DRN-4568821

The complaint

Mr J is unhappy that Aviva Insurance Limited has declined payment of medical treatment claimed under his private medical insurance policy.

What happened

Mr J has private medical insurance through Aviva, which he has renewed annually since 2015.

In late 2021, Mr J went for a health check and was told that he had a slight heart murmur. He was referred to a consultant who completed tests and found that, whilst there was no issue with his heart, there were growths on his lungs. The growths had increased in size following a scan in March 2022 and it was decided that a biopsy should be taken. Following an additional scan, when it was noted that the growths had remained the same size, Mr J said that the consultant and radiologist (who would be carrying out the biopsy) agreed the best course of action would be to wait 12 months before doing anything further. Mr J met with his consultant in March 2023 and had a further scan, along with completing a sleep study test.

The invoices were submitted to Aviva, but payment was declined. Mr J was contacted by the hospital and told that he had to meet the costs of this treatment – which totalled almost £2000.00. Unhappy with this, Mr J contacted Aviva. Aviva said it wouldn't pay for these costs as they would be considered as routine check ups or monitoring. Mr J complained to Aviva about this outcome and brought his complaint to us.

Our investigator looked into this matter but didn't uphold Mr J's complaint. He found that the policy didn't provide cover for routine medical examinations or medical screening. And he said that, as the follow up appointments appeared to be to check if the growths had increased, these costs would be considered as being for medical screening.

Mr J disagreed with our investigator's view. He said that the visit was due to the specialist's concern for continued monitoring of the nodules' growth. So, he didn't think payment should be refused. He said Aviva didn't tell him that this visit wouldn't be covered when he contacted them at the time.

As no agreement could be reached, the matter has been passed to me to decide.
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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.

It is important to point out that we're an informal dispute resolution service, set up as a free alternative to the courts for consumers. In deciding this complaint I've focused on what I consider to be the heart of the matter rather than commenting on every issue or point made in turn. This isn't intended as a discourtesy to Mr J. Rather it reflects the informal nature of our service, its remit, and my role in it.

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 Mr J's complaint.

The policy terms and conditions

I've first considered the policy terms and conditions, as these form the basis of the contract between Mr J and Aviva. Aviva has said that Mr J's ongoing scans and follow ups with the consultant are excluded under the policy as cover isn't provided for routine check-ups or monitoring. The policy includes a section titled '*What's not covered – policy exclusions*'. Contained within that section is the following:

> *Routine medical examinations, screening and preventative treatment*
>
> *We do not cover:*
> - *routine medical examinations (such as sight tests), medical screening, health check-ups or vaccinations*
> - *treatment to prevent a disease or illness, or*
> - *any treatment to discover the presence of a potential disease or illness if symptoms are not present, for example genetic tests.*

Has Aviva fairly declined the claim?

From the information detailed above, it is clear that there are restrictions to the treatment or tests that Aviva will provide cover for. In particular, Aviva doesn't provide cover for any routine medical examinations, medical screening or health check-ups.

Following initial tests and scans, Mr J's specialists recommended that he wait 12 months before they reviewed his condition again in order to see if further treatment was necessary. And I've seen a letter from Mr J's consultant who says there was a clinical need to follow up with scans over a period of time to confirm the nodules were benign. This would suggest that the tests completed following that 12-month period were to monitor his condition, rather than any ongoing treatment for the condition. Therefore, I'm persuaded that this would be classed as a check-up or a medical screening. As the policy excludes both medical screening and health check-ups, I'm satisfied that Aviva has acted fairly when declining to make payment for the costs incurred.

Mr J says that the consultant has confirmed that there was a clinical need for the review and so this should be covered by Aviva. But the fact there may be a clinical need to follow up doesn't automatically mean the claim should be paid. As in commonplace with all insurance policies, Aviva's policy doesn't provide cover for every eventuality. And, as long as Aviva sets out what is and isn't covered by the policy in its terms and conditions, it can decline to pay for anything which is excluded within those terms. I'm persuaded that Aviva has applied its policy terms reasonably, so I don't require it to do anything more.

Mr J says Aviva never told him that this wouldn't be covered when he spoke with them in 2022. He says as a result this has caused him a financial impact. Aviva said Mr J was advised that the policy wouldn't cover this 12-month check. Unfortunately, Aviva has been unable to locate the call recording. Where such evidence isn't available, I must decide, on balance, what I think is most likely to have happened. Aviva has provided copies of the call notes made by the advisor at the time of the call. There is a note of a conversation with Mr J on 17 March 2022 which says:

> "*Memb has been adv that heart is clear and wants to see memb in a years time, adv no ben for routine on the policy and memb would need to self fund or use the NHS."*

From this note, it would appear that Mr J was informed that there wouldn't be cover for the costs incurred in this check-up. As this note was entered on the day of the call, I'm persuaded that it is likely to reflect the conversation that took place. So, I'm satisfied that Aviva advised Mr J as soon as possible.

Overall, based on all I've seen, I don't think Aviva acted unfairly when it concluded that the claim wasn't covered. I think it's shown that the costs would be considered as medical screening. And so it follows that I think it was fair for Aviva to turn down this claim.

My final decision

For the reasons mentioned above, I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr J to accept or reject my decision before 17 April 2024.

Jenny Giles
Ombudsman