complaint

Mr and Mrs B complain about Aviva Health UK Limited's decision to turn down Mr B's claim made under a private medical insurance policy.

background

Mr B held private medical insurance cover with another insurer and made a successful claim under it in early 2014 for a problem with his left knee. Mr and Mrs B's membership of that policy ended and they took out a new policy with Aviva in September 2014. After doing so, Mr B had more problems with his left knee. He'd been diagnosed with arthritis and needed a partial knee replacement. Mr B made a claim to Aviva in early 2015.

Aviva turned down the claim, saying the policy didn't cover any illness or injury the insured sought medical advice about in the five years leading up to the start of the policy. Unless, that is, the insured went two years without tests, treatment and so forth after the policy started. Aviva said the evidence showed Mr B had a "*significant history of degeneration*" in the knee.

Mr and Mrs B went ahead with the surgery privately and complained to us. Our adjudicator didn't recommend the complaint be upheld. He felt the evidence showed Mr B's condition was likely to be pre-existing and that Aviva had fairly turned down the claim.

Mr and Mrs B appealed. They said, among other things, Mr B hadn't been diagnosed with arthritis until after the policy started. His doctors mentioned degeneration but that wasn't the same as arthritis. Their complaint was passed to me to consider.

my findings

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've decided not to uphold this complaint. I'll explain why.

The policy terms say Aviva won't cover, among other things, treatment of any pre-existing medical condition if the insured had symptoms of, diagnostic tests for, treatment for or advice about that condition in the five years before the start of the policy.

The terms go on to say Aviva will cover treatment of a pre-existing condition if there aren't diagnostic tests for (and so on) that condition for a continuous two-year period after the start of the policy. This is what's known as a moratorium clause.

So, for me to find Aviva fairly turned down the claim, I'd need to see evidence showing the condition Mr B claimed for was related to a condition he had and was advised about in the five years before September 2014.

I believe, from the medical information, that Mr B was advised about arthritis more than once in that period. For example, Mr B saw his GP in October 2013 for left knee pain. The GP noted there was a restricted range of movement in the knee and he'd suffered with knee pain in the past. Mr B was having physiotherapy and his GP had prescribed medication for the pain.

Mr B's first consultant orthopaedic surgeon reported in October 2013 that he thought most of the left knee discomfort was "*osteoarthritic in origin*". An MRI revealed "*medial compartment degeneration*" – the medial compartment being the inside of the knee – and a "*medial meniscal tear*".

In February 2014, the consultant said Mr B was still suffering with symptoms in the medial compartment. He recommended an arthroscopy but advised Mr B that would treat the tear but not any underlying degeneration.

In April 2014, after the arthroscopy, the consultant said surgery revealed "*fairly significant degeneration with a degenerative type effusion*". Despite the success of the arthroscopy, the consultant told Mr B he was likely to have some ongoing symptoms from the underlying degeneration within the knee. He advised Mr B regarding exercise and his weight.

Mr B saw a second consultant orthopaedic surgeon in January 2015 because of significant pain and stiffness mainly to the inside of his left knee. The second consultant said clinical examination and x-rays confirmed Mr B had arthritis in his inner knee whereas the other two compartments within the knee appeared to be "*well preserved*". He recommended a partial knee replacement, which is what Mr B paid to be done privately.

In April 2015, the second consultant said Mr B had recovered well from surgery. He said "*In the main his arthritic symptoms have all but disappeared now…*"

Mr and Mrs B argue Mr B wasn't formally diagnosed as suffering with arthritis of the inner knee until after the policy started. But that doesn't mean that condition wasn't pre-existing in line with the policy terms. That's because of how the terms describe a pre-existing condition – it's enough that there were symptoms experienced or advice given before a diagnosis was made. I believe that's what happened in this case.

Mr B's first consultant mentioned arthritis and found knee degeneration in the inner knee before the policy started. His second consultant's findings were consistent with the first's, to the extent he found arthritis in the same part of the same knee. Fortunately, replacement of that part of the knee appears to have gone well for Mr B. I know that degeneration and arthritis aren't always the same thing, although arthritis is a form of degeneration. In the circumstances, and given the absence of anything showing otherwise, I find it likely the arthritis Mr B suffered with after the policy started had also caused him problems before it started.

It's not that I think there was a connection between the arthritis Mr B claimed for with Aviva and the tear he claimed for with his previous insurer. Rather, I believe Aviva's shown the arthritis – whether diagnosed or not – was something Mr B had suffered symptoms of and/or received advice about in the five-year period before the policy started.

I realise Mr and Mrs B have referred to some general medical studies in support of their claim and complaint. While I've looked at what they've said and considered it carefully, I've placed more weight on Mr B's personal medical information and the findings of his treating doctors in reaching my decision. That's because I think that's the information most relevant to Mr B's condition.

Overall, I think it was fair for Aviva to turn down Mr B's claim. I think it handled the claim appropriately.

my final decision

For the reasons given, I've decided not to uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr and Mrs B to accept or reject my decision before 11 April 2016.

Nimish Patel
ombudsman