

2. The Respondent is Medihelp Medical Scheme (the “Respondent” or the “Scheme”), registered and regulated under the Medical Schemes Act, Act 131 of 1998 (the “MSA”).
3. This is an appeal under section 48(1) of the MSA, providing that –

“(1) Any person who is aggrieved by any decision relating to the settlement of a complaint or dispute may appeal against such decision to the Council.”

INTRODUCTION

1. The Appeals Committee heard the Appeal on 8 May 2025, *via* audio and video Microsoft Teams conferencing.
2. Ms T represented herself as the Appellant. The member’s team leader at the bargaining council, Ms S Carter was also present.
3. Ms A , legal advisor at Medihelp Scheme, appeared for the Respondent.
4. The Appellant lodged an appeal against the Registrar’s ruling of the 16 January 2024, which emanated from the initial complaint from the member, for the Scheme to fund the co-payment levied, as a complication from the operation on the 11th May 2023 at the hospital, to be treated as an emergency condition.

BACKGROUND AND REGISTRARS RULING

5. Ms T , is member of the Medihelp Medical Scheme, belonging to the Medvital Elect option, and where members need to use network hospitals and network specialists.
6. She required a hysterectomy and chose to use her existing service provider, Dr TP, who performed the procedure on the 11th May 2023.
7. The member willingly paid the co-payment of R10 000 after engagement with the Scheme on the 9th May 2023, wherein she was made aware of the 35% co-payment rule for hospitals and specialists outside the network.
8. On the 16th May 2024, an updated application was received by the Scheme, stating that the member had suffered a complication arising from the operation, necessitating emergency treatment.

9. A Section 47 complaint was registered by the Appellant on the 13th October 2023, stating that the Scheme had applied the co-payment rule to the entire hospital bill and should pay the shortfall of R44 789.04 as the treated complication was an emergency.
10. The Scheme in their response on the 13th November 2023¹ acknowledged the complication suffered by the Member but stated that it paid the claim properly and according to its Rules, as there were 2 closer network hospitals, and the Member was aware of the required co-payment prior to the admission.
11. The Registrar found that the Scheme was correct in terms of its managed rules to impose the co-payment.
12. The Registrar's Ruling was issued on 16th January 2024.
13. The Appellant appealed this ruling on the 8th February 2024 in terms of Section 48(1).

RELEVANT STATUTORY AND REGULATORY PROVISIONS

14. The relationship between the Scheme and the Respondent is governed by the terms of the contract ("the Schemes rules") the Scheme concluded with the Respondent. The contract in turn is governed by the "MSA" and the regulations (as amended) made in terms of the Act.
15. The Regulations in terms of the Medical Schemes Act 131 of 1998: Section 8 Prescribed Minimum Benefits states: ²
 - (1) Subject to the provisions of this regulation, any benefit option that is offered by a medical Scheme must pay in full, without copayment or the use of deductibles, the diagnosis, treatment and care costs of the prescribed minimum benefits conditions.
 - (2) Subject to section 29(1)(p) of the Act, the rules of a medical Scheme may, in respect of any benefit option, provide that –
 - a. the diagnosis treatment and care costs of a prescribed minimum benefit condition will only pay be paid in full by the medical Scheme if those services are obtained from a designated service provider in respect of that condition; and
 - b. a copayment or deductible, the quantum of which is specified in the rules of the medical Scheme, may be imposed on a member if that member or his or her dependent obtains such services from a provider other than a designated service provider, provided that no co-

¹ Paginated pages 19 – 20 of appeal bundle of documents

² Medical Schemes Act 131 of 1998. Regulation 8: Prescribed Minimum Benefits.

payment or deductible is payable by a member if the services was involuntary obtained from a provider other than a designated service provider.

(3) For the purposes of sub regulation (2)(b), a beneficiary will be deemed to have involuntarily obtained a service from a provider other than a designated service provider, if -

- a. The service is not available from the designated service provider or would not be provided without unreasonable delay
- b. Immediate medical or surgical treatment for a prescribed minimum benefit condition was required under circumstances or at locations which reasonably precluded the beneficiary from obtaining such treatment from a designated service provider; or
- c. There was no designated service provider within reasonable proximity of the beneficiary's ordinary place of business or personal residence

(4) Subject to sub-regulations (5) and (6) and to section 29 (1) (p) of the Act, these regulations must not be construed to prevent medical schemes from employing appropriate interventions aimed at improving the efficiency and effectiveness of health care provision, including such techniques as requirements for pre-authorisation, the application of treatment protocols, and the use of formularies.

(5) When a formulary includes a drug that is clinically appropriate and effective for the treatment of a prescribed minimum benefit condition suffered by a beneficiary, and that beneficiary knowingly declines the formulary drug and opts to use another drug instead, the scheme may impose a co-payment on the relevant member.

(6) A medical scheme may not prohibit, or enter into an arrangement or contract that prohibits, the initiation of an appropriate intervention by a health care provider prior to receiving authorisation from the medical scheme or any other party, in respect of an emergency medical condition.

16. This is a wide appeal. The Appeals Committee may consider the matter afresh and is not restricted to the record of proceedings that were before the Registrar.

17. The burden of proof rests on the Appellant who must prove on a balance of probabilities that the appeal should succeed.

THE ISSUE IN DISPUTE

18. The issue in dispute is whether the Scheme was correct to impose a co-payment resulting in a shortfall on the account, on the basis that it constitutes voluntary use of a non-DSP hospital

and whether the emergency condition incurred by the Member was interpreted and adjudicated on correctly.

DISCUSSION AND LEGAL FRAMEWORK

APPELLANTS SUBMISSION

19. Ms commenced her submission by informing that she chose to continue treatment with her trusted obstetrician and gynaecologist, Dr TP e, for the hysterectomy operation, which was performed on the 11th May 2023 at the Netcare Park Lane Hospital.
20. The Appellant indicated that she consulted the Scheme on the 9th May 2023 and was made aware of the 35% co-payment in terms of the Scheme rules as she was not using the network hospitals that were part of the Scheme's designated service provider (DSP) network.
21. She paid in the co-payment amount of R10 000.
22. The Appellant informed that the operation unfortunately led to a complication of pulmonary embolus, which had to be treated as an emergency in the ICU setting of the hospital
 - i. During this time, she was heavily sedated and was not in any position to engage with the Scheme on her continued treatment.
 - ii. The condition was life threatening and out of her control
 - iii. The Appellant informed that the letter from Dr³, confirms the above-mentioned complication.
23. Ms continued to state that the Scheme had adjudicated on the entire hospital bill and from her perspective, given that this was an emergency the amount of the hospital bill and the Parklane Radiology bill shortfall of R3400 should be settled by the Scheme, which was the crux of her complaint.
24. The Appellant mentioned that she has been a member of the medical scheme since 2015 and has diligently paid all her contributions and fees. She is a single mum, and she is not in a financial position to pay this bill.
25. The Appellant in concluding his submission, requests that the ruling made by the Registrar be set aside and the Scheme settle the co-payment amount of R44 789.04 plus the R3400.00 .

³ Paginated page 4 of the Appeal bundle of documents

RESPONDENTS SUBMISSION

26. Ms A, on behalf of the Respondent, commenced her submission by stating that the authorization for the planned procedure was approved, and that the Appellant was aware she was using a non-DSP hospital, which was confirmed on the correspondence of the 9th May 2023.
27. She confirmed that the authorisation was updated on the 16th May 2023 with the further ICU treatment and the supporting ICD codes.
28. Regarding the procedure of 11th May 2023, the Respondent informed from the time of the communication to the member, there was ample time for the member to seek the consultation of the recommended DSPs, but the Member had voluntarily chosen her service provider and the non-DSP hospital.
29. The Respondent put forward that the Scheme rules dictate that co-payments should be imposed in the event of a voluntary use of a non-DSP, which was the initial event; and that she is not sure when the emergency arose as this was not expected.
 - i. The Scheme is aware that the length of the hospital stay and the concomitant bill changed from 3 days to 7 days.
 - ii. Ms A is not aware of any of her medical colleague's interaction with the treating provider at the time of the event nor post the event, once the bill was received.
30. The Scheme further informed that it was the member's responsibility to acquaint herself on the rules of the Scheme.
31. For the reasons set out above, it is submitted that this Appeal Committee find in favour of the Respondent and uphold the decision of the Registrar.

ANALYSIS AND FINDINGS

32. The Appeals Committee considered the papers filed in this Appeal; the further submissions the parties made; the relevant provisions of the MSA; and the rules of the Scheme.

33. It is common cause that -

- a) Ms. is member of the Medihelp medical scheme and belongs to the Medvital Elect option which has managed care rules including designated hospital networks.
- b) The service provider, Dr TP , is a registered obstetrician and gynaecologist under the HPCSA and is in private practice.
- c) There is no dispute that the Member chose to use her existing doctor and had made a copayment in respect of the planned hysterectomy operation.

34. The Appellant provided evidence that she had agreed to the co-payment for the hysterectomy procedure but that the complication was unforeseen, and the emergency nature of the ensuing treatment was beyond her control.

35. The Committee, acknowledged the patient choosing voluntarily to see Dr TP and noted the following from the Appeal bundle of documents:

- a. The treating doctor has provided a letter supporting the clinical evidence of the complication that arose from the operation⁴
- b. The bill from the Netcare Park Lane hospital including the supporting ICD codes for the supporting ICU treatment was updated on the 16th May 23 reflecting that the outstanding amount of R44 789.04 was member liable⁵
- c. The evidence from paginated page 13 of the bundle also points to an outstanding amount of R3400 from the Parklane Radiology for the chest investigation for the pulmonary embolus.
- d. The Scheme response, on the 13th November 2023 in response to the CMS acknowledgement of the Member complaint, and per paginated page 19 - 20 of the bundle of documents, informs about their DSP guidelines and the member being aware of the co-payment due.

⁴ Paginated page 4 of the Appeal bundle of documents

⁵ Paginated page 12 of the Appeal bundle of documents

e. At the same instance, the Scheme did not query the emergency status of the treatment and did not interrogate the matter further.

36. Specifically, to this matter, the Respondent attested that the medical advisory team did not engage with the treating provider and hospital on the emergency treatment that was rendered and adjudicated the entire hospital bill on the initial procedure that was authorised.

i. There is no evidence of the Scheme reviewing the emergency condition and treatment any further in the bundle of documents.

37. From the MSA, an emergency medical condition is defined as, *“the sudden and unexpected onset of a health condition that requires immediate medical or surgical treatment. Failure to provide such treatment would result in serious impairment to bodily functions, serious dysfunction of a body organ or part, or would place the person's life in serious jeopardy”*.

38. Hence Medical Schemes are required to cover the diagnosis, treatment, and care costs of PMB conditions, which include emergency medical conditions.

i. The committee is clear that medical schemes may not deny benefits due to the absence of prior authorization or the presence of a different and elective procedure.

ii. The onus is on treating healthcare providers to ensure that the necessary care is provided promptly as verified in the treating doctors note on page 4 of the bundle of documents.

iii. The Scheme despite receiving the updated bill with supporting ICD codes did not make the proper and further attempt to adjudicate the emergency treatment appropriately

39. The Committee is of the view that the Registrar failed in his review of the Scheme response to the complaint that funding must be provided in full, without co-payment, regardless of whether the services are obtained from a designated service provider.

i. In emergency situations, medical schemes cannot deny coverage due to the absence of prior authorization.

ii. Regulation 8(6) explicitly states that schemes may not prohibit or delay the initiation of appropriate interventions by healthcare providers in emergencies.

iii. Furthermore, if a beneficiary receives emergency treatment from a non-designated service provider due to circumstances beyond their control (e.g., unavailability of the designated provider, unreasonable delay, or lack of proximity), the medical scheme is obligated to cover the costs without imposing co-payments or deductibles.

40. From the evidence provided, The Appeal Committee is of the view that the Respondent had not fully abided the rules of the Scheme in terms of Regulation 8 of the MSA, which sets out rules for the scheme to pay for the diagnosis and treatment of a PMB benefit condition.
- i. Regulation 8(1)⁶ must be paid in full.
 - ii. Regulation 8(2)⁷(a) read with 8(2)(b) allows for schemes to charge a co-payment, if the member uses a non-DSP under voluntary circumstances; and which is not applicable in this case
 - iii. The Appeal Committee is further of the view that the Appellant's case was outside her control due to the ensuing complication of the pulmonary embolus, which had to be treated as an emergency.
 - iv. The criteria for Regulation 8(3)⁸, which is the basis for payment in full and preventing the Scheme from imposing a co-payment when a PMB Condition, the emergency condition, is being treated by a non-DSP, and where a member has involuntarily obtained the service of a non-DSP
 - v. Regulation 8(6) where a medical scheme may not prohibit, or enter an arrangement or contract that prohibits, the initiation of an appropriate intervention by a health care provider prior to receiving authorisation from the medical scheme or any other party, in respect of an emergency medical condition applies in this case.

FINDING

41. The Scheme is liable to fund the account for services rendered in full, with no co-payments or deductibles.

⁶ 8(1) Subject to the provisions of this regulation, any benefit option that is offered by a medical scheme must pay in full, without co-payment or the use of deductibles, the diagnosis, treatment and care costs of the prescribed minimum benefit conditions

⁷ Regulation 8(2) provides:

Subject to section 29(1)(p) of the Act, the rules of a medical scheme, in respect of any benefit option, provide that-

(a) the diagnosis, treatment and care costs of a prescribed minimum benefit condition will only be paid in full by the medical Scheme if those services are obtained from a designated service provider in respect of that condition; and

(b) a co-payment or deductible, the quantum of which is specified in the rule of the medical Scheme, may be imposed on a member if that member or his or her dependent obtains such services from a provider other than a designated service provider, provided that no co-payment or deductible is payable by a member of the service was involuntarily obtained from a provider other than a designated service provider.⁹

⁸) Regulation 8(3) reads as follows

For the purposes of subregulation (2) (b), a beneficiary will be deemed to have involuntarily obtained a service from a provider other than a designated service provider, if—

(a) the service was not available from the designated service provider or would not be provided without unreasonable delay;

(b) immediate medical or surgical treatment for a prescribed minimum benefit condition was required under circumstances or at locations which reasonably precluded the beneficiary from obtaining such treatment from a designated service provider;

(c) there was no designated service provider within reasonable proximity to the beneficiary's ordinary place of business or personal residence."

42. The Appeal Committee agrees that the relationship between a Scheme and its member is contractual. The terms of the contract between the member and the Scheme consist of the Scheme Rules, the Medical Schemes Act and its Regulations.

43. Section 32⁹ of the MSA stipulates that the Appellant is bound by the Rules of a medical scheme.

ORDER

44. Having considered the matter the Appeals Committee orders that:

- i. The appeal is upheld.
- ii. The ruling of the registrar of the 16th January 2024 is dismissed.
- iii. The Scheme is liable to pay the co-payment of R44 789.04 plus the shortfall in the radiology account of R3 400.

DATED AT CAPE TOWN ON THIS 17th June 2025

Dr S Naidoo

For: The Appeal Committee (Chairperson)

WITH –

Dr K Chetty

Dr H Mukhari

Dr X Ngobese

Ms M Ramagaga

CONCURRING, IT SO BE RULED

⁹ Section 32. The binding force of rules.—The rules of a medical scheme and any amendment thereof shall be binding on the medical Scheme concerned, its members, officers and on any person who claims any benefit under the rules or whose claim is derived from a person so claiming.