DRN-4455578

The complaint

Mrs H and Mr L complain that Vitality Health Limited didn't pay a claim they made on their private medical insurance policy.

What happened

Mrs H consulted a Vitality GP (VGP). The VGP recommended that Mrs H attended the accident and emergency department due to her symptoms. Mrs H was admitted to hospital for several days. They claimed for the NHS cash benefit provided by the policy.

Vitality declined the claim on the basis that no NHS cash benefit was payable for admission in an emergency. However, they did offer £100 compensation in their final response letter for customer service issues including issuing a claim form unnecessarily, delays and lack of responses. They also offered to pay the cost of the GP completing the claim form upon receipt of an invoice. Unhappy, Mrs H and Mr L complained to the Financial Ombudsman Service.

Our investigator looked into what had happened and recommended Vitality increased the compensation to £250. However, he thought the claim had been fairly declined.

Vitality accepted the investigator's recommendation. Mrs H and Mr L didn't agree. In summary, they didn't agree that Mrs H had been admitted as an emergency and that it was routine. They didn't think it was fair for Vitality to rely on the exclusion and said that they'd breached rules and regulations. Mrs H and Mr L also referred to legislation and case law in support of their position. They also said the compensation was paid for a different reason.

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 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.

The policy terms and conditions say:

> The NHS hospital cash benefit is only available for treatment that would have been eligible under your plan had you decided to be treated privately. If you are admitted to hospital in an emergency, no benefit will be payable for any part of the admission. If you choose to transfer to a private hospital for part of your treatment, there is no benefit payable for any of the nights you spent as a non-paying NHS patient. If you are admitted as an in-patient after midnight, then no benefit is payable for that first night spent in hospital.

There is also a general exclusion for emergency treatment which is defined as:

- Treatment in an Accident & Emergency unit or other urgent care centre

- Any admission to hospital that was scheduled less than 24 hours in advance.

I think £250 compensation is fair and reasonable. I'm not directing Vitality to do anything further to put things right. I say that because:

- I think that it was reasonable for Vitality to conclude Mrs H received emergency treatment. She discussed her symptoms with VGP who recommended she attended the accident and emergency department. Mrs H presented there and was subsequently admitted. I don't think was routine treatment as Mrs H and Mr L have suggested. I don't find their representations that this wasn't an emergency persuasive.

- I have considered that Mrs H was recommended to attend the hospital by VGP. But I don't think this means Vitality have acted unreasonably by declining the claim. VGP made this recommendation due to the symptoms Mrs H was experiencing. And she was diagnosed and treated at the hospital for several days.

- I do think the definition of emergency treatment applies. It's a general exclusion which applies to the whole policy. So, I do think it applies to the NHS cash benefit section. And, in any event, the NHS cash benefit section makes it clear there is no cover for emergency admissions.

- I think Vitality have demonstrated to the required standard of proof that there was no cover under the policy for Mrs H's stay in the NHS hospital.

- Mr L has said that he's not received an Insurance Product Information Document as required by ICOBS. That's not something he raised in his initial complaint to Vitality. That's a different document to a quotation. And, in any event, I'm persuaded that Vitality have fairly relied on the policy terms.

- I'm satisfied that Mrs H and Mr L were given enough information to decide if the policy was right for them. I think the information was sufficiently clear, fair and not misleading. If the NHS cash benefit or cover for emergency treatment was particularly important to Mrs H and Mr L they also had the opportunity to cancel the policy within the cooling off period. It's also not uncommon for private medical insurance policies to limit cover for emergency admissions or to have similar exclusions.

- Vitality acknowledged that Mrs H and Mr L didn't receive good service. Mr L says the £100 compensation was because Vitality alleged Mrs H wasn't eligible because she'd not been registered with a GP for five years, but this wasn't in the terms and conditions. That's not reflected in Vitality's final response letter. But, overall, I still think the award of £250 fairly reflects the impact of Mrs H and Mr L's distress and inconvenience. That includes the distress and inconvenience of being given incorrect information, having to complete a claim form unnecessarily and delays.

Putting things right

Vitality needs to put things right by paying Mrs H and Mr L £250 compensation, inclusive of £100 they've already offered.

My final decision

I'm partly upholding Mrs H and Mr L's complaint against Vitality Health Limited and direct them to put things right in the way I've outlined above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs H and Mr L to accept or reject my decision before 2 January 2024.

Anna Wilshaw
Ombudsman