DRN-4107887

The complaint

Mr T complains that Vitality Health Limited has turned down an NHS cash benefit claim he made on a private medical insurance policy.

What happened

In December 2021, Mr T visited his local hospital with severe abdominal pain. He was prescribed antibiotics. However, Mr T's symptoms didn't resolve and so he sought further medical attention. Mr T underwent a scan and it was suggested that he may need an appendectomy. Mr T says that he spoke to his broker, who indicated that this procedure would be covered by his private medical insurance.

So Mr T obtained a quote for the surgery from a private hospital, which was for around £13,000. He felt the cost of treatment was too high and he therefore decided against private surgery. He says that he returned to his GP who referred him to an NHS hospital for elective treatment. He also says that due to the time of admission, he was admitted to a ward via A and E.

Mr T underwent eight days of treatment for inflammatory bowel disease (IBD) and an inflamed appendix. He didn't undergo appendectomy surgery. He made a claim on his private medical insurance policy for NHS cash benefit.

Vitality looked into Mr T's claim. In placed particular weight on Mr T's hospital discharge summary which suggested that Mr T had been admitted to a ward from the emergency department. It therefore concluded that he'd been admitted as an emergency patient. And it didn't think Mr T's treatment had been scheduled more than 24 hours in advance. So it said he wasn't eligible for NHS cash benefit. It did acknowledge that it hadn't handled Mr T's claim as promptly as it should've done.

Mr T was unhappy with Vitality's decision and he asked us to look into his complaint.

Our investigator thought it'd been fair for Vitality to turn down Mr T's claim. She thought it had been reasonable for Vitality to conclude that the claim wasn't covered by the policy terms. However, she felt that Vitality should pay compensation for the delays in its handling of Mr T's claim and so she recommended that it should pay him £150.

Vitality accepted the investigator's recommendation.

Mr T disagreed with the investigator and I've summarised his telephone and written responses. He maintained that his broker had been assured that his treatment was covered and that he'd paid for the top level of private medical cover. He said he'd been admitted to hospital on an elective basis, but that he could've chosen to go in on the following day. He provided a letter from his broker which stated that the appendectomy procedure Mr T had been recommended was eligible for cover under his policy, subject to normal underwriting checks. And he felt the compensation award was too low, given the time and inconvenience he'd been put to by Vitality.

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 T, I think it was fair for Vitality to turn down his NHS cash benefit claim. I'm also satisfied that Vitality has now agreed to pay him fair compensation for the way it handled his claim. 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 Mr T's policy and the circumstances of his claim, to decide whether I think Vitality treated him fairly.

I've first considered the terms and conditions of Mr T's policy, as these form the basis of the contract between Mr T and Vitality. The policy states that Vitality will cover NHS cash benefit of £250 per night up to a limit of £2000 per year for in-patient treatment a policyholder receives which they would've been eligible to undergo privately. However, the policy also sets out a specific list of things Vitality has chosen to exclude from cover. The contract explicitly states that Vitality won't pay NHS cash benefit if a policyholder is admitted to hospital as an emergency. The policy also explicitly excludes any admission to hospital that was scheduled less than 24 hours in advance. Vitality considers that the medical evidence indicates Mr T was admitted to hospital as an emergency. So I've gone on to think about whether this was a fair conclusion for Vitality to reach.

It's a general principle of insurance that it's for a policyholder to provide enough medical evidence to show they have a valid claim on their insurance policy. In this case, Mr T provided Vitality with a copy of his hospital discharge summary. This shows that Mr T was admitted to hospital in the evening of 7 January 2022. The report says:

'Patient was admitted to the surgical team from GP to ED on 07/01/2022 for abdominal pain...Patient was investigated with CTAP on 07/01, and was discussed with radiology…Findings were confirmed to determine appendicitis and…colitis.'

The report shows that Mr T underwent further testing a few days later and was diagnosed with ulcerative colitis. He was treated with steroids and prescribed antibiotics. The report says that Mr T was to be followed-up three months later to *'consider an elective appendectomy.'*

I appreciate Mr T says that he saw his GP who referred him for surgery, but on an elective basis. He says this meant that he could attend and be admitted to hospital the following day if he wished to. However, I don't think it was unfair for Vitality to rely on the discharge summary it was sent when it assessed the claim. This report stated that Mr T had previously attended A and E around a week earlier for a similar issue and had been prescribed antibiotics. On 7 January 2022, he had been admitted to hospital via A and E after seeing his GP. It seems that this was because he was continuing to experience abdominal pain, despite the earlier antibiotic treatment. In my view, this report indicates it was more likely than not that Mr T wasn't admitted for a planned procedure, but instead, had been admitted as an emergency for further investigation into potential appendicitis. Our investigator asked Mr T if he could provide a copy of the GP referral letter, but this hasn't been sent to us. So I haven't seen persuasive medical evidence to show that Mr T's admission was planned or that it had been scheduled more than 24 hours in advance. On that basis, I don't find it was unfair for Vitality to conclude that the claim for NHS cash benefit was specifically excluded from cover.

Mr T has provided a letter from his broker which says that they'd understood Mr T would be eligible for a private appendectomy, in line with Vitality's standard underwriting checks. I haven't seen enough evidence to show me that Vitality did authorise such a procedure. But even if it did, the available medical evidence shows that Mr T *didn't* undergo an appendectomy while he was an NHS inpatient. It seems he was treated with steroids and antibiotics. His treatment plan indicates that a discussion around a planned appendectomy was intended to take place around three months later. On that basis, I don't think I could fairly find that Vitality had authorised the treatment Mr T *actually* received, even if his broker had been told appendectomy surgery was covered.

If Mr T is able to obtain further evidence from his GP or the treating hospital which shows that his admission wasn't an emergency, and that it had been planned and scheduled more than 24 hours in advance, it's open to him to send this evidence to Vitality for it to consider. However, on the evidence I have before me, I find that it was fair for Vitality to conclude that Mr T's NHS cash benefit claim wasn't covered by the policy terms. So it follows that I'm not directing Vitality to pay Mr T's claim.

It's clear though that Vitality didn't handle the claim as well as it should've done. It took some months for it to assess the medical evidence and Mr T was put to some unnecessary time and trouble in dealing with the claim. I agree then with the investigator that it's fair and reasonable for Vitality to pay Mr T some compensation to reflect the material distress and inconvenience its errors had on him. In my view, £150 compensation is a fair award to recognise the trouble and upset I think Mr T was likely put to. Our role isn't to fine or punish the businesses we cover and I can't see that any delay in the claims handling caused Mr T to suffer any delays in further treatment or cause him material distress. I was pleased to note that Vitality accepted the recommendation to pay Mr T £150 compensation and I now direct it to pay this award if it hasn't done so already.

My final decision

For the reasons I've given above, my final decision is that it was fair and reasonable for Vitality to turn down Mr T's claim, but that it didn't handle his claim fairly.

I direct Vitality Health Limited to pay Mr T £150 compensation if it hasn't already done so.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr T to accept or reject my decision before 16 June 2023.

Lisa Barham
Ombudsman