

## The complaint

Mr B complains because Vitality Health Limited hasn't paid for the full cost of his medical test under a private medical insurance policy.

## What happened

Mr B has 'Countrywide' hospital cover under a group private medical insurance policy, underwritten by Vitality Health Limited.

In 2024, Mr B had a medical test carried out and raised a complaint with Vitality about a 40% copayment charge under the policy. Vitality subsequently said it had paid the whole bill in error but wouldn't seek to claim this back from Mr B and explained that a 40% copayment charge would apply to any further treatment at an off-list hospital.

Mr B subsequently made a second claim for another medical test and, when Vitality said he'd need to pay a 40% copayment charge, Mr B complained. Mr B said Vitality had agreed to pay the whole bill for the same test previously and it had told him it would fully cover this claim. Vitality maintained its position that Mr B was responsible for the 40% of the bill.

Unhappy, Mr B brought the matter to the attention of our Service. One of our Investigators looked into what had happened and said she didn't think Vitality had acted unfairly or unreasonably in the circumstances. Mr B didn't agree with our Investigator's opinion, so the complaint has now been referred to me to make a decision as the final stage in our process.

## 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.

Industry rules set out by the regulator say insurers must handle claims fairly and shouldn't unreasonably reject a claim. I've taken these rules, as well as other relevant considerations, into account when making this final decision.

Mr B's certificate of insurance says: *'if you choose to attend a hospital not on your chosen list, you will need to pay 40% of the cost for treatment, diagnostic tests and scans....'*

The terms and conditions of the contract between the group policyholder and Vitality set out the limits of the cover Mr B is entitled to benefit from. The terms and conditions say:

*'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 cost of the treatment (excluding consultant's fees) yourself.'*

I'm satisfied Vitality clearly told Mr B during calls in September 2024, December 2024 and

January 2025 that a 40% copayment charge applied to claims at the hospital in question.

Although a letter from Vitality to Mr B dated 30 September 2024 explained that the whole bill for the first test had been paid in error, I think Vitality could have done more to explain this to Mr B again during the telephone calls I've mentioned. I think it's clear Mr B was confused about why the first bill had been paid in full. However, a previous error by Vitality in relation to the 40% copayment charge doesn't mean it would be fair and reasonable for it cover the entire bill for other claims at this hospital going forward, when the policy terms are clear that a 40% copayment charge applies in these circumstances.

I've considered the authorisation letter which Vitality sent to Mr B in January 2025. I understand Mr B feels this letter is ambiguous, but the letter does refer to a copayment charge being applicable in certain circumstances. And, even if I were to agree that the letter was open to misinterpretation, Vitality made it very clear to Mr B during a call in December 2024 that a copayment charge would apply if he went ahead with the test at the hospital being discussed. I understand Mr B wanted continuity of care but the policy he is insured under just doesn't cover the full cost of tests at that hospital.

I'm sorry to disappoint Mr B but I don't think it would be fair or reasonable in the circumstances to conclude that Vitality should pay this claim in full when it isn't otherwise covered under the terms and conditions of the policy.

I can't comment on hypothetical scenarios relating to possible future claims. If Mr B wishes to make another claim, then he'd need to contact Vitality for information about what is covered under the policy.

### **My final decision**

My final decision is that I don't uphold Mr B's complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr B to accept or reject my decision before 14 November 2025.

Leah Nagle  
**Ombudsman**