

The complaint

Mr M complains about The Prudential Assurance Company Limited's decision to reject a claim he made under his critical illness policy. He's also unhappy about how the claim was handled.

What happened

Mr M took out a life and critical illness policy with Prudential in 2000. In March 2020 he made a critical illness claim having undergone an angioplasty. Prudential declined the claim because Mr M didn't meet the policy definition which required him to have needed treatment to two or more of his coronary arteries.

Mr M appealed Prudential's decision. He said he fully met the policy definition albeit for the need to have treatment to two or more coronary arteries – but that his case should be looked at '*holistically*' because he'd needed treatment to the most important artery – and because he believed Prudential's terms and conditions were outdated given the advances in angioplasty procedures. Mr M referred to a similar case published by our service. He also told Prudential he was unhappy with how his claim had been handled and the way he'd been communicated with.

Prudential accepted there had been delay and poor communication during the handling of Mr M's claim and paid him £400 in recognition of that. But it didn't change its decision on his claim. It maintained Mr M's treatment didn't meet the policy terms and conditions which required treatment to two or more coronary arteries. And Prudential said the published case he'd cited from our service concerned the percentage of the narrowing of the arteries – not the number of arteries treated.

Mr M didn't agree and referred his complaint to our service. He said Prudential had wrongly declined his claim and had misinterpreted the published case. He also said the terms and conditions were out of date with medical advances, which showed the severity of treatment was more significant than the number of arteries affected. Mr M wanted us to look at his case in a rational and holistic way, based on the severity of his condition, and to compare it to the published case he'd cited to apply a consistent and fair approach.

Our investigator reviewed the complaint but didn't uphold it. He said it wasn't disputed that Mr M had treatment to one artery. And so, he didn't meet the terms and conditions of his policy. Looking at the published case Mr M had cited, our investigator said there was nothing to indicate we'd made a finding that the policy requirement that two or more arteries needed treatment was unfair.

Our investigator said we look at each case on its own merits, but that we've previously taken the view that the number of arteries affected is a separate requirement that must be met, alongside factors such as the percentage of the blockage. And so, he thought we had applied a consistent approach in Mr M's case.

In addressing whether the policy terms were outdated, our investigator said our focus is on the terms and conditions Mr M had agreed to when taking the policy out. And we wouldn't expect an insurer to deviate from those terms based on later developments or advances.

Finally, our investigator said Prudential had accepted it could've handled Mr M's claim better, but he didn't think it needed to take any more action to address this.

Mr M disagreed and has asked for an Ombudsman to review his complaint. He said the investigator had taken a *'light touch'* approach to his case and hadn't fully addressed his points of complaint. He also said the published case he referred to related to the treatment of one artery – as in his case – and so was relevant to his situation. Mr M said we should take a broader, objective view of his case, taking account of different scenarios where the exact policy wording might not be met, but the required treatment demonstrated a level of severity the policy was designed to cover. Mr M maintained we had upheld cases like his in the past – and that we should therefore apply a consistent approach.

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 reached the same conclusion as our investigator. And for largely the same reasons. I know Mr M feels strongly about this complaint and so this will come as a disappointment to him. He's been through a difficult and worrying time, and I can understand why he's pursued matters. But as I'll go on to explain, I don't think Prudential's decision to decline his claim was unreasonable.

I've read and considered the whole file. But I'll concentrate my comments on what I think is relevant. If I don't mention any specific point, it's not because I've failed to take it on board and think about it, but because I don't think I need to comment on it to reach what I think is the right outcome. I've not commented on Prudential's handling of Mr M's claim, as he's not disputed the investigator's findings on this point.

In reaching my outcome I've only looked at whether Prudential's decision to decline Mr M's claim was fair, and in line with the policy terms and conditions he agreed to when he took the policy out. I've not commented on the hypothetical scenarios Mr M has outlined in support of his complaint – as I don't consider that to be relevant here.

I'm not medically trained, and so can't pass comment on the severity of Mr M's condition or the treatment he underwent. But I can see it's not in dispute that Mr M had treatment to *one* of his coronary arteries – and whilst I appreciate the points he's made around the severity of his condition and the medical advances in treatment since he took the policy out – I must consider the specific treatment Mr M underwent and whether that met the terms and conditions of his policy – the basis of which forms the contract Mr M and Prudential are bound by.

The applicable policy wording is as follows:

“Angioplasty

*The undergoing of a balloon angioplasty, atherectomy, laser treatment or stent insertion on the advice of a Consultant Cardiologist to correct at least 70% narrowing or blockage, **of two or more coronary arteries.** Angiographic evidence to support the necessity for the above operations will be required.”*

Mr M didn't meet the policy requirement that two or more coronary arteries required treatment. I'm satisfied this part of the policy term is clear and unambiguous, and that Mr M agreed to the terms and conditions when the policy started.

Mr M says his claim should be looked at in terms of the severity of his condition and the treatment he had – rather than focusing alone on the requirement that two or more arteries were treated. As our investigator has explained, no critical illness policy can cover every possible illness – and the severity of such an illness alone doesn't mean it's more likely to be covered. If it did, then critical illness policies would simply be unfordable.

I don't see anything unusual in the policy term applicable to this case. In the past we may have considered requirements around the percentage of the narrowing or blockage of arteries to be vague – given the disparity that can occur in such measurements – but having a requirement that treatment to a specific number of arteries must be met is, I believe, clear and unambiguous, and isn't open to interpretation.

In support of his complaint Mr M mentioned a previous case considered by our service. Whilst we look to take a consistent approach to cases – I'm mindful that each case should be looked at on its own merits. The case Mr M has cited might raise similar issues to his, and I can see it talks about when the overall severity of a condition *might* be a factor when a policy term is onerous to prove or ambiguous. But I don't think this is relevant to the merits of Mr M's case – or to the specific reason why his treatment didn't meet the policy definition.

Taking everything into account, I don't think Prudential's decision to decline Mr M's claim on the basis he didn't meet the policy terms and conditions for angioplasty was unfair or unreasonable. So, I won't be asking it to take any action.

I appreciate this isn't the outcome Mr M was hoping for. If he has more evidence to support his claim, then he should provide that to Prudential. He's also able to make a new claim, any time before the policy ends, if his situation changes.

My final 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 Mr M to accept or reject my decision before **11 March 2021**.

Anna Jackson
Ombudsman