DRN-4138421

The complaint

Mr P complains that Vitality Health Limited has turned down a dental treatment claim he made on a group private medical insurance policy.

What happened

Mr P is a member of his employer's group private medical insurance policy.

In November 2022, Mr P had a dental check-up and was given two fillings. He made a claim on his policy for the costs of the check-up and treatment.

Vitality paid for Mr P's check-up. But it turned down the claim for the costs of his treatment. That's because it said the policy only covered dental treatment if a policyholder had had a dental check-up and undergone all necessary treatment in the 15 months before cover under the policy began. In this case, Mr P hadn't had a dental check-up since 2019, so Vitality concluded that his treatment costs weren't covered.

Mr P was unhappy with Vitality's decision and he complained. He accepted that the policy 'Membership Guide' set out the relevant term. But he felt the term was buried in the text. He considered Vitality should have clearly highlighted it. And he didn't think either Vitality's online 'Member Zone' or his policy certificate made the term sufficiently clear.

Vitality maintained its stance, although it did update the dental section on the 'Member Zone' to include the term following Mr P's complaint. Remaining unhappy with Vitality's decision, Mr P asked us to look into his complaint.

Our investigator didn't think Mr P's complaint should be upheld. He noted the 'Member Zone' stated that the 'dental, optical and audiological cover' information was only a summary of cover and to check the full terms and conditions. And he felt the policy 'Membership Guide' made the term sufficiently clear. He considered it was Mr P's employers' responsibility to highlight the key terms of the policy. So he concluded it had been fair for Vitality to turn down Mr P's claim for the treatment costs.

Mr P disagreed and I've summarised his response. He noted that the reference to checking the full policy terms wasn't detailed in the specific dental section of the 'Member Zone'. He said he'd also had to search for the full terms and conditions. He maintained that the relevant term had been hidden in the policy terms. He added that he'd checked the policy terms and conditions but had missed the applicable clause. And he referred again to the fact that Vitality had changed the 'Member Zone' following his complaint to clearly set out the requirement to have had a check-up and undergone all necessary dental treatment in the 15 months before cover began.

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 sorry to disappoint Mr P, I think it was fair for Vitality to turn down his claim and I'll explain why.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. So I've considered, amongst other things, the terms of the group policy and the circumstances of his claim, to decide whether Vitality treated him fairly.

I've first considered the terms and conditions of the group scheme, as these form the basis of Mr P's employer's contract with Vitality. Mr P made a dental claim, so I think it was reasonable and appropriate for Vitality to consider the claim in line with the 'Dental Care' section of the policy. The Dental Care cover is set out on page 15 of the Membership Guide. The policy says that Vitality will reimburse members up to 80% of the costs for treatment which is clinically necessary. But the dental care section also includes the following term:

'…you must have undergone a check-up with your regular dentist and have completed all dental treatment recommended in the 15 months before your cover start date. If you have not seen a dentist in the 15 months before your cover start date, then eligibility for this cover will only begin after you have undergone a check-up by a dentist and completed all dental treatment recommended.'

In my view, this term makes it clear that Vitality will only pay for treatment if a member has seen a dentist in the 15 months before their cover begins and if they've already undergone recommended treatment. I don't find that it's been laid out confusingly or that it's been buried within the text.

Vitality has provided us with evidence which shows that Mr P last had a dental check-up in 2019 – which was significantly longer than 15 months before his cover start date in April 2022. On that basis, I think Vitality was reasonably entitled to turn down Mr P's claim for his treatment costs.

It's clear how strongly Mr P feels that Vitality didn't make the term sufficiently clear, given its importance. I acknowledge that it isn't set out in Mr P's policy certificate. Neither is it displayed in the 'dental, optical and audiological' section of the benefits table, which provides an at-a-glance summary of cover. However, the first paragraph on page one of the policy certificate says:

'To understand your cover properly, please read this certificate together with the 'Your Plan Terms and conditions document'. (The Membership handbook).

And under the 'further information' section of the benefits table relating to dental cover, it says:

'Please refer to the 'Your benefits explained' section, under 'Dental care' on page 15.'

As such, I think Vitality made it sufficiently clear that the benefits table and policy certificate didn't list the full cover terms. And I think it made it clear too that members ought to check the full contract terms in order to understand the policy and the way cover worked.

I accept that at the time of Mr P's claim, the specific 'Member Zone' dental section didn't include the relevant clause. But I can see that the 'dental, optical and audiological benefit' section of the Member Zone included a brief overview of cover, called '*Protecting your teeth, eyes and hearing'.* I think it was clear enough then that the information underneath referred

to all three types of cover. And the 'Member Zone' specifically stated:

'the following is a summary of your Dental, Optical and Audiological cover'. You can read the terms and conditions here.' A hyperlink was included, which ultimately took a member to the full policy terms. Again then, I think Vitality did enough to make the term clear to its members.

Vitality made a decision to change the 'Member Zone' after Mr P made his complaint. This was a commercial decision Vitality was entitled to make and I don't think it suggests that Vitality had previously made any error.

I'd also add that Mr P's employer held the contract with Vitality – it took out the cover. So while the policy terms needed to be set out in a clear and understandable way – I don't think Vitality had any responsibility to highlight the relevant term to Mr P at the point he was added to the corporate cover.

Overall then, despite my natural sympathy with Mr P's position, I think it was fair for Vitality to turn down his 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 Mr P to accept or reject my decision before 15 August 2023.

Lisa Barham
Ombudsman