DRN-5241789

The complaint

Mrs W complains about the sale of her private medical insurance policy with BUPA Insurance Limited ('Bupa'), as well as some other issues.

What happened

In 2020, Mrs W took out an individual private medical insurance policy with Bupa. It was taken out on a continuous cover basis from her previous corporate scheme.

In 2024 Mrs W saw a specialist as she was experiencing problems with both her hips. The specialist carried out an x-ray and MRI scan. He advised Mrs W she needed an injection in her left hip and physiotherapy to help with the inflammation in her right hip.

Bupa told Mrs W that she couldn't claim for the physiotherapy needed for her right hip, as this would only be covered if it related to in-patient or day-patient treatment in hospital.

Mrs W complained to Bupa about the sale of her policy. She said she was aware she needed to pay for the initial consultation (as she had done) and her excess of £150 would be deducted from treatment. However, she thought she would be covered for all treatment and physiotherapy and follow-up consultation fees after a procedure.

Bupa issued an update to Mrs W on her complaint. She was unhappy that her complaint hadn't been resolved and raised a few more queries about her cover.

Bupa issued its first final response on 8 April 2024. It apologised for the length of time Mrs W had needed to wait for a response on her complaint and acknowledged that its update email had been sent at an unusual time. In response to her complaint, Bupa thought the policy terms sent to Mrs W each year had been clear about how the policy worked.

Mrs W queried why Bupa hadn't listened to the sales call before answering her complaint, and again explained why she thought the policy had been mis-sold. She also referred to the policy wording since taking out the policy and why she thought this was misleading.

Bupa issued its second final response on 17 May 2024. After listening to the sales call, it thought Mrs W had been correctly advised how the policy worked before taking it out. Bupa explained that it had incorrectly covered a follow-up consultation previously, but it shouldn't have done this as the consultation didn't follow in-patient or day-patient treatment. It recognised this had been confusing for Mrs W and paid her £200 compensation for this.

Mrs W remained unhappy with Bupa's responses, and therefore brought a complaint to this service.

Our investigator looked into things but didn't recommend the complaint be upheld. She didn't agree with Mrs W that the policy had been mis-sold. Our investigator thought that Bupa's compensation payment of £200 was reasonable for the confusion it had caused Mrs W by paying for a consultation that wasn't eligible under the terms of her policy.

Mrs W didn't accept our investigator's findings and so the matter has been passed to me for a 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.

Mrs W has raised a number of concerns to Bupa. I'd like to reassure Mrs W that I've considered all of her points, but I've only addressed those I consider relevant to the outcome of the complaint. This isn't meant as a discourtesy, it merely reflects the informal nature of this service.

Sale of policy

The policy was sold on a non-advised basis. That meant Bupa didn't give Mrs W any advice about the suitability of the cover for her. Nonetheless, it was required to give her sufficient information about the policy so she could make an informed decision about whether to take it out.

I've listened to the sales call from April 2020. Mrs W made it clear she required continuation cover, as she wanted cover for an existing condition. The adviser explained there were two options available to her – Bupa Care and Local Hospital Care. He explained that Bupa Care was the more comprehensive option, with consultations covered in full (amongst other benefits). The adviser then spoke about the Local Hospital Care. He said:

"You will get an annual allowance of £500 for consultations and therapies within six months of being discharged from hospital when related to in-patient or day-case treatment, and that's a maximum of two consultations per procedure that would be covered."

Initially Mrs W wanted the Bupa Care option but then thought this was too expensive. The adviser therefore provided Mrs W with a quote for the Local Hospital Care option. Mrs W and the adviser had a further discussion about this cover. Mrs W asked if the aftercare would be covered, other than medication. The adviser clarified:

"In terms of your aftercare, as I mentioned, for the six months after you've been discharged from hospital when related to in-patient or day-case treatment, you've got £500 allowance for your consultations and your therapies, and that's up to a maximum of two consultations per procedure."

Mrs W asked if the hospital care would be covered. The adviser confirmed her in-patient, day-patient, surgeon and anaesthetist fees, and hospital fees would all be covered so long as her surgeon and anaesthetist were fee assured.

Mrs W decided to go ahead with the Local Hospital Care option. At the end of the call, the adviser again explained that consultations and therapies were only covered within six months of being discharged from hospital, and when related to in-patient or day-case treatment.

So, I'm satisfied the adviser had made it clear to Mrs W how the policy worked in respect of consultations and therapies. I therefore don't think the policy was mis-sold.

Mrs W says she now knows she could have had three months to decide whether to take out the Bupa policy on an individual basis. Bupa's website confirms it allows people leaving corporate schemes three months to take out individual cover. Though its website also says

that the new policy would be backdated to the date of leaving the corporate scheme, and that the member would start their policy by paying from the date the corporate scheme cover ended. So, it seems Mrs W wouldn't have been any better off financially if she had delayed taking out the individual policy.

Mrs W says the adviser gave her the wrong information about the continuous cover. During the call Mrs W asked the adviser if she would still be able to take out the Local Hospital Care option without any exclusions later if she didn't take out continuous cover. He answered no and explained that if she took out a new customer policy she would be underwritten again. This was correct.

Policy wording

Mrs W says the information provided by Bupa about her out-patient cover was misleading.

I've looked at the information Mrs W has provided, but I don't agree with her that the wording is misleading. In one example, Mrs W has referred to the 2023 membership guide under 'what is covered', as this lists out-patient consultations as being covered. However, it's made clear that the section explains the types of treatment, services and charges which Bupa *can* cover.

The policy explains at the outset that there are three documents that set out full details of the cover, and one of those is the membership certificate which shows Mrs W's specific cover and is personal to her. The membership certificate made it clear what outpatient cover Mrs W had. This was also explained elsewhere in the policy terms.

In another example, Mrs W says the policy sets out that for treatment to be covered, it needs to show that it's covered on the membership certificate. She says her membership certificate shows her as being covered for consultations fees and therapies. That is correct, but it also includes a clear explanation that there's a limitation to this cover and sets out what that is (that they are covered when they follow on from and are related to in-patient or day-patient treatment).

Overall, the information I've seen from Mrs W doesn't persuade me that the information she was given by Bupa regarding her cover was unclear or misleading.

Other issues

Mrs W says the policy covers diagnostic tests in full, along with the interpretation of the results by the consultant. I note she has obtained this information from the section of the policy that sets out what Bupa *can* cover. Mrs W's membership certificate confirms details of the cover that's personal to her, and this says diagnostic tests are covered in full (but doesn't say the interpretation of the results by a consultant are covered).

The policy explains that the insured must pay part of any treatment costs covered by the policy up to the excess amount. Bupa deducted the excess from the invoices it received – an x-ray and MRI scan. As these were diagnostic tests that means they were covered by the policy, and Bupa was correct to deduct the excess from the costs. So, I don't think Bupa did anything wrong in this regard.

Mrs W thinks she ought to have had a caseworker talk her through what was the best policy for her. However, Bupa sold the policy on a non-advised basis, which meant it couldn't offer Mrs W advice about the suitability of the cover for her. Mrs W has pointed out that a membership guide from an earlier year says that Bupa could provide a case manager to someone having eligible treatment where Bupa thought they could benefit from case

management support. However, this is completely different to a case worker/manager providing someone with advice about a suitable policy for them.

Mrs W thinks that Bupa should have put her premiums on hold whilst it investigated her complaint. I don't agree that Bupa ought to have done this. As Bupa has pointed out, this would have meant that Mrs W's policy would have been suspended and she wouldn't have been able to claim for any treatment during that time.

Mrs W took out the cover after the Covid-19 pandemic had begun. As there were a significant number of patients with Covid-19 requiring treatment, this meant private hospitals and consultants needed to provide support to the NHS, which had an impact on non-urgent private operations. Mrs W was awaiting treatment at the time, and this was unfortunately delayed because of the pandemic. She points out she had to pay premiums for nearly a year before she was able to have the treatment.

Whilst I can appreciate Mrs W's frustration, the terms of the policy say that premiums must be paid for cover to be provided. Insurance policies are intended to cover the risk of an uncertain event happening whilst the policy is in place, and an insurer is entitled to retain a premium paid to cover the risk, even if a successful claim isn't made. I wouldn't expect an insurer to refund premiums if medical treatment or services were unavailable due to circumstances outside its control, as was the case here.

However, Bupa acknowledged that some treatments were delayed as it supported the NHS during the pandemic, and that it had made an exceptional financial benefit as a result of Covid-19. It therefore paid some policyholders a rebate, and Mrs W received a rebate of £104.22 of her premiums. This was a commercial decision made by Bupa. Though overall I'm satisfied that Bupa treated Mrs W fairly.

Bupa has accepted that it caused Mrs W confusion, as it had previously paid for a follow-up consultation after her previous hip injection when it shouldn't have done so. Bupa didn't ask for that payment back and has paid Mrs W £200 compensation for any confusion she was caused. I think this was reasonable in the circumstances, and recognises the impact to Mrs W.

Bupa also didn't give Mrs W advice on how to cancel her policy when she emailed it on 4 April 2024. However, Bupa backdated the lapse of her policy to that date so she wouldn't be financially disadvantaged, so again I'm satisfied Bupa put things right here.

My final decision

My final decision is that I don't uphold Mrs W's complaint about BUPA Insurance Limited.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs W to accept or reject my decision before 9 April 2025.

Chantelle Hurn-Ryan
Ombudsman