DRN-5838534

The complaint

Mrs L is unhappy with the way in which Vitality Health Limited has applied the outpatient benefit limit under her private health insurance policy ('the policy'), and the service she 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.

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

I can see that Mrs L feels very strongly that Vitality hasn't acted fairly; she's paid for consultant's fees that she thinks should be covered under the policy. I empathise with her situation.

I know she'll be very disappointed, but I'm satisfied Vitality has fairly applied the outpatient limit under the terms of the policy, given the invoices received for outpatient consultations.

The policy terms say:

> Out-patient Cover
>
> You will be covered up to the limit shown on your membership certificate for appointments with a consultant, following a referral from a GP, along with any diagnostic tests they order.
>
> If you have a limit on your Out-patient Cover, you may have cover so that diagnostic tests (such as pathology, X-rays, ultrasound scans, and ECGs) are covered in full.
>
> Your membership certificate will show which options apply to you.

Out-patient is defined by the policy terms as:

> A patient who attends a hospital, consulting room or out-patient clinic and is not admitted as a day-patient or an in-patient.

The certificate of insurance confirms that the outpatient limit was £500 for the relevant policy year.

In December 2024, Vitality provided authorisation for Mrs L to see a consultant and was subsequently referred for diagnostic tests by that consultant, who I'll refer to as Professor V.

For the policy year, Vitality says Mrs L had already had another outpatient appointment which cost £160. Mrs L doesn't seem to dispute this. Further, Mrs L doesn't dispute that the invoice for the initial outpatient consultation with Professor V (also £160) should come out of the policy limit of £500.

So, that left a balance of £180 remaining.

Mrs L is unhappy that Vitality also deducted from the remaining balance of the outpatient policy limit, two telephone discussions she had with Professor V on 23 December (in the sum of £120) and 27 December (the remaining £60 – leaving Mrs L to self-fund £60 of the amount invoiced for that discussion).

The out-patient definition makes no mention of telephone discussions, appointments and/or consultations. I appreciate that Mrs L didn't attend an in-person appointment at a hospital, consulting room or outpatient clinic. However, I don't think Vitality has acted unreasonably by deducting the amounts invoiced for those telephone meetings with Professor V from the remaining balance of the outpatient policy limit in the circumstances of this case.

The invoices received for 23 and 27 December 2024 are described as follow up outpatient consultations. And I don't think it's unfair for Vitality to treat them as such.

When making this finding, I've taken into account what Mrs L says about them being part of the overall 'procedural package' of the treatment she received. However, the conversations with the consultant took place on different dates than the treatment she had. The conversations didn't take place in the context of her being an in-patient or a day-patient and Vitality were charged separately for them. So, I think it's fair that the amounts of invoices were offset against the outpatient limit of £500.

Mrs L did self-fund an outpatient consultation with Professor V on 24 December 2024.

Vitality ended up reimbursing her for the amount she paid (£120) outside of the outpatient policy limit. I can see that this took place on the same day a biopsy was taken although they were billed separately. I think Vitality acted fairly and reasonably by reimbursing her for this cost, but I don't think this means that it would be fair and reasonable to hold Vitality responsible for other follow up consultations/discussions Mrs L had with Professor V.

In its final response letter dated January 2025, Vitality accepted that Mrs L was given incorrect advice on one call and was told that a follow up consultation after a planned procedure on 18 January 2025 would be covered under a procedure package deal.

However, it was charged as a separate outpatient appointment. So, as the outpatient limit had been exhausted by this time, Mrs L was responsible for this fee. I can see why this would've been confusing and upsetting for Mrs L. Vitality did apologise and offered £50 compensation to Mrs V for any distress and inconvenience caused.

I don't think being given incorrect information means it would be fair and reasonable for Vitality fund that outpatient fee outside the terms of the policy as she would've needed the follow up consultation. But I appreciate this unfairly raised her expectations that this fee might be paid and it would've been disappointing to find out that it wasn't covered. I'm satisfied £50 fairly reflects how this incorrect information impacted her.

Having considered everything, I don't think Mrs L was given any other incorrect information by Vitality during this time about the outpatient benefit. Nor do I think that anything else meant that the overall service she received was unreasonable.

My final decision

Vitality Health Limited has already made an offer to pay £50 compensation for distress and inconvenience. I think this offer is fair in all the circumstances.

So, my decision is that Vitality Health Limited should pay compnesation in the sum of £50 for distress and inconvenience.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs L to accept or reject my decision before 22 October 2025.

David Curtis-Johnson
Ombudsman