DRN-5308139

The complaint

Ms L has complained that Vitality Health Limited refused to cover the cost of a diagnostic health test on a private medical insurance policy.

What happened

In April 2024 Ms L's consultant advised that she should have a certain test. He recommended a comprehensive test from a specific provider. Vitality agreed to cover the test in principle, but not from the named provider, as that lab was not on its approved list.

In responding to the complaint, Vitality maintained its decision. However, it accepted that there had been some poor service and so offered £25 compensation.

I wrote a provisional decision recently in which I concluded that £100 would be a more appropriate level of compensation for the distress and inconvenience caused.

Both Vitality and Ms L agreed with my provisional decision, with Ms L adding some helpful additional points.

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.

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I've carefully considered the obligations placed on Vitality by the Financial Conduct Authority (FCA). Its 'Insurance: Conduct of Business Sourcebook' (ICOBS) includes the requirement for Vitality to handle claims promptly and fairly, and to not unreasonably decline a claim.

Looking at the policy terms, they state:

'The plan does not generally cover drugs and treatment that is not considered to be established medical practice in the UK, or where there is insufficient evidence of safety or effectiveness. This includes drugs that are used outside the terms of their UK or European licence or treatment that has not been reviewed and approved for general use in the NHS.'

I set out in my provisional decision that the test supplied by that particular lab (hereafter called the 'specific test') is not available on the NHS. So, based on the above policy wording, Vitality had acted reasonably in declining to cover it. Ms L no longer disputes this.

The consultant sent a copy of Ms L's clinic letter to Vitality on 23 April 2024, stating that a standard test could be repeated or that the specific test could be arranged. In contrast to the standard test, the specific test would be more comprehensive, including a check for the presence of fungi.

Vitality agreed to pay for the test. But it seems to have assumed initially that this was a standard test, or that the specific test was more widely available. So, it gave her the name of an alternative lab, that it did cover, and sent Ms L a list of hospitals who used that lab. This resulted in Ms L ringing round those facilities, only to find out that they didn't provide the specific test.

It was on 26 July 2024 that Vitality identified that there was no provider on its approved list that could provide the specific test. I concluded in my provisional decision that it could have done that on or around 23 April 2024 when it received the letter from the consultant. Ms L eventually self-funded the test and I'm persuaded she would have done that at an earlier date if it had not been for the three-month delay caused by Vitality.

Overall, I considered that £100 would be appropriate compensation for the distress and inconvenience caused. As neither party has disagreed, I see no reason to depart from the findings I made in my provisional decision.

My final decision

For the reasons set out above, I uphold the complaint and require Vitality Health Limited to pay £100 total compensation.

I understand that it has already paid the £25 originally offered. Therefore, it should pay the remaining £75 now.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms L to accept or reject my decision before 4 March 2025.

Carole Clark
Ombudsman