DRN-5317290

The complaint

Mr S has complained that Vitality Health Limited hasn't fully covered his treatment under a private medical insurance policy.

What happened

In July 2023 Mr S received approval from Vitality to see a back specialist. He saw this consultant, who referred him for further investigative scans. He subsequently received an invoice for 40% of the cost of the scans.

Our investigator thought that Vitality had acted fairly and reasonably in only paying 60% of the charge itself, in line with the policy terms and conditions.

Mr S disagrees with the investigator's opinion and so the complaint has been passed to me for 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.

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:

'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.

Costs you might have to pay yourself

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.

How to arrange treatment

It is very important for you to contact us before having any treatment, so we can ensure the treatment, medical practitioner and hospital are covered on your plan. Following the conditions and processes outlined below will help ensure that you are not faced with any unexpected costs relating to your treatment.

Getting authorisation for your treatment

We will only authorise treatment that takes place at a hospital eligible on your plan, under the care of a consultant or therapist recognised by us. You should check your cover so you understand if there are any payments you will need to make yourself (such as an excess). For further information on costs you may have to pay yourself, please refer to the "Costs you might have to pay yourself" on page 29.'

Mr S was originally given the option of another hospital at which to see a consultant and that was his first choice. However, upon contacting Vitality to confirm that, he was told there had been a mistake and that hospital was no longer on the list. He then chose another consultant at a different hospital.

That consultant, and the hospital he was based at, were both on Vitality's approved list and so fully covered under the policy. However, the consultant then referred Mr S for scans at a hospital that was not on the list.

Mr S accepts that he didn't call Vitality to get pre-approval for the scans. He thought that, as the consultant had referred him, and it was the consultant's secretary that arranged it, that the treatment was still within the scope of the policy terms.

The consultant doesn't work directly for Vitality. Patients on a variety of plans, with different insurers, would be able to access his clinic. So, the consultant and his secretary would have been unaware of the particular limitations of Mr S's policy or what hospitals were covered under its list. So, although Mr S says he relied on the guidance of the consultant, it was his own responsibility to ensure that every stage of treatment was covered. Similarly, it was not the role of the hospital where the scans took place to double check his arrangements with his insurer.

He says at no point was he informed that the second hospital was not covered under his plan. However, had he called Vitality to check, he would have been told at that point that it was an off-list facility.

Mr S says he was led to believe that Vitality was aware of and actively managing the network compliance of his care. However, beyond receiving approval to see the consultant, I'm not persuaded that he would have been given that impression.

The above policy terms make it clear that a 40% co-payment would be due if treatment happened off-list. In addition to that, Vitality sent Mr S a treatment approval letter on 28 July 2023, which said:

'*For this treatment, you are eligible to be under the care of one of the consultants noted above. Please get in touch with us should you be referred to someone else or you wish to change your consultant, to ensure their fees are fully covered.*

You have benefit available for the hospital fees agreed in this letter. Should you attend a hospital that's not on your list, a co-payment will apply. It is important that you check that the hospital your consultant suggests you attend is eligible on your plan. Details of your hospital list options can be found on the Member Zone. Click on Health – My plan details – Your hospitals.'

I think the wording in this letter served as a timely reminder to check if a hospital where treatment has been suggested is covered by the policy.

I have a great deal of sympathy for Mr S's situation. He was in pain at the time and went along with what his treating consultant was recommending. However, the matter at hand is whether those circumstances are covered under the policy terms – and I'm afraid to say that they are not.

I've thought about everything Mr S has said. However, on balance, I'm satisfied that Vitality has acted fairly and reasonably in only paying 60% of the cost of the scans due to them being performed at an off-list hospital. It follows that I do not uphold the complaint.

My final decision

For the reasons set out above, I do not uphold the complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr S to accept or reject my decision before 8 April 2025.

Carole Clark
Ombudsman