DRN-4696881

The complaint

Mr P is unhappy with how Aviva Insurance Limited (Aviva) has handled his private medical insurance claim.

Any reference to Aviva includes all its agents.

Mr P is being represented on this complaint.

What happened

Mr P took out a private medical insurance policy in October 2015. The policy is underwritten by Aviva and was taken out on a moratorium basis.

Mr P's says Aviva has told him the full cost of the treatment he requires isn't covered under his policy. The hospital he has chosen isn't an eligible facility available under his policy terms and conditions because it's not one that's listed under the hospital list.

The hospital where Mr P was due to have treatment contacted Aviva on 25 May 2023 inform it that Mr P was due to have a procedure on his foot. This was scheduled to take place on 31 May 2023.

Previously, in July 2022, Mr P had authorisation from Aviva for a consultation and x-ray. Mr P hadn't informed Aviva that he had been back to see the consultant on 3 May 2023 and that the procedure was due to take place.

The hospital wasn't listed as an eligible one under the policy and the consultant's fees weren't within Aviva's guidelines. Aviva informed Mr P the fees it would pay for the consultant and hospital so he could check whether he needed to cover any shortfalls. Aviva didn't provide Mr P with an authorisation number as he would be regarded as a self-pay patient.

Mr P contacted Aviva to make a complaint as it had informed him that the procedure wouldn't be fully funded. Aviva contacted the hospital who confirmed that treatment at this hospital was the choice of the surgeon, and he uses it as a teaching base. No clinical reasons were provided by the hospital. So, Aviva said the procedure could take place at another hospital that was listed in the policy document, and it would not cover the full cost of the procedure as this wasn't in line with the policy terms and conditions. It also said it could help locate another hospital that was listed so Mr P's treatment wasn't delayed further.

Unhappy with Aviva's response, Mr P referred his complaint to this service. Our investigator looked into it and didn't uphold the complaint. She didn't think Aviva had declined the claim unfairly or unreasonably. She also said the claim had been declined in line with Mr P's policy terms and conditions.

Mr P 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.

I'd like to explain, firstly, that this decision will focus on the complaint Mr P raised with Aviva and to which Aviva responded on 28 November 2023. The crux of the complaint raised was that Aviva wasn't covering the full cost for Mr P's foot procedure. This was because the hospital where he wanted the procedure to take place wasn't a listed hospital under the policy.

At the outset I acknowledge that I've summarised this complaint in less detail than Mr P has, and in my own words. I won't respond to every single point made. No discourtesy is intended by this. Instead, I've focussed on what I think are the key issues here. The rules that govern our service allow me to do this as we are an informal dispute resolution service.

If there's something I've not mentioned, it isn't because I've overlooked it. I haven't. I'm satisfied I don't need to comment on every individual point to be able to fulfil my statutory function.

I've started by looking at the terms and conditions of Mr P's policy.

On page 2, it sets what cover is provided:

Where you're covered for treatment

'Hospital lists

If you have a hospital list, in-patient and day-patient treatment will be covered when it takes place at a hospital on the chosen hospital list or at a facility within one of our networks.

All treatment and diagnostic tests must be carried out by providers (such as hospitals, facilities, specialists) recognised by us. If you have treatment with a provider that we do not recognise, we will not pay that provider's fees.'

On page 12, it provides further detail about this:

'*Benefit Terms Hospital lists*

If you have a hospital list, hospital charges for in-patient and day-patient treatment are covered in full if you have treatment at a hospital on your hospital list, a facility on one of our networks or an NHS pay-bed at an NHS hospital.

If you receive treatment as an in-patient or day-patient in a hospital or facility that is not:

- *included on your hospital list, or*
- *included on one of our networks, or*
- *an NHS pay-bed at an NHS hospital but is recognised by us,*

we will calculate the average cost of hospital charges for equivalent treatment across all hospitals on your list and that average cost is the maximum we will pay. This could leave you with a shortfall that the policy does not cover. If the actual cost of the treatment is less than the average cost, we will pay the hospital costs in full. We will cover specialists' fees up to the limits in our fee schedule.'

Based on both above terms, I think it's clear that there is cover for treatment when it takes place at a hospital from the chosen hospital list or from a facility within one of Aviva's networks.

I think it's also clear that there is full cover for treatment if the treatment takes place at a hospital from the hospital list or at a facility from one of the networks. *And*, in this case, if treatment is received at a hospital or facility that's *not* on the hospital list or from a chosen network, then the average cost of hospital charges for equivalent treatment across all hospitals on the list will be applied by Aviva. The average cost will be the maximum paid by Aviva.

Mr P went to the hospital that he wanted to use for his foot procedure, but this wasn't on the hospital list under his policy. It was only when that hospital contacted Aviva that it became aware the procedure was scheduled. As Mr P is aware from prior experience; he needed to have prior authorisation from Aviva for the procedure and as he hadn't obtained this, Aviva had to look into whether cover would be provided. And when it did do so, it informed Mr P that it couldn't fully cover the cost of his procedure because the hospital he had chosen wasn't on the hospital list.

Under the terms and conditions of Mr P's policy, while he has cover under his policy for the procedure, this is only if it is at one of the hospitals from the hospital list. And, if the procedure takes place at another hospital, Aviva has confirmed the full cost cannot be covered. I can see that Aviva has also said that it will assist Mr P in finding an alternative hospital from its hospital list if this is what Mr P wishes to do.

Based on all of the above and taking everything into account, I don't think Mr P has been treated unfairly or unreasonably by Aviva. I can also see what Aviva has said is in line with the terms and conditions of Mr P's policy.

I appreciate that Mr P has put his procedure on hold, and I can understand this is difficult. But ultimately, the procedure needs to take place in a hospital from the hospital list as per his policy or the cost is averaged and therefore the full cost, in this instance, cannot be covered. It's also not incorrect that any shortfalls incurred in paying for the treatment would be Mr P's responsibility. I'm persuaded that Aviva has followed its processes to ensure that Mr P has all the information to make a decision about how to proceed with his claim. It's important to note that Aviva hasn't said the claim isn't covered and it has provided alternative options to Mr P if he's not happy with any given hospital. Given the situation of the claim, Aviva has said it can't cover the full cost of the procedure. I think this is in line with Mr P's policy terms and conditions.

Overall, therefore, based on the circumstances of this complaint, I don't think Aviva has done anything wrong and I'm satisfied it hasn't treated Mr P unfairly. It follows that I don't require Aviva to do anything further.

My final decision

For the reasons given above, I don't uphold Mr P's complaint about Aviva Insurance Limited.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr P to accept or

reject my decision before 9 May 2024.

Nimisha Radia
Ombudsman