DRN-4429591

The complaint

Ms K complains because Vitality Health Limited ('Vitality') didn't pay a claim under her private medical insurance policy.

Ms K also complains about how Vitality handled her claim, Vitality's failure to ensure she had access to her policy documents and Vitality's auto-renewal of her policy.

What happened

Ms K has held a private medical insurance policy, provided by Vitality, since 2018. The policy renews automatically on an annual basis.

In April 2019, Ms K enquired with Vitality about making a claim relating to her shoulder. The claim never went ahead.

In December 2021, Vitality sent Ms K an email saying she needed to update her account details to access its online member zone.

In December 2022, Vitality received invoices for medical investigations and consultations which Ms K had earlier the same month. The invoices Vitality were sent quoted the claim reference number which had been allocated to Ms K's enquiry in April 2019.

On 22 December 2022, Vitality emailed Ms K in relation to her claim. Ms K telephoned Vitality on the same day to say she couldn't access the online member zone. Vitality restored Ms K's member zone access and said it would arrange a call-back for her in relation to her claim. On 30 December 2022, Ms K chased Vitality for the call-back she'd been promised and sent it a letter from her GP. On 31 December 2022, 4 January 2023 and 6 January 2023 Vitality sent Ms K correspondence saying the costs she was claiming for weren't covered under her policy as they hadn't been authorised in advance.

Ms K made a complaint to Vitality in March 2023 and said she'd been given authorisation for the claim during a telephone call with Vitality on 5 December 2022. Vitality sent Ms K a final response letter in April 2023 maintaining its position that her claim wasn't covered.

Unhappy, Ms K brought the matter to the attention of our service. One of our investigators looked into what had happened and said she didn't think Vitality had acted unfairly or unreasonably in the circumstances. Ms K didn't agree with our investigator's opinion, so the complaint has been referred to me as the final stage in our process.

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.

The Financial Ombudsman Service is an informal alternative to the civil courts. While the law is a relevant consideration when making my final decision and is something which I've taken into account, I'm not bound to strictly apply it. I've also had regard to relevant industry rules

set out by the regulator (namely, the Financial Conduct Authority's 'Insurance Conduct of Business Sourcebook') when making my decision about Ms K's complaint, but my over-riding remit is to decide what I think is fair and reasonable in all the circumstances.

Private medical insurance policies don't cover every claim for the cost of private medical care. Mrs K isn't paying Vitality for access to private healthcare – she is paying for Vitality to cover the cost of private healthcare in certain circumstances as set out in her contract with it. Most, if not all, private medical insurance policies in the UK require a policyholder to contact the insurer in advance to request pre-authorisation for a claim. This isn't unfair. And this doesn't mean that a policyholder requires an insurer's permission to access private medical care – it simply means that, if a policyholder wants a claim to be paid under their policy, they need to obtain authorisation from their insurer in advance because not every consultant, hospital and/or treatment may be eligible for cover under the terms and conditions of their policy.

Ms K holds 'Consultant Select' cover, which means that only claims relating to consultants which are recognised by Vitality are covered under the policy. Ms K's policy certificate clearly states that Vitality will choose a consultant for Ms K and will only pay for treatment that has been authorised in advance.

Insurers have a duty to provide reasonable guidance to help a policyholder make a claim. I don't think the extract from Vitality's website which Ms K has provided is unclear. This says that policyholders need to go to the member zone to start a new care request. I'm satisfied that Ms K knew in December 2021 that she needed to reactivate her member zone account – regardless of whether the notification from Vitality specifically said that Ms K would be unable to access the account unless it was reactivated. If Ms K was unable to access the member zone and/or access and review her policy terms and conditions before she arranged her private medical investigations in December 2022, then I don't think it's unreasonable to expect Ms K to have contacted Vitality for further information about how to make a claim at that point. But, by the time Ms K contacted Vitality to let it know that she couldn't access her member zone account, her medical investigations had already taken place. Furthermore, Vitality's records show Ms K was told in April 2019 that only claims to see certain consultants were covered under the terms and conditions of her policy.

I've seen no evidence of a telephone call taking place between Ms K and Vitality on 5 December 2022 and, in any event, I find it unlikely that Vitality would have incorrectly confirmed cover for Ms K's claim or incorrectly led her to believe that her claim would be covered in these circumstances.

This means I don't think Ms K's claim is covered under her policy, and I don't think Vitality has acted unfairly or unreasonably in the circumstances by turning down her claim. Ms K's private medical care wasn't authorised in advance by Vitality and, if Ms K had contacted Vitality in advance, she'd have been told that the consultant in question wasn't one who was covered under her policy. The fact that Ms K subsequently discovered she couldn't access the member zone and/or her policy terms and conditions doesn't mean it would be fair and reasonable for Vitality to depart from a strict application of the cover Ms K holds and pay her claim regardless. Overall, having taken into account the information which Ms K did have access to, I'm satisfied that it would have been reasonable for Ms K to have contacted Vitality before she arranged for her private medical care. The time that passed between the events of April 2019 and/or December 2021, and December 2022 doesn't change my decision on this point.

I can understand why Vitality may not have appreciated that the invoices it received in December 2022, which contained the claim reference number from April 2019, in fact related to a different, new claim. However, I've listened to a call between Ms K and Vitality which

took place on 22 December 2022 and I think Vitality could have done more during that call to clarify the situation. I also note that Vitality didn't arrange for a call-back to Ms K, as it had said it would do. But, by this point, Ms K had already had the medical investigations and consultations which are being claimed for. So, I don't think any failings by Vitality in how it dealt with Ms K's claim disadvantaged her financially. And Vitality sent its final response letter to Ms K within the timeframe set out by the regulator.

Ms K's policy renews automatically and has done since its inception in 2018. The policy terms and conditions say that Vitality will automatically renew the policy, and Vitality sent Ms K notice on 5 October 2022 that her policy would automatically renew on 1 November 2022. I'm satisfied that Vitality was entitled to automatically renew Ms K's policy and that it did so in line with the relevant industry rules and guidance applicable at the time. The fact that Vitality may have followed a different renewal process in subsequent years doesn't mean that Vitality acted incorrectly, unfairly or unreasonably when it automatically renewed the policy in 2022.

I'm sorry to hear that Ms K is being pursued by a third party for the costs of her private medical care and I have no doubt that this will be stressful, but I don't think Vitality has acted unfairly or unreasonably in the circumstances so I won't be directing it to do anything further.

My final decision

My final decision is that I don't uphold Ms K's complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms K to accept or reject my decision before 29 November 2023.

Leah Nagle
Ombudsman