DRN-4603030

The complaint

Mr A has complained that Vitality Health Limited only partially settled a claim he made under his group private medical insurance policy.

What happened

The background to this complaint is well known to the parties so I won't repeat it in detail here. In summary Vitality settled Mr A's claim at 60% - as the treatment he had was at a hospital not on the list of hospitals covered by his policy. Our investigator didn't find that Vitality had done anything wrong. Mr A appealed.

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've summarised the background to this complaint and focused on what I find are the key issues here. Our rules allow me to take this approach. It simply reflects the informal nature of our service as a free alternative to the courts. I recognise that Mr A will be disappointed by my decision, but for the following reasons I agree with the conclusion reached by our investigator:

- The relevant regulator's rules say that insurers must handle claims promptly and fairly. They must provide reasonable guidance to help a policyholder make a claim and that they mustn't turn down claims unreasonably. So I've considered, amongst other things, the terms of Mr A's policy and the available evidence, to decide whether I think Vitality treated him fairly.

- The terms of Mr A's policy provide: *If a hospital list has been included on your plan, you must use a hospital on that list. If you use a hospital that is not on your list, you will have to pay 40% of the costs of the treatment (excluding consultant's fees) yourself. Even if you do decide to use a hospital not on your list you must still ensure the hospital or facility you use, and the consultant that treats you, is recognised by us.*

  To avoid any doubt about whether your treatment will be covered, you should always have your treatment authorised by us in advance.

  I find this term was in a format that a consumer would understand. Mr A's treatment was at a hospital not on his plan's list – so on the face of it Vitality only needed to meet 60% of his claim – which is what it has done.

- Mr A has said he wasn't advised that the hospital was off-list when he called to have his treatment authorised. I'm satisfied that a different hospital name was given by Mr A initially. Mr A called Vitality in July 2023 to make a new claim. He was advised that this was linked to his previous claim made in April 2023 and treatment was approved but the hospital wasn't discussed. Again, on 22 August 2023 when Mr A spoke to an

operator, he was advised that the previous authorisation was valid. He called again two days later to discuss the upcoming scan and xray he was to have. But although the consultant was named, no hospital was. Unfortunately, the scan and xray on 29 August 2023 resulted in a co-payment invoice as the hospital Mr A used wasn't on the approved list.

- I've thought about the support Mr A was given. Vitality wasn't made aware that the facility where Mr A would have the scans was changed from that originally given. So Vitality didn't have the opportunity to tell Mr A that hospital wouldn't be covered in full. It might have been prudent to remind Mr A of the hospital option his plan was on – but I don't find that Vitality was obligated to do so.

- I say this because I note that when Vitality wrote to Mr A on 20 July 2023 with regard to his claim he was clearly advised that if he should attend a hospital not on his hospital list, a co-payment would apply. Mr A sent us a copy of this letter, which continued: *It is important that you check that the hospital your consultant suggests you attend is eligible on your plan. Details of your hospital list options can be found on the Member Zone. Click on Health - My plan details – Your hospitals.* He was also advised about the hospital list when he made the first claim in April 2023.

- I accept that if Mr A had been aware that he would be liable to pay 40% of the costs as the hospital was off-list – he would have arranged to have the diagnostic tests done elsewhere. But I don't find that he was misadvised by Vitality. Neither do I find that his policy terms, or the documentation he was sent in relation to his claim was unclear or misleading.

- I'm sorry that my decision doesn't bring Mr A more welcome news but in all the circumstances I don't find that Vitality treated Mr A unfairly, unreasonably, or contrary to the terms of his policy by settling his claim in the way it did.

My final decision

For the reasons 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 A to accept or reject my decision before 18 March 2024.

Lindsey Woloski
Ombudsman