DRN-5000929

The complaint

Mrs K complains that AXA PPP Healthcare Limited has unfairly declined her claim under her private medical insurance policy.

Mrs K has been represented throughout by a family member, however, for ease of reading I will only refer to Mrs K in this decision.

What happened

Mrs K has private medical insurance cover through a group employment scheme. This policy is insured with AXA.

In January 2023, when in the early stages of pregnancy, Mrs K contacted her broker to obtain authorisation from AXA for a Caesarean section (C-section). The broker contacted AXA and advised Mrs K that this had been agreed. However, a few months later, AXA requested information about the procedure code for the treatment being claimed and also asked for medical information. In June 2023, AXA declined the claim, stating that cover is only provided for treatment following a medical condition that occurred in that current pregnancy – it said that Mrs K had a known condition which didn't arise in this pregnancy and that the reason for the C-section was more for precautionary reasons.

Mrs K disagreed with AXA's decision and made a complaint. She said that AXA had paid for a C-section on a previous pregnancy and so she didn't see why this one wouldn't be covered. She provided further letters from her consultant explaining the reasons she required this type of delivery. She also said that she had never received a copy of the policy at renewal and so didn't have the policy terms that related to that policy year. AXA looked at this medical evidence but didn't change its decision. And it said that if Mrs K hadn't received the policy she could have requested this. However, AXA paid £200 to Mrs K as a gesture of goodwill. It also agreed to pay for the initial consultation with the consultant as it said the communications with her broker could have been clearer when it was first contacted.

Unhappy with this response Mrs K brought her complaint to our service. Our investigator looked into the matter but didn't uphold the complaint. He said the policy states cover is only provided for medical conditions that arise from the current pregnancy. And the medical evidence supplied said that the original reason for the C-section was to do with a known medical condition that Mrs K suffered from in her previous pregnancy. He also noted that a new condition Mrs K was now suffering from required this to be brought forward – but the reason for having the procedure was because she had previously had a C-section and it was recommended for this pregnancy too. He found that AXA's decision to decline the claim was fair and reasonable. He said that AXA's offer to pay the initial consultation, along with £200 compensation was fair. He noted that Mrs K had gone ahead with the private delivery but as AXA had notified Mrs K of the decision to decline the claim some months before the birth, he said Mrs K had time to make alternative arrangements via the NHS and so he didn't think that AXA had to pay these costs.

Mrs K disagreed with our investigator. She said she had entered into a verbal contract with the consultant prior to the claim being declined in June 2023 and therefore she had to pay

for the procedure. And she said that she feels very strongly that she has been misled as she had previously been covered for the procedure.

As no agreement could be reached the matter has been 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 above is intended to provide just a summary of the situation. It is important to point out that we're an informal dispute resolution service, set up as a free alternative to the courts for consumers. In deciding this complaint I've focused on what I consider to be the heart of the matter rather than commenting on every issue or point made in turn. This isn't intended as a discourtesy to Mrs K. Rather it reflects the informal nature of our service, its remit, and my role in it.

The relevant policy terms and conditions

Mrs K's policy doesn't cover routine pregnancy and childbirth. The policy terms and conditions state the following:

> *"As pregnancy and childbirth are not medical conditions and because the NHS provides for them, our cover is limited.*
>
> *We don't cover the checks or other interventions, such as antenatal and postnatal monitoring and screening that you will have during pregnancy and birth."*

It then goes on to describe what is covered where it says:

> *"We will cover the additional costs for treatment of medical conditions that arise during your current pregnancy or childbirth. For example:*
>
> - *ectopic pregnancy (pregnancy where the embryo or foetus grows outside the womb)*
> - *hydatiform mole (abnormal cell growth in the womb)*
> - *retained placenta (afterbirth retained in the womb)*
> - *eclampsia (a coma or seizure during pregnancy and following pre-eclampsia)*
> - *post partum haemorrhage (heavy bleeding in the hours and days immediately after childbirth)*
> - *miscarriage requiring immediate surgical treatment."*

The terms medical condition is defined as "*any disease, illness or injury, including psychiatric illness".*

Has AXA fairly declined the claim?

The relevant rules and industry guidelines say that insurers must handle claims fairly and promptly and shouldn't unreasonably reject a claim. I've taken these rules into account when deciding what I think is fair and reasonable in the circumstances of Mrs K's complaint.

Based on the terms above, I can see that there is cover for treatment under Mrs K's policy during pregnancy, however, this is limited to those medical conditions that arise in that pregnancy.

In its final response, AXA has referred to the information provided by the specialist and said it appears the reason for the procedure was for the same condition as that which had caused her previous C-section.

From my review of the medical information provided by Mrs K's consultant I can see that the initial correspondence referred to Mrs K having had a C-section previously as a result of conditions that had arisen and therefore the consultant was recommending that she had the same procedure this time. In further letters, the consultant has referred to the C-section being necessary to prevent long term harm and damage to Mrs K's pelvic floor. In a letter from July 2023, he says that Mrs K has also developed symptoms of pre-eclampsia and would therefore need to be induced. However, as a result of a previous C-section, it wouldn't be possible and she would therefore need another C-section.

I've considered this information carefully. It appears that the initial cause of Mrs K's need for a C-section was the problems with her pelvic floor weakness. This was already a known condition prior to this pregnancy and therefore didn't arise in this current pregnancy. And when Mrs K developed signs of pre-eclampsia, the reason for needing the C-section wasn't as a result of that condition, it was because she couldn't be induced as she had previously had a C-section. Based on this information, I'm persuaded that the reason for Mrs K needing a C-section was related to the events that had occurred in a prior pregnancy. Therefore, I'm satisfied it is fair and reasonable for AXA to decline the claim for this reason.

I've noted that Mrs K had said that she didn't receive a copy of her policy booklet at the time of renewal. I'm aware that this is a group policy through an employer and therefore the renewal of the cover is completed with the employer, not the individual members of the scheme. So it was down to the employer to ensure that the information was available for the members. And AXA has confirmed that this could have been requested at any point. But I recognise that not having the document readily available was frustrating for Mrs K. I note that AXA has made an offer of £200 for the fact this wasn't provided at renewal - I think that seems reasonable in the circumstances.

Mrs K has also referred to the time it took for AXA to decline the claim. She says that the claim was initially authorised in January 2023. I understand that the authorisation request was completed by Mrs K's broker and it was the broker who incorrectly informed her about the authorisation. AXA has confirmed that it could have been clearer when explaining the situation to the broker and this may have led to them misunderstanding exactly what had been agreed. As a result, AXA has agreed to pay the initial consultation which Mrs K had in February 2023.

I've listened to the call that Mrs K's broker had with AXA. In the call AXA states that it has set up the claim but further information will be needed, such as specialist details and the procedure code, and the broker confirms this will be provided. I don't think that AXA confirms what will be covered in the call, however, AXA has accepted that it could have been clearer. Based on what I've heard, I think that AXA's offer to pay the initial consultation is fair and reasonable.

I appreciate that my decision will come as a disappointment to Mrs K. I would point out that there is no suggestion that the treatment requested wasn't medical necessary, the evidence provided indicates the need for Mrs K to have a C-section, however, I must base my outcome on the cover provided by the policy that has been purchased. And the fact that the procedure has been covered previously doesn't mean that a further claim would be covered.

Mrs K has stated that she had already agreed to have the procedure with the consultant by the time she was made aware of the claim not being covered and therefore she had to go

ahead with the treatment privately. She has provided invoices from the consultant to show this has been paid. Whilst I appreciate Mrs K went ahead with this treatment privately, as I've already stated, I'm satisfied that AXA didn't authorise the treatment. So I'm not persuaded it needs to pay the claim. However, even if I did think that AXA had made an error, I'm not of the opinion that AXA needs to reimburse these costs. The information I've seen shows that Mrs K had made enquiries with the consultant about her treatment prior to June 2023, however, the invoice appears to be dated after Mrs K was advised that her claim wouldn't be covered. And although it may be that Mrs K feels she entered into a verbal agreement with the consultant prior to that date, I'm not persuaded that this means she was legally required to make any payment. So, this doesn't make a difference to my outcome.

My final decision

For the reasons stated above, I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs K to accept or reject my decision before 5 November 2024.

Jenny Giles
Ombudsman