DRN-4524245

The complaint

Mr L complains about the way BUPA Insurance Limited handled a claim he made on a group private medical insurance policy.

What happened

Mr L is insured under his employer's group private medical insurance policy. In August 2023, Mr L contacted BUPA because he was experiencing tendonitis. BUPA arranged for a physiotherapist to contact Mr L to discuss his symptoms and recommend a way forward. Mr L was subsequently authorised to undergo five sessions of physiotherapy.

Mr L underwent two sessions with a physiotherapist. However, ahead of undergoing the third session, Mr L learned that he'd need to pay an excess of £150 to the physiotherapist. Mr L was unhappy with this because he said he hadn't been made aware that he'd need to pay an excess, either in his calls to BUPA, or on his policy documents. He didn't undergo any further sessions while the matter was looked into. And he asked us to look into his complaint.

Our investigator didn't think Mr L's complaint should be upheld. She felt Mr L's policy certificate made it clear that an annual excess of £150 would be applied each year. And she felt this was also made clear in the membership handbook. So she thought it had been fair for BUPA to require Mr L to pay an excess of £150 towards his physiotherapy treatment.

Mr L disagreed with the investigator. In summary, he said he felt BUPA should have highlighted that an excess would apply when he contacted it to obtain authorisation for physiotherapy treatment. He said that he hadn't asked BUPA to clarify whether an excess applied, because he wasn't aware that it could do so.

The complaint's been passed to me to decide.

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 Mr L, I think BUPA has treated him fairly and I'll explain why.

First, I'd like to reassure Mr L that while I've summarised the background to his complaint and his submissions to us, I've carefully considered all he's said and sent us. In this decision though, I haven't considered each point that's been made and nor do our rules require me to. Instead, I've focused on what I think are the key issues.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. So I've considered, amongst other things, the terms of this policy and the circumstances of this claim, to decide whether I think BUPA treated Mr L fairly.

I've first considered the policy terms and conditions, as these form the basis of Mr L's employer's contract with BUPA. Page 21 of the Membership Guide explains how BUPA will deal with claims if an employer has opted to include a policy excess. The policy says:

'*The sponsor may have agreed with us that either an excess or co-insurance shall apply to your benefits. Your membership certificate shows if one does apply and if so,*

- *the amount*
- *who it applies to*
- *what type of treatment it is applied to, and*
- *the period for which the excess or co-insurance will apply.*

Some further details of how an excess or co-insurance works are set out below and should be read together with your membership certificate.

Having an excess or co-insurance means that you have to pay part of any eligible treatment costs that would otherwise be paid by us up to the amount of your excess or co-insurance.

By eligible treatment costs we mean costs that would have been payable under your benefits if you had not had an excess or co-insurance.

If your excess or co-insurance applies each year it starts at the beginning of each year even if your treatment is ongoing. So, your excess or co-insurance could apply twice to a single course of treatment if your treatment begins in one year and continues into the next year.

We will write to the main member or dependant having treatment (when aged 16 and over) to tell them who to pay their excess or co-insurance to, for example, their consultant, therapist or treatment facility. The excess or co-insurance must be paid direct to them – not to Bupa.'

I think the policy document makes it clear what an excess is and how it applies to claims. In my experience, most, if not all, private medical insurers require beneficiaries or policyholders to pay an excess - a defined amount towards the cost of their treatment, up to an annual limit.

Page two of Mr L's membership certificate sets out the details of Mr L's cover. In emboldened, large text, the certificate says:

'Excess'. *It states an excess amount of £150 and immediately underneath says:*

'The excess amount applies to each member individually.

The excess applies each year to treatment costs for eligible treatment.'

In my view, the membership certificate makes Mr L's applicable excess sufficiently clear. And I find that the totality of Mr L's policy information sufficiently draws his attention to the excess and how it will be applied to claims.

I accept that BUPA's call handler didn't specifically refer Mr L to his excess when they arranged for a physiotherapist to call Mr L to discuss his symptoms and the way forward. However, at this point, no physiotherapy treatment had been approved and no costs had been claimed. The call handler was simply arranging for a physiotherapist to contact Mr L to discuss the most appropriate treatment for his condition. So in these circumstances, I don't think BUPA's call handler made any material failing. And, as I've set out above, I think the policy documentation highlighted the excess in a clear and not misleading way.

Mr L has queried whether physiotherapy would fall within the ‘eligible treatments’ which attract an excess. In my view, it would. It was for treatment of an acute condition – tendonitis. So I find it was fair for BUPA to require Mr L to pay an excess of £150 for the costs of his treatment.

Overall, while I’m sorry to disappoint Mr L, I don’t think BUPA has treated him unfairly. I think it was reasonably entitled to require Mr L to pay the contractual excess of £150 to the physiotherapy provider. It’s now open to Mr L to return to the physiotherapist for further treatment.

My final decision

For the reasons I’ve given above, my final decision is that I don’t uphold this complaint.

Under the rules of the Financial Ombudsman Service, I’m required to ask Mr L to accept or reject my decision before 6 February 2024.

Lisa Barham
Ombudsman