DRN-4742528

The complaint

Mr S complains that AXA PPP Healthcare Limited has turned down a claim he made on a personal private medical insurance policy.

What happened

The background to this complaint is well-known to both parties. So I've simply set out a summary of what I think are the key events.

In March 2021, Mr S took out a personal private medical insurance policy with AXA, which was underwritten on moratorium terms. This meant AXA wouldn't cover any conditions Mr S had suffered from in the five years prior to taking out the cover unless he'd been trouble-free from that condition for at least two consecutive years after the policy started.

Subsequently, in June 2023, Mr S made a claim on the policy. He explained that he'd been under the care of a urologist previously due to a raised PSA level. However, he'd been discharged from the urologist's care in February 2021 and since then, his PSA levels had been monitored by his GP. He explained that his PSA level had risen and that his urologist had suggested he undergo an MRI scan.

AXA turned down Mr S' claim. It concluded that Mr S had suffered from raised PSA levels in the five years before the policy began. And it also concluded that as Mr S underwent regular blood tests which included a check on his PSA level, he hadn't been 'trouble-free' for at least a two-year period. It considered he'd been receiving a medical opinion during the relevant period. Therefore, it thought Mr S' claim was excluded by the terms of the moratorium. It did accept though that it had made some errors while it was handling Mr S' claim and so it paid him £50 compensation for his trouble and upset.

Mr S was unhappy with AXA's decision and he asked us to look into his complaint. He said that the PSA checks were a standard part of an overall blood pressure check. He said the results weren't reviewed by his GP and were simply sent on to him. Therefore, he didn't agree that the checks could be treated as a 'medical opinion'. And Mr S was also unhappy with the way AXA had handled his claim.

Our investigator didn't think Mr S' complaint should be upheld. She felt it had been fair for AXA to conclude that Mr S hadn't been 'trouble-free' for a two year period. So she thought it had been reasonable for AXA to turn down Mr S' claim.

I issued a provisional decision on 22 March 2024 which explained the reasons why I didn't think it had been unfair for AXA to turn down Mr S' claim. I said:

'The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. So I've considered, amongst other things, the terms of Mr S' policy and the circumstances of his claim, to decide whether I think AXA treated Mr S fairly.

I've first considered the policy terms and conditions, as these form the basis of Mr S' contract with AXA. It's agreed that Mr S took out the contract on moratorium terms. The policy says this means:

'If you joined us on moratorium terms, it means that you won't have cover for treatment of medical problems you had in the five years before you joined us until:

• you've been a member for two years in a row, and
• you've had a period of two years in a row, since you joined, that have been trouble-free from that condition.'

AXA has also set out what it means by 'trouble-free' as follows:

'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
• taken medication (including over-the-counter drugs)
• followed a special diet
• had medical treatment
• visited a practitioner, therapist, homeopath, acupuncturist, psychologist, cognitive behavioural therapist, optician or dentist.'

There's no dispute that Mr S had been under the care of a urologist for a raised PSA level in the five years before he took out the policy. So I think it was reasonable for AXA to conclude that a raised PSA level was a pre-existing condition. The key issue for me to decide here is whether it was fair for AXA to conclude that Mr S hadn't been trouble-free from that condition for a continuous two year period after the policy began.

I've seen evidence that Mr S was discharged from the care of the urologist before he took out the policy. However, I've also listened to calls he had with AXA's claim handlers when he looked into making a claim for the MRI. Mr S told AXA that his prostate had been monitored for two to three years. He also said that his PSA levels had been monitored by his GP for a couple of years. And he said it had been left to his GP to do annual checks.

On that basis, I can understand why AXA concluded that Mr S hadn't been trouble-free for a two year period because it did appear that he was undergoing regular monitoring with his GP and accordingly, receiving a medical opinion.

Mr S has since said that his PSA checks form a standard part of a blood test for high blood pressure. He said his GP doesn't provide any medical view on the PSA results – they simply leave it to Mr S to decide whether or not to get back in touch with the urologist. He's provided a text message from his GP which does appear to show a simple reporting of Mr S' PSA level by a doctor.

However, even if I accept this was the case, in order for a policyholder to be trouble-free for a two year period, they must not have had medical treatment for a pre-existing condition during the relevant timeframe. AXA has defined 'treatment' as follows:

'surgical or medical services (including diagnostic tests) that are needed to diagnose, relieve or cure a disease, illness or injury.'

In my view, I think regular blood tests - which by Mr S' account were intended at least partly to monitor his PSA levels - can reasonably be considered to be treatment in line with the

policy terms. And as Mr S says, the PSA levels reported in those tests determined whether or not he sought further urological care.

So even if I were to find that the regular blood tests weren't a 'medical opinion' (and I make no finding on this point), I think AXA would have been reasonably entitled to conclude that Mr S had undergone treatment, as defined by the policy terms, in the two years after he took out the policy.

Therefore, I currently don't think AXA acted unfairly or unreasonably when it concluded that Mr S' claim wasn't covered.

Next, I've turned to think about the way AXA handled Mr S' claim. It accepts that it made errors in its dealings with Mr S and it seems to me that it therefore acknowledges that it didn't meet its regulatory obligations. I can see that AXA incorrectly referred to wording which didn't form part of the policy terms when it communicated with Mr S; it referred to a referral letter which hadn't been sent; and it didn't respond to his concerns within the regulator's timeframes. I don't doubt that these issues caused Mr S additional, avoidable material distress and inconvenience in addition to his understandable disappointment at the decline of his claim. And therefore, I think it's fair and appropriate that AXA recognised those service failings and paid Mr S compensation to reflect the impact of those failings.

Having considered everything, I currently think the £50 compensation AXA has already paid is a fair, reasonable and proportionate award to reflect the reasonably minor mistakes I think it made here. And so I'm not planning to direct it to pay Mr S anything more.'

I asked both parties to send me any additional evidence or comments they wanted me to consider.

AXA had nothing to add.

Mr S didn't accept my provisional findings and I've summarised his response:

- He set out a timeline of his treatment and testing regime from 2018 until June 2023;
- The annual blood tests he underwent do not accurately diagnose the root cause of a prostate condition. A PSA reading is therefore inconclusive and does not provide a diagnosis;
- Mr S referred to AXA's acknowledged errors and the policy terms which applied to the circumstances of his claim;
- My reason for concluding that AXA had handled the claim fairly was because I felt it was reasonable to treat the blood tests as 'treatment' in line with the policy terms. Whilst AXA had referred to this in earlier claims correspondence, it hadn't relied on this clause in its final response to Mr S' complaint;
- Mr S maintained that it was unreasonable to treat the blood tests as constituting a medical opinion;
- He said he was unable to accept that an annual blood test, representing a form of diagnostic tool, could be classed as medical treatment;
- AXA's definition for diagnostic test when applied to a PSA blood test is inconclusive, as it is only an indicator that a medical condition exists and not what treatment might be required. So Mr S felt AXA's definition was open to interpretation;
- Even if the definitions are deemed to be valid, he would be unable to accept the outcome without further medical clarity. He felt the policy terms and exclusions were multi-layered and appeared to be biased against claimants. He considered this made any successful claim for a pre-existing condition unlikely in most circumstances – especially in relation to a raised PSA level, which doesn't go away;

- A blood test is accepted as the global medical procedure used for measuring a person's health for their own well-being. So Mr S questioned why this was a primary reason used for turning down a medical insurance claim;
- He felt it would be beneficial for claimants if AXA clarified its policy terms or removed exclusions for certain existing conditions from the policy entirely;
- Mr S provided medical definitions of blood tests, treatment etc, which he felt supported his complaint.

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.

Having done so, whilst I'm sorry to disappoint Mr S, I still think it was fair for AXA to turn down his claim and I'll explain why.

First, I'd like to reassure Mr S that while I've summarised his response to my provisional decision, I've carefully considered all he's said and sent us. However, in this decision, I haven't commented on each point he's raised and nor do our rules require me to. Instead, I've focused on what I think are the key issues.

As I explained in my provisional decision, I make no finding on whether or not Mr S' annual blood test should be treated as a 'medical opinion'. However, it remains the case that I don't think AXA acted unreasonably at the outset by relying on Mr S' testimony regarding his GP's role in monitoring his PSA levels to conclude that he had received a medical opinion about this particular condition.

I'm grateful to Mr S for the medical definitions he's sent to me. Nonetheless, my decision focuses on the contractual definitions AXA has set out in its policy terms. And I must make it clear that as I'm not a medical expert, it wouldn't be appropriate for me to make any clinical finding or provide any medical commentary. My role here is to decide whether AXA has acted fairly and reasonably and handled Mr S' claim in line with its policy terms and conditions, along with its regulatory obligations and other relevant considerations.

It's clear how strongly Mr S feels that it's unreasonable for AXA to consider an annual blood test to be classed as 'treatment' in line with the policy definition. He states that a blood test can't diagnose the root cause of a raised PSA level nor what treatment might be required. While I accept this may be the case, by Mr S' account, at least part of the reason for the annual blood tests is to monitor his PSA levels, following previously raised levels which required urological input. And the outcome of the blood test results determine whether or not Mr S requires further urological care. As such then, I don't think it was unreasonable for AXA to conclude that the annual blood tests are a diagnostic test and therefore fall within the definition of treatment.

I appreciate why Mr S feels the policy terms are unfair. However, in my experience, moratorium policies generally contain similar terms, definitions and exclusions. AXA has clearly defined what it means by both 'trouble-free' and 'treatment' and I'm satisfied it's fair for AXA to rely on those definitions and terms when it assesses claims. I'd add too that it isn't my role to tell insurers what risks they should and shouldn't insure or what conditions they must accept.

Overall, I still don't think AXA acted unfairly when it concluded that Mr S' claim wasn't covered by the policy terms. So I'm not telling it to pay his claim. And while AXA acknowledges it did make mistakes during the life of the claim, I'm still persuaded that the £50 compensation it's paid Mr S to reflect the impact of those mistakes is fair and

reasonable in all the circumstances.

My final decision

For the reasons I've given above and in my provisional decision, my final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr S to accept or reject my decision before 20 May 2024.

Lisa Barham
Ombudsman