DRN-4297306

The complaint

Miss F complains about the way Aviva Insurance Limited handled a private medical insurance claim for her son, Mr F.

What happened

I've only described what happened in brief as both parties are familiar with this complaint.

Miss F had a private medical insurance policy. It was underwritten by Aviva and provided cover for her son, Mr F. When he became unwell in 2022 a claim was submitted, and after some discussion about fee limits Aviva authorised Mr F to see a consultant paediatric neurologist.

That neurologist referred Mr F on to a hospital (which I'll call "P") for an MRI under general anaesthetic plus blood and urine tests. However, P wasn't included on the specific key hospital list that formed part of Miss F's policy.

A different hospital (which I'll call "C") was included on that list. It was the only hospital that had availability in the near future, could admit Mr F, and could provide the diagnostics needed. But Miss F didn't want to take Mr F there and detailed numerous concerns about it. She said, for example, that C wasn't a dedicated children's hospital and she'd been told the neurologist didn't normally refer children there. That she'd had a previous bad experience with C and difficulty getting in touch with it. And that even when she had spoken to it was concerned by what she'd heard in the background.

Miss F asked Aviva to authorise cover for P instead, but Aviva declined and explained P wasn't included on the policy. It confirmed C was, and could admit Mr F and provide the diagnostics recommended. It explained how the policy would work if Miss F were to go ahead with P – namely that it'd leave her with a shortfall in costs covered. It also said the policy was designed to cover the cost of healthcare, not the healthcare itself, and P would have only been available if the extended hospital list had been selected for the policy, which wasn't what Miss F had chosen when she bought it.

Unhappy with what had happened Miss F approached this service. She told us she'd decided not to renew the policy and said she now wanted a refund in premiums to put towards Mr F's care.

Our investigator thought Aviva had acted in line with the policy terms. They said the diagnostics recommended for Mr F were available at C, which was a hospital covered by the policy. And that even though there'd been some poor customer service from C itself, the available evidence had indicated C would have been able to book Mr F in. Our investigator also said it wouldn't be fair to recommend a refund in premiums because Aviva had paid more in claims than Miss F had paid in premiums, meaning she'd benefitted from the policy.

Miss F disagreed and reiterated her concerns. She also said she'd continued to have difficulty contacting C, so even if she had wanted to take Mr F there she wouldn't have been able to. She said the policy didn't reflect what a policyholder was actually able to get from it

either, Aviva had lied and tried to cover up the fact there were no hospitals available, and it'd gotten out of paying.

Our investigator's opinion remained the same, so as no agreement was reached the matter was passed to me to decide.

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 want to highlight that I'll not be addressing every point or argument raised. I will instead focus on those matters I consider central to the outcome of this complaint.

For the avoidance of doubt I'll not be considering any of Miss F's concerns about the sale of her policy either. It wasn't sold by Aviva and as I understand matters her sale-related concerns have been shared with the relevant party.

I was sorry to read about the circumstances surrounding this claim, but I will not be upholding this complaint. Aviva acted in line with the terms and conditions of the policy, and I don't think its position was unfair or unreasonable based on the information it had available. Let me explain:

- Aviva had a responsibility to handle claims both promptly and fairly, and to not reject them unreasonably.

- A key hospital list was chosen when Miss F's policy was purchased, and C was included on it. At the time of Mr F's claim the other hospitals on that list weren't in a position to provide the recommended diagnostics for a number of different reasons. I understand Miss F's frustration with that, but C had the ability to perform them and so despite there not being a wider choice in the specific requirements of this claim, cover was still available.

- Miss F may have wanted to use hospital P, but Aviva wasn't required to authorise cover outside of the policy terms. P wasn't included in the key hospital list that had been selected and Aviva correctly explained how the policy would work should Miss F choose to go off-list:

  "*If you have a hospital list, hospital charges for in-patient and day-patient treatment are covered in full if you have treatment at a hospital on your hospital list, a facility on one of our networks or an NHS pay-bed at an NHS hospital.*

  If you receive treatment as an in-patient or day-patient in a hospital or facility that is not:

  - *included on your hospital list, or*
  - *included on one of our networks, or*
  - *an NHS pay-bed at an NHS hospital*

  but is recognised by us, we will calculate the average hospital charges for equivalent treatment across all hospitals on your list and that average cost is the maximum we will pay. This could leave you with a shortfall that the policy does not cover. If the actual cost of the treatment is less than the average cost, we will pay the hospital costs in full. We will cover specialists' fees up to the limits in our fee schedule."

- There was evidence of delays with C making a booking for the diagnostics, but I don't

think this demonstrated to Aviva that C was completely unable to book Mr F in and/or provide what had been recommended for him. As our investigator explained, the last email from C said it'd be in a position to book Mr F in after the person responsible for doing so returned from annual leave.

- Following our investigator's opinion Miss F told us she'd gone on to make a further two unsuccessful calls to C. As far as I understand matters Aviva was not aware of that at the time it considered Miss F's complaint. But, and as I think Aviva rightly explained, its role was to cover the costs of private healthcare in accordance with the relevant terms and conditions, it was not responsible for the service provided by an individual medical facility. Outside of the delay issue Aviva wasn't provided with evidence to corroborate a number of Miss F's wider concerns about C's suitability, for example that C wouldn't have known how to deal with Mr F's needs, and I don't think its position based on the evidence available to it was unreasonable.

- Without wanting to diminish any of the wider concerns Miss F had about the suitability of C, Aviva acted in line with the relevant policy terms, I don't think it's position in this claim was unreasonable, and it is not on risk anymore because this policy is no longer in place.

- When the policy was live, Aviva paid more in claims than Miss F paid in premiums. Benefit was therefore had from the it and it'd be unfair of me to direct a refund of premiums as a result. However, even if I were to have found a refund fair, I would have directed Aviva to deduct any claims paid so no money would have actually been due to Miss F.

My final decision

My final decision is that I do not uphold this complaint against Aviva Insurance Limited.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr F and Miss F to accept or reject my decision before 2 October 2023.

Jade Alexander
Ombudsman