DRN-5818956

The complaint

Mr and Mrs R are unhappy with Vitality Health Limited's decision to maintain its declinature of their claim.

(As this complaint relates solely to Mr R, I'll refer to all submissions as being made by him personally).

What happened

Mr R was diagnosed with type two diabetes in July 2024 and was prescribed medication to help control his symptoms. He brought a complaint to this service previously about Vitality's decision to decline his claim to see a specialist related to his condition. That complaint wasn't upheld because our investigator was satisfied Vitality had fairly determined his diabetes was a chronic condition and relied on its chronic exclusion to decline the claim.

Since then, however, Mr R said the intended appointment with the specialist wasn't to manage his condition, rather it was to determine which test should be used to measure it, and to rule out type one diabetes. This wasn't an argument Mr R had made previously and so he brought this complaint about that point in particular. Mr R said at least part of the appointment was of a diagnostic nature (ruling out type one diabetes) and so Vitality should look to cover at least part of the £200 fee.

Vitality said it declined to cover the cost because the appointment was for the management of a chronic condition. It said Mr R's type two diabetes was well controlled and so there wasn't an acute flare up that needed to be addressed. It said the new complaint point doesn't alter its view that this appointment was for the management of his type two diabetes and so maintained its position on the claim.

Our investigator didn't uphold this complaint. She said the reason for the referral to the specialist was so that Mr R could better understand which test, the HBA1c or the fructosamine, would be most appropriate to monitor his type two diabetes. She accepted there was a question to be answered about whether Mr R had type one diabetes, but she said this constitutes management of his chronic condition and therefore Vitality had declined his claim in line with the policy terms.

Mr R, unhappy with this, asked for an ombudsman to consider his case. In summary, he said he'd been actively trying to reverse the effects of his diabetes through a healthy diet and had managed to lose enough weight that his condition is now in remission. He explained he suffers with another chronic condition, thalassaemia, which can affect the monitoring of his type two diabetes and that he needed the appointment to better understand how he should measure it moving forward. He maintains Vitality should cover at least part of the cost because the specialist tested for type one diabetes. And so, I must now reach a final decision.

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.

I'm mindful to not revisit the merits of Mr R's previous case and so I'll focus solely on whether the appointment was for the management of his chronic condition of type two diabetes. Having done so, I've also decided not to uphold Mr R's complaint and for the same reasons explained by our investigator. I agree Mr R wanted the appointment to better understand how to monitor his diabetes, given the perceived impact his thalassaemia could have on the HB1Ac test. But I'm persuaded by Vitality's argument that it considers that to be monitoring of a chronic condition and therefore is caught by the policy exclusion. I'll explain why.

The relevant rule in this case comes from the Insurance Conduct of Business Sourcebook (ICOBS) which, in summary, says Vitality must handle claims promptly and fairly and must not reject a claim unreasonably. I've thought about Vitality's obligations under ICOBS whilst considering Mr R's case. Mr R has referred to other pieces of industry guidance, like the Consumer Rights Act 2015 and said Vitality's terms are ambiguous and should be considered in his favour. To be clear, I've considered that too, however, ICOBS is the most appropriate test in this case because the complaint he's brought is about Vitality's refusal to pay his claim.

The relevant terms say about chronic conditions;

"What is a chronic condition?

A 'chronic condition' is a disease, illness, or injury that has at least one or more of the following characteristics: • it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and/or tests • it needs ongoing or long-term control or relief of symptoms • it requires your rehabilitation or for you to be specially trained to cope with it • it continues indefinitely • it has no known cure • it comes back or is likely to come back"

I'm satisfied Mr R's type two diabetes falls within the policy's definition of a chronic condition. This was addressed in the previous case, but for contextual purposes, I think it's appropriate to set that out here. There are instances where Vitality will look to cover treatment for a flare up of a chronic condition, but the medical evidence in this case shows Mr R's diabetes was being managed well alongside his weight loss. His blood sugar readings showed he was within the non-diabetic tolerance range in March 2025 and so I'm satisfied there was no flare up or sudden deterioration in his condition.

The evidence I've seen says Mr R spoke with a private GP and asked for an appointment with the specialist. He wanted to see an endocrine specialist as he was concerned about the impact his thalassaemia had on the monitoring of his blood sugars in the context of his type two diabetes. The following was noted by his private GP;

"Discussed endocrine referral not always needed for new diabetic patients, but I agree with his minor thalassaemia it would be helpful for endocrine review re: any additional testing needed for blood sugar monitoring"

Mr R said he also wanted to discuss reducing his tablet medication as he'd been actively trying, and succeeding, to lose weight. And so, I'm persuaded that was the reason for the referral to the endocrine specialist. I should say I'm satisfied this is considered management of his type two diabetes and so Vitality's decision to rely on the chronic exclusion is fair.

Mr R subsequently said during the appointment, the consultant recommended he be tested for type one diabetes, and gave advice about which blood sugar test he should use moving forwards. He said it's for these reasons, Vitality should cover some of the cost as testing for

type one diabetes is of a diagnostic nature, for which he's covered by the policy. But I'm not persuaded by his argument on that point. I say that because Mr R was already diagnosed with diabetes in July 2024, therefore any further testing or monitoring of this condition is caught by the chronic exclusion condition.

After careful consideration of the consultant's report, it suggested he was concerned about Mr R's weight loss. He noted that although Mr R had actively been trying to lose weight, the consultant felt it was a little atypical. And so, he recommended a urine C peptide test and GAD antibodies test to better understand whether Mr R's diabetes was type one, rather than type two. This concern couldn't have been known to Mr R before he asked Vitality for the referral as it was only discovered by the consultant during the appointment. And so, Mr R would have always been responsible to pay for the cost of seeing that specialist as the reason he was referred was directly linked to the management of his chronic condition.

Further, the evidence shows Mr R was aware he'd need to pay the consultant's costs of £200 in January 2025 following its decision to decline his claim. This was more than two months before he was due to see the specialist in March 2025. I've also not seen any evidence that shows the consultant's recommendation for further testing increased the overall cost of that consultation. In addition, the evidence also shows Mr R intended to have the recommended tests completed through the NHS and so there were no additional costs incurred in that regard either.

Mr R argued the terms are unclear and that his expectations were unfairly raised. He said the terms don't explicitly state that the exclusion effectively overrides eligible diagnostic treatment. But I disagree. I think the terms are clear. They say;

"Exclusions – what's not covered

In this section, we have set out the medical conditions, treatment and tests that we do not cover on the plan. Any consultations, complications or subsequent treatment related to these exclusions are also not covered...Chronic conditions"

This means all treatment must be eligible treatment and the exclusions apply to all element of cover. This appointment was for the management of a chronic condition and therefore is excluded from cover.

But even if I agreed with Mr R's arguments and accepted his treatment wasn't related to the management of his chronic condition – and to be clear, I'm not saying I do – the specialist Mr R saw wasn't recognised by Vitality. And so, it's likely his claim still would have been declined because the specialist he saw in March 2025 wasn't part of its approved network.

My final decision

For the reasons I've explained, I don't uphold Mr R's complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs R and Mr R to accept or reject my decision before 5 February 2026.

Scott Slade
Ombudsman