DRN-4962799

The complaint

Mr and Mrs W complain that BUPA Insurance Limited hasn't fully settled a claim Mrs W made on a group private medical insurance policy.

As Mrs W brought the complaint to us, I've referred mainly to her.

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 and Mrs W are insured under a group private medical insurance policy. The cover includes an annual out-patient allowance (OPA) of £1000 per insured member.

Mrs W underwent an initial consultation for chronic pain in January 2024. Following that appointment, she called BUPA to obtain authorisation for further tests, including an ultrasound and blood tests. During the call, Mrs W asked BUPA how much of her annual OPA she had remaining and was told that she had £898 but that the cost of the initial consultation hadn't yet been deducted. Mrs W asked how much the ultrasound and blood tests would cost and BUPA's call handler directed her to check directly with the hospital. Ultimately, BUPA provided pre-authorisation for Mrs W to undergo an ultrasound, blood tests and a follow-up consultation.

In mid-January 2024, Mrs W underwent the diagnostic tests. However, while BUPA partly settled the costs, the bill exceeded Mrs W's outpatient allowance by around £2000. Therefore, BUPA directed her to pay the outstanding balance directly to the hospital.

Mrs W was very unhappy with BUPA's position, as she said the call handler had told her all of her costs fell within the OPA. So she and Mr W asked us to look into this complaint.

Our investigator didn't think BUPA had led Mrs W to believe that the costs of the diagnostic tests would be less than her OPA. And he didn't think it would be fair to tell BUPA to pay the full balance of Mrs W's claim because he felt it had been her decision to go ahead with the tests despite not knowing how much they would cost.

But while he accepted that BUPA couldn't have provided Mrs W with an exact price, he felt that it should have had a rough idea of the cost of ultrasounds and blood tests and that the total costs would likely exceed Mrs W's remaining OPA. So he thought BUPA ought to have done more to avoid this foreseeable harm to Mrs W. And he recommended it pay her £200 compensation to reflect the disappointment she was caused as a result of the lack of information it had given her.

Mrs W accepted the investigator's view. But BUPA did not. In brief, it said it had never been told to provide this kind of information previously. It said any cost estimates it provided would be guesswork, as only the provider would know the price of necessary tests or treatment. And it was concerned that providing cost estimations might deter its members from making claims.

I issued a provisional decision on 29 July 2024, which explained the reasons why I didn't think BUPA had treated Mrs W unfairly. I said:

'The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. I've taken those rules into account, along with other regulatory principles and guidance and other relevant considerations, when deciding whether I think BUPA has treated Mrs W fairly.

Firstly, I've considered the terms and conditions of the policy, as these form the basis of the group contract with BUPA. Mr and Mrs W's membership certificate sets out that each insured member has an annual allowance of £1000 per policy year for out-patient consultations, therapies and diagnostic tests. The policy terms define diagnostic tests as:

'Investigations, such as x-rays or blood tests, to find or to help find the cause of your symptoms.'

In my view, I think BUPA's policy documentation makes it sufficiently clear that Mrs W has an OPA of £1000 per year, which includes out-patient consultations and diagnostic tests. I also think that ultrasound scans and blood tests fall within the scope of the diagnostic test definition.

As BUPA appears to have settled Mrs W's claim up to the OPA of £1000 for the relevant policy year, I'm satisfied it's settled the claim in line with the policy limits.

Mrs W complained to us because she felt BUPA had led her to believe that all of her tests and consultations fell within the OPA. Our investigator listened to calls between Mrs W and BUPA and concluded that BUPA hadn't incorrectly led Mrs W to believe the combined costs of her tests and consultations would be less than her annual OPA. Mrs W appears to have accepted the investigator's conclusions on this point.

I have also listened to the call of 10 January 2024 between Mrs W and BUPA. I'm satisfied the call appears to be genuine and not doctored in any way, despite concerns Mrs W raised earlier in our process. And I don't find that the call handler told Mrs W that all of the costs would fall within the OPA. Instead, they explicitly told Mrs W that they couldn't say how much the tests would cost and that Mrs W would need to check this with the hospital directly. In my view, Mrs W understood what the call handler had told her. And she clarified with BUPA that she'd need to get in touch with the treating provider's secretary to find out about the costs of the proposed treatment. While I appreciate Mrs W says she wasn't able to obtain this information from the treating provider, I don't think I could reasonably find BUPA responsible for any action or inaction taken by a third-party hospital.

BUPA was responsible for ensuring it provided Mrs W with correct and clear information about its policies and the services it provided. In this case, I'm satisfied that it met these obligations and it gave Mrs W clear and accurate information about her level of cover. I don't think it misled Mrs W or mismanaged her expectations in any way. So I don't find it's made any error here for which I could fairly or reasonably direct it to pay any compensation.

I sympathise with Mrs W's position, as I appreciate she's incurred significant medical expenses over and above the OPA. But overall, I don't currently think BUPA has treated her unfairly. And therefore it follows that I don't intend to tell it to do anything more.'

I asked both parties to send me any further evidence or comments they wanted me to consider.

BUPA accepted my provisional findings.

Mrs W questioned how she was supposed to find out the cost of her treatment, when neither BUPA nor the treating hospital had been able to provide her with this information. She questioned how this was fair when she'd suffered from chronic pain for a number of years. She said she'd found my provisional decision thorough and that she'd understood the call recordings and how they sounded. But she said she could assure me that BUPA's call handler had understood what she meant when she asked whether she was covered.

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, whilst I'm sorry to disappoint Mrs W, my final decision is the same as my provisional decision and for the same reasons.

I appreciate it was frustrating for Mrs W that she was unable to find out how much her treatment would cost. But it remains the case that I don't think it was unreasonable for BUPA to direct Mrs W to check the costs with the treating hospital. And I still don't think I could fairly or reasonably hold BUPA responsible for the actions or inactions of a third-party provider.

It's clear Mrs W feels BUPA's call handler did understand her question regarding cover. It seems then that she feels the call handler didn't respond appropriately. I've thought about this and whether I consider the call handler dealt with Mrs W's question in a reasonable way. In my view, the call handler didn't mislead Mrs W. I think they gave her clear and accurate information about her cover. And I still think the call recording indicates that Mrs W had understood what the call handler had told her. So I don't think the call handler made any error or acted unreasonably.

Overall, despite my sympathy with Mrs W's position, I still find that BUPA met its regulatory obligations to give her clear, fair and not misleading information about her policy and about its services. So I make no award against BUPA.

My final decision

For the reasons I've given above and in my provisional decision, my final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs W and Mr W to accept or reject my decision before 10 September 2024.

Lisa Barham
Ombudsman