DRN-5255270

The complaint

Mr S complains about the service he received from BUPA Insurance Limited ('Bupa') in respect of his International Health and Hospital policy, and a claim decision it made.

What happened

Mr S was the lead policyholder of his International Health and Hospital policy, and his wife was also insured. He held the cover with Bupa for many years and the policy was serviced through Bupa's Denmark office. Bupa then moved the servicing of the policy to its UK office.

In 2023, Mr S had a procedure and was admitted to hospital where he stayed for two nights. He made a claim to Bupa (claim ending 913), and it paid for the procedure but refused to pay for the hospital admission costs. Bupa said the procedure was usually carried out as day-case treatment, and there was no clinical evidence to support that Mr S needed to remain in hospital for two nights.

Mr S complained to Bupa about this, as well as some confusion about deductibles, and the service he'd received since his policy was moved across to the UK. Bupa issued a final response letter on 16 August 2023. It accepted it ought to have been clearer about the deductibles and paid Mr S €150 by way of apology. It apologised for the service Mr S had received since his policy was moved across to the UK. However, Bupa confirmed that its decision for the claim ending 913 remained the same.

Mr S responded to Bupa and repeated his concerns, including his unhappiness with how his policy had been dealt with since moving to the UK office.

Bupa issued a second final response letter on 12 October 2023. It reviewed Mr S's concerns about the claim ending 913, but concluded its decision had been correct – it referred Mr S back to its earlier letter of 16 August 2023 if he remained unhappy about this. Bupa also addressed some further concerns raised by Mr S - a claim ending 355 had been rejected, he hadn't received answers about his policy moving from Denmark to the UK, and some delays.

Bupa accepted that Mr S had received a poor service and paid him €200. It agreed to pay for the claim ending 355 on an ex-gratia basis. It said Mr S could send it any questions he had about moving from the Denmark office to the UK. Finally, Bupa suggested that Mr S called it for pre-authorisation before having treatment so it could advise him what was covered.

Further correspondence then took place between Bupa and Mr S. Bupa advised Mr S that it couldn't guarantee that any medical treatment he had would be fully reimbursed as it said the treatment would need to meet its definition of eligible treatment.

Mr S then contacted Bupa to obtain pre-authorisation for an MRI scan. Bupa asked for more information and wouldn't pre-authorise the scan.

Mr S made a further complaint to Bupa in December 2023. He said that since his policy had been moved to the UK, there appeared to be different claim procedures. He was concerned that his policy no longer provided him and his wife with reliable health insurance for the

future. Mr S again complained that Bupa had refused to cover the hospital admission for the claim ending 913, and its reasoning for that. Mr S was concerned that Bupa's medical team had made the decision that he hadn't had eligible treatment, despite the two-night stay taking place on his doctor's orders. Mr S also explained he'd taken Bupa's advice and tried to obtain pre-authorisation for an MRI scan, but this had been rejected.

Bupa issued a third final response letter on 11 January 2024. It said it had been wrong to request more information in relation to the MRI scan and said this had been due to human error. Though it confirmed it still needed the name of the provider and the date the scan had been arranged. It asked Mr S to get in touch if he still wanted the MRI scan. Bupa also acknowledged that it had taken too long to respond to some emails. To recognise its errors, Bupa paid Mr S €420. Bupa again said that it had reached the correct outcome for the claim ending 913, but given Mr S's past experiences with claims, it had decided to pay this on an ex-gratia basis. Finally, Bupa said that some of its processes were different in the UK, and this couldn't be avoided.

Mr S was unhappy with Bupa's latest response to his complaint, and so he brought his concerns to this service.

Our investigator explained that he couldn't consider the matters that had been addressed in Bupa's final response letters of 16 August 2023 and 12 October 2023, as Mr S hadn't brought his complaint to us in time. He therefore only considered the points that were addressed in Bupa's final response letter of 11 January 2024. In summary, he said:

- He thought Bupa's compensation payment of €420 was reasonable for the errors it had made with the MRI scan and delays.
- Bupa's decision to move Mr S's policy from Denmark to the UK was up to Bupa and we wouldn't ask Bupa to change this.
- He said he would expect Bupa to substantiate a claim before approving treatment, and that it had been reasonable for Bupa to request confirmation from Mr S's doctor about the reasons for his hospital admission.
- Although Mr S wanted his cover paused from August 2023, he remained covered until the policy lapsed.

Mr S 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.

Mr S has raised a number of points in his submissions to Bupa and this service. Whilst I've considered everything he's said, I've only focused on the issues that 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.

I'm not able to consider the matters addressed solely in Bupa's final response letters of August and October 2023 as Mr S didn't bring a complaint to this service in time for me to do so. However, with regards to Bupa's claims decision for the claim ending 913, I'm satisfied I can consider this. I say that because Bupa addressed this in its final response of January 2024 and there was a material difference in the outcome to the complaint compared to August 2023 (as Bupa decided to cover the claim, albeit on an ex-gratia basis).

<u>Claim ending 913</u>

Mr S stayed in hospital for two nights, and this length of stay was decided upon by his treating doctor. So, on the face of it, I can understand his frustration that Bupa refused to cover the cost of his hospital stay.

Bupa told Mr S that his hospital stay didn't fall under its definition of eligible treatment. I think Bupa caused Mr S some confusion here as the policy doesn't refer to or define the term 'eligible treatment'. Presumably Bupa meant treatment that was eligible under the terms of the policy. I've therefore considered whether Bupa's claim decision was reasonable, taking into account the policy terms.

In its submissions to this service, Bupa has referred to the below policy exclusion in its explanation of why the hospital admission isn't covered:

'…the Company shall not be liable for any expenses which concern, are due to or are incurred as a result of:
…
h) hospital stay when it is used solely or primarily for any of the following purposes: receiving general nursing care or any other services which do not require the customer to be in a hospital and could be provided in a nursing home or other establishment that is not at hospital; receiving services which would not normally require trained medical professionals (eg help in walking and bathing) and pain management.'

However, since Bupa doesn't know why Mr S stayed in hospital for two nights, I don't agree that this exclusion would apply here.

I've looked at the policy myself, and this says that a private room is covered under hospital services during hospitalisation. The policy definition of hospitalisation is:

'Surgery or medical treatment in a hospital or clinic as an in-patient when it is medically necessary to occupy a bed overnight.'

The policy also says that Bupa may ask for more information about a claim, such as medical reports or other information about the treatment.

Bupa says that Mr S's treatment is usually carried out as day-case treatment. Therefore, it wanted more information about why he had to stay in hospital for two nights before paying this part of his claim. That seems reasonable to me, given that occupying a bed overnight needs to be medically necessary.

Bupa gave Mr S the option to obtain further information from his doctor to explain why the two-night hospital stay was needed, but Mr S decided not to do so. That of course was up to Mr S, but then I think Bupa acted reasonably when it refused to cover the hospital admission costs without a clinical explanation for the two-night stay.

Since then, Bupa agreed to cover the hospital admission costs on an ex-gratia basis. That was up to Bupa.

<u>Pre-authorisation for MRI scan</u>

Bupa has accepted that it requested information from Mr S that it already had, and that it was at fault for doing so. Though it did still need some treatment details from him (provider name and date) before it could provide him with the pre-authorisation. Bupa had confirmed to Mr S that pre-authorisation wasn't a requirement under the policy. Nonetheless, Bupa did make an error when it asked for information it didn't need.

Bupa has accepted this and paid Mr S €420 to recognise the impact this caused, as well as its delays in responding to some emails. Taking everything into account, I'm satisfied this was reasonable and reflected the impact to Mr S by its handling of the matter.

Mr S has raised some concerns about a delay that happened with his MRI scan after Bupa issued its final response in January 2024. He should raise any concerns about this directly with Bupa in the first instance. If he's unhappy with its response, he may be able to bring a new complaint to this service.

Transfer of policy from Denmark to UK office

Bupa closed its Denmark office and therefore his policy was transferred to Bupa's UK office. Mr S says this happened without his approval, and he's unhappy that his claims were dealt with differently after this happened.

Bupa has acknowledged that some of its processes are different in the UK office and says that this can't be avoided.

Bupa's decision to transfer Mr S's policy to be serviced by a different office was a commercial decision that Bupa was entitled to make, and I won't interfere with that. It's also not for me to comment on Bupa's processes. Whilst Bupa acknowledges that some of these are different in the UK office, it's up to Bupa what processes and procedures it puts in place. Though ultimately Mr S's policy remained the same, regardless of which office serviced the policy.

Refund of premiums since August 2023

Mr S says he and his wife haven't used the policy since August 2023. He had told Bupa that he wanted more information (such as a written statement from its medical team, and details of that person's CV) on why Bupa had challenged his doctor's opinion that he needed to stay in hospital for two nights (regarding claim ending 913). Without this information, Mr S said he was pausing his monthly premiums.

I note Mr S continued to pay the premiums but said he expected Bupa to compensate him for them in the future. So, Mr S now wants a refund of the premiums paid from August 2023 until the policy lapsed in March 2024. He says that he and his wife postponed some medical treatment and paid for other treatment themselves because they didn't use the policy in this time.

I don't agree with Mr S that Bupa should refund the premiums paid since August 2023. He and his wife remained insured and could have claimed for any treatment eligible under the policy terms that they had between August 2023 and March 2024. Bupa made it clear to Mr S at the time that his policy remained active and hadn't been paused.

I've noted Mr S's explanation that he and his wife apparently did have medical treatment but didn't claim for this. That was up to them, but since they were insured until 1 March 2024, they can contact Bupa to make a claim for any treatment they had whilst they were covered under the policy.

Other compensation requested

Mr S says that he and his wife had intended to keep the insurance for the rest of their lives, and Bupa's actions/errors were the only reasons why the policy became inoperable. He has explained how he and his wife might be impacted in the future due to their decision to let the

policy lapse, as they are now without private healthcare. He thinks Bupa should pay compensation (€250,000) to serve as a replacement for the intended security of the lifelong insurance.

I don't agree with Mr S that the policy was impossible to use. Ultimately, it was Mr S and his wife's decision not to continue with the policy. I don't require Bupa to pay Mr S compensation for the fact that he and his wife no longer have private healthcare.

My final decision

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 15 April 2025.

Chantelle Hurn-Ryan
Ombudsman