111th Session **Judgment No. 3031**

THE ADMINISTRATIVE TRIBUNAL,

Considering the second complaint filed by Mr H. S. against the European Patent Organisation (EPO) on 7 July 2009 and corrected on 30 August, the EPO's reply of 22 December 2009, the complainant's rejoinder of 4 February 2010 and the Organisation's surrejoinder of 17 May 2010;

Considering Article II, paragraph 5, of the Statute of the Tribunal;

Having examined the written submissions and decided not to order hearings, for which neither party has applied;

Considering that the facts of the case and the pleadings may be summed up as follows:

A. The complainant is a Belgian national, born in 1957, who joined the European Patent Office – the EPO's secretariat – in December 1990. His appointment was terminated with effect from 1 June 2003 after an Invalidity Committee had determined that he was permanently unfit to perform his duties.

On 31 October 2005 the complainant submitted a claim to the insurance broker responsible for the day-to-day administration of the

EPO's Collective Insurance Contract (CIC) seeking reimbursement of a medicine prescribed for him by his physician. On 10 November the insurance broker sent him a statement showing that it had reimbursed 80 per cent of the cost of the medicine, in accordance with Article 20(b)(2) of the CIC. In February 2006 he purchased more of this medicine, again with a medical prescription, but when he sought reimbursement from the insurance broker, his claims were refused on the grounds that he was not suffering from either of the two medical conditions justifying reimbursement of the medicine in question.

On 24 April 2006 the complainant wrote to the President of the Office to challenge that refusal. He pointed out that in November 2005 the insurance broker had reimbursed him for the same medicine and that its position was therefore incoherent and unacceptable. He requested that the Office reimburse him 80 per cent of the cost of the medicine, failing which his letter was to be treated as an internal appeal. The Director of Employment Law informed him by letter of 1 June 2006 that, following an initial examination of the case, the President considered that his request could not be granted and that the matter had therefore been referred to the Internal Appeals Committee. The Director also indicated that the reimbursement he had received in November 2005 was a mistake, as the complainant had already been informed that he would not be reimbursed for the medicine in question, and he drew the complainant's attention to the fact that the Medical Committee was competent to decide upon disputes concerning medical issues.

On 21 December 2006, while that appeal was pending before the Internal Appeals Committee, the complainant submitted another claim for reimbursement of a similar medicine prescribed by his physician. By a letter of 19 January 2007 the insurance broker informed him that his claim had been refused, as its medical adviser had found no medical indication for his use of the medicine. On 31 March 2007 the complainant lodged a second appeal with the President of the Office, challenging that refusal. This appeal was likewise referred to the Internal Appeals Committee.

After having heard the complainant on 23 October 2008, the Committee requested further information from the Office as to how the insurance broker had dealt with his claims and which medical conditions gave rise to reimbursement of the medicine in question. The Office submitted this information on 28 October and the complainant was then invited to comment. In each of his appeals the complainant objected to the fact that the Office's submissions were drafted in French, whereas his own submissions were in English. Furthermore, in his second appeal he contended that the Office had breached medical secrecy by mentioning the name of the medicine for which he sought reimbursement. The Committee issued an opinion on both appeals on 12 February 2009. The majority of its members found no error in the way in which the insurance broker had examined the complainant's claims and held that the appeals should be dismissed as unfounded. Referring to Circular No. 236, they recalled that "the fact that expenses have been incurred on prescription by medically qualified persons does not in itself mean they are reimbursable, and [the insurance broker] has to make sure that they really are covered by the insurance contract". They emphasised that they could only review the legal aspects of the challenged decisions, as only the Medical Committee was competent to give an opinion on the core issue of whether the medicine should be reimbursed in this case. Lastly, the majority considered that there had been no breach of medical secrecy, as the Office had relied on the information provided by the complainant himself, and that his allegation that the insurance broker had not acted with due diligence was unproven.

The minority considered that the insurance broker's role was simply to verify that the complainant's claims satisfied the conditions set out in Articles 16 and 20 of the CIC, i.e. that they related to expenditure incurred in respect of medical treatment, prescribed by a medically qualified person, as the result of illness, accident, pregnancy or confinement. It had no authority to limit the scope of those provisions by applying additional criteria which had never been published and which had not been the subject of a proper consultation

process. As the complainant's claims clearly fulfilled the conditions of Articles 16 and 20, he was entitled to reimbursement of his medical expenses. The minority also recommended that he be awarded 500 euros for the costs of the proceedings and "the time and effort" he had devoted to them.

By a letter of 9 April 2009 the Director of the Regulations and Change Management Directorate informed the complainant that the President of the Office had decided to reject his appeals as unfounded in their entirety, in accordance with the recommendation of the majority of the Internal Appeals Committee. That is the impugned decision.

B. The complainant contends that the Office ought to have respected his choice of language in its submissions to the Internal Appeals Committee. He asserts that it is difficult to obtain legal assistance in the French language in Germany and that the EPO created an unequal situation by not responding to his appeals in English. According to the complainant, the decision to join his two appeals, despite the fact that they were filed almost a year apart, resulted in a breach of medical secrecy, because although the first appeal contained no medical information, in examining that appeal the Internal Appeals Committee relied on medical information that was disclosed only in the second appeal. In his view, the delay in dealing with his appeals is inexplicable. He points out that two letters relating to his appeals were dated incorrectly and that the President's final decision was initially sent to him bearing no date at all.

The complainant argues that the Organisation cannot rely on an alleged agreement between the medical advisers of the Office and of the insurance broker regarding the circumstances in which the medicine in question will be reimbursed in order to refuse his "legally and medically justified claims". He submits that by considering that there are only two medical conditions warranting reimbursement of that type of medicine, the insurance broker has in effect decided that all other medical indications for use of the medicine are simply

non-existent. In his view this case raises a legal issue, namely that of the correct interpretation and application of the CIC, and not a medical issue.

In addition to the reimbursement of the medical expenses at issue, the complainant claims 5,000 euros for breach of medical secrecy, 500 euros in moral damages, 500 euros for the delay in dealing with his appeals and a further 500 euros for "extra costs".

C. In its reply the EPO explains that, pursuant to Article 16 of the CIC, for each reimbursement claim the insurance broker must examine whether the medicine in question has been prescribed by a medically qualified person and whether it has been prescribed in respect of medical treatment as a result of illness, accident, pregnancy or confinement. Contrary to the opinion of the minority of the Internal Appeals Committee, it cannot be inferred from the fact that a medicine is available only on prescription that it has been prescribed as a medical treatment in respect of illness, and this is a matter which the insurance broker has to verify in each case. Guidelines have been agreed between medical advisers of the Office and of the insurance broker regarding the circumstances in which four types of product will be reimbursed. Those products include the medicine at issue in this case, which is reimbursed only where the claimant suffers from one of two pathologies. According to the EPO, this was explained to the complainant on several occasions not only by the insurance broker but also by the Office's medical adviser. The insurance broker examined his claims for reimbursement with due care and, having obtained further information from him, reached the conclusion that the conditions for reimbursement were not satisfied. The EPO emphasises that the guidelines followed by the insurance broker are merely indicative and can be adapted to individual cases. However, they are not published, since that would tend to "finalise" them, whereas in fact they evolve in line with medical progress.

Regarding the language used in the internal appeal proceedings, the Organisation submits that the complainant's objection is unfounded.

Not only is French an official language of the EPO and one of the languages of the country of which he is a national, but the personal data stored in the Office's Finance and Personnel Software indicates that it is his preferred language.

The EPO also rejects the allegation that there was a breach of medical secrecy in those proceedings. It points out that the complainant was informed that his appeals would be joined when he was invited to the hearing, but he raised no objection to that course either before or during the hearing. Moreover, the name of the medicine at issue was clearly indicated on a medical prescription which the complainant himself submitted to the Internal Appeals Committee in support of his claims. In accordance with Article 7 of the CIC, the Office had no access to medical information concerning him.

With regard to the delay in the internal appeal proceedings, the EPO observes that the matter would have been dealt with more rapidly had the complainant referred the matter to the Medical Committee instead of the Internal Appeals Committee, as was suggested to him on several occasions. It adds that the decision to join his two appeals, apart from being justified by the similarity of the issues of fact and law that they raised, was aimed at speeding up the proceedings.

Lastly, the EPO submits that the clerical errors mentioned by the complainant did not constitute procedural flaws that could invalidate the internal appeal proceedings. Moreover, they had no adverse effect on his situation and his claim in this respect should therefore be dismissed.

D. In his rejoinder the complainant presses his pleas. He reiterates that a breach of medical secrecy occurred in connection with his first appeal.

E. In its surrejoinder the EPO maintains its position.

CONSIDERATIONS

1. This complaint arises from two internal appeals in relation to the insurance broker's refusal on two occasions to reimburse the complainant for a physician-prescribed medicine. The Internal Appeals Committee joined the two appeals.

2. In the autumn of 2005 the complainant submitted a claim for the purchase of the medicine at issue and was reimbursed by the insurance broker. In February 2006 he submitted other claims for the same physician-prescribed medicine. The insurance broker refused these claims on the basis that reimbursement is allowed for only two medical indications and that his reason for the use of the product was not for either of the two medical indications. This refusal was the subject of the first appeal.

3. In the autumn of 2006 the complainant obtained another prescription for the same medicine and on 21 December 2006 he submitted a claim to the insurance broker for the purchase of the medicine. In January 2007 the insurance broker denied the claim for the same reason. This was the subject of the second appeal.

4. Based on its review of the applicable provision of the Service Regulations, the CIC, and Circular No. 236, the Internal Appeals Committee majority concluded that the complainant's position was unfounded. In the majority's opinion, although the medicine had to be prescribed by a physician for the purpose of reimbursement, this fact alone was not sufficient. The majority also found that the complainant had failed to prove the alleged lack of diligence on the part of the insurance broker in the processing of the claims. The minority found that the medical nature of the treatment could not be disputed since the medicine was available only on prescription. The President of the Office accepted the recommendation of the majority and dismissed the appeals.

5. The complainant maintains that he is entitled to reimbursement because the medicine in question could only be acquired on prescription. He contends that simply by virtue of the fact that the medicine in question requires a physician's prescription it meets the requirement that the medicine is a medical treatment resulting from illness, accident, pregnancy or confinement.

6. He also contends that the insurance broker breached the CIC by automatically excluding reimbursement for the medicine unless it was prescribed for one of two medical conditions. Moreover, he questions the legality of the insurance broker's refusal on the basis of a "non published agreement" between the medical advisers of the Office and of the insurance broker. The complainant argues that reliance on this agreement unlawfully restricts the coverage under the CIC and excludes reimbursement for any other possible medical diagnosis.

7. The EPO points out that the so-called "agreement" is in fact a set of guidelines that cannot be applied without prior examination of the case and that they are only "indicative". As such, they can be adapted to the particular case under review. In the Organisation's view, this approach favours the insured staff members. The EPO also notes that the guidelines evolve as a function of medical progress. The publication of these guidelines would give them finality and prevent their evolution in line with medical progress. Lastly, the EPO observes that the complainant was informed of the conditions for reimbursement in relation to the medicine at issue.

8. It should be noted that the scope of the impugned decision is not in dispute: it is limited to the issue of whether the insurance broker properly exercised its authority in refusing to reimburse the complainant for his cost of purchasing the medicine.

9. Article 83 of the Service Regulations relevantly provides that a permanent employee shall be insured against expenditure incurred in case of sickness, accident, pregnancy and confinement.

10. Article 16 of the CIC reads:

> "This insurance shall cover reimbursement, within the limits set out below, of expenditure incurred by insured persons in respect of medical treatment, prescribed by medically qualified persons, as the result of illness, accident, pregnancy and confinement."

11. The EPO did not include the above-mentioned "guidelines" in the materials filed with the Tribunal. However, an e-mail of 10 March 2008 written by the EPO's medical adviser provides some insight into these "guidelines". The medical adviser states:

> "As you know the definition of 'medicament' is more general in the Codex [the compendium of rules applicable to staff] than the interpretation of [the insurance broker] in the context of the [CIC]. This situation leads now and then to disagreements and therefore appeals. For certain medicines/pharmaceutical products there is an agreement between the Medical Advisor of [the insurance broker] and myself."

These products are then specified, including the product at issue in the case. The e-mail continues:

> "These products will only be reimbursed when there is a documented pathology justifying the reimbursement. Those agreements are however not published."

12. In Judgment 2063, under 8, the Tribunal described the insurance broker's authority as follows:

> "Clearly, the authority of the insurance brokers goes beyond a simple right to make an administrative check of the claims it receives. As the Tribunal held in Judgment 1288 […], 'the insurers are entitled to information which identifies the nature of the ailment and enables them to determine whether the prescribed treatment is appropriate' and, more generally, have the right to check whether, under the insurance contract, they are liable for the costs of the care dispensed. But they must so exercise that authority as to provide the insured with a guarantee that their claims to coverage are examined with all due care."

13. The Tribunal rejects the complainant's argument that it is only necessary to show that the medicine was prescribed by a physician to qualify for reimbursement. Article 83 of the Service Regulations and Article 16 of the CIC make it clear that to qualify for

reimbursement, in addition to the requirement that the medical treatment must be prescribed by a medically qualified person, the medical treatment must be as a result of one of the following circumstances: illness, accident, pregnancy or confinement. However, this does not end the inquiry.

14. It is clear that the insurance broker's decisions to reject the complainant's claims were based on the unpublished agreement entered into between the medical advisers of the EPO and of the insurance broker whereby the cost of the medicine at issue would only be reimbursed for two medical indications. However, the CIC provides that reimbursement will be made if the medical treatment is prescribed by a medically qualified person and is the result of one of the four circumstances enumerated in the CIC. In refusing the claims on the basis of the agreement, the insurance broker acted outside the scope of its authority.

15. Contrary to the EPO's assertion, the "guidelines" do not reflect a "generous" approach favouring the staff that includes an examination of the particularities of each case to determine whether the medical treatment is a result of illness or one of the other enumerated circumstances. Moreover, the submissions on the part of the Organisation that the guidelines are merely indicative and that they provided flexibility to accommodate medical progress are unsound.

16. The EPO was well aware that it was the insurance broker's narrower interpretation of the meaning of "medicine" in the Codex that gave rise to the agreement to limit coverage for four types of medicine, contrary to the provisions of the Service Regulations and of the CIC.

17. The Tribunal also notes that the form for claiming reimbursement of medical expenses from the insurance broker, which is included in the materials filed with the Tribunal, does not require that a claimant provide the medical diagnosis for which the

medicine was prescribed at the time of claiming reimbursement. Further, Article 23 of the CIC states that reimbursement will be made following "receipt […] of the claim and supporting documents, such as originals of bills and, if possible, medical prescriptions stating the diagnosis". It appears, therefore, that at the time the claim is submitted the claimant is not required to submit proof that the medicine is a medical treatment as a result of the four circumstances mentioned above.

18. If there is a question as to whether the medicine is a medical treatment as contemplated in the Service Regulations and the CIC, then it is open to the insurance broker to require the claimant to substantiate the claim. In the present case, by failing to do so, the insurance broker failed to exercise due care in the processing of the claims.

19. As the President's conclusion that the insurance broker determined correctly that the medicine for which the complainant claimed reimbursement did not meet all of the criteria for reimbursement involves an error of law, it will be set aside and remitted to the Organisation for a redetermination. The complainant is entitled to moral damages for the lack of due care in the processing of his claims.

20. The complainant also alleges procedural irregularities in the processing of his internal appeals. He submits that by joining his two appeals the EPO failed to respect his right to medical secrecy, that the EPO did not respect his choice of language, that the appeals were unduly delayed, that two documents submitted by the EPO concerning the appeals had incorrect dates and that the final decision was undated.

21. With regard to the joinder of the two internal appeals, Article 10(2) of the Rules of Procedure of the Internal Appeals Committee provides that appeals filed by the same person may be combined for a common hearing and opinion. The fact that this

resulted in the name of the medicine for which he was claiming reimbursement and which was provided in one of the appeals becoming known in the other does not amount to a breach of his right to medical secrecy. Further, the EPO's refusal to remove the references to the medicine from its submissions before the Internal Appeals Committee does not violate the complainant's right to privacy.

22. As to the complainant's allegation that the EPO did not respect his choice of the English language during the internal appeals process, the Tribunal notes that according to his personnel file his preferred language is French. Additionally, he did not request a different language for the hearing as contemplated in Article 15 of the above-mentioned Rules of Procedure and he did not request free translations of the Administration's position or the Committee's opinion.

23. On the question of delay, the Tribunal notes that the first internal appeal was initiated in April 2006, the second appeal was initiated in March 2007 and the final decision was taken in April 2009. The Tribunal rejects the EPO's submission that if the complainant wished to have a speedier process he should have pursued his claim with the Medical Committee, as was suggested on a number of occasions. Having regard to the issue raised in the appeals, the Internal Appeals Committee was the proper forum. The Tribunal observes that the factual underpinning for the appeals was uncomplicated and, in large measure, undisputed, and the appeals concerned essentially a single legal issue. Even if the length of the internal appeal process is calculated from the date the second internal appeal was initiated, it amounts to a period of 24 months. As the EPO has not provided a valid justification for the delay, the complainant is entitled to an award of moral damages.

24. As to the incorrectly dated documents and the undated final decision, as soon as the errors became known they were corrected and the complainant was not prejudiced by these errors.

25. In conclusion, the complainant is entitled to moral damages in the amount of 1,000 euros for the delay in his internal appeals and lack of care in the processing of his claims. He is also entitled to costs in the amount of 300 euros. All other claims will be dismissed.

DECISION

For the above reasons,

1. The President's decision of 9 April 2009 is set aside and the matter is remitted to the Organisation for a redetermination in accordance with the Service Regulations and the CIC.

2. The EPO shall pay the complainant moral damages in the amount of 1,000 euros.

3. It shall also pay him costs in the amount of 300 euros.

4. All other claims are dismissed.

In witness of this judgment, adopted on 13 May 2011, Ms Mary G. Gaudron, President of the Tribunal, Mr Giuseppe Barbagallo, Judge, and Ms Dolores M. Hansen, Judge, sign below, as do I, Catherine Comtet, Registrar.

Delivered in public in Geneva on 6 July 2011.

Mary G. Gaudron
Giuseppe Barbagallo
Dolores M. Hansen
Catherine Comtet