The **Laferla** Healthplans

Health Insurance Policy

HEALTH INSURANCE POLICY

In consideration of the Insured named in the schedule attached hereto having completed a Proposal Form to MAPFRE Middlesea plc (hereinafter referred to as 'the Company') which together with any statement made in writing by the Insured for the purpose of this policy is deemed to be incorporated herein and having paid or agreed to pay to the Company the Premium mentioned in the said schedule, the Company agrees to indemnify the Insured in the manner and to the extent hereinafter provided subject to the terms, exclusions, provisions and conditions contained herein or endorsed hereon.

MARTIN GALEA
CHAIRMAN
MAPFRE MIDDLESEA PLC

FELIPE NAVARRO
PRESIDENT & CEO
MAPFRE MIDDLESEA PLC

SECTION 1 - POLICY DEFINITIONS

Certain terms have a special meaning defined as follows:

1. ACCIDENT

A sudden and unexpected event causing bodily injury, which is caused by something external and brought about unintentionally.

2. ACUTE MEDICAL CONDITION

A medical condition which lasts a short time and can be treated and cured quickly by medical treatment or immediately responds to and reduces in intensity to medical treatment: or is not chronic as defined in 4 below.

3. BENEFICIARY

The Insured, member or members, dependant or dependants as herein defined as the case may be.

4. CHRONIC MEDICAL CONDITION

A medical condition which:

a. fails to respond to medical treatment; or
b. is ongoing or consistently recurring; or
c. requires palliative treatment; or
d. requires long periods of medical supervision; or
e. has no known cure; or
f. leads to permanent disability; or
g. is caused by changes to the body which cannot be reversed; or
h. requires you to be specially trained or rehabilitated.

5. COMMENCEMENT DATE

The date on which your insurance cover first starts.

6. CONGENITAL ABNORMALITIES

Any medical condition, deformity, disease, illness or injury present at birth, whether diagnosed or not.

7. CONSULTANT

A surgeon, anaesthetist or physician who:

a. is legally qualified to practise medicine or surgery following attendance at a recognised medical school; and
b. is recognised by the relevant authorities in the country in which the treatment takes place as having specialised qualification in the field of, or expertise in, the treatment of the disease, illness or injury being treated.

By "recognised medical school" we mean a medical school which is listed in the World Directory of Medical Schools as published from time to time by the World Health Organisation.

8. DAY-CASE TREATMENT/DAY-CARE TREATMENT

This is where the Beneficiary is admitted to hospital as a registered Day-Case/Day-Care patient and has signed an admission form, occupied a bed or undergone a surgical procedure which is medically necessary but not stayed overnight.

9. DENTAL OR ORTHODONTIC CONDITION

Any disease, illness or injury normally treated by a dentist or orthodontist.

10. DEPENDENT/S

These are the Insured's or Member's husband, wife or partner whose details are shown in the Policy Schedule. By Partner we mean a person to whom the Insured or Member is not legally married but with whom he or she lives and/or own unmarried children including any children living with the Insured or Member as part of the household as shown in the Policy Schedule.

11. EMERGENCY

A sudden and unexpected Acute Medical Condition which, without treatment within 48 hours of onset, could result in death or cause serious bodily impairment.

12. EMERGENCY DENTAL TREATMENT

Emergency dental treatment that is necessary to repair or replace damaged teeth following your involvement in an accident/fortuity.

13. EXCESS/DEDUCTIBLE

That percentage/sum of the payable claim which you will pay.

14. FAMILY

You, your spouse/partner and children, or any other individual as approved by the Company, as individually named in the Schedule of this Policy.

15. GENERAL PRACTITIONER

A registered medical practitioner in general practice and/or a registered medical specialist in family medicine licensed to practise medicine in the country where treatment is received.

16. HOSPITAL

A national hospital; a private hospital or clinic or a nursing home in Malta or overseas with specialist facilities for Treatment and permits for carrying out Treatment in terms of the applicable legislation and approved by the Company.

17. IN-PATIENT TREATMENT

This is where the Beneficiary is admitted to Hospital for treatment which is medically necessary, has signed an admission form; undergone a surgical procedure which is medically necessary and stayed in Hospital for one or more nights.

18. INSURED

The person named in the Schedule who holds a contract of insurance with Us, also known as the Policyholder.

19. MALTA

The Islands of Malta, Gozo and Comino.

20. MATERNITY CASH BENEFIT

This benefit is payable to the mother who has given birth, as long as the mother has been insured for a minimum of ten months prior to childbirth.

21. MEDICAL CONDITION

Any disease, illness or injury.

22. MEDICALLY NECESSARY

Treatment that in the opinion of either the Beneficiary's General Practitioner or Specialist is both appropriate and consistent for the Medical Condition diagnosed, which in accordance with generally accepted medical practice, if not given would have serious and adverse effect on the Beneficiary's health.

23. MEDICAL UNDERWRITING

The process by which your application form is evaluated on the basis of your medical history and age in order to set the premium rate for the policy, to decide whether to offer coverage or not and whether to apply exclusions on the policy for medical conditions/symptoms/injuries that were existent prior to the inception of your policy, and conditions arising from or related to these conditions, whether medical advice has been sought or not, or conditions which you may reasonably be foreseen to suffer in future.

24. MEMBER/S

A person who has joined the Policy as part of a Group.

25. MORATORIUM

This is an automatic exclusion which may be lifted in future as explained in your Schedule, Scheme, Plan or Policy Benefits.

26. NEW BORN CHILDREN

Policyholder's children born during the period of insurance will be covered at the same level of cover of either the mother or the father, free of charge, until the next date of renewal, provided that such cover is applied for within three months of birth and the relative original birth certificate is forwarded to Us within the same period.

26. OUT-PATIENT TREATMENT

Treatment received from a Specialist or under the control of a Specialist at a Hospital, Specialist's consulting room or other place approved by Us where the Beneficiary does not go in for Day-Case or In-Patient Treatment.

27. PALLIATIVE

Any medical procedure which is given to temporarily relieve rather than cure a Medical Condition.

28. PHYSIOTHERAPIST

A practitioner who is either State registered or a Chartered Physiotherapist; and a member of the relevant Chartered Society of Physiotherapists and holds the qualification of FCSP, MCSP, SRP or Grad. Dip. Phys., or equivalent.

29. POLICY

Our contract of insurance with the Insured providing the cover as detailed in this policy document and the relevant Schedule, Scheme, Plan or Policy Benefits. The proposal/application form, financial statement, schedule of surgical procedures, financial statements, policy schedule and policy benefits for part of the contract and must be read together with this policy document (as amended from time to time).

30. POLICY YEAR

The period beginning on your commencement date or renewal date and ending on the day before your next renewal date. By commencement date we mean the "effective from" date on your first membership certificate for your current continuous period of membership.

31. POLICY BENEFITS

Any benefits set out in the relative Scheme, Plan or Table of Benefits appended to this Policy.

32. PRE-EXISTING MEDICAL CONDITION

Any Medical Condition for which:

- the Beneficiary has received medication, advice, diagnostic tests or treatment; or
- the Beneficiary has experienced symptoms or should have reasonably known about;

whether the condition has been diagnosed or not before the Beneficiary joined the Policy.

33. PRIVATE AMBULANCE

A road vehicle designed to be used as an ambulance and operated by a registered private ambulance service.

34. QUALIFIED NURSE

A qualified nurse whose name is currently on the relative professional register of nursing in Malta or in the country where Treatment is being received.

35. QUALIFIED PRACTITIONER

A health care professional who is currently practising profession complementary to medicine and is a registered member of the relative national professional association for their field.

36. REASONABLE FEE

The reasonable charge made for medical services. A Reasonable Fee will be calculated by taking into account the complexity of the Treatment involved, the degree of professional skill and other relevant factors, or as per list of applicable maximum benefits published from time to time by the Company.

37. REHABILITATION CENTRE

A facility providing in-patient treatment for the rehabilitation of patients following an in-patient stay in a hospital.

38. RENEWAL DATE

The renewal date shown in the Policy Schedule.

39. SCHEME

The health insurance plan effected by the Insured as specified in the Schedule and attached thereto.

40. SPECIALIST

A medical practitioner (excluding Specialists in Family Medicine) who:

- is registered in terms of local requirements and who is or has been a Consultant in a national hospital and is currently practising in that appointment in the speciality for which the Beneficiary needs treatment; or
- is approved and recognised as a Specialist in a given field of medicine by the Company.

41. SCHEDULE OF SURGICAL PROCEDURES

Current list of Surgical Procedures and the maximum benefits payable for each procedure maintained by the Company. This may also be referred to as the "List of Reasonable Fees" or "List of Maximum Benefits".

42. TREATMENT

Any Medically Necessary surgical or medical procedure, consultation, test or investigation carried out or controlled by a Specialist to cure or actively and substantially relieve an Acute Medical Condition.

43. WE, US, OUR

This means the Company.

44. YOU, YOUR

This means the Insured.

SECTION 2 - PAYMENT OF PREMIUMS

In this section we have set out the conditions for paying the premium.

1. You are responsible for paying the entire annual premium for each person included under the Policy.
2. Premiums are payable to us in Euro and must be paid on the date when they become due. If they are not paid by such date, then we reserve the right to cancel the Policy with effect from the day when the premium or any instalment thereof became due.
3. Should any new Member/s or their Dependent/s be accepted by Us under this Policy, an additional premium will be payable by You. This additional premium will be a pro-rata premium based on the number of days remaining between the date of acceptance and the renewal date following the said date
4. Should a Member or his/her Dependent wish to cancel the cover provided to him/her hereunder during the policy year, a pro-rata refund of premium will be made by use provided that no claim/s whether paid or outstanding shall have been made in connection with this policy during the policy year in which this cover is to be cancelled. Subject to the above, the refund of premium will be based on the number of days remaining between the cancellation date and the expiry date of the policy. We reserve the right to also deduct a cancellation charge/fee from the pro-rata refund.
5. The premium is to be paid annually in advance or by instalment if indicated in the policy schedule. In the case of an agreement between Us and You to pay the premium by instalments, this does not waive your responsibility to pay the entire annual premium.

SECTION 3 - WHAT IS COVERED

The purpose of the Policy is to provide cover for the Reasonable fees of recognised and Medically Necessary Treatment of Acute Medical Conditions. This Policy is not intended to cover experimental or unproven Treatment, but should such situations arise we will discuss these with the Beneficiary's Specialist and decide whether the cost of the proposed Treatment is covered. Claims will be paid for those items specified in the Policy Benefits (up to the amounts stated, if applicable).

If the Policy Benefits do not cover the full cost of Treatment, the Beneficiary will be liable for paying the balance.

SECTION 4 - EXCESS/DEDUCTIBLE

The Beneficiary and/or the Company may apply an Excess or Deductible on the Policy at inception of the policy or its renewal. In the case of a claim, the Company will first calculate the eligible amount of each and every claim which is due to be reimbursed by the Company in accordance with the Policy terms and conditions, deduct the Excess or Deductible from that eligible amount and the reimburse the balance to the Beneficiary.

SECTION 5 - HOW TO CLAIM

The Beneficiary MUST give the Company advanced notice of any planned In-Patient Treatment. This will give the Company the opportunity to confirm whether or not your proposed Treatment is covered under your Policy and the level of cover you have. A breach of this condition will prejudice the payment of the claim.

1. The Company may ask the Beneficiary to provide it with such information/documents as the Company may require from time to time.
2. For a claim to be payable, all Treatment must be undertaken:
   i. on the referral of the General Practitioner, except for consultations/treatment given by gynaecologists,
   ii. paediatricians or ophthalmologists; and
   iii. given by and under the control of a Specialist for the purpose of curing an Acute Medical Condition.
3. Payment of the Policy Benefits will be made at the discretion of the Company either:
   i. to the Insured, Member, or Beneficiary, as the case may be; or
   ii. to the person or company who has provided the Treatment; or
   iii. in the event of the Insured's or Member's death, to the executors or the legal heirs of the relative estate.
4. When you pay for eligible overseas Treatment in currency other than in Euro, we will pay the equivalent in Euro at the rate of exchange prevailing at the time of settlement of the claim, or at the time when you paid the claim, whichever is the lower.
5. To qualify for the Home Nursing or Rehabilitation Centre Costs benefits, all Home Nursing must immediately follow a period of In-Patient or Day-Case Hospital treatment covered by the Policy; be approved by a Specialist as being Medically Necessary; be for skilled nursing care which would otherwise be provided on an In-Patient basis in hospital; be on a full-time basis (i.e. at least 7 hours per day); and be given by a qualified nurse under the direction of a Specialist.
6. Alternative treatment must be received under the overall control of the referring Specialist.
7. The Policy Benefits are only payable for eligible Treatment received during the period for which the required premium has been paid.
8. Claims can only be considered for payment once the Beneficiary has provided Us with all the necessary information and documentation We require.
9. Invoices and receipts for Treatment will only be considered for payment provided they are the original documents; and sent to us within 3 months of the date Treatment was received.
10. We are entitled, at our expense, to appoint an independent medical examiner to examine the Beneficiary and to review the claim.
11. The Beneficiary must advise Us if any of the Benefits claimed for under the Policy can also be claimed from a Third Party or under another insurance policy.

    If the expenses can be claimed under another insurance policy, then we will only pay our proportion of the total amount for those expenses which are eligible for payment under this Policy.

If the expenses can be claimed from a Third Party, we may exercise our subrogation rights to recover from the third party the amount of benefit we had paid. In these circumstances, the Beneficiary must:

i. tell us as soon as reasonably possible that the expenses being claimed for are due to the fault of a third party and provide us with those details which the Company may require; and

ii. do everything we may reasonably and practically require to ensure that the benefits are recovered from the third party.

SECTION 6 - EXCLUSIONS

We cannot pay claims for any of the following, unless otherwise specified in Your policy Schedule or Benefits:

1. Treatment for a Medical Condition which we may have specifically excluded from benefits as shown under the heading "Special Terms" in the Policy Schedule, or in other relevant documentation.
2. Pre-Existing Medical Conditions. However, We will offer cover after five years' continuous insurance cover with us, provided that during the five year period the Beneficiary has not:
   i. consulted any doctor for treatment or advise (including check-ups); or
   ii. taken any medication (including drugs, medicines, special diets and injections) for that Pre-Existing Medical Condition.

   We will only cover pre-existing cardiac or cancer conditions provided at the time when the condition recurs the Beneficiary has been free from Treatment, advice or medication for that Medical Condition during the previous ten years.
3. Fees charged for providing medical reports and prescriptions.
4. Pregnancy or childbirth, other than for related complications arising at least ten (10) months after the expectant mother joined the Policy. In the case of a Caesarean section the Company will only pay the difference between the Reasonable fees for the intervention and the fee which would have been charged for a normal delivery.
5. Any type of contraception, sterilisation, termination of pregnancy, infertility and/or any form of assisted reproduction, and treatment of sexual problems, including impotence, sex changes or treatment for, or arising from, any of the above.
6. Treatment for symptoms caused by ageing, menopause or puberty, or other natural physiological cause.
7. The cost of vaccinations, routine or preventive medical examinations, medical screening including breast and prostate screening, smear tests and bone densometry tests, health check-ups, sight and hearing tests or any preventive treatment and treatment to remove any tissue that is not diseased.
8. Fees charged for accommodation and ancillary items, home nursing and rehabilitation, which are for or related to social and domestic reasons or are for reasons not related to treatment of an Acute Medical Condition.
9. Clinic fees and waiting room fees.
10. Treatment received in health hydros, spas, nature clinics or in any similar establishments even if they are registered as a Hospital.
11. Regular or long-term kidney dialysis or end stage renal failure.
12. Treatment arising from failure to seek or follow medical advice, or from a deliberate self-inflicted injury or attempted suicide.
13. Treatment to:
    i. change your physical appearance, whether or not it is needed for medical or psychological reasons, or any treatment which relates to it or is needed as a result of previous cosmetic surgery; or
    ii. remove healthy tissue (i.e. tissue which is not diseased), or the removal of surplus or fat tissues, whether or not it is needed for medical or psychological reasons.

    The exclusions in 13(i) and 13(ii) will not apply where surgical intervention takes place in order to restore appearance following an Accident or as a direct result of cancer intervention, occurring during the current period of insurance and not later than 24 months from such accident or surgery. The original treatment for the accident or cancer must have taken place whilst the Beneficiary was covered by this insurance policy and must also be eligible for claim in terms of this Policy.
14. Any Dental or Orthodontic condition except for a procedure listed on the list of Surgical Procedures we publish and which must be carried out by an oral and maxillofacial surgeon, or, if specifically covered, for emergency dental treatment necessary to restore or replace sound natural teeth lost or damaged following an Accident.
15. Treatment given to relieve any allergic condition or disorder (including Allergic Asthma amongst other conditions).
16. Treatment arising in any way from diseases that are transmitted sexually or those which according to generally accepted classification are classified as Sexually Transmitted Diseases/Infections (STDs/STIs).
17. Treatment arising in any way from the Human Immune Deficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) or any other similar or related condition or syndrome.
18. Treatment arising in any way from alcohol, drug or substance abuse.
19. Treatment arising from or related to a sex change.
20. Treatment arising from nuclear or chemical contamination, war, terrorism, invasion, act of foreign enemy, hostilities (whether war be declared or not), civil war, riot, civil disturbance, rebellion, revolution, military force or coup.
21. Fees charged for aids and appliances including spectacles, contact lenses, hearing aids, wheelchairs, stair lifts and the like.
22. Fees charged where the Beneficiary was admitted to Hospital either as an In-Patient or on a Day-Case basis prior to the date Treatment began; or as part of a recuperation process which otherwise could have satisfactorily taken place away from hospital at no expense. Where there is no specific medical necessity to receive Treatment on an In-Patient basis, as this could have been carried out as an Out-Patient Treatment, benefit will be paid out of the Out-Patient benefits section.
23. Drugs, dressings, surgical or dental appliances prescribed on an Out-Patient basis or while as an In-Patient but for use as an Out-Patient, unless specifically covered.
24. Treatment for Congenital Abnormalities, whether diagnosed at birth or not, other than for Congenital Abnormalities undertaken in an emergency operation carried out within twenty eight days of birth.
25. Fees charged for weight management and control.
26. Injuries arising from taking part in sporting activities of any kind for which the Beneficiary either gets paid or receives benefit, or has a paid or unpaid professional or semi-professional contract to perform such activities.
27. Treatment or monitoring given in respect of a Chronic Medical Condition or Palliative Treatment of a terminal Medical Condition.

28. Treatment directed towards development delay in children whether physical or psychological, speech disorders or learning difficulties.
29. Treatment for Psychiatric illness received during the first twelve months after joining the Policy. For Day-Case or In-Patient Treatment, cover is limited to a maximum collective total of 90 days every five years. Out-Patient treatment for eligible psychiatric illness will only be payable on referral by a psychiatrist and requires our prior approval.
30. Treatment for sleep studies and sleep disorders, including treatment for sleep apnoea, insomnia, snoring or any other sleep related breathing problems, amongst other related conditions and Treatment.
31. Treatment to correct eyesight including spectacles or contact lenses and laser treatment, unless caused as a result of an injury or an acute medical condition.
32. Treatment following an organ transplantation where the Beneficiary is the donor.
33. Treatment not carried out by a qualified Medical Practitioner.
34. Services rendered by a provider who is a member of the Beneficiary's immediate family, including spouse, sibling, parent or child.
35. Treatment following a criminal act of the beneficiary, violation or attempted violation of law and resistance to lawful arrest or any resultant imprisonment.
36. The use of life support machines and/or similar devices beyond the first 14 days of use.

SECTION 7 - CANCELLING THE POLICY

In this section we have set out the conditions under which we can cancel or change the Policy.

We can cancel or amend the Policy and/or cover immediately if the Beneficiary:

i. Has provided us with false or wrong information, or incomplete answers, relating to a proposal/ application form, Policy or claim hereunder;
ii. Has failed to fully comply with the terms and conditions of the Policy;
iii. Has failed to pay the premium due or an instalment thereof.

SECTION 8 - CONDITIONS OF THE POLICY

In this section we have set out the General Policy Conditions:

1. None of the terms or benefits of the Policy can be changed by any person except by an Endorsement issued by Us.
2. The Policy shall for all effects and purposes be a Maltese Contract and shall be governed by and according to Maltese law and subject to the exclusive jurisdiction of the Maltese courts.
3. We have the right to alter the Policy including the terms, premium rates and other fees and charges, and policy benefits at the annual renewal of the Policy.
4. We will not add interest to any money paid or due by Us under the Policy.
5. Wherever relevant, singular words include the plural and words in the masculine apply to the feminine.

COMPLAINTS PROCEDURE

We are committed to providing good quality services. We recognise that a client may not be satisfied with the service provided. To deal with this we have a complaints procedure. For the sake of clarification a complaint is broadly defined as being a written expression of dissatisfaction with services that we provide or actions we have taken that require a response. We distinguish complaints from queries. Queries are challenges to specific decisions in specific circumstances.

The Company will deal with your complaint.
The Company does not look at complaints as unwanted. In fact, they may help the Company to see where its services or procedures may be improved. It is in the parties' interest for the Insured to let the Company know when the Insured feels that the Company has made a mistake or done something which the Insured finds unsatisfactory. Even if the Insured does not think that the particular concern amounts to a complaint the Company would still like to know about it. The Insured will help the Company improve its service further.

HOW TO COMPLAIN

STEP 1 – CONTACTING THE COMPANY

The first step is to talk to a member of the Company's personnel or of the intermediary if the Policy was arranged through one. This can be done informally either directly or by telephone. Usually the best person to talk to will be the person who dealt with the matter the Insured is concerned about as they will be in the best position to help the Insured promptly and to put things right. If they are not available or the Insured would prefer to approach someone else then address the matter to the manager or senior person responsible. The Company will seek to resolve the problem immediately. If the Company cannot do this then the Company will take a record of the concern and arrange the best way and time for getting back to the Insured. This will normally be within two working days.

STEP 2 – TAKING THE COMPLAINT FURTHER

If the Insured is still unhappy the next step is to put the complaint in writing, addressing it to the Complaints Officer, setting out the details, explaining what the Insured thinks went wrong and what the Insured feels would put things right. If the Insured is not happy about writing a letter, the Insured can always ask a member of the Company to take notes of the complaint which the Insured will be then asked to sign. The Insured will be provided with a copy for their own reference. This record will be passed promptly to the Complaints Officer to deal with.

Once the Complaints Officer receives a written complaint, s/he will arrange for it to be fully investigated. The complaint will be acknowledged in writing within five working days of receiving it and the letter will state when the Insured can expect a full response. This should normally be within fifteen working days unless the matter is very complicated such as where other organisations need to be contacted. Where this is the case the Company will still let the Insured know what action is being taken and will inform the Insured when the Company expects to provide a full response.

TAKING YOUR COMPLAINT ELSEWHERE

If you are still not satisfied with the Complaints Officer's response, you can always seek advice elsewhere. You may contact:

Office of the Arbiter for Financial Services
First Floor, St Calcedonius Square,
Floriana FRN1530. Malta.

Telephone: 8007 2366 or 21249245
E-mail: complaint.info@financialarbiter.org.mt
Website: www.financialarbiter.org.mt

The Office of the Arbiter will expect that you have a final reply to your complaint from us before approaching them.

Laferla Insurance Agency Ltd.
204A, Vincenti Buildings, Old Bakery Street, Valletta VLT 1453. Malta.

Postal Address: P.O. Box 347, Valletta VLT1000.

Tel: +356 2124 6340
E-Mail: medical@laferla.com.mt
Web: www.laferla.com.mt

LAFERLA
INSURANCE AGENCY LIMITED

Agents for:
MAPFRE | MIDDLESEA

Ref: **LHP-POL-2018**