DRN-4417989

The complaint

Ms B is unhappy with the level of cover provided by BUPA Insurance Limited. She complains her private medical insurance policy was mis-sold.

What happened

Ms B had private medical insurance provided by her previous employer. In December 2022, she set up her own private medical policy on a continuation of cover basis. That's to say she wanted to keep similar levels of cover, including retaining the opportunity to see the same surgeon and physiotherapist she was treated by on her group scheme. Ms B said she made this clear to BUPA, however, her new policy wouldn't provide cover for any treatment with her existing surgeon.

Ms B said she contacted BUPA within the 21-day cooling off period to advise changes needed to be made, however, it refused her request. Ms B wanted BUPA to accept it made a mistake when setting up the policy and to allow her to see her preferred surgeon at the same place she was treated previously. Ms B's policy is up for renewal at the end of November 2023.

BUPA declined Ms B's request to make amendments to her policy. Initially, it said Ms B hadn't contacted it within the 21-day cooling-off period. However, when our investigator determined otherwise, BUPA said the cooling-off period was effectively null and void because Ms B had made a claim during that time. It said the policy can only be amended at renewal. BUPA said there are some instances where amendments can be made, although this is only with its written approval and that wasn't given here.

BUPA accepted it'd provided poor customer service as two of Ms B's calls were not returned and so it paid £100 compensation as an apology for the distress and inconvenience caused.

Our investigator said BUPA hadn't mis-sold the policy because it made clear at the time there were differences in the level of cover Ms B had opted for. She also said BUPA sent Ms B all the necessary sales literature in a clear and non-misleading format. However, she also said Ms B had requested to make an amendment to her policy within the cooling-off period and therefore felt BUPA should've allowed the changes to be made. She also said BUPA would've been entitled to charge a higher premium for the upgraded level of cover. Our investigator awarded an additional £100 compensation for the overall distress and inconvenience caused.

Ms B accepted her findings, however, BUPA didn't. In summary, it said Ms B didn't mention her preferred hospital or surgeon prior to the policy being set up. It recognised the request came later but disputed this happened in January 2023. BUPA maintained its position that because she'd already received treatment under the policy, she couldn't make changes to it within the cooling-off period. And so, it's now for me to make a final decision.

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, I too agree the policy wasn't mis-sold and for the same reasons explained by our investigator. BUPA made it clear that London hospital cover wasn't included in the policy Ms B had opted for and I'm satisfied she accepted cover on that basis. However, I think BUPA were unclear about whether changes could be made to Ms B's policy and whether she'd contacted it in time to make those changes.

BUPA initially said Ms B didn't contact it within the cooling-off period and therefore her request to make changes was made out of time. Then, it later said she'd never have been able to make changes because she'd also began receiving physiotherapy treatment during the cooling-off period. I think this caused Ms B unnecessary confusion as she was given mixed messages and for that, I feel the compensation awarded by our investigator is fair. I'll explain why.

When Ms B initially spoke to BUPA to discuss her options for continuing cover, I'm satisfied one of her key considerations was cost. I'm highlighting this because throughout the initial call, Ms B frequently said she wanted private medical insurance cover, but affordability was her main concern as she wasn't working at the time. She received quotes based on hospital coverage and she opted for middle level cover as this was more affordable. I've not found any evidence that persuades me that Ms B asked for a specific hospital to be covered at the point of sale and therefore I don't uphold that part of her complaint.

Ms B opted for hospital cover which didn't include central London hospitals and I'm satisfied BUPA made it clear that was the case. I think it reasonable to expect that Ms B ought to have explained she had a hospital preference at that time, but she didn't. Instead, Ms B expressed her wishes to be treated by the same medical professionals, which I'm satisfied her policy gave her access to, but not necessarily at the same London-based hospital she was previously treated at. Ms B was able to see the same physiotherapist at the London hospital because he was part of BUPA's recognised network and so he could charge BUPA directly.

Ms B was also able to see her existing surgeon, should she need to, but only for consultations as he was part of BUPA's approved network and he can therefore charge BUPA directly. Anything other than a consultation would need to be completed at another BUPA hospital within the scope of Ms B's policy range. I should also note that Ms B was able to see her surgeon at another hospital within her policy range without those restrictions. It was simply because she chose not to have central London hospital cover because of the costs involved.

I should also highlight that during the sales call, Ms B was asked whether she had any planned, or ongoing surgery requirements, to which she said she did not. Ms B explained she was now being treated with physiotherapy and that this was what she wanted covered. Ms B explained she still wanted cover in case other spinal-related issues occurred, to which BUPA said it would provide cover. But at no point was there a discussion about where that treatment would take place, or which surgeon would carry out that treatment.

Ms B became concerned about her policy cover when she was told her physiotherapy wasn't covered. She called BUPA to discuss this and was unable to get a response from BUPA for over one month. She eventually was able to speak to the adviser that sold her policy, and he confirmed the physiotherapy was covered and that she'd been misadvised previously. I'm satisfied that's the case and I've seen that BUPA has been paying Ms B's physiotherapist.

The issue here is with the level of service offered to Ms B. BUPA's already paid £100 compensation as Ms B was unable to speak directly with the adviser and she'd not received

a call back on a couple of occasions. I'm satisfied that's fair. But there are other service-related issues that BUPA hasn't acknowledged, and I think that's unfair. In particular, Ms B spoke with BUPA on 17 January 2023 to share her concerns about her policy not covering her physiotherapy sessions.

During the call, Ms B said she wanted cover on a continuation basis and that should she need to see her physiotherapist, *or her surgeon*, she would be able to. She also made it clear she needed to see her physiotherapist at the London-based hospital. I think the adviser should have probed further here to better understand what Ms B needed. I say that because having listened to the internal call made by the adviser to check whether Ms B's policy was able to cover this, he was asked by his BUPA colleague about the surgeon Ms B had seen previously, and he explained this wasn't needed as Ms B's treatment was now solely focussed on physiotherapy – which wasn't accurate given Ms B had said in the same call that she wanted to be able to see the same surgeon. I also thought it clear Ms B wanted this to happen at the London-based clinic, as she'd also explained that was her preferred choice in the call.

I think BUPA should've made it clear at this point Ms B was unable to make changes to her policy because she'd already made a claim. BUPA told our investigator that Ms B wouldn't have been able to make changes to her policy at that time because she'd already received physiotherapy treatment in December and January. However, it failed to mention that previously to Ms B.

Ms B explained the sales literature she'd received said she could make amendments to her policy within 21 days of receiving the documentation. And so, when she called in December and January to do that, she wasn't told it wasn't possible. I think BUPA should've told her that when she called to make adjustments to her policy. I also note this wasn't explained correctly within the final response from BUPA months later. I believe this caused Ms B unnecessary distress, inconvenience and confusion.

To put things right, I think BUPA should pay a further £100 compensation for the overall distress and inconvenience caused.

My final decision

I'm partially upholding Ms B's complaint for the reasons I've explained and BUPA Insurance Limited should pay £100 compensation for the distress and inconvenience caused by the poor service she received.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms B to accept or reject my decision before 5 December 2023.

Scott Slade
Ombudsman