DRN-3470766

## The complaint

Mr and Mrs M complain that CIGNA Life Insurance Company of Europe SA-NV didn't pay a medical emergency claim they made on an international medical insurance policy.

## What happened

In October 2017, CIGNA sold Mr and Mrs M a 'Global Health Options' international medical insurance policy. This provided cover for, amongst other things, emergency medical treatment. Mr and Mrs M later completed a medical questionnaire and Mr M declared that he'd previously had a cardiac condition. So CIGNA excluded cover for any cardiovascular disorder and associated/linked conditions, symptoms or complications for Mr M.

Mr and Mrs M were living abroad. In July 2021, Mr M was admitted to hospital. The hospital contacted CIGNA to obtain a guarantee of payment for his treatment. At that point, CIGNA understood that Mr M was suffering from a gall-bladder issue. It asked the hospital to provide a copy of Mr M's medical report. On receipt of the report, it noted that Mr M was suffering from chest pain and required a cardiac catheterisation. On this basis, CIGNA concluded that Mr M's condition was down to a cardiovascular disorder and declined to offer the guarantee of payment. It told the hospital it wouldn't provide a guarantee of payment.

Ultimately, Mr M underwent surgery and incurred treatment costs of thousands of pounds. He said that friends and family had had to provide financial support. He and Mrs M complained to CIGNA and to us, both about CIGNA's decision not to provide a guarantee of payment and about the way the policy had been sold to them. He said that the sales person had told him that the 24 hour emergency section of the contract would cover his heart condition regardless.

Our investigator thought Mr and Mrs M's complaint should be partly upheld. CIGNA no longer had a copy of the sales call between Mr M and its sales person, so she couldn't listen to exactly what was said. But she noted that all of the policy schedules Mr M had been sent since the policy had started clearly set out the cardiovascular exclusion. So she didn't think it was likely Mr M had been told his cardiac condition would be covered. And she felt the policy terms made it clear that while there was cover for emergency medical treatment; pre-existing conditions were excluded. In her view, the medical evidence showed Mr M had had a pre-existing medical condition. She was satisfied that the condition causing the claim was linked to a cardiovascular condition. So she felt it'd been fair for CIGNA to decline to offer a guarantee of payment for Mr M's costs.

But she noted that CIGNA hadn't told Mr and Mrs M directly that it wasn't offering a guarantee of payment. It had only discussed this with Mrs M some weeks later. The investigator thought this had likely caused Mr and Mrs M additional upset, so she recommended that CIGNA should pay Mr and Mrs M £250 compensation.

CIGNA accepted the investigator's recommendation.

Mr and Mrs M disagreed. In summary, they said there'd been a lack of equality in the investigation. They said at the point of sale, they'd been guaranteed that all medical

conditions would be covered. They didn't think it was right that cover for new conditions could be declined if those conditions were related to an existing condition. They said they'd never have taken out the policy if they'd known it didn't provide 24-hour emergency cover for all conditions. They felt CIGNA had guaranteed to the hospital that it would cover Mr M's costs and so it needed to honour that agreement. And they felt the compensation the investigator had recommended was an insult. They referred to a medical condition Mr M had and said that as CIGNA couldn't provide a copy of the sales phone call, it was a breach of CIGNA's requirement to make reasonable adjustments for him. They also considered it convenient that the sales call couldn't be found.

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 and Mrs M, I think it was fair for CIGNA to decline to cover their medical costs, although I do find it must pay some compensation. I'll explain why.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And they mustn't turn down claims unreasonably. So I've considered, amongst other things, the terms of Mr and Mrs M's policy and the available evidence, to decide whether CIGNA treated them fairly.

It seems to me that there are key issues I need to decide. Did CIGNA handle this claim fairly? Is there evidence it mis-sold the policy to Mr and Mrs M? Did it fail to make reasonable adjustments for Mr M's medical condition? I'll deal with each point in turn.

*Did CIGNA handle this claim fairly?*

First, I appreciate what an upsetting and worrying time this must've been for Mr and Mrs M after Mr M became seriously ill abroad. I sympathise with their situation and I do hope Mr M has made a good recovery.

I've looked closely at Mr and Mrs M's policy schedule for the 2020-21 policy year. This sets out the cover CIGNA had agreed to offer for that particular contract period. I can see that on page two, at the top of the page, CIGNA has listed the 'Medical Exclusions' which apply to the policy. Adjacent to Mr M's name, the following medical condition is listed as excluded from cover:

*'In addition to the standard policy exclusions in the Policy Rules, we will not pay for any medical attention or treatment arising directly or indirectly from the condition(s) stated below:*

*CARDIOVASCULAR DISEASE/DISORDER – CARDIOVASCULAR DISEASE/DISORDER and any associated or related conditions or symptoms and any complications arising therefrom.'*

Having looked at Mr M's medical screening questionnaire, it's clear that he declared he'd previously suffered from a cardiac condition. And I think too that it's clear CIGNA decided that whilst it was prepared to offer Mr M a policy, it *wasn't* prepared to cover any condition which was down to or related to a cardiac condition. So if Mr M's illness in July 2021 was due to a cardiac issue, then I think CIGNA was entitled to conclude that it wasn't covered.

Accordingly then, I've looked carefully at the medical report which the treating hospital sent CIGNA. This states:

*'Current illness; chest pain'* (It also set out that Mr M had a history of Ischaemic Heart Disease and a stent).

*Observations: ecg* (echocardiogram) *with ST elevation in V2, V3, V4 and dynamic changes with respect to initial ecg, chest pain with ST elevation protocol was activated.*

*SBAR (*situation, background, assessment, recommendation) *reasons: Cardiac catheterisation.'*

In my view, the medical report clearly shows that Mr M was undergoing diagnostic testing for chest pain and was recommended for cardiac catheterisation – a more invasive diagnostic test. On this basis then, I think it was reasonable for CIGNA to conclude that Mr M's condition was linked to a symptom of cardiovascular disease or disorder and that therefore, any claim wouldn't be covered.

Mr and Mrs M feel strongly that CIGNA gave the treating hospital a guarantee of payment and that it should be bound to honour such a guarantee. I've looked closely at the contact records between CIGNA and the hospital and I'm afraid I don't agree that any guarantee was given. On 6 July 2021, the hospital called CIGNA to request a guarantee of payment. CIGNA told the hospital it would need to see a medical report and a cost estimate. This is standard procedure in medical insurance claims, so that an insurer can check whether a medical claim appears to be covered before agreeing to pay any costs. The hospital sent CIGNA a copy of the medical report and invoice that day for it to consider. CIGNA responded on 7 July 2021 and said:

*'I truly apologies* (sic) *as member have an exclusion on cardiovascular diseases which means we unable to cover for the emergency treatment.*

*Member should be aware on* (sic) *the exclusion.'*

CIGNA's records don't indicate that it agreed to give a guarantee of payment. Instead, the contemporaneous evidence shows that CIGNA requested evidence from the hospital (as it's entitled to do) so that it could assess whether or not to offer cover. On receipt and consideration of that evidence, it let the hospital know that it wouldn't be able to pay Mr M's emergency costs. So I don't find that any payment guarantee was given to the hospital and it follows that I don't agree that CIGNA is bound to pay any treatment costs.

What is clear from the records though is that CIGNA wasn't able to let Mr and Mrs M know directly that any costs would not be met. In the circumstances, I think it ought reasonably to have made more effort to do so, even if that isn't its standard procedure. And there were several months between CIGNA deciding not to cover Mr M's costs and it issuing a final response to the complaint. I don't doubt that this caused Mr and Mrs M additional upset and concern at an already distressing time for them. So I think it's appropriate for CIGNA to pay compensation to recognise the impact its failure to keep Mr and Mrs M fully updated had on them. In the round, I'm satisfied that £250 is a fair award of compensation to reflect its mistake and I was pleased to note CIGNA agreed to the investigator's recommended award. I'm directing CIGNA to pay Mr and Mrs M £250 compensation.

*Did CIGNA give Mr and Mrs M inaccurate information about the policy?*

Mr and Mrs M say that when they took out the policy by phone, CIGNA's call handler told them that all emergency-related claims would be covered, including claims related to Mr M's

heart. Unfortunately, CIGNA's told us that given over three years have passed since the call took place, it's no longer available due to its internal record-keeping requirements. Therefore, I need to make a decision based on the evidence I have and what I think is most likely to have happened at the point of sale.

It's possible that Mr and Mrs M were told that Mr M's existing cardiac condition would be covered in emergency situations and that they chose to buy the cover on this basis. But I need to bear in mind that the phone call happened a few weeks before Mr and Mrs M filled out CIGNA's medical screening questionnaire. It was on this questionnaire that Mr M declared that he'd had prior heart disease and stent surgery. And it was following this questionnaire that CIGNA assessed the risk of Mr M needing to make a claim and decided not to cover any conditions related to his heart. As medical screening took place *after* the phone call, it seems less likely that the call handler would've been in a position to confirm cover or to agree that all medical conditions would be covered without exception.

And I need to bear in mind too the documentation that Mr M was sent after the sale. A policy schedule was first issued to cover the November 2017-18 policy year and a new schedule has been issued at each subsequent annual renewal. These set out the terms on which CIGNA has agreed to cover Mr and Mrs M – the price, their excess and the cover level. As I've explained above, each schedule also sets out the specific exclusion clause for cardiovascular conditions in relation to Mr M and explains that no treatment will be covered for related symptoms or illnesses. So I think this was clear enough to let Mr and Mrs M know that there wouldn't be cover for any cardiac-related conditions. And if this wasn't the cover they'd been led to expect they'd receive, the policy terms gave them 14 days to cancel the policy and receive a full refund.

Overall, the totality of the evidence makes me think, on balance, that it's more likely than not that CIGNA didn't give Mr and Mrs M inaccurate information about the policy.

*Did CIGNA fail to make reasonable adjustments for Mr M?*

Mr M says that he has a long term condition which impairs his ability to read and write. He says that CIGNA is aware of this and that when it failed to send him the sales phone call, it failed in its duty to make reasonable adjustments under the Equality Act 2010. Mr M's condition isn't one that is automatically deemed to be a disability as defined by the Equality Act 2010. However, even if – for the purpose of this decision – I assumed that he is disabled as defined by the Act and CIGNA was under a duty to make reasonable adjustments to ensure that he wasn't placed at a disadvantage because of this condition and the Equality Act 2010 is a relevant consideration when deciding this complaint, I don't think CIGNA has acted unfairly or unreasonably here.

I say that because CIGNA has told us it has no record of Mr M telling it about this particular condition and it isn't noted on the policy paperwork or contact notes I've seen. On balance, I haven't seen enough evidence to show me that Mr M did tell CIGNA about his condition at the time the policy was sold to him. And the reason CIGNA can't provide Mr M with a copy of the sales call is because it only retains call records for a certain number of years, which appears to be a reasonable explanation for its inability to provide this evidence. If Mr and Mrs M feel that CIGNA hasn't complied with any data subject access request they've made though, they may be able to make a complaint to the Information Commissioner's Office about that issue alone.

In summary, I find that CIGNA didn't act unfairly when it declined to pay any medical costs. I find the compensation it's agreed to pay Mr and Mrs M is reasonable and I don't think there's evidence to show Mr M was treated unfairly.

## My final decision

For the reasons I've given above, my final decision is that I think CIGNA has now made a fair offer of compensation.

I direct CIGNA Life Insurance Company of Europe SA-NV to pay Mr and Mrs M £250 compensation.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr M and Mrs M to accept or reject my decision before 20 July 2022.

Lisa Barham
**Ombudsman**