DRN-5775491

The complaint

Mr M is unhappy that BUPA Insurance Limited has declined to offer cover for emergency admissions related to an existing urinary condition under a private medical insurance policy.

What happened

Mr M has held a policy with BUPA for a long time. He has an existing medical condition and over the years has had cover for urgent admissions related to this condition. Mr M is unhappy because BUPA initially declined to cover a recent admission, which they then agreed to cover as a gesture of goodwill. BUPA also then said that any further admissions of this nature wouldn't be covered as they've changed their interpretation of the policy terms. He complained to BUPA about this and the customer service he received.

BUPA said they'd not changed the policy terms but had updated guidance about the terms which is why their position had changed. They acknowledged Mr M hadn't always received a good service and offered a total of £400 compensation. Unhappy, Mr M complained to the Financial Ombudsman Service.

Our investigator looked into what happened. He didn't think that BUPA had acted unreasonably in the circumstances. He thought they'd acknowledged the poor service Mr M had received and that they didn't need to do anything further to put things right.

Mr M asked an ombudsman to review his complaint. He says, in summary, that BUPA have made a major change to their interpretation of the policy which has diluted the cover. Mr M said he ought to have been made aware of this at an earlier stage he wouldn't have renewed 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.

The policy contains an exclusion clause relating to accident and emergency treatment. It says there isn't cover for:

> Any accident or and emergency treatment, including immediate care, provided by an NHS or private accident and emergency (A&E) department, urgent care or walk-in clinic isn't covered.

The policy terms go on to say:

> Any urgent treatment or treatment you need immediately when you are admitted to hospital, including accommodation costs, isn't covered if you are admitted directly after and in connection with:
>
> - Attending an NHS or private A&E department, an urgent care centres or a

walk-in clinic or

- A consultation with a GP or a consultant.

The relevant rules and industry guidelines say that BUPA have a responsibility to handle claims promptly and fairly. And they shouldn't reject a claim unreasonably. They also need to give Mr M enough information to decide at renewal whether the policy is right for him and met his needs. That information should be clear, fair and not misleading.

I don't think BUPA needs to do anything further to out things right because:

- I'm satisfied BUPA have fairly applied the policy terms and conditions to say that they won't be able to cover future claims of a similar nature. I think the circumstances of Mr M's claim fell within the relevant policy terms and conditions and they covered the additional admission as a gesture of goodwill. That was reasonable, as they were entitled to decline cover.

- BUPA has explained that their own guidance has been updated but the policy term has been in existence for some time. Mr M has benefitted from cover because the previous admissions were covered when they shouldn't have been. So, Mr M was able to access treatment which, strictly speaking, was not covered under the terms.

- I'm not persuaded BUPA's actions amount to a breach of contract. I don't think it would be fair and reasonable in the circumstances of this case to conclude that previously authorising claims, which ought not to have been covered, means that BUPA should continue to pay such claims. I think it was reasonable for BUPA to agree to cover the treatment on the last occasion and then explain that further treatment of a similar nature wouldn't be covered.

- There have been some minor changes to the wording of the policy over time. But, I'm not persuaded that those changes have fundamentally changed the policy benefits available to Mr M or diluted them in the way he's suggested. I'm also not persuaded that the renewal documentation provided to Mr M was unclear or misleading. The term is clearly set out and is also highlighted on the Insurance Product Information Document. So, on balance, I'm persuaded that BUPA has acted reasonably.

- BUPA has reviewed the application of the terms and adapted their internal guidance to ensure greater consistency. I think that's reasonable decision which they are entitled to take.

- I think a total of £400 compensation fairly reflects the overall distress and inconvenience caused to Mr M. BUPA accepts Mr M didn't receive a good service, including during the phone calls he made. I appreciate that this was very upsetting news for Mr M when he was unwell, and it could have been handled with greater sensitivity. I've considered what Mr M has said about the compensation, and how the figures were broken down. But, on balance, I think £400 in total fairly reflects the impact of the distress and inconvenience caused.

My final decision

I'm not upholding this complaint as I don't think BUPA Insurance Limited needs to do anything further to put things right.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr M to accept or reject my decision before 1 October 2025.

Anna Wilshaw
Ombudsman