DRN-5148383

The complaint

Mrs D is unhappy that Aviva Insurance Limited (Aviva) only partly covered her private medical insurance claim.

What happened

Mrs D has a private medical insurance policy taken through her husband's group policy. Aviva is the underwriter.

In June 2024, Mrs D had a procedure and Aviva only partly covered her claim. Aviva said Mrs D had reached her out-patient benefit limit under her policy.

Unhappy, Mrs D made a complaint to Aviva. She said Aviva couldn't provide exact costs of the procedure and had she known the full extent of the cost, she would have used the NHS instead. She also wasn't told that the specialist was no longer part of the approved list.

Aviva responded and said it would not know the cost of the procedure until the invoice had been received from the provider and the fees that specialists charge differs. It said it had acted appropriately and advised Mrs D correctly throughout regarding her out-patient benefit limit. It apologised for the length of time she had to wait for her calls to be answered and offered her £50 compensation in recognition of this.

Mrs D brought her complaint to this service. Our investigator didn't uphold the complaint. She thought Aviva had applied the out-patient benefit limit fairly and had handled the claim in line with the policy terms and conditions. She also thought £50 compensation offered by Aviva was fair for the lengthy call wait times Mrs D had experienced.

Mrs D 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 relevant rules and industry guidelines say that insurers must handle claims fairly and shouldn't unreasonably reject a claim. I've taken these rules into account when deciding what I think is fair and reasonable in the circumstances of Mrs D's complaint.

Mrs D has a policy which has a limit of £1,500 for the out-patient benefit. The key issue here is that Mrs D exceeded the £1,500 out-patient limit on her policy, so I have to determine whether Aviva treated her fairly in this regard.

I've reviewed the information provided and also listened to the call recordings Aviva has provided from April 2024 to May 2024. Having done so, I don't think Mrs D was led to believe in the calls that her claim would be fully covered.

Aviva explained in the calls that her out-patient benefit limit is £1,500 so any tests and/or procedures she had would be covered up to that limit. Aviva also advised Mrs D to check the cost of the treatment before going ahead, with the relevant providers, as it wouldn't know the cost of these exactly. Whilst there wasn't any dispute about whether the claim would be covered, it's clear that there was a benefit limit, and that Mrs D was made aware of it and she needed to check prior to going ahead with the treatment and procedure.

Mrs D says Aviva should have told her that the specialist she was intending to use was no longer on its approved list. However, Aviva can only do that to the extent that it's been updated by the specialist. I can see, in the circumstances here, that Aviva hadn't received the update from the specialist and therefore when Mrs D was referred to him, it would not have been aware of this. I appreciate it was frustrating for Mrs D to then have to contact Aviva again for a different specialist, But I don't think Aviva acted unfairly in referring her to the specialist.

I've reviewed the service Mrs D has received from Aviva. I understand it has offered her £50 compensation for the length of the call waiting times. I think this is fair in the circumstances. I also think Mrs D was provided with clear information about the benefit limit on her policy and that she should contact the providers to find out the full cost of the treatment before going ahead. So, for the distress and inconvenience she suffered, I think £50 is fair compensation in recognition of this.

Overall, I understand that the whole situation has been upsetting for Mrs D and she's left with having to pay the remaining bill for the procedure she's had. But, I'm sorry to disappoint Mrs D, I think Aviva handled the claim in line with the policy terms and conditions and I think it treated her fairly. It follows therefore that I don't require Aviva to do anything further.

My final decision

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

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs D to accept or reject my decision before 8 January 2025.

Nimisha Radia
Ombudsman