DRN-4377123

The complaint

Mr P complains that Vitality Health Limited hasn't fully settled the costs of a claim he made on a group private medical insurance policy.

What happened

Mr P is insured under his employer's group private medical insurance policy. The contract included up to £1000 of out-patient cover per policy year.

In February 2023, Mr P saw Vitality's virtual GP after experiencing symptoms of light-headedness. The GP referred Mr P to a specialist. Vitality provided Mr P with the names of three consultants and authorised the costs of two consultations.

Subsequently, in March 2023, Mr P called Vitality to discuss the claims process. The call handler explained that Vitality had agreed to cover two consultations and associated histology. They discussed the out-patient limit with Mr P and explained, in brief, how the cover worked. They suggested that if Mr P wanted to know how much consultations or treatments would cost, he should ask the hospital when he called to book the appointment.

Mr P saw a consultant and was referred for diagnostic testing as an out-patient. Vitality paid Mr P's costs up to the policy limit of £1000. However, Mr P's total consultation and test costs exceeded the policy limit and so he was asked to pay the outstanding balance.

Unhappy with Vitality's position, Mr P asked us to look into his complaint. In summary, he didn't think the policy was worded clearly and he didn't think Vitality had made the claims process clear. He'd believed his full costs had been covered. He also didn't think he'd been properly informed about the cost of the consultations or tests. He said that if he'd known the costs would exceed the policy limit, he would have undergone treatment on the NHS.

Our investigator didn't think Mr P's complaint should be upheld. She thought the policy paperwork made the out-patient limit clear and she thought Vitality's call handler had appropriately explained to Mr P how the policy worked. So she didn't think Vitality needed to do anything more.

Mr P disagreed and I've summarised his responses to the investigator. He said he'd been under the impression that all tests following his initial consultation would be covered. He felt the policy terms stated that this was the case. He said that no-one had informed him about the costs of the consultations or the costs of the diagnostic tests – and Vitality had only informed him about the shortfall over a month after he'd undergone testing. He didn't think the process was sufficiently transparent and it had been far too easy for him to spend money without any prompting from Vitality as to what to do next. He maintained that the policy wording and claims process had been misleading.

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 Mr P, I think Vitality has settled his claim fairly and I'll explain why.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. So I've considered, amongst other things, the policy terms and the available evidence, to decide whether I think Vitality handled Mr P's claim fairly.

I've first considered the policy terms and conditions, along with Mr P's policy certificate, as these form the basis of the contract between Mr P's employer and Vitality – and which set out the terms under which Mr P is insured.

Mr P's policy certificate was issued on 1 March 2023. It includes a table called 'Your Cover' which lists the benefits Mr P's employer opted to take out when it entered into the contract with Vitality. One of the benefits listed is 'out-patient cover'. This sets out the following cover:

'*Up to £1,000 cover for out-patient consultations, consultant fees and out-of network physiotherapy (max £35 per session) when needed as part of your treatment. This limit will also cover diagnostics such as blood tests, x-rays, radiology and pathology.*

Full cover for in-network physiotherapy.

Full cover for out-patient diagnostic scans such as MRI, CT & PET scans when referred by a consultant.'

In my view, the policy certificate makes it sufficiently clear that Mr P is covered for up to £1000 of out-patient care per year – including both consultations and most diagnostics. A specific exception is made for MRI, CT and PET scans which are fully covered if a member is referred by a consultant. The policy terms do explain that in some circumstances, where an out-patient limit applies, there *might* be full cover for diagnostic tests. But the policy terms also state that a member's policy certificate show which options will apply. In this case, Mr P's policy certificate shows that his employer *didn't* opt to add full diagnostic tests cover to this particular contract. I don't think the policy terms or Mr P's policy paperwork are unclear or misleading on this point.

I understand that in Mr P's case, he didn't undergo an MRI, CT or PET scan – instead he saw a consultant about his symptoms and underwent other forms of diagnostic testing. So I don't think it was unfair or unreasonable for Vitality to conclude that the out-patient limit of £1000 would apply to Mr P's particular claim.

It's clear that Mr P feels that Vitality didn't make the claims process or policy limits sufficiently clear to him. I've considered this carefully and I've listened to the call between Vitality and Mr P which took place prior to Mr P booking the consultation with the specialist. I think the call handler clearly explained the out-patient limit to Mr P and what costs would fall within that. They explained that Mr P had been authorised for two consultations and follow-up blood work. They told Mr P about the MRI, PET and CT scan exception to the out-patient limit. Mr P asked a direct question about the charges which would apply. The call handler clearly told Mr P that it would depend on the particular consultant and that Mr P should check costs with the consultant at the time of booking. They also informed Mr P that the hospital could email him a price list of charges and costs. And they made it clear to Mr P that if the costs exceeded the out-patient limit, any outstanding balance would need to be self-

paid.

Having listened to the call, I think the call handler gave Mr P clear, fair and not misleading information about the way the policy worked. I think they correctly informed Mr P that they couldn't say what charges would be applied and suggested that he ask the hospital about costs at the time of booking. I think this was a sensible and appropriate suggestion from Vitality. And I can't I fairly hold Vitality responsible for the prices the hospital charged for treatment or testing, or for any failure on the part of the hospital to provide Mr P with a price list.

I've looked carefully at the authorisation letter Vitality sent Mr P too. I don't think it suggested that any and all costs Mr P incurred which were associated with the referral would be covered. Instead, it stated that Mr P would be covered for up to two consultations. It also said:

'*If you do need more treatment, other than what we've agreed so far, you should let us know straight away, as we'll need to ensure you're covered.'*

I haven't seen anything to suggest that Mr P contacted Vitality to check that the testing the consultant had recommended would be covered, or whether it was likely to fall outside of the out-patient limit. Nor would Vitality be in a position to tell Mr P about what cover he had left until it had received the invoices from the hospital.

On that basis, while I sympathise with Mr P's position, as I appreciate he's been left with a significant outstanding shortfall balance to pay, I don't think Vitality has settled his claim unfairly. I think it provided him with clear information about the cover and the way it worked. And it isn't responsible for Mr P's treatment plan or the charges the hospital applied. So I don't think it's done anything wrong which I could reasonably ask it to put right and it follows that I'm not directing Vitality to pay anything more.

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 Mr P to accept or reject my decision before 24 November 2023.

Lisa Barham
Ombudsman