DRN-5292975

The complaint

Mr F is unhappy BUPA Insurance Limited (Bupa) mis-sold his private medical insurance policy to him and that the premium being charged on the policy doesn't reflect the level of cover he has.

What happened

The background to this complaint is well-known to both parties. So, I've simply set out a summary of what I think are the key events.

Mr F has a private medical insurance policy with BUPA. He had a policy through his employer until 11 July 2024.

A new personal policy was taken out with BUPA as a continuation to the previous policy which started on 13 July 2024. The policy was set up joined with Mr F's wife and their two children. BUPA is the underwriter on the policy.

On 17 July 2024, Mr F called BUPA to discuss the level of cover offered on the policy. Following various options that BUPA went through with Mr F, a level of out-patient cover was chosen. The policy and premium were accepted based on the information that BUPA provided.

Mr F contacted BUPA for pre-authorisation for a consultation. He was informed that this consultation would be applied to the £750 out-patient limit.

Mr F made a complaint to BUPA that the out-patient cover wasn't explained to him. BUPA responded and said Mr F chose the £750 out-patient allowance and options were provided to him as to the level of benefits available on the policy. It said the policy wasn't mis-sold. The benefit for out-patient cover was available up to a limit of £750 for consultations, diagnostic tests and therapies. BUPA said since 13 July 2024, the out-patient benefit was subject to a £750 limit and anything above this would be Mr F's responsibility.

Unhappy, Mr F brought his complaint to this service. Our investigator didn't uphold it. She didn't think the policy was mis-sold or that the premium was unfair based on the information available.

Mr F disagreed and asked for the complaint to be referred to an ombudsman. He says the significant premium he's paying doesn't reflect the level of cover he has on the policy.

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.

It's important to point out that we're an informal dispute resolution service, set up as a free alternative to the courts for consumers. In deciding this complaint I've focused on what I consider to be the heart of the matter rather than commenting on every issue or point made

in turn. This isn't intended as a discourtesy to Mr F. Rather it reflects the informal nature of our service, its remit and my role in it.

The key issues I will need consider is whether the policy was mis-sold and whether the premium Mr F is paying is fair based on the out-patient level of cover he has.

Has the policy been mis-sold?

I've listened to the call recordings provided by BUPA on 17 July 2024. I note the adviser ran through some policy options. He explained Mr F can choose the level of cover on his policy for the out-patient cover, the hospital list, the cancer cover and the excess. And once Mr F had chosen the options, he could still come back and amend the options chosen. The adviser provided general information about the process and the availability of a GP on the policy. In relation to the out-patient cover, the adviser said there were two options available on the policy. Mr F had the option of having full out-patient cover or taking the option up to a £1,000 or £750 or £500 allowance limit. I note that Mr F clarified what would be covered under the £750 allowance limit. He asked if treatment such as physiotherapy, consultations, minor tests, therapy would fall under the out-patient limit. The adviser said that was correct. Mr F decided to have the limit for him and his wife for £750 and the children to £500. The adviser explained if they were admitted as an in-patient or day patient, they would be fully covered for things such as surgery. Mr F chose to have the £750 out-patient limit for himself on the policy. The policy was agreed based on the options provided, backdated to 13 July 2024 and the premium to be paid was just over £993. Mr F was informed that policy documents would be received and any changes that needed to be made, he should contact BUPA.

Having listened to the calls, I don't think the policy was mis-sold. Mr F agreed to the out-patient limit and I can see he did clarify with the adviser whether consultations would fall under the out-patient limit. Whilst I do understand that having sought authorisation for a consultation, he was informed this would affect the out-patient limit, this doesn't mean the policy was necessarily mis-sold. The telephone discussion on 17 July 2024 did clarify that a consultation would affect Mr F's out-patient limit and I note the premium was accepted based on the options Mr F chose.

Is the policy premium too high based on the out-patient cover provided?

As this issue relates to the premium price of the policy, I will consider whether BUPA's premium is in line with how it charges premiums for other customers in similar situations.

As a starting point, I should say that the Financial Ombudsman Service doesn't set the rules on how an insurer can price policies. It's up to an insurer how much to charge for its policies so long as it exercises its judgement fairly and also that it hasn't treated Mr F unfairly compared to others in a similar position.

Insurers consider many factors when setting premiums. When deciding how much to charge for their policies they will assess the likelihood of a policyholder making a claim and how much they might have to pay out for those claims. And each insurer will go about that in its own way. It's for BUPA to decide which factors it wishes to take into account. Age, healthcare costs, and claims made in the last year are just some of the factors that are mentioned in the policy handbook.

BUPA has provided an explanation of how its premiums were priced. I've checked the criteria applied by BUPA. And I haven't seen anything to indicate that Mr F has been treated any less favourably than other policyholders in the same position. So, I don't think it's done anything wrong here.

I can't ask BUPA to share commercially sensitive information. But I have seen and checked the information and calculations it has provided. And I haven't seen anything which shows Mr F has been differently or unfairly.

I understand that Mr F thinks the out-patient level of cover he has on the policy doesn't reflect the premium he's being charged. However, having listened to the calls, Mr F chose the out-patient level of cover to be £750 for himself and the premium was based on this, amongst other things. Had he chosen a different level, the premium would have gone up or down dependent on that level. The premium will always reflect the level of cover provided on the policy based on the factors that are relevant. That's not unusual.

Whilst I appreciate that Mr F is unhappy and feels his policy doesn't provide the cover he would like, I don't think he's been treated differently or outside the terms and conditions of the policy. It's open to Mr F to decline the policy and it remains the case that he's not obliged to take it. I do however understand that's not always possible.

Overall, having taken the individual circumstances of this complaint into account, I don't think BUPA has treated Mr F unfairly or unreasonably. I'm not persuaded that the policy was mis-sold or that Mr F has been treated unfairly in applying the premium on the policy. I'm sorry to disappoint Mr F but it follows that I don't require BUPA to do anything further.

My final decision

For the reasons given above, I don't uphold Mr F's complaint about BUPA Insurance Limited.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr F to accept or reject my decision before 28 April 2025.

Nimisha Radia
Ombudsman