DRN-5291473

The complaint

Mr M complains about Western Provident Association Limited's ("WPA") decision on his dental insurance claim.

What happened

Mr M holds a private health insurance policy that's provided by WPA. Mr M paid for an optional extra that provides cover for dental emergencies and injuries.

Mr M suffered an unfortunate dental injury in July 2024. He made a claim under his policy for the dental work needed – this included fixing a fractured tooth and bite misalignment. WPA accepted the claim but said it would only pay for treatment up to the limits in its dental fee schedule. It also said the policy excluded cover for orthodontic and cosmetic treatment.

Mr M didn't think WPA had treated him fairly. So, he brought a complaint to our service. One of our investigators looked into what had happened. Having done so, she thought WPA had acted in line with the terms and conditions of the policy when setting out what costs were covered, and what were excluded, under the policy. She also thought WPA had acted fairly and reasonably when it paid Mr M £150 for the distress and inconvenience caused for how it handled the claim.

Mr M didn't agree with our investigator's findings. In short, he said orthodontics are the only way his teeth and bite can be effectively restored. And WPA's own dental advisor said the work needed wasn't cosmetic, it was restorative. Mr M also doesn't think the limits in WPA's dental fee schedule reflect the cost of dental treatment.

As no agreement was reached, the complaint has 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.

Industry rules set out by the regulator (the Financial Conduct Authority) say insurers must handle claims fairly and shouldn't unreasonably reject a claim. I've taken these rules, and other industry guidance, into account when deciding what I think is fair and reasonable in the circumstances of Mr M's complaint.

Mr M's policy covers treatment for dental injuries, and it defines a dental injury as:

> *"An injury to the patient's teeth caused by an extra oral impact (and external blow to the teeth, face or jaws)."*

It's not in dispute that Mr M has a valid claim under his policy based on the above. However, WPA has declined to pay Mr M's claim for aligners based on the following exclusion:

> *"Dental consumables i.e. toothpaste, toothbrushes, dental floss, interdental brushes or mouthwash and/or orthodontic treatment and appliances such as mouthguards."*

Mr M's treatment plan includes realignment with orthodontics, following an injury. Unfortunately, as the above exclusion sets out, orthodontic treatment and appliances are not something the policy covers. I appreciate it's clear the realignment is done for restorative reasons, rather than cosmetic, but the above exclusion doesn't say it only applies when done for cosmetic reasons. So, I think WPA acted in line with the terms and conditions of the policy when it declined to pay Mr M's claim for realignment, as orthodontic treatment is excluded under the policy terms.

The policy terms and conditions refer to a dental fee schedule and say that WPA will only reimburse up to the maximum amounts listed there. And this is what WPA has done when assessing Mr M's claim. It has said it will pay for a temporary crown, crown, root canal, x-ray and a consultation up to the maximum amounts in the dental fee schedule. WPA also applied a fee uplift on the crown and root canal. I think this was fair and reasonable based on the information WPA had at the time of the claim.

The treatment plan Mr M's dentist has provided doesn't provide a detailed breakdown of the costs. For example, it appears that these costs include elements such as x-rays but the costs of these aren't broken down in the plan. If Mr M's dentist can provide a more detailed breakdown of the treatment plan and/or the final costs, I'd expect WPA to consider these in line with the policy terms (including the dental fee schedule).

Mr M has also disputed that WPA hasn't paid his claim for bonding, as it said it considers this to come under the cost of root canal. Although I note WPA's claim notes also refer to this being part of the crown allowance. If Mr M's dentist can provide a further information/breakdown for the claim for bonding, I'd expect WPA to consider this in line with the policy terms and the dental fee schedule. But as the dental fee schedule doesn't have a separate cost for bonding, I don't think WPA did anything wrong when it declined to pay for this based on the information it had at the time of claim.

I think this is something WPA could have made clearer to Mr M when he asked if he needed to detail the costs in the claim form – that this will help WPA to assess all the elements of the claim in detail. Instead, WPA said he should just send the treatment plan, which unfortunately wasn't detailed. But this is something Mr M can still do to ensure that WPA considers all the costs for his claim.

WPA has said it won't pay for whitening due to the following exclusion under the relevant policy terms:

> *"Cosmetic or aesthetic treatment i.e. veneers/bleaching unless needed as part of a treatment plan that we have pre-authorised."*

As Mr M has pointed out, the treatment plan says the cost of whitening is £0. However, Mr M has said whitening is included as part of the treatment. For completeness, the treatment plan doesn't set out that this is "needed as part of the treatment plan", as per the above exclusion. So, based on the information WPA had at the time of the claim, I'm satisfied it acted fairly and reasonably when it declined to pay for whitening.

Mr M has referred to a specific policy exclusion which says WPA will provide a benefit for cosmetic/aesthetic surgery when needed as a direct result of an accident or injury. However, I don't think this applies in the circumstances of Mr M's claim, as he's not having surgery.

Lastly, Mr M isn't happy about the amounts the dental care part of the policy covers. He says he's not able to get treatment in line with WPA's dental fee schedule. But fundamentally, it's for insurers to decide what risk they're willing to accept in return of a premium, and the applicable benefit limits. The dental care cover is an optional extra that Mr M chose to add to his main policy. I'm satisfied the information about benefit limits was available for Mr M when he bought the policy online, and it was for him to make sure that the cover he bought was suitable for his needs.

Having considered everything, I think WPA acted fairly and reasonably in how it considered the claim, based on the information it had. And I think the compensation it has paid Mr M for the service it gave him – including delays and not receiving call backs – is fair and reasonable in the circumstances.

My final decision

My final decision is that I don't uphold Mr M's complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr M to accept or reject my decision before 15 April 2025.

Renja Anderson
Ombudsman