DRN-3816644

The complaint

Mr B complains about CIGNA Life Insurance Company of Europe SA-NV's settlement of his private medical insurance claim. My references to CIGNA include its agents.

What happened

From January 2018 Mr B had private global medical insurance, silver level, insured by CIGNA. The policy renewed each 31 December.

The background of this complaint is well known to the parties, but very briefly on 29 August 2020 Mr B had a very serious accident in the USA and had extensive private medical treatment. He claimed on the policy for his medical costs. CIGNA accepted the claim and paid some of Mr B's costs. Mr B's complaint to us is that CIGNA didn't pay all of his CT scan or physiotherapy costs or the ambulance costs.

CIGNA said it had paid for the treatment in line with Mr B's policy terms and limits as the policy limit for physiotherapy was $2,500 and the policy limit for a CT scan was $5,000. CIGNA also said it had paid the full cost of the ambulance transferring Mr B from the intensive care unit (ICU) to the rehabilitation centre.

Mr B complained to us. In summary he said his policy document showed the silver level policy limits were $5,000 for physiotherapy and $10,000 for a CT scan. And CIGNA had only partly paid the ambulance cost transferring him from the ICU to the rehabilitation centre and hadn't paid any of the cost of the initial ambulance to the hospital on the 29 August 2020.

Ultimately our investigator said CIGNA acted fairly in assessing Mr B's claim against the policy limits it referred to. The policy limits Mr B referred to applied to his policy from 31 December 2020, which was after Mr B's treatment. But our investigator said CIGNA should reassess the claim for the two different ambulance costs in line with the terms and conditions of the policy.

CIGNA accepted our investigator's recommendations. Mr B remained unhappy and said CIGNA had hidden the dates on the policy documents. The complaint has been referred 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.

The relevant industry guidance says CIGNA must handle claims promptly and fairly and must not unreasonably decline a claim.

I think CIGNA fairly and reasonably applied the policy limits it referred to when it assessed Mr B's claim but it must reassess the two ambulance costs. So I'm partly upholding this complaint and I'll explain why.

The policy limits CIGNA referred to were in the policy document published in May 2018. The policy limits Mr B referred to were in the policy document published September 2020, which was just after his admission into hospital. However, the September 2020 policy terms and limits wouldn't have been in force for Mr B until his policy renewed on 31 December 2020.

Both versions of the policy documents say:

'Subject to the terms of this policy, we will pay for the following costs related to your claim:

Costs as described in the list of benefits section of this Customer Guide as applicable on the date(s) of the beneficiary's treatment'.

So the policy limits that applied to Mr B's treatment costs were those in force for his policy at the date of his treatment.

The policy document published in September 2020 didn't apply to Mr B until his policy renewal on 31 December 2020 and I've seen no evidence that he had any of the treatment claimed for on or after 31 December 2020. As Mr B's claimed for treatment was between 29 August 2020 and 30 December 2020 the policy limits applicable to his treatment were those for his policy from 31 December 2019 to 30 December 2020 policy, which were the limits published in May 2018.

I'm satisfied CIGNA acted within the policy terms and fairly and reasonably in applying the $2,500 limit for physiotherapy treatment and the $5,000 limit for a CT scan to Mr B's claim.

The date of publication is on the last page of each policy document. I appreciate the date isn't prominent to a policyholder. But I think it's more likely than not that Mr B only received the policy terms published in September 2020 when he received his policy documents around the date of his policy renewal on 31 December 2020, which was after he had treatment. Even if Mr B received the policy terms published in September 2020 around that time there's no evidence that he only had the amount of physiotherapy he had, or had a CT scan, because he thought the higher limits applied to his treatment costs.

The policy terms relevant to Mr B's claim say:

'Where it is medically necessary, (CIGNA) will pay for a local ambulance to transport a beneficiary:

- *from the scene of an accident or injury to a hospital;*
- *from one hospital to another'.*

The invoice received for the ambulance for Mr B's transfer from the ICU to the rehabilitation centre totalled $1,147.5. CIGNA said it paid the discounted amount of $490.8, which is supported by the invoice provided by the transport provider. But the transport provider then contacted Mr B to pay the remaining $656.7.

As the policy terms cover the full ambulance cost of transfer from one hospital to another CIGNA should reassess Mr B's claim for that cost in line with the terms and conditions of the policy. If CIGNA believes the transport provider's cost isn't reasonable CIGNA should negotiate with the transport provider directly. Under the policy terms Mr B shouldn't have to pay any of those ambulance costs.

I've not seen any evidence why CIGNA didn't pay the cost of the ambulance that took Mr B to the hospital after his accident. The policy terms cover the costs of an ambulance to a hospital from the scene of an accident or the policyholder's home. So CIGNA should reassess Mr B's claim for that cost in line with the terms and conditions of the policy.

Putting things right

CIGNA must reassess Mr B's claim for the ambulance costs that I've detailed below in line with the terms and conditions of the policy.

My final decision

I partly uphold this complaint.

I require CIGNA Life Insurance Company of Europe SA-NV to reassess Mr B's claim for the costs of the ambulance that took him to hospital on 29 August 2020 and the ambulance for Mr B's transfer from the ICU to the rehabilitation centre in line with the policy terms and conditions.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr B to accept or reject my decision before 8 February 2023.

Nicola Sisk
Ombudsman