DRN-5276670

The complaint

Mr and Mrs M are unhappy that Western Provident Association Limited (WPA) have declined a claim they made on a group private medical insurance policy.

What happened

Mr M is a member of his employer's group income protection policy. The policy covers Mr and Mrs M but I'll refer to Mr M as he's been representing a child also covered by the policy.

Mr M made a claim on their policy in relation to their child, who I'll refer to as 'A'. The claim was for A to be assessed for Attention Deficit Hyperactivity Disorder (ADHD). WPA declined the claim based on an exclusion in the policy.

Mr M complained to WPA but they maintained their decision was fair, and in line with the policy terms. Mr M also raised concerns that he'd not been notified of important changes in the policy. WPA said Mr M's employer was sent information about the policy each year when it was renewed and it was the employer's responsibility to communicate any major changes to Mr M. Unhappy, Mr M complained to the Financial Ombudsman Service.

Our investigator looked into what happened and didn't uphold the complaint. She thought WPA had fairly relied on the exclusion. And, she was satisfied WPA hadn't acted unfairly by communicating with Mr M's employer at renewal.

Mr M didn't agree and asked an ombudsman to review the complaint. He didn't think WPA had acted fairly as the policy terms were ambiguous and he'd reasonably relied on the policy wording. Furthermore, he didn't think WPA had made his employer aware of the removal of key clarifying language and highlighted that A continued to suffer with ongoing symptoms. So, the complaint was referred to me to make a decision.

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 rules and industry guidelines say that WPA has a responsibility to handle claims promptly and fairly. And they shouldn't reject a claim unreasonably.

The policy terms and conditions

The claim was declined in March 2024. The relevant policy terms and conditions say there is a general exclusion which says:

> There is no benefit available under your scheme for treatment arising from or related to the exclusions in this Section. These exclusions apply to all the benefits in this Guidance and on Your Benefit schedule in addition to any personal exclusions…
>
> > Developmental (physical or psychological), behavioural or educational problems (or speech problems arising from these).

'Treatment' is defined as:

> Surgical or medical services (including diagnostic tests) that are needed to investigate, relieve and/or cure a symptom, disease, illness or injury. This includes any form of medical care.

Diagnostic tests are defined as:

> Investigations, such as x-rays or blood tests, to find or help to find the cause of your symptoms. For the purposes of this scheme, diagnostic tests also include ultrasounds.

Was the claim fairly declined?

I'm very sorry to read of the circumstances of the claim and I have a lot of empathy with the circumstances Mr M has described. However, I'm satisfied WPA has acted fairly and reasonably when declining the claim.

I say that because:

- The referral letter from A's Consultant Child and Adolescent Psychiatrist said, 'I formulate that A's anxiety may be underpinned by possible ADHD. I recommend that A has a formal diagnostic assessment, as treatment of ADHD, if diagnosed, may resolve much of A's anxiety'.

- I think it was reasonable for WPA to conclude that an assessment for ADHD fell within the general exclusion I've outlined above. I think it was reasonable to conclude that Mr M was claiming for a diagnostic test to investigate possible ADHD. I also think they fairly concluded an ADHD assessment was to find or help to find the cause of the symptoms A was experiencing.

- I'm not persuaded that the exclusion I've outlined above is ambiguous. I think the exclusion is sufficiently clear that there's no benefit available under the scheme for such circumstances.

Did WPA act fairly when the policy renewed?

I'm not persuaded that WPA has acted unfairly or unreasonably in relation to providing Mr M with information about the policy at renewal. I say that because:

- I'm not persuaded, on balance, that there was a significant change to the core cover available under the policy as Mr M suggested. Based on the evidence that's available I think that ADHD assessments of this nature were not covered under the policy during the relevant time that Mr M was a member of the scheme.

- In any event, even if I accepted there was a change to the level of cover under the scheme, I still don't think it's fair and reasonable to uphold this complaint for other reasons.

- Mr M's employer is the policyholder. The policy terms are sent to the policyholder each year for approval at renewal and it's for Mr M's employer to ensure that relevant information is communicated to the beneficiaries of the scheme. WPA is entitled to make changes to the policy terms. That's set out in the policy terms and is also common industry practice at the renewal of a policy.

- Mr M highlighted a section of the regulatory handbook in relation to group policies. I'm not considering a complaint made by Mr M's employer. However, I think it's relevant to note that Mr M's employer concluded that they had, 'reviewed with WPA, with support of our broker, the process for them to notify [redacted] of any benefit changes and I am happy that the current process is working to my satisfaction. WPA would notify us of any material changes, although the smaller tweaks to wording and structure they would not'. So, the information in the section of the regulatory handbook Mr M has highlighted in response to our investigator, hasn't changed my thoughts about the overall outcome of this complaint.

- Furthermore, it's for Mr M to check at the point of renewal whether the policy continued to meet his needs. As I've outlined above, I think the exclusion was sufficiently clear in the terms provided when the policy renewed. If Mr M had any queries about this specific aspect of cover, or hadn't been provided with the relevant documentation, it was open to him to query this before continuing his membership of the scheme.

- Taking into account all of the above, I'm satisfied that WPA have most likely acted fairly and reasonably in all the circumstances.

My final decision

I'm not upholding this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr and Mrs M to accept or reject my decision before 25 February 2025.

Anna Wilshaw
Ombudsman