DRN-5296267

The complaint

Mrs M is unhappy that AXA PPP Healthcare Limited (AXA) has declined to fully cover payments for treatment as the out-patient limit was exceeded.

What happened

Mrs M has a private medical insurance policy through her employer which started on 6 June 2023. AXA is the underwriter of the policy. The policy includes her husband and their two children.

In July 2023, Mrs C's son (who I'll refer to as B) received a GP referral for counselling and Mrs M contacted AXA for authorisation. In August 2023, AXA provided authorisation and a claim number. B received his first session on 24 August 2023 and had further sessions.

In November 2023, the therapy provider contacted AXA for authorisation for a psychiatriac assessment. The provider said if B saw a psychiatrist instead of a therapist, the out-patient allowance wouldn't be sufficient to provide further cover and may reach the allowance limit. On 21 November 2023, AXA left a voicemail message for Mrs M to call back due to a potential shortfall in the allowance. An email was sent to the therapy provider and a text message was sent to Mrs M to call back about B's healthcare claim.

AXA uploaded the benefit statements online. The statements showed when B had the sessions and the cost of each session. From January onwards, the statements informed Mrs M to make payments for treatments provided to B as the out-patient allowance had run out. In February 2024, the therapy provider requested authorisation for a further ten sessions but there was no allowance left until the policy was renewed in April 2024. Mrs M received an email from the provider to check the cover as the allowance had run out. She was required to make a payment to cover the shortfalls on the sessions B had as the limit had been reached.

Mrs M made a complaint to AXA in July 2024. She said she was led to believe they had ten sessions fully covered and the sessions should be covered. It responded and said it couldn't cover the payment shortfalls and it hadn't treated Mrs M unfairly.

Unhappy, Mrs M brought her complaint to this service. Our investigator didn't uphold the complaint. She didn't think AXA had acted unfairly in requesting for the shortfalls to be paid as there was no remaining cover for these.

Mrs M disagreed and asked for the complaint to be referred to an ombudsman. So, it's been passed to me.

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 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 this private medical insurance policy and the circumstances of Mrs M's claim, to decide whether AXA treated her fairly.

At the outset I acknowledge that I've summarised this complaint in far less detail than Mrs M has, and in my own words. I won't respond to every single point made. No discourtesy is intended by this. Instead, I've focussed on what I think are the key issues here. The rules that govern our service allow me to do this as we are an informal dispute resolution service.

I've started by looking at the terms and conditions of Mrs M's policy as these form the basis of the insurance contract with AXA.

Page 25 of the policy document states:

> '*Who will be paid for mental health treatment?*
>
> *We will pay for the out-patient treatment you need with a practitioner up to the limits shown in the benefit table.'*

Under the '*Your benefits'* section of the policy, it confirms that the out-patient limit on this policy was £1,000 each year.

Mrs M was sent an email on 7 August 2023 when the authorisation for the therapy was provided which said:

> *'Please note:*
>
> *The policy is due to renew on 01.04.2024*
> *Your excess of £100 will apply which is per person per year.*
> *£1,000 out-patient allowance will apply which is per person per year.'*

I can see Mrs M responded to this email by providing confirmation that they wished to proceed with the treatment with the provider mentioned in the email.

A second email was sent to Mrs M on 9 August 2023 asking her to provide her contact telephone number. She replied to this providing her mobile number. B's treatment continued until the provider contacted AXA in November 2023 regarding a potential authorisation for referral to a psychiatrist. The email pointed out the issue with the out-patient allowance being exceeded.

AXA said it would contact Mrs M. The notes provided show that AXA left a voicemail with Mrs M and sent her a text message asking her to contact it.

Mrs M says AXA never made her aware of the out-patient allowance being exceeded or of any shortfalls. She says she only found about this in February 2024 through the provider, not AXA. However, AXA did attempt to call and also sent her a text message to speak to her. I appreciate Mrs M says this was in relation to the psychiatry referral. Either way, there's no evidence to suggest she did contact AXA in November 2023.

AXA says it uploaded all the benefit statements onto Mrs M's member portal and from these she would have been aware what was happening. And in February 2024, the benefit statement stated there was a shortfall. I understand that Mrs M may not have known to look at the online portal. But given that she knew the limit was £1,000 and that she was contacted by AXA in November 2023, I don't think AXA has acted unfairly in not covering the sessions that fell outside of the out-patient allowance. I think it did try to contact her by telephone,

leaving a voicemail as well as sending her a text message. There's no dispute that Mrs M didn't receive these. So, I think AXA did enough in its attempt to contact Mrs M and I can't reasonably ask it to therefore cover the remaining shortfalls in the payments.

Mrs M also says she wouldn't have known the cost of each of these sessions. But she was aware that ten sessions had been approved and there was a limit to the cover provided. So, I think she also had a responsibility to check how far the limit had been reached.

Overall, I'm sorry to disappoint Mrs M. But, given the circumstances, I'm not persuaded that AXA acted outside the terms of the policy or that it has declined the claim unfairly. It follows therefore that I don't require AXA to do anything further.

My final decision

For the reasons given above, I don't uphold Mrs M's complaint about AXA PPP Healthcare Limited.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs M to accept or reject my decision before 26 March 2025.

Nimisha Radia
Ombudsman