DRN-5895545

The complaint

Mr A is unhappy that CIGNA Life Insurance Company of Europe SA-NV mis-sold him a 'silver' international medical insurance policy ('the policy').

What happened

The policy was sold to Mr A in 2015. In 2024, Mr A required treatment and subsequently claimed on the policy to cover the costs incurred. The claim was partially paid by CIGNA, but it applied deductibles payable under the policy and limited costs to the financial limits under different heads of claim.

Unhappy Mr A complained to CIGNA. And after if maintained that it had correctly calculated the claim payable under the policy, he complained to the Financial Ombudsman Service about the policy being mis-sold to him. Our investigator didn't uphold the complaint. Mr A disagreed. So, his complaint has been passed to me to consider everything afresh 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.

When providing advice about insurance, CIGNA has a regulatory obligation to ensure that the policy is suitable. And whether or not advice is given when selling a policy, CIGNA still needs to ensure that clear, fair and not misleading information is given about the main policy terms.

Around the time the policy was first sold in 2015, Mr A made clear to CIGNA that for health insurance coverage to be adequate in the country he was due to be residing in, it needed to correspond in its nature and scope to the statutory health insurance scheme in that country. That included not:

- containing large scale exclusions of benefit.
- requiring high percentage excess payments from the insured person.
- limiting the costs of reimbursement in any way in the event of illness.
- containing any expiration or indemnity clauses with respect to the insured's age, the cessation of activity, changes in the purpose of residency or loss of legal residency status.

Mr A also received a letter from CIGNA around the time of the sale in 2015, which said:

- all documentation will be emailed out in due course.
- he had a 'full' policy with no exclusions, or waiting periods.
- he's free to use any hospital and CIGNA will pay for 100% of treatment.
- he'll be covered for all major medical needs and also as an outpatient. As an

outpatient Mr A was free to use any doctor he wished, and CIGNA would pay 100% of the claim.

Having looked at the letter, I'm satisfied that the intention wasn't to summarise the main terms of the policy for Mr A but rather to support that coverage complied with the statutory health insurance requirements of the country he was residing in. And there had been email correspondence between the parties leading up to the letter being provided around what information should be included.

However, I can understand why Mr A says the contents of the letter aren't reflective of the terms of the policy as there were limitations and 100% of a claim wouldn't be covered, particularly the sections of the policy where there are financial limits.

It's not clear whether CIGNA advised Mr A to take out the policy. But I don't think that's a determinative issue in the circumstances of this case. That's because even if CIGNA advised Mr A to take out the policy and it wasn't suitable and / or it failed to give him clear, fair not misleading information about all the key features of the policy, I'd still need to consider the impact of any failings in the sale process had on Mr A and whether he's lost out as a result.

Looking at the customer guide from around the time, and subject to the maximum annual benefit (8000,000 euros for silver cover and 2,500,000 euros for platinum), the following were paid in full under both levels of cover for inpatient and day patient care:

- hospital charges
- intensive care charges
- surgeons' and anaesthetists' fees
- specialists' consultation fees
- pathology, radiology and diagnostic tests

However, based on what I've seen, I'm satisfied the 'platinum' policy would've been better suited for Mr A's needed. For example, the platinum policy provided:

- a maximum annual benefit for outpatient cover in the sum of 61,000 euros (compared with 7,400 euros for the policy he was sold);
- subject to the annual benefit, all outpatient consultations with medical practitioners and specialists were paid in full. So too were diagnostic tests, physiotherapy and drugs and dressings (compared with the policy he was sold which contained financial limits under each of those headings).

I've also seen an email from CIGNA to Mr A dated 12 May 2015. I'm satisfied that he was told that the platinum policy cost around 45 euros each per month - rising to 100 euros more each month with the optional 'add ons' for international outpatient and medical evacuation which his policy also included.
So, if Mr A had been sold platinum cover rather than silver, he would've paid around 1,200 euros more for international health insurance than he did for the first year. And he had no reason to claim for the first year.

The policy has renewed each May to date. Even if I was satisfied that the information Mr A thereafter received about the main features of the policy (including financial limits) at the time of each renewal didn't rectify the information Mr A was given by CIGNA around the time of sale in 2015 - and he reasonably remained under the impression that he had more

comprehensive cover than he did - it's likely that he would've paid many thousands of euros extra in premiums than he has.

Mr A only recently had reason to claim under the policy, in relation to medical treatment he had in 2024. So, although that claim has been subject to deductibles (which I think were likely made clear to Mr A when the policy was first sold to him and at the time of each policy renewal since) and the various financial limits under separate heads of claim under the policy terms, I'm satisfied that the amount he's saved in additional premiums over the years far outweighs the financial losses incurred as a result of the financial limits applied to his claim.

Since bringing the complaint to the Financial Ombudsman Service, CIGNA has offered to waive deductibles for the claims already made under the policy (which I understand is more than 500 euros) and any further deductibles up until the date of next renewal (May 2026). That's more than I think it's required to do in the circumstances, so I think that's fair and reasonable. If Mr A would like to accept this offer, he's free to contact CIGNA.

If Mr A would like to renew the policy without deductibles at renewal in 2026, he can do so, but this will be reflected in the premiums payable. Further, Mr A has the option of upgrading from silver to platinum cover, subject to medical underwriting. So, if he does want more comprehensive cover than he thought he had, he's free to contact CIGNA closer to the next renewal date to discuss.

I've also thought about the upset Mr A would've experienced upon finding out that he didn't have the extent of cover he says he thought he had, that the financial limits of the outpatient cover have impacted his treatment plan and that he has been put to the unnecessary inconvenience of trying to sort this out with CIGNA.

In the circumstances of this particular case, and even if the policy sold in 2015 was mis-sold, I don't think it would be fair and reasonable for me to direct CIGNA to pay him separate compensation to reflect the impact of this. As explained above, Mr A has incurred a significant saving each year by not having the level of cover he believed he had. Whilst I appreciate that this may seem to Mr A that CIGNA has been absolved of responsibility, I've focussed on the impact caused on the basis that the policy taken out in 2015 was mis-sold.

My final decision

I don't uphold this complaint. Under the rules of the Financial Ombudsman Service, I'm required to ask Mr A to accept or reject my decision before 10 March 2026.

David Curtis-Johnson
Ombudsman