DRN-4661480

The complaint

Miss R complains about how Aviva Insurance Limited dealt with a claim against a group private medical insurance policy and about how it dealt with her complaint.

What happened

The details of this complaint are well known to both parties, so I won't repeat them again here in full. In summary, Miss R was a member of a group private medical scheme provided by her employer. The policy year starts on 1 October each year and there's an outpatient limit of £1,000 each policy year.

In July and September 2023, Miss R made claims against the policy in relation to certain tests and consultations, which Aviva authorised. In the message of authorisation on 11 September 2023, Aviva reminded Miss R of the outpatient limit of £1,000 and said that her remaining benefit for the policy year was £644.10.

When Miss R attended the hospital for one of the tests, she was asked to sign a form that set out the costs. Miss R says that she used the costs provided by the hospital to estimate how much of her outpatient benefit she was using on each occasion, so that she could manage costs and possibly delay some costs to a new policy year.

On 3 October 2023, Aviva told Miss R that her outpatient limit had been reached (for the year ending 30 September 2023) and that it had paid part of an invoice, leaving a balance payable by Miss R.

Miss R was shocked to learn that Aviva paid the hospital more than the amount that the hospital had set out on the forms she signed. She asked the hospital about this and it told her that it charged Aviva negotiated rates and the lower rates it had shown Miss R were for self-funding patients.

Miss R says that when she contacted Aviva for authorisation, it should have told her the exact amount it would pay the hospital, so that she could keep track of what she'd have to pay. Miss R says that it's not right that she agreed to tests but was unaware of the cost. Miss R also complaint about how Aviva handled her complaint in that it didn't act on her initial complaint and didn't return her call when it had promised to do so.

In response to Miss R's complaint, Aviva said that it couldn't tell Miss R exactly how much it would pay the hospital as that's confidential information. It said that it had told Miss R how much of her outpatient benefit remained when it authorised her claim.

Aviva subsequently said that it couldn't tell Miss R the costs of the tests until it received the invoices because charges may be higher than expected, tests or treatment may change and costs vary for each specialist and hospital. It said that it's for the policy member to manage and monitor their out-patient limit. Aviva said that it sent Miss R compensation of £50 in relation to service issues.

One of our investigators looked at what had happened. He didn't think that Aviva had acted unfairly. The investigator said we don't expect an insurer to set out the cost in advance.

Miss R didn't agree with the investigator. She said she wouldn't expect Aviva to pay more than the price the hospital had told her it would charge self-funding patients. Miss R said that it's impossible to budget and asks how she would know when she was near the limit of the policy.

Miss R asked that an ombudsman consider her complaint, so it was passed to me to decide.

Miss R has expressed concern about how Aviva handled her complaint. Our service can only consider complaints about financial services. So, I can't consider the additional points Miss R has raised about the handling of her complaint because it isn't a regulated activity. I note that Aviva says it has paid Miss R compensation of £50 in relation to service issues. If Miss R hasn't received that payment, she may wish to contact Aviva directly about that.

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.

The relevant rules and industry guidance say that Aviva has a responsibility to handle claims promptly and fairly.

I understand Miss R's frustration but I don't uphold her complaint and I'll explain why.

- Insurance policies aren't designed to cover every eventuality or situation. An insurer will decide what risks it's willing to cover and set these out in the terms and conditions of the policy document. In general terms, insurers can decide what risks they wish to cover and the limits of cover. Here, the relevant limit is £1,000 per policy year for certain out-patient tests and treatment.

- Miss R is responsible for the costs she incurs in having private treatment. However, if her treatment is eligible treatment, Aviva pays the costs that are covered under her benefits and in accordance with the terms of cover. As Miss R is aware, she's responsible for any costs not covered under her benefits.

- Aviva doesn't necessarily know precisely how much the tests or treatment it has authorised will cost before it receives the invoice from the treatment provider. That's because its contracts differ with different providers and a test it has authorised may include varying elements or the exact type of test may change on the day. So, I don't think that Aviva was at fault in failing to tell Miss R at the point of authorisation the exact amount it will pay to the treatment provider.

- Aviva says that its contracts with main hospital providers are for a large array of treatments, operations and services and are fixed for the contract term, whereas the prices the hospitals charge self-funding patients may change. Aviva isn't responsible for the level of charges a hospital may charge self-funding patients. Nor is it responsible for the pricing information the hospital made available to Miss R on the day of her tests.

- I've seen on the sample *'[…] Charge Sheet'* Miss R has provided that the fees are described as *'(for Self-Pay patients)*'. And a note at the top of that sheet says: '*Insured Patients*
  It is your responsibility to check with your insurer that any additional tests or procedures are covered by your policy. Any fees not covered by your insurer will be charged to you directly by the hospital. The Hospital's self-pay fees are different to fees paid by insurers.'

- In order to budget effectively, it's open for a patient to ask a treatment provider how much it will charge the insurer. I've noted that in correspondence with Miss R, her treatment provider said that it was unable to provide prices for insured patients. That's a matter for Miss R to take up with her treatment provider.

- I think that Aviva acted fairly in reminding Miss R of the out-patient limit, the amounts it had already paid and the amount remaining. I don't think it needed to do any more than that.

- I agree with Miss R that it's not logical for Aviva to say that it couldn't tell Miss R exactly how much it would pay the hospital as it's confidential information. Aviva tells members what it has paid after it has paid it, so it's not a matter of confidentiality.

- I'm sorry to disappoint Miss R but, for the reasons I've explained, I don't uphold this complaint.

My final decision

My final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss R to accept or reject my decision before 6 June 2024.

Louise Povey
Ombudsman