DRN-5348480

The complaint

Mr R has complained that Aviva Insurance Limited wouldn't authorise cover on his private health insurance policy for a medical procedure.

What happened

Mr R began to suffer from sudden fainting episodes. He contacted Aviva who authorised investigations into the cause of these symptoms. Mr R was found to have a heart condition and it was recommended that he should have a pacemaker fitted as a matter or urgency. However, Aviva would not cover the cost of that treatment as it considered Mr R's health conditions to be chronic in nature and chronic conditions are not covered under the policy. Mr R had to wait two months before having the treatment on the NHS.

Our investigator thought that Aviva had acted reasonably, in line with the policy terms and conditions. Mr R disagrees and so the complaint has been passed to me for a 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.

I've carefully considered the obligations placed on Aviva by the Financial Conduct Authority (FCA). Its 'Insurance: Conduct of Business Sourcebook' (ICOBS) includes the requirement for Aviva to handle claims promptly and fairly, and to not unreasonably decline a claim.

The policy states:

'*There is no cover on the policy for chronic conditions.'*

Chronic conditions are defined as:

'A disease, illness or injury which has at least one of the following characteristics:

it needs ongoing or long-term monitoring through consultations, examinations, check-ups and/or tests

it needs ongoing or long term control or relief of symptoms

it requires your rehabllitation or for you to be specially trained to cope with it

it continues indefinitely

it has no known cure

it comes back or is likely to come back.'

Mr R has said that, as a pacemaker requires monitoring, it would always be excluded under the policy terms above. He has therefore questioned Aviva's online literature which mentions pacemakers as a possible treatment option. According to Mr R, Aviva's position is that a pacemaker is only for the treatment of chronic conditions – which are not covered – which would mean that it would never provide cover for pacemaker installation. However, that is not the case. I cannot see that Aviva has ever said that. It would provide cover for a pacemaker in circumstances where the device proved curative. However, that would not have been the case here.

The claim wasn't declined because Mr R needed a pacemaker that would subsequently need monitoring. It was declined on the basis that he had chronic conditions which would not be cured by the device. Whilst the pacemaker would manage the symptoms, it would not cure the underlying conditions.

Mr R had an appointment with his cardiologist on 14 May 2024 who then referred him to a further consultant, whom he had a telephone appointment with on the same day.

Mr R had supplied a clinic letter from the consultant dated 14 May 2024 which provided a diagnosis of left bundle branch block (LBBB) and cardiomyopathy. Mr R has said that, as he never saw the consultant in person, Aviva shouldn't rely on the contents of this letter. However, I consider that Aviva is entitled to rely on information provided by a specialist medical professional.

Mr R would prefer Aviva to rely on what the referring cardiologist, who actually examined him, said in a later email chain to him. He says that she clearly states he was suffering from a new condition. Looking at the emails, I can't see that she says that exactly, although it is the case that she says in one email that '*you no longer have left bundle branch and your heart function has improved*,' and in another that 'you don't have LBBB at the moment and so they (Aviva) may consider this is not a pre existing condition', although she then goes on to say that she wasn't sure about what type of device he would need and to see if the ECG changes. However, the emails don't contain information of any alternative diagnosis of a new condition. Aviva looked at the emails and said that it would nevertheless have declined the claim due to the diagnosis of cardiomyopathy and heart failure.

As mentioned, Mr R had the pacemaker fitted under the NHS and this took place on 24 June 2024, the same day as Aviva provided its final response letter to the complaint. He then provided a copy of the first page of the discharge summary showing a further, principal diagnosis, of complete atrioventricular block, together with dilated cardiopathy, heart failure and LBBB. Mr R says he understands atrioventricular heart block to be an acute, rather than a chronic, condition.

Aviva requested the full discharge summary. This stated that Mr R had been transferred to hospital for LBB implant insertion, following LBBB being found within a positive exercise tolerance test. The procedure was described as left bundle pacing. Aviva therefore concluded that the pacemaker had been inserted due to LBBB.

Additionally, I haven't seen any evidence that Aviva had received information about a diagnosis of atrioventricular heart block at the time that it was assessing the claim or prior to the procedure taking place. Therefore. it would not have been in a position to factor this into its assessment.

I have a great deal of sympathy for Mr R's situation. He had a serious condition that needed treating as a matter of urgency. Unfortunately, he had to wait two months to have the procedure, during which time he couldn't carry out his usual responsibilities for aging

relatives or go on a planned trip abroad. However, the matter at hand is whether Aviva did anything wrong in declining to authorise the procedure, and I don't consider that it has.

On balance, I'm satisfied that it fairly assessed the medical information it had at the time, to conclude that the pacemaker was required as a result of chronic conditions which were not covered under the policy terms.

So, I'm sorry to disappoint Mr R but it follows that I do not uphold the complaint.

My final decision

For the reasons set out above, I do not uphold the complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr R to accept or reject my decision before 30 May 2025.

Carole Clark
Ombudsman