DRN-4229527

The complaint

Mr B and Mrs H are unhappy with the way Aviva Insurance Limited ('Aviva') dealt with a claim.

What happened

Mr B and Mrs H have a private medical insurance policy, underwritten By Aviva.

Mrs H made a claim in March 2020. She saw a consultant and underwent treatment. Due to Covid-19 Mrs H wasn't able to attend any further appointments until November 2021. She was referred back to her consultant as her condition had worsened.

Aviva said Mrs H's condition met their definition of a 'chronic' condition.

Mr B and Mrs H complained as they didn't think Aviva had fairly classed the condition as chronic and were unhappy with the limitations and deadlines applied to the cover. Dissatisfied with Aviva's response, they referred their complaint to this Service.

Mrs H needed surgery and Aviva agreed to cover this which went ahead in May 2022.

Aviva limited the amount of follow up care to a specific date but then agreed to cover consultations up to March 2023.

Our investigator looked into the complaint and found Aviva had acted reasonably by offering to review additional medical information to fully consider the conditions Mrs H was being treated for.

Mr B and Mrs H disagreed and said they wanted an Ombudsman to review the matter as they weren't happy that Aviva were time-limiting cover before Mrs H's consultant had discharged her from care. And they wanted Aviva to agree cover from the core policy for a post operative consultation and follow ups.

And so the case has been passed to me for a final 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.

Having done so, I agree that Aviva's offer to review the medical information before agreeing to cover further treatment was fair and reasonable. I'll explain why.

The relevant rules and industry guidelines say an insurer should handle claims promptly and fairly. And shouldn't unreasonably reject a claim.

The policy covers treatment of acute conditions and does not cover chronic conditions. The policy terms say:

"An acute condition is defined as a disease, illness or injury that is likely to respond quickly to treatment which aims to return a member to the state of health they were in immediately before suffering from it, or which leads to their full recovery.

A chronic condition is defined as a disease, illness or injury that has one or more 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 a member's rehabilitation or for them 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."*

Aviva's system notes show that Mrs H had a history of abdominal symptoms which had been investigated since 2018. On that basis, Aviva said the treatment of those symptoms met the definition of 'chronic'. I don't think that was an unreasonable conclusion for Aviva to reach based on the medical information it had.

Mr B and Mrs H disagreed with Aviva and following correspondence back and forth, it agreed to cover treatment and Mrs H had an operation. Following this, it requested further information from Mrs H's treating consultants and agreed to cover further consultations until the end of March 2023.

Mr B and Mrs H were unhappy with the deadlines set by Aviva and said cover should have continued until Mrs H had been discharged and shouldn't be stopped or limited, using arbitrary dates.

But that isn't how the policy works. As the policy provides cover for acute conditions which are likely to respond quickly to treatment, I don't think setting deadlines and dates was unreasonable. Aviva is entitled to review medical evidence before deciding whether to continue providing cover. And I am satisfied it managed expectations in relation to what it considered to be a chronic condition.

Although Mrs H was unable to see a consultant quickly due to the Covid-19 pandemic, Aviva did agree to and authorised the treatment she required. It also paid £100 compensation for delays and an apology relating to an initial complaint regarding her treatment which she accepted at the time.

Mr B and Mrs H say the outstanding issue which remains is the date Aviva set to end cover by 31 March 2023. But I don't think the deadline was an unreasonable one based on the need to review further medical evidence after this date and also because the policy covers acute conditions which respond quickly to treatment.

Aviva has since confirmed that it had reviewed further medical evidence and authorised treatment post March 2023 from the 'option 2' benefit as outlined in the policy. The policy and benefit renewed from 1 June 2023. As Aviva acted in line with the policy terms in relation to follow up treatment, I don't think this is unreasonable and so I won't be asking it to

do anything further.

My final decision

For the reasons set out above, I think Aviva's actions have been reasonable so I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr B and Mrs H to accept or reject my decision before 3 August 2023.

Shamaila Hussain
Ombudsman