DRN-3735803

The complaint

Mrs A complains about the service received from CIGNA Europe Insurance Company SA-NV when she was admitted to hospital for urgent treatment.

What happened

Mrs A's complaint is brought on her behalf by her husband. But for ease, I will refer to all representations as having been made by Mrs A herself.

Mrs A is a beneficiary of a private medical insurance policy, provided through her husband's employer. Mr and Mrs A previously held their cover through another provider, and this was changed to a policy with CIGNA with effect from 1 May 2021.

Mrs A was admitted to hospital the day after the new policy with CIGNA started. At this time, Mr and Mrs A had been provided with details of the policy terms by Mr A's employer, but had not received all of their documentation about the policy. Mr A attempted to contact CIGNA and had difficulties getting through on the phone due to long wait times. He said he tried over several days, and also used a call back facility, but he was not contacted.

Ultimately Mrs A received care in an NHS hospital and was not transferred to a private facility. She underwent surgery and stayed in hospital for more than three weeks overall. She made a claim for the NHS hospital benefit available under the policy, however this was declined as CIGNA said Mrs A had been admitted to hospital as an emergency and did not have pre-planned treatment.

Whilst Mrs A had still been in the NHS hospital receiving treatment and care, Mr A had asked if nursing at home was covered under the policy, and CIGNA said it wasn't. However Mr A later found this was covered, based on the terms and conditions CIGNA said applied to the policy.

Mrs A complained to CIGNA about the level of service received, information provided about the cover, and the declinature of the claim.

CIGNA said it had been correct to decline the claim for hospital benefit, as Mrs A's circumstances didn't meet the policy terms. It acknowledged Mrs A had been provided with a differing member guide, but said the policy wording was the same, and the admission would not have been covered under either set of wording.

It said although the policy included a nursing benefit, there hadn't been a recommendation from a medical practitioner that this was necessary. And it agreed there had been long wait times when Mr A had tried to get in touch, and offered £100 in compensation.

Unhappy with CIGNA's response, Mrs A brought her complaint to this service. An investigator here looked into what had happened, and said they thought CIGNA had correctly declined the claim for hospital benefit. However they thought the £100 CIGNA had

offered for the distress and inconvenience it had caused Mrs A was insufficient. And they recommended this be increased to £350.

CIGNA accepted the investigator's view. However Mrs A disagreed with some of the investigator's conclusions. In summary she said nursing at home was covered and she would like to obtain a letter from the treating doctor confirming this was needed. And the care received on the NHS ward was not to the same standard as would have been available privately. She said a private room would have made a huge difference to her experience and the lack of nursing at home meant her recovery was longer and more painful than it needed to be.

Mrs A asked for a decision from an ombudsman, and so the case has 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.

And I've looked at the relevant rules and industry guidelines, which say CIGNA has a responsibility to handle claims promptly and fairly and shouldn't reject a claim unreasonably.

Firstly, I should set out that Mrs A has made a detailed submission about her complaint. If I haven't commented on a particular point in my decision, this doesn't mean I haven't considered it. I'm not required to comment on each and every point, but instead I'm concentrating on the main issues in the complaint. No discourtesy is intended by this; it simply reflects the informal nature of the ombudsman service and my role in it.

And I've not considered the issues around the set-up of the policy. Mr A's employer provided the first set of terms and conditions to Mr and Mrs A. And as Mr A's employer is the policyholder, it would need to bring any complaint about the policy set-up and documents it received from CIGNA.

NHS hospital benefit

The terms and conditions Mrs A received at the point of taking out the policy include the following exclusion related to this benefit.

> *"What's not covered: NHS Cash benefits are not paid when you are admitted to hospital for any treatment that has not been pre-planned."*

And the below exclusion is stated in the terms and conditions CIGNA said are the correct ones for the policy.

> *"What's not covered: NHS Cash benefits are not paid when you are admitted to hospital following a visit to Accident & Emergency."*

I've considered both versions of the exclusion, however in either case, I don't think it was unreasonable for CIGNA to decline the claim for this benefit. I'm satisfied Mrs A was admitted to hospital via Accident and Emergency and her treatment was not pre-planned. Whilst I appreciate what Mrs A's has said about being unable to see her GP on the Sunday, I don't think this makes a difference in the application of the exclusion. I think it's reasonable to expect that if Mrs A's situation wasn't an emergency, she could have waited until the next day to see her GP to get a referral for treatment.

Nursing at home benefit

Both sets of terms and conditions provide the same wording in relation to nursing at home. And this is as follows.

> "*Cover may be provided for home nursing instead of hospital treatment provided under the plan where this is medically necessary and recommended by your specialist.*
>
> *What's covered: This cover applies to Level 2 & 3 only. Cover may be provided for home nursing instead of hospital treatment provided under the plan where this is medically necessary and recommended by your specialist. In all cases, home nursing for cancer treatment will only be paid for active treatment*."

I'm aware Mr A was wrongly advised during a call with CIGNA, that there was no cover for nursing at home under the policy. And I've commented on this further in this decision. However, in terms of the cover available, I don't think CIGNA acted unreasonably in its decision that nursing at home wouldn't have been covered in Mrs A's particular circumstances. And I say that because the terms clearly state nursing at home must be medically necessary and recommended by the treating specialist. And the evidence I've seen doesn't show that this was the case.

I've considered Mrs A's points around this not being recommended due to her being on an NHS ward, and having been told nursing at home wasn't covered under the policy. However, I'm not persuaded this would have deterred her treating specialists from recommended nursing at home if it was medically necessary in her circumstances.

Mrs A has said it may be possible to obtain a retrospective letter from the specialist about the need for nursing at home. If that's the case, she can provide the new evidence directly to CIGNA and ask it to assess it. And if she's unhappy with its answer, she can raise a further complaint.

Customer service

CIGNA has acknowledged that it caused distress and inconvenience to Mrs A, both due to its long wait times when Mr A initially tried to get in touch, and in the confusion around the correct policy terms in force and whether or not nursing benefit was included. And it offered £100 in compensation.

I've considered whether or not I think this level of compensation is reflective of the impact caused to Mrs A. I don't think that it is, and I'll explain why.

Had Mr A been able to contact CIGNA sooner, I think it's most likely Mrs A would have been able to receive treatment privately rather than on the NHS. However I've also noted an email Mr A sent to CIGNA four days after Mrs A had been admitted to hospital, which stated Mrs A "*doesn't intend on using a private hospital / ward currently since she feels those most familiar with her case are where she is*".

I appreciate it would have been distressing to have been unable to speak with the insurer when in an ongoing claim situation, plus the later confusion over the correct policy terms. However I've also thought about the demands on CIGNA which were beyond its control. And I've taken into account what CIGNA did to put things right once Mr A was able to get in touch; I note it agreed it was possible for Mrs A to transfer to a private hospital ward, providing this was medically approved. And I think that was reasonable. However, at that

point Mrs A was scheduled for surgery and her treating doctor advised she should remain in the NHS ward where she was receiving treatment.

CIGNA incorrectly advised Mr A around the cover for nursing at home, however as explained above, this wasn't recommended as necessary by the specialists treating Mrs A, so I don't think this error had a significant impact on her.

I've also thought about Mrs A's comments around the difference in the care she would likely have received privately over the NHS, and what she has said about the prolonging of her recovery. However I've seen no evidence which persuades me there were failings in the care Mrs A received in the NHS hospital. And there's also no evidence supplied which shows private care would have sped up her recovery period.

Putting things right

Overall I think the £350 recommended by the investigator more accurately reflects the distress and inconvenience caused to Mrs A. In particular in being unable to make contact with CIGNA for advice for several days after she was first admitted to hospital. So CIGNA should pay £250 in addition to the £100 it had already offered in compensation.

My final decision

For the reasons I've given, it's my final decision that I uphold this complaint. And I direct CIGNA Europe Insurance Company SA-NV to pay Mrs A £350 in compensation for the overall distress and inconvenience caused.

CIGNA must pay the compensation within 28 days of the date on which we tell it Mrs A accept my final decision. If it pays later than this, it must also pay interest on the compensation, from the date of my final decision to the date of payment, at 8% simple.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs A to accept or reject my decision before 19 December 2022.

Gemma Warner
Ombudsman