DRN-4358594

The complaint

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

What happened

Miss W is insured under her employer's group medical insurance policy. Cover under the policy began in June 2022 and the policy was underwritten on moratorium terms. This meant that Vitality wouldn't pay claims for any medical conditions which had existed in the five years before the policy began, except in defined circumstances.

In July 2022, Miss W called Vitality to make a claim on the policy. She said she'd had a scan, which had identified ovarian cysts and possible endometriosis. She'd been referred to a gynaecologist. During the call, Miss W told Vitality's call handler that her usual menstrual symptoms had worsened in October 2021 and had deteriorated further in April 2022. She explained that she'd been prescribed strong pain relief medication.

Vitality turned down Miss W's claim. Miss W had indicated both that her symptoms had worsened and that she'd been prescribed pain medication prior to the start date of the policy. So it concluded that her condition was pre-existing and therefore fell within the scope of the moratorium clause.

Miss W was unhappy with Vitality's decision and she asked us to look into her complaint. She said she hadn't formally been diagnosed with endometriosis until August 2022. So she didn't think it had been fair for Vitality to decline her claim.

Our investigator didn't think Miss W's complaint should be upheld. He said that the policy didn't require a diagnosis to have been made in order for the moratorium clause to apply. And he felt that given Miss W's timeline of her symptoms, it had been fair for Vitality to conclude that the claim wasn't covered.

Miss W disagreed. She said she'd also been diagnosed with a further condition. So she didn't think there was any way of attributing the pain she'd experienced to a pre-existing medical condition.

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 Miss W, I don't think it was unfair for Vitality to turn down her claim and I'll explain why.

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 the insurance policy and the available evidence, to decide whether Vitality

treated Miss W fairly.

I've first considered the policy terms and conditions, as they form the basis of the contract between Miss W's employer and Vitality. The policy was accepted on moratorium terms. So I've looked carefully at what Vitality means by 'the moratorium clause'. The policy 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.

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, or injections)*

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

I think the policy terms make it clear that Vitality won't pay for claims for any medical condition if an insured member had had symptoms of it; asked for advice about it, had received treatment for it; or was aware it existed in the five years before the policy began, except in the specific circumstances outlined above. I also think the policy terms make it sufficiently clear that a specific medical condition *doesn't* need to have been formally diagnosed in order for the moratorium clause to apply. Vitality considers that Miss W's claim was excluded by the moratorium clause, so I've considered whether I think this was a fair conclusion for Vitality to draw.

I've listened carefully to the call between Vitality and Miss W. During the call, Miss W explained her symptoms and the suspected diagnosis. She explained that her usual menstrual pain had worsened in October 2021 and deteriorated more severely in April 2022. She also told the call handler that she'd been prescribed pain relief medication. This policy didn't start until June 2022, around eight months after Miss W's symptoms had worsened and two months after they'd worsened even further. So I don't think it was unfair for Vitality to conclude that Miss W had symptoms of the condition she was claiming for *and* had been prescribed treatment for it in the five years before the policy started. As such, I think it was reasonable for Vitality to consider that Miss W's claim was excluded by the moratorium clause.

Miss W strongly feels that as her condition hadn't been diagnosed at the point of claim and as she's since been diagnosed with another condition which can cause pain, it isn't fair for Vitality to decline her claim. However, whilst I sympathise with Miss W's position, as I appreciate she's very worried about the impact her conditions may have on her in the future,

I don’t think I could fairly uphold her complaint on these grounds. As I’ve explained, the policy terms don’t require a diagnosis before the moratorium clause applies. And the evidence Miss W gave Vitality indicates that symptoms of either condition did exist before the policy began and that she was taking prescription pain relief for those symptoms.

Overall then, I don’t think Vitality acted unfairly or unreasonably when it turned down Miss W’s claim.

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 Miss W to accept or reject my decision before 7 November 2023.

Lisa Barham
Ombudsman