DRN-4459950

The complaint

Mrs W complains about the way AXA PPP Healthcare Limited has settled a claim she made on a group private medical insurance policy.

What happened

The background to this complaint is well-known to both parties, so I've simply set out a summary of what I think are the key issues.

Mrs W is insured under a group private medical insurance policy. Her daughter, Miss W, is also insured under the policy. The policy includes outpatient cover up to an annual limit of £1000. The policy renews in January of each year.

In February 2023, Miss W saw a consultant, who recommended that she undergo blood tests. Mrs W called from the hospital to check whether Miss W's tests would be covered. AXA's call handler said that it could authorise an initial consultation and diagnostics. So Miss W underwent blood tests. The total cost of the consultation and testing was £4294.94,

However, AXA only partly settled the invoice. It paid £610 of the total costs. That's because taking into account other costs it had already settled, it had already paid up to the limit of £1000 for the 2023 policy year.

Mrs W was very unhappy with AXA's decision and she complained. She said AXA's call handler had told her that Miss W's costs would be covered and that if she'd known a limit would apply, she'd have acted differently.

AXA agreed to settle £2500 of the total invoice as a gesture of goodwill. But it didn't agree that its call handler had given Mrs W incorrect or misleading information. And it stated that only a few weeks earlier, the outpatient limits had been clearly explained to Mrs W. So it maintained that Mrs W would be responsible for paying the claim shortfall.

Mrs W remained unhappy with AXA's position and she asked us to look into her complaint.

Our investigator didn't think Mrs W's complaint should be upheld. She felt that Mrs W's policy terms clearly set out the annual outpatient limit of £1000. And she noted that Mrs W had recently been reminded about the applicable policy limit. She didn't think AXA's call handler had misled Mrs W about the cover at the time of her call in February 2023. So she didn't think AXA needed to pay anything more.

Mrs W disagreed. In summary, she didn't think information she'd been given previously in relation to different treatment was applicable to the circumstances of this claim. She said Miss W had had to switch consultants during the course of the claim and each time, Mrs W had checked what was authorised specifically for each consultant and treatment. She said she'd relied upon being given accurate information by AXA. And on the day in question, she didn't think the call handler had specifically explained the relevant terms.

The complaint's 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.

Having done so, whilst I'm sorry to disappoint Mrs W, I think AXA has settled this claim fairly and I'll explain why.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. So I've carefully considered, amongst other things, the terms of this policy and the circumstances of Mrs W's claim, to decide whether I think AXA treated her fairly.

I've first considered the policy terms and conditions, as these form the basis of the group contract with AXA. Page four of the contract includes a table of benefits, which sets out a list of the cover AXA provides, along with the applicable annual policy limits. I can see that this policy provides cover for specialist consultations and diagnostic tests up to a combined limit of £1000 per year. This limit resets at the beginning of each policy year.

In my view, AXA's terms make it clear that a combined limit of £1000 applies for specialist consultations and diagnostic tests. And so I think AXA was reasonably entitled to apply the limit to the circumstances of Mrs W's claim. It's clear that the diagnostic tests Miss W underwent significantly exceeded the applicable annual limit. Therefore, I don't think AXA acted unfairly when it initially settled the invoice in line with the policy terms.

It's clear how strongly Mrs W feels that she was led to believe that the full costs would be covered. But having listened carefully to the call between Mrs W and AXA's call handler, I don't agree. The call handler correctly informed Mrs W that initial consultations and diagnostic tests were covered by the policy. There was no discussion about the potential costs of the tests Miss W's consultant had proposed she undergo. And the call handler didn't suggest that AXA would pay all of the diagnostic testing costs, or that it would pay above the policy limit. So while the call handler didn't refer specifically to the applicable policy limits, I think they gave Mrs W accurate information about what the contract would cover.

And I've borne in mind too that only around two and a half months earlier, Mrs W had spoken to AXA regarding Miss W's treatment – even if it didn't relate to the same part of this claim. During the call, the call handler explained the £1000 limit and recommended that Mrs W check the costs of any proposed tests with the treating hospital, as diagnostics could be very expensive. The call handler put this in writing and specifically stated: '*once you've used up your out-patient entitlement in any membership year you'll have to pay any further out-patient treatments yourself.'* As such, I think AXA had already given Mrs W clear information about the applicable limit and the way the policy worked only a few weeks before her call of February 2023.

Nonetheless, AXA agreed to step outside of a strict interpretation of the policy terms and paid £2500 of the total invoice. In my view, this was a very fair and reasonable step from AXA, especially given its actual liability under the policy terms.

Overall then, while I sympathise with Mrs W's position, as I appreciate there is still a shortfall balance to pay, I find that AXA has already settled this claim promptly, fairly and reasonably. And so it follows that I'm not directing AXA to pay anything more.

My final decision

For the reasons I've given above, my final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs W to accept or reject my decision before 28 December 2023.

Lisa Barham
Ombudsman