

The complaint

Ms S is unhappy with BUPA Insurance Limited's decision to apply an excess to her treatment. She's also unhappy with the way it handled her claim.

What happened

Ms S has private medical insurance with BUPA. She also has another policy which offers similar benefits with a separate provider, which I'll refer to as Company B. Ms S needed ophthalmic surgery and so she claimed on her BUPA policy. The treatment was approved in February 2024 and the claim was paid. However, BUPA said Ms S needed to pay the first £1,000 towards her treatment as this was the agreed excess on her policy.

Ms S said no excess was due because she'd already used Company B's policy for the initial investigations and diagnostics, which effectively saved BUPA money. She explained the two policies work in conjunction with one another as both are provided by BUPA and her understanding was Company B's policy effectively contributes towards the excess of her BUPA policy. Ms S also complained there were issues arranging the surgery and that her preferred surgeon, although approved by BUPA, wasn't authorised to perform the treatment at her preferred hospital.

BUPA said the excess is payable in this case. It explained the excess must be paid for the first eligible treatment in the relevant policy year. It also said Company B is a separate entity to BUPA and there was no such agreement like the one Ms S has outlined. BUPA acknowledged there were issues with Ms S's preferred surgeon and the hospital, however, it paid for the treatment in full, despite the hospital not being part of its approved network.

Our investigator didn't uphold Ms S's complaint. She agreed the two companies are separate and therefore the respective policy terms and cover were independent from one another. She found it was appropriate for BUPA to apply the excess to her claim and said she cannot comment on Company B's actions in this case.

Ms S disagreed with her findings. She explained her understanding was Company B's policy was there to effectively cover the excess incurred when she used her BUPA policy for treatment. She mentioned other family members always used the two policies in that way. Ms S also mentioned she was sent a letter from Company B, which was actually sent by BUPA and said this proves both are effectively the same entity. And so, it's now for me to make a final decision on whether BUPA can apply the excess in this case.

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, I've also decided not to uphold it. I say that because I think BUPA has applied the policy excess fairly and in line with its policy terms. I also think BUPA offered Ms S good service by paying her claim in full, less the applicable excess, for treatment performed outside of its approved network. I'll explain why.

BUPA must adhere to the rules set by the Financial Conduct Authority. This comes from the Insurance Conduct of Business Sourcebook and, in summary, says BUPA must handle claims promptly and fairly and mustn't avoid a claim. It must also provide reasonable guidance to help a policy holder to make a claim. I've thought about BUPA's obligations under this rule whilst considering Ms S's complaint.

The policy terms say about the excess;

"Having an excess or co-payment means that for each policy year you must pay part of any treatment costs covered by your policy up to the excess or co-payment amounts"

The excess on Ms S's policy is £1,000 per policy year and so I'm satisfied BUPA has applied the excess correctly in this case. I say that because Ms S first brought her claim for ophthalmic treatment to BUPA in January 2024. This was for the anaesthetists costs which were £700. As this was less than the applicable excess, BUPA explained on 19 February she should pay this directly to the treatment provider. This meant the next invoice for treatment Ms S submitted, for the surgery, Ms S would need to pay the remaining £300 of the applicable excess to the provider, and BUPA would pay the remaining costs.

The evidence I've seen shows BUPA fulfilled its obligation here and on 23 February, BUPA paid £4,407.99 – which was the full cost of Ms S's surgery, less the remaining policy excess. And so, I'm satisfied BUPA handled Ms S's claim fairly in the circumstances as it paid for the treatment she needed in the way the policy described it would.

I also note BUPA's policy says it'll only contribute 40% co-payment for treatment provided outside of its approved network. Ms S's treatment was paid in full, despite taking place in a hospital that fell outside of its approved network. I thought that was a very fair outcome for Ms S in the circumstances. Although Ms S's surgeon was recognised by BUPA, where the treatment takes place is an equally important consideration. Both have to be part of the approved network. The hospital BUPA originally suggested Ms S to have the treatment was unable to provide the necessary facilities. So BUPA said it'd pay the full cost of the treatment, performed at another hospital outside of its network, so Ms S's treatment wasn't delayed. I thought that was a good outcome for Ms S as BUPA went beyond its policy terms here.

Ms S argued she received earlier diagnostic treatment, prior to having her surgery and that she used Company B's policy to pay for that. She explained she was under the impression by opting to use Company B in that way, it meant she wouldn't have to pay BUPA's policy excess. I understand the argument she's making here, that she's effectively saved BUPA paying her diagnostic treatment costs, but that doesn't persuade me BUPA shouldn't apply the excess to her claim. I say that because BUPA's policy is independent from Company B and there's no provision in her BUPA policy that links the two in the way she's described. If that's something Ms S still disagrees with, then she'll need to complain to Company B about that as it's not something BUPA has told her. And there's nothing in the BUPA policy to explain that.

Ms S has made other arguments about BUPA's affiliation with Company B. She explained BUPA handles claims for Company B and that it's effectively the same company. I can see how that's perhaps caused some confusion here, but it's not unusual for insurers to sometimes delegate other insurers to handle some of their claims. But it should also be perceived in that circumstance the insurer's remain independent from one another.

Ms S claimed to have received a letter from Company B, sent by BUPA, but BUPA explained that's not the case. I've seen the letter in question and I'm satisfied this wasn't sent by BUPA. It has Company B's heading and branding and also lists a different office address.

And so, even if BUPA sent that letter on behalf of Company B – and I’m not suggesting it did – the content of that letter would have always been from Company B and completely independent of BUPA.

My final decision

For the reasons I’ve explained, I don’t uphold Ms S’s complaint.

Under the rules of the Financial Ombudsman Service, I’m required to ask Ms S to accept or reject my decision before 10 October 2025.

Scott Slade
Ombudsman