

The complaint

Miss G complains that Vitality Health Limited turned down a claim she made on a group private medical insurance policy.

What happened

The background to this complaint is well-known to both parties. So I've simply set out a summary of what I think are the main events.

Miss G is insured under her employer's group private medical insurance policy. In October 2023, Miss G made a claim on the policy due to suffering from breast pain. Vitality accepted the claim and Miss G was seen by a consultant. She was found to have bilaterally normal breast tissues. But during the investigations at that time, the consultant noted that Miss G had extremely dense breast tissue. And therefore, they recommended that Miss G should undergo annual mammograms, biannual breast MRI scans, alternated with ultrasound scans.

In 2024, Miss G made a new claim for a consultation and scans. Vitality says it agreed to cover this claim because Miss G told it she was suffering from breast pain again.

Subsequently, in September 2025, Miss G got in touch with Vitality to make a further claim for a mammogram, MRI and ultrasound.

However, Vitality turned down Miss G's claim. That's because it concluded that the purpose of the planned tests was monitoring. And it said the policy specifically excluded routine, precautionary and preventative screening and monitoring tests.

Miss G was very unhappy with Vitality's decision and she asked us to look into her complaint. She didn't agree that the tests were preventative in nature – instead, she felt they were diagnostic monitoring tests which had been clinically recommended by her consultant. And as Vitality had paid Miss G's claims in 2023 and 2024, she felt it had created a legitimate expectation that this claim would be covered.

Our investigator didn't think Miss G's complaint should be upheld. In summary, he thought it had been fair for Vitality to conclude that Miss G's claim wasn't covered by the contract terms. And he didn't think she'd lost out as a result of its decision to pay her claims in 2023 and 2024.

Miss G disagreed and so the complaint's been 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.

Having done so, whilst I'm very sorry to disappoint Miss G, I don't think it was unfair for Vitality to turn down her claim and I'll explain why.

First, I'd like to reassure Miss G that while I've summarised the background to her complaint and her detailed submissions to us, I've carefully considered all that's been said and sent. In this decision though, I haven't commented on each point that's been raised and I'm not required to under our rules. Instead, I've focused on what I think are the key issues.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. I've taken those rules into account, amongst other relevant considerations such as regulatory principles, the law, the policy terms and the available medical evidence, to decide whether I think Vitality treated Miss G fairly.

I've first considered the policy terms and conditions, as these form the basis of the insurance contract. This group policy renews annually on 1 April of each year – meaning that each policy year, a new annual contract begins between Vitality and Miss G's employer.

The policy provides cover for the treatment of 'acute conditions' – a disease, illness or injury that's likely to respond quickly to treatment which aims to return a group member to the state of health they were in immediately before they became unwell or injured.

Miss G's plan includes specific Cancer benefits and Advanced Cancer Care. However, page 25 of the contract says:

*'Our plans are primarily designed to help diagnose and treat an eligible condition where symptoms have occurred after your cover under the plan has started. **This means we don't cover:***

- *normal screening such as breast screens*
- *genetic tests to see if you are susceptible to a certain type of cancer*
- *vaccines, such as the vaccine to prevent cervical cancer.'* (My emphasis added.)

And pages 31 and 32 of the contract sets out a list of costs Vitality has chosen not to cover. These include the following:

- *'treatment to maintain your state of health or to monitor your health on a regular basis*
- *routine, precautionary or preventive examinations, routine dental, hearing and sight tests (except for the cover available under the Optical, Dental and Hearing Cover option), vaccinations, screenings (including screenings of familial conditions or genetic tests to determine your risk of getting an illness or disease) or preventive treatment (but we will cover the removal of healthy tissue for the prevention of cancer in specific circumstances)'*

In my view then, Vitality has explained, in a clear, fair and not misleading way, that it doesn't cover the costs of testing which is precautionary or preventative. I also think the contract terms make it sufficiently clear that Vitality doesn't cover the cost of breast screening.

Having assessed the evidence, Vitality concluded that Miss G's mammogram, ultrasound and MRI scans were precautionary or preventative. And so it turned down the claim. Therefore, I've carefully considered the available evidence to decide whether I think this was a fair conclusion for Vitality to draw.

In October 2023, Miss G's consultant recorded that following bilateral mammograms, while extreme breast tissue density was noted, Miss G's diagnosis was of '*bilaterally normal breast tissues.*' As such, it doesn't appear that Miss G was diagnosed with breast cancer or any other illness or disease following the consultation.

The consultant also stated: *'We have recommended mammograms annually with bilateral synchronous ultrasounds. As your breast tissue is extremely dense, we have recommended a baseline breast MRI that should be alternated with ultrasound every other year at the same time as screening mammograms.'*

I must make it clear that I'm not a medical expert and it's not my role to interpret evidence to reach my own clinical judgment. Instead, my role is to consider the evidence and decide whether I think Vitality relied upon it fairly.

The consultant referred to Miss G's planned mammograms as screening. It seems to me that the recommended MRI and ultrasound scans were intended to supplement the mammograms on an ongoing basis. And it appears that the tests were intended to monitor Miss G's health annually. So I don't find Vitality unfairly concluded that these tests were routine monitoring or precautionary in nature because there's no medical evidence that they were required to treat an underlying acute illness or disease. That means then that I don't think it was unreasonable for Vitality to decide that the scans weren't covered by the policy terms and therefore turn down the claim.

I do appreciate Miss G's consultant recommended that Miss G should undergo the relevant testing and that's medically necessary for her. But that doesn't mean that the cost of the tests are covered by the policy in circumstances where Vitality has decided to specifically exclude claims for routine monitoring, precautionary tests and breast screening under the terms of the contract.

Miss G considers that by accepting her claims in 2023 and 2024, Vitality has given her a legitimate expectation that future claims will be paid and that she's therefore detrimentally relied on its past actions. I've considered this carefully. However, Vitality accepted the 2023 claim because Miss G had reported symptoms of breast pain and therefore, it agreed that these symptoms could be investigated. And it says that it paid the 2024 claim because Miss G indicated the pain had begun again – although it now considers it should have undertaken further investigations before doing so.

And I don't agree that because Vitality had previously paid claims for the same tests during previous policy years, it's bound to continue to do so. Nor do I think I could reasonably find Miss G relied on anything Vitality did in 2024 to her detriment. That's because she benefited from the claim being paid in circumstances where it now isn't clear that it should have been.

So overall, while I sympathise with Miss G's position, I don't think Vitality acted unfairly or unreasonably when it concluded that her claim wasn't covered by the policy terms and accordingly turned it down. And I don't think there are any reasonable grounds upon which I could direct Vitality to pay Miss G's claim.

My final decision

For the reasons I've given above, my final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss G to accept or reject my decision before 9 April 2026.

Lisa Barham
Ombudsman