DRN-5485118

The complaint

Mrs P is unhappy that Aviva Insurance Limited (Aviva) declined her private medical insurance claim.

What happened

The background to this complaint is well-known to both parties. So, I've simply set out a summary of what I think are the key events.

Mrs P had a private medical insurance policy with BUPA which started on 16 December 2022. The policy was cancelled on 16 June 2024.

The policy was underwritten by BUPA and was taken on a moratorium basis. This means any pre-existing conditions from the previous five years of the start date are excluded. And pre-existing medical conditions can become eligible for cover if the policyholder has been symptom free for two continuous years after the start of the plan.

Mrs P was diagnosed with an incontinence condition. Her consultant recommended a laparoscopic colostomy to replace the sacral nerve stimulator (SNS) that was used to treat the condition as the symptoms were worsening.

In June 2024, she submitted a claim to Aviva. It declined the claim as the condition was pre-existing. It also said the condition was chronic and there was no cover under the policy for this.

Unhappy, Mrs P brought her complaint to this service. Our investigator upheld the complaint. He didn't think Aviva had acted fairly and reasonably by declining the claim. He recommended that Aviva reconsiders Mrs P's claim as based on the current available information, he didn't think the claim had been declined fairly.

Aviva disagreed and asked for the complaint to be referred to an ombudsman. So, it was passed to me.

I issued a provisional decision to both parties on 7 April 2025. I said the following:

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, my intention is to not uphold this complaint. I'll explain why below.

The insurance industry regulator, the Financial Conduct Authority ('FCA'), has set out rules and guidance for insurers in the 'Insurance: Conduct of Business Sourcebook' ('ICOBS').

ICOBS says that insurers should act honestly, fairly and professionally in accordance with the best interests of their customers, and that they should handle claims promptly and fairly.

The policy terms and conditions

Pre-existing condition

The policy terms and conditions, on pages 24 and 25 state:

> *'We do not cover treatment of any pre-existing condition, or any related condition, if you had:*
>
> *- symptoms of*
>
> *- medication for*
>
> *- diagnostic tests for*
>
> *- treatment for, or*
>
> *- advice about*
>
> *that condition in the five years before you joined the policy.*
>
> *However, we will cover a pre-existing condition if you do not have:*
>
> *- medication for*
>
> *- diagnostic tests for*
>
> *- treatment for, or*
>
> *- advice about*
>
> *That condition during a continuous two-year period after you joined the policy.'*

Treatment is defined in the policy document on page 37 as:

> *'Surgical or medical services (including diagnostic tests) that are needed to diagnose, relieve or cure a disease, illness or injury.'*

Based on the policy start date of 16 December 2022, there would be no cover for a pre-existing medical condition from the previous five years – from 16 December 2017 to 15 December 2022. And if Mrs P was symptom-free for a continuous two years from the start date of the policy, the pre-existing condition would be covered.

Aviva declined the claim as Mrs P's symptoms were present within the immediate five-year

period before the start date of the policy, and she didn't fulfil the two-year criteria as per the policy terms and conditions above.

I've reviewed the letters Mrs P has provided regarding her condition from her GP and her consultant. It's clear from the letters that Mrs P suffered from long-standing incontinence and the SNS was used as a form of treatment to help relieve her symptoms.

The GP referral letter dated 9 February 2024 stated her condition is long-standing and as it was worsening, Mrs P wanted to be referred for a laparoscopic colostomy.

The consultant letter dated 1 May 2024 stated Mrs P has long-standing incontinence and takes huge amounts of 'Imodium' to control this. A SNS was performed in 2000 and a new battery inserted in 2007 and she was keen to have a colostomy to help with her worsening

symptoms. The consultant provided a further letter dated 12 June 2024. This states that Mrs P has had no incontinence for the last 24 years and that she has managed things very well.

Both the GP letter and the first consultant letter states the condition has been long-standing. And it is the treatment she's received in the form of the SNS which has relieved her of the symptoms. So, in the five years prior to the start of the policy, as she's had the treatment, the condition would be considered as pre-existing as per the policy terms and conditions.

I've considered that the second consultant letter states Mrs P has had no incontinence for the last 24 years and has managed things very well. But this letter was provided by the consultant following Aviva informing Mrs P that the claim had been declined. So, on balance, I don't think this is a contemporaneous note but rather a letter in support of the claim being accepted by Aviva.

Based on the above, I don't think Aviva has declined the claim unfairly or unreasonably.

I've gone on to consider whether I think the condition is chronic.

Chronic condition

The policy terms and conditions state on page one:

> *'The policy does not cover chronic conditions.*
>
> *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 your rehabilitation 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.'*

As I've said above, Mrs P suffered from incontinence which has been long-standing and the SNS was used as treatment to help relieve her symptoms.

I've considered information from the NHS website about SNS. In terms of monitoring, I can see that regular follow-up appointments are needed to monitor the effectiveness of the treatment and make any necessary adjustments. And an annual follow-up appointment would usually be scheduled.

The information on the website also confirms that the battery has to be replaced periodically - usually every four to seven years. And Mrs P's consultant has said the battery was replaced in 2007. Whilst it's not clear of subsequent timings of the battery replacement for Mrs P, it wouldn't be out of turn to expect that this happened at least every seven years

based on the information on the NHS website and based on what the consultant has said. But even if I don't take this into account, it's clear that the condition and the SNS require long-term monitoring.

I therefore think Mrs P's condition is one that is chronic and therefore not covered under the policy.

Overall, having taken everything into account, I'm currently not persuaded that Aviva has declined Mrs P's claim outside the terms and conditions of her policy or that it was done so unfairly or unreasonably.

I now invite both parties to provide their comments or further arguments by 21 April 2025.

Both parties responded to the provisional decision.

Mrs P said she couldn't see why she had to pay a lot to have the treatment as it was essentially to improve her lifestyle.

Aviva said it accepted the provisional decision. But to assist in its understanding, it asked about the interpretation of the definition of treatment.

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, as I've received no further arguments from either party, I see no reason to depart from what I've said in my provisional decision.

In terms of the interpretation of the definition of treatment, the NHS website explains that SNS is a form of treatment. This along with the definition of treatment in the policy document, I thought it was more likely than not that SNS was a form of treatment because it was a surgical or medical service that was needed to relieve the symptoms of the condition.

Overall, I understand that the treatment was to help improve Mrs P's lifestyle and that it was costly to her. So, I'm sorry to disappoint Mrs P. In the circumstances of this complaint, I'm not persuaded that Aviva has declined the claim outside the terms and conditions of her policy or that it did so unfairly or unreasonably. It follows therefore that I don't require Aviva to do anything further.

My final decision

For the reasons given above, I don't uphold Mrs P's complaint about Aviva Insurance Limited.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs P to accept or reject my decision before 13 May 2025.

Nimisha Radia
Ombudsman