DRN-5128193

Financial Ombudsman Service

The complaint

Mr A is unhappy with Vitality Health Limited's decision not to pay his claim in full.

What happened

Mr A had private medical insurance with Vitality. He began suffering with hip and leg pain and so, called Vitality to make a claim. Mr A said he visited a consultant for a blood test and an MRI scan, however, the consultant then referred him to a neurologist for further treatment. Mr A said Vitality won't pay for the neurologist's treatment costs and that he's been left with a bill for £2,723.34. He would like Vitality to pay these costs.

Vitality said it would pay for the MRI scan costs and the blood test, but not the neurologist's costs. It said Mr A didn't call for authorisation prior to receiving that treatment and that Mr A was treated by a specialist that wasn't part of its approved network. Vitality also said that Mr A had exhausted the policy's outpatient limit and therefore, it wouldn't reimburse him those costs. Vitality, did however, pay him £50 compensation for the delay handling his claim – which he accepted.

Our investigator didn't uphold Mr A's complaint. She said Vitality had declined his claim in line with the policy terms and therefore it didn't need to do anything more in respect of his complaint.

Mr A disagreed. In summary, he explained that he saw a specialist from the hospital recommended by Vitality and so he doesn't accept its position on that. Mr A also said he was referred to this particular neurologist by his treating consultant and therefore this wasn't his choice. And so, it's now for me to make 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.

Having done so, I've also decided not to uphold it and for the same reasons given by our investigator. I understand this will come as a disappointment to Mr A, but Vitality wasn't consulted prior to his visit to the neurologist and so he didn't receive authorisation for the treatment. But even if had done that, I'm still persuaded that Vitality wouldn't have to pay the neurologist's costs. I'll explain why.

There are rule insurers, like Vitality, must follow when handling claims. These rules are from the insurance code of business sourcebook (ICOBS) and are set by the regulator, the Financial Conduct Authority. These rules say Vitality must handle claims promptly and fairly and must not unreasonably reject a claim or avoid one. I'm satisfied Vitality fulfilled its obligations here because it assessed Mr A's claim fairly, based on the available medical evidence before reaching its decision.

I agree there was an issue with the timeliness of its assessment, however, I'm satisfied this was relatively minor and delayed things by around two weeks. Vitality explained that it

wanted to validate the claim by requesting information from Mr A's GP, however, it realised this wasn't needed and so proactively reached out to Mr A to apologise for the error and paid him £50 compensation by way of an apology. I thought that was fair in the circumstances and I note Mr A accepted that. He asked that Vitality consider reducing his excess in addition to the compensation, however, it declined to do that. I also didn't think Vitality had to do that as I thought the £50 compensation fairly reflected the level of upset the short delay caused.

The policy terms say;

"WHICH HOSPITALS ARE ELIGIBLE UNDER YOUR PLAN?

• *If you have chosen our Consultant Select option, you must contact us before having treatment so we can arrange for you to see a consultant on our panel. Alternatively you can make an appointment with a Vitality GP who will arrange for you to see a consultant. The consultant will then choose the hospital you are treated in. We will not pay for treatment we have not authorised in advance"*

I'm satisfied Mr A discussed seeing a consultant with Vitality, however, that was for an MRI and a blood test. There was also a discussion about which hospital Mr A should go to for that treatment. But I've not seen any evidence that Mr A discussed going to see the neurologist with Vitality. I accept he was referred by his treating doctor, however, the terms say he must receive authorisation from Vitality prior to any treatment being received. And so, because that didn't happen, Vitality declined his claim, which I thought was fair.

I should also say that Mr A's neurologist wasn't part of Vitality's approved network, meaning that it didn't have a working-relationship with the specialist, which is another reason I wouldn't expect Vitality to pay for the treatment he received. But even if the specialist was part of its approved network, I still wouldn't have expected Vitality to pay his claim. The reason I say that is because Mr A had exceeded the policy limit for outpatient treatment.

Mr A's policy had a £500 limit for all outpatient treatment which I'm satisfied was used to pay for his blood tests at the private hospital. I also note Vitality paid for the MRI scan in full, which was eligible under the policy. However, given he'd exceeded the policy limit so early on, there would've been nothing left to cover other outpatient treatment costs. Vitality made Mr A aware this would most likely happen during a phone call on 1 November 2023. It explained the policy limit and said the treatment costs would most likely exceed the policy limit and that he'd need to self-fund treatments should that be the case. Mr A also confirmed his understanding of that. Further, I think had Mr A called to authorise the neurologist's costs, he'd most likely have been told that again.

It's for these reasons, I don't uphold Mr A's complaint.

My final decision

I don't uphold this complaint because I don't think Vitality has made an error in declining Mr A's treatment costs.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr A to accept or reject my decision before 12 January 2025.

Scott Slade
Ombudsman