DRN-4623302

The complaint

Miss V complains about BUPA Insurance Limited's decision to decline payment of some of her private medical insurance costs.

What happened

Both sides are familiar with the background to this complaint so I will only summarise what happened below.

Miss V has access to a group private medical insurance policy with BUPA. In September 2023 she contacted BUPA and had a consultation authorised by it. However, some of the medical costs she later incurred following it were declined for payment as she had, by then, used up all of her out-patient benefit.

Miss V complained. She said BUPA hadn't told her how the out-patient benefit would be used when she'd originally spoken to it about the consultation, but BUPA didn't agree.

While BUPA said it was sorry Miss V had a reason to complain, it explained it was unable to cover the shortfall of the exhausted benefit because it had provided her with correct advice. It told Miss V it had listened to the call with her and couldn't agree that it'd been unclear about how the out-patient benefit applied and what it covered. It told her it had sent her a text message at the same time too, which provided further confirmation about the out-patient benefit. And that her policy documentation had also detailed information about the out-patient benefit.

Unhappy with BUPA's reply Miss V approached this service. She told us BUPA had incorrectly used the out-patient benefit on her pathology and scan costs, she owed money to her treatment provider which she could not pay, BUPA's actions had caused her stress which had delayed her recovery, and to put things right she wanted it to pay all of her claims plus £1,000 compensation.

Our investigator didn't think BUPA had acted unreasonably. They were satisfied the policy documentation had informed Miss V of the out-patient benefit and what it covered, and that when she was speaking with BUPA directly too it'd provided her with correct information about the out-patient benefit she had remaining and what it would cover.

Miss V disagreed with that opinion and said she wanted her complaint escalated to an ombudsman. In doing so she said she'd had to undergo some tests twice due to incorrect test results and that had been completely outside of her control.

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 won't be upholding this complaint for the following reasons:

- The group policy benefits available to Miss V were detailed in the relevant policy documentation, namely the policy terms and conditions and the membership certificate. Together these explained how a benefit limit worked, what out-patient benefit limit Miss V had available to her, and what that benefit would be applied to. For example:

  - Page 22 of the terms and conditions said, "***Benefit limits****: these are limits on the amounts* ***we*** *will pay and/or restrictions on the cover you have under your* ***benefits****. Your* ***membership certificate*** *shows the benefit limits and/or restrictions that apply to your* ***benefits****.*"

  - Page 2 of the membership certificate confirmed Miss V has a benefit limit of up to £1,500 per policy year for out-patient consultations, therapies, and diagnostic tests.

  - And pages 25 and 26 of the terms and conditions explained the types of charges that BUPA would pay for out-patient treatment in further detail.

- I can't agree that BUPA didn't explain what the outpatient benefit would apply to when speaking with Miss V in September 2023. Having listened to this call in full, BUPA told Miss V how much out-patient benefit she had remaining (that being £1,208 at the time) and explained what that would apply to. BUPA's explanations were in line with the policy documentation I noted above and I didn't hear it mis-inform Miss V in any way.

- BUPA also sent Miss V a text message during the above call which explained its authorisation was for her consultation and minor diagnostic tests. It reconfirmed she had £1,208 of her out-patient allowance remaining and advised Miss V would need to pay anything above that amount because it wouldn't be covered. Again, I think BUPA's explanation here was in line with the policy documentation and I am aware that Miss V confirmed receipt of its text.

- I realise Miss V says BUPA incorrectly used the out-patient benefit on her pathology and scan costs, but I'm not persuaded that it did. I say this because the policy documentation had explained the out-patient benefit would be applied to out-patient consultations, therapies, and diagnostic tests, and because BUPA had reiterated this to Miss V when it spoke with her too.

- While I am of course sorry to hear Miss V owes her treatment provider money it would not be fair of me to direct BUPA to pay these outstanding costs. Miss V had an out-patient benefit limit of £1,500 which she exhausted, and BUPA wasn't liable for paying out-patient costs beyond that. BUPA isn't responsible for the actual treatment Miss V's medical facility provided either. And so although I appreciate her frustration surrounding the incorrect test results and being tested twice, it would be unfair of me to hold BUPA responsible for this.

- Within its final response letter BUPA highlighted the mental health provisions Miss V had available through the group policy and explained it could arrange for one of its mental health nurses to get in touch with her directly too. BUPA also sign posted Miss V to charities and organisations that might have been able to provide support in relation to financial difficulties. Given Miss V had said BUPA had caused her stress, delayed her recovery, and she was unable to pay the costs she owed, I think this was appropriate information for BUPA to have provided in the circumstances.

I realise Miss V may be further disappointed by these findings, but I'll not be interfering with

BUPA's position. I am satisfied it provided Miss V with correct information about her out-patient benefit and that it did not act unreasonably in declining to cover her outstanding private medical costs.

My final decision

My final decision is that I do not uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss V to accept or reject my decision before 29 March 2024.

Jade Alexander
Ombudsman