DRN-4747924

The complaint

Mr H complains that Vitality Health Limited hasn't fully settled a claim he made on a group private medical insurance policy.

What happened

Mr H was insured under a private medical insurance policy by an insurer I'll call A. However, on 1 June 2022, his cover was transferred to a group scheme underwritten by Vitality.

On 6 June 2022, Mr H contacted Vitality because he had an open claim with A, which he wanted to transfer to Vitality. He was asked to provide Vitality with proof of his previous insurance and of A's claim authorisation. Mr H sent this evidence on to Vitality which appears to have taken no further action with the claim.

Subsequently, in July 2022, Mr H underwent planned surgery and a claim was made on the policy. Vitality accepted the claim and partly settled it. However, as the surgery took place at a hospital which wasn't on Mr H's hospital list, Vitality only paid 60% of the hospital fees, in line with the policy terms.

As Mr H received a payment request for 40% of the hospital fees, he complained to Vitality. He said if Vitality had made it clear to him that the treating hospital wasn't on his list, he wouldn't have undergone treatment there and therefore incurred costs. But Vitality maintained its stance and so Mr H asked us to look into his complaint.

Our investigator thought Mr H's complaint should be upheld. He noted that Vitality no longer had a copy of the call of 6 June 2022 but that its notes indicated Mr H had been told that the particular hospital wasn't on his list. However, he felt the primary purpose of Mr H's call had been to make a claim and he'd provided the information he'd been asked for. He considered that Vitality had failed to progress the claim in a timely way and that, if it had done so, it was likely it would have been in a position to let Mr H know whether or not the claim was covered. He thought that Mr H would then have been in a position to undergo treatment in a hospital which was on his list and wouldn't have incurred any costs. So he concluded that Vitality should settle the remaining hospital fees.

Vitality disagreed. It said Mr H had been made aware that the hospital wasn't on his list and nor had he contacted it ahead of the procedure to obtain authorisation. It did agree that there'd been delays in the way it had handled the claim and it suggested it would be prepared to pay Mr H compensation to reflect this.

I issued a provisional decision on 28 March 2024, which explained the reasons why I thought the fair outcome to this complaint was for Vitality to pay him £350 compensation. I said:

'The relevant regulator's rules say that insurers must handle claims promptly and fairly; that insurers must provide policyholders with reasonable guidance to help them make a claim and updates on its progress; and that they mustn't turn down claims unreasonably. So I've taken these rules into account, amongst other things, when deciding whether I think Vitality treated Mr H fairly.

I've first considered the policy terms and conditions, as these form the basis of the group insurance contract. Page 27 of the policy says:

'When you need treatment covered by the plan, you will be able to choose the medical professional who treats you, and where the treatment takes place. The choices available to you will depend on the options chosen by the planholder. You must always have your treatment approved by us in advance, so you know that you will be covered.'

Page 29 of the contract states:

'Using a hospital not on your plan

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.'

In my view, the policy terms make it sufficiently clear that if a member opts to undergo treatment at an 'off-list' hospital, then they will be responsible for paying 40% of the treatment costs.

Mr H's policy certificate shows that his employer had selected the 'Countrywide' hospital list. Having checked Vitality's 'hospital finder' list, I can see that the hospital in which Mr H underwent surgery wasn't on the Countrywide list. As such then, I don't think it was unreasonable for Vitality to conclude that it was only liable to pay 60% of the fees in line with the policy terms.

Our investigator felt that given issues with the way Vitality handled Mr H's claim, it would be fair and reasonable for it to step away from a strict interpretation of the policy terms and pay the full claim. I've thought very carefully about this point, as I'll go on to explore.

Both Vitality's records and Mr H's testimony show that Mr H called Vitality on 6 June 2022 to discuss continuing a claim which A had already agreed to accept under the terms of his previous policy. Unfortunately, Vitality no longer has a copy of that call available, so I can't listen to exactly what was said or understood. Instead, I must necessarily base my decision on the evidence which is available - in the form of Mr H's testimony; Vitality's call notes; and its review notes from the time of Mr H's original complaint - to decide what I think is most likely to have happened.

Vitality's notes show that Mr H called to discuss transferring his existing claim with A to Vitality. He was told he'd need to provide proof of his insurance and proof of A's claim authorisation, so that the claim and his plan could be updated. It seems Mr H sent Vitality both pieces of evidence on the same day. The letter from A showed that it had covered a consultation Mr H had had with a specialist in February 2022 – which seems to have taken place at the off-list hospital.

Following its review of what happened at the time of claim, it seems Vitality listened to the call of June 2022 in March 2023, while the call remained available. Vitality's notes state:

‘There is a call….on 06/06 where the hospital list is discussed and the member is advised (hospital) being…not eligible.’

It appears that this call was reviewed by three different members of Vitality’s staff when it first looked into Mr H’s concerns and all concluded that Mr H had been told that the hospital he was later treated at wasn’t eligible under his list. Given Mr H appears to have been discussing continuing a claim following a consultation at an off-list hospital, it does seem more likely than not that the call handler would have explained that the particular hospital wasn’t on Mr H’s list.

Based on the totality of the evidence then, I currently think, on the balance of probabilities, that it’s most likely Vitality did tell Mr H, on 6 June 2022, that the relevant hospital wasn’t on his list, even if it didn’t give a specific claims decision at that point. So I think Mr H ought to have been put on notice that he was likely to incur significant costs if he underwent off-list treatment.

It doesn’t appear that Vitality took any further action with Mr H’s claim in early June 2022 or indeed until Mr H contacted it to ask why he was responsible for paying 40% of the fees. So I’ve thought about whether I think it would be reasonable for me to direct Vitality to pay his full claim on that basis. I don’t currently think it would. In my view, the policy makes it clear that to ensure a claim is covered, a member should call to obtain Vitality’s authorisation before undergoing treatment. But there’s no suggestion that Mr H contacted Vitality in order to seek such authorisation. In the circumstances, I think it might have been reasonable for Mr H to have done so ahead of undergoing surgery – especially since it seems he had been made aware only a few weeks earlier that the treating hospital wasn’t on his list. And given Mr H hadn’t heard anything more about his claim or whether it would be covered, I think it would have been reasonable for him to contact Vitality ahead of the procedure. Had he done so, he could have made alternative arrangements at a hospital which was on his list.

So I currently don’t think it was unfair for Vitality to limit settlement to 60% of Mr H’s hospital fees.

On the other hand, I don’t think Vitality met its regulatory obligations to deal with Mr H’s claim promptly and fairly. It was aware that Mr H was seeking to continue an ongoing claim and it was provided with evidence that A had previously paid for a consultation. I don’t think A’s authority letter ought to have indicated that there might be an issue with Mr H’s claim because there’s no reference to what treatment Mr H would need or where it would take place – although I accept it showed the outpatient consultation had taken place at the off-list hospital. But I do think that if Vitality had progressed Mr H’s claim in a timely way, it would have been in a position to remind him that he would be liable for 40% of his costs if he underwent treatment off-list. So I think it’s fair and reasonable for Vitality to pay Mr H compensation to reflect the likely impact of this mistake.

Having considered everything, I currently think compensation of £350 is a fair, reasonable and proportionate award which takes into account the frustration I think Mr H is likely to have experienced because of the claim delays and the disappointment he suffered when he learned settlement had been limited. So I intend to direct Vitality to pay Mr H £350.’

I asked both parties to send me any further evidence or comments they wanted me to consider.

Vitality didn’t respond by the deadline I gave.

Mr H disagreed with my provisional findings. He said he was disappointed with my provisional conclusions. He said he had read the policy terms and conditions. But he has a

medical condition which meant he couldn't confidently say he'd understood them. So he'd proactively called Vitality and emailed it several times before the policy started.

And Mr H refuted my findings in regard to the phone call. He said while it may be the case that Vitality had reviewed the call it could no longer provide; he'd had other calls with Vitality's staff who'd championed his cause and said he shouldn't have to pay out. He said he'd been consistent in his recollections and that Vitality couldn't provide evidence to support its position.

Mr H added that it would have been terrifying had Vitality handled his claim in a timely way, as I would have concluded it hadn't done anything wrong. He questioned what he should do given his medical condition, if he's unable to understand the information he's being given and despite proactively seeking to obtain the information he needed.

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 Mr H, I still think the fair outcome to this complaint is for Vitality to pay him £350 compensation and I'll explain why.

I'd like to reassure Mr H that in reaching my decision, I've carefully considered all of the evidence that's been provided to me, including Mr H's testimony. I do appreciate that Mr H called Vitality to discuss the continuance of his existing claim with A. And I don't doubt that he took proactive steps to understand how the policy worked and the cover it provided.

However, in the absence of the call of 6 June 2022, I've had to make a decision based on what I think is most likely to have happened, given the available evidence and the circumstances. It would have been helpful to be able to listen to the call recording – although I do appreciate why it's no longer available. But it's still the case that three members of Vitality's staff listened to the call in March 2023. And it was noted that during the call, Mr H was told that the off-list hospital wasn't eligible for treatment. As I explained, given Mr H was calling to discuss his claim with Vitality, I do think it's more likely than not that the hospital he intended to receive treatment at would have been discussed and that Vitality's call handler would have explained that it wasn't eligible under his plan. I've thought about Mr H's comments very carefully. But on balance, I still find Vitality most likely gave Mr H clear enough information about the way the policy worked to put him on notice that if he underwent treatment off-list, he'd be responsible for paying 40% of the costs.

And I still think the policy made it clear enough that a policyholder should contact Vitality for authorisation before undergoing treatment. As I set out, there's no persuasive evidence to show that Mr H did contact Vitality before undergoing off-list treatment or that any authorisation was given. And it isn't clear that Mr H contacted Vitality between June 2022, when he provided it with information about his previous policy and October 2022, when he received the hospital bill.

In the circumstances then, whilst I sympathise with Mr H's position, I remain persuaded that Vitality didn't act unfairly when it concluded that it was only responsible for paying 60% of Mr H's claim costs.

Nonetheless, I still don't think Vitality met its regulatory obligations to handle Mr H's claim promptly or fairly. As Vitality hasn't made any further representations on this point, I see no reason to change my provisional findings. I find Vitality's failure to handle Mr H's claim in a timely way meant it lost an opportunity to provide him with a further reminder that if he

underwent treatment ‘off-list’, he’d be responsible for 40% of the claim costs. So I’m satisfied that Vitality should pay Mr H total compensation of £350 to reflect the likely impact of its mistake on him.

My final decision

For the reasons I’ve given above and in my provisional decision, my final decision is that I direct Vitality Health Limited to pay Mr H £350 compensation.

Under the rules of the Financial Ombudsman Service, I’m required to ask Mr H to accept or reject my decision before 21 May 2024.

Lisa Barham
Ombudsman