

APPEAL COMMITTEE OF THE COUNCIL FOR MEDICAL SCHEMES

In the matter between:

G [REDACTED]

Appellant

and

REGISTRAR OF MEDICAL SCHEMES

First Respondent

LIBERTY HEALTH MEDICAL SCHEME

Second Respondent

RULING

- 1 This is an appeal² against a decision of the office of the registrar in which it found that the scheme had correctly made a short payment for an elective dental procedure. The scheme's annual limit for the procedure under the appellant's chosen benefit option is R6 300.00. The scheme paid R2 100 leaving the balance for the member's account.

- 2 The appellant says telephonic authorisation was granted for payment of the entire cost of the procedure without co-payment. She says a copy of the

¹ Now Mrs van der Walt

² The appeal hearing was chaired by Adv Gumede. For purposes of preparing the ruling I read the documents and listened to the audio recording of the appeal hearing.

written authorisation was received only weeks after the procedure had been done. The written authorisation contains a disclaimer that where membership commences during the benefit year, benefits would be pro-rated. The result of this is that where a member joins the scheme, say, in September, only one-third of the annual limit will be funded. That is what has occurred in this case.

3 The appellant takes the view that because this was not conveyed to her or to her spouse who underwent the procedure, the scheme must pay in full. She says when the telephonic authorisation was granted in conversation with one Isabel of the service provider's office, it was confirmed to her that the scheme would pay the full amount. The scheme does not deny this.

4 I have listened to the tapes of the telephonic authorisation. There is no doubt that what was conveyed was that the procedure would be covered in full. There was no mention of any pro-rated benefits. There was no mention of any co-payment. The scheme cannot escape the responsibility that flows from that representation.

5 The pro-rating of benefits where membership commences during a benefit year is countenanced by regulation 9 to the Medical Schemes Act, 131 of 1998. The authorisation letter contains a disclaimer to this effect. But this is not the issue. The issue is whether this was conveyed in clear and unambiguous terms during the telephonic authorisation. On the undisputed facts, not less than five persons confirmed with her that full payment will be made by the scheme for the procedure. The recorded telephonic authorisation confirms this.

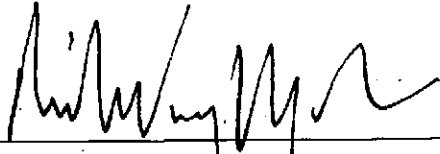
- 6 After receiving the written authorisation, Isabel telephoned the scheme to enquire whether the benefit would be paid in full and this was confirmed. No evidence was presented of a contract between the scheme and the appellant indicating the pro-rating of benefits.

- 7 It is correct that benefits are governed by the rules read together with the schedule of benefits applicable to the benefit option to which the member belongs. But where misrepresentation is made by the scheme to the member as regards the extent of cover for authorisation in relation to a particular procedure, the scheme cannot seek refuge in the rules.

- 8 The scheme's representative at the hearing called the telephonic authorisation a "red hearing". He says we have no jurisdiction to grant delictual relief founded on misrepresentation by the scheme and its agents. He says that in effect would be what we would be doing if we relied on the 5 cases of what now appears to have been a misrepresentation. He says we are to make "nothing" of these instances of misrepresentation.

- 9 These are extraordinary submissions in the circumstances. What the scheme's representative in effect says is that the scheme is immune from any liability when it misleads members into believing that a procedure will be covered in full while the benefit option provides otherwise.

- 10 When pointed to the scheme's written authorisation that provides for "100% of cost unlimited up to negotiated tariff" the scheme's representative seeks refuge in the pro-rating provisions. But this does not detract from the misrepresentation to the appellant.
- 11 The submission that we do not have delictual jurisdiction was no more than that – a submission – without any attempt at pointing to any authority for it. I doubt it is a correct exposition of the powers of this committee.
- 12 In these circumstances, the scheme must make good on its representation on which the appellant relied and is, as a result, out of pocket. She says she paid R6 200 and the scheme has not denied this.
- 13 The scheme is directed to pay for the benefit in full.
- 14 A lesson for all schemes is that clear and unambiguous communication with members is crucial. The scheme cannot absolve itself from liability where its agents make certain representations to a member on which a member relies to her detriment. Moreover, a scheme cannot seek refuge in the rules where its agent has misrepresented the true position as regards the extent of cover to a member. Otherwise, schemes would with impunity promote their products under false pretences. If permitted to continue, that would be unconscionable.



VUYANI NGALWANA for Appeal Committee

For the Appellant: Ms [REDACTED] G [REDACTED]

For the 2nd respondent: M Kanyane

Date of hearing: 11 February 2010

Date of Ruling: 15 June 2010