DRN-4918700

The complaint

Mr S complains that BUPA Insurance Limited wrongly told him that it might be able to provide cover for treatment under his private medical insurance policy.

What happened

In April 2020, Mr S applied for a private medical insurance policy which was underwritten by BUPA. Mr S told BUPA that he'd previously been diagnosed with multiple sclerosis (MS). So BUPA applied a 'special condition' to Mr S' policy excluding cover for any claims related to MS. The policy renewed each year.

Subsequently, on 20 March 2024, Mr S called BUPA to ask whether it could potentially provide cover for treatment of MS. BUPA told Mr S to provide it with medical information so it could look into whether or not it could help. Mr S sent BUPA medical evidence in support of his claim.

A couple of days later, Mr S spoke with BUPA again. During this call, Mr S checked that it had received his medical evidence. The call handler told Mr S he'd need to get a GP referral. So Mr S had an appointment with a remote GP to obtain this information.

On 25 March 2024, Mr S called BUPA again. At this point, the call handler told Mr S that it wouldn't be able to provide cover for any treatment because of the special condition excluding claims for MS.

Mr S was very unhappy with BUPA's position because he felt it had given him false hope. BUPA accepted that its call handlers should have told Mr S that his treatment wouldn't be covered because of the specific policy exclusion. And it acknowledged that this had caused Mr S frustration and upset. So it apologised for its errors and it paid him £150 compensation.

Remaining unhappy with BUPA's stance, Mr S asked us to look into his complaint.

Our investigator thought BUPA had already settled Mr S' complaint fairly. He was satisfied that Mr S' treatment wasn't covered by the policy terms, so he didn't think it would be fair to tell BUPA to pay his claim. He acknowledged that BUPA ought to have told Mr S that there wouldn't be any cover for his treatment during its calls with him and that it had raised his expectations. And he thought this had caused Mr S some distress. But overall, he felt that BUPA had already paid Mr S fair compensation.

Mr S disagreed and so 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 very sorry to disappoint Mr S, I think BUPA has already settled his complaint fairly 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. I've taken those rules into account, along with other relevant considerations, such as the policy terms and industry principles, to decide whether I think BUPA has settled this complaint fairly.

I've first considered the policy terms, as these form the basis of the contract between Mr S and BUPA. Mr S' policy was underwritten. Page 47 of the policy membership guide says that if cover has been underwritten, BUPA won't pay claims for pre-existing medical conditions. The evidence suggests that Mr S was diagnosed with MS around six years before he took out the policy and so BUPA concluded that this was a pre-existing condition. As such, it applied a special condition to Mr S' policy excluding cover for MS. Therefore, I don't think BUPA acted unfairly when it ultimately concluded that Mr S' claim for the treatment of MS wasn't covered by the policy terms.

However, it's clear that when Mr S called BUPA to look into making a claim, he was twice given wrong information. I think it should have been reasonably clear to both of the call handlers that Mr S' MS was specifically excluded from cover and therefore wouldn't be covered by the contract. Instead, the first call handler told Mr S that he'd need to send in supporting medical evidence in order for a claim to be assessed. And the second call handler told Mr S that he'd need a GP referral for treatment. So I can understand why Mr S believed that if he provided this medical information, his claim for treatment might be covered. It seems he did obtain the relevant evidence and was put to some time and trouble in doing so. And I can also appreciate that Mr S must have been very disappointed and upset when he learned that, in fact, his claim wasn't covered by the policy.

With that said, like the investigator, I'm satisfied that neither of the call handlers told Mr S his treatment *would* be covered. I think both made it clear enough that payment of the claim wasn't guaranteed. And I also think that BUPA gave Mr S accurate information reasonably promptly, letting him know five days later that the claim wasn't covered and why.

So on that basis, I find that the total compensation of £150 which BUPA has already paid Mr S, along with its apology, is a fair, reasonable and proportionate award to reflect the likely impact of its mistakes on him. I don't think it would be reasonable for me to award compensation commensurate with the cost of the treatment. And so while I sympathise with Mr S' position, I'm not telling BUPA to do anything more.

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 S to accept or reject my decision before 22 August 2024.

Lisa Barham
Ombudsman