DRN-4587789

The complaint

Mr E complains that Vitality Health Limited has turned down 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 key events.

In September 2022, Mr E took out a personal private medical insurance policy on moratorium underwriting terms. This meant that Vitality wouldn't cover any conditions Mr E had suffered from or had symptoms of in the five years before the policy began.

Around a week later, he self-referred for physiotherapy on his right knee. And a claim was set-up and authorised for five sessions of physiotherapy to treat Mr E's right knee pain. Mr E was told that if he needed further treatment, he'd need to complete a Condition Information Request (CIR).

Subsequently, in January 2023, Mr E made a claim for an MRI on his right knee. Mr E's GP provided a medical report which stated Mr E's symptoms had begun around seven months beforehand. So Vitality concluded that Mr E's symptoms had started before the policy began and the claim was therefore excluded by the terms of the moratorium. Mr E underwent the MRI at his own cost and he was found to have a small meniscus tear. The MRI also indicated that Mr E had symptoms of osteoarthritis.

Mr E was unhappy with Vitality's decision and he felt the medical report had included an error. His GP submitted further evidence stating that Mr E had indicated his pain had begun 'several months ago' rather than seven months ago. Vitality reviewed the evidence but felt it needed a CIR to be completed.

In May 2023, Mr E's policy was cancelled because his premiums hadn't been paid. A few weeks later, Vitality obtained copies of Mr E's medical records. It noted that in 2018, Mr E had undergone an MRI on his right knee, which had shown, amongst other things, osteoarthritis.

Meanwhile, in July 2023, Mr E met with a consultant, who I'll call Mr G, and he subsequently underwent right-knee surgery.

Based on the available evidence, Vitality maintained its decision to turn down Mr E's claim, although it agreed to pay the costs of his physiotherapy. It still concluded that Mr E's symptoms had likely begun before the policy start date. And it also noted that Mr E's consultation with Mr G and the surgery had taken place after the policy had been cancelled. So it said there was no cover for those costs. It added too that Mr G wasn't a recognised consultant under Mr E's chosen list.

Mr E remained unhappy with Vitality's decision and he asked us to look into his complaint. He was also unhappy that Vitality had wrongly shared details of another of its customers with

him.

Our investigator didn't think Vitality had treated Mr E unfairly. She thought it had been reasonable for Vitality to conclude that Mr E's claim was caught by the moratorium terms. And as Mr E had undergone treatment with Mr G after the policy had ended, she didn't think the costs he'd incurred were covered by the policy either. She accepted that Vitality had made a mistake with another customer's data. But she thought it had taken reasonable steps to put things right.

Mr E 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 E, I don't think Vitality has treated him unfairly and I'll explain why.

First, I'd like to reassure Mr E that while I've summarised the background to his complaint and his 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 he's raised and nor do our rules require me to. Instead, I've focused on what I think are the key issues.

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 E's policy and the circumstances of his claim, to decide whether I think Vitality treated him fairly.

The policy terms and conditions

I've first considered the policy terms and conditions, as these form the basis of Mr E's contract with Vitality. The policy was underwritten on moratorium terms. The moratorium clause says:

'*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.'

I think the policy terms make it sufficiently clear that Vitality won't pay claims if a policyholder has had symptoms of, asked advice for, or received treatment for the condition they're claiming for (or a related condition) in the five years before the policy began.

Mr E chose to take out 'Consultant Select' cover. This means that Vitality's consultant panel will choose the most appropriate consultant for a policyholder, based on their medical need. The policy says:

'The consultant you choose must be recognised by Vitality Health and eligible under your plan. To ensure this is the case, you must always get authorisation for your treatment from

us in advance.'

The policy terms also say that Vitality won't pay for:

'diagnostic tests that have been arranged by anyone other than your consultant, except minor diagnostic tests ordered by a Vitality GP or a private GP in our network.'

Was it fair for Vitality to turn down much of Mr E's claim?

Vitality assessed the medical evidence Mr E had provided and concluded that his claim was caught by the terms of the moratorium. Mr E says that his symptoms didn't begin until after the policy began. So I've looked carefully at the available medical evidence to decide whether I think Vitality reached a fair conclusion.

In July 2018, Mr E saw a GP with a two-three month history of right-sided medial knee pain. He underwent an MRI which showed patellofemoral osteoarthritis, amongst other things.

Subsequently, in January 2023, Mr E saw his GP. The GP's notes of that consultation say:

'Ongoing right knee pain for last 7 months…R knee pain began following (sports) 7 months ago…inside of knee pain.'

Following that appointment, Mr E's GP completed a referral form for Mr E to see a private orthopaedic consultant. The referral letter included the following:

'*Many thanks for seeing this…gentleman with ongoing right knee pain for last 7 months. He reports pain in the inside of right knee which began following a (sports) trip.'*

Based on the GP's evidence, I don't think it was unreasonable for Vitality to have concluded that Mr E had likely been suffering from symptoms of right-sided knee pain for around seven months. This meant his pain would appear to have begun in around June 2022 – broadly three months before he took out the policy.

It's clear how strongly Mr E disputes that his symptoms began before the policy began. Following the decline of the claim, his GP provided further evidence. Mr E's medical records show that in February 2023, he'd undergone a self-paid MRI, which had found a small meniscal tear, along with evidence of osteoarthritis. And the GP records show that he saw his GP again in mid- March 2023. The GP recorded the following:

'*Patient reports that he meant he had the right knee pain for several months prior to presentation and not '7 months' as documented in previous consult. He now reports injury to right knee while (doing sporting activity in September 2022).'*

The GP completed a further referral form in mid-March 2023. The letter said:

'*Many thanks for seeing this…gentleman who have [sic] represented stating that right knee pain began 'several' months ago rather than seven months ago as did hear [sic] at the time.*

Patient is convinced this injury occurred (in September 2022)…'

I've weighed-up the medical evidence very carefully. I'm not a medical expert and so I must base my decision on the expert evidence available to me. I appreciate the GP indicated that Mr E felt his injury had happened after the policy began and that the GP had misheard the duration of his pain previously. I accept it's possible this was the case.

But I don't think it was unfair for Vitality to place more weight on the contemporaneous GP

notes and referral letter from January 2023, as I think they indicate what's more likely to have been said and discussed at the time. In my view, the contemporaneous evidence does indicate that it's more likely than not Mr E had been suffering from symptoms of right-sided knee pain for around seven months. I'd add too that both the 2018 and 2023 MRI scans indicated that Mr E had some symptoms of osteoarthritis in his right knee. So I don't think it was unfair for Vitality to conclude that Mr E's symptoms had existed in the five years before he took out the policy in September 2022. And therefore, I don't think it was unfair for Vitality to conclude that his claim for right knee pain fell within the scope of the moratorium clause.

As I've set out above, Mr E self-paid for the February 2023 MRI scan. This wasn't authorised by a consultant or by Vitality. So I don't think it was unfair for Vitality to rely on the exclusion clause I've referred to above to turn down this part of the claim.

Both parties agree that Mr E's policy ended in May 2023. This means he was no longer covered for any medical treatment under the policy. But he didn't consult Mr G or undergo surgery until July 2023. So although Mr G considered Mr E's symptoms were likely caused by the meniscal tear, there was no longer a policy in place which would have allowed Vitality to reconsider the claim in any event. Therefore, I don't think it was unreasonable for Vitality to conclude that those costs weren't covered by the policy either. I'd also add that Vitality says Mr G wasn't included on Mr E's Consultant Select list. And it hadn't authorised him to undergo treatment with Mr G. So even if the policy *had* remained in force, I think it's more likely than not that these costs would have been excluded by the contract terms.

Vitality agreed to pay the costs of Mr E's physiotherapy. I find this to have been fair and reasonable in the circumstances. But for the reasons I've explained, I don't think it acted unfairly when it concluded that neither Mr E's MRI costs nor his treatment costs were covered by the policy terms.

The data breach

Mr E feels strongly that Vitality has mishandled personal data. Vitality accepts it wrongly sent Mr E another customer's details and it asked Mr E to delete this information, as he wasn't entitled to see it. It said it had provided feedback to the relevant member of its staff.

I don't think it would be appropriate for me to make a specific finding about whether there was a breach of relevant data protection legislation. I think the Information Commissioner's Office would be best placed to make a finding on that point.

Nonetheless, I can consider whether the sharing of information has caused Mr E any material harm, trouble or inconvenience. But Mr E hasn't pointed to any specific financial loss or harm which flowed from the sharing of this information. And I don't think there's evidence to show it impacted on the way Vitality handled his claim either.

Summary

Overall, whilst I sympathise with Mr E's position, I don't think it was unfair for Vitality to turn down much of his claim. And nor do I think it needs to pay him any compensation. So it follows that I'm not telling Vitality to do anything more.

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 E to accept or reject my decision before 1 March 2024.

Lisa Barham
Ombudsman