DRN-5560136

The complaint

Mrs M complains that AXA Health Limited has unfairly refused a claim she made under her private medical insurance policy.

What happened

Mrs M has held her AXA private medical insurance policy since 1979. Her policy includes an NHS six-week option. This meant that Mrs M was covered for the costs of private in-patient treatment, day-patient treatment and any surgical procedure, if the NHS couldn't offer that treatment within six weeks of when it should take place.

On 20 September 2024, Mrs M was admitted to hospital after suffering a fall and breaking her leg. This occurred whilst visiting a family member, more than 100 miles from her home address. The following day she had a complex operation on her leg. Mrs M says she tried to be transferred to an NHS hospital closer to her own home but there was no spare capacity.

On 27 September 2024, Mrs M emailed AXA to explain the accident she had suffered, the required treatment and her rehabilitation options.

That same day, AXA emailed Mrs M back to explain she wouldn't be insured should she transfer to a private hospital for any ongoing treatment, nor could she claim for the cost of rehabilitation following orthopaedic treatment. AXA did set out that Mrs M could claim daily cash benefit of £50 for each night she stayed in the NHS hospital, up to a maximum of 40 days by supplying confirmation of her discharge documentation to AXA.

Mrs M spoke with AXA again on 30 September 2024 by telephone, as she was still awaiting transfer to a local hospital and was not well enough to be discharged yet. AXA's call handler noted that it may be able to assist her. The call handler asked Mrs M to obtain further information about her ongoing treatment, to ascertain if it would cover the cost of her being transferred to a private facility.

On 1 October 2024, Mrs M called AXA to ask about any options for financial support with NHS rehabilitation, though she noted she had a specific private rehabilitation centre that she wished to be transferred to. However, the call handler explained that it could not cover Mrs M's transfer to a private facility as that was not included within the six-week option; and the previous call handler from the day before had unfortunately given Mrs M incorrect guidance.

A further call took place on 2 October 2024, where the call handler reiterated that coverage wasn't available for Mrs M's private rehabilitation or out-patient treatment. However, Mrs M felt she had been previously promised assistance. Thereafter, Mrs M proceeded with a transfer to a private medical facility, where she stayed from 3 to 12 October 2024.

Mrs M complained. She also chased AXA for callbacks on 7 October and 19 October 2024.

On 25 October 2024, AXA upheld the complaint in part. It accepted that it had incorrectly advised Mrs M on 30 September 2024 that it may be able to cover her claim – but on all other occasions, its call handlers had rightly explained that a transfer to a private facility

would not be covered. It also accepted that it had promised Mrs M callbacks which hadn't happened. To recognise the poor service Mrs M had received, AXA sent her a £250 cheque.

AXA also told Mrs M it could pay her NHS cash benefit once she had sent it the evidence of her hospital stay. Mrs M supplied that evidence to AXA on 24 November 2024. She also appealed the complaint outcome.

On 13 December 2024, AXA sent Mrs M a second final response letter. It said it still believed that it had treated Mrs M fairly in its resolution of the complaint, and it was not prepared to change its decision on either the compensation or payment of the claim.

On 16 December 2024, AXA paid Mrs M £600 for her daily hospital cash benefit claim.

Mrs M remained unhappy and brought her complaint to this service. She explained that she had been left significantly out of pocket, and she felt AXA should reimburse the costs of her rehabilitation and treatment from 3 to 12 October 2024. Mrs M said she wouldn't have booked it but for the actions of AXA telling her it could help. She also felt AXA's process had been unfair, so she ought to receive greater compensation for the upset it had caused her.

One of our investigators reviewed the complaint and didn't think AXA needed to do anything further to resolve it. He said that Mrs M's policy terms were clear that it did not cover transfer to a private medical facility if the same treatment was available within six weeks via the NHS. The investigator also believed the amount AXA had paid Mrs M for the upset she had been caused was appropriate in all of the circumstances.

Mrs M asked for the complaint to be referred to an ombudsman. She also sent our investigator a further email which recounted the chronology of events from her perspective.

AXA had nothing else to add. The complaint has now 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.

I thank both parties for their patience whilst this matter has awaited an ombudsman's decision. I was sorry to hear how difficult things have been for Mrs M due to her ongoing health concerns and I send her my best wishes.

I'm aware I've set out the background to this complaint in less detail than the parties and I've done so using my own words. However, in reaching my conclusion I've focused on what I consider are the key issues. Our rules allow me to take this approach; it simply reflects the informal nature of our service as a free alternative to the courts, and no discourtesy is intended by it. If there's something I haven't mentioned, it isn't because I've ignored it. It's since I don't need to comment on each individual argument to be able to reach what I consider is the right outcome in the circumstances.

Having reviewed this complaint carefully, I agree with the outcome reached by our investigator – that means though I realise my decision will be disappointing for Mrs M, I won't be asking Aviva to do anything further to resolve the complaint. I'll explain my reasons below.

The relevant rules and industry guidelines say that AXA has a responsibility to handle claims promptly and fairly. And it shouldn't reject a claim unreasonably. So, I have looked at the

terms and conditions of Mrs M's policy.

I haven't set out the wording here, as both parties are familiar with it. However, the policy explains that cover will be provided if the NHS can't provide treatment within six weeks. It also makes it clear that the policy won't cover urgent or emergency treatment, as this would take place within six weeks.

Though Mrs M had understandable reasons to wish to transfer to her chosen private facility, I am satisfied that – barring the one occasion where confusing information was given on 30 September 2024 – AXA fairly refused the claim for the cost of Mrs M's stay and treatment at the facility. It's not in dispute that Mrs M needed emergency in-patient treatment, and she received this under the NHS within six weeks. That means she wasn't entitled to claim under the policy for private treatment due to the six-week option.

The policy also provides benefit of £50 per night (up to £2,000) if Mrs M has inpatient treatment on the NHS that could have been claimed under the policy if she'd had it privately. This is known as 'NHS cash benefit' and AXA correctly paid Mrs M's claim for that benefit within a prompt timescale once she had provided evidence to it.

Mrs M was not entitled to claim for the private treatment, so I can't ask AXA to pay it to her now – even if a mistake was made about the prospect of making such a claim. However, Mrs M was disappointed to learn that she wasn't entitled to pursue the claim. AXA has recognised this and paid £250 compensation by way of apology for its error. I'm satisfied this was reasonable in the circumstances.

What this service does is consider if a business has treated a complainant unfairly because of actions or inactions. And if it has done so, we then go on to consider what ought to be done to put the mistake(s) right. As well as putting right any financial losses in a complaint (though there are none in this circumstance since I agree the claim for the private in-patient treatment was rightly declined), we also consider the emotional or practical impact of any errors on a complainant.

AXA acknowledges that Mrs M had gone through a particularly distressing set of circumstances given she was away from home, and it offered her a sincere apology for its administrative errors. I believe the payment AXA made to Mrs M of £250 was reasonable in the circumstances where its claim handling procedure caused undue worry for Mrs M over a short-term period. Though it quickly corrected the error one day later, Mrs M was unduly confused by AXA at what was already a very distressing time for her. And AXA didn't call her back when it said it would on a few further occasions. Overall, I am satisfied the offer AXA has made is fair in the circumstances of that ongoing upset.

I recognise Mrs M feels that the compensation ought to be higher, but when we consider awards of this nature, we do not fine or punish businesses; the Financial Conduct Authority undertakes the role of regulator. Instead, we consider the impact upon a complainant. It may also be helpful for Mrs M to review the guidance available on our website which explains the amounts and types of awards made in instances of upset, trouble, inconvenience and distress caused by businesses in the complaints we see at this service.

Finally, I note that whilst this complaint was awaiting referral to an ombudsman, Mrs M sent further information to this service about another claim she has with AXA whereby she has experienced issues in August 2025. To be clear, those issues are distinct from this complaint, and I have not considered them here. If Mrs M has not done so already, she may consider pursuing her concerns to AXA as a new complaint.

My final decision

My final decision is that I don't uphold this complaint, as I find that AXA Health Limited has already paid Mrs M reasonable compensation for its errors.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs M to accept or reject my decision before 2 October 2025.

Jo Storey
Ombudsman