

The complaint

Mrs A complains about the service she received from Vitality Health Limited when she wanted to claim on a group private medical insurance policy.

What happened

Mrs A contacted Vitality to check whether she was entitled to policy benefits. She'd previously been looking to have a procedure related to breast cancer treatment and it had been declined. She'd sought treatment via the NHS and the consultant had agreed to put her on the waiting list for a procedure with a time estimate of two years before it would take place. Mrs A unexpectedly received a cancellation slot and contacted Vitality to ask about cover.

Mrs A complained to Vitality as she was unhappy with the service she received and that Vitality failed to log multiple complaints she made about this. She felt this had forced her to undergo NHS treatment despite paying for an expensive policy. Mrs A also explained that the cost of the policy had recently increased significantly.

Vitality acknowledged there were issues with the service Mrs A received and offered her £200 compensation for failing to log the complaints, failing to provide a callback and failing to act on the information that Mrs A's procedure had been deemed medically necessary by the NHS. They also explained that the pricing of the policy was determined by the risk profile of the group policy and that's what had led to the increase in the price of the policy. Unhappy, Mrs A complained to the Financial Ombudsman Service.

Our investigator looked into what happened and didn't uphold the complaint. He thought Vitality hadn't needed to ask for further information from Mrs A's consultant as the information she'd provided confirmed that Mrs A was having the procedure done via the NHS. This meant she'd fulfilled the strict criteria about when it could be offered. However, he thought by this point it was clear Mrs A was going ahead with the procedure via the NHS and that the compensation offered was fair for the customer service issues she experienced.

Mrs A disagreed. In summary she said she had complained on three occasions, and it was only on the fourth attempt that it was correctly logged. She said she didn't want to have the operation in May 2025 or in an NHS hospital but felt she had no choice. She highlighted that the procedure would have cost Vitality £12 000 and said that £200 compensation was unfair. She felt the claim for the procedure ought to have been authorised when she first contacted Vitality in mid-April 2025. Our investigator looked into Mrs A's additional points and asked for further comments from Vitality. Ultimately, the further representations didn't change the investigator's thoughts about the overall outcome of the complaint.

Mrs A requested that an ombudsman review her complaint. In summary she said she was offered the procedure in mid-April and called Vitality to determine where she stood with this. She said she didn't recall cashback being discussed on this day. She felt that when the documents were supplied on that date she should have been confirmed as being covered and should have been able to have the operation and follow ups privately. This would have given two weeks before her planned operation date. So, the complaint was referred to me to

make a decision.

At my request the investigator clarified with Mrs A when she contacted Vitality with the documents. She provided a copy of her email and the attachments.

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 want to say at the outset that I have a lot of empathy for the circumstances that Mrs A has described. It's clearly been a very difficult experience for her, and I can understand her disappointment that her procedure took place in an NHS facility rather than a private one.

The relevant rules and industry guidelines say that Vitality has a responsibility to handle claims promptly and fairly. And they shouldn't reject a claim unreasonably. Having reviewed the available evidence I think the total of £200 compensation which Vitality has offered is fair and reasonable for the reasons I'll go on to explain.

During the initial call to Vitality Mrs A did ask about cashback benefits and asked about cover in the event there were complications following the procedure. She did query whether she could be covered privately. But she also said she was planning to go ahead and get it on the NHS. So, I don't think Vitality acted unreasonably based on the information Mrs A provided to them.

I don't think Vitality could have reasonably given Mrs A a definitive answer about cover when she first contacted them in mid-April 2025. Her claim was complex and had involved input from a specialist team. So, in the circumstances, I don't think it was unreasonable for Vitality to ask that she put the request in writing.

Mrs A emailed information to Vitality on the 20 April which was the Easter Bank Holiday. In line with Vitality's usual service standards this was reviewed within 5 working days and referred to the medical team. I don't think that was unreasonable given the complexity of the claim and the information Mrs A provided during the calls.

Vitality then asked for more information from Mrs A's consultant about the NHS eligibility criteria. In their final response they accepted this was unnecessary as the criteria for the procedure taking place on the NHS is so stringent. So, I think Vitality were in a position to confirm to Mrs A that there was cashback cover at that point in time. That's on the basis that Mrs A had met the criteria for an admission for NHS treatment and therefore would qualify for the cashback benefit.

Instead, as I've outlined above, Vitality emailed the consultant with some eligibility questions. He responded the following day and Vitality's usual process is to review the correspondence within 5 days. The consultant's response was reviewed slightly outside those timescales, by which time Mrs A's surgery had taken place. However, I note that even if Vitality had responded within their usual timescales the planned date of surgery would have most likely already passed.

I also don't think that the overall evidence demonstrates that Vitality were most likely in a position to authorise private treatment for the procedure itself. In that case the process was for further information to be sought from the consultant. That's because there was a distinction between funding for the cashback benefit and funding for the procedure. That's reflected in the medical team's notes and the information Vitality have provided about their processes. So, I'm satisfied, on balance, it is most likely that Vitality would have been unable

to give Mrs A a definitive answer about funding for the procedure before the date of the NHS surgery.

I've thought very carefully about Mrs A's testimony that she didn't want the surgery on the NHS or at that time and whether Vitality's actions led to her missing the opportunity to have the procedure carried out privately rather than on the NHS. I'm not persuaded, on the balance of probabilities, that's the case. I think it's unlikely that she would have not proceeded with the NHS procedure in the circumstances I've outlined above. That includes factors such as the length of the potential waiting list, the symptoms she was experiencing and the proximity of the planned date.

I also bear in mind that Mrs A was placed on the NHS waiting list in January 2025 and said to her NHS team that she was happy to accept cancellation appointments. However, she didn't contact Vitality until April 2025 to discuss the position. I fully understand that Mrs A was facing very difficult family circumstances during that time, that she received a cancellation appointment and had been told the waiting list was around two years. But it did limit the time available to Vitality to investigate the updated position and give her guidance on what policy benefits could be available to her. That's no criticism of Mrs A, particularly given what she's said about her family circumstances, but I do think it's relevant as it impacted on the time Vitality had available to assist her.

I appreciate that Mrs A feels £200 doesn't fairly reflect the impact of the service issues she experienced and that she feels Vitality have saved around £12 000 as she's had NHS treatment. I don't think it's fair to direct Vitality to pay compensation of that amount. I'm not persuaded the failings that have been accepted, and which I've outlined above, caused Mrs A to lose out on private treatment. Nor am I persuaded they caused Mrs A extreme distress and inconvenience which mean an award of £12 000 compensation would be fair and reasonable. However, there were some minor delays, and her complaint was not correctly logged on a number of occasions. This had a negative impact on her in the days and weeks before and after her surgery. I accept that this caused Mrs A distress and inconvenience which was more than minimal, but I think £200 fairly reflects the impact of this.

Mrs A also expressed concern about the increase in the price of her policy. The policy is a group scheme arranged by an employer and therefore the price of the policy is something that the policyholder agrees with the insurer. Vitality has explained that the premiums have been impacted by the age of the insured members and reflects the risk profile the policy now presents. I'm therefore satisfied Vitality has provided a reasonable explanation for the increase.

My final decision

Vitality Health Limited has already made an offer to pay £200 to Mrs A to settle the complaint and I think that's fair in all the circumstances.

My final decision is that Vitality Health Limited should pay £200 to Mrs A if it hasn't already done so.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs A to accept or reject my decision before 14 May 2026.

Anna Wilshaw
Ombudsman