DRN-4656701

The complaint

Mr S complains about the way Vitality Health Limited handled a claim he made on a personal private medical insurance policy.

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 main events.

In January 2022, Mr S took out a personal private medical insurance with Vitality on two-year moratorium underwriting terms. This meant that Vitality wouldn't cover any pre-existing medical conditions a policyholder had had in the five years before the policy began. However, a condition could become eligible if a policyholder had been 'trouble-free' for at least two continuous years after the policy began.

Unfortunately, in June 2023, Mr S suffered a heart attack. He was diagnosed with severe coronary artery disease and mitral valve regurgitation. His medical team concluded that he needed urgent coronary artery bypass graft (CABG) and mitral valve surgery. So Mr S made a claim on the policy.

Vitality looked into Mr S' claim. It assessed the medical evidence Mr S had provided and felt that it needed further medical information in order to determine whether the claim was covered. Ultimately, it concluded that the CABG surgery fell with the scope of the moratorium and therefore, wasn't covered. That's because it noted Mr S had suffered a heart attack in 2004 and had been on medication ever since. It also noted that it had paid for Mr S to undergo a cardiac MRI scan in 2018.

While Vitality continued to consider whether or not the mitral valve surgery was covered, Mr S underwent surgery on the NHS for both conditions in August 2023. Vitality later concluded that it would have authorised Mr S' claim for mitral valve surgery and it agreed to assess a claim for NHS cash benefit.

Mr S was unhappy with the way Vitality had handled his claim. He didn't agree that his claim for CABG was excluded by the moratorium terms. And he felt there'd been unreasonable delays in Vitality's assessment of the claim. He asked us to look into his complaint.

Our investigator didn't think Mr S' complaint should be upheld. He felt it had been fair for Vitality to conclude that Mr S' CABG surgery was excluded by the moratorium clause. And he didn't think Vitality had caused unfair or excessive delays in the handling of the claim.

Mr S disagreed and so the complaint's been 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, whilst I'm very sorry to disappoint Mr S, I don't think Vitality handled his

claim unfairly and I'll explain why.

First, I'd like to reassure Mr S that while I've summarised the background to his complaint and his detailed submissions to us, I've carefully considered all he's said and sent us. In this decision though, I haven't commented on each point that's been raised and nor do our rules require me to. Instead, I've focused on what I think are the key issues.

I must also make it clear that this decision won't consider the way Vitality went on to handle Mr S' claim for cash benefit after he underwent surgery on the NHS. That's because that particular point has been considered separately by our service.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. So I've considered, amongst other things, the terms of Mr S' policy and the available evidence, to decide whether I think Vitality treated Mr S fairly.

Was it fair for Vitality to conclude that the claim for CABG surgery was excluded by the moratorium clause?

I've first considered the policy terms and conditions, as these form the basis of the contract between Mr S and Vitality. When Mr S took out the personal policy, he did so on moratorium underwriting terms. The policy terms explain what Vitality means by moratorium underwriting as follows:

'We don't pay claims for the treatment of any medical condition or related condition which, in the five years before your cover started:

- *you have received medical treatment for, or*
- *had symptoms of, or*
- *asked advice on, or*
- *to the best of your knowledge and belief, were aware existed.*

This is called a 'pre-existing' medical condition.

However, subject to the plan terms and conditions, a pre-existing medical condition can become eligible for cover providing you have not;

- *consulted anyone (e.g. a GP, dental practitioner, optician or therapist, or anyone acting in such a capacity) for medical treatment or advice (including check-ups), or*
- *taken medication (including prescription or over-the-counter drugs, medicines, special diets or injections)*

for that pre-existing medical condition or any related condition for two continuous years after your cover start date.'

Vitality has also defined what it means by 'treatment' as follows:

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

Vitality assessed the available medical evidence, including with clinical members of its staff. And it felt Mr S' significant coronary artery disease was a pre-existing condition, meaning that the CABG surgery wasn't covered. So I've carefully considered the medical evidence to decide whether I think this was a fair conclusion for Vitality to draw.

I've looked carefully at the claim form which was completed by Mr S and his GP. The claim form asked the GP whether Mr S had any other medical conditions which might be related and to detail those conditions below. The GP noted that in 2004, Mr S had been diagnosed with single vessel coronary artery disease. And they stated that they felt it was related to Mr S' claim due to *'pre-existing IHD'* (ischaemic heart disease). Later in the form, again, the GP stated that Mr S had '*hx* [history] *of coronary artery disease in 2004.*'

In 2018, Vitality paid for Mr S to undergo a cardiac MRI. Mr S says he was suffering from indigestion at that time, although the cardiologist's letter of January 2018 says that Mr S was suffering from breathlessness and a heavy feeling in his chest on exertion. It also referred to Mr S suffering from left-sided chest pains. The letter recorded that Mr S took daily cardiac medication – and it appears that Mr S had continued to take this medication daily at the point of the claim in 2023. The MRI results from 2018 didn't show significant new arterial narrowing and Mr S says his symptoms passed.

It's clear that Mr S was diagnosed with coronary artery disease and undergone surgery around 18 years before the policy was taken out. However, it also appears that Mr S had continued to take daily cardiac medication from 2004 onwards. And the cardiologist's report indicates that Mr S had experienced chest pain and breathlessness in 2018, which had necessitated investigations in the form of an MRI.

Vitality's clinical team reviewed the evidence and concluded that Mr S' previous history, including the claim in 2018 and his ongoing medication, were linked to his 2023 CABG claim and accordingly excluded by the terms of the moratorium. Based on the evidence I've seen; I don't think this was an unreasonable position for Vitality to take. I say that because the evidence indicates Mr S was diagnosed with coronary artery disease in 2004 and has been taking medication for it since that point. And it does seem that Mr S underwent treatment (as defined by the policy terms) for symptoms of chest pain and breathlessness in 2018 – around four years before the policy was taken out. Therefore, I don't think Vitality acted unreasonably when it concluded that Mr S' condition fell within the five year moratorium period and was therefore excluded from cover.

As I've said, it seems Mr S was taking daily cardiac medication since 2004. So I don't think it was unfair for Vitality to conclude that Mr S hadn't met the two year trouble-free period either. I'd add that when Vitality referred to a 'two-year' moratorium on Mr S' policy certificate, it meant the potential for pre-existing conditions to become eligible if a policyholder had been trouble-free for a continuous two-year period after the policy began.

On that basis, I don't think I could fairly conclude that Vitality acted unreasonably when it declined to cover the costs of Mr S' CABG surgery (although I appreciate it agreed to cover any costs up to diagnosis).

At the point Mr S underwent surgery on the NHS, Vitality was still considering whether or not to authorise the valve surgery. It later said this claim would've been met. But based on the available medical evidence, I can understand why Vitality wanted to satisfy itself that this part of the claim too wasn't caught by the moratorium clause.

Did Vitality unreasonably delay the assessment of Mr S' claim?

I appreciate that Mr S' surgery was classed as urgent. It's clear how worried he was about the risks of potential delays in him receiving the surgery he needed. But based on all I've seen; I do think Vitality took prompt and appropriate steps when it assessed Mr S' claim. It requested medical evidence in timely way; it referred the claim internally when it was appropriate for it to do so and it continued to move the claim forwards. I haven't seen enough evidence to show, on balance, that Vitality failed to take action or progress the claim

promptly.

And I also think Vitality's notes show that it took reasonable steps to keep Mr S' wife up to date with how it was assessing the claim and what the next steps were. I understand that Mr S feels Vitality didn't do enough to keep him updated and I appreciate it did make incorrect references to information in Mr S' medical notes. But I'm not persuaded there were unreasonable delays, material errors or failures to communicate that would lead me to find that Vitality should pay Mr S compensation for material distress and inconvenience.

Overall, I sympathise with Mr S' position, as I appreciate he was in a difficult and worrying situation. But I don't find that Vitality handled his claim unfairly or unreasonably.

My final decision

For the reasons I've given above, my final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr S to accept or reject my decision before 16 April 2024.

Lisa Barham
Ombudsman