

The complaint

Mr B has complained that Vitality Health Limited declined a claim he made on a private medical insurance policy.

What happened

Mr B had a sight test on 29 August 2023 and made a claim under the policy for the test and for contact lenses, which was paid. Without undergoing a new sight test, he then made a further claim in June 2024 for glasses, using the prescription received in August 2023.

Vitality declined the claim on the basis that the circumstances are not covered under the policy terms.

I recently wrote a provisional decision in which I explained why I wasn't thinking of upholding the complaint and inviting the parties to provide any additional information or evidence. Mr B provided some further comments that I will address below.

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, there is a table of benefits stating what is covered. It sets out that sight tests and new prescription glasses or contact lenses supplied by its network provider carries a benefit limit of '*£500 per plan year*' and for prescription glasses or contact lenses supplied by another optician, the benefit limit is '*£300 per plan year*'.

Next to this information it states:

"Further information

Please refer to the 'Your benefit explained' section under 'Optical care'"

On turning to the 'Your benefits explained' section on page 16, it states:

'Benefit is available for sight tests at a frequency recommended by your optometrist. It also includes new prescription glasses or contact lenses required following that sight test.'

Vitality declined the claim for glasses on the basis that Mr B had already claimed for contact lenses as a subsequence of the 2023 sight test. As the recall period for his next sight test was for two years' time, it said Mr B wouldn't be entitled to claim again until 2025.

As I said in my provisional decision, the terms are designed to be read in their entirety, rather than picking out certain sections in isolation. It's appropriate that the table of benefits refers to 'per plan year' as the maximum possible benefit in all circumstances. And I'm satisfied that the terms adequately draw attention to the 'further information' section that provides the fuller details of the optical care benefit.

In response to my provisional decision, Mr B has reiterated his objections about the way the policy is worded. His view remains that the alignment of the benefit to the frequency of the sight test applies solely to the cost of the sight test itself, whereas one claim can be made each plan year for either glasses or contact lenses. He believes that he has fully complied with the terms and conditions as written.

I do understand Mr B's position. However, I'm still not persuaded that the terms are ambiguous or that most people would interpret them in the way that he has.

He says he hasn't made a claim for glasses in any other years and Vitality is getting away with not having to pay for glasses now simply because he made the claim a number of months after claiming for contact lenses.

Insurance policies aren't designed to cover every eventuality or situation. An insurer will decide what risks it's willing to cover and set these out in the terms and conditions of the policy document. The test then is whether the claim falls under one of the agreed areas of cover within the policy.

Mr B says he made the claim in good faith, which I don't doubt. Whilst appreciating his frustration at having his claim for glasses declined, the question is whether the circumstances of the claim are covered under the policy terms – and unfortunately, for the reasons I've explained, I don't think they are.

Mr B has said that the case comes down to a 'very fine judgement'. As such, and as the dispute is over a sum of only £200, he says he's surprised that Vitality or myself haven't just agreed that the claim should be paid. However, in deciding what is fair and reasonable, I don't consider it would be fair to ask Vitality to settle the claim outside of the policy terms. Overall, I'm satisfied that it was entitled to decline the claim.

I'd like to thank Mr B for his additional comments. However, I've not been persuaded to depart from the outcome I reached in my provisional decision. 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 B to accept or reject my decision before 29 August 2025.

Carole Clark
Ombudsman