DRN-5973550

The complaint

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

What happened

In January 2025 Mr G registered a claim for prescription glasses under the optical benefits section of the policy.

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

Our investigator thought that Vitality had acted reasonably, in line with the policy terms and conditions. Mr G disagrees and so the complaint has been passed to me for a 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.

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.

In support of his complaint, Mr G has referenced legislation and guidance which underpins the professional obligations of opticians. Whilst appreciating why he has highlighted this, it is not a relevant consideration here. That's because insurers are entitled to decide what risks they are 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.

Looking at the policy terms, they state:

'*Optical care*

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.'

In this case, Mr G had a sight test on 29 December 2023. The next sight test was due on 29 December 2025, meaning that they take place at a frequency of every two years.

Mr G made a claim for contact lenses shortly after the sight test in December 2023. Therefore, according to the above term, he wouldn't be able to make another claim until after his next sight test on or after 29 December 2025. Accordingly, his claim for glasses in January 2025 was declined on the basis that he'd already made a claim for contact lenses following the December 2023 sight test.

Mr G also had a contact lens test on 29 December 2023. He says that his claim for contact lenses followed on from that test and not the sight test. As such, he says he's never made a claim as a result of the sight test.

I note that on one document, the optician has stated: '*Please note, an up-to-date sight test is legally required in order for a contact lens check test to be conducted, these are different tests and prescriptions.'* Therefore, I would say that Mr G's claim for contact lenses essentially originated from the December 2023 sight test.

I'm satisfied that the intention of the policy is to align the optical benefit with the frequency of sight tests. And that cover under that term is for glasses *or* contact lenses, but not both, for any one period. It is the timing of the claim that is important.

Therefore, it doesn't matter that Mr G also had a contact lenses test and that it resulted in a separate prescription. What matters is that he'd made a claim for contact lenses after the sight test in December 2023, so he is not able to make a further claim for glasses (or contact lenses) until after his next sight test.

I have some sympathy with Mr G's position. He made the claim for glasses in good faith, with the expectation of recouping some of his costs. However, the matter at hand is whether the circumstances of the claim are covered under the policy terms, and unfortunately, they are not. 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 G to accept or reject my decision before 14 January 2026.

Carole Clark
Ombudsman