DRN-5314546

The complaint

Mr and Mrs A are unhappy that they've only recently been notified that they owe outstanding excess payments for treatment accessed by Mrs A for previous policy years under their private medical insurance policy, underwritten by Aviva Insurance Limited ('the policy').

What happened

The details of this complaint are well known to both parties, so I won't repeat them again here. I'll focus on giving the reasons for my decision.

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.

Mr and Mrs A have referred to the Consumer Duty which I've taken into account along with all the relevant rules and regulations including Aviva's regulatory obligation to handle insurance claims fairly and promptly.

I know Mr and Mrs A feel very strongly that Aviva has acted unfairly here, and I appreciate they'll be disappointed, but I don't uphold their complaint. I'll explain why.

In relation to the excess, the policy terms say:

- If you have chosen an excess, Aviva will pay benefits up to the amounts shown after the excess has been paid. The excess is applied to each member, each policy year. This means that if a claim or course of treatment continues from one policy year to the next, the excess will apply again.
- The excess is applied on the date the treatment takes place and not the date Aviva pays the bill.
- If any excess applies, Aviva will write to the member to advise who the excess should be paid to. The member is liable for the amount of the excess, and this should be paid directly to the provider of treatment or service.

Each policy year ran from 1 May to 30 April and Mr and Mrs A had a member excess of £250.

From what I've seen, I'm satisfied Mrs A had treatment in the following policy years, the cost of which exceeded the member excess:

- 1 May 2021 to 30 April 2022;
- 1 May 2022 to 30 April 2023; and
- 1 May 2023 to 30 April 2024.

It's agreed that the excess wasn't paid.

Mr and Mrs A say they didn't receive anything from Aviva or the treatment provider to say the excess was payable until early 2024 and this prompted them to raise concerns.

Aviva has provided copies of the statement of account letters which it says Mrs A would've been sent. As the letters have now been archived, it says the letters don't have the date on which they were originally sent; only the date they were recently regenerated to send to Mr and Mrs A after they raised their complaint.

However, the letters are addressed to Mrs A and have the correct postal address.

Aviva has explained that when it settles or partially settles an invoice, the letters are automatically generated, printed and sent by its document services team. I have no reason to doubt what it says about that, and I accept Aviva's submissions on this point. It's also provided screenshots to support that the letters were generated during the relevant policy years and shortly after the hospital charges were incurred in 2022 and 2023.

It's possible that these letters were generated and for whatever reason weren't sent to Mrs A, or that she didn't receive them. However, on the balance of probabilities, and in the absence of anything else to the contrary, I'm persuaded that these letters were sent by Aviva and were (more likely than not) received by Mrs A.

Mr and Mrs A only received reminders that there were outstanding excess payments due for previous policy years in early 2024. Mr and Mrs A say that had been aware of the outstanding excess payments, they would've been able to claim these back under a cash benefit policy Mr A had the benefit of through his work, but he no longer has.

However, I'm satisfied that the policy documents reasonably clearly set out to Mr and Mrs A when the excess payment is due so I don't think it would be fair and reasonable for me to direct Aviva to cover the excess payments owed for previous policy years. Particularly as I'm satisfied on the balance of probabilities that the statement of account letters were sent to Mrs A at the relevant times.

I've taken into account Mr and Mrs A's point that when Mr A received treatment, he received the relevant letters about the excess and arranged payment. So, they suspect there's an issue when dealing with those other than the lead insured member under the policy. However, I remain satisfied that the relevant letters were (more likely than not) sent to Mrs A during the relevant policy years shortly after receiving treatment.

I've also considered Aviva's complaints data referred to me by Mr and Mrs A but I've determined this complaint based on its individual circumstances as I'm required to do.

Since bringing this complaint to the Financial Ombudsman Service, I'm pleased to see that Aviva noted that it had incorrectly applied two excesses for the treatment accessed by Mrs A during the policy year 1 May 2022 to 30 April 2023. It has arranged for one of the excesses for that policy year to be settled to the provider.

However, I'm satisfied that Aviva has acted fairly and reasonably by maintaining that £750 is owed by Mr and Mrs A for the excess to be paid for the three policy years Mrs A claimed on the policy to cover treatment costs. That's based on a member excess of £250 per year multiplied by three years.

My final decision

I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr and Mrs A to accept or reject my decision before 10 April 2025.

David Curtis-Johnson
Ombudsman