

The complaint

Mr S has complained that Vitality Health Limited refused to pay the cost of blood tests that were part of a claim he made on a private medical insurance policy.

What happened

Mr S had blood tests in July 2023 that cost a total of £990. However, Vitality would not pay for them as Mr S had already reached the annual outpatient limit on the policy.

As Mr S hasn't paid the invoice himself, the provider passed the debt to a debt collections agency, who have added fees and charges. The outstanding amount is now £1,238.55.

In response to the complaint, Vitality maintained its position in regard to payment. However, it accepted that there had been some poor customer service when it failed to fully respond to his request for copies of statements. It therefore offered him £50 compensation for distress and inconvenience.

Our investigator thought that Vitality had acted reasonably in declining payment, and with its offer of £50. Mr S disagrees with the investigator's opinion 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.

I've also considered the Financial Conduct Authority's overarching Principles for Businesses. That includes Principle 12 of the Financial Conduct Authority's Principles for Businesses ('the Consumer Duty') which says a firm must act to deliver good outcomes for retail customers (such as acting in good faith and avoid causing foreseeable harm).

Mr S holds a corporate policy with an annual outpatient limit of £1,500. He doesn't dispute this. His complaint is that Vitality failed to communicate with him about this issue. Had it done so, he says he would not have undergone the tests.

Our investigator has previously set out the relevant policy wording; therefore, I won't repeat it here now. The wording is clear that there is a £1,500 limit for such costs. And this is also clearly set out in the shorter policy certificate that Mr S received.

The policy renewal date was 1 May 2023, so from that point Mr S had a £1,500 allowance towards outpatient costs. Between May and June 2023, he'd had a number of other treatment or tests, so he should have known that he'd incurred some costs that had reduced the available balance.

A condition of the policy is that pre-authorization for treatment needed to be requested. Whilst Mr S had set up the claim with Vitality, which had been approved, he did not subsequently contact it to seek pre-authorization for any further treatment. So, he hadn't contacted it for authorisation for the consultation that led to the blood tests, or for the blood tests themselves. Had he contacted Vitality, it could have clarified the benefits limit with him and what the remaining balance was.

Mr S says he was never told that the set of blood tests would cost £990 or that he might become personally liable for paying for them. He didn't contact Vitality in advance of having the tests, so it wasn't afforded the opportunity of having a conversation with him. Even if he had contacted it in advance, it wouldn't have been able to give him that information. However, it would have told him that he'd need to check the cost with the provider, so that he could make a decision about going ahead with the tests, in the context of his remaining benefit limit.

Mr S says he was unwell and was following the advice of a specialist consultant. He says he relied on that consultant and assumed that the authorised treatment would be covered.

Firstly, although the claim had been agreed, he did not have pre-authorization for the blood tests. As a policyholder, he had an obligation to familiarize himself with the available benefits and to use the policy as intended and as set out in the policy terms. Secondly, cover under the policy is not guaranteed just because treatment is advised by a consultant, and there was no reason why Mr S should have assumed that to be the case. Instead, cover is determined by the available benefit limit. Had he contacted Vitality at the point when the consultant referred him for tests, it would have been able to explain to him that he might end up incurring some or all of the costs himself if he went ahead.

Overall, based on the available evidence, I'm satisfied that Vitality acted reasonably in declining payment, in line with the policy terms and conditions. I appreciate that the cost has been added to due to the debt being taken over by debt collectors. However, as I consider that Vitality is not responsible for paying the invoice, it follows that it also has no responsibility for any actions taken by the provider for recovery of the debt, or the stress that has been caused to Mr S as a result.

In terms of the customer service issue of not sending the statements when requested by Mr S, I'm satisfied that the £50 offered by Vitality is fair compensation for the distress and inconvenience caused.

I am very sympathetic to Mr S's situation. He has health issues that he has been having investigative tests for and feels let down that the full extent of treatment and tests is not covered under the policy. And on top of that, he has the stress of being chased for payment. However, the matter at hand is whether Vitality did anything wrong, and I'm unable to conclude that it did. The benefit limit is clearly set out in the policy terms, together with the requirement to seek pre-authorization for treatment. On balance, I consider that it acted fairly in declining payment, in line with the policy terms and conditions and regulatory requirements.

My final decision

For the reasons set out above, I do not uphold the complaint. However, Vitality Health Limited should pay the £50 compensation now if it hasn't already done so.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr S to accept or reject my decision before 12 February 2026.

Carole Clark
Ombudsman