the delivery only.

The Complainant states that the midwife confirmed that the services she provided related to homebirth and that too much emphasis is being placed on the recording between the midwife and the Provider's representative. The Complainant states that this conversation was led by the Provider's representative and no open questions were asked. The Complainant states that the midwife simply confirmed that the home birth did not go ahead and at no stage did she say that the charge was for pre-natal care only.

The Complainant states that the Provider is not distinguishing between *"normal pre-natal care and the preparation for a homebirth by a midwife"*. He wants the Provider to pay €700 maternity benefit under the policy.

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The Provider's Case

The Provider in its Final Response Letter dated **6 November 2020**, states that on **8 September 2020** the Complainant submitted a receipt for €700 from midwife Ms. M via the Provider's online healthcare app. The date entered on the app was **16 July 2020**. The Provider maintains that there was no date on the receipt and no maternity claim form attached.

The Provider states that on **28 October 2020** a claims assessor contacted Ms. M and she confirmed the date of her visit to the Complainant's home was in **June** and as the birth of the Complainant's daughter did not occur until **July**, these charges were not for home-birth costs. The Provider submits that Ms. M confirmed that the services provided on the receipt were pre-natal charges at home.

The Provider states that in order for the Complainant's maternity benefit receipt to be eligible for benefit under the home birth benefit *"it must actually cover the delivery itself"*. The Provider further states that it was entitled to follow up with the midwife, to confirm details of the treatment provided. The Provider relies on the general rules of the policy document in this regard. The Provider states that the midwife confirmed that the receipt for €700 was for care prior to the birth and not for the delivery of the baby.

Regarding the online app, the Provider states that the online app is used for submitting outpatient expenses only. When the Complainant first submitted the receipt for assessment, it was submitted via the online claims app under the pre and post-natal benefit for everyday medical expenses. The Provider states that upon review by its outpatient claims assessment team, it was found that this receipt was not eligible for benefit under pre and post-natal benefit as the policy the Complainant holds does not cover this benefit.

The Provider states that *"in order to be as fair as possible to the Complainant"*, its healthcare outpatient claims department contacted the inpatient claims department to check if this receipt was eligible under any inpatient benefit which the Complainant might have.

The Provider states that

> *"for any claim to be submitted under the inpatient stream an inpatient claim form must accompany the receipt. Until this claim form was received it was not possible to assess this receipt under the inpatient benefit. That is why a completed claim form was requested"*

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The Provider states that the online app does not advise that an inpatient claim form must accompany a receipt as the online app is for outpatient claims only. The Provider states that the Complainant was made aware of the requirement for a claim form, by phone call on **30 January 2020** and by email on **3 February 2020**. The Provider states that a claim form was issued to the Complainant on **6 February 2020**.

The Provider states that the Complainant's wife's benefit under the policy did not cover *"pre & post-natal package of benefits"* and based on this, the claim will remain rejected as the charges were not for home birth costs.

The Provider made further submissions by way of email dated **1 September 2021**, stating that in accordance with its rules, the benefit for a homebirth is for *"a normal delivery at home"* and not for any preparations that are required in advance. The Provider states that the Complainant's policy does not cover preparatory expenses associated with the delivery.

The Complaint for Adjudication

The complaint is that the Provider wrongfully denied the Complainant's claim for maternity benefit. He also says that the Provider's claims process as operated through the Provider's online app, gave rise to an unnecessary delay in the assessment of the claim.

Decision

During the investigation of this complaint by this Office, the Provider was requested to supply its written response to the complaint and to supply all relevant documents and information. The Provider responded in writing to the complaint and supplied a number of items in evidence. The 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.

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.

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A Preliminary Decision was issued to the parties on **15 March 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.

The Complainant holds a health insurance policy with the Provider incepted on **1 October 2019**. The following provisions of the policy are relevant. On the first page of the benefits table of the policy it states that there is *"no cover"* for pre and post-natal care, as follows:-

Pre & post natal package of benefits (full list of benefits included in your rules)	No cover

On page 15 of the general rules of the policy booklet, paragraph 10(e) states:

> (e) In order to process a claim we require a fully completed claim form. If information required to process the claim is incomplete or ambiguous on the claim form, our claims department will follow up with the necessary party to obtain this information.
>
> **Please note: if the required information is not received within six months, the claim will be deemed ineligible for benefit.**

In addition, on page 23 of the general rules of the policy booklet under the heading *"Maternity Benefit"* the policy states that the "*Home birth*" benefit is:

> *"benefit for a normal delivery at home with your GP or Consultant's approval up to the amount payable on the scheme for a hospital delivery"*

as follows:-

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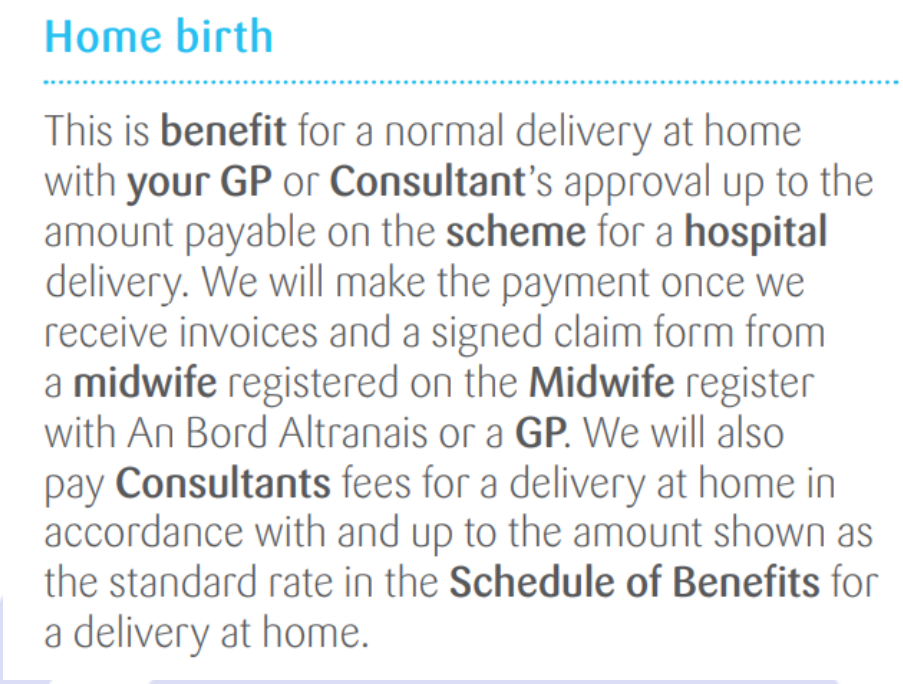

I also note that on **3 February 2020**, the Provider emailed the Complainant details of the maternity benefits and included the following sentences:

- *"for a normal delivery at home we will pay benefit up to a maximum of €3500…for the delivery of the baby only"*;
- *"No pre or post natal care will be covered….this does not fall under the delivery benefit"*
- *"if a member ends up being admitted to hospital (having planned to have a home birth) she will need to be admitted as a public patient….there would still be charges from the midwife/GP even if the baby was not physically delivered at home"*

I note that in his **21 August 2021** submission, the Complainant accepts that his wife is not entitled to pre-natal care. Further to the provisions in the policy and further to the Complainant's own admission, I agree that there is no entitlement for recovery for pre-natal care such as the €700 charged by the midwife to make preparations for the home birth. I have considered carefully the submission made by the Complainant, that there is a difference between *"normal pre-natal care and the preparation for a homebirth by a midwife"*, however, I accept that the policy and the explanatory email of **3 February 2020** are clear - it is *"the delivery of the baby only"* which is covered and any pre-natal care *"does not fall under the delivery benefit"*.

With regard to the complaint that the Provider's online app led/contributed to a delay in the claim process, I accept the Provider's submission that the online app was designed for outpatient claims rather than in-patient claims such as the one the Complainant was making.

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I also note that the Complainant acknowledges in his email dated **21 August 2021** that he made a mistake in making his claim, through the online app. Therefore, on the evidence available, I do not accept that there has been any wrongdoing by the Provider in its decision to decline the claim and accordingly, I do not consider it appropriate to uphold this complaint.

Conclusion

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

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

MARYROSE MCGOVERN
Financial Services and Pensions Ombudsman (Acting)

11 April 2022

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—

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(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.