HSF Health Plan®

HSF Health Plan (Malta) for Employees from **€1.50 a week**

Everyday Wellness Plans



hsfhealthplan.com.mt | Tel: +356 2778 0685

Helping you to cover the costs of everyday healthcare

Who is HSF Health Plan (Malta)?

HSF Health Plan (Malta) is a health cash plan provider, committed to delivering simple and affordable ways to help you cover the cost of everyday healthcare such as dental, optical and physiotherapy, plus much more.
Our plans are intended for employees in Malta.

HSF Health Plan (Malta) Ltd, with company registration number C 93406 and registered office address at No. 4, Triq Sant' Andrija, Valletta VLT 1341, Malta, is the trading company of The Hospital Saturday Fund, a Registered Charity in the UK No 1123381 and in Ireland Registered Charity No 20104528.

HSF Health Plan (Malta) Limited is authorised under the Insurance Business Act (Chapter 403 of the Laws of Malta) and regulated by the Malta Financial Services Authority to carry on business of insurance in Malta.

How does it work?

It's simple. You pay a premium for the plan that suits you best, then you claim cash back for your treatments as and when you need it. The maximum payable shown in any 12 consecutive calendar months.

What am I covered for?

Our Everyday Wellness Plans EW1 to EW5 offer a wide range of health categories at affordable prices and we reimburse you up to 100% of your professional costs up to the maximum shown in the benefits table.

There is a total limit on benefits calculated on a rolling balance over a 12 month basis with a further limit from the start of your policy on some hospital benefits. Please see 'Policy Terms & Conditions' on pages 12 & 13 in this brochure.

Are there any restrictions?

There are pre-existing health restrictions on all benefits (see 'Waiting periods' and 'Restrictions' on pages 12 & 13) with the exception of Dental, Optical, General Practitioner, Accident & Emergency and Chiropody/Podiatry.

Waiting Periods

Claims incurred from the inception date of the policy for Dental, Optical, General Practitioner, Accident & Emergency and Chiropody/Podiatry can be retained and submitted after 3 months.

Claims incurred during the first 3 months of the policy under the Consultation, Medical Tests, Practitioners (excluding Chiropody/Podiatry), Hospital, Day Case and Recuperation categories do not qualify for settlement.

Claims related to pregnancy or fertility incurred in the first 10 months of the policy under the Consultation, Medical Tests, Practitioners (excluding Chiropody/Podiatry), Hospital, Day Case and Recuperation categories do not qualify for claim settlement.

Claims under the Birth and Adoption Grant category do not qualify for claim settlement if the birth or adoption is in the first 10 months from the inception date of the policy.

Claims relating to Eye Laser Treatment and Implantable Contact Lenses may be made following the first 6 months of cover. Please refer to page 12 for further details on waiting periods.

Making a claim

Claim forms can be obtained by downloading a form from our website or by contacting our office on + 356 2778 0685 (our address can be found on page 21).

Original receipts must be sent with the claim form. Your payment will be made direct into your bank account (a current account in your name or joint names). All claims must be submitted within six months of the date of treatment/purchase, accident taking place or discharge from a hospital. Claims can only be considered if appropriate premiums have been paid.

Duration of the policy

Your policy is renewed automatically on a monthly basis unless you cancel the policy or your premiums fall into arrears.

Can I cancel my policy?

When your application is accepted, you will receive a "Welcome Pack" via email. We can send this by post if required. On receipt of this, you have 14 days in which to write to us and change your mind. Please see 'Decreasing or ceasing premiums' on page 13.

How to complain

Should you find it necessary to make a complaint, you should in the first instance contact our Customer Services Department at complaints@hsfhealthplan.com.mt.
If your complaint has not been resolved within 15 days, we will explain why it remains unresolved and inform you of your right to refer the matter to the Office of the Arbiter for Financial Services, N/S in Regional Road, Msida MSD 1920, Malta. Email to Complaint.info@financialarbiter.org.mt or telephone on Freephone: 80 072 366 or (+356) 21 249 245. Their website address is www.financialarbiter.org.mt

The Office of the Arbiter for Financial Services (OAFS) is an autonomous and independent body.

It has the power to mediate, investigate and adjudicate complaints filed by customers against financial services providers. Consumer complaints against financial institutions licensed by the Authority may be lodged by residents and non-residents at the Office of the Arbiter for Financial Services in terms of Act XVI of 2016 – The Arbiter of the Financial Services Act, 2016.

The Arbiter will try mediation as the first and best option for resolving the matter. If the mediation

has not been successful or has been refused, the Arbiter will start investigating your complaint. All the circumstances surrounding the complaint will then be examined and the case will be judged on its individual merits.
For more information, please refer to the complaints procedure on our website: hsfhealthplan.com.mt

HSF Health Plan (Malta) & The Hospital Saturday Fund
HSF Health Plan (Malta) is a trading company of the registered charity, The Hospital Saturday Fund. All those who join HSF Health Plan (Malta), just by belonging, are making a contribution to the important work of the charity, not something which usually happens when an insurance policy is taken out.

HSF Health Plan (Malta) is an insurance undertaking, and all information is provided in order for applicants to choose the plan to suit their personal circumstance as HSF Health Plan (Malta) is not authorised to provide a professional recommendation.

Statement of demands and needs
This product meets the demands and needs of individuals who wish to manage their healthcare expenses such as dental and optical, hospital admissions, consultations and investigations. Advice is not available from HSF Health Plan (Malta) and HSF Health Plan (Malta) is not in a position to determine whether the product is appropriate for you. Applicants should choose the plan to suit their personal circumstances and review in future whether this remains suitable.

Definitions

Accident
An accident is defined as a sudden unforeseen and fortuitous identifiable event and the word accidental shall be construed accordingly.

Day Case
Treatment which, for medical reasons, normally requires a patient to occupy a bed in hospital or clinic but do not have to stay overnight.

General practitioner
A medical practitioner in general practice whose name is enlisted into the Medical Council's register in Malta.

In-patient treatment
Treatment which, for medical reasons, means that you have to occupy a hospital bed overnight or for longer.

Out-Patient
Preventive, diagnostic or treatment services received in a hospital, out-patient clinic or pharmacy consulting room. Such services do not require the patient to occupy a bed in a hospital or clinic.

Invasive investigation
An invasive procedure is one where purposeful/ deliberate access to the body is gained via an incision, percutaneous puncture, where instrumentation is used in addition to the puncture needle, or instrumentation via a natural orifice. It begins when entry to the body is gained and ends when the instrument is removed, and/ or the skin is closed. Invasive procedures are performed by trained healthcare professionals using instruments, which include, but are not limited to, endoscopes, catheters, scalpels, scissors, devices and tubes.

Medical practitioner
A person who has a degree in the practice of medicine, surgery or dentistry, having attended a medical school recognized in Malta. This person must be licensed to practice such medicine, surgery or dentistry by the Medical Council.

Specialist / Consultant
A medical practitioner who is registered in the Medical Council register in Malta and who is currently practising in the area of specialisation for which the beneficiary needs treatment.

Waiting period / Qualifying Period
A waiting / qualifying period is the amount of time an insured must wait before some or all of their coverage comes into effect.

Pre-existing health condition
Any disease, illness, injury, signs, symptoms and results of investigations for which you have received medical advice or treatment or of which you have experienced symptoms prior to the inception date of your policy, whether medical attention has been sought or not.

Malta
"Malta" means the Maltese islands and shall be construed accordingly throughout the brochure.

HSF Health Plan (Malta)
Throughout this brochure, when "HSF Health Plan (Malta)" is used, it should be understood as a shortened form of our legal name, "HSF Health Plan (Malta) Limited".

Benefits Summary

	Plan EW1	Plan EW2	Plan EW3	Plan EW4	Plan EW5
Weekly premium	€1.50	€2.50	€5.00	€7.50	€10.00
Monthly premium	€6.50	€10.83	€21.67	€32.50	€43.33

Benefits	Claim allowance				
Dental	€50	€75	€100	€125	€150
Optical	€50	€75	€100	€125	€150
GP, Prescribed Drugs & A&E Limit: 12 occasions	€10	€15	€20	€25	€30
Practitioner Physiotherapy, Physical Therapy, Osteopathy, Chiropractic.	€75	€100	€200	€300	€400
Wellbeing & Alternative Treatments Acupuncture,Homeopathy, Chiropody/Podiatry.	€75	€100	€200	€300	€400
Consultations	€100	€130	€250	€370	€490
Medical Tests	€80	€100	€160	€240	€320
Birth / Adoption Grant Amount per child	€100	€200	€300	€400	€500
Day Case - Surgery and Treatment Limit: 4 occasions	€25	€30	€50	€75	€100
Hospital Limit: 25 nights	€25	€30	€50	€75	€100
Recuperation Limit: after 10 nights	€50	€85	€170	€250	€330

Our Everyday Wellness Plans

HSF Health Plan's (Malta) Everyday Wellness Plans have been specially designed for individuals who wish to claim up to a 100% cash refund on many of their healthcare expenses. Dental, optical, physiotherapy, consultations and medical tests and a number of complementary treatments are included, and we also pay grants for general practitioner visits and prescription charges.

Everyday Wellness Plan choices

We offer 5 different plans to choose from, ranging between €1.50 and €10.00 per week. All you have to do is select the one which best suits your needs.

How to join

1. Select the plan which suits you best.
2. Complete the application form from page 18 onwards.
3. Provide all the medical information requested on page 19.
4. Complete the payroll deduction form on page 20.
5. Send all completed forms to the address printed at the bottom of the payroll deduction form on page 20 or hand them to an HSF Health Plan (Malta) Account Executive – we will do the rest.

A welcome pack will be sent to you via email and the date stated on the welcome letter will denote when your cover started.

Pre-existing conditions and health problems

If you have a pre-existing health condition, there will be a waiting time before cover for certain claims will start. There is a waiting period of 5 years from when you are first registered for cover before you can claim for any pre-existing health conditions. In addition, should you wish to increase cover for this section, a further 2 years waiting time from the time of increase will apply for a claim to be valid under the increased limit of cover.

Claims

You may start making claims three months after your policy start date, unless otherwise stated. Reimbursement for most claims is made on a rolling balance principle over any 12 consecutive months. This period starts from the date we pay your claim. See pages 13 and 14 for full details.

Weekly/monthly costs	Plan EW1	Plan EW2	Plan EW3	Plan EW4	Plan EW5
Weekly premium	€1.50	€2.50	€5.00	€7.50	€10.00
Monthly premium	€6.50	€10.83	€21.67	€32.50	€43.33



Benefits and Claim Allowances

Dental & Optical

	Plan EW1	Plan EW2	Plan EW3	Plan EW4	Plan EW5
Dental	€50	€75	€100	€125	€150
Optical	€50	€75	€100	€125	€150

Financial help towards the cost of all dental treatment including check-ups, and the cost of a sight test and optical appliances, up to the maximum shown. This benefit may be used flexibly according to requirements for both categories. It is payable in any 12 consecutive calendar months. The cost of Eye Laser Treatment, Implantable Contact Lenses (to correct long or short sightedness) and assessments claims can only be accepted at least 6 months after the policy start date.

General Practitioner, Prescribed Drugs and Emergency Department

	Plan EW1	Plan EW2	Plan EW3	Plan EW4	Plan EW5
GP, Prescribed Drugs & A&E Limit: 12 occasions	€10	€15	€20	€25	€30

An amount payable towards the cost of a visit to a General Practitioner (Family Doctor), prescribed drugs or an attendance at an Accident and Emergency Department in a public or private hospital/clinic. Limited to 12 payments in any 12 consecutive calendar months. **The maximum repaid per visit or purchase is as shown or actual charges if less.**

Practitioner: Physiotherapy, Physical Therapy, Osteopathy, Chiropractic

	Plan EW1	Plan EW2	Plan EW3	Plan EW4	Plan EW5
Practitioner Physiotherapy, Physical Therapy, Osteopathy, Chiropractic.	€75	€100	€200	€300	€400

Financial help towards the cost of consultation and treatment (not including medication or appliances) by a qualified and registered practitioner in the categories above, up to the maximum shown. This benefit may be used flexibly according to requirements for all categories. Payable in any 12 consecutive calendar months.

Wellbeing & Alternative Treatments: Acupuncture, Homeopathy, Chiropody/Podiatry

	Plan EW1	Plan EW2	Plan EW3	Plan EW4	Plan EW5
Wellbeing & Alternative Treatments Acupuncture,Homeopathy, Chiropody/Podiatry.	€75	€100	€200	€300	€400

Financial help towards the cost of consultation and treatment (not including medication apart from Homeopathy or appliances) by a qualified and registered practitioner in the categories above, up to the maximum shown. This benefit may be used flexibly according to requirements for all categories. Payable in any 12 consecutive calendar months.

Consultations

	Plan EW1	Plan EW2	Plan EW3	Plan EW4	Plan EW5
Consultations	€100	€130	€250	€370	€490

Financial help towards the cost of specialists' consultation fees listed in the rules, **all undertaken on an outpatient basis (consultation carried out as an A&E visit are not covered)** up to the maximum shown. Payable in any 12 consecutive calendar months.

Medical Tests

	Plan EW1	Plan EW2	Plan EW3	Plan EW4	Plan EW5
Medical Tests	€80	€100	€160	€240	€320

Financial help towards the cost of medical tests including initial allergy testing, vaccination, health screening, pathology tests, x-rays, scans, electrocardiograms and other investigations listed in the rules, **all undertaken on an outpatient basis (medical tests carried out as an A&E visit are not covered),** up to the maximum shown. Payable in any 12 consecutive calendar months.



Birth / Adoption Grant

	Plan EW1	Plan EW2	Plan EW3	Plan EW4	Plan EW5
Birth / Adoption Grant Amount per child	€100	€200	€300	€400	€500

A benefit payable to the policyholder, whether the mother or father of the baby, for each registered birth in hospital or at home. Hospital benefit is payable for the mother (if the policyholder) in addition to the grant from the sixth night onwards. The grant is also payable for a registered adoption up to the age of 10. **Claims for this grant only qualify for claim settlement where the birth or adoption is at least 10 months from the inception date of the policy.**

Day Case Surgery and Treatment

	Plan EW1	Plan EW2	Plan EW3	Plan EW4	Plan EW5
Day Case - Surgery and Treatment Limit: 4 occasions	€25	€30	€50	€75	€100

For a planned admission to occupy a bed for a day in a public or private hospital to undergo surgery, treatment or a procedure. Limited to 4 occasions within any 12 consecutive calendar months.

All amounts shown are per day.

Hospital

	Plan EW1	Plan EW2	Plan EW3	Plan EW4	Plan EW5
Hospital Limit: 25 nights	€25	€30	€50	€75	€100

General Hospitalization: For an in-patient admission to a hospital to receive medical treatment. Payable for up to 25 nights in any 12 consecutive calendar months. (See pages 10 & 11 for full details).

Accident: For an in-patient admission to a hospital immediately following an accident. Payable for up to 25 nights in any 12 consecutive calendar months. (See pages 10 & 11 for full details). There is no waiting period if the admission is in relation to an accident.

Elderly and Mental Illness: For an in-patient admission to a hospital for elderly medical care / long stay / rehabilitation / respite or for a mental illness. Payable for up to 35 nights elderly and 35 nights mental illness from the date your policy began, but not for more than 25 nights in a 12 month period. (See pages 10 & 11 for full details).

All amounts shown are per night.

Recuperation

	Plan EW1	Plan EW2	Plan EW3	Plan EW4	Plan EW5
Recuperation Limit: after 10 nights	€50	€85	€170	€250	€330

Following each stay in a hospital or hospice for which benefit has been paid for a minimum of 10 nights, a recuperation grant is payable.



Policy Terms & Conditions *(please read carefully)*

HSF Health Plan (Malta) Limited is the provider of this health plan.

About the HSF Health Plan (Malta) plans in this brochure

The plans provide standard cover against in-patient &/or out-patient costs such as visits to practitioners such as the dentist, optician and various other practitioners, grants for hospital admissions and additional benefits such as the birth / adoption of a child.

The limits provided by the various plans are explained on pages 6-9 of this brochure. The following conditions apply in addition to the General terms and conditions section of the 'Rules and further explanations of categories' or 'General terms and conditions':

- There is a total limit on payments this is calculated on a rolling balance over a 12 month period basis with a further limit from the date your policy began on some of the hospital benefits. See 'Claims' on pages 13 & 14 and 'Hospital' on pages 11 & 12.
- Claims cannot be accepted until at least three months after your policy inception date, unless otherwise stated.
- Existing health conditions and health problems present when you take out a new policy or increase cover are not covered for an initial period under many plan categories. See 'Waiting periods', 'Restrictions' and 'Increasing premiums' on pages 12 &13.
- Switching between plans is allowed. See 'Increasing premiums' and 'Decreasing or ceasing premiums' on page 13 for the terms.

Full policy terms and conditions, and the cover provided, are shown in this brochure.

Paying premiums

Details of the prices of each plan are shown in this brochure. Payment can be made by payroll deduction through your employer. It is the Policyholder's responsibility to check that payments have commenced, either by checking their payslip, or with their payroll, in order that they are received regularly by HSF Health Plan (Malta). When your application is accepted you will receive a welcome pack via email. This will include details of any restrictions which are in place if you have any existing medical conditions.

Changing your mind

On receiving confirmation of your policy, you have 14 days in which to change your mind and withdraw your application (telephone or write to the HSF Health Plan (Malta) office – details on page 24). If any premiums have been paid you will receive a full refund providing no claims have been settled. See 'Decreasing or ceasing premiums' on page 13 for cancelling after this period.

Duration of cover

Cover is provided continuously from month-to-month, beginning with your policy start date, until it is cancelled or otherwise comes to an end. It is automatically renewed.

Making a claim

Upon marking three months after the start date of the policy or another stated period, you may start claiming. Claim forms are provided on request by calling the HSF claims team or can be downloaded from our website. Please scan or post the original receipt and submit with your claim form. Please quote your policy number. Your payment will be made direct into your bank account (a current account in your name or joint names).

Rules and Further Explanations of Categories

Dental and Optical

The dentist or optician must be suitably qualified and listed under the Medical Council Registers. Sundry items purchased at Dental Surgeries and Opticians premises, eg. solutions, cleaners, contact lens removers and floss are not covered and charges for any kind of medication are not covered under this category. Claims cannot be accepted for the purchase of spectacles or contact lenses supplied without prescription (a copy of the prescription must be submitted when claiming under this benefit) or for any dental treatment (including teeth whitening) not carried out at a dental surgeon's practice (eg. if undertaken at a cosmetic/retail outlet).

Consultations with Consultant Oral Surgeons, Consultant Facio-Maxillary Surgeons, Consultant Orthodontic Surgeons and Consultant Ophthalmic Surgeons are not covered under this category. These should be claimed under the Consultations category. The cost of treatment or operative procedures undertaken by these Consultants is not included in any category. If Eye Laser Treatment or a permanent contact lens implant (to correct long or short sightedness) is carried out by a Consultant Ophthalmic Surgeon or undertaken in hospital as a day case patient or an inpatient, claims cannot be accepted for Consultations, Medical Tests or for Hospital or Day Case, in addition to the Optical category.

The cost of Eye Laser Treatment, Implantable Contact Lenses (to correct long or short sightedness) and assessments claims can only be accepted at least 6 months after the policy start date.

Rules concerning pre-existing conditions do not apply to this particular category.

General Practitioner, Prescription and Emergency Department

The amount is repaid up to the maximum (but if the actual charge is less, only this amount will be refunded) on the production of a paid receipt supplied by one of the following:

1. General Practitioner
(Family Doctor), indicating minor surgery. Any procedures carried out during the visit are covered by the grant and may not be claimed for separately under this or any other category;

2. Pharmacy
(Dispensing Chemist), indicating that a prescription supplied by a registered pharmacy has been dispensed. Only one grant is payable on each receipt regardless of the number of items;

3. Hospital/Clinic
Under the General Practitioner section, Hospital/Clinic is indicating attendance at an Accident and Emergency Department. Limited to 12 individual grants in total between the above three types in any 12 consecutive calendar months. Rules concerning pre-existing conditions do not apply to this particular category.

Practitioner: Physiotherapy, Physical Therapy, Osteopathy, Chiropractic

The maximum payable is split between Physiotherapy, Physical Therapy, Osteopathy, Chiropractic. For example, €300 is the maximum payable under Plan EW4. Claims will only be accepted following the provision of paid receipts from qualified practitioners. Policyholders, in their own interests, should only consult with properly qualified practitioners who are registered with professional organisations which maintain high standards. This benefit does not cover the cost of any medication or any surgical appliances supplied or prescribed by the practitioners. Claims cannot be accepted for prophylactic treatments or sports massage/therapy.

Wellbeing & Alternative Treatments: Acupuncture, Homeopathy, Chiropody / Podiatry

The maximum payable is split between Acupuncture, Homeopathy, Chiropody / Podiatry. For example, €300 is the maximum payable Under Plan EW4. Claims will only be accepted following the provision of paid receipts from qualified practitioners. Policyholders in their own interests, should only consult with properly qualified practitioners who are registered with professional organisations which maintain high standards. This benefit does not cover the cost of any medication (apart from Homeopathy) or any surgical appliances supplied or prescribed by the practitioners. Consultations with Consultant Podiatric Surgeons (of hospital consultant status) are not covered in this category because they should be claimed under the Consultations category. The cost of treatment or operative procedures undertaken by these consultants is not included in any category. Rules concerning pre-existing conditions do not apply to Chiropody/Podiatry.

Consultations & Medical Tests

Claims must be for consultations held in a hospital or clinic on an outpatient basis only and carried out by a doctor of consultant status. Treatment (including radiotherapy) and operative procedures (including delivery of a baby) are not covered, neither is any radiography during such treatment/ procedures. Reimbursement is only on the initial consultation with a Consultant Psychiatrist, subsequent visits are classified as treatment. Claims will not be accepted for examinations / investigations carried out while an inpatient or as a day case or for medico-legal reports, possible legal evidence (including paternity testing), or for insurance, employment, fitness/occupational assessments or immigration/emigration purposes.

The following are covered under Medical Tests:

Any out-patient investigations undertaken in a hospital such as an X-ray, MRI/CT scanning, pathology or nuclear medicine / medical physics department (or its equivalent elsewhere); electrocardiogram (ECG), electroencephalogram (EEG); electromyogram (EMG); audiogram and orthoptic investigations. Minor invasive investigations carried out at the same time as an out-patient consultation, and not requiring the use of a separate treatment room, are also covered. Claims are accepted for visits to health screening clinics and for the cost of a vaccination administered at a GP surgery or clinic or the issue of a prescription for a vaccination (which may be in the form of vaccine or medication).

For allergy testing the initial consultation and diagnosis of problems by a qualified practitioner with a personal consultation in a clinical environment is covered but not any subsequent consultation, therapy or treatment.

The following are NOT covered

Invasive investigations, such as endoscopies, carried out with some form of anaesthetic, and requiring the use of an out-patient treatment room (for which the hospital or clinic charges an additional fee) or occupancy of a bed on a day stay basis. The Day Case benefit may be claimed in these circumstances if applicable.

Birth Grant and Adoption Grant

A claim will not be considered for births or adoptions occurring within the first 10 months of cover. This period also applies to anything relating to pregnancy and fertility under the Consultation, Medical Test, Practitioners (excluding Chiropody/Podiatry), Hospital, Day Case and Recuperation categories. The Birth Grant is also applicable for a still birth if an official death certificate is submitted and the still birth is not within the first 10 months. The Adoption Grant can only be claimed up to the child's 10th birthday.

Hospital

The hospital must be in Malta and its name, admission and discharge dates along with a copy of the discharge letter must be submitted with the claim form. Benefit is payable for up to a maximum of 25 nights as a patient in any consecutive 12 calendar months. The amount payable is the stated grant and no direct costs (e.g. consultants' fees, room

charges, medication/dressings involved with the hospital admission) are covered. Stays in nursing or convalescent homes are not covered.

Benefit is restricted to a maximum of 35 nights in total in a period of continuous cover, regardless of plan, for admissions to mental illness and geriatric (elderly medical / long stay / rehabilitation / respite care) wards. These 35 nights are counted as part of and not in addition to the ruling in the sentence above eg. within a 12 month period the number of nights for which benefit is payable will not exceed 25, regardless of the reason for admission.

In accordance with the usual practice, the date of admission is counted as the first night but the date of discharge is not counted. Time spent within an Accident and Emergency Department (A&E) is not considered as part of an admission unless the hospital declares it to be so in accordance with their records. Claims must be submitted after each discharge from hospital. Weekend leave or longer periods of home leave do not count as a discharge, although no amounts will be paid for nights spent at home. Transfers from one hospital to another without a period at home in between are counted as a continuous period in hospital.

Invasive investigations, such as endoscopies, carried out In In cases of long stay admissions, a claim may be submitted after 25 nights and an amount will be paid up to the number of nights due within the rules. Recuperation only, as appropriate, will be payable upon discharge. However, if an admission extends beyond 12 months a further claim may be submitted. There are special rules for these unusual circumstances. If, on the date of admission to hospital, the benefit limit is shown to have been reached in the preceding 12 months then no payment is made for that admission at all unless the current admission is of a duration which takes it past the anniversary of the discharge date 12 months earlier. In these cases the balance of nights due will be paid.

Recuperation

This grant is paid automatically, subject to qualifying for the appropriate number of nights in the hospital categories and actually having been discharged. There is no requirement to make an additional claim. If re-admissions occur after less than seven nights following discharge, and the second or subsequent admissions by virtue of their length would also qualify for a grant, only one such grant will be paid at the rate set for the longest of the admissions. The grant is not payable when the patient dies in hospital or if an admission includes a confinement and qualifies for the Birth Grant.

Day Case Surgery and Treatment

The claim form must be signed by a medical official at the hospital and bear the official stamp to verify the information given by the policyholder. Policyholders admitted overnight following a Day Case attendance will be entitled to the Hospital and not the Day Case benefit. The following are not included: Geriatric, psychiatric or rehabilitation day hospitals or units; an unplanned day or period spent in an Accident and Emergency or Casualty Department; minor surgery, treatment or procedures undertaken in outpatient or similar departments. The amount payable is the stated grant and no direct costs, e.g. consultants' fees, room charges, medication/ dressings involved with the hospital admission are covered.

Becoming a Policyholder

Anyone who is 18 and over and is an employee of a group or company offering a payroll deduction facility for the product may apply for cover indefinitely, and cover will continue for life if the policyholder so wishes, and if:

a. Premium payments are kept up to date via your salary deductions which your payroll department must submit directly to HSF Health Plan (Malta) and

b. The rules and conditions are adhered to.

Cover is provided continuously from month to month until it is cancelled or otherwise comes to an end. You will not receive renewal documentation unless we change the terms and conditions of your policy. When your application is processed you will receive a welcome pack. Upon its receipt you have 14 days in which to change your mind (telephone or write to HSF Health Plan (Malta) at: Avenue 77 Business Centre, Level 2. Office 237, Triq in-Negozju, Zone 3, Central Business District, Birkirkara, CBD 3010, Malta.

If any premiums have been paid you will receive a full refund providing that no claims have been settled during this period.

Waiting periods

All claims are not valid within the first 3 months of cover, apart from:

1. Claims under the Dental, Optical, General Practitioner, Accident & Emergency and Chiropody/ Podiatry (expenses incurred for these claims may be retained and submitted after 3 months from the inception of cover).
2. Under the Birth and Adoption Grant, where claims may only be made following the first 10 months of cover and this time also applies to other categories if the claim is related to infertility or pregnancy; and
3. Eye Laser Treatment and Implantable Contact Lenses where claims may only be made following the first 6 months of cover . Any temporary restrictions (see paragraph below), include conditions which existed or for which symptoms were present before your cover began; development of existing conditions; recurrence of conditions which have existed in the past; hereditary, congenital or perinatal conditions which may already exist but which manifest symptoms only after cover commences and any which previously existed but were not disclosed. Until the relevant waiting periods have been served, it may also be necessary to refuse claims relating to a particular area or structure of the body where there has been a problem in the past unless medical advice indicates that there is no connection.

The above restrictions for pre-existing conditions are removed after set waiting periods from the date your policy began, or from the date of any increase in cover.

The set waiting periods are:

a. On first registration: 5 years.
and
b. For increases: 2 years.

The set waiting period may be reduced for cover from the date your policy began (but not increases) where; Immediately prior to cover on this policy starting, you were covered for the pre-existing condition under an HSF Health Plan (Malta) policy in which case the previous level of cover will be maintained.

Any claim for any benefit that relates to an accident can be made immediately once your policy has been issued. Should you need to claim during the Waiting Period as a result of an accident, you will need to include with your claim submission, details of the accident and any substantiating evidence that the treatment you received for which you are claiming for, was a result of that accident.

Any pre-existing health conditions will be taken into account as to the injuries sustained.

Restrictions

Claims cannot be accepted for anything related to plastic surgery and consultations / treatment for cosmetic reasons; addictions (eg misuse of alcohol or drugs); self harm or self inflicted injuries or HIV / AIDS; Infertility Treatment. Conditions which begin during the three month period after cover commences should be notified in writing and you will then be advised if any restrictions apply. Optical, Dental, Chiropody/Podiatry, General Practitioner/Emergency Department and Prescription are the only categories not subject to the pre-existing condition rules.

No policyholder may be named in more than a single plan. These rules are based on the insurance principle of not being able to make a profit from the reimbursement of any expenditure.

Change of address

Any change of address must be notified in writing to HSF Health Plan (Malta) so that our records remain up-to-date.

Death of a policyholder

When a policyholder dies, any outstanding claims at the time of death will be settled as appropriate, payments being made on production of the required proof of entitlement.

Payment of premiums

Policyholders should check that payments have commenced in order that they are received regularly by HSF Health Plan (Malta). Policyholders who fall into arrears for more than six months will be required to rejoin under the usual conditions of enrolment.

Increasing premiums

Any existing policyholder is able to apply to increase to a higher value plan by completing an application form.

Acceptance may be subject to a proviso or restriction and a waiting period for any new health condition which may have arisen. In transfers to any plan, the periods before claims may be submitted are waived in all categories except the following: Birth and Adoption Grants; all other categories if the claim is associated with pregnancy; Eye Laser Treatment in the Dental and Optical category only when transferring from EW1 to a higher Plan. If it is less than three months since the policy start date at the time of any plan transfer all such periods will apply.

Claims related to medical conditions existing at the time of increasing or linked to previous medical conditions will be paid at the appropriate former plan rate. There may be circumstances where categories are grouped together for flexibility (eg. Practitioners) when it is necessary to settle claims at a former plan rate for all categories in that group.

Decreasing or ceasing premiums

While it is possible to reduce premiums by transferring to a lower plan, cover at the higher plan should have been of at least six months' duration before such an application is made. Entitlement at the higher rate then ceases immediately upon transferring. If the maximum has been reached in any category in the higher rate plan, there will be a period of six months before claims may be submitted under the new lower rate plan. Cover at the new lower rate plan must be of at least 12 months' duration before increasing or decreasing again.

Policyholders who wish to cease premiums should provide written notification to HSF Health Plan (Malta). Past premiums will not be refunded. Entitlement to claim will continue throughout any period of time covered by premiums. Any errors in premium payments must be notified to HSF Health Plan (Malta) within two years of the occurrence for refunding to be possible.

Claims

Claims will not be paid unless the appropriate premium payments for your policy are up-to-date.

Claims must be made within six months from the date of the treatment/purchase or discharge from hospital or the accident taking place. All claims are subject to premium checks and it may be necessary to ask you for additional medical or supporting information in connection with any claims. Please see payment of premiums.

All payments are tax free and easy to claim with claim forms provided on request by telephoning the HSF Claims Team or writing to us at: Avenue 77 Business Centre, Level 2. Office 237, Triq in-Negozju, Zone 3, Central Business District, Birkirkara, CBD 3010, Malta.

Reimbursement of most claims is made on a rolling balance principle over any 12 consecutive months. This period starts from the date we pay your claim (not from your joining or plan increase date or from a

calendar year).

For example: an EW3 policyholder, after serving the waiting period, who has up to €100.00 to claim for dental expenses in any 12 consecutive months, could have the following claim record:

Date Claim Paid	Claim Paid Amount	Remaining Balance in the Plan EW1 Dental Category
17 June 2019	€75.00	A balance of €25.00 remains.
5 October 2019	€25.00	Now a nil balance is left. The next available amount will be €75.00 on 17 June 2020.
11 August 2020	€50.00	A balance of €25.00 remains.

Within any consecutive 12 month period, the claim paid amount has not exceeded €100.00. After each claim is paid the amount becomes available again 12 months later. Balances available in each category can be checked by telephoning the claims department who will give guidance on when to submit a claim.

Claims will only be accepted where accumulated receipts

total €7 or more. Benefit payments which relate to amounts paid for a service provided will be up to 100% of the cost, depending on the maximum shown in the brochure. Payment will be by direct credit into your own bank account.

The receipts must:

a. be originals
b. include the practitioner's stamp / name, qualifications and date of issue;
c. include the patient's full name and address;
d. state the type of service and items provided;
e. be for a service for which payment has been met directly by the person registered under the cover;
f. be for a service covered by the HSF Health Plan (Malta) categories only and not for any insurance premiums paid to cover that service.

We cannot accept statements or summaries. In circumstances where part or all of of the amount stated on the receipt has been met by another organisation or insurance company, HSF Health Plan (Malta) will limit or decline benefit payment to ensure that overall a policyholder does not receive more than the amount paid as to do so would be an illegal act.

Claims cannot be accepted for treatment or services provided outside Malta.

Should any overpayment be made in respect of any of the benefits, the amount in question will be set against any future claims, or a repayment may be requested. Any fee paid by a policyholder to a practitioner for any type of medical statement or to a hospital for a statement concerning admission / attendance cannot be reimbursed by HSF Health Plan (Malta). Claims cannot be accepted from service providers who are related to the insured person

General Terms and Conditions

Regardless of any amendments to benefits, the Birth & Adoption grants will remain available to all existing policyholder at the time of the amendment in the form outlined in the brochure for a minimum of 13 calendar months from the date of joining or changing plans.

In the interest of the majority of the policyholders, the Board of Directors of HSF Health Plan (Malta) reserve the right at renewal to:

a. vary the premium rates by giving at least 28 days' notice in writing;
b. vary the range and rates of benefits and the conditions and terms relating thereto;
c. make amendments to these rules with such changes applying at the next renewal date;

At other times the Board of Directors reserve the right to:

d. refuse to settle the claim of any policyholder who is in breach of the rules and conditions, or has been unwilling to cooperate in the process of considering a claim;
e. take legal action against anyone who makes a fraudulent claim and terminate cover immediately;
f. take legal action against anyone who makes, or is associated with, a fraudulent claim and terminate cover immediately;
g. use information provided on application and claim forms for the prevention and detection of crime.

Regulatory Information

Regulation
HSF Health Plan (Malta) Limited is authorised and regulated by the Malta Financial Services Authority.

Advice and Reviews
HSF Health Plan (Malta) is not authorised to provide advice and our employees are only allowed to provide factual information on our products. They are not in a position to determine whether the product is appropriate for you.

Applicants should carefully consider the plans available to them and choose the plan to suit their personal circumstances. Policyholders should regularly review their policy documents to ensure the plan remains suitable for their circumstances.

Remuneration of our employees
Our employees receive a salary and also receive a bonus based on sales and on meeting certain quality thresholds.

Compliments and Complaints
We endeavour to provide a high standard of service to our Policyholders and welcome comments and suggestions. Should you find it necessary to make a complaint, you should in the first instance contact our Customer Services Department at complaints@hsfhealthplan.com.mt.

While we are investigating your complaint, we will keep you regularly updated. If your complaint has not been resolved within 15 days, we will explain why it remains unresolved and inform you of your right to refer the matter to the Office of the Arbiter for Financial Services, N/S in Regional Road, Msida MSD 1920, Malta. Full details of our complaints procedures are automatically sent on receipt of a complaint and at each stage relevant addresses are provided. Such details are available on request at all time.

Governing Law
Cover in your plan within this HSF Health Plan (Malta) will be governed by and interpreted subject to the laws of Malta.

Annual premium calendar
Below are the annual premiums for the HSF Health Plan plans.

EW1 = € 78.00
EW2 = € 129.96
EW3 = € 260.04
EW4 = € 390.00
EW5 = € 519.96

Data protection laws that affect you

This section informs you of the information we record about you. It sets out the conditions under which we may process any information that we collect from you, or that you provide to us. It covers information that could identify you ("personal information") and information that could not. In the context of the law and this notice, "process" means collect, store, transfer, use or otherwise act on information. We take seriously the protection of your privacy and confidentiality.

Our policy complies with the EU General Data Protection Regulation (GDPR). The law requires us to tell you about your rights and our obligations to you in regards to the processing and control of your personal data.

Data Privacy Policy

What does this mean to you?
Under the GDPR, we have a legal duty to protect any information we collect from you. We use leading technologies to safeguard your data and keep strict security standards to prevent any unauthorised access to it. Upon the demonstration of satisfactory identification evidence, you may request a copy of the information we hold about you.

What information do we collect?

Health Cash Plan Applications
If you make an application for a Health Cash Plan, we collect three types of information: your personal details, your medical details and payment details.

Personal details
The personal details we collect are: Your personal and contact details including name, address, date of birth, company name and address, email address and telephone numbers.

Medical details
The medical details we collect are: Any conditions or illness you may have had (or have) and the date any of the symptoms began.

Payment details
The payment details we collect can be bank details or Credit Card information to support premium deductions or claim payments being made directly into your bank account.

Sending a message to our support team

When you contact us, whether by telephone, through our website or by e-mail, we collect the data you have given to us in order to reply with the information you need. We record your request and our reply in order to increase the efficiency of our business.

How we use your information and the legal basis

When you make an application for a Health Cash Plan or otherwise agree to our terms and conditions, a contract is formed between you and us. In order to carry out our obligations under that contract we must process the information you give us. Some of this information may be personal information in order to:

- Verify your identity for security purposes
- Sell products to you
- Provide you with our services
- Provide you with suggestions and advice on products, services and how to obtain the most from using our website.

We process this information on the basis there is a contract between us, or that you have requested we use the information before we enter into a legal contract.

Additionally, we may aggregate this information in a general way and use it to provide class information, for example to monitor our performance with respect to a particular service we provide. If we use it for this purpose, you as an individual will not be personally identifiable.

Who we share your information with

HSF Health Plan may share your data with regulatory bodies when it is a legal requirement to do so for the purpose of monitoring and enforcing compliances;

- Office of the Arbiter for Financial Services
- Fraud Prevention Agencies
- Data Protection Authorities

We may also share aspects of your information on occasions with organisation to enable continuity of service, these include:

- Organisations that pay premiums on your behalf in line with the policy contract.
- IT Support & Technical Service Providers
- Service providers to assist in the continuity and provisions of benefits if applicable.

How long do we hold your data for?

Except as otherwise mentioned in this privacy notice, we keep your personal information only for as long as required by us:

- To provide you with the services you have requested
- To comply with other law, including for the period demanded by our tax authorities
- To support a claim or defence in court.

In line with our current retention policy, we retain the covered person/s personal data for 10 years after the health plan policy has ceased.

Where is your information stored?

The disclosure of personal information to the affiliates and other third parties set out above may involve the transfer of data outside the EEA. We have put in place the Standard Contractual Clauses approved by the European Union Commission for such transfers of personal data'.

Implications of not providing data

If you do not provide information we may not be able to:

- Provide requested services to you
- To continue to provide and/or renew existing products or services

We will tell you when we ask for information which is not a contractual requirement or is not needed to comply with our legal obligations.

How to exercise your information rights including the right to object

Right to be informed:

We will always be transparent in the way we use your personal data. You will be fully informed about the processing through relevant privacy notices.

Right to Access

You have the right to request a copy of all information about you held by us. Please note that we are not obliged to take proactive steps to discover that a subject access has been made. If we cannot view a subject access request without paying a fee or signing up to a service, we will not respond to the request.

Data Portability

You have the right to exercise your right to data portability in certain circumstances.

Right to Object or to Restrict Processing

You have the right to object to our use of your personal information, or to ask us to delete, remove, or stop using your personal information if there is no need for us to keep it. Please note our policy is to only keep personal information for as long as is reasonably required for the purpose(s) for which it was collected.

We are required to keep certain transactional records – which does include personal information – for more extended periods to meet legal, regulatory, tax or accounting needs. We are also required to retain an accurate record of dealings with us for at least six years after your last interaction with us, so we can respond to any complaints or challenges you or others might raise later.

We may sometimes be able to restrict the use of your data. This means that it can only be used for certain things, if this is the case we would not use or share your information in other ways whilst it is restricted. You can ask us to restrict the use of your personal information if:

- It has been used unlawfully but you don't want us to delete it.
- You have already asked us to stop using your data, but you are waiting for us to tell you if we can keep on using it.

Right to Rectification

We want to make sure that the personal data we hold about you is accurate and up to date. If any of your details are incorrect, please let us know and we will amend them.

When we receive any request to access, edit or delete personal identifiable information we shall first take reasonable steps to verify your identity before granting you access or otherwise taking any action. This is important to
safeguard your information.

Right to Erasure

You have the right to have your data 'erased' in the following situations:

- Where the personal data is no longer necessary in relation to the purpose for which it was originally collected or processed.
- When you withdraw consent.
- When you object to the processing and there is no overriding legitimate interest for continuing the processing.
- When the personal data was unlawfully processed.

Please note that each request will be reviewed on a case-by-case basis and where we have a lawful reason to retain the data or where exceptions exist within our retention policy, then it may not be erased. If you wish to exercise any of your above right, you can do so by contacting the Data Protection Team.

Right to Complain.

Should you not be happy with the way we handle your personal data, you have the right to complain. You can do so by contacting the Data Protection Team.

If your complaint reasonably requires us to contact a third party, we may decide to give to that third party some of the information contained in your complaint. We do this as infrequently as possible, but it is a matter for our sole discretion as to whether we do give information, and if we do, what that information is.

You also have a right to lodge a complaint with the supervisory, the Information & Data Protection Commissioner

Data Protection Teams contact details

The Data Controller is HSF Health Plan (Malta).

You can contact the Data Protection Team of HSF Health Plan (Malta) by telephone on +356 2778 0685 or in writing at: Avenue 77 Business Centre, Level 2. Office 237, Triq in-Negozju, Zone 3, Central Business District, Birkirkara, CBD 3010, Malta.

Review of this privacy policy

We may update this privacy notice from time to time as necessary. The terms that apply to you will be also available on our website. **Privacy Policy – HSF Health Plan Malta**



Your questions, answered

Q Can I join at any age?
A Employees aged 18 or over may join through their employer.

Q Can I increase to a higher plan at any time?
A Yes, subject to terms and conditions.

Q Do I have to have a medical assesment to join?
A No. You need only complete and sign the health declaration on the application form.

Q Why do you need medical information?
A In order to explain the cover you will receive, and any restrictions which may apply.

Q Do older people pay higher premiums?
A No, all ages pay the same rates.

Q How do I pay?
A By salary deduction.

Q Are benefits taxable?
A No. You keep all you receive from HSF Health Plan (Malta).

Q When can I make a claim?
A For most benefits claims will be accepted after 3 months, any exceptions are clearly indicated in the brochure.

Q How do I make a claim?
A Claim forms are available on request by telephoning our claims team or from our website.

Q How do I receive my money?
A By direct credit into your bank account.



Application to join HSF Health Plan (Malta)

THIS PART MUST BE COMPLETED IN ALL CASES (PLEASE USE BLOCK CAPITALS)

Date Received I HSF Health Plan (Malta) use

I apply to join HSF Health Plan (Malta) at the rate indicated (please tick)

Plan name	Plan EW1	Plan EW2	Plan EW3	Plan EW4	Plan EW5
Cost/Premium	€1.50 Weekly €6.50 Monthly	€2.50 Weekly €10.83 Monthly	€5.00 Weekly €21.67 Monthly	€7.50 Weekly €32.50 Monthly	€10.00 Weekly €43.33 Monthly
Tick your choice	☐	☐	☐	☐	☐

Employer

Surname

Forename | Other initials | Initials Ms/ Mr/Mrs/Miss

Address

Postcode

Email | Tel Work

Date of Birth Day Month Year | Tel Home

Identity card number or Passport number | Mobile

Tear along perforation

If already covered by HSF Health Plan (Malta) please state:

Existing Premium (€)	Policy No. (if known)

HSF Health Plan (Malta) uses the information given above for its own purposes. Any communications which you may receive are directly related to HSF Health Plan (Malta) services and those of the Hospital Saturday Fund.

By completing health information on the reverse of this form you will assist us in the administration of your policy. Failure to do so will not affect the registration.

Please view our privacy policy at www.hsfhealthplan.com.mt/privacy-policy

Declaration

This application is made on behalf of myself (the policyholder). I confirm that no advice has been received regarding this application from HSF Health Plan (Malta). I agree to HSF Health Plan (Malta) holding data relevant to my plan registration. I agree to abide by HSF Health Plan (Malta) rules and conditions and the right of the Board of Directors to vary them and the range or rates of benefits or premiums if deemed necessary, with notice. I declare that all the information I have given on this application form is true and complete to my knowledge and belief and that if found to the contrary I understand that HSF Health Plan (Malta) may need to impose some restrictions on my cover. I am a Maltese resident.

Signature or Type name: **Date:**

Medical information

Your cover has to be based on the information you supply on the whole of this application form. It is your responsibility that the information provided on this form is correct to the best of your knowledge and belief. To withhold or fail to disclose relevant facts (or to knowingly give false information) about the health and / or treatments could affect the benefits we are able to offer or could seriously influence your cover in the event of a claim. To give false information could be considered to be a fraudulent act and lead to termination of cover.

Please tick the boxes below for any long term / chronic / congenital conditions even if at present under control. If any condition is not listed please complete the 'Other' section, stating conditions in full and avoiding abbreviations.

If you DO NOT have any conditions to declare, please leave the boxes below blank and sign the signature box below.

Condition / Illness	**Date symptoms began**
☐ Arthritis please state part(s) of body affected below ☐ Asthma / Chest problems ☐ Diabetes ☐ Epilepsy ☐ Kidney disease ☐ Liver disease ☐ Raised blood pressure / Angina ☐ Congenital (conditions from birth) please state ☐ Clinical Obesity	

Please list other illnesses / operations, either current or in the past (stating conditions in full and avoid abbreviations). Also list any medication being taken currently and state the condition / illness requiring the treatment.

Any other Condition / Illness	**Date symptoms began**
Signature or Type name:	**Date:**

Authority for deduction from pay for HSF Health Plan (Malta)

This is the plan I wish to join and have the weekly/monthly amount indicated deducted from my pay.
(PLEASE TICK BELOW)

Plan name	Plan EW1	Plan EW2	Plan EW3	Plan EW4	Plan EW5
Cost/Premium	€1.50 Weekly €6.50 Monthly	€2.50 Weekly €10.83 Monthly	€5.00 Weekly €21.67 Monthly	€7.50 Weekly €32.50 Monthly	€10.00 Weekly €43.33 Monthly
Tick your choice	☐	☐	☐	☐	☐

Surname

Forename

Other initials

Initials Ms/ Mr/Mrs/Miss

PLEASE COMPLETE THE SECTIONS BELOW WHICH ARE APPLICABLE TO YOUR EMPLOYMENT

Employer

Department/Location

Identity card number or Passport number

Salary frequency PLEASE TICK ☐ Weekly ☐ Fortnightly ☐ Four weekly ☐ Monthly

Tear along perforation

To be filled in by new policyholder

Company premium (if applicable)	€	c

Your Premium (deduction)	€	c

To be filled in by existing policyholder changing premium

Company premium (if applicable)	€	c

Your Existing Premium (deduction)	€	c

Your New Premium (deduction)	€	c

I authorise my employer to deduct from my salary the above sum (or such future amounts as apply for my cover), and remit to HSF Health Plan (Malta). If my salary is not paid for any reason, any premium arrears should be deducted when my income resumes.

Signature or Type name: **Date:**

Date Received I HSF Health Plan (Malta) use

Recorded in Salary Dept.

Initials	Date

Email form to: enquiries@hsfhealthplan.com.mt

If posting, send to:

HSF Health Plan (MALTA),
Avenue 77 Business Centre, Level 2. Office 237,
Triq in-Negozju, Zone 3, Central Business District,
Birkirkara, CBD 3010, Malta.

Notes

Notes



Head Office

Avenue 77 Business Centre, Level 2. Office 237, Triq in-Negozju, Zone 3, Central Business District, Birkirkara, CBD 3010, Malta.

HSF Health Plan (Malta) Ltd, with company registration number C 93406 and registered office address at No. 4, Triq Sant' Andrija, Valletta VLT 1341, Malta, is the trading company of The Hospital Saturday Fund, a Registered Charity in the UK No 1123381 and in Ireland Registered Charity No 20104528.

HSF Health Plan (Malta) Limited is authorised under the Insurance Business Act (Chapter 403 of the Laws of Malta) and regulated by the Malta Financial Services Authority to carry on business of insurance in Malta.

HSF Health Plan®