DRN-5802953

The complaint

Ms H complains that Vitality Health Limited trading as VitalityHealth unfairly declined her claim.

What happened

Ms H has a Personal Healthcare Plan with Vitality. In 2024 she made a reimbursement claim for treatment under two consultants, but Vitality declined it and said the consultants weren't covered under her policy.

Ms H disagreed with that decline and said the consultants were registered with Vitality and experts in their fields. She said her policy documentation said she had access to "*premier consultants*" and "*10 of the highest-ranking consultants*" too. And, that given the consultants' professional standings and the dictionary definition of premier she'd reasonably assumed they'd be covered.

Vitality investigated Ms H's concerns. It explained her policy offering was based on her chosen level of cover, which was Consultant Select, and the consultant's she'd chosen to see weren't available under it. Vitality also explained that its premier consultants weren't solely based on reputation. And it directed Ms H to the parts of her policy that set out both her cover level and the designation of premier consultants.

Unhappy with what had happened Ms H approached this service. She said Vitality had misrepresented what her policy offered, and she wanted her treatment costs reimbursed and the policy literature revised.

Our investigator didn't uphold the complaint and said Vitality had acted in line with the policy terms. They said that while the use of terminology like "*premier consultant*" could have been clearer, overall, the Consultant Select restrictions were sufficiently set out. And, that the need for pre-authorisation had been made explicit but Ms H hadn't sought that for the consultants she'd seen.

Ms H disagreed with that at length. She said Vitality hadn't provided clear information and we should be requiring it to amend its literature. Vitality had refused to disclose the criteria behind its definition of a premier consultant. She'd not been treated fairly, especially as a consumer making decisions about treatment in a medically urgent situation. And she could not have sought pre-authorisation for a consultant she had no reason to believe would be excluded from her cover.

Ms H asked that her complaint be referred to and ombudsman, so as no agreement was reached the matter was passed to me to decide.

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.

Ms H has set out her position at length. Although I've only summarised what happened above, I will reassure both sides that I have fully considered everything said. It's important for me to highlight however that I'll not be addressing every argument made. Rather, I'll be focussing on those matters I consider central to the outcome of this complaint and for the following reasons I will not be upholding it.

Vitality had a responsibility to handle this claim both promptly and fairly and not reject it unreasonably. It was required to provide Ms H with information that was clear, fair and not misleading too.

I've looked at the relevant policy documentation, namely the policy guide, the membership certificate and the full terms and conditions.

The membership certificate confirmed the level of cover Ms H had chosen for her policy was Consultant Select. It said:

"*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 provided further information about that level too, and under the heading "*Your hospital and treatment options*" said:

"*When you need **treatment** covered by the plan, you will be able to choose the medical professional who treats you, and where the **treatment** takes place. The choices available to you will depend on the options chosen by the **planholder**. You must always have your **treatment** approved by us in advance, so you know you will be covered. See "How to arrange treatment" on pages 32 and 33 for further details.*"

They also explained:

"*Consultant Select*

*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.*"

I understand the consultants Ms H had treatment with were registered with Vitality, but not all registered consultants are available under all cover levels. Here, the consultants Ms H chose to see weren't available under the level she'd opted for. And Ms H would have been aware of that had she sought pre-authorisation before going ahead.

Ms H says she didn't attempt to get her treatment pre-authorised because she had no reason to believe her consultants would be excluded. And, that given the urgent and serious nature of her condition she'd acted reasonably in following clinical advice and seeking treatment from globally recognised experts.

I appreciate what Ms H has said here, but even if her assumptions about who would have been covered had been right, that still would not have negated the requirement for her to get all treatment pre-authorised. The policy terms and conditions were clear on that and explained:

"*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 process outlined below will help ensure that you are not faced with any unexpected costs relating to your **treatment**.*"

Unfortunately, as Ms H made the decision not to seek pre-authorisation, the treatment she went ahead with invoked one of the policy's general exclusions. And I don't think it was unreasonable of Vitality to decline her claim because of that:

"*We will not pay any claims relating to:*

- ***treatment** that is available under a cover option that you have not chosen. Please refer to your membership certificate to check which cover options you (the **planholder**) have selected.*"

I also appreciate that Ms H thinks Vitality's policy was misleading. She says her policy documentation referred to "*premier consultants*" and "*10 of the highest-ranking consultants for your condition*". And that the two consultants she saw were indisputably among the UK and Europe's top specialists in their field but not available to her.

I understand why Ms H considers the consultants she saw to have been of a premier standard. And I acknowledge the ordinary meaning and dictionary definition of premier too. But I don't think the policy documentation was unclear, unfair or misleading about how Vitality determined which consultants it would appoint as premier or how planholder's would be able to access premier consultants either.

The policy guide, as an example, referred to premier consultants being assigned by Vitality to those who had shown to deliver superior performance across several key measures – including, length of stay, re-admission rates and the need for patients to change consultants.

The policy terms and conditions further explained that Vitality assessed consultants based on a range of different factors – from robust clinical practice, to how efficiently they delivered their healthcare. They also said premier consultants were designated to those that scored highly in that assessment too. And that Vitality would highlight them as part of any treatment authorisation.

I recognise Ms H's strength of feeling about this matter. But the word "*premier"* and the phrase "*10 of the highest-ranking consultants for your condition*" weren't intended to be read in isolation. The policy documentation was designed to be read together to get a full understanding of the cover being provided, and that was explained in the policy guide, the membership certificate, and the full policy terms and conditions.

Vitality's policy documentation didn't provide any guarantee or inference that every consultant registered with it would automatically be available to every plan holder. It didn't imply that the specific consultants Ms H chose to see would automatically be categorised by it as premier consultants and available to regardless of cover level either. And it did not set out that treatment need not be pre-authorised.

I realise that Ms H is likely to be further disappointed by my findings, and I emphasise with her position. But I don't think Vitality declined this claim unreasonably, and I'm not persuaded it would be fair of me to direct it to reimburse the costs Ms H has claimed for.

If Ms H remains unhappy with the way the policy and its cover levels were explained to her during its sale, that is of course something she can raise with the business that sold it to her. But in view of all the reasons given above I will not be interfering with Vitality's position on

this occasion.

My final decision

My final decision is that I do not uphold this complaint against Vitality Health Limited trading as VitalityHealth.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms H to accept or reject my decision before 29 December 2025.

Jade Alexander
Ombudsman