DRN-5393747

The complaint

Ms T has complained about the way AXA PPP Healthcare Limited (trading as AXA Healthcare) handled a claim she made on a private medical insurance policy.

What happened

Ms T requested a referral to a gynaecologist, which was approved on 5 January 2024. Having had an initial consultation with a specialist on 27 January 2024, she then asked if she could change to a hospital that was nearer to her (hospital A) and was told that she could. However, her chosen specialist would not see her at hospital A and would only do consultations and the proposed surgery at an alternative hospital (hospital B).

In response to the complaint, AXA accepted that there had been some poor customer service and offered a total of £300 compensation. However, it maintained that its advice around treatment options had been correct.

Our investigator thought that AXA had acted reasonably, both in its handling of the claim and the amount of compensation offered. Ms T 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.

Ms T's main complaint is that the specialist should not be described by AXA as being 100% covered under the policy as she has not been able to receive fully funded treatment from him.

I won't repeat the policy terms here, which have previously been set out by our investigator.

AXA has clinicians that are fully covered under the policy and facilities that are fully covered under the policy. Generally speaking, for a policyholder to receive treatment at no cost to themselves, they would need to see a recognised consultant at a recognised venue.

Ms T's preferred consultant is fully covered by AXA. Hospital A is also fully covered by AXA. The consultant's correspondence lists hospital A as somewhere he works. Ms T has said that the consultant also told her that he had a base at Hospital A too. So, based on the available evidence, I'm not persuaded that AXA has given incorrect advice. If she had been able to see the consultant at Hospital A, then it would indeed have been fully covered.

Ms T's policy covers her for unlimited diagnostics. She says that the consultant referred her for scans at locations which AXA wouldn't fully cover. The consultant wouldn't know the

details of her particular policy and which facilities were covered or not. Whilst I appreciate Ms T's frustration, I'm not persuaded there was any fault on the part of AXA. There's no mistake in the policy stating that diagnostics are uncapped as that is the case, subject to tests taking place at a recognised facility.

Problems arose because the consultant refused to see her at Hospital A, for reasons that remain unclear. AXA doesn't directly employ specialists and so has no control over their actions. Therefore, I cannot hold it responsible for the consultant only agreeing to see Ms T at Hospital B. Similarly, I cannot hold AXA responsible for what Ms T describes as the consultant's dismissive manner in his interactions with her.

Ms T says she bought the policy on the understanding that she'd be able to use Hospital A. Because she hasn't been able to, the policy was mis-sold. The available evidence suggests Ms T took out the policy via a broker, so I can't look at any mis-selling issue against AXA as it was not the seller. Regardless of that, as I understand it, Hospital A was on AXA's approved list at the point of sale and remains an approved hospital. So, she could use it under the right circumstances. But it's unrealistic to expect that Hospital A would have the necessary facilities and specialists for every single medical condition. It's unfortunate in this instance that the consultant felt unable to see her there.

The consultant told Ms T on 20 February 2024 that the surgery would have to be at Hospital B. Upon informing AXA, it told her that treatment at Hospital B would only be 60% covered. So, at this point she knew there would likely be a financial implication if she carried on with that course of action.

However, AXA had also said that, before it could confirm what it would pay for, it needed to see a copy of the consultant's clinic letter regarding the procedure. It made requests for her to send this on 21 and 22 February 2024.

Had AXA had a chance to review the evidence, if it had found that it was medically necessary for the operation to take place at Hospital B, it could have applied a 'network exemption', meaning that it would fully cover the costs.

Due to the level of cover that Ms T choose, the policy covered her for three consultations. By this point she had used those up and was having to self-fund. She says she didn't want to have to pay for another consultation to get the requested information without knowing for sure if the surgery would be fully covered. However, AXA was asking for clinic letters from the consultations that she had already had. I think that's reasonable. After all, the consultant had already stated that the surgery would have to be at Hospital B. He'd told Ms T in an email dated 20 February 2024 to inform the insurer that it was complex surgery that needed a gynaecologist and colorectal surgeon together. So, having apparently reached that conclusion, the consultant should have been able to provide more information in writing in support of that position.

I accept that the consultant said he wouldn't be able to provide the procedure code until after assessing her again. However, had she provided the information she did have from her previous consultations, it's possible that might have moved the situation on. Even if AXA didn't agree the network exemption, it would still have been better placed to help source an alternative specialist.

In the event, Ms T then did see the consultant again on 11 April 2024, which she self-funded. He referred her for an ultrasound, which she also self-funded. She then raised a complaint on 22 April 2024 about the consultant not being 100% covered.

AXA repeated the request for clinic letters on 25 April 2024 and reiterated it again in its complaint final response letter of 31 May 2024. However, despite this, Ms T did not supply the information.

Ms T says the consultant was her only option for surgery as she did not have the names of any other consultants. Therefore, by continuing to see the consultant, she had to spend her own money. However, AXA had given her names of other specialists.

It is the case that Ms T's claims journey was not straightforward. To some extend that's due to the apparent complex nature of the treatment required. In such cases it can take time to identify the correct specialist, which might involve numerous consultations. For example, she had her first consultation with a different specialist on 27 January 2024 but changed track because, as well as preferring a nearer hospital, that consultant would not have been available to discuss the results of the scan for two months. Issues like that are outside of AXA's control. And it's unfortunate that Ms T's particular policy only covered her for three consultation per policy year, meaning that she was having to self-fund before getting to the point of finding a specialist and hospital where the treatment would be fully funded.

In summary, I find no error in AXA stating that the consultant was fully covered. The information it had was that the consultant had a base at Hospital A, and information from the consultant himself confirmed that. It could not have foreseen that the consultant would refuse to see her at Hospital A.

Ms T has more recently raised the issue of poor communication, particularly around AXA's online messages not giving a breakdown of costs. Whilst taking this extra point into account, overall, I consider that the £300 offered by AXA is reasonable and proportionate compensation for any distress and inconvenience caused.

AXA also asked Ms T for copies of invoices that she had self-funded, so it could assess whether these qualified for some reimbursement, in line with the policy terms and conditions. It's said it will apply 8% simple interest to any payments it does make. I understand that Ms T has provided these to AXA now.

I've thought very carefully about what Ms T has said and I have a lot of sympathy for her situation and her ongoing health issues. However, the matter at hand is whether AXA has done anything significantly wrong, and I don't think that it has. It follows that I do not uphold the complaint.

My final decision

For the reasons set out above, I do not uphold the complaint. However, AXA should pay the £300 to Ms T now if it hasn't already done so.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms T to accept or reject my decision before 27 June 2025.

Carole Clark
Ombudsman