

The complaint

Mrs H complains about BUPA Insurance Limited's ('Bupa's) handling of her private medical insurance claim.

What happened

Mrs H held private medical insurance cover with an insurer (that I'll call A). In 2023, she underwent eye surgery and this was covered by A.

In 2024, Mrs H's broker changed her insurer to Bupa. This applied from the date of Mrs H's renewal on 1 June 2024.

In December 2024, Mrs H had a consultation that related to her eye surgery from 2023. She made a claim to Bupa, but this was turned down. Bupa said she had a diagnosis of macular degeneration, and this would be considered a chronic condition which was excluded under the policy. However, it said that as a gesture of goodwill it would cover her December 2024 consultation.

Mrs H complained to Bupa and clarified she doesn't have macular degeneration.

Bupa issued a final response to the complaint on 6 June 2025. It made the following main points:

- It had confirmed that the consultation was routine as the consultant had arranged six monthly check ups following Mrs H's 2023 surgery, but she didn't have any symptoms. Bupa said this wasn't covered under the policy.
- It accepted it had given Mrs H conflicting information. It had referred to the wrong eye condition of macular degeneration in its correspondence with her, and had also wrongly told her the consultation had been authorised.
- Bupa apologised for its errors and again confirmed it would cover the December 2024 consultation as a gesture of goodwill. It also offered Mrs H £100 compensation.
- It said it had received further invoices for a consultation and a test with the same consultant on 2 June 2025. These hadn't been paid because Mrs H hadn't renewed her policy on 1 June 2025, but it said that even if her cover had renewed, she wasn't covered for routine consultations.

Unhappy with Bupa's response to her complaint, Mrs H brought a complaint to this service.

Our investigator looked into things but didn't recommend the complaint be upheld. She noted Bupa had turned down the claim because the policy didn't cover routine consultations, and it had also said Mrs H had a chronic condition. She thought it had been reasonable for Bupa to say this, though as its handling of the claim had been poor, she thought its offer to put things right was fair.

Mrs H 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.

I've noted Mrs H's request to speak with me. However, I don't think that's necessary, as I'm satisfied that I understand both parties' views and have sufficient information to make my decision.

Industry rules set out by the regulator (the Financial Conduct Authority) say insurers must not 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 Mrs H's complaint.

The policy says:

'What we do not pay for:

- (a) Ongoing, recurrent or long-term **treatment** of any **chronic condition**.*
- (b) The monitoring of a **medical condition**.*
- (c) Any **treatment** which only offers temporary relief of symptoms rather than dealing with the underlying **medical condition**.*
- (d) Routine follow-up consultations.*
- (e) Regular or long-term dialysis in the case of chronic organ failure.*
- (f) Any hormone replacement therapy (HRT).'*

The policy defines 'chronic condition', but I won't include the definition here.

When assessing the claim, Bupa wrongly said that Mrs H had macular degeneration which it said was a chronic condition. It now accepts she doesn't have this condition.

However, Bupa still says the claim isn't covered because it thinks Mrs H's December 2024 consultation was a routine follow-up. It later told this service that it also thinks Mrs H has a chronic condition.

I've listened to a call that took place between Bupa and the hospital. Bupa noted that Mrs H had undergone a procedure in 2023 and wanted to know if the recent invoice (for the December 2024 consultation) was a regular check up or if Mrs H had new symptoms. The hospital confirmed that Mrs H had had check ups every six months since her 2023 operation. They also confirmed this was for monitoring reasons.

The hospital later wrote to Bupa and said the consultant wouldn't continue with the follow ups if there was not a clinical need for this. The hospital thought Bupa had turned down the claim because it had the wrong condition recorded for Mrs H.

Based on Bupa's call with the hospital, I think it was reasonable for Bupa to conclude that the invoice was for a routine follow up consultation. This fell under the above exclusion and therefore I find that it was reasonable for Bupa to say the claim wasn't covered.

Bupa has told this service it thinks Mrs H's condition is chronic. It seems this conclusion was based on information it had received from her consultant after it had issued its final response letter. I assume this related to a later invoice it received for a consultation Mrs H had on 2 June 2025. But Mrs H's cover didn't renew on 1 June 2025, so any treatment she had after

this date wasn't covered anyway. So, I don't think I need to decide here whether Mrs H's condition fell under the chronic condition exclusion. We've explained this to Mrs H.

Bupa accepts it caused confusion when it wrongly advised Mrs H that her consultation would be covered, and when it wrongly referred to a different eye condition. By way of apology for this, Bupa covered the cost of the December 2024 consultation as a gesture of goodwill. It also offered her £100 compensation. It's clear Bupa did cause Mrs H unnecessary confusion by its actions, but I think its offer here was reasonable and reflected the impact on Mrs H.

Mrs H says she asked Bupa to put her 2025 renewal on hold until Bupa amended the details of its final response letter, and that she wants Bupa to reinstate her cover as it was on 1 June 2025. If Mrs H is unhappy with Bupa's handling of her renewal, she would need to raise this with Bupa in the first instance. If Bupa can't resolve this for her, she can bring a new complaint to this service, subject to our usual time limits.

My final decision

My final decision is that BUPA Insurance Limited has made an offer to pay £100 (and has also covered the cost of the consultation) to settle the complaint and I think this offer is fair in all the circumstances.

So, my decision is that BUPA Insurance Limited should pay Mrs H £100 if it hasn't already done so.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs H to accept or reject my decision before 30 April 2026.

Chantelle Hurn-Ryan
Ombudsman