DRN-5284606

The complaint

Mr T complains that Vitality Health Limited has declined a claim under a private health insurance policy.

What happened

Mr T held private health cover through his employer, provided by Vitality. The policy was underwritten on a moratorium basis, and the start date of the policy was 1 July 2022. This meant that treatment for pre-existing medical conditions Mr T had in the five years prior to taking out the policy were excluded from cover for at least the first two years. These could become eligible for cover if the policyholder hadn't received any treatment, advice or medication for those conditions for two continuous years after the cover start date.

Mr T made a claim for back issues in April 2023. Vitality first authorised and paid for the treatment, but it declined to pay for further treatment on 28 May 2024 as it thought Mr T's lower back issue was a pre-existing condition as per the policy terms. Vitality acknowledged it hadn't always given Mr T the appropriate level of service, so it offered him £200 to compensate for the distress and inconvenience caused. Unhappy with Vitality's position, Mr T brought a complaint to our service.

One of our investigators looked into the complaint. Having done so, she thought Vitality had acted fairly and reasonably when it declined the claim, for the reasons it did. She also thought the compensation Vitality had offered was fair in the circumstances.

Mr T didn't agree. He doesn't think we've investigated his complaint appropriately, including consulting relevant medical professionals. As no agreement was reached, the complaint has 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.

Firstly, I've only considered Mr T's complaint about Vitality refusing to cover the treatment on his lower back, as that's the complaint he originally brought to us.

Industry rules set out by the regulator (the Financial Conduct Authority) say insurers must handle claims fairly and shouldn't unreasonably reject a claim. I've taken these rules, and other industry guidance, into account when deciding what I think is fair and reasonable in the circumstances of Mr T's complaint.

The Moratorium Clause is set out in the policy terms and conditions 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."

The policy defines a related condition as follows:

"A related condition is any symptom, disease, illness or injury which reasonable medical opinion considers to be associated with another symptom, disease, illness or injury. It could be deemed to be an underlying cause of, or directly caused by, another medical condition."

Mr T saw a specialist on 27 March 2024 who diagnosed him with disc extrusion in his cervical spine and disc prolapse in his lumbar spine (left L5/S1). The specialist said in the report that Mr T had *"been experiencing pain in [his] lumbar spine and cervical spine for the past two years"*. The specialist further noted that *"In November 2022, you started to experience left-sided low back pain associated with left leg sciatica"*.

Vitality declined the claim on 28 May 2024. It said that as Mr T had experienced pain in his spine for the past two years, this meant that his symptoms started before the policy start date of 1 July 2022. So, Vitality considered the condition pre-existing.

Mr T then asked the specialist to amend the duration of symptoms as this wasn't correct. The specialist amended the letter on 3 June 2022 to say *"for the past 18 months"* instead of two years. Mr T says his lower back symptoms started in November 2022. The specialist recommended surgery on Mr T's lower back.

Vitality said this amendment put the onset of symptoms to September 2022, which wasn't in line with Mr T saying the symptoms started in November 2022. So, Vitality asked for Mr T's medical records to assess the claim further. After reviewing these, Vitality maintained its position to decline the claim. I've looked through the medical records and considered what both parties have said.

Firstly, I haven't placed much weight on the specialist changing the date in the March 2024 report. I say this because this report refers to discussing Mr T's clinical history and symptoms. So, the report doesn't suggest the specialist reviewed Mr T's full medical records at the time.

Vitality says the physiotherapy notes in October 2019 show Mr T had experienced back pain during the moratorium period. Mr T says this wasn't related to his claim, as he was diagnosed with a gluteal muscular strain. He says this isn't related to a prolapsed disc, which was the diagnosis in March 2024. I can see that these notes refer to both *"back pain"* and *"gluteal pain"*, as well as *"LBP/Coccyx pain"* for 2 years. The notes also refer to *"lumbar spine referral"* and *"gluteal deficiency"*.

The GP notes on 20 February 2023 refer to *"intermittent low back pain"* and *"pin point pain – coccyx area"*. And the notes on 4 August 2023 say that *"discussed how over the last 16 months he has had neck pain, back pain (slipped discs) and has been seeing spinal team at [….]"*. Vitality says this means Mr T's symptoms started before the policy start date.

Having considered the evidence, I don't think Vitality acted unfairly or unreasonably when it considered Mr T's lower back issue to be pre-existing, as per the policy terms, based on the evidence it had. I appreciate Mr T says the issue in October 2019 was a gluteal muscular strain, but the contemporaneous notes refer to both back pain and gluteal pain, and they specifically mention a lumbar spine referral. I also note that the records in October 2019 and August 2023 both refer to pain in coccyx. So, I think the evidence shows Mr T experienced lower back pain during the moratorium period, and Mr T's claim with Vitality was for lower back pain.

I appreciate there is no diagnosis for Mr T's lower back pain in 2019. But the definition of a pre-existing condition includes symptoms of a condition, as well as a related condition. If Mr T has further medical evidence to show his symptoms in the five years before his policy started were unrelated to his claim, he can send this to Vitality in the first instance.

Mr T has said we should consult a spinal doctor and a physiotherapist when considering his complaint. However, it's for the parties of the complaint to provide the evidence they want us to consider. And as I'm not a medical professional, my role is to look at the evidence provided, and decide if Vitality has acted fairly and reasonably in light of that evidence, as I've done here.

It's clear that Vitality didn't handle everything as it should have done. It's acknowledged that it didn't issue Mr T a formal decline letter in May 2024, and it didn't call him back as promised. I also think it should have done more to keep Mr T updated during his claim. It would have also been frustrating to first have his claim authorised, but then later declined. Overall, I think Vitality's offer to pay Mr T £200 for the distress and inconvenience caused is fair and reasonable.

My final decision

My final decision is that the offer Vitality Health Limited has made is fair and reasonable, and so I direct it to pay Mr T £200 for the distress and inconvenience caused.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr T to accept or reject my decision before 21 February 2025.

Renja Anderson
Ombudsman