DRN-5790733

The complaint

Mr I complains about AXA PPP Healthcare Limited's decision to turn down his private medical insurance claim, and its refusal to cover the cost of an MRI scan.

What happened

On 6 October 2023, Mr I joined his employer's private medical insurance scheme. The scheme had moratorium underwriting, which meant that Mr I wouldn't be covered for any pre-existing medical conditions.

Later that month, Mr I contacted AXA to make a claim for a problem with his left knee. After obtaining information from Mr I's GP, AXA turned down the claim and said it fell under the moratorium.

In March 2024, Mr I requested an appointment with a clinician through AXA's third-party provider that offers an outpatient service (that I'll call 'H'). AXA authorised Mr I to have a remote appointment and remote physiotherapy with H.

Mr I had the remote appointment with a clinician through H, and they arranged for him to have an MRI scan at a hospital. He had a follow-up remote appointment with the clinician to discuss the results of the scan.

Mr I was then told by the hospital that he needed to pay for the MRI scan. Mr I complained to AXA about this. He said he hadn't arranged the scan and hadn't been told by H that it would cost him anything, so he thought it was covered by AXA.

AXA issued a final response to the complaint on 18 October 2024. AXA said it hadn't authorised the MRI scan, and neither did H. Unhappy with this response, Mr I brought a complaint to this service. He explained he was being chased for the cost of the MRI scan by a debt collection agency.

I issued a provisional decision on 20 August 2025. Here's what I said:

'I've considered all the available evidence and arguments to decide what's fair and reasonable in the circumstances of this complaint.

Mr I asked us to consider two issues – AXA's decision to turn down his claim, and its refusal to pay for the MRI scan. It's not clear to me if Mr I complained to AXA about its decision to turn down his claim. AXA's final response to the complaint didn't address this. However, our investigator did so, and AXA didn't object to this. I've therefore also considered this.

Claim decline

The moratorium underwriting on the policy explains that there's no cover for treatment of any conditions in the five years before joining the scheme. And this includes symptoms of a condition that hasn't been diagnosed.

Mr I joined the scheme on 6 October 2023. When he made a claim a few weeks later, he said he'd experienced left knee pain for about a month.

I've looked at Mr I's medical information. I see that he visited his GP on 6 October 2023, and the notes say 'left knee pain for a few weeks. Plays and coaches football and has kne [sic] pain occasionally. Flare of pain after wheeling a waste bin.'

As the medical evidence from the GP supports that Mr I had experienced his left knee pain for a few weeks before joining the scheme, I'm satisfied it was reasonable for AXA to conclude that this fell within the moratorium and turn down his claim.

MRI scan

AXA has confirmed that even though Mr I's knee problem fell within the moratorium, he could still access virtual treatment through H as this isn't subject to the underwriting on the policy.

Although Mr I was aware that AXA wouldn't pay his claim for medical treatment of his left knee, he requested an appointment with a clinician through H. He was on the waiting list to see a specialist on the NHS, but this was taking some time.

I've looked at the email that AXA sent Mr I on 7 March 2024 about this. The email said that H had been in touch to obtain authorisation for a remote appointment with a clinician. AXA said benefit had been confirmed for this and remote physiotherapy only. The email also said that Mr I's membership didn't have benefit for any other types of treatment for this condition, and that was because it was in connection with a condition he had before joining.

I'm satisfied the information AXA gave Mr I here was clear, and he was made aware that AXA would only cover a remote consultation and remote physiotherapy.

Mr I went ahead with the remote appointment with a clinician, and they wanted him to have an MRI scan. This appointment was arranged by H directly with the hospital and so Mr I went there for the scan. H then scheduled a follow-up appointment for Mr I with the clinician to review his MRI results.

AXA has found out there was a system issue with H's platform at the time, and this allowed the clinician to make a referral for an MRI scan, even though AXA had only authorised a remote consultation and remote physiotherapy.

I do have sympathy for Mr I here. He shouldn't have been referred for an MRI scan by the clinician. But a system error meant that the appointment was arranged for him by H. And he wasn't told that it would cost him anything.

However, I don't think AXA was at fault here. It authorised the treatment that Mr I was entitled to and was clear about what it would cover. H is a third-party service provider that AXA has a partnership with. AXA wasn't responsible for the system issue with H's platform. I'm sorry to disappoint Mr I, but I don't intend to require AXA to cover the cost of the MRI scan.'

I asked both parties for any further comments they wished to make before I made a final decision.

AXA responded to confirm it didn't have any further comments.

Mr I responded with the following main points:

- The MRI was not requested by him, it was arranged by H. He wasn't told he could be personally liable for the cost of the MRI.
- He thinks AXA can't avoid responsibility for the system error by outsourcing to H, and that AXA is responsible for the conduct of its appointed representatives.
- He questions why my provisional decision has departed from the investigator's findings when no new evidence has been provided.
- Whilst he accepts that AXA's policy definition of treatment includes diagnostic tests, he says the context matters because the moratorium applies to treatment of pre-existing conditions. And an MRI doesn't treat a condition.
- His GP report said that his injury arose after twisting his knee while moving bins, and this was a new and specific event. Whilst he had occasional discomfort in the past, this was different in nature and severity.
- AXA didn't respond to his complaint in line with the regulator's requirements. He thinks I should direct AXA to pay him compensation for this, over and above the MRI bill.

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'll address each of Mr I's points in turn.

I accepted in my provisional decision that the MRI was arranged by H, and not Mr I. However, I was satisfied that AXA hadn't caused the error which allowed the MRI scan to be arranged.

Mr I thinks that AXA has outsourced a service to H on its behalf.

The financial regulator, the Financial Conduct Authority ('FCA') explains that a firm would be outsourcing when they are involved in an arrangement where a service provider performs a process, service or activity on behalf of a firm which the firm would otherwise carry out itself. H is a provider of healthcare outpatient services, such as clinician consultations. This is not a role that AXA normally carries out itself, and has outsourced to H. So, I'm satisfied that AXA hasn't outsourced services to H, and therefore isn't responsible for errors made by H.

Mr I has also referred to H as an appointed representative of AXA.

The FCA explains that an appointed representative carries out regulated financial activities under the responsibility of an authorised firm (known as 'the principal'). The principal is responsible for making sure the appointed representative is fit and proper and complies with FCA rules. However, H is not an authorised representative of AXA's, as it isn't carrying out regulated financial activities on its behalf.

I therefore remain satisfied that AXA isn't responsible for what happened.

Mr I has queried why I reached a different outcome to our investigator. Our investigator issued an initial assessment and partly upheld the complaint. Though under our rules, if either party disagrees with the initial assessment, then they can ask for the case to be referred to an ombudsman. The ombudsman reviews the case afresh and may or may not agree with the investigator's initial assessment. Here, whilst I agreed with our investigator's

findings in respect of the claim decision, I didn't agree with his findings in respect of the MRI scan.

Mr I thinks the policy wording is unclear, in respect of the moratorium.

The membership certificate says *'No benefit will be payable for pre-existing medical conditions during the first 2 years of membership...'*

The policy says:

*'If you joined us on moratorium terms, you won't have cover for **treatment** for any conditions you had in the five years before you joined…'*

The policy explains that some of the words and phrases used have a specific meaning (it gives the example of treatment), and explains those words are in bold and their meanings are in the glossary.

Treatment is defined in the glossary as:

*'surgical or medical services (including **diagnostic tests**) that are needed to diagnose, relieve or cure a disease, illness or injury.'*

Diagnostic tests are defined in the glossary as:

'investigations, such as x-rays or blood tests, to find or help to find the cause of your symptoms.'

Mr I says that a diagnostic investigation is not the same as treatment. If I were to apply the ordinary and everyday meaning of the word treatment, then I'd agree with him. But here, the policy makes it clear that words in bold have specific meanings, and the definition of the word treatment (which is in bold) does include diagnostic tests. So, I don't agree with him that the policy is unclear.

Mr I says the GP report states his injury arose after twisting his knee while moving bins, and this was a new and specific event. He says that whilst he had occasional discomfort in the past, this was different in nature and severity. He says there's no medical evidence establishing a link between his new knee pain and his previous knee pain.

In my provisional decision, I'd quoted the notes from Mr I's medical records that his GP had made after examining him on 6 October 2023. For further context, here's what the GP recorded in his medical notes after the initial phone consultation that took place earlier that day.

'had cruciate repair 26 years ago and he was back to playing football. Had occasional pain which settled quickly but had more persistent pain past couple of weeks after a match. Then developed flare of pain after moving bins.'

It's not clear if Mr I is saying that he moved the bins on 6 October 2023 and therefore he experienced new pain that day (the same day the policy started). If it is, then I think the GP notes make it clear that Mr I had been experiencing knee pain before the policy started. Whilst the notes refer to a 'flare of pain', I don't think they show that this was unrelated to the knee pain he'd already been experiencing. So, in the absence of further evidence to show the knee pain he experienced on 6 October 2023 was an entirely new issue, I remain satisfied it was reasonable for AXA to conclude that his knee pain was pre-existing.

Mr I says that AXA didn't respond to his complaint in line with FCA timescales.

I should explain here that any failure of AXA in relation to this amounts to complaint handling, which isn't one of the regulated activities the Financial Ombudsman Service has the power to consider, on its own. We can sometimes comment on complaint handling where it is ancillary to a regulated activity, as it is here, but it is not our role to punish a business for poor complaint handling. Instead, we'd consider the impact any poor complaint handling had on the consumer, and whether compensation should be paid as a result.

Mr I says he raised a complaint on 30 July 2024. I've looked at AXA's contact logs and it seems he'd raised a query about why he was being charged for the MRI around this date, but this wasn't raised as a complaint at the time. I see that AXA looked into it, and on 29 August 2024 they decided to deal with it as a complaint. FCA rules say that firms should send a final response or holding letter within eight weeks of receiving a complaint. AXA sent Mr I its final response on 17 October 2024, which was within eight weeks of the date it had decided to deal with the matter as a complaint. So, I don't find that AXA did anything wrong here.

My final decision

My final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr I to accept or reject my decision before 30 September 2025.

Chantelle Hurn-Ryan
Ombudsman