DRN-5308951

The complaint

Mrs E and Mr T complain because Vitality Health Limited ('Vitality') refused to pay for certain physiotherapy sessions under their private medical insurance policy.

What happened

Mrs E and Mr T were insured under a private medical insurance policy, provided by Vitality.

Vitality authorised six physiotherapy sessions for Mrs E under the policy. When Mrs E needed more sessions, Vitality asked for her physiotherapist to complete a form but later said additional sessions weren't covered. Vitality said this was because its internal guidelines provided for a maximum of six physiotherapy sessions to be covered in Mrs E's situation.

Mrs E and Mr T complained to Vitality, who said it would cover a further two sessions of physiotherapy for Mrs E. Vitality subsequently offered Mrs E and Mr T £125 compensation for incorrectly issuing the form to Mrs E's physiotherapist and for its delays in addressing the issues Mrs E and Mr T had raised.

As Mrs E and Mr T remained unhappy, they brought their complaint to the attention of our service.

One of our investigators looked into what had happened and said he didn't think Vitality had acted fairly or reasonably in the circumstances. He recommended that Vitality should pay the costs of the outstanding physiotherapy sessions which Mrs E was claiming for.

Vitality didn't accept our investigator's opinions and provided clarification to our service about the reasons why it said Mrs E's additional physiotherapy sessions weren't covered. As no resolution was reached, the complaint was referred to me to make a decision, as the final stage in our process.

I issued my provisional decision about Mrs E and Mr T's complaint in January 2025. In it, I said:

'Industry rules set out by the regulator say that insurers must handle claims fairly and shouldn't unreasonably reject a claim. I've taken these rules into account when making my provisional decision.

The terms and conditions of Mrs E and Mr T's policy, in common with most if not all private medical insurance policies available on the market, only cover the costs of treatment to cure an acute condition. An 'acute condition' is defined as:

> *'A disease, illness or injury that is likely to respond quickly to treatment which aims to return you to the state of health you were in immediately before suffering the disease, illness or injury, or which leads to your full recovery.'*

Treatment for chronic conditions isn't covered. 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.'

Vitality isn't obliged to cover the cost of medical treatment solely on the basis that a medical professional has recommended the treatment or said the treatment is medically necessary. The cost of medical treatment is only covered by Vitality if the treatment meets the criteria for a valid claim to be paid under the terms and conditions of the policy.

While Mrs E and Mr T's certificate of insurance refers to 'full cover' for in-network physiotherapy, this is subject to the full terms and conditions of the policy. So, physiotherapy is only covered for the treatment of acute, not chronic, conditions. To reach a conclusion that the reference in the certificate of insurance to 'full cover' means there is unlimited cover for physiotherapy regardless of the reason it's required would, I think, be wholly unreasonable.

Mrs E and Mr T's policy doesn't specifically state that Vitality will only cover six sessions of physiotherapy in this situation. But I don't think it needs to. The six session treatment limit forms part of Vitality's internal criteria for deciding whether it considers a condition to be chronic. Vitality is entitled to set and apply these internal criteria as long as it does so fairly and treats customers in the same situation in the same way.

Vitality has provided extracts from its confidential underwriting guidelines which set out the medical reasons why it considers the condition which Mrs E was claiming for to be a chronic one. Vitality's stance is that it will pay for six sessions of physiotherapy for any policyholder claiming for this condition. And, Vitality appears to have told Mrs E and Mr T this when the claim was originally made in late 2023. While I can't share Vitality's commercially sensitive underwriting information with Mrs E and Mr T, I want to assure them that I have given it careful and detailed consideration. I'm satisfied this evidence demonstrates that Vitality hasn't acted unfairly or unreasonably by refusing to pay for any further physiotherapy sessions for Mrs E, and that Vitality has treated Mrs E fairly and in the same way it would have treated other policyholders in the same situation.

I've taken into account Mrs E's physiotherapist's comments on the completed form explaining that she had achieved a 40% improvement and that her prognosis was to return to a certain activity symptom-free. It's not in dispute that further physiotherapy sessions were recommended for Mrs E but, as I've already explained, this doesn't automatically mean that the cost of these is covered under the terms and conditions of the policy. Overall, I don't think Vitality has acted unfairly or unreasonably in the circumstances by considering Mrs E's condition to be a chronic one.

However, I think it's clear that Vitality made a mistake when dealing with the claim for additional physiotherapy sessions. It unnecessarily requested information from Mrs E's physiotherapist, which gave Mrs E and Mr T an expectation that the further sessions would be paid for. I understand Mrs E and Mr T question whether the form was sent to the physiotherapist in error, but I'm satisfied from the contents of Vitality's file notes that this was indeed the case.

When Vitality told Mrs E and Mr T that no further physiotherapy sessions would be paid for, I think Vitality could have been clearer about the reasons why these weren't covered under the policy terms and conditions, and I also note there was confusion on Vitality's part as to whether its March 2024 final response letter had addressed Mrs E and Mr T's complaint.

Mrs E and Mr T have said they want a refund of the premiums they paid to Vitality, less the value of their claims that were paid. However, Mrs E and Mr T had the benefit of cover and Vitality bore the risk of valid claims being made (over and above those that actually were paid) during the period the cover was in force. So, refunding the premiums isn't something which I can fairly direct Vitality to do in these circumstances.

Vitality has paid for two further physiotherapy sessions which weren't covered under the policy terms and conditions and has offered to pay Mrs E and Mr T £125 compensation. Overall, having taken into account the impact of Vitality's errors on Mrs E and Mr T, I think this is fair and reasonable in the circumstances.

I'm sorry to hear that Mrs E has been through such a difficult time, and I understand Mrs E and Mr T will be disappointed that I've reached a different outcome to our investigator, but I won't be asking Vitality to do anything more.'

So, my provisional decision was that I didn't uphold Mrs E and Mr T's complaint. Vitality responded to my provisional decision and said it had nothing further to add. Mrs E and Mr T replied to my provisional decision with additional comments, which I've summarised as follows:

- they dispute my findings that the policy terms and conditions don't need to set out limitations on the cover provided;
- Vitality has subsequently changed its policy documentation to state there is a limitation of six sessions on physiotherapy cover, which supports the argument that Mrs E and Mr T's policy documentation was unclear;
- they don't agree that Mrs E's medical condition meets the policy definition of 'chronic' and the physiotherapist's report mentioning a prognosis of returning to running symptom-free aligns with the policy definition of 'acute'. Furthermore, Mrs E and Mr T say that a desktop definition or assessment of whether a medical condition is 'acute' or 'chronic' shouldn't be relied upon by Vitality;
- at no point did Vitality mention 'acute' or 'chronic' to Mrs E and Mr T and this reasoning was only provided after a complaint was made to our service;
- a discussion took place with Vitality, during which it said the physiotherapist would be asked whether surgery was recommended;
- after Vitality closed Mrs E and Mr T's complaint without their agreement, a new complaint had to be opened. Vitality didn't get in contact when it said it would and didn't meet any of its stated time-frames;
- Mr T spent hours on the phone to Vitality. Both he and Mrs E experienced stress and anxiety which impacted their mental health and their relationship, and they find the compensation of £125 offered to be insulting.

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.

I've carefully thought about all the submissions which Mrs E and Mr T have made in response to my provisional decision. I can certainly understand their point of view, but I must reach an independent and impartial outcome which is fair to both parties involved and, I'm afraid I simply don't agree with much of what they've said.

It's just not possible for or reasonable to expect this policy (or any other private medical insurance policy) to set out every limitation on cover which applies to every combination of known medical condition and available medical treatment within the terms and conditions. Instead, private medical insurers each have their own internal underwriting guidelines which set out the criteria for cover for different combinations of medical conditions and medical treatments. And, as I've explained, this isn't unfair or unreasonable, as long as the insurer can demonstrate that they are treating policyholders in the same situation in the same way. I don't think the evidence which Vitality has provided in this regard is selective, and I'm satisfied that it demonstrates Vitality has acted fairly and reasonably in the circumstances. I accept that Mrs E and Mr T feel this makes the cover disingenuous and misleading, but it's how private medical insurance policies work.

The number of physiotherapy sessions which Vitality covers under its internal underwriting criteria varies according to the medical condition being claimed for. While I can see from Vitality's website that it now describes the physiotherapy cover as providing *'up to 6 physiotherapy sessions…'*, this doesn't mean that the previous description entitled Mrs E to a level of treatment which Vitality doesn't cover under its internal guidelines. For the avoidance of doubt, I don't think the previous description was unclear.

Its not unreasonable for a private medical insurer to rely on recognised medical research, medical publications and/or expert medical opinion to categorise a medical condition as either 'acute' or 'chronic'. I would, however, expect an insurer to take any available medical evidence provided by a treating medical professional into account when making a decision about a claim on an individual case.

Vitality has used general, recognised medical knowledge to categorise the condition which Mrs E was claiming for as 'chronic' in this instance. It says that ongoing face-to-face physiotherapy sessions for this condition are not curative. I don't think Mrs E's physiotherapist's report is persuasive medical evidence that Vitality has acted unfairly or unreasonably in reaching this conclusion. While the report refers to a prognosis of returning to running symptom-free, it also refers to *'returning to running without symptoms … getting worse'*. Overall, having taken all of the available medical evidence into account, I'm satisfied that it wasn't unfair or unreasonable for Vitality to consider that Mrs E's claim was for ongoing treatment of a chronic condition. And Vitality provided cover for two more physiotherapy sessions than I think it needed to in the circumstances.

My provisional decision acknowledged that Vitality could have been clearer in its reasons when explaining to Mrs E and Mr T that the ongoing physiotherapy sessions weren't covered. It would have been helpful if Vitality had provided what I think is the correct explanation to Mrs E and Mr T as to why the ongoing physiotherapy sessions weren't covered but the fact that Vitality didn't do this doesn't prevent it from subsequently raising the 'acute'/'chronic' distinction with our service.

I've taken into account what Mr T has said about what was discussed during the conversation with Vitality. I haven't requested a copy of this call recording from Vitality, as I don't think it's necessary for me to do so. It's for me to determine what information I think is relevant to my decision and I don't doubt Mr T's version of events. But, even accepting what Mr T has said, this doesn't change my findings or the outcome I'm reaching. I'm satisfied,

based on the evidence I've seen, that the form should never have been sent to the physiotherapist, and the fact that it was sent was a mistake on Vitality's part.

I'm sorry Mrs E and Mr T find my conclusion that Vitality's compensation offer is fair and reasonable insulting. But I can only award compensation for the impact of what I think Vitality's errors were and I have no power to punish or fine a business through an award of compensation. Vitality's errors were incorrectly requesting information from Mrs E's physiotherapist and its handling of Mrs E and Mr T's complaint. An offer of £125 falls within our published guidelines on the appropriate level of compensation for errors causing more than the levels of frustration and annoyance which might be expected from everyday life, where the impact has been more than minimal.

For these reasons, as well as for the reasons set out in my provisional decision, I'm satisfied that Vitality's compensation offer is fair and reasonable in the circumstances, and I won't be directing Vitality to do anything further.

If Mrs E and Mr T wish to complain about the information given to them when this policy was sold, then this would need to be the subject of a separate complaint. A complaint hasn't been made to the business responsible for the sale of the policy about what happened when the policy was sold, and the Financial Ombudsman Service has no power to consider the matter unless the business involved has been given the opportunity to do so first.

My final decision

My final decision is that I don't uphold Mrs E and Mr T's complaint.

Vitality Health Limited has already made an offer to pay Mrs E and Mr T £125 compensation and I think this offer is fair in all the circumstances. So, my final decision is that Vitality Health Limited should pay Mrs E and Mr T £125 if it hasn't already done so.

Vitality Health Limited must pay the compensation within 28 days of the date on which we tell it Mrs E and Mr T accept my final decision. If it pays later than this it must also pay interest on the compensation from the deadline date for settlement to the date of payment at 8% a year simple.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs E and Mr T to accept or reject my decision before 5 March 2025.

Leah Nagle
Ombudsman