DRN-4390768

The complaint

Mr F is unhappy with BUPA Insurance Limited's decision to not pay his claim in full.

What happened

Mr F has private medical insurance with BUPA. In September 2022, Mr F sadly suffered a stroke and was taken to hospital for treatment. Mr F was in hospital for 35 days, during which, he made a claim so he could be treated in a private facility. His claim was declined because BUPA said it wouldn't cover outpatient treatment, or rehabilitation treatment, without initially being treated privately. Mr F also made a claim for hospital cash benefit which he said was significantly and unnecessarily delayed. Mr F is unhappy with the overall customer service received and the outcomes of both claims.

BUPA said Mr F's policy doesn't cover him for the first claim. It said Mr F had to be treated as a private inpatient before it would consider his claim for rehabilitation physiotherapy. It also highlighted there was a limit on that element of cover of £500, which likely wouldn't have been enough to cover the treatment he received, and so, treatment on the NHS would've been better for him in the circumstances.

BUPA accepted it'd caused unnecessary delays handling Mr F's hospital cash benefit claim. It said there were missed opportunities where it could've thoroughly investigated the claim, which ultimately meant it could've paid it sooner than it did. It eventually paid the full 35-day claim and Mr F's associated costs. It also paid £750 compensation to acknowledge the distress and inconvenience caused by the delay.

Our investigator agreed with BUPA that the first claim wasn't covered by the policy terms. But she also said BUPA should've paid the hospital cash benefit sooner than it did, because she was satisfied BUPA had all the necessary information to assess and settle the claim in December 2022 and noted it wasn't paid until February 2023. She thought the compensation paid was a fair reflection of the distress and inconvenience caused.

Mr F disagreed with her findings. In summary, he said the policy wasn't there to support him in the way he'd hoped and he felt let down by BUPA. He said BUPA should've accepted his initial claim and by not doing so, has left him questioning the relevance of his private medical insurance. He'd like more compensation because of that. And so, it's now for me to make a final 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.

Having done so, I've decided not to uphold it. My reasons for doing so are similar to those already explained by our investigator; BUPA declined Mr F's claim for private treatment fairly and I think the compensation awarded adequately reflects the level of distress and inconvenience for the delay in paying the hospital cash benefit. I'll explain why.

The relevant rule here is the Insurance Conduct of Business Sourcebook (ICOBS) which says that BUPA must handle claims promptly and fairly and mustn't reject a claim unreasonably.

I think it's important to recognise private medical insurance doesn't cover every eventuality, or medical condition and that policies are subject to limitations for those reasons. Mr F suffered a stroke in September 2022 and whilst I accept the seriousness of his condition, I think the correct course of action was taken to stabilise and treat him, as Mr F was given emergency care by the NHS. I say that because there are no private A&E hospitals and given Mr F suffered a stroke, he received care by the NHS as everyone in the UK would. I wanted to highlight this as Mr F has made arguments about BUPA not doing enough to offer treatment for his stroke and so for the avoidance of any doubt, there wasn't anything BUPA could've done to arrange treatment for symptoms where emergency medical care was required.

BUPA was made aware of Mr F's situation in October 2022. Mr F wanted to know whether BUPA was able to offer any support with his recovery at this stage but was told cover wasn't available because he wasn't treated at a private facility. This prompted Mr F to question the usefulness of his policy, given he didn't have the option to receive treatment in that way. But for the reasons I've explained, I'm satisfied this would never have been possible in these particular circumstances, because of the urgency and severity of his illness. I know that's a contentious point for Mr F, and he's made several arguments about why he thinks BUPA should've done more in relation to that claim, but private medical insurance isn't designed to replace the NHS, rather it's to work alongside and supplement it where appropriate and safe to do so. In Mr F's case, his stroke meant he needed to be treated as an emergency and receive the relevant level of care. I've also considered BUPA's policy terms which say;

"You have the Essentials cover level which means that your benefits do not cover out-patient consultations or therapies before day-patient treatment or in-patient treatment, you will need to choose whether to pay yourself for a private out-patient consultation or therapy or use the NHS. If you decide to pay yourself call us and we can talk through your options and help you find a recognised practitioner covered under your benefits in case you should go on to need day-patient treatment or in-patient treatment."

Given what I've just explained, I'm satisfied BUPA declined Mr F's claim fairly because it's acted in accordance with those terms. Mr F wasn't treated privately and therefore rehabilitation treatment isn't covered in these particular circumstances.

NHS Cash Benefit

Mr F's policy offered cash benefit for each day he spent in hospital. BUPA has paid £1,878.42 to Mr F. This figure includes the £50 for each of the 35 days he was in hospital, plus associated court costs. It also paid £750 compensation for the overall distress and inconvenience caused. I should say it's not in dispute that BUPA could've handled this claim better than it did. I'm satisfied it caused unnecessary delays and that this had a significant impact on Mr F. I say that because Mr F said he'd planned to use that money to pay for his private rehabilitation and so it was important he receive it in good time. BUPA also accepted it missed the opportunity to investigate the claim properly.

Mr F had tried on a few occasions, 9 and 27 January and 7 February 2023 to get BUPA to pay his claim and gave all the necessary information to BUPA by early December 2022. However, BUPA didn't assess this correctly and at times, ignored Mr F's continued attempts to get his claim resolved. In these circumstances, I'm satisfied BUPA didn't adhere to the principles of ICOBS as it didn't pay Mr F's claim promptly. Mr F was left with little choice but to begin court proceedings against BUPA on 13 February, however, I note both parties were

able to resolve the issue without the need for a court hearing and BUPA paid the claim in full and covered Mr F's court fees – which I thought was fair – 10 days later.

I agree that compensation was due given the distress and inconvenience caused and I'm satisfied BUPA has taken that seriously because it's already paid £750 to Mr F for the impact of its mistake. It's for those reasons I don't think it needs to pay anything more, because I feel the compensation already paid is enough in these particular circumstances**.**

My final decision

For the reasons I've explained, I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr F to accept or reject my decision before 29 November 2023.

Scott Slade
Ombudsman