DRN-4845118

The complaint

Mrs W complains that Vitality Health Limited has unfairly declined her claim for surgery under her private medical insurance policy.

What happened

Mrs W has a private medical insurance policy which she had renewed every March since 2016. This is insured with Vitality.

In October 2022, Mrs W started to experience pain in her leg and foot. She started a claim with Vitality. Following investigations, Mrs W was diagnosed with a type of ganglion cyst. She was referred to a consultant specialist, who I will call Mr F. She was told he was the leading specialist in this field.

Mrs W contacted Vitality in March 2023 for authorisation to see Mr F, but Vitality said he wasn't registered as one of its recognised consultants. Mrs W decided to see him anyway and he informed her she needed urgent surgery. Vitality maintained it couldn't authorise the treatment but said it would find another surgeon. Mrs W says she chased Vitality, but it still didn't provide any alternative surgeon. Due to her concern that she could be permanently impacted if she didn't have the operation, Mrs W went ahead with the surgery under the care of Mr F in May 2023.

She made a complaint to Vitality about its handling of her claim. Vitality said Mr F wasn't a recognised consultant and that the policy states it will only provide cover for treatment that takes place at an eligible hospital and under the care of a recognised consultant. It noted that it had failed to offer Mrs W a list of alternative consultants before she had the surgery and so it offered £25 in compensation.

Unhappy with the response, Mrs W brought her complaint to us. Our investigator looked into the matter but didn't find that Vitality should pay the claim for the surgery. He noted that her claim for treatment was approved on 15 May 2023, following receipt of a GP report, however, this was after Mrs W had the surgery. He said that while he understood the concerns of Mrs W that she may suffer a permanent disability if she didn't have surgery, she still went ahead with the treatment knowing that Mr F wasn't a recognised consultant, rather than trying to see an alternative. He did, however, think that Vitality should have done more to make sure it provided alternative consultants to Mrs W and so he recommended the compensation was increased to £150.

Mrs W disagreed with the investigator's opinion. She said that the surgery couldn't have been done by just any surgeon and Mr F was a specialist for this type of nerve surgery. She thought it was essential it was done by him. She also said it was unfair that Vitality hadn't even offered any contribution to the cost. Faced with the prospect of permanent disablement, Mrs W said she did what any reasonable person would have done.

As no agreement could be reached, the matter was passed to me to decide.

I issued my provisional decision on 6 June 2024. In it I said the following:

“The relevant rules and industry guidelines say that insurers must handle claims fairly and promptly and shouldn’t unreasonably reject a claim. I’ve taken these rules into account when deciding what I think is fair and reasonable in the circumstances of Mrs W’s complaint.

The policy terms and conditions

Within the policy there is a section called ‘Your benefits explained’. And relevant to this complaint is the following part:

> *Hospital fees and critical care*
>
> *Your treatment must take place at a hospital eligible under your plan, and under the care of a consultant recognised by us. To ensure this is the case, you must always get authorisation for your treatment from us in advance.*

Has Vitality fairly declined the claim?

Based on the policy term detailed above it is clear that for any hospital treatment to be covered it needs to take place at a hospital that is eligible under the policyholder’s particular plan and that the consultant must be one that appears on Vitality’s recognised list. Vitality has said that Mr F wasn’t a recognised consultant and therefore this exclusion applies in respect of Mrs W’s claim for her surgery. And based on the relevant policy term, it’s clear that there isn’t cover for this claim.

As an Ombudsman my role, and the fair and reasonable remit afforded to me, entitles me to step away from the strict interpretation of the policy terms and conditions where I think this doesn’t necessarily provide a fair outcome. And I’ve considered whether it would be reasonable for me to do so in the particular circumstances of this complaint.

It is important to state at this point I’m not a medical professional and in order to reach any decision on this case, it is necessary for me to rely on the information provided from the medical experts who Mrs W has seen.

The main issue here is that the consultant is not recognised by Vitality, and it is on that basis that Vitality has declined her claim. Mrs W has provided a letter from Mr F in which he explains that there are only three surgeons (including himself) who work in this country who could have successfully operated on and treated Mrs W’s medical condition. So, it appears that the options available to Mrs W were extremely limited.

I asked Mrs W to obtain the details of the other two specialists and provided this information to Vitality to find out if either of these other specialists were recognised consultants. Vitality confirmed that both of the other consultants are recognised, however, neither of them are available on the ‘Consultant Select’ cover option Mrs W had taken out. So, they wouldn’t have authorised Mrs W to have treatment with them either.

Mrs W purchased the ‘Consultant Select’ option of cover when taking out the policy. This level of cover restricts the consultants and hospitals that Mrs W could use to those within an agreed group. Often this will exclude those consultants who practice in hospitals which are in more expensive areas, such as those in London.

I’ve thought about this carefully. Mr F has stated that the surgery Mrs W required was complex and could only be completed by three specialists in this country. And although two of those specialists are recognised by Vitality, neither of them are available within the level of cover that Mrs W had purchased. It would appear to me that, based on the medical evidence

supplied, Mrs W wouldn't have been able to obtain treatment for her condition elsewhere under her policy cover. Vitality has confirmed that the treatment itself has been agreed, albeit after the event, however, I haven't seen anything to show Vitality would have been able to provide her with a suitable alternative within her level of cover to enable her to utilise her private medical insurance. I'm not satisfied that this provides a fair and reasonable outcome.

Taking into account the particular circumstances of this case, I'm persuaded that, on a fair and reasonable basis, Vitality should consider the claim for the costs of Mrs W's surgery. I'm aware that, if the surgery had been completed by a recognised consultant, Vitality would have only paid up to the amount in its procedure of fees list (the list of fees that Vitality has agreed with consultants for procedures completed). And so on that basis, I don't think Vitality should have to pay for the full cost of the surgery charged by a specialist not recognised, if this is more than the listed amount. I think it reasonable for Vitality to limit the payment to the amount shown in the procedure of fees list. It may also be that the hospital where Mrs W received her surgery isn't one that would be authorised under her plan. It is likely that Mrs W would have had to pay an additional premium in order for treatment to be covered. I don't think it would be fair for Mrs W to receive the benefit of cover for hospital costs that she hasn't paid the premium for. If the costs are higher than those for a similar hospital which is within the list Mrs W has available under her plan, Vitality can restrict the payment to this amount.

Vitality customer service

Vitality agreed to provide a list of alternative consultants to Mrs W when it advised that Mr F wasn't recognised. However, this was never sent to her. Vitality has accepted that it had made a mistake and so it offered £25 as compensation.

Our investigator didn't think this was a fair award for what had happened. He said the compensation should be increased to £150.

When she was told she couldn't receive treatment under her plan with Mr F, Mrs W was expecting to receive details of alternative consultants who she could use. Mrs W has said that she chased Vitality for these details but didn't receive them. Considering Mrs W had explained her concerns about the urgency of having the operation, I would have expected Vitality to have ensured this information would have been provided to her quickly. However, this was not forthcoming. Had Vitality looked into this at the time, I think it would have likely found out that only three specialists could do the procedure, none of whom were recognised within Mrs W's choice of plan. Vitality could have then considered alternative options at that time.

I can fully appreciate how the lack of information from Vitality would have caused Mrs W to worry. In the circumstances, I think that the investigator's recommendation to increase the compensation to £150 is fair and reasonable."

Mrs W accepted my provisional decision, however, Vitality didn't agree. I've summarised the points raised below:

- Mrs W was fully aware from the time she was referred to Mr F that she could not see him under her particular plan. She went ahead knowing that Vitality wouldn't pay the invoices.
- At the time of the call when Vitality said it would offer alternatives, the claim hadn't been accepted and it didn't know what procedure was being undertaken – so couldn't have located the alternatives now provided. So it doesn't think this call is relevant.

- If Mrs W had made contact again she could have proceeded in accordance with her chosen policy terms.
- Vitality must be fair to all members who have chosen this hospital list. It doesn't pay for surgery by a de-recognised consultant regardless of whether alternatives are available. And it doesn't pay for surgery that hasn't been pre-authorised.
- It doesn't see any valid reason for the policy terms and conditions to be overridden when the member has gone against what they had been told on more than one occasion.

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.

And having done so, while I appreciate Vitality's response to my provisional decision, I'm not persuaded to alter my outcome. I'll explain why.

Vitality said it would provide alternative surgeons to Mrs W but it didn't do so. It has referred to this being before the treatment had been agreed and so it didn't have details of the procedure and therefore could not have provided an alternative. Vitality has said if Mrs W had contacted it again it could have helped her proceed within the cover under her plan. However, I don't think it is reasonable to put this back on Mrs W when Vitality failed to do what it said it would.

Vitality has also said if Mrs W had contacted it again it would have arranged for her to see another consultant – but the medical evidence supplied suggests that no one else within her plan could have done the surgery. And I note Vitality hasn't provided any evidence to contradict the comments of the treating surgeon, despite having time in which to do so.

Mrs W has said that the surgery was required urgently as otherwise there was a risk of a permanent disability. I'm sure this was a frightening thing to hear and so I think it is reasonable that she went ahead on that basis, despite knowing that Mr F wasn't a consultant within Vitality's list. That's because she was told that only three surgeons in the country could do the surgery, and Vitality hadn't suggested any alternative surgeons to her.

Vitality has said that Mrs W didn't adhere to her own chosen plan details and it wouldn't be fair to other members who have chosen the same hospital list if it was to consider the claim. But Vitality hasn't been able to show that she could have had the treatment within her plan. And it is important to point out that I've not asked Vitality to pay the full costs of the procedure but stated this can be limited to the costs that would be incurred in the procedures of fees lists and for hospital costs that would be within her plan. I therefore don't think Mrs W could be considered as benefitting from this.

Putting things right

Vitality needs to:

- Deal with Mrs W's claim (payment for the procedure fees can be restricted to the applicable amount in Vitality's list of procedure fees and any payment for hospital charges can be limited to those charges that would be payable if this had been received in a hospital available in Mrs W's plan);

- Add 8% simple interest to the settlement, from the date Mrs W paid the costs to the date of settlement.; *

- Pay Mrs W £150 compensation

**If Vitality considers that it's required by HM Revenue & Customs to deduct income tax from that interest, it should tell Mrs W how much it's taken off. It should also give Mrs W a tax deduction certificate if she asks/ask for one, so she can reclaim the tax from HM Revenue & Customs if appropriate.*

My final decision

For the reasons stated above, I'm upholding this complaint.

I direct Vitality Health Limited to put things right as detailed.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs W to accept or reject my decision before 5 September 2024.

Jenny Giles
Ombudsman