



**BEFORE THE APPEAL COMMITTEE OF THE COUNCIL FOR MEDICAL
SCHEMES (SECTION 48 APPEAL)**

REFERENCE No: CMS 85353

In the matter between

Polmed Medical Scheme

Appellant

And

A obo V B

Respondent

Appeals Committee Hearing Panel:

Dr S Naidoo

Ms P Beck

Dr K Chetty

Date of Appeal Hearing:

4 December 2025

RULING AND REASONS

THE PARTIES

1. The Appellant is Polmed Medical Scheme (the “Appellant” or the “Scheme”), registered and regulated under the Medical Schemes Act, Act 131 of 1998 (the “MSA or the “ACT”).
2. The Respondent is Mr A (the “Respondent”), a service provider to the member of the

Polmed Medical Scheme, Mrs B.

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

4. The Appeals Committee heard the Appeal on 4th December 2025, *via* audio and video conferencing.
5. Advocate X, as instructed by Ms Y, an attorney, confirming instruction from the Polmed Medical Scheme, appeared for the Appellant. He was accompanied by Adv XX. Also present from the Scheme was chief of staff, Mr XXX and senior manager of legal, Ms XXXX.
6. Mr C, a healthcare consultant, who is also an alternative dispute resolution specialist, appeared for the Respondent, confirming that he has a mandate from the service provider, Mr A. Mr A was also present, confirming that the dependent member, Mrs B, provided consent to register the complaint to the CMS.
7. The Appellant lodged an appeal against the Registrar’s ruling of the 12th of December 2024, which emanated from the initial complaint from Mr A for the Scheme to fund in full the costs of the below-knee prosthesis he prescribed to the dependent member.
8. The Registrar in his ruling rejected the Scheme's funding decision and instructed the scheme to pay for the prosthesis in full as it constituted PMB level of care.

BACKGROUND

9. Mrs B is 83 years old and is a dependent member of Polmed Medical Scheme on the Marine benefit option .

10. She is a pensioner, who developed complications from underlying Diabetes and required a left transtibial, below knee amputation in 2009.
11. She has been a patient of the prosthetist, Mr A since 2009, and has used a prosthesis since with ongoing refits. A new prosthesis fitted in April 2021, needing a refit of the same prosthesis in 2022 and new silicone liners in 2023.
12. She consulted the prosthetist, Mr A on the 8th May 2024, whose evaluation determined that the prosthetic foot was worn out and that pressure points were developing in the residual limb and then prescribed a new specialized below left knee prosthesis to the patient.
13. The cost of the below knee right knee prosthesis came to R 124 892.79¹ and was submitted via a quote to the Scheme on the 13th May 2024.
14. On the 16th July 2024, Mr A consulted with Dr D from the Polmed Medical Scheme, informing them, that the condition is at a PMB level of care. He was informed then that the funding limit on the prosthesis was R75 180 and that the member can apply for ex gratia assistance.
15. On 6th August 2024, Mr A lodged a section 47 complaint to the Council of Medical Schemes (CMS), stating that the full amount of the prosthesis should be paid as the condition qualified as a prescribed minimum benefit (PMB).
16. On 4th October 2024, the Medical Scheme responded to the complaint, stating that the Prosthesis benefit is subject to the available benefits in the Scheme Rules and Benefit guide, also informing that service provider has not provided a discounted quotation in response to its request.
 - a. The Scheme confirmed that the benefit limit for prosthesis per family is R75 180 for 2024 and that the balance would need to be funded by a co-payment.
 - b. The Scheme stated that the PMB regulations, Annexure A and the supporting code of conduct notably section 29(1)(o) and section 29(1)(p) of

¹ Paginated pages 5 – 8 of Appeal Bundle

the MSA guide on the level of care and scope of care.

- c. That the tariff charged by the private service provider is unregulated and that the care cost exceeds the recognized PMB level of care².
- d. Hence they are bound by the Rules of the Scheme and cannot fund more than the available benefit for the prosthesis.

17. The Registrar, after consulting with the Clinical Review Committee (CRC) of the CMS, ruled on 12th December 2024³:

- 15. It is common cause that the member's condition is a PMB condition. What the Respondent is disputing is that the care costs for the PMB level of care. The Complainant argued that the Respondent does not have a DSP, therefore it can be said that the member voluntarily used a non-DSP. In its opinion the CRC advised that considering the specified treatment component for DTP code 915E, amputation that was performed in 2009 is PMB level of care for the member's condition.
- 16. The CRC confirmed that diagnosis, treatment and care costs of PMBs must be funded in line with the PMB Regulations. In this case, the member would not have required a prosthesis if an amputation was not done. The prosthesis therefore constitutes a PMB related service.
- 17. The CRC also confirmed that the Respondent is not correct to short fund the required prosthesis. Therefore, it follows from CRC opinion that the member's treatment constitutes PMB level of care and should thus be funded in full, in accordance with Regulation 8(1) of the Act.

FINDINGS

- 18. Having considered the merits of the complaint, the Respondent submissions and the CRC opinion cited above, the Office of the Registrar finds that the member's condition is PMB, and treatment required therefore, qualifies as PMB level of care. The Respondent is hereby directed to fund in full, the costs of the member's prosthesis in accordance with the provisions of Regulation 8(1) of the Act.
- 18. As the Member's condition is regarded as a PMB condition, Regulation 8(1) of the MSA provides that the diagnosis, treatment and care of a PMB condition must be paid in full.
- 19. The Registrar ordered the Scheme to fund the prosthesis in full.
- 20. The Scheme appealed the decision of the Registrar in terms of section 48(1) Appeal submitted on the 10th of March 2025, stating the following:

² Paginated pages 12 – 20 of Appeal Bundle

³ Paginated page 128 - 131 of Appeal bundle

- a) The CRC and the Registrar had failed to properly interpret the PMB regulations and supporting codes of conduct in terms of the scope and level of care required.
- b) In the absence of a regulatory pricing framework and a scheme appointed private prosthetist and orthotist designated service provider (DSP), there is no way to curb PMB claims.
- c) The pricing of the below knee prosthesis in this case, is excessive.

RELEVANT STATUTORY AND REGULATORY PROVISIONS

21. The relationship between the Scheme and the Member is governed by the terms of the contract (“the Schemes rules”) the Scheme concluded with the Member. The contract in turn is governed by the “MSA” and the regulations (as amended) made in terms of the Act.

22. Section 32 of the Act stipulates as follows: *“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.”*

23. Section 29(1) Matters for which rules shall provide- (1) *The Registrar shall not register a medical scheme under section 24, and no medical scheme shall carry on any business, unless provision is made in its rules for the following matters- Section 29(1)(o) The scope and level of minimum benefits that are to be available to members and dependants as maybe prescribed; and 29(1)(p) No limitation shall apply to the reimbursement of any relevant health service obtained by a member from a public hospital where this service complies with the general scope and level as contemplated in paragraph (o) and may not be different from the entitlement in terms of a service available to a public hospital patient.*

24. Regulation 8 stipulates as follows –

“8. Prescribed Minimum Benefits.—(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.”

25. 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.

26. 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

27. The issue in dispute is whether the Scheme was correct to not fund the prosthetic legs in full for a PMB condition, as PMB level of care, and whether the quotation received is above the PMB level of care.

DISCUSSION AND LEGAL FRAMEWORK

APPELLANTS SUBMISSION

28. Adv X, for the Appellant, submitted that the Appeal is premised on the grounds that both the Registrar had 'misinterpreted and misapplied' the MSA in his ruling that the Scheme needs to fund the below -knee prosthesis in full.

29. He stated that the primary issue is founded on the Constitutional Court's jurisprudence, citing the judgment of the Constitutional Court in Vodacom versus Makati of the 31st July 2025

- a. In the matter Vodacom (Pty) Ltd v Makate and Another (CCT 51/24) [2025] ZACC 13; 2025 (10) BCLR 1174 (CC) (31 July 2025) ("Makate 2") where in this case the Concourt held that failure by an adjudicator to engage with the core issue that it is called upon to decide constitutes a total failure of justice in breach of the rule of law which impacts on a party's right to a fair hearing as guaranteed by section 34 of the Constitution. In this respect, the Concourt said at par 93: *"To put it bluntly, the real appeal was not decided. That constituted a total failure of justice in breach of the rule of law and the fair hearing right protected in section 34 of the Constitution"*
- b. The CRC of the CMS and the Registrar failed entirely to address the core issue in its response to the complaint and hence constitutes a total failure of justice.
- c. Instead of engaging with the core issue, the CRC simply set out one aspect of the Scheme's case, making the case about whether the prosthesis is a PMB related service and whether the Scheme short funded the required prosthesis.
- d. The Scheme's case is much wider than that, concerning the interpretation and application of the Medical Schemes Act and PMB regulation.
 - i. The Ruling failed to engage with the interpretation of annexure A to the PMB regulations, and the explanatory note about the cost being pegged at public hospital rate.
 - ii. The Ruling also did not interpret and apply Section 29(1)o and

Section 29(1)p and left to the conclusion that the members condition is a PMB and the treatments required is at a PMB level of care and therefore the Scheme must pay in full.

e. In referencing their heads of argument⁴, to substantiate how flawed the Registrar's ruling was in law, and where he had 'misinterpreted and misapplied' the MSA, he cited 3 further cases:

- i. *SARB v Khumalo* 2010 (5) SA 449 (SCA) par 12 where the Supreme Court of appeal stated "No matter how clear and unequivocal regulations may appear to be, their interpretation and validity are dependent upon the empowering provisions which authorise them." This view was supported in *Min of Health v Clicks* 2006 (2) SA 311 (CC) par 211;
- ii. In *Min of Health v New Clicks* 2006 (2) SA 311 (CC) par 236. In that case, the Concourt said: "*The choice of price regulation, if not inconsistent with the Medicines Act, was a policy decision within the domain of the legislature and the executive with which this Court will not interfere. This Court is concerned with whether the scheme meets the requirements of the Medicines Act and was adopted in accordance with the provisions of the Constitution and PAJA, and not with whether there may be better ways of achieving the same purpose.*"
- iii. Referring to the case of the Constitutional Court in the Democratic Alliance v President of South Africa and Others (CCT 122/11) [2012] ZACC 24; 2012 (12) BCLR 1297 (CC); 2013 (1) SA 248 (CC) (5 October 2012) wherein it was decided that where an irrational process, leads to a decision that is irrational, it must be set aside.

30. He added that the Ruling, failed to interpret Regulation 8 in its entirety, not just Regulation 8(1) and 8(2).

- a. The Scheme in its response to the initial complaint stated that the care costs quoted by the provider in this case are inconsistent with PMB care costs as envisaged in Regulation 8.

⁴ Supplementary bundle – Appellant's heads of argument

- b. The Scheme had implemented processes for which the funding is kept as a reasonable and fair care for the PMB level of care⁵.
- c. A Scheme can be paying unlimited, unkept PMB costs simply because it is dealing with PMB condition.
- d. Regulation 8(1) says informs that the Scheme is liable only for benefits to which the member is entitled and no more; and as such this regulation must be interpreted in line with the overall provisions of the MSA.

31. Referring to paragraph 28 onwards from the Section 48 affidavit⁶...the heart of the issues on appeal is the misinterpretation and misapplication of Section 29(1)o and Section 29(1)p of the Act.

- a. Annexure A to the PMB regulations speak to the diagnosis and treatment pairs constituting the PMB package under Section 29(1)o and whether it's obtained in public hospitals or private hospitals makes absolutely no difference.
- b. The Act is put in place with a view to regulate the cost of healthcare, and it does so both in public and in the private sector. The purpose of the Act in general cannot be to regulate the pricing in the public sector and not in the private sector.
- c. This section is to reduce risk of unfunded utilization of public hospitals, and the second objective is to encourage improved efficiency.
- d. The PMB code of conduct determines where a member voluntarily incurs PMB treatment costs in excess of the schemes defined basket of benefits, the scheme is allowed to impose reasonable co-payment in terms of the PMB conduct, and it's a policy decision that it intends keeping.
- e. Regulation 8 (4) further affords the scheme, appropriate interventions aimed at reducing the cost of treatment, and such care should be interpreted as referring to prevailing hospital-based medical and surgical diagnostic and treatment practice for the specified condition.
- f. Where significant differences exist between public and private sector

⁵ Paginated pages 12 – 20 of Appeal Bundle

⁶ Paginated pages 143 of Appeal Bundle

practices, the interpretation of the PMB should follow the predominant public hospital practice as outlined in the relevant provincial and national public hospital clinical protocols where these exist.

- g. Only if the type of prosthesis available at the Scheme rates is ineffective or would cause harm to the patient, then could the scheme deviate from the schedule of its benefits in terms of Regulation 15H(c).

32. Adv X, in concluding informed that the Registrar followed the flawed reasoning from the CRC of the CMS and did not deal with the actual complaint, including the fact that the Scheme has requested a discount on the quotation and for the Member to follow an ex gratia process to assist with settling the co - payment.

- a. The Registrar and the CRC left to determining that since the condition was a PMB, it had to be funded at a PMB level of care, and did not . interpret Section 29(1)(p) of the MSA and the supporting code of conduct properly.

- i. As such Regulation 8 cannot be interpreted in isolation from the MSA, its regulation and Scheme rules.
- ii. The reimbursements set out in government gazettes for prosthesis was not taken into account in the price determined by the private service provider.
- iii. Guidelines contained in Annexure A provided safeguards into how to manage reimbursements for PMB conditions
- iv. The approved Scheme rules for the option allowed for managed care measures to be put into place.

- b. The amount quoted for the below-knee prosthesis was well above that required as a PMB level of care.

- c. He added that the Registrar had failed to recognize that there is no supply side regulation of the private sector pricing with the policy and choice of pricing being beyond the remit of the Appeal; further noting that the Scheme had no DSP in place for these services.

33. As per their heads of argument⁷, and their Appeal supporting affidavit, the Scheme was obliged in terms of the MSA to fund appropriately and that the regulation was in place to prevent open ended financial liabilities for Schemes,

⁷ Supplementary Bundle – heads of argument of the Appellant

including for PMB conditions.

a. In applying Regulation 8(1) to fund the cost of the prosthesis in full was flawed and misdirected:

i. No claim had been submitted to the Scheme

ii. The MSA and section 29(1)(o) guided on the case cost for PMB conditions

34. The Appellant concluded that the Scheme had the right to not fund the below - knee prosthesis at the quoted price as its Rules provided a limit of R75 180 cost and for the above mentioned reasons, requests that the Appeal Committee rule that the matter goes back to the Registrar to attend to the matter properly, and accordingly the Appeal should be upheld.

RESPONDENTS SUBMISSION

35. Mr C, for the Respondent, commenced his submission by stating that after the Registrar's ruling, Mrs.B received a prosthesis from Mr. A, who has been treating her since 2009

a. The leg was amputated due to complications from Diabetes and she required a transtibial, below knee prosthesis.

36. The Scheme's approach in this case to the authorization and needing additional quotes, frustrated the provider, as this is not the normal practice in the medical profession.

37. He added that the Rules of the medical scheme are silent where a service provider rendering the service must provide additional quotes.

38. He believes that Polmed had no right to ask the service provider to reduce the price and any contravention of the Competition Act and possible collusion shouldn't be permitted.

39. He stated that the process was followed correctly in terms of Section 47 of the MSA, and after the Scheme response, the Registrar made a correct ruling.

40. Accordingly the only issue in this is Appeal, pertains to Regulation 8(1). He stated that the Scheme had handled the application process incorrectly, and

not according to regulation 8(1) of the MSA, which guides funding of PMBs.

41. He informed that the Appellant had failed to complete setting up a designated service provider (DSP) network with their discussions with the South African Orthotist and Prosthetist Association (SAOPA)
 - a. If it had done so, then measures as outline in Regulations 15(H) could have been implemented
 - b. The Scheme further did not apply for exemption under Regulation 8(h)
 - c. He added that Regulation 8(4) does not permit limitations of PMB but allows for the Scheme to use authorization, protocols and formularies.
42. He mentioned that the Appellant's reasoning and interpretation of the PMB regulations is incorrect in that the Section 29(1)(p) does not limit the cost of the PMB level of care.
 - a. The MSA is clear in what defines what a PMB, including Regulation 7 which is consistent with the provisions of the diagnosis, treatment, the care costs of PMB conditions including any emergency condition.
43. He mentioned that the the Scheme's rules, can never conflict with the provisions of the PMB regulations and indicated that the prosthesis should be funded in full.
44. On behalf of the Respondent, he refutes the argument that the benchmark price of private sector prosthesis can be compared with that offered at public sector institutions as the state receives subsidized prices to the components of the prosthesis.
45. Mr C concluded that the Appellant has not properly determined minimum prosthetic care within the PMB provisions and has not fulfilled aspects of Regulation 8.
 - a. For the reasons set out below , it is submitted that this Appeal Committee find in favour of the Respondent and uphold the decision of the Registrar.

ANALYSIS AND FINDINGS

46. 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.

47. It is common cause that-

- i. Mr B is 83 years old and has been a dependent member of Polmed Medical Scheme on the Marine benefit option
- ii. She developed the complication due to underlying Diabetes and required a transtibial, left below knee amputation in 2009.
- iii. She consulted, the prosthetist, Mr A on the 8th May 2024, whose evaluation determined that the prosthetic foot was worn out and that pressure points were developing in the residual limb and then prescribed a new specialized below left knee prosthesis to the patient.
- iv. The cost of the below knee right knee prosthesis came to R 124 892.79 and was submitted via a quote to the Scheme on the 13th May 2024
- v. On the 2nd October 2024, the Scheme requested the service provider provide 2 additional quotes with a lesser amount in order to reduce the Member's co - payment.
- vi. Mr A provided an amended quote of R96 501.36 on the 14th October 2024 and thereafter correspondence from the Scheme on the 17th October 2024 was not answered by the service provider including that the member can apply for ex gratia assistance.
- vii. On the 16th July 2024, Mr A consulted with Dr D from the Polmed Medical Scheme, informing that the condition is at a PMB level of care. He was informed then that the funding limit on the prosthesis was R75 180 and that the member can apply for ex gratia assistance.
- viii. On 6th August 2024, Mr A lodged a section 47 complaint to the CMS, stating that the full amount of the prosthesis should be paid as the condition qualified as a prescribed minimum benefit (PMB).

48. According to the Appellant:

- a. The Registrar had not dealt with the actual complaint appropriately and his interpretation of Regulation 8 was

misdirected and whilst it should direct Schemes to reimburse on the one hand, it needs to also protect access to necessary and cost effective care.

- b. In terms of Section 29(1)o, it should not expose the Scheme to unlimited liability, noting also that there is no DSP in place.
- c. These costs can be limited as contained in Regulation 8(4).
- d. The overall legislature of the MSA, including the PMB regulation and code of conduct could not have intended that the cost of care be determined by a private sector service provider only.
- e. The service provider did not exhaust the internal process laid out by the Scheme.
- f. The Scheme hence does not have authority in terms of its registered rules and was not at a stage of claims adjudication to fund the below knee prosthesis based just on the quotation.

49. The Appellant, in their submissions, does assert that the provisions of Regulation 8 must be interpreted in light of what has been set out in section 29⁸ and states that the benefits payable with respect to PMB's are contained in their Rules, where such benefits must be paid accordingly on a scale, tariff or recommended guide.

50. According to the Respondent:

- a. The real issue in this case is that given the no dispute to the condition being a PMB, the clinically indicated prosthesis following the amputation is PMB-level care.

⁸Section 29(1) Matters for which rules shall provide- (1) *The Registrar shall not register a medical scheme under section 24, and no medical scheme shall carry on any business, unless provision is made in its rules for the following matters- Section 29(1)(o) The scope and level of minimum benefits that are to be available to members and dependants as maybe prescribed; Section 29(1)(q) provides that provision must be made in the medical scheme rules for the payment of any benefits according to: (i) a scale, tariff or recommended guide, or (ii) specific directives prescribed in the rules of the medical scheme*

- b. Regulation 8(1) then requires the Scheme to fund such PMB care “in full” in the absence of a DSP under Regulation 8(2), and the Scheme has not been able to develop a DSP.
- c. Sections 29(1)o and Section 29(1)p should not be interpreted to restrict the Scheme’s Regulation 8(1) liability.
- d. Section 29(1)(p), is in place to prevent default referral to public hospitals.
- e. The Scheme own rules (including rule 16.8 and Annexures) confirms that PMBs should be paid at cost.
- f. A valid quote with specifications was submitted to the Scheme.

51. The Committee agrees with the Appellant that the PMB Guidelines contained in Annexure A provided safeguards into how to manage reimbursements for PMB conditions, and is in place to prevent open ended financial liabilities for Schemes, including for PMB conditions.

52. The Committee accepts the point that there is no supply side regulation of the private sector pricing with the policy and choice of pricing but is of the view that these policy related issues are beyond the remit of the Appeal and Appeals Committee at this juncture; further noting that the Scheme had no DSP in place for these services.

- a. It further points out that the PMB regulations in general and the required review lie in the domain of the National Department of Health.
- b. The Committee does not agree with the Appellants arguments that the Registrar’s application of Regulation 8(1) to fund the cost of the prosthesis in full was flawed and misdirected in this case.

53. In the Supreme Court of Appeal (“SCA”) case, Council for Medical Schemes and another v Genesis Medical Scheme and others⁹ the judge stated that “*the relationship between a medical scheme on the one hand and its members on the other, is not governed solely by that scheme’s rules but also by the obligations imposed by statute upon medical schemes.*” The Judge went further

⁹ Supreme Court of Appeal: Council for Medical Schemes and another v Genesis Medical Scheme and others (20518) [2015] ZASCA 161 (16 November 2015). Para 43

to quote DL Pearmain - The Law of Medical Schemes in South Africa¹⁰ correctly observes that “*although the Act states that the scheme is bound by its rules, if one or more of these rules is contrary to the law the law will take precedence*”.

- a. Accordingly, the Scheme’s reliance only on its own Rules as a basis for limiting its liability is not sustainable in law.

54. It is the Appeals Committee’s opinion that whilst the Service provider did not respond to the discount request, or submit a claim, the quote contained the functional aspects required, and was supported by a letter of motivation.

- a. There was no evidence put to the Committee from the Scheme of the same functionally aligned prosthesis for the patient to be obtained elsewhere at a cheaper cost.

55. The Committee notes that the policy challenge with private sector or supplier side regulation which is beyond the remit of the Appeal Committee in terms of the Section 48(1) Appeal.

56. Further the Committee agrees with the points made of the necessity for the Scheme to implement a DSP for prosthetists soonest, thereby empowering it with measures to manage costs and care within the regulations.

57. In this matter, the Committee further notes that services were not obtained from the public sector and the Rules of the Scheme do not limit PMB to the public sector.

58. From the evidence provided, there is no dispute that the treated condition is a PMB condition.

- a) In terms of submissions and the information provided for the member’s condition, the Appeal committee agrees with the Registrar’s ruling that an below knee prosthesis constitutes PMB level of care for the

¹⁰ DL Pearmain The Law of Medical Schemes in South Africa para 7.1.1

member's condition and that Regulation 8(1)¹¹ of the MSA provides that the diagnosis, treatment and care of a PMB condition must be paid in full.

- b) The Appeal Committee is of the view that the Respondent had abided the rules of the Scheme in terms of Regulation 8(2)¹².
- c) The Appeal Committee is further of the view that the Appellant's case does not meet the criteria for Regulation 8(3)¹³, which is the basis for payment in full and preventing the Scheme from imposing a co-payment as there is no Scheme DSP network in place.
- d) Considering that below -knee prostheses are available at state facilities, the committee agreed with the Respondent that the Scheme should not be allowed to only fund up to the amount that a prosthesis would cost in the public sector as these devices are supplied to the public sector at a much lower cost when compared to the private sector.
- e) The committee is also of the view that the the Scheme should have taken into account the member's age, specific medical condition and complications, which emphasised the need for specific functionality from the prosthesis.
- f) The Appeal Committee, for the reasons above, accepted that the requirements of Regulation 8 for payment in full have been met and concurred with the Registrar's findings.

59. The Committee is also of the view that the Regulations, including Regulation 7, 8 and PMB regulations, including Annexure A, are subordinate legislation made under the Act; and further Scheme approved Rules approved under section 24 of the MSA should not

¹¹ Regulation 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.

¹² 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."

¹³) 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; or
- (c) there was no designated service provider within reasonable proximity to the beneficiary's ordinary place of business or personal residence."

override the Regulations.

60. 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.

FINDING

61. The Member's condition is a Prescribed Minimum Benefit (PMB) and PMB level of care is required.

62. The Scheme therefore must fund the Member's prosthetic leg in full, as provided for in Regulation 8(1) of the Act.

ORDER

63. The Appeals Committee dismisses the Appeal and upholds the Registrar's decision of 12th December 2024.

64. There is no order to costs

DATED AT CAPE TOWN ON THIS 12th January 2026

Dr S Naidoo

For: The Appeal Committee (Presiding officer)

WITH –

Ms P Beck

Dr K Chetty

CONCURRING, IT SO BE RULED