DRN-5547019

The complaint

Miss L complains that Vitality Health Limited turned down a claim she made on a group private medical insurance policy.

What happened

Miss L has been insured by her employer's group private medical insurance policy since November 2021. The contract is underwritten on moratorium terms and Miss L holds 'Consultant Select' cover. This means that if an insured member needs treatment, Vitality will choose a consultant for them from its approved list.

In January 2023, Miss L had made a claim for low back pain. Vitality ultimately turned down that claim because it said her GP had provided evidence that she'd suffered from lower back issues in the five years before she joined Vitality. So it said the claim was excluded by the terms of the moratorium.

In April 2024, Miss L underwent an MRI scan, which found a large spinal disc protrusion, which was pressing on her cauda equina nerve roots. Miss L's GP therefore referred her to a spinal, orthopaedic specialist. Miss L also spoke with Vitality's GP service.

On 23 April 2024, Miss L saw a specialist, who I'll call Dr C. He recommended that Miss L should undergo spinal surgery, which was booked in for 26 April 2024.

So Miss L made a claim on the policy for the costs of the surgery. However, Vitality turned down the claim. It told Miss L that the cause of her claim was linked to her pre-existing back issues and therefore, wasn't covered by the policy terms. It also told Miss L that neither Dr C nor the hospital where she planned to undergo surgery were covered under the terms of her plan. It sent Miss L a list of consultants who were on her 'list' but told Miss L she'd need to self-fund treatment.

On 24 April 2024, Miss L sent Vitality a copy of a letter from Dr C which, in brief, stated that Miss L's disc protrusion was recent and acute and had likely happened in the past month or so. Vitality reviewed Dr C's letter later that day but its claims decision remained unchanged. It emailed Miss L on 25 April 2024 to confirm it was still declining the claim and it also spoke with Miss L's mother later that day to reiterate that it didn't think the claim was payable. It maintained that Dr C wasn't covered by Miss L's plan.

Miss L's mother made a complaint on Miss L's behalf. And on 26 April 2024, Miss L underwent surgery with Dr C as planned.

In early May 2024, Vitality reviewed Miss L's claim again. Based on Dr C's letter, it concluded the claim wasn't excluded by the terms of the moratorium. But it didn't agree to reimburse Miss L for her costs because it said she'd chosen to undergo surgery at an off-list hospital and with a consultant who wasn't covered by her plan. It offered to pay Miss L £100 compensation.

Miss L was very unhappy with Vitality's position and she asked us to look into her complaint.

Our investigators thought Miss L's complaint should be upheld. In summary, they accepted that neither the hospital nor Dr C were covered by the terms of Miss L's plan. But they felt Vitality had had the information it needed to accept the claim before Miss L underwent surgery. And they considered that if Vitality had accepted the claim when it should have done, Miss L would have opted to cancel the surgery with Dr C and undergone surgery with a specialist who was covered by the plan and at a facility which was on her approved list. So they felt Miss L had lost out as a result of Vitality's mistake and they recommended that it should pay her claim plus interest.

And the investigators also felt that Vitality hadn't handled its calls with Miss L as well as it could have done, which had caused her unnecessary trouble and upset. So they recommended that Vitality should pay Miss L £200 compensation.

Vitality disagreed. It didn't think it had had enough time to assess the claim fully. And it felt it had made it clear that neither Dr C nor the facility he worked at were covered by Miss L's plan. It considered Miss L had always planned to undergo treatment with Dr C and it was unfair to require it to pay Miss L's full costs. However, it did agree to pay 60% of Miss L's surgical costs and so we put this offer to Miss L.

Miss L didn't accept Vitality's offer and therefore, 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, I don't think Vitality has treated Miss L fairly and I'll explain why.

First, I do hope Miss L has made a good recovery from her surgery. I appreciate this was a very worrying time for her and for her family.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. I've taken those rules into account, amongst other relevant considerations, such as regulatory principles, the policy terms and the available evidence, to decide whether I think Vitality treated Miss L fairly.

I've first considered the policy terms and conditions, as these form the basis of the insurance contract between Miss L's employer and Vitality. Miss L's cover was underwritten on moratorium terms. This means that Vitality won'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.'

Miss L made a claim to Vitality for treatment of low back pain in January 2023. Information sent by Miss L's GP at that time showed that she'd sought advice for low back pain in 2018 and 2019. Therefore, Vitality had concluded that Miss L's claim was caught by the terms of the moratorium.

The Vitality GP report of April 2024 stated that Miss L had had low back pain for several years. And Miss L's GP referral letter of April 2024 also said that Miss L had had back pain for over 10 years. So I don't think Vitality acted unreasonably by concluding that the cause of the claim was likely a pre-existing condition, given the evidence it had available when Miss L initially got in touch to make the claim. I also don't think it was unfair at this point for Vitality to have turned the claim down and directed Miss L to Vitality consultants who she could self-pay for surgery.

However, on 24 April 2024, Miss L sent Vitality a copy of Dr C's letter. This said:

'*You have a recent acute disc prolapse at the L4-5 level. This is something that is likely to have happened over the past month or two and your back pain may be due to other levels or facet joint issues in the past but this disc prolapse looks more recent.'*

Vitality's records show that Dr C's letter was reviewed at 16.56 on 24 April 2024 – the day it was sent the report. This was an extremely prompt review by Vitality. I can see from the notes that Vitality didn't think this letter was sufficient evidence to show that Miss L's condition wasn't linked to her previous back pain. So it noted it needed more information.

On 25 April 2024, at 08.11, Vitality emailed Miss L *'to advise spec(ialist) letter doesn't change decision.'* Later that afternoon, Vitality confirmed its decision to Miss L's mother over the phone. It told Miss L's mother that the claim had been escalated to a more specialised team and that the decision wouldn't change. It's clear Vitality reiterated to Miss L's mother that surgery under Dr C wouldn't be covered.

Vitality accepts that it should have accepted the claim based on Dr C's letter of 23 April 2024. I think Dr C's letter set out a persuasive, expert medical opinion that Miss L's surgery was necessary due to a new, acute condition and wasn't linked to a pre-existing back issue. So I think it ought to have accepted the claim upon its initial review of this letter. However, Vitality didn't change its cover decision until 9 May 2024. By this time, Miss L had already undergone surgery and incurred significant costs. Vitality acknowledges that it therefore made a mistake when it assessed this claim. And therefore, I'll go on to explore whether I think Vitality's error led Miss L to suffer a financial loss she wouldn't otherwise have done and, if so, how I think it should put things right.

Generally, I wouldn't reasonably expect an insurer to assess a piece of medical evidence the day it's received. And I accept that the timeframe between Miss L seeing Dr C and the date of the surgery on 26 April 2024 was very short. In some cases, I might conclude that Vitality couldn't reasonably have been expected to assess all of the available evidence and make a claims decision in such a short space of time. I'm also mindful that Miss L opted to seek treatment with a specialist who was 'off-list' and at a hospital which wasn't covered by her plan either.

But based on the specific circumstances of this complaint, I think Vitality had all of the evidence it needed to accept Miss L's claim on 24 April 2024, when it received and – as its own records show - assessed Dr C's letter. It maintained its decision to turn down Miss L's claim. If it had correctly admitted Miss L's claim either on 24 or 25 April 2024, I agree with our investigators that it's most likely Miss L would have chosen to cancel her surgery with Dr C, Instead, I think she'd have most likely arranged treatment with a specialist from the list of approved consultants Vitality had sent her two days earlier. It seems to me there would have been little benefit to Miss L remaining under Dr C's care if her full costs could be met by Vitality. And Miss L has also sent me evidence from Dr C's medical secretary which definitively states that Miss L wouldn't have been charged a cancellation fee, either by Dr C or the treating hospital, if she'd cancelled the surgery on 25 April 2024. Therefore, it doesn't seem Miss L would've incurred any financial penalty had she cancelled her surgery and

arranged treatment which would be fully covered by Vitality.

Nor do I think it was unreasonable for Miss L to have opted to see Dr C in the first place. She'd been told upfront that her claim wouldn't be covered and she was sent a list of specialists who she could self-pay to see. I wouldn't have expected her to choose one of Vitality's specialists when there was no indication it would go on to accept her claim. And, as I've said, given Vitality had maintained its decision to turn down her claim despite Dr C's letter, I don't think it was unreasonable for her to have remained under his care when she believed she'd need to pay for the surgery herself. Had Vitality correctly admitted the claim on 24 or 25 April 2024, I'm satisfied Miss L would have sought treatment with one of Vitality's consultants.

As such, based on the very specific facts of this complaint, I think that if Vitality had accepted Miss L's surgery when I think it ought to have done, Miss L wouldn't have incurred any surgical costs at all. So I think Vitality's mistake caused her to suffer the loss of the full costs of the surgery she underwent on 26 April 2024, as well as interest on the savings she withdrew to pay for the treatment.

Therefore, I don't think that in this case, Vitality's offer to settle 60% of Miss L's surgical costs is fair and reasonable or that it reflects the losses I think it likely caused. Instead, I find that Vitality must settle Miss L's claim for the costs of her surgery, in line with the remaining terms and conditions of the policy. I find too that it must add interest to the settlement at an annual rate of 8% simple from the date Miss L paid for the surgery until the date of settlement, to reflect the interest Miss L lost on her savings and access to that money.

I also agree with our investigators that Vitality didn't handle Miss L's claim as well as it could and should have done. It was aware that Miss L had vulnerabilities and I think it put her to unnecessary time, trouble and upset in dealing with the claim when I think it could have accepted it some days earlier than it did. I've borne in mind that she'd already been through significant surgery too. Therefore, I also find that a compensation award of £200 is fair, reasonable and proportionate in all the circumstances to reflect the trouble and upset I think Vitality's errors caused Miss L.

Putting things right

I direct Vitality Health Limited to:

- Settle Miss L's claim for the costs of her surgery on 26 April 2024, in line with the remaining terms and conditions of the policy;
- Add interest to the settlement at an annual rate of 8% simple, from the date Miss L paid for the treatment until the date of settlement*; and
- Pay Miss L total compensation of £200.+

*If Vitality considers that it's required by HM Revenue & Customs to deduct income tax from that interest, it should tell Miss L how much it's taken off. It should also give Miss L a tax deduction certificate if she asks for one, so she can reclaim the tax from HM Revenue & Customs if appropriate.

+Vitality must pay the compensation within 28 days of the date on which we tell it Miss L accepts my final decision. If it pays later than this, it must also pay interest on the compensation from the deadline date for settlement to the date of payment at 8% simple a year.

My final decision

For the reasons I've given above, my final decision is that I uphold this complaint and I direct Vitality Health Limited to put things right as I've outlined above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss L to accept or reject my decision before 14 July 2025.

Lisa Barham
Ombudsman