DRN-5335552

The complaint

Mrs G has complained that AXA PPP Healthcare Limited hasn't fully covered the cost of her treatment under a private medical insurance policy.

What happened

In March 2024 AXA confirmed that it would provide cover for Mrs G to see a consultant. She then needed to undergo a medical procedure for which approval was also given. AXA sent confirmation that the procedure by the consultant, at a particular hospital, was fully covered.

Mrs G then opted to see the same consultant but at a different hospital, undergoing the procedure on 8 May 2024. She was then surprised to receive a bill for 40% of the cost, on the basis that she had used a hospital that wasn't part of the policy's approved list.

Our investigator thought that AXA had acted fairly and reasonably in only paying 60% of the procedure cost, in line with the policy terms and conditions. Mrs G disagrees and so the complaint has been passed to me for 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.

I've carefully considered the obligations placed on AXA by the Financial Conduct Authority (FCA). Its 'Insurance: Conduct of Business Sourcebook' (ICOBS) includes the requirement for AXA to handle claims promptly and fairly, and to not unreasonably decline a claim.

On 31 July 2023, the Consumer Duty was introduced by the Financial Conduct Authority. It sets higher and clearer standards of consumer protection and says that a firm must act to deliver good outcomes for retails clients.

So, I've considered, amongst other things, the terms of the policy and the circumstances of the claim to decide whether AXA handled the claim fairly and in line with the industry guidelines.

Looking at the policy terms, they state:

'1.1 Why it's important to use hospitals or day-patient units in the hospital list
If you have treatment at a hospital or day-patient unit that's not in the hospital list, we will only pay 60% of the charges from that hospital or day-patient unit as long as they charge up to the normal rates published and charged by that hospital or day-patient unit. You will be responsible for paying the remaining charges.'

Mrs G says she chose the second hospital for a more convenient date but would have opted for treatment at the original hospital, to ensure full cover, if she'd been properly informed.

The above policy terms make it clear that a 40% co-payment would be due if treatment happened off-list. However, in addition to that, AXA sent her a letter on 1 April 2024, in response to her notification of a change of hospital for the procedure. It stated:

'*Please be advised that whilst your chosen specialist is fully covered under the policy, your chosen hospital is not on your hospital list. This means we will pay 60% of the eligible charges from that facility and you will be responsible for paying the remaining charges. The contribution you will need to make may be significant and we would recommend you speak to the hospital beforehand. If you would like our assistance in sourcing an alternative hospital that we are able to cover in full, please let us know.*'

Upon being told that she would have to pay the remaining 40% cost, Mrs G told AXA that it had authorised the operation at the named hospital on 1 April 2024 with no indication that it would not be fully funded. She said that any reasonable person would understand from that correspondence that her chosen hospital was fully covered. It's therefore apparent that Mrs G missed the above wording when reading the letter or didn't read the entire letter.

She says this is because the letter was not customer friendly in terms of readability and understanding. She's pointed out that the letter starts by saying 'We're happy to confirm that your membership covers the following, under the care of (consultant) at (named hospital). Because this opening wording didn't say anything about being subject to certain conditions, she says she finds it beyond unreasonable that she was expected to understand that the procedure was not fully covered.

Mrs G says the situation is particularly aggrieving because she disclosed the change of hospital specifically to ensure it was covered. But AXA's response acknowledges the change of hospital, informs her that it isn't fully covered and offers assistance in looking for an option that would be fully covered.

I accept that the relevant wording is 15 lines down. But I'm not persuaded that makes the overall message unclear. The entire letter isn't overly long, so I wouldn't say that the sentence is buried in dense text. I take Mrs G's point about the structure and layout of the letter. However, overall, I'm satisfied that it is clear and unambiguous, and that AXA has met its regulatory obligations, including under consumer duty, with regard to communicating information about the chosen hospital not being fully covered.

Mrs G has referenced another ombudsman's decision in support of her complaint. I'm unable to comment on that case. Instead, I've looked at the available evidence relating to this case to decide whether or not AXA has done anything wrong.

I've thought about everything Mrs G has said. However, on balance, I'm satisfied that AXA has acted fairly and reasonably in only paying 60% of the cost of the procedure due to it being performed at an off-list hospital. It follows that I do not uphold the complaint.

My final decision

For the reasons set out above, I do not uphold the complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs G to accept or reject my decision before 9 April 2025.

Carole Clark
Ombudsman