DRN-5561976

The complaint

Miss B and Miss B2 complain about how AXA PPP Healthcare Limited handled claims under a private health insurance policy.

What happened

Miss B2 is covered by a group private health insurance policy through her employer, and she added Miss B on the policy from 1 January 2024 onwards.

In short, Miss B is unhappy that AXA didn't give clear information about the claims she made, and what costs were covered by her policy. She's also unhappy how AXA handled everything, including the delay in processing a Subject Access Request ("SAR") she made. As a result, Miss B is now being chased for payments she owes to medical providers, which she thought were covered by her policy. Miss B2 wants AXA to use her outpatient allowance towards Miss B's treatment costs to help resolve the matter.

AXA says it did give Miss B enough information about what the policy covered, and the limits of her policy, when she made claims. It accepted that the benefit statements weren't available on Miss B's online account, that its staff member didn't handle a particular call well, and that it caused a delay in processing the SAR. AXA apologised for these errors and paid Miss B £250 for the distress and inconvenience caused. But it didn't think it was liable for the medical costs Miss B incurred above her outpatient limit.

Unhappy with AXA's position, Miss B brought a complaint to this Service. One of our investigators looked into what had happened. Having done so, she accepted AXA hadn't done everything right. But she thought AXA had done enough to let Miss B know about her policy limit, and what she could do to make sure her treatment was within that limit. Overall, our investigator thought that what AXA had done to put things right was fair and reasonable in the circumstances.

Miss B didn't agree. In summary, she made the following points, and she said AXA's errors led to a financial loss:

- AXA's failure to provide benefit statements meant Miss B couldn't track her outpatient limit accurately.
- AXA sent inconsistent and misleading messages about treatment coverage.
- Neither AXA nor the treatment providers gave her timely information about costs which led to Miss B reasonably assuming her treatments were covered.
- The compensation offered doesn't reflect the damages incurred.
- Miss B2's consent to use her outpatient allowance hasn't been considered.
- There was a delay in receiving all the crucial information from AXA.
- AXA hasn't followed regulatory requirements.

As no agreement was reached, the complaint has been passed to me to decide.

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.

Miss B has outlined her concerns in detail. I've focused on the issues that I consider to be material to the outcome of the complaint, as I'm required to do. So, my findings are a lot less detailed than Miss B's submissions. This reflects the informal nature of this Service.

Industry rules set out by the regulator (the Financial Conduct Authority) say insurers must handle claims fairly and shouldn't unreasonably reject a claim. Insurers must also handle claims promptly and should provide reasonable information about the progress of a claim. Businesses are also required to give consumers information they need, at the right time, and presented in a way they can understand – so they can make informed decisions.

I've taken these rules, and other industry guidance, into account when deciding what I think is fair and reasonable in the circumstances of Miss B and Miss B2's complaint.

AXA sent Miss B emails through its online portal to authorise treatment. Even if she didn't receive the first emails at the time, Miss B has said she got a text alerting her to an email in the portal on 29 April 2024, which she responded to. And I can see that she received an email on 29 May 2024 as well. I think the emails on 29 April and 29 May 2024 are most relevant in the circumstances, as Miss B hadn't yet used all of her outpatient limit.

The emails said the following:

> *"Your membership includes a limit of £1000.00 for outpatient treatment for each member each year. Your membership will cover the outpatient treatment we've listed up to this limit.*
>
> *Some outpatient tests or treatment, including blood tests, can be expensive. Please check with the specialist or hospital about the cost of treatment beforehand, so you know whether you have enough left from your outpatient limit to pay for the treatment."*

The emails also set out how much Miss B had left from her outpatient limit. This included the invoices AXA had already reviewed and this might change if it received more after this. The amounts Miss B had left were £915 on 29 April and £592.23 on 29 May 2024.

Miss B doesn't think AXA's emails were clear, and the one on 29 April 2024 also said that *"If we help you choose a specialist, your membership will cover their fees in full"*. However, I do think the emails are clear that AXA was authorising Miss B to have treatment that was covered by her policy, the policy covered AXA's chosen specialist fees in full – but all costs would be subject to the £1,000 outpatient limit on Miss B's policy.

The information in the emails AXA sent is also supported by the terms and conditions of the policy, which set out that the annual outpatient limit is £1,000 a year and that *"The limit applies to out-patient specialist consultations, diagnostic tests, practitioner, therapist and acupuncturist charges"*.

Overall, I'm satisfied AXA made it clear in its emails and policy terms that it would only pay for outpatient treatment up to £1,000 per policy year. I'm satisfied it also let Miss B know of the amounts she had remaining on 29 April and 29 May 2024, based on the invoices it had received and reviewed at the time (which was subject to change).

As set out above, AXA also let Miss B know in these emails that she should check with the specialist or hospital about the cost of treatment beforehand so she would know if she had enough left of her outpatient limit to pay for the treatment. If the providers didn't provide this information upon request, this isn't something AXA is responsible for. AXA's role, as a health insurer, is to authorise treatment that's covered by the policy, and pay for the invoices providers submit for the treatment in line with the policy terms and limits.

AXA has accepted that due to an IT issue, benefit statements weren't available on Miss B's online portal. This would clearly have been frustrating for Miss B when she couldn't check what costs AXA had paid. But this information will be subject to the medical providers submitting invoices in a timely manner. Any delays due to this wouldn't be AXA's responsibility.

As I'm satisfied AXA did enough to let Miss B know about the limits of her policy, if she was concerned about the amount she had left of the outpatient limit, she could have got in touch with AXA to check this. So, I don't agree that not providing the benefit statements means that AXA should now pay for Miss B's treatment outside the policy terms or pay these under Miss B2's benefit limit. But I agree that AXA should pay Miss B compensation for the distress and inconvenience caused in not providing her with benefit statements in a timely manner.

It's clear that AXA didn't handle the phone call on 1 July 2024 as well as it should have done, which it has acknowledged and apologised for. This also meant that AXA didn't respond to Miss B's concerns about her not receiving benefit statements until 29 August 2024. AXA also accepted it didn't start Miss B's SAR after her email of 10 July 2024 until 29 August 2024. It has again apologised for this.

Overall, AXA has paid Miss B £250 to recognise unnecessary distress and inconvenience it caused Miss B. Having considered everything, I think this is fair and reasonable compensation in all the circumstances of the complaint.

My final decision

My final decision is that I don't uphold Miss B and Miss B2's complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss B and Miss B2 to accept or reject my decision before 21 July 2025.

Renja Anderson
Ombudsman