

**IN THE APPEAL COMMITTEE OF THE COUNCIL FOR MEDICAL
SCHEMES**

In the matter between:

DBV

Appellant

and

REGISTRAR OF MEDICAL SCHEMES

Respondent

RULING

[1] On 19 March 2007 the appellant joined the Discovery Medical Scheme and on that date signed a document containing certain terms and conditions to which his membership was subject. His membership became effective from 1 April 2007.

[2] One of the conditions to which the appellant's membership of the scheme was subject read as follows:

“During waiting periods, Discovery Health may pay for certain expenses related to the treatment of specific conditions as required by the Prescribed Minimum Benefits.

You should be aware that the scheme will not pay for Prescribed Minimum Benefits during a “Category A” waiting period. This exclusion also applies in emergency situations that arise both during the three-month general waiting period and the 12 month condition-specific waiting period. . . .”

[3] A Category A waiting period is defined thus:

“If you were not previously a member of a registered South African medical scheme or you had a break in membership of longer than 90 days, we may exclude from cover any claims related to conditions, whether disclosed to Discovery Health or not (including pregnancy and HIV) that existed before your membership became effective. Accordingly, the scheme may impose either the three-month general waiting period or the 12-month condition-specific waiting period or both at its discretion and we advise you to check with your intermediary whether your waiting period is a category A waiting period or not. We may also terminate your membership should we deem a non-disclosure to apply. Please note that the general scheme exclusions will apply to your Discovery Health Plan and we reiterate that we will not cover any Prescribed Minimum Benefits during a category A waiting period.”

- [4] Category B and category C waiting periods, which apply to persons who had previously been members of a registered South African medical scheme, are also defined but these are not relevant for purposes of this case because the appellant had never previously been a member of a medical scheme.¹ Thus, since the appellant disclosed no previous condition for which a condition-specific waiting period of 12 months could be imposed, his waiting period was set at three months from date of commencement² in accordance with the category A definition.
- [5] In the early morning hours of 27 May 2007 (that is, still within the three-month waiting period) the appellant suffered a severe pain on the right hand side of his abdomen. His partner, Ms H, called the scheme's emergency number³ that is reflected in the membership card and enquired whether the appellant would still have to wait until expiry of the three-month waiting period before calling an ambulance (presumably for the scheme's account). The consultant's answer was that she can call an ambulance.
- [6] The appellant now considers this answer as acquiescence by the scheme in funding his admission to hospital and treatment received there. The scheme points to the terms and conditions and says even Prescribed Minimum Benefits are not funded during the waiting period. The

¹ See part J of the application form

² 1 April 2007

³ Discovery 911

Registrar found in the scheme's favour and now the appellant appeals against that ruling.

- [7] It is common cause that the scheme has paid for the cost of the ambulance.
- [8] The definition of a category A waiting period mirrors the provisions of section 29A(1) of the Medical Schemes Act.⁴ The only material difference is that where the section is silent as regards whether or not Prescribed Minimum Benefits will be funded during the waiting period, the definition expressly excludes such funding.
- [9] The significance of this emerges from a comparison between section 29A(1) on the one hand, and sections 29A(2)(a) and 29A(3) on the other. While the latter two sections provide that the waiting period does not apply in respect of the treatment and diagnosis of Prescribed Minimum Benefits, section 29A(1) makes no such provision. Thus, on a plain reading of section 29A(1), applicants for membership of a medical scheme who had not previously been members of a medical scheme for at least 90 days prior to date of application are not covered for Prescribed Minimum Benefits during either the general waiting period of three months or the condition-specific waiting period of 12 months.

⁴ 131 of 1998 – “the MSA”

Those who have previously been members are, however, covered on a plain reading of sections 29A(2)(a) and 29A(3).

- [10] The reason for this distinction is not hard to find. The medical history of an applicant who has previously been a member of a medical scheme is easier to procure than that of an applicant who has not previously been a member for the preceding three months or more.⁵
- [11] Section 29A(1) read together with the definition of a category A waiting period converge to form an insurmountable difficulty for the appellant. The section does not envisage cover for Prescribed Minimum Benefits in respect of category A applicants, while category A makes it quite clear that Prescribed Minimum Benefits will not be covered during the waiting period.
- [12] The appellant avers that he was misled into believing that his condition would be covered. The transcript of the telephone conversation with Ms H does not bear that out. At no stage did the scheme's consultant say the appellant will be covered for Prescribed Minimum Benefits. What she said was that the appellant "can call an ambulance". That is a far cry from that for which the appellant contends.

⁵ The records of former members are usually destroyed by schemes after 3 months.

[13] In these circumstances, the appeal cannot succeed.

V NGALWANA for the appeal committee

Date of Hearing: 12 August 2008
Date of Ruling: 8 September 2008

For Appellant: Mr DBV
For the scheme: Mr Krawitz
For Registrar: Mr Mavuso