

The complaint

Mr and Mrs N are unhappy that Vitality Health Limited declined a claim made under their private medical insurance policy ('the policy') for surgery Mrs N needed on her hip.

They're also very unhappy about the way the claim was handled and the service received.

What happened

The details of this complaint are well known to both parties, so I won't repeat them again here. I'll focus on giving the reasons for my 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.

That includes all submissions made by both parties to the Financial Ombudsman Service. Whilst I've considered these in detail (along with all the other evidence) I won't be responding to each point made.

I hope the parties understand that no discourtesy is intended by this. Instead, I've focussed on what I think are the key issues here. The rules that govern the Financial Ombudsman 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 point to fulfil my statutory remit.

Vitality has a regulatory obligation to handle insurance claims fairly and promptly. And it mustn't unreasonably decline a claim.

The policy started in July 2022 and is underwritten on a moratorium basis. The policy terms and conditions explain the moratorium as:

We don't pay claims for the treatment of any medical condition or related condition which, in the five years before your cover started:

- you have received medical treatment for, or
- had symptoms of, or
- asked advice on, or
- to the best of your knowledge and belief, were aware existed

The policy terms refer to this as a pre-existing condition.

A related condition is defined as:

any symptom, disease, illness or injury which reasonable medical opinion considers to be associated with another symptom, disease, illness or injury. It could be deemed to be an underlying cause of, or directly caused by, another medical condition.

However, under the policy, pre-existing medical conditions can become eligible for cover providing:

you have not:

- consulted anyone (eg a GP, dental practitioner, optician or therapist, or anyone acting in such capacity) for medical treatment or advice (including check-ups).
- taken medication (including prescription or over the counter drugs, medicines or injections)

for that pre-existing medical condition or any related condition for two continuous years after your cover start date.

When first assessing the claim, Vitality concluded that Mrs N's hip condition was pre-existing and that Mrs N had consulted a medical professional about this condition within two years of the policy starting. So, it declined the claim.

However, after Mr and Mrs N brought a complaint to the Financial Ombudsman Service, Vitality accepted that it had unfairly relied on this reason to decline the claim. It offered £250 compensation to apologise (on top of the £150 compensation it had already offered in its final response letter to reflect the impact of some service failings).

After the claim was declined, Mrs N proceeded with the surgery she needed and Mr and Mrs N funded this by way of a finance agreement. They say Vitality should be responsible for the cost of treatment as it should've been covered.

I've thought very carefully about this point and when doing so, I've considered what is most likely to have happened on the balance of probabilities if Vitality hadn't unfairly declined the claim.

Mr and Mrs N's certificate of insurance says:

You are covered under our Consultant Select option. Our consultant panel will choose a consultant for you based entirely on your medical needs. The consultant will choose the most appropriate hospital for your treatment. We will only pay for treatment that we have authorised in advance.

The policy terms and conditions also say to be covered:

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.

And in relation to 'consultant select' it says:

We recognise the vast majority of consultants working in private practice in the UK. To help you make an appropriate choice, we assess all consultants for robust clinical practice, excellent treatment outcomes and how efficiently they deliver healthcare. Should you need to see a consultant, we provide you with a choice of recognised consultants to choose from who score highly on these measures, and that are appropriate for your condition and where you live.

From what I've seen I'm satisfied that the consultant orthopaedic surgeon who operated on Mrs N ('the consultant') isn't on consultant select list. This doesn't seem disputed by Mr and Mrs N. So, his costs weren't covered under the policy Mr and Mrs N had the benefit of. I'm also persuaded that Vitality never authorised Mrs N's consultations and treatment with the consultant.

Before the claim was declined Mrs N had already met with the consultant for an initial consultation and later, the consultant discussed surgery with her. Mr and Mrs N say they'd chosen the consultant as he had good revision data, and they had confidence in him as he was a specialist hip surgeon.

However, after the claim was declined and, importantly in this case, before Mrs N went ahead with the surgery to be performed by the consultant, I'm satisfied that Mr and Mrs N were made aware by Vitality that it wouldn't cover the consultant's fees.

In an email dated 7 November 2024 (around two weeks before the intended date of surgery), Mr and Mrs N were told by Vitality:

...You are now disputing the claim decline and informed [sic] would want full reimbursement from us. If the claim is later accepted, then in order for us to reimburse those cost [sic], the consultant and hospital would need to be registered with us and on your hospital list.

I have checked and [the consultant] is not on your hospital list – consultant select, so we would not be able to reimburse any cost associated with this consultant. If the claim is accepted and you want us to cover the cost of treatment, then we can send you alternative consultants on your hospital list to review.

Within Mr and Mrs N's reply they said:

Due to the serious nature of [Mrs N's] problem, we have committed to [the consultant]. This is primarily due to availability. We have never received a full list of Vitality consultants, this is despite asking...

So, I'm satisfied that Mr and Mrs N were aware that if Vitality changed its position and decided to accept the claim, it wouldn't cover the consultant's fees because he wasn't on Mr and Mrs N's consultant list.

Further, based on what I've seen, I'm satisfied that Vitality suggested details of a number of recognised consultants to Mr N in September 2024. Mr and Mrs N say no one was suitable and some didn't have any reviews. However, I don't think this means that the suggestions were unsuitable. I've also seen no evidence which convinces me that Mr and Mrs N contacted any of the consultants suggested by Vitality and / or that they were all either unavailable to meet with Mrs N, insufficiently experienced or otherwise unsuitable.

And even if Vitality reasonably ought to have sent the list again after the email of 7 November 2024, from Mr and Mrs N's response at the time, I don't think they would've chosen to meet with a different consultant then. So, I don't think it was this that prevented them from doing so.

I've also taken into account what Mr and Mrs N say about a booklet (seemingly dated 2016) explaining the consultant select and the patient charter contained therein, giving them the right to switch to another panel approved consultant if they weren't happy with the original named consultant. However, Vitality has provided information which supports that the contact it had with the panel named in the charter ended before Mr and Mrs N's policy

started. So, even if this was given to them when the policy was sold by a third party, I don't think it's relevant here. In any event, I'm more persuaded by what's said in the terms and conditions of the policy about authorised consultants.

So, whilst Mr and Mrs N were free to go ahead with any consultant of their choice, I don't think it would be fair and reasonable to hold Vitality responsible for the consultant's fees in the circumstances of this complaint. I completely appreciate why Mr and Mrs N feel Vitality should be responsible; after all the claim was unfairly declined. I accept this decision put them to significant and unnecessary distress and inconvenience at an already worrying time for Mrs N when she was situationally vulnerable. I'll address that below.

However, I don't think its error resulted in the financial losses Mr and Mrs N would like to be covered. The medical costs incurred are substantial – over £15,000. And reading the consultant's letter dated the end of October 2024, I can see that Mrs N's health had deteriorated since meeting him the month before.

However, given what Mr and Mrs N said around the time the claim was declined, and the surgery took place – and their actions - I'm persuaded that even if Vitality had concluded that the claim was covered before the surgery had taken place, Mrs N would've gone ahead with the consultant. When making this finding, I'd like to make clear that I have a lot of empathy for the situation Mr and Mrs N found themselves. I know they'll be very disappointed – particularly given the financial impact of them. However, for the reasons set out above, I think this is what would've happened on the balance of probabilities.

Understandably, in addition to the financial impact, I can see that Mr and Mrs N were both very upset about having the claim declined.

I'm satisfied Vitality acted fairly by initially seeking medical information to enable it to verify the claim and see whether treatment was covered under the terms of the policy. It's standard industry practice for an insurer to request medical information to see whether a condition is pre-existing – especially when the insurance has been underwritten on a moratorium basis.

However, once it had the information it needed, Vitality's early insistence that treatment was for a condition not covered under the policy unnecessarily delayed matters and caused Mr and Mrs N to have to correspond a number of times to challenge this. This would've been frustrating, especially as it turns out the claim had been declined unfairly and there were opportunities to realise this a lot earlier.

I'm satisfied this would've exacerbated an already frustrating and distressing time for Mr and Mrs N.

I can see – and Vitality has already accepted - that it didn't provide responses to some of the questions Mr and Mrs N raised. Further, it didn't give clear information at times and it missed an opportunity to update Mrs N's mobile number. This resulted in further communications (and, so, inconvenience) which could've been avoided. I'm satisfied this would've also been unnecessarily distressing and frustrating for Mr and Mrs N.

Whilst I don't think it was unfair for Vitality to forward a complaint on Mr and Mrs N's behalf, I'm satisfied that it reasonably ought to have given Mr and Mrs N a copy of the complaint they'd forwarded to the seller of the policy raising concerns that the policy had been mis-sold. It could've also better explained why it was doing this. I can understand why Mr and Mrs N would've wanted to see the correspondence to ensure that it accurately set out their concerns and can see that they had to raise this issue with Vitality a number of times before receiving it. I don't think that's fair and would've added to their distress and inconvenience.

I can also understand why Mr and Mrs N were left frustrated by speaking with several different representatives using different communication channels; without explaining at the time why some correspondence was being encrypted.

Mr and Mrs N are also unhappy that Vitality says it didn't receive some emails despite Mr and Mrs N getting 'read receipts'. The evidence on this is inconclusive and on the balance of probabilities, I don't think Vitality unfairly failed to reply to these emails (if received). For example, Mr and Mrs N's email dated 28 September 2024. I'm also satisfied, that in any event, when Mr and Mrs N chased for a response, Vitality did promptly respond. So, I don't think any delays in responding to these messages were impactful in the circumstances of this case.

Having read the overall correspondence between Mr and Mrs N and Vitality's representatives, I don't agree that Vitality's representatives were unprofessional or unreasonable in their dealings with them.

I'm satisfied that total compensation in the sum of £750 fairly reflects the cumulative impact of Vitality's errors on Mr and Mrs N.

Mr and Mrs N have also asked for a return of the premiums they've paid for the policy since it started. I know Vitality unfairly declined Mrs N's claim and I'm not directing it to cover the consultant's costs. However, I don't think it would be fair and reasonable for me to direct Vitality to refund the premiums. Mr and Mrs N were insured and if there were other reasons to claim under the policy since it started, such claims could've been covered (subject to the terms of the policy). So, Vitality was on risk for other claims being made.

Putting things right

I direct Vitality to pay Mr and Mrs N £750 compensation for distress and inconvenience. It can deduct the two sums of £150 and £250 it's offered, if already paid to Mr and Mrs N.

My final decision

I partially uphold this complaint and direct Vitality Health Limited to put things right as set out above. Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs N and Mr N to accept or reject my decision before 14 October 2025.

David Curtis-Johnson
Ombudsman