Ankenævnet *for* Forsikring

Den 2. august 2018 blev i sag nr. 91305:

xxxxxxxxxxxxxxxxxxxxx
xxxxxxxxxxxxxxxx
xxxxxxxxxxxxxxx

mod

Bupa Denmark Services A/S
Palægade 8
1261 København K

afsagt

k e n d e l s e :

_____

Forsikringstageren har sundhedsforsikring. I klageskema af 10/9 2017 til nævnet har han blandt andet anført:

> "1. Statement of claim, a brief outline of the case. A Supplementary statement may be enclosed. From 2011 May 1st, and while working in …, I was covered under an international health insurance contract, IHI-BUPA (#1 a,#1b.#1c). I was diagnosed with symptomatic severe obstructive sleep apnea in November 2011 f#2a). The obstructive sleep apnea was initially treated with medical device therapy (CPA, #2b) but later found to be due to narrowed airway requiring surgical correction involving the jaw (#3a, #3c). I needed prompt treatment in order to maintain the demanding responsabilities of my job in a foreign country. I had jaw surgery to open my airway in May 2012 (#3b,#3c). Due to a broken mandibular nerve complication during this first surgery, a second surgery was required to repair the nerve in February 2013 (#4). I filed for benefits for both surgeries in 2013 (#5), but rather than reimbursing for the surgical therapy 100% minus deductible per my contract, IHI-BUPA decided to reimburse only 50% (#6), stating that altough the surgical treatment was medically essential in my case, that the surgery also had 'aesethic aspects' and was thus considered cosmetic (#7). They said they came to this conclusion due to a cosmetic questionaire I was required to fill out for the jaw surgery asking me hypothetical questions regarding my face (#8). I and my surgeon Dr. … strongly disagree the jaw surgery was performed to any degree for cosmetic reasons (#9). The surgery was performed only to open the airway, however as with any surgery involving the face and which will change the facial appearance, there are cosmetic concerns that need to be addressed, and according to my surgeon such should not be used to deny coverage, any more than a surgery for removal of a jaw tumor would be partly unreimbursed because of concomitant scar management or facial reconstruction. I was asked to describe frankly about my face in that cosmetic questionaire, this is true, but this was also a required document to fill and completely hypothetical. No procedures were performed for cosmetic purposes. Dr. … understood this, and I actually explicitly told him that although advancing the law would

change my facial appearance, the only purpose of this procedure was to open the airway, and any changes to my face he should adjust so that I looked as much the same after as before the surgery. I and my surgeon contest that this surgery was performed for partly cosmetic reasons and request that the full amount be reimbursed according to the insurance contract.
…
I have had to deal with other issues in the last few years, and was unable to further address the matter until now. Now, I would like to appeal to your Denmark Ombudsman service for help and advise if it is possible to hold IHI-BUPA accountable for the insurance contract.

2. What specifically is it you want the insurance company to do? (must be filled in).
The insurance company should reimburse for 100% (minus deductible) of the surgical costs for a covered medically essential surgery, as per the conditions of my insurance policy."

Selskabet har i brev af 12/10 2017 til nævnet blandt andet oplyst:

"The Complainant was insured with the Company from 01.05.2011 to 01.11.2014 under an individual health insurance, the International Health and Hospital Plan which was concluded between the Company and the Complainant .

The complainant has complained, because the Company has covered the expenses of [the complainant's] jaw surgery on 24.05.2012 (the Lefort I osteotomy) with 50%. Under [the complainant's] hospital plan surgeries would normally be covered 100% apart from the yearly deductible of [currency 1] 1.600. Bupa had in order to evaluate this medical surgery contacted an external medical consultant specializing in oral and maxillofacial surgery. The diagnosis of obstructive sleep apnea was the medical ground to support the need for the surgery, however there were cosmetic aspects in the operation which are not covered by [the complainant's] insurance. This was stated in [the complainant's] patient motivation questionnaire dated 26.02.2012 and in treatment planning summary dated 09.03.2012. Besides the concern to treat the obstructive sleep disorder, facial esthetics were considered and performed during the operation.

The condition of sleep apnea is normally treated with the use of a CPAP device during sleep. Some patients, however, do not tolerate the treatment in which case a maxilla-mandibular advancement may be considered in order to increase the volume of upper airways and thus treat the obstructive sleep apnea. As the maxilla-mandibular advancement will change the facial appearance when the jaws are brought forward, it is primarily indicated when the growths of one or both jaws are inadequate, and the facial change can be tolerated by the patient.

The indication for such an orthognatic surgery is normally malocclusions and asymmetries that cannot be corrected to a stable result by orthodontic treatment alone, or symptoms from the masticatory system due to malocclusion or risk for loss of teeth due to the bite. The medical records and x-rays of [the complainant] indicated that the patient was retrusive in both upper and lower jaw. The occlusion was recorded as Class 1, and there were no records of complaints regarding malocclusion and symptoms of the masticatory system. The Lefort I osteotomy is a commonly used procedure to correct midface deformities, and it is indicated, often in conjunction with mandibular surgery, for class II and Ill malocclusion, facial asymmetry, obstructive sleep apnea, and maxillart atrophy. However, the evaluation was in this case that the surgery was indicated to treat the obstructive sleep apnea and as a secondary outcome had an improvement of the

facial appearance of [the complainant]. Bupa therefore believes that it was the correct decision to cover 50% of the surgery.

[The complainant's] jaw surgery took place on 24.05.2012, and he pre-paid for the treatment on 27.03.2012. The paid invoices with request for reimbursement was sent to Bupa on 07.02.2014, and the reimbursement was processed on 24.03.2014. Bupa made a final response to [the complainant] complaint 05.05.2014 about our decision to maintain to cover the costs for the surgery with 50%. Consequently, the Complainant's claim is time-barred and already for this reason Bupa maintains the decision to cover the claim with 50%."

Klageren har i brev af 9/2 2018 til nævnet blandt andet bemærket:

"I first became aware of the Danish Limitations Act in late 2017 after inquiring from your office and further researching on the internet (see Attachment #2b). My insurer made a reference their being a time-barr in 2014, but they also knew I was an … citizen, and I feel they would have known I would have no familiarity with this term nor its influence to contest any decision by them legally outside of their company. I believed wrongly that the reference to time-barred was an internal rule regarding their evaluation process and that it would not affect a legally-binding insurance agreement in a court of law. Neither the meaning of this statement, nor its consequences, were ever explained to me by IHI-BUPA's sales agents, in their brochures (see Attachment #2c), or in my correspondences with IHI-BUPA following my claims in 2013 and 2014. In addition, there were several problems generated entirely or influenced by IHI-BUPA which prevented a timely filing of a complaint. For one, my claim was initially denied by falsely claiming a pre-existing condition of my sleep apnea, and then delayed for about 6 months during which time I was asked repeatedly to send redundant information, and make requests for re-consideration. The funds available to cover medical expenses were also not reimbursed to the 50% they decided was their debt burden, and that issue had to be dealt with as well. When l contested IHI-BUPA's final decision in May 2014 and asked them to provide me with an Ombudsmen service for arbitration, they provided information on a Danish and an English Ombudsman service in London (Attachment #2d) that they said could provide this service. I began filing in June of 2014 for the Ombudsman service in London since my native language is English. However, I received an email in October of 2014 from this same service stating that they could not help because my insurance policy was under Danish law (Attachment #2e). I feel I was misled by IHI-BUPA in this regard, and that by initially rejecting my claims, repeatedly asking for redundant information, and then misleading me in sending me to an ombudsman service that was unable to help, this appeared to me to be a tactic to exhaust and distract me so that the time-barred statute would cause my claim to expire. For these reasons I feel my case was mishandled. In addition, while I do not know if this would help my case, there were also some extenuating circumstances as well that prevented me from filing again another complaint with a second Ombudsmen service (your service) until recently. By 2014, I had other health issues. Namely, I suffered nerve damage as a result of my first surgery and also had a series of several chest wall surgeries as well, which kept me in the hospital and for which there were multiple complications. My only response from BUPA in this regard was a retroactively denying any responsibility for the chest wall surgeries due to preexisting condition and also covering only 50% of the cost of the nerve repair surgery. There are only so many battles one can fight, and the financial and health stress of the last several years were too much to be able to try and contest these issues again until recently when my health has improved. Although I believe IHI-BUPA mishandled my case with regards to not informing me about the meaning of the time-barred rules while placing other obstacles to take advantage of Danish laws, I hope that your committee can

consider these extenuating circumstances and IHI-BUPA's partial influence over them as well. I am not aware of all details of the Danish Law, but I read in my researches (Attachment #2a, 2nd and 3rd highlighted areas), that there may be exceptions to the time-barred rule when there is acknowledgment of the debt and in some cases of insurance debt. I am not a legal expert, or know whether these conditions could apply or no to my case, but I wanted to mention them here in this letter as well.

While the main purpose of this letter was to state that I feel this case was mishandled by IHI-BUPA, and I am hoping you can still consider it under exceptions of the Danish Limitations Act, I also want to reiterate the argument that this operation was 100% a medically essential procedure, and my surgeons and other doctors were in agreement in this matter. The letter dated October 13 2017 from IHI-BUPA (Attachment #2a) makes the claim that the orthognathic surgery I underwent is usually for the purpose of correcting a deformity. While that may be the usual reason for this procedure, in my case, my deficient jaw was causing a narrow airway and causing obstructive sleep apnea. Unbiased reviews from my orthognathic surgeon and orthodontist on seeing my airway x-rays have come to this same conclusion. The goal of any medical procedure for a serious medical condition is to provide a cure for that condition, which would have only been surgery in my case. For conditions such as sleep apnea which have many associated health risks, this may also be the least costly option as well for both the patient and the insurance company in the long term. I hope you and the insurance company will take these into consideration in my case, and also in future cases of this nature as well."

Af selskabets brev af 8/3 2018 til nævnet fremgår det blandt andet:

"The Complainant started the insurance with our Company as per 1 May 2011. The Complainant sent paid and receipted medical bills for reimbursement to the Company on 19 August 2013. This was the first time that the Company received medical bills for reimbursement from the Complainant since he has started the insurance. The paid medical bills concerned performed sleep studies from July 2011, a subsequent jaw surgery performed on 24 May 2012 followed by a nerve repair surgery performed 5 February 2013 due to complications after the jaw surgery. The total amount of the submitted medical bills amounted to [currency 1] 82.963,23.

As the Company had not previously been notified of any of the planned medical surgeries by the Complainant, the Company had thus not been able to confirm prior to the Complainant's medical surgeries how the treatment would be covered. The Company consequently requested medical information from the Complainant in order to evaluate how the medical bills should be covered in accordance with the valid List of Reimbursements and policy conditions.

As the underlying diagnosis for the sleep studies, for the jaw surgery, as well as for the nerve repair surgery was severe obstructive sleep apnea, and the dates of service on the medical bills for the sleep studies being July 2011, only two and a half months after the Complainant's policy started, the Company found it reasonable to investigate whether this medical diagnosis of sleep apnea was pre-existing.

A medical request for dental records and medical records for sleep apnea was sent on 9 September 2013 to the Complainant. The Company sent on 27 September 2013 a reminder for the medical request. The Company received medical information on 28 September 2013.

The received medical information prompted an additional medical request on 4 October 2013 for the diagnosis of skeletal dental deformity and CL I malocclusion with severe retognatism of the mandibula and maxilla. On the 22 October the Company sent a reminder for the medical request. The medical information was received on 12 November 2013.

On 18 November 2013 the Company issued a letter to the Complainant indicating that the diagnosis of sleep disorder was pre-existing as the date of first symptom for this disorder was prior to joining. This was based on a medical report dated 13 December 2011 from [clinic] stating that the clinic was seing the Complainant for his symptoms of excessive daytime sleepiness, snoring, unrefreshing sleep, and episodes of nocturnal choking. According to the medical report the Complainant endorsed these symptoms for several years, but noted worsening over the last two years (see annex 1). The start date of the symptoms was however contested by the Complainant, and the exclusion for obstructive sleep apnea was removed on the poliy on 10 February 2014.

Factually, the Company has documentation from December 2011 showing diagnosis of obstructive sleep apnea in December 2011. This diagnosis was established seven months after the Complainant's joining, and logically there have been symptoms prior to December 2011. The Complainant had sleep studies performed in July 2011 two and half months after his policy start. Furthermore, the Complainant had himself completed a questionnaire regarding Epworth Sleepiness Scale dated 26 February 2011 prior to joining the Company, in which he confirms sleeping with CPAP oral machine, and confirms that the symptoms of sleep apnea has probably been for many years (see annex 2). However, as the Company could not with certainty establish when the Complainant's symptoms started and how severe they were, the exclusion for obstructive sleep apnea was removed on 10 February 2014.

The Company did not in any way prolong the process in an unreasonable way. It was a reasonable investigation in order to determine whether the diagnosis of severe obstructive sleep apnea was pre-existing which was essential for being able to process the paid medical bills for the surgeries. Furthermore, additional medical information was needed in order to determine the degree of cosmetic elements in the jaw surgery performed on 24 May 2012 already described in our reply 5 March 2018.

The Company must underline that the Complainant waited 1 year and 4 months to submit the paid medical bills after his first surgery on 24 May 2012. It was not until 19 August 2013 that the Company received the medical bills, and the Complainant has himself postponed the submission of his paid medical bills for a considerable amount of time. With regards to the time bar of three years under the Danish Limitations Act, the Company will refer to the policy conditions in Article 13.2 'How to report a claim' where it is stated: 'Any claim shall be reported to the Company immediately and no later than three months after the circumstances underlying the claim have become known to the insured'.

With regards to the actual reimbursement of the medical bills, please note that the sleep studies with service date 7 November 2011 for an amount of [currency 1] 6.122 was reimbursed 100 %. The jaw surgery performed on 24 May 2012 was reimbursed at 50% due to the cosmetic aspects in the surgery, and the nerve repair surgery was reimbursed 50% as this operation was a consequence of a partly cosmetic opreation.

…

There was thus a pay out of [currency 1] 39.208,95 for the submitted invoices after the deductible of [currency 1] 1.600 for the policy year 2011 and the deductible of [currency 1] 1.600 for the policy year 2012 had been written down. A total of [currency 1] 42.280,95 was thus reimbursed to the Complainant.

The following medical bills were not reimbursed as the services were outpatient services, and the Complainant was insured under a Hospital plan only: [currency 1] 550, [currency 1] 989, [currency 1] 240,63 ([currency 2] 900,-), [currency 1] 1.256,60 ([currency 2] 4,700,-)= total [currency 1] 3.036,23.

When the Complainant decided to take his complaint further to FOS, the Financial Ombudsman, subsequently receiving a decline from FOS to look into the complaint due to the policy being subject to Danish law, the Company was not informed of this neither by FOS nor by the Complainant. The Company can however confirm that FOS dealt with complaints in 2014 for policies being subject to Danish law, and this is still the case today. As we were not informed by the Complainant about this in 2014, we were not able to contact FOS in 2014. The Company did in no way misled the Complainant, and the Company had no idea of which complaints board the Complainant would choose to refer to. The Company's policyholders with policies subject to Danish law are presently given both referal rights to Ankenævnet for Forsiking as well as FOS as can be seen from the insurance guide from 2018 under Article 18 Complaints (see annex 3).

With regards to the Complainant's enclosure from the The New Danish Limitations Act, the Company maintains that the time bar for this claim is three years."

Klageren har i brev af 18/4 2018 til nævnet blandt andet oplyst:

"Thankyou for giving me the opportunity to answer IHI-BUPA's letter to you dated 15 March 2018 and in this my third letter to you. In my second letter to you dated 09 Feb 2018, I made the claim that my case was mishandled by IHI-BUPA insurance company because...
I. IHI-BUPA delayed any coverage many months and reimbursed 50% for reasons not supported by my medical documents, and placed me in financial hardship during a time of other medical problems,
II. IHI-BUPA referred me to an Ombudsman service in the United Kingdom who was not able to help me in 2014, exhausting my resources for further arbitration until recently because I have had other medical problems to deal with in the meantime, and
III. IHI-BUPA did not define the extent of meaning of the time-barred reference, even though I was purchasing this health insurance coverage as a foreigner who never lived in Denmark and was working in … and would be unfamiliar and unaware of Danish laws applying to an advertized international health insurance policy.

IHI-BUPA's response letter dated 15 March 2018 did not address assertion Ill, so I would ask you to refer to my second letter dated 09 Feb 2018 to review my discussion and argument about this point.

IHI-BUPA did address assertion II in their last letter stating that the United Kingdom Ombudsman service had the ability to make a judgment on my case. In this matter, I can only refer you to the email I received from the UK Ombudsmen on 07 October 2014 who rejected my application (Attachment #3a of this letter and Attachment #2e of my second letter). I did attempt to contact

these people through subsequent phone calls and emails, and they said they could not help me. I am not knowledgeable about how their response relates to the law regarding jurisdictions for Ombudsman services, so I defer to your assessment in the matter and give you any permissions to contact them regarding my case if you so need to resolve this matter with them if it is important to your decision.

With regard to assertion I., additional information about what I believe was an unreasonable delay with regard to time-barred Danish law is provided here. In the last letter, IHI-BUPA makes the claim that I sent to them in August a series of medical bills and invoices, for which they needed to gather additional medical information, and that this was the cause of the delay in their decision for many months until 2014. I do not believe this is either accurate or true. In reality, I sent to IHI-BUPA a detailed email letter describing my situation on August 18, 2013, along with 18 official document attachments, including not only bills and invoices, but all pertinent diagnostic studies, clinical notes, operative notes, and physician contact information I had available on my case (see Attachment #3b). This comprised the most professional, official, and informative documents they could obtain, and I believe was more than adequate to make a medically-informed decision for coverage within weeks, not many months. Those documents describe my first study and diagnosis for sleep apnea in December 2011 (7+ months after the start of my insurance coverage), and that I first consulted with the maxillofacial surgeon Dr. … in 2012 who found that the cause of my obstructive apnea was a jaw deformity requiring surgical jaw advancement to cure my apnea.
…
IHI-BUPA claimed that a second reason for the delay was to ascertain whether or not a cosmetic procedure was performed. The detailed clinical notes, airway x-rays, and surgical notes and contact information records which IHI-BUPA had in August 2013 provided in no uncertain terms that the surgery performed was medically essential and 100% performed for the purpose of opening my airway and treating obstructive sleep apnea. After a prolonged and unnecessary search, IHI-BUPA did come across a personal questionnaire I was required to fill out in Dr. …'s office regarding how I felt about my face cosmetically. They then disregarded all of the professional medical documentation they already had and misused this single questionnaire to make a claim (refuted by Dr. …) that because according to their maxillofacial consult my surgery had 'aesthetic aspects' that they could make an unwarranted conclusion that 50% of of the surgery was performed for cosmetic reasons and thus non-reimbursable. My maxillofacial surgeon, Dr. …, said this questionnaire was required for me to fill out prior to surgical treatment because there are always cosmetic considerations which are standard-of-care when skin or face or other visible parts of the body are involved with a surgical procedure.
…
The above was to address or re-address the main points 1, II, and III for which I believe this case was mishandled through delays and misinformation, and thereby request if an exemption for time-barr status is possible. Perhaps unrelated to my complaint of mishandling, in their last letter, IHI-BUPA also made claims that I filed for benefits late after treatment and should have inquired about coverage earlier. I understand why they would want to prepare and evaluate coverage prior to treatment, but am not certain how this pertains to my current complaint."

Selskabet har i brev af 7/5 2018 til nævnet blandt andet anført:

"With regards to the identification of a bill for sleep studies, the Company has misunderstood the date for the conducted sleep studies to be July 2011 as the date on the bills for the sleep studies

was written in American date format. The date written on the bill was 11.07.2011 meaning the service date was 7 November 2011.

However, the Company still maintains that it was a reasonable investigation in order to determine whether the diagnosis of severe obstructive sleep apnea was pre-existing which was essential for processing the Complainant's paid bills for the Complainant's surgeries. In our reply dated 08.03.2018, the Company had referred to two annexes, annex 1 was a medical from [clinic] dated 13.12.2011. According to the medical the Complainant was examined due to symptoms of excessive daytime sleepiness, snoring, unrefreshing sleep and episodes of nocturnal choking. The Complainant had endorsed these symptoms for several years but noted worsening over the last two years according to the medical report. Annex 2 was a questionnaire regarding Epworth Sleepiness Scale completed and dated 26.02.2011 by the Complainant prior to joining the Company, in which the Complainant confirmed sleeping with CPAP oral machine and confirmed that the symptoms of sleep apnea had probably been present for many years."

Nævnet er forelagt bilag fra sagen.

Af et spørgeskema af 26/2 2012 udfyldt af klageren fremgår det blandt andet:

"**PATIENT MOTIVATION QUESTIONNA7RE**
Patients often request changes in their bites or faces and relief from pain or discomfort. Please help us understand your problem by checking the following information; please be specific (circle the words more, less, forward, backward, longer, shorter, etc."

...

Face: If your facial appearance could be changed, what would you change?
[X] get rid of sag under lower jaw
[X] move chin (*forward*) / *backward*
[ ] move chin *left / right* to center it
[ ] move lower lip *forward / backward*
[ ] move upper lip *forward / backward*
[ ] move the area around my nose *forward / backward*
[ ] make the profile of my nose *longer / shorter*
[X] move the area under my eyes (*forward*) / *backward*

Af operationsbeskrivelsen af 24/5 2012 fremgår det blandt andet:

"PREOPERATIVE DIAGNOSIS:
1. Maxillary anterior posterior hypoplasia.
2. Obstructive sleep apnea.
3. Posterior vertical deficiency.
4. Maxillary right deviation.
5. Mandibular anterior posterior hypoplasia.
6. Mandibular posterior vertical deficiency.
7. Mandibular left deviation.
8. Hypogenia.

...

OPERATION PERFORMED
1. Le Fort I osteotomy.
2. Bilateral sagittal split osteotomies.
3. Genioplasty.
4. Bone graft harvest.
5. Bone grafting to the mandible.
6. Bone grafting to the maxilla

…

INDICATIONS FOR SURGERY: This is a …-year-old male with a skeletal dental deformity requiring surgical correction. Prior to surgery I discussed at length with the patient the risks and complications and he consented to undergo the procedure.

…

After this, using a curved chisel, I took down the pterygoid plate attachment to the posterior maxilla which allowed me to down fracture the maxilla as planned. I stretched the maxilla in order to get good visualization of the posterior. I completed the dissection of the floor of the nose in the posterior. I then removed the Schneiderian membranes from the lateral nasal walls. I took down the lateral nasal walls and used this as bone graft material as well as the nasal septa) footplate. I identified the neurovascular bundle in the posterior, unroofed and performed pyramidal bone release and removed any extraneous pterygoid plates in the posterior which might interfere with positioning of the maxilla.

Having done this on both sides, I was able to stretch the maxilla including inferiorly in the posterior in order to stretch the pterygoid muscular attachments. This allowed me to passively position the maxilla over the mandibular occlusion without tension. I then placed the patient into intermaxillary fixation using 25-gauge wire from canine to canine, premolar in the anterior and from first molar band to skeletal fixation screw in the posterior. achieved good relationship with 2 mm of over jet, 3 mm of over bite. The maxillary midline was 0.25 mm to the right. This was a tooth sized discrepancy. The patient was class 1 at the first premolars.

…

Because the chin projection was inadequate as a result of the osteotomies, I turned my attention to the chin where the B-point incision was expanded slightly, subperiosteal dissection identifying the mantle foramens and staying inferior to the mantle foramens. I performed a genioplasty with reciprocating saw. I then used a 6 mm 2.0 KLS chin plate and advanced the chin, having previously marked the midline to maintain midline of the chin. I then secured it with four 6 mm 2.0 screws. I irrigated out the area and closed with #4-0 Vicryl in the periosteal layer times two, #4-0 Vicryl to the muscular layer and then #40 Vicryl running at the mucosal layer."

I udtalelse af 14/5 2014 fra klagerens læge er det blandt andet anført:

"[The complainant] sought treatment from me for the sole purpose of curing his obstructive sleep apnea. Every patient that comes to my office, regardless of their stated reason, is asked to fill out a form about their perceptions of their face. Orthognathic surgery is surgery on the facial skeleton. Even if the surgery is performed for the sole reason of curing sleep apnea, it would be below the standard of care to disregard the effect the surgery has on the face.

The advancement of [the complainant's] jaws is the source of the apnea cure. A by-product of the advancement is to provide the facial support that he lacked because his jaws were developmentally recessed. For you to say that the reason for the denial is because one of the side effects of

the surgery is a better facial esthetic, it is like denying payment for the treatment of a humerus fracture just because the orthopedic surgeon made the arm straight (an obvious esthetic benefit).

To reiterate, every patient is asked to fill out the form you refer to in your denial. Every sleep apnea patient who has ever been treated in my office has filled out the said form. The fact that [the complainant] filled out the form does not mean he had cosmetic surgery."

I forsikringsbetingelserne hedder det blandt andet:

"**Art. 12**
Exceptions to cover
12.1 The *insurance* shall not cover expenses incurred for any disease, illness or injury known to the *policyholder* and/or the *insured* at the time of *application*, unless agreed upon with *the Company*.

12.2 Furthermore, the *Company* shall not be liable to pay reimbursement for expenses which concern, are due to or are incurred as a result of:
a) Cosmetic *surgery* and treatment unless medically prescribed and approved by *the Company*.
…
Art. 13
How to report a claim
13.1 Any *claim* for reimbursement of expenses incurred for treatment by a physician or specialist as well as hospital treatment and medicine shall be reported by submitting receipted and itemized bills provided with the policy number to *the Company*. *The Company* scans submitted bills upon receipt. Any retrieval of the submitted bills is not possible.

The Company reserves the right at any time to require provision of original bills from the *insured*.

13.2 Any *claim* shall be reported to *the Company* immediately and no later than three months after the circumstances underlying the *claim* have become known to the *insured*.

13.3 *The Company* shall be notified immediately of any stays in hospital and such notification must include the physician's diagnosis. All notifications should be made by telephone, fax or email; *the Company* shall defray all expenses incurred in this connection.
…
Art. 18
Complaints
…
It is very rare that we cannot settle a complaint, but if this does happen, you may be entitled to refer your complaint to an indepedent organization for review. Which organization it will be depends on the nature of the complaint and the location of the ihi Bupa office where the cause of complaint occurred. We will advise you at the time. In most cases this will be either the Danish Insurance Complaints Board or the UK Financial Ombudsman Service.
…
Please let us know if you want a full copy of *our* complaints procedure (None of these procedures affect your legal rights.)
…
Art 21 Applicable Law

11. 91305

> 21.1 Your policy is governed by Danish law. Any dispute that cannot otherwise be resolved will be dealt with by courts in Denmark. If any dispute arises as to the interpretation of this document, then the English version of this document shall be deemed to be conclusive and taking precedence over any other language version of this document."

Nævnet udtaler:

Klageren fik den 24/5 2012 foretaget en kæbeoperation, efter han var diagnosticeret med søvnapnø. Han blev den re-opereret den 5/2 2013 på grund af en skade på en nerve. Han er utilfreds med, at selskabet alene har dækket 50 % af omkostningerne til operationerne, og han har afvist selskabets påstand om, at operationen delvist var begrundet i kosmetiske forhold.

Klageren har anført, at han også er utilfreds med selskabets sagsbehandling, idet selskabet ikke rådgav ham korrekt om hans klagemuligheder og om forældelsesfristerne i dansk ret. Herudover er han utilfreds med, at selskabet brugte tid på at undersøge, om hans søvnapnø var opstået før forsikringstiden i forbindelse med anmeldelsen af sagen.

Selskabet har anført, at klagerens krav er forældet, at der er givet korrekt klagevejledning, og at selskabet var berettiget til at undersøge, om søvnapnøen var opstået før forsikringstiden. Selskabet har også anført, at operationen var indikeret på grund af klagerens søvnapnø, men at der også var tale om en "improvement of the facial apperance".

Selskabet har oplyst, at klageren forudbetalte operationen den 27/3 2012, og at kravet om refusion fra selskabet blev sendt af klageren til selskabet den 7/2 2014, ligesom betalingen fra selskabet blev foretaget den 24/3 2014. Selskabet har også anført, at klagerens krav på fuld dækning blev endeligt afvist den 5/5 2014.

Det fremgår af forsikringsaftalelovens § 29, stk. 1 og forældelsesloven § 3, stk. 1, at forældelsesfristen er 3 år, medmindre andet følger af andre bestemmelser. Af forældelsesloven § 3, stk. 2 fremgår det, at fristen først regnes fra den dag, hvor fordringshaveren har fået kendskab til fordringen eller skyldneren, hvis han har været ubekendt hermed.

12. 91305

Det følger af forsikringsaftalelovens § 29, stk. 5, 1. pkt., at forældelse uanset 3-årsfristen tidligst kan indtræde 1 år efter, at selskabet har meddelt klageren, at kravet helt eller delvist er afvist. Nævnet lægger til grund, at klagerens krav blev endeligt afvist den 5/5 2014. Den 1-årige tillægsfrist udløb derfor senest i maj 2015.

Nævnet lægger til grund, at klageren har været bekendt med både sit krav, selve forsikringens eksistens og selskabet på tidspunktet, han betalte for operationen og da operationerne blev gennemført. Nævnet lægger også til grund, at klageren i 2014 blev informeret af selskabet om sine klagemuligheder hos enten den engelske Financial Ombudsman og nævnet, og at sagen blev afvist fra Financial Ombudsman i oktober 2014, hvor han blev henvist til nævnet.

Det fremgår af forsikringsbetingelsernes Art. 21, at klagerens police er underlagt dansk ret, og i Art. 18 er det oplyst, at klager over selskabet enten kan rettes til Financial Ombudsman eller nævnet afhængig af sagens art og sted, hvor årsagen til klagen er opstået.

Nævnet finder efter en gennemgang af sagen, at klagerens krav mod selskabet er forældet forud for indbringelsen af sagen for nævnet den 10/9 2017. Allerede af denne grund kan nævnet ikke kritisere selskabets afslag på at udbetale yderligere dækning for udgifterne til operationerne den 24/5 2012 og 5/2 2013.

Nævnet har blandt andet lagt vægt på, at klageren har været bekendt med både kravet og skyldneren siden betalingen den 27/3 2012 og operationerne den 24/5 2012 og 5/2 2013.

Nævnet finder, at det forhold, at klageren ikke kendte til dansk rets regler om forældelse ikke kan føre til andet resultat. Nævnet har i denne forbindelse lagt vægt på, at det klart fremgik af forsikringsbetingelserne, at klagerens forsikring var underlagt dansk rets regler. Nævnet finder ligeledes ikke grundlag for at fastslå, at en henvisning til både den engelske Financial Ombudsman og nævnet har medført, at forældelsesfristen har været suspenderet. Nævnet har i denne

forbindelse lagt vægt på, at sagen blev afvist fra Financial Ombudsman med henvisning til nævnet i oktober 2014, og kravet endnu ikke var forældet på dette tidspunkt.

Nævnet finder videre ikke grundlag for at kritisere selskabets sagsbehandling i forbindelse med vurderingen af sagen. Nævnet finder, at det var relevant for selskabets dækning at vurdere, hvornår klagerens lidelse var opstået med henblik på at fastslå, om behandlingen var omfattet af forsikringen. Nævnet finder videre ikke grundlag for at fastslå, at selskabet havde en forpligtigelse til at gøre særskilt opmærksom på forældelsesreglerne.

Som følge heraf

b e s t e m m e s :

Klageren får ikke medhold.

Peter Thønnings