complaint

Mr and Mrs H are unhappy about Vitality Health Limited's ("*Vitality*") handling of Mrs H's claim made under their private medical insurance policy. Vitality has refused to reimburse the costs of Mrs H's treatment over and above the overall outpatient care limit of £600.

background

Mr H asked Vitality to authorise some treatment for Mrs H. Vitality talked about some of the policy features and limitations and authorised the treatment, subject to a limit of £600 per person per policy year for outpatient care.

When paying the invoices for the treatment Mrs H had received, Vitality applied the £600 limit and didn't pay any more. It told Mr and Mrs H they would be responsible for the remaining costs. These were well above the outpatient benefit limit, largely because of blood tests that had been carried out.

Mr and Mrs H were unhappy and complained to Vitality. They thought Vitality should have told them about all the possible diagnostic tests, including blood tests, which would be considered under the £600 limit when Mr H called for authorisation. They said the policy literature was also unclear about what was and wasn't included as part of the £600 limit.

Vitality didn't uphold the complaint. It said the adviser told Mr H diagnostic tests would be paid from the outpatient fund. It said it wasn't practical to list all possible diagnostic tests and that it couldn't reasonably advise consumers of every diagnostic test that would fall within the limit when authorising treatment.

Mr and Mrs H were still unhappy and complained to us. Our adjudicator didn't recommend the complaint be upheld, for much the same reasons given by Vitality.

The complaint was passed to me to look in to afresh as Mr and Mrs H didn't agree with the adjudicator.

my findings

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, I've decided not to uphold the complaint. I'll explain why.

In terms of how the policy works, I can see the terms explain that treatments as an outpatient have different benefit limits. The policy explains there's a difference, for example, between diagnostic *scans* and other diagnostic *tests*. Diagnostic scans are said by the policy to include CT, MRI and PET scans. Other diagnostic tests according to the policy include pathology, X-rays and physiological tests such as ECG. The summary of benefits Vitality sent Mr and Mrs H echoes the relevant policy terms. Unlike diagnostic scans, the payment for diagnostic tests falls within the overall outpatient limit of £600 per person per year. And it's on that basis that Vitality has limited payments for Mrs H's blood tests.

I take Mr and Mrs H's point that the policy terms (or summary of benefits) don't actually say blood tests will be classed as a type of diagnostic test and so limited to £600 per person per year. But I don't see how it could, from a practical point of view, list all of the types of

diagnostic test that would be caught by the limit. There are simply too many types of test to list and I think the wording, if anything, would become harder to understand for consumers.

If Mrs H's blood tests weren't classed as a type of diagnostic test (and I think Vitality was entitled to find that they were), I've thought about whether they could reasonably be described as anything else covered by the outpatient care benefits. But I don't think they could. I've already mentioned diagnostic scans but the policy explains the type of scan Vitality intends to cover under that section. A blood test isn't recognised as a type of scan.

So I think Vitality has acted in line with the policy terms in limiting Mrs H's claim benefits as it has. That said, I've also gone on to consider whether Vitality somehow mis-led Mr and Mrs H in to believing the policy would operate differently and in a way that suggested they would be covered in full once they needed to claim.

I've listened very carefully to three calls between Mr H and Vitality. In the first call in July 2014, Mr H said his wife was ill and needed to see a consultant. The adviser explained there wasn't an excess to pay but that there was an outpatient limit of £600 per person per year. Things caught by the limit included consultations, x-rays and ECGs. The adviser added that scans such as MRI and CT didn't come from the £600 limit and that if they were needed Mr H should call Vitality again to get them covered in full.

The second call was made shortly after the first and Mr H said in fact they were going to see a different consultant because he could see them before the first consultant. Vitality confirmed Mrs H was still authorised for the appointment and reminded him that there was a £600 outpatient limit. Mr H said he knew about the limit.

In the third call, several days after the first, Mr H said Mrs H needed an MRI and blood tests. The MRI was to take place but the blood tests had been done that morning. The adviser said the blood tests had already been authorised and that he would add a record about the MRI.

The first two calls and third call were followed up by Vitality in writing. In both letters, Vitality told Mrs H she was only covered for the treatment confirmed in them. Both letters included a claim authorisation summary which mentioned that the first consultation, radiology (all x-rays except scans), follow up consultation, pathology and ultrasound (other than pelvic) had all been authorised. The second letter also confirmed an MRI scan with contrast had been authorised. Both letters highlighted that the authorised treatment was limited to £600 for outpatient care for other diagnostic tests such as x-rays and ECGs and set out how much of the limited benefit was still available.

Overall, I think the advisers that Mr H spoke to gave an accurate account of the policy's benefits and limitations. I don't think they suggested blood tests weren't covered by the £600 limit or would be paid without limit. And in any case, I see that Mrs H's blood test had already taken place before the second call was made. I also think the follow up information Vitality sent to Mrs H was clear enough and wasn't mis-leading.

Mr and Mrs H say Vitality should change its practices and procedures and that its complaint handlers shouldn't be referring to themselves as being independent of Vitality. As Mr and Mrs H know, this service doesn't regulate the industry. That's the role of the Financial Conduct Authority. While we can't punish financial businesses or force them to change how they operate, we can decide if a consumer has been treated unfairly and, if so, whether they've suffered a loss and if compensation is due.

In the circumstances of the complaint I've looked at, I don't think Vitality has treated Mr and Mrs H unfairly.

my final decision

For the reasons given, I've decided not to uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr and Mrs H to accept or reject my decision before 13 November 2015.

Nimish Patel
ombudsman