DRN-5494910

The complaint

Mr K is unhappy that AXA PPP Healthcare Limited (AXA) declined the claim under his private medical insurance policy.

What happened

Mr K took out a group private medical insurance policy with AXA in August 2024. His wife and daughter are also joined onto the policy.

The policy is underwritten by AXA and was taken on a moratorium basis. This means that no medical underwriting takes place at the start of the policy. Instead, claims are assessed based on information the policyholder provides and any medical information that's required. The plan is a moratorium and means any pre-existing conditions from the previous five years of starting the plan are excluded. And pre-existing medical conditions can become eligible for cover if the policyholder has been symptom free for two continuous years after the start of the plan.

Mr K's daughter (Miss K) was admitted to hospital for a chest infection on 18 November 2024. He contacted AXA to find out whether Miss K would be eligible for treatment in a private hospital. AXA referred to its underwriters who confirmed the chest infection would be considered a pre-existing medical condition based on the medical history provided. So, the condition would be excluded from cover and therefore AXA couldn't arrange for Miss K's treatment to be done in a private hospital.

AXA said Mr K could claim for the NHS benefit available under the policy. But when he made the claim, this was declined. Mr K complained to AXA. It said an error was made in informing Mr K that the claim could be made and apologised for this.

Unhappy Mr K brought his complaint to this service. Our investigator partly upheld the complaint. She didn't think the claim had been declined unfairly. But she recommended that AXA pay £100 compensation for the error it made in its communication.

AXA accepted the investigator's findings.

Mr K 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 insurance industry regulator, the Financial Conduct Authority ('FCA'), has set out rules and guidance for insurers in the 'Insurance: Conduct of Business Sourcebook' ('ICOBS').

ICOBS says that insurers should act honestly, fairly and professionally in accordance with the best interests of their customers, and that they should handle claims promptly and fairly.

The key issue in dispute is the cover available for the NHS cash benefit under the policy. Mr K said the policy is unclear that the NHS cash benefit wouldn't be eligible for a pre-existing condition. Mr K also said the compensation recommended isn't sufficient for what happened.

Should the claim be covered?

I've first considered the relevant terms and conditions within the policy.

Mr K's membership certificate states:

> '*No benefit will be payable for pre-existing medical conditions during the first 2 years of membership, after which benefit will become available for these conditions, if at the time of receiving treatment there has been a trouble-free period of 12 months.'*

On page 10 of the policy document, it states:

> *'Cash payment for when you have free in-patient treatment under the NHS*
>
> *£100 a night up to £2,000 a year.*
>
> *We will pay this when:*
>
> *• you are admitted for in-patient treatment before midnight; and*
> *• we would have covered your treatment if you had had it privately.'*

On pages 16 to 17, there is information on what isn't covered.

> '*1 .3 The main things we don't cover*
>
> *Like all health insurance plans, there are a few things that are not covered whatever options you have. We've listed the most significant things here, but please also see the detail later in your handbook.*
>
> *Does my membership mean I don't need to use the NHS?*
> *No. Your insurance is not designed to cover every situation. It is designed to add to, not replace, the NHS. There are some conditions and treatments that the NHS is best at handling — emergencies are a good example.*
>
> *What are the key things my membership doesn't cover?*
> *The cover you have will depend on the options your group has chosen for you.*
>
> *Your plan does not cover*
> *Treatment of medical conditions you had, or had symptoms of, before you joined.'*

And on page 27, eligible treatment is defined as:

> *'treatment of a disease, illness or injury where that treatment:*
>
> - *Falls within the benefits of this plan and is not excluded from cover by any term in this handbook.'*

Based on the terms and conditions of Mr K's policy, the claim for the NHS cash benefit isn't eligible for cover. AXA said the claim was for a pre-existing condition and therefore isn't

covered. I think this was fair.

I've considered Mr K's comments that the policy is unclear that there won't be cover for the NHS cash benefit for a pre-existing condition. Having reviewed the policy terms and conditions, I don't think it was unclear. I'm satisfied Miss K's treatment wouldn't have been covered under the policy due to it being pre-existing and therefore it wouldn't have been eligible for the NHS cash benefit. I don't think therefore AXA declined the claim unfairly.

Is the compensation award fair and reasonable?

In terms of the compensation award, I agree that Mr K was told the NHS cash benefit would be payable. But I've also taken into account the AXA accepted the error in its communication, and it apologised for this. Our investigator recommended compensation of £100 for this error and AXA has accepted this.

I understand this was an emotional and stressful time for Mr K and his family. Mr K says this had a financial impact on them having to take time off from work and he incurred additional costs during the time their daughter was in hospital. I also understand the effort involved in gathering information and making a claim.

In response to the investigator's findings, Mr K talked about her recommendation of £100 being an insufficient amount. However, it is not our role to punish the business. Awards of compensation are primarily to reflect the impact on the consumer. The costs Mr K says he incurred would still have been incurred. Miss K was in hospital and regardless of whether the claim was payable, these costs couldn't have been avoided. I don't think AXA is responsible for these.

I have a great deal of sympathy for the situation Mr K found himself in. And I can understand why he believes he should receive a more significant amount for the trouble and upset he has incurred. However, as an alternative dispute resolution service, our awards are lower than he might expect and probably less than a court might award.

Having thought very carefully about what Mr K has said. An error was made by AXA, and this caused an additional amount of stress for Mr K as he had to then submit a claim which inevitably involved a degree of effort. Had AXA not informed Mr K that a claim for the NHS cash benefit was possible, this could have been avoided. I consider that overall £100 is fair and reasonable compensation for the distress and inconvenience caused by AXA in its communication.

Putting things right

I direct AXA to put things right by:

- Paying Mr K £100 compensation for the distress and inconvenience caused by its poor communication.

My final decision

For the reasons given above, I partly uphold Mr K's complaint about AXA PPP Healthcare Limited.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr K to accept or reject my decision before 16 June 2025.

Nimisha Radia
Ombudsman