DRN-5571013

The complaint

Mr A complains that AXA PPP Healthcare Limited declined a claim for a scan under his private health insurance policy.

What happened

Mr A is covered by a private health insurance policy through his employer. The insurer is AXA.

Mr A made a claim for an appointment with a cardiologist, and a CT coronary angiogram ("scan") that was carried out following this. AXA declined to pay for the scan, as it noted Mr A had been asymptomatic. So, AXA said this wasn't covered under the policy terms.

Unhappy with AXA's position, Mr A brought a complaint to this Service. He said that he had been symptomatic, which is evidenced in the medical reports. And AXA had already authorised the appointment with the cardiologist, including diagnostic tests.

One of our investigators reviewed the complaint. Having done so, he didn't think AXA had acted unfairly or unreasonably when it declined to pay for the CT coronary angiogram, for the reasons it did. But he didn't think the service AXA had given Mr A during his claim was fair or reasonable. The investigator noted that Mr A had to chase AXA for responses, and AXA even sent Mr A a letter with part of the address missing. So, he thought AXA should pay Mr A £100 for the distress and inconvenience caused.

AXA accepted the investigator's recommendation, but Mr A didn't. As no agreement was reached, the complaint 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.

Industry rules set out by the regulator (the Financial Conduct Authority) say insurers must handle claims fairly and shouldn't unreasonably reject a claim. I've taken these rules, and other industry guidance, into account when deciding what I think is fair and reasonable in the circumstances of Mr A's complaint.

Mr A had an appointment with a private GP on 16 November 2023 due to heart symptoms. It was noted that Mr A wanted to know more about his *"'cardiac status' / presence of [coronary artery disease]"* and he was keen for a second opinion with a cardiologist. The doctor concluded that *"I would appreciate your review of this patient given the history and ongoing symptoms for a second opinion and risk stratification regarding future coronary artery disease"*. The suspected diagnosis was noted as high blood pressure reading, high cholesterol and stress.

AXA authorised a second opinion with a cardiologist in November 2023. It confirmed the consultation and minor diagnostics (such as, but not limited to blood tests, x-ray, ultrasounds and ECG) were covered. Mr A then asked AXA to authorise an appointment with a specific cardiologist, which it did. In this authorisation email AXA confirmed that a consultation was covered. The email also said that *"If you need further tests or treatment in addition to what's listed above, including MRI, CT or PET scan, please reply to this message or give us a call, and we'll let you know what your membership covers"*.

Firstly, having looked through the correspondence regarding the authorisation, I'm satisfied AXA was clear that a CT scan wasn't part of the pre-authorisation. AXA had let Mr A know that minor diagnostic tests were covered, but the list didn't include a CT scan. And in the later formal authorisation, AXA specifically said that if Mr A needed further tests or treatment in addition to what had been listed, including a CT scan, he should get in touch with AXA.

I appreciate Mr A doesn't think AXA was clear, but I don't agree, for the reasons I've set out. So, that means that Mr A had the CT coronary angiogram without receiving a pre-authorisation for it. AXA has declined to pay for the scan, as it said the following policy exclusion applied:

> *"We do not pay for:*
> - *preventative screening tests; or […]*
> - *tests to check whether you have a medical condition when you have no symptoms;"*

AXA said it had reviewed the cardiologist's letters who noted Mr A was asymptomatic, and that the scan was to assess the risk of disease. So, AXA said the scan wasn't eligible under the policy due to the above exclusion.

Mr A had an appointment with a cardiologist on 28 June 2024. They noted that Mr A was *"currently asymptomatic from the cardiovascular viewpoint. He has been found to have high blood pressure and high lipid levels, hence the referral."* The cardiologist noted that they had an *"extensive conversation regarding cardiovascular risk"* with Mr A, and that Mr A was *"very keen to have a CT coronary angiogram to further assess his coronary risk and I think this is entirely acceptable"*. In the CT coronary angiogram report the cardiologist said the *"scan was undertaken for the purposes of risk stratification"*.

Having considered everything, I think AXA acted fairly and reasonably when it declined to pay for the CT coronary angiogram, for the reasons it did. The cardiologist said Mr A was asymptomatic from cardiovascular viewpoint, and the scan was undertaken for the purposes of risk stratification. The private GP notes also support this. AXA's medical advisor has said that Mr A's risk factors for cardiovascular disease (high cholesterol, elevated blood pressure and family history) are managed in primary care, and they don't require a referral to secondary care.

I appreciate Mr A has said he had symptoms. But I think AXA has acted fairly and reasonably when it relied on the medical evidence when assessing the claim. I'm satisfied that based on Mr A's cardiologist's comments and what AXA's medical advisor has said, AXA acted in line with the above exclusion when it declined the claim.

Mr A has also said that AXA's advertising is misleading as these say (amongst other things): *"get as many tests, scans and x-rays as you need"*. AXA has confirmed there is no limit to how much can be claimed on outpatient diagnostic tests under Mr A's policy. However, any claim is always subject to the terms and conditions of the policy. I think this is fair and reasonable, and I don't think AXA has misled Mr A.

As the investigator set out, it's clear that AXA didn't always communicate with Mr A as promptly as it should have done. This meant that Mr A had to chase for responses, and this would have been frustrating. AXA has now agreed to pay Mr A £100 for the distress and inconvenience caused. I think this is fair and reasonable in the circumstances.

My final decision

My final decision is that I uphold Mr A's complaint in part and direct AXA PPP Healthcare Limited to pay him £100 for the distress and inconvenience caused.

*AXA must pay the compensation within 28 days of the date on which we tell it Mr A accepts my final decision. If it pays later than this, it must also pay interest on the compensation from the deadline date for settlement to the date of payment at 8% simple per annum.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr A to accept or reject my decision before 30 July 2025.

Renja Anderson
Ombudsman