DRN-4899503

The complaint

Mr S complains that Vitality Health Limited didn't settle invoices for his treatment and has provided him with poor customer service when he claimed on his private medical insurance policy.

What happened

Mr S claimed on his group scheme private medical insurance policy as he was having investigations into suspected heart issues. He complained as there were some invoices unpaid and he didn't think Vitality had responded appropriately to the update from his specialist.

Vitality looked into what happened. In their final response letter they offered Mr S £100 for poor customer service.

Mr S complained to the Financial Ombudsman Service. Our investigator looked into what happened and ultimately upheld Mr S's complaint in part. She thought that Vitality should increase the compensation to a total of £250 for the poor service Mr S received. However, following her investigation, she was satisfied that all the invoices had been settled by Vitality and the only outstanding invoices were due to the policy excess which needed to be paid. And, she was satisfied that Vitality were reasonable to request more information from the consultant about the need for further testing.

Vitality agreed to pay the £250 compensation. Mr S didn't agree with the investigator's recommendations. In summary, he didn't think the compensation was sufficient. And, he felt that Vitality had adequate information to demonstrate why the further tests were needed. He maintained that he had paid for one of the scans (a CaRi scan) and said that he'd provided ample evidence that this had been authorised and paid for.

So, the complaint was referred to me to make a 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.

At the outset I acknowledge that I've summarised this complaint in far less detail than Mr S has, and in my own words. I won't respond to every single point made. No discourtesy is intended by this. Instead, I've focussed on what I think are the key issues here.
The rules that govern our service allow me to do this as we are an informal dispute resolution service. If there's something I've not mentioned, it isn't because I've overlooked it. I haven't. I'm satisfied I don't need to comment on every individual point to be able to fulfil my statutory remit.

The policy terms and conditions say that the policy doesn't usually cover long term treatment of chronic conditions where the purpose of that treatment is primarily to just keep the symptoms under control.

A chronic condition is defined as:

> A disease, illness or injury that has at least one or more of the following characteristics:
>
> - It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and/or tests
> - It needs ongoing or long-term control or relief of symptoms
> - It requires your rehabilitation or for you to be specially trained to cope with it
> - It continues indefinitely
> - It has no known cure
> - It comes back or is likely to come back.

The terms also say:

> Your plan covers the cost of treatment for acute conditions. These are conditions that respond quickly to treatment which aims to return you to the state of health you were in before suffering the condition, or which leads to your full recovery.

The relevant rules and industry guidelines say that Vitality has a responsibility to handle claims promptly and fairly. And they shouldn't reject a claim unreasonably. I'm partly upholding Mr S' complaint but I think a total of £250 compensation is fair and reasonable. I say that because:

- On balance, I'm persuaded that it's most likely Vitality have settled the invoice for the CaRi scan. Based on the available evidence I think it's most likely that this invoice was presented to Vitality as an invoice for an MRI scan and was paid by them on the basis an MRI scan had been authorised.
- Mr S was asked to provide evidence, for example a bank statement, to demonstrate that he made payment for a CaRi scan to the facility. He's not provided the evidence that's been requested and, based on the evidence I have seen, I'm not persuaded there is sufficient evidence Mr S has made a duplicate or additional payment to the facility for the scan.
- Vitality has now demonstrated, in my view, that it's most likely the CaRi scan has been paid for. So I don't think it's central to the outcome of this complaint whether Mr S's scan was authorised during a call or not as Vitality have paid the invoice.
- The medical report from April 2022 says that there will be a follow up plan to re-evaluate matters in a couple of years. A further report from November 2023 says that 'the finding of early coronary disease and a raised hear CaRi Heart score has meant that preventative measures with aspirin and statins had been initiated to lower his long term risk'. The consultant contacted Mr S in February 2024 about a repeat CaRi and MRI scan and this was around two years after the initial scan. I also note the consultant concluded the cause of Mr S's chest pains and chest discomfort is non-cardiac. Therefore, don't think it's unreasonable for Vitality to request further information from the consultant about why these appointments are medically necessary or whether they are to monitor Mr S's cardiovascular health.
- Mr S feels Vitality are not agreeing to cover up necessary follow-up tests. I don't agree that's the case. Based on the medical evidence presented by Mr S's consultant, which I've referred to above, I think it's reasonable to conclude that the

appointments and tests that are proposed are most likely for monitoring rather than diagnosis.

- Mr S referred to the policy information including a section which he said highlighted a similar example of a heart condition being diagnosed after the policy had started. He says it would be misleading if Vitality now say his condition isn't covered. But, I think that section needs to be placed in the wider context of the policy terms, including the sections I've quoted above. A condition can become a chronic condition during the life of the policy and the terms also give an example of when a condition becomes a chronic condition and explains that monitoring of a well controlled condition won't be covered. Therefore this point hasn't changed my thoughts about the overall outcome of the complaint.
- Mr S wants clarity about what Vitality will and won't cover in relation to ongoing investigations into his heart. However, that's not something that's possible and that's not how private medical insurance policies operate. At the point of claim Mr S needs to submit the relevant information and it will be assessed in line with the policy terms and conditions. It's not possible to provide Mr S with the information he wants as it will be dependent on the available medical evidence at the point of claim.
- I think that £250 compensation Vitality has offered reflects the impact of the poor customer service on Mr S. I think the poor communication and confusion caused during the claims process resulted in avoidable worry and stress. I appreciate that Mr S would like Vitality to compensate him at his professional hourly rate but I don't think that would be fair and reasonable in the circumstances of this case. Mr S brings his complaint in his capacity as a beneficiary of the policy. So, I think it's fair and reasonable to consider the distress and inconvenience caused to him as an individual.
- I've thought about whether Vitality should offer Mr S a refund of premiums. I don't think that would be fair and reasonable in the circumstances of this case. Mr S brings this complaint as an individual and he's had the benefit of the cover offered by the group scheme. So, I don't think it's fair to direct Vitality to pay Mr S, as an individual, a refund of the premiums, despite his close personal and professional connection to the business operating the group scheme.

Putting things right

I am directing Vitality to pay Mr S a total of £250 compensation to reflect the distress and inconvenience caused to Mr S by poor customer service. That includes not receiving timely responses to his correspondence and the confusion caused during the claims process.

My final decision

I'm upholding this complaint and direct Vitality Health Limited to put things right in the way I've outlined above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr S to accept or reject my decision before 21 November 2024.

Anna Wilshaw
Ombudsman