DRN-5200696

The complaint

Miss D is unhappy that Aviva Insurance Limited (Aviva) applied a second excess to her private medical insurance policy.

What happened

Miss D had a private medical insurance policy with Aviva. The policy year ran from 1 April 2023 to 31 March 2024. She renewed the policy the following year which started on 1 April 2024.

Miss D submitted a claim online on 13 November 2023. She was charged an excess of £175. In May 2024, Miss D had a follow-up consultation from the claim she made in November 2023 and was again charged an excess of £175.

Unhappy about being charged a second excess fee, Miss D made a complaint to Aviva. She said she hadn't been made aware that a second excess would be charged, and she didn't think this was fair as the follow-up consultation was part of the claim that she made in November 2023.

Aviva responded and said it had informed Miss D about the applicable policy excess. This explained that the excess would be applied per person, per policy year and that the excess was payable on an annual basis, not per claim. Aviva said it had acted in line with the policy terms and conditions.

Miss D brought her complaint to this service. Our investigator didn't uphold the complaint. She thought Aviva had applied the excess in line with the policy terms and this was done correctly.

Miss 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.

Industry rules set out by the regulator (the Financial Conduct Authority) say that insurers must handle claims promptly and fairly. I've taken these rules into account when making my decision about Miss D's complaint.

I've started by looking at the terms and conditions of Miss D's policy as this forms the insurance contract with Aviva.

Page 14 of the policy document sets out the information about the excess that applies. This states that a £175 excess applies to each member every policy year.

The crux of Miss D's complaint is that a second excess of £175 was applied which she thinks is unfair.

Miss D contacted Aviva on 13 November 2023 to obtain a referral to a specialist. Aviva authorised the claim for an investigation to take place into her condition. An email dated 14 November 2023 was sent to confirm this. The email provided information about how the policy excess would apply which stated the excess would be payable per person and per policy year.

On 4 March 2024, Miss D contacted Aviva to seek authorisation for a follow-up consultation. The email confirmed the applicable policy excess was £175 per person per policy year and that Miss D's policy year runs from 1 April 2023 to 1 April 2024. And it said the excess would be deducted from the first invoice Aviva processes in the policy year. The email also confirmed the excess would be payable on an annual basis, not per claim, regardless of whether the claim is new, or part of an ongoing claim and that Miss D could keep track of her excess online.

On 29 May 2024, Miss D contacted Aviva online and cover was confirmed again by Aviva by email to Miss D. This explained that the policy has an excess of £175 which is applicable for each member, every policy year. The current policy has been referred to as 1 April 2024 to 31 March 2025 and that the excess would be deducted from the first eligible invoices Aviva processes on or after the renewal date.

Based on the communication Miss D received, I don't think the excess applied on Miss D's policy is unfair. The follow-up consultation was in the new policy year and therefore an excess would apply in line with the policy terms and conditions.

There's no dispute that Miss D received the emails. I think the communication was sufficiently clear for Miss D to have been made aware how the policy excess applied in each policy year and not per claim. I appreciate that the additional cost is difficult to bear for Miss D but that doesn't necessarily mean that Aviva did anything wrong.

Miss D says the information should have been more prominent. I can't comment on how Aviva decides to provide its information, but I can look at whether I think the way it's done is fair. I can see that the information about the policy excess is within the emails Miss D received. Whilst I acknowledge her comments, there is also some onus on the consumer to ensure that these are fully read.

Overall, in the circumstances of this complaint., I'm satisfied that Aviva has applied the policy excess in line with Miss D's policy terms and conditions and done so fairly and reasonably. 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 Miss D's complaint Aviva Insurance Limited.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss D to accept or reject my decision before 13 March 2025.

Nimisha Radia
Ombudsman