DRN-4729740

The complaint

S, a limited company, complains about the way Vitality Health Limited handled a claim a policy beneficiary made on S' group private medical insurance policy. S also complains that Vitality cancelled the group plan without agreement.

S is represented by Mr S.

What happened

S took out a group private medical insurance policy in September 2022. The policy was an annual contract.

In October 2023, Mr S made a claim on the policy for Miss S, a policy beneficiary. Vitality considered the claim to be eligible for talking therapies without the need for further underwriting. It referred Miss S to N – its third party provider. However, N had no availability for face-to-face appointments.

Vitality told Mr S that it could arrange for Miss S to go out of network. But it said that it would need a Claim Information Request to be completed by her GP so that it could check whether the claim was covered by the policy terms.

Mr S was unhappy with Vitality's handling of Miss S' claim. He indicated that S intended to cancel the plan and that he was seeking a refund of all the premiums S had paid for the policy from the start.

Vitality told Mr S that if S wished to complain about N's actions, a complaint would need to be raised directly with it. It cancelled S' policy from the date Mr S had first expressed his intention to cancel the plan – on 29 November 2023. But it said it couldn't refund the premiums S had paid for the plan from the start.

Mr S remained unhappy with Vitality's stance and so he asked us to look into S' complaint.

Our investigator didn't think S' complaint should be upheld. He didn't think Vitality was responsible for N's actions under the terms of the policy. And he thought Vitality had handled Miss S' claim fairly. He also didn't think Vitality had acted unreasonably when it cancelled S' plan.

Mr S disagreed and so S' complaint has 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 sorry to disappoint Mr S, I don't think Vitality handled Miss S' claim unfairly and nor do I think it cancelled S' plan unreasonably. I'll explain why.

First, I must make it clear that this decision will only consider events which took place before

and which were addressed in Vitality's final decision letters of 18 and 20 December 2023. I understand S has further concerns about payments requests it's received. However, it isn't clear that Vitality has had a chance to look into or respond to those concerns. And therefore, I don't think it would be appropriate for me to consider those issues here. It's open to S to make a new complaint to Vitality about those particular concerns should it wish to do so.

The relevant regulator's rules say insurers must handle claims promptly and fairly. And the regulator's principles say that a financial business must provide support which helps its customer meet their needs. I've taken these rules into account, along with other relevant considerations, when deciding whether I think Vitality treated S fairly.

It seems to me that there are two key issues for me to decide. First, whether Vitality handled Miss S' claim fairly. And secondly, whether it was reasonable for Vitality to cancel S' plan. I'll deal with each in turn.

Did Vitality handle Miss S' claim fairly?

When Mr S made a claim on Miss S' behalf, it appears that Vitality promptly agreed that the claim was eligible and referred Miss S for treatment from N. It's clear how important it was to Mr S that Miss S should have face-to-face treatment. But it appears that N had no availability for this type of appointment. Instead, it offered Miss S virtual appointments.

Vitality says it isn't responsible for N's actions, as it's a third-party provider. So I've looked carefully at the relevant policy terms to decide whether I think Vitality is liable for any issues Miss S experienced with N. Page 39 says:

'Our liability under this plan is limited to paying for treatment or services in respect of eligible claims under this plan.

The choice of provider of the treatment or services ("provider") for which you are claiming under this plan is your responsibility, except:

• if you are covered under our Consultant Select option, in which case your treatment will be provided by a hospital, consultant or therapist on our panel

• for Weight loss surgery or Corrective surgery benefits which must be arranged through a consultant group nominated by us.

We make no representations or recommendations to you or any of your insured dependants regarding the availability and standard of any treatment or services offered or provided by any provider.

We will not be held liable to you or any insured dependant for any loss, harm or damage of any description resulting from lack of availability or from a defect in the quality of any treatment or service offered or provided by such provider*. This plan represents the whole and only agreement between you (the insured member) and Vitality Health relating to the provision of private medical insurance.'* (My emphasis added).

In my view, the group policy terms make it clear that Vitality isn't responsible for the lack of availability of treatment or service offered by its providers – which include N. It's responsibility is to pay for eligible treatment or services. So I think it was reasonable for Vitality to direct Mr S to complain to N about any problems Miss S experienced in arranging treatment with it.

Having considered the available evidence, I think Vitality took steps to handle Miss S' claim

promptly and fairly. It says N told it that virtual appointments were clinically appropriate for Miss S and so it seems it would have paid for eligible treatment through N had Miss S undergone therapy through it. Vitality also offered Mr S the option to go out of network to arrange treatment for Miss S – dependent on the completion of a Claim Information Request form from Miss S' GP. I think this was an appropriate and reasonable response from Vitality which offered Miss S the ability to seek face-to-face treatment. And I also think Vitality was reasonably entitled to check whether the claim was covered through the completion of the Claim Information Request form. That's because it would've allowed Vitality to confirm Miss S hadn't suffered from symptoms of the condition she was claiming for prior to the policy beginning.

While I can understand Mr S was concerned about the potential time and cost of asking the GP to complete the form, I don't think I could reasonably hold Vitality responsible for his decision not to do so. I'm satisfied then that it did take steps to ensure Miss S had access to eligible and clinically appropriate treatment.

Did Vitality cancel the policy fairly?

The policy terms set out S' cancellation rights as follows:

'If you wish to cancel your plan, you may do so from the annual renewal date by notifying us in advance. We will not pay for any treatment that takes place after the date that cover comes to an end, and there will be no further benefit available under the Healthy living Programme. The cancellation provisions of any benefit taken out with a partner under the Healthy Living Programme (such as gym memberships, or credit agreements to spread the cost of certain devices or membership fees) depend on the terms and condition of that partner.

You may not cancel your plan at any other time. The only exception to this is if your membership consists of a business partnership of three business partners of fewer. In this case you may cancel during the course of a plan year, and your premium will be adjusted accordingly.'

I think the policy terms make it clear that except in limited circumstances, a group can only cancel its policy at the annual renewal date. S is not a business partnership and so it wasn't entitled to cancel the plan at any time. Under the terms then, S couldn't cancel the plan until the September 2024 renewal.

However, Mr S had a call with Vitality during the life of the claim, which I've listened to. Mr S has been provided with a copy of this call. During the conversation, Mr S explained that he intended to cancel the plan 'either way' and that he wanted a full refund of premiums from inception. So Vitality agreed to cancel the plan, with effect from 29 November 2023 – the first date Mr S had expressed an intention to cancel S' plan - outside of a strict application of the policy terms. In my view, this was a fair and proportionate action for Vitality to take given Mr S had made his plan to cancel the contract clear. So I don't agree that it acted without notice and I think it cancelled the plan reasonably.

Mr S indicated that he wanted a full refund of all of the premiums S had paid for the cover. But I don't think it would be fair for me to make such an award. That's because S and its beneficiaries benefited from the cover Vitality was providing during the life of the policy. And it seems both parties acknowledge that group members did make successful claims on the contract.

Overall, having considered everything, I don't think Vitality has done anything wrong which it needs to put right.

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 S and Miss S to accept or reject my decision before 30 July 2024.

Lisa Barham
Ombudsman