DRN-3734319

The complaint

Mrs B complains about how AXA PPP Healthcare Limited dealt with a claim against her private medical insurance policy. Mrs B's husband, Mr B, is helping her to bring the complaint.

What happened

The details of this complaint are well known to both parties, so I won't repeat them again here in full. In summary, in 2014, Mrs B was diagnosed with aortic stenosis. She had annual check-ups. In 2015, Mrs B took out private medical insurance policy with AXA. The policy renews in October each year.

In September 2020, Mr B contacted AXA on Mrs B's behalf and asked about cover for treatment for her heart problem. I'll refer to that conversation in more detail below. Following that conversation, Mr and Mrs B understood that the policy would cover replacement of Mrs B's aortic valve.

In February 2022, Mrs B made a claim against her policy in relation to surgery to replace her aortic valve. AXA declined the claim. It said that Mrs B's annual check-ups were for a medical opinion, so the proposed treatment wasn't covered by the policy. AXA relied on the moratorium provision in her policy.

Mrs B says that AXA acted unreasonably in declining her claim. She says that the annual monitoring and assessment she had wasn't treatment. Mrs B wanted AXA to cover the cost of the operation but since brining the complaint, she's had surgery in the NHS.

One of our investigators looked at what had happened. She said that AXA fairly declined the claim, as it isn't covered by the policy. But the investigator thought that AXA had given Mrs B a false expectation that her claim would be covered. She recommended that AXA pay Mrs B compensation of £250 in relation to that.

Neither Mrs B nor AXA agreed with the investigator. Mrs B said that if they had been aware of the true position following Mr B's phone call to AXA in September 2020, she would have discontinued the policy and not renewed it for the following two years. She said that it's not clear in the policy that monitoring a pre-existing condition is treatment. Mrs B said that she hadn't claimed on the policy for two years and that compensation of £250 isn't fair. She suggested the return of one year's premium.

AXA said whilst it gave Mrs B the impression that it would be able to assist with a claim for her aortic valve problem, it did so on the basis that Mrs B saw the consultant regularly for her own peace of mind. It said that the medical information shows that Mrs B was seen in the NHS since 2018, so the claim comes within the moratorium period. AXA also said that it told Mrs B that it would need medical information to consider the claim.

Mrs B asked that an ombudsman consider the complaint, so it was passed to me to decide.

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.

the relevant terms and conditions

The starting point is the terms and conditions of the policy. Mrs B's policy is on a moratorium basis. That means that it doesn't cover pre-existing medical conditions Mrs B had in the five years before the policy began until she has been a member for two years in a row and had a period of two years in a row trouble-free from that condition. The policy says:

"*Trouble free means that you have not done any of the following for the medical condition you need treatment for:*

- *had a medical opinion from a medical practitioner, including a GP or specialist; or*
- *taken medication (including over-the-counter drugs); or*
- *followed a special diet; or*
- *had medical treatment; or*
- *visited any medical practitioner, including but not limited to a practitioner, homeopath, acupuncturist, physiotherapist, osteopath, optician or dentist."*

has the claim been declined unfairly?

The relevant rules and industry guidance say that AXA has a responsibility to handle claims promptly and fairly and it shouldn't reject a claim unreasonably. I uphold Mrs B's complaint in part and I'll explain why:

- I don't think that AXA was at fault in declining Mrs B's claim. In the two years before the claim, Mrs B had visited a medical practitioner about the medical treatment she needed treatment for. So, she hadn't had two years "*trouble free*", as defined by the policy. I have noted Mr and Mrs B's comments about the nature of the consultations – that it was simply monitoring for Mrs B's peace of mind - but that doesn't alter the outcome here.

- I don't agree with Mr and Mrs B that the policy isn't clear. I've set out above the policy's definition of "*trouble-free*". I think it's sufficiently clear.

- I've listened to the phone call in September 2020 between Mr and Mrs B and AXA. I think that AXA led Mrs B to believe that a future claim for replacement of her aortic valve would be covered. It said that she satisfied the two year trouble-free period, she hadn't had active treatment and didn't have symptoms. But based on the information Mr B provided during the call, it was clear that it was likely that a future claim wouldn't be covered. That's because Mrs B was having regular check-ups. It didn't matter whether those check-ups were for her own peace of mind or at the direction of medical practitioners. So, I think that the phone call was misleading in that it led Mrs B to believe that a future claim was likely to be covered.

- I've noted that AXA also told Mr B that it would probably need further medical information at the time of any claim but that doesn't alter my view that the phone call was misleading.

- When mistakes like this happen, we don't proceed on the basis that the misleading information is true. We look at the effect of the misleading information on the

individual. Mrs B says that if she'd known the true position she would have discontinued the policy and not renewed it for the following two years. At this distance it's not possible to say with any certainty what Mrs B would have done if she hadn't been given misleading information. I don't think I can fairly direct AXA to refund premiums, as Mrs B has had the benefit of cover. But Mrs B was no doubt disappointed to discover the true position at an already distressing time. I think fair compensation for that is £250. In reaching that view, I've taken into account the nature, extent and duration of Mrs B's distress and inconvenience caused by the misleading information.

Putting things right

In order to put things right, AXA should now pay Mrs B compensation of £250 in relation to her distress and inconvenience.

My final decision

My final decision is that I uphold this complaint in part. AXA PPP Healthcare Limited should now take the step I've set out above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs B to accept or reject my decision before 9 January 2023.

Louise Povey
Ombudsman