DRN-3728920

The complaint

Ms B complains that Vitality Health Limited has turned down a claim she made on a private medical insurance policy.

What happened

The background to this complaint is well-known to both parties, so I've set out a brief summary of the key events.

In September 2019, Ms B took out a personal private medical insurance policy. This policy was underwritten on a 'moratorium' basis, which meant that Vitality wouldn't provide cover for any pre-existing medical conditions a policyholder had had (including symptoms of that condition) in the five years before the policy was taken out.

In March 2020, Ms B was diagnosed with Benign Paroxysmal Positional Vertigo (BPPV) by a neurologist and she made a claim on her policy. Vitality turned down Ms B's claim. That's because it concluded the medical evidence showed that Ms B had suffered symptoms of BPPV in the five years before the policy had been taken out.

Ms B was unhappy with Vitality's decision and so she asked us to look into her complaint.

Our investigator didn't think Ms B's complaint should be upheld. He thought the medical evidence did indicate that Ms B had been suffering from symptoms of BPPV in the five years before the policy was taken out. So he thought it'd been fair for Vitality to turn down the claim.

Ms B disagreed and so the complaint was passed to me to decide.

Subsequently, I asked for additional medical evidence from Ms B's treating neurologist about her condition. The consultant provided further evidence and concluded with the following statement:

'*In my opinion, the BPPV found in March 2020 definitely represented a new diagnosis or problem (of <2 months duration),and was not a chronic or pre-existant* (sic)*condition*.'

I asked Vitality for its comments on the neurologist's evidence. In brief, it responded to say that it could now accept the claim, at least for the additional consultation and diagnostic tests. It asked Ms B to forward invoices to allow it to review the contribution it could provide for Ms B's condition. And it said that it couldn't fully cover the costs of treatment or diagnostic tests which hadn't taken place at a hospital on Ms B's 'list.' So I put Vitality's offer to Ms B. Ms B didn't accept the offer. She felt the offer included too many conditions. She disputed that she'd had treatment which had taken place off-list. She referred to previous surgery she'd undergone and Vitality's contribution to it, which she said showed its policy was fluid and varied from case to case. She requested that I direct Vitality to pay her claim in full, given it had ignored medical facts and there was ambiguity in the way it had interpreted her

medical condition. She asked whether I could reprimand Vitality.

I issued a provisional decision on 13 September 2022. In my provisional decision, I explained why I intended to direct Vitality to reconsider Ms B's claim, in line with the remaining terms and conditions of the policy. I said:

'First, it's important that I explain our role. We're not the industry regulator and so we have no power to punish or fine the financial businesses we cover. Our role is to look into individual complaints brought by consumers where a consumer feels a business has done something wrong which has caused them to lose out. And if we think a financial business has made an error, we consider what it should do to put things right.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And they mustn't turn down claims unreasonably.

There's no dispute that the terms of Ms B's contract with Vitality exclude pre-existing conditions a policyholder has suffered from in the five years before a policyholder took out their policy – including symptoms of that condition. Based on the medical evidence provided to it, Vitality concluded that Ms B had been suffering from symptoms of BPPV in the relevant moratorium period. The medical evidence on the claim form completed by a GP stated that Ms B had suffered from dizziness (a symptom of BPPV) in September 2015 and headaches (another symptom of BPPV) and dizziness in March 2017. Both of these episodes happened in the five years before the policy was taken out.

However, it has now had the chance to consider the new evidence provided by Ms B's consultant neurologist, which I've referred to above. This states unequivocally that Ms B's condition definitely represented a new diagnosis, which wasn't pre-existing. This ties-in with further evidence provided in June 2021 by the GP who completed Ms B's claim form, which stated that Ms B's symptoms had represented a different, newly diagnosed condition. Vitality did ask Ms B's consultant for further information about Ms B's condition at that point, which it said indicated that Ms B's symptoms had been present for some time. But, following its review of the new evidence from the consultant, Vitality has now agreed to accept the claim and to consider it, albeit it has stated that it won't be in a position to fully cover any tests or treatment which took place off-list.

I was pleased to note that Vitality has now agreed to accept and consider this claim. For completeness, I should make clear that based on the neurologist's evidence, had Vitality not overturned its original claims decision, I would've directed it to do so and to reassess the claim without reference to the pre-existing condition exclusion.

Nonetheless, I'm not planning to direct Vitality to pay Ms B's claim. Ms B complained to us that Vitality had declined her claim because it considered it to be caught by the moratorium. Vitality has now accepted the claim and so I think it's reasonable for Vitality to be given an opportunity to reconsider it in line with the remaining terms and conditions of its contract with Ms B. It will be for Ms B to provide Vitality with the evidence it requires to determine which of Ms B's costs are covered by the policy terms and conditions – whether fully, partially or potentially not covered. I don't have copies of Ms B's invoices and it would be inappropriate for me to direct Vitality to pay a claim when it hasn't had sight of all of the claims information it needs to assess the claim, or to check which costs are payable.

Ms B says that she hasn't had treatment 'off-list'. Again, this is something for Vitality to determine when it assesses the claim in line with the policy terms and conditions. I note that Ms B's policy doesn't fully exclude claims for treatment in a hospital which isn't on her list – the policy states that Ms B will need to pay 40% of her treatment costs at an off-list hospital. But as I've set out, it would be inappropriate for me to make a finding about Vitality's actual

policy liability before it has had an opportunity to reconsider Ms B's claim taking into account all of the evidence it requires.

If Ms B is unhappy with any settlement she receives, it's open to her to make a new complaint to Vitality about this point. We may then be in a position to consider a new complaint about that issue alone.

Overall, I currently find that the fair outcome to this complaint is for Vitality to reconsider Ms B's claim, without reference to the pre-existing condition exclusion and in line with the remaining terms and conditions of the policy.'

I asked both parties to provide me with any further evidence or comments they wanted me to consider.

Vitality accepted my provisional findings.

Ms B made further submissions. She felt that her GP had provided the same comments about her medical condition in February 2020 which the neurologist had recently provided. She felt Vitality had ignored this evidence. She said that previously, Vitality had agreed to pay 80% of the costs of treatment at an off-list hospital, rather than 60%. She maintained that she would like Vitality to pay her claim in full to allow her to forget the stress it had caused her.

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 still find that the fair outcome to this complaint is for Vitality to reconsider Ms B's claim, without reference to the pre-existing condition exclusion, and in line with the remaining terms and conditions of the policy.

I accept that over two years have passed since Ms B made her claim and I don't doubt that she has found the situation frustrating and upsetting. I also acknowledge that, in June 2020, a GP indicated that Ms B's condition was different and unrelated to anything she'd had before.

But the medical evidence which had been provided to Vitality in March 2020, by Ms B's neurologist, suggested that she had experienced symptoms of headaches and dizziness before taking out the policy. And the claim form completed in 2020 (by the GP who later sent the June 2020 letter), stated that Ms B had suffered from symptoms of BPPV in the form of headaches and dizziness in the five years before the policy was taken out. Taken together, this evidence had been suggestive that Ms B may have been suffering from symptoms of BPPV in the five years before the policy began. So I don't think it was unreasonable for Vitality to place more weight on the specialist evidence of the neurologist and the information on the claim form when it initially assessed the claim.

However, upon review of the neurologist's new evidence, Vitality has now agreed to accept this claim. And I'm still persuaded that this is a fair and appropriate response from Vitality. As I explained in my provisional decision, I don't think I could fairly direct Vitality to *pay* Ms B's claim. That's because I still think it's fair for Vitality to be provided with an opportunity to request any additional evidence it may need and consider the costs Ms B has claimed for in line with the remaining terms and conditions of the policy. And it remains the case that I don't think it would be reasonable for me to determine Vitality's actual liability before it's had the chance to consider the claim further and take into account any additional evidence it

requires.

So my final decision is that Vitality must reconsider Ms B's claim, without reference to the pre-existing condition exclusion and in line with the remaining terms and conditions of the policy. It will be for Ms B for provide Vitality with any reasonable evidence it may need to reassess this claim.

My final decision

For the reasons I've given above and in my provisional decision, my final decision is that uphold Ms B's complaint.

I direct Vitality Health Limited to reconsider Ms B's claim, subject to the remaining terms and conditions of the policy.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms B to accept or reject my decision before 28 October 2022.

Lisa Barham
Ombudsman