STUDIUM Fee-for-Service Health Insurance – General Terms and Conditions (STUDIUM16)

These general terms and conditions of STUDIUM Fee-for-Service Health Insurance (hereinafter: general conditions or policy conditions) set out the standard conditions for **STUDIUM Fee-for-Service health insurance policies (hereinafter: insurance policy)** offered by **Generali Biztosító Zrt. (hereinafter: Insurance Company)**, provided that the policy has been concluded by reference to these general conditions. All matters not regulated by these general conditions will be governed by the provisions of the **Hungarian Civil Code** or the provisions of other **effective Hungarian legislation**.

In the event of discrepancy between the document titled 'Customer Information and General Provisions governing Insurance Policies' and the policy conditions, the provisions of the policy conditions shall prevail.

Definitions

1. **Application and Policy** (containing the insured's statements): a numbered written document which is the standard Application Form of the Insurance Company and is also used as a certificate of coverage (Policy), so it evidences that the application has been approved and the insurance has taken effect. (The insurance application is a unilateral written statement which the policyholder may complete to apply for insurance coverage and request the conclusion of the policy.) The Application and Policy contains the Insured's declarations with respect to the health insurance policy, and in particular information regarding the rights and obligations of the Insured, the name of authorities and institutions which the insurance company's confidentiality obligation shall not apply to, as well as the Loss Payable Clause with respect to the payment of benefits, all forming an integral part of the Insured's statement to which it is annexed. The Application and Policy shall constitute an integral part of the STUDIUM insurance policy.
2. **Primary care** (availability of a physician or health care services): basic (not specialty) medical and health care services generally available, required to treat illness or accident consequences: GP or similar services.
3. **Nursing:** a group of care services and procedures of nursing directed to improve health status, to preserve and reinstate health, to stabilize patient status, to prevent diseases by preserving the patient's human dignity, and by preparing and involving the patient's surroundings in nursing tasks.
4. **Accident:** one-time, external physical impact and/or chemical exposure which the Insured suffers beyond his/her control or is unwillingly exposed to during the policy term, and as a result of which the Insured suffers permanent physical or mental impairment or dies.
5. **Disease (illness):** any deviation from or interruption of the normal structure or function of the human body.
6. **Healthcare (medical) document, documentation:** records, registers or data recorded otherwise, containing healthcare and personal identification data related to the treatment of the patient, prepared under current regulations and in compliance with healthcare and medical professional requirements, disclosed to healthcare staff in the course of providing healthcare services, regardless of data carrier or form. For the purposes of the general conditions, healthcare documents specified by law shall particularly include the following documents also partially regulated by law: outpatient records, hospital discharge summary, surgery description, examination records, nursing and care documentation, test findings, medical expert opinion, laboratory records, images made during diagnostic or histology tests, prescriptions (copy), referrals (copy).
7. **Health insurance card:** A card bearing the same serial number as that of the Application and Policy, issued by the Insurance Company containing the most important data related to the insurance coverage, in particular the covered insurance period certified by a hologram sticker, which is designed to be proof of the insurance coverage before the Health Care Service Provider. The Insurance Company issues the Application and Policy as well as the Health Insurance Card at the time when the insurance is duly concluded. The Health Insurance Card will be validated by a hologram for all subsequent insurance periods.

8. **Prepaid health care:** health care services provided by a person or institution duly authorized to render health care services, received by the Insured in medically justified cases, where the costs have been prepaid to the service provider directly by a person or entity other than the Insurance Company.
9. **Annual limit/pro rata limit:** the upper threshold (annual limit) of the Insurance Company's total benefit payment in relation with the Insured's medical care during any given policy year and with respect to the particular benefit types, as specified in the STUDIUM Application and Policy, which is an integral part of the insurance policy, above which the Insurance Company is not required to provide services (pay benefits). Pro rata limit: the pro rata annual limit applicable to the coverage relating to the Insured's medical care in the particular policy year and specified in the STUDIUM Application and Policy material, which is an integral part of the insurance policy.
10. **Inpatient care is** provided when a person is admitted to a medical facility (hospital) for several days in order to resort to medical care which is necessary to treat a disease or the consequences of an accident, in a way that such person spends each night in such institution between the day of admission to and the day of discharge from such institution in respect of the provision of medical and health services. Admission to a medical facility is for several days if such person is discharged from the institution at a later date than being admitted.
11. **Medication, dressings and bandages, durable medical equipment:** only those agents, accessories and means shall be deemed as medication, dressings and bandages, durable medical equipment which are registered and recognized in Hungary as medication, dressings and bandages, or durable medical equipment. Lenses for the correction of vision (glasses, contact lenses, glass for vision, etc.), tools for improve hearing and materials and means used in dental care (artificial teeth, prostheses, fillings, implants, braces, substances and tools to whiten teeth etc.) are not qualified as durable medical equipment.
12. **Outpatient specialty care** includes health care services which are provided to a person who, as a result of an accident or illness, receives primary medical or specialty care the duration of which does not exceed 24 hours, and which is not considered as inpatient care.
13. **Treatment**: medical activities performed by special healthcare staff aimed to cure diseases, stabilize a patient's medical condition, and to relieve pain (or other complaints) using diagnostic results.
14. **Designated service provider**: the designated health care provider and/or the designated medical care management company contracted by the Insurance Company to provide health care services or manage patient treatment. The designated service provider is shown on the Health Insurance Card.
15. **Medical facility** (institution): any private healthcare entrepreneur, legal entity or organization without a legal personality, regardless of ownership and maintenance arrangement, which is entitled to provide medical and health care services under current legal regulations in possession of a license of operation issued by a public administrative body of healthcare in respect of Hungary. For the purposes of these policy conditions, health care service providers shall not include sanatoriums, rehabilitation institutes, thermal or hydro-mineral establishments, asylums and care centers for patients with mental disorders and other psychiatric diseases, geriatrics, chronic institutes, social homes, alcohol and drug detoxification institutes (hereinafter jointly referred to as: other health care institutions), even if these provide health care services, or departments of health care institutions which provide health care services in line with the operations of health care institutions as defined herein (for the purposes of this section, hereinafter: department), provided that the Insured person has received services in line with the specialization of the other health care institution or of the department.
16. **Medical care:** any and all medical and health care activities pursued by the health care provider in possession of an operation permit issued by the health care supervisory authority, and which aims at examining and treating the Insured, caring for, attending him/her, decreasing pain and suffering and for the purpose of the above, the processing of the patient's examination documents in order to preserve the Insured person's health, as well as for the prevention, early recognition, establishment, treatment of illnesses, averting dangers of life, improving the condition occurred due to attaches, or as a consequence of accidents and for the purpose of preventing further condition deterioration.
    Health care shall furthermore include activities related to medications, bandage, medical aids, medical care in accordance with effective legislation, and patient transport.
17. **Medical care management company:** an entity, irrespective of its ownership structure or operator, authorized and obligated under a service contract it concluded with the Insurance Company, to manage medical and health services covered under the insurance policy of the Insured, in particular elective procedures and care, and to supervise the quality and professional aspects of the medical and health

services delivered to the Insured. As much as possible, the medical management service provider shall provide the medical and health services which the Insured may receive under the insurance policy through its contracted health care providers.

18. **Medical care management:** the arrangement and coordination of medically necessary health care services (in particular, elective outpatient and inpatient care) for the Insured. For the purposes of these general conditions, medical services management shall mean the following: managing the provision of medical and health services to the Insured, monitoring and checking medical and health services and their routes, liaison with the medical facilities or service providers treating the Insured, administration of medical and health services arranged or notified to and approved by the medical management service provider.
19. **Deductible**: a benefit limit specified in the STUDIUM Product Information, an integral part of the insurance policy, corresponding to an amount applicable for each insured event which the insured shall pay himself/herself for the insured's medical care in the cases defined in the product information.
20. **Specialty health care**: health care services received by the Insured pursuant to a referral of a primary care physician.
21. **Emergency** (medical emergency): the deterioration of the Insured's medical condition as a result of which the Insured's life would be in direct danger or the Insured would suffer serious or permanent health impairment without immediate medical attention. In such a case the emergency services number must be called.
22. **Fee for service:** payment of the costs of medical and health care services, partially or entirely, in the form of insurance benefits, within the framework of an insurance policy subject to the terms and conditions set out and stipulated therein.
23. **Test** (medical): a healthcare activity aimed to survey the Insured's medical conditions, to preserve his/her health, to test for diseases, injuries, health impairments, consequences of accidents and/or any risks thereof, to diagnose specific disease(s), to establish prognosis and any change thereof, and to check the effectiveness of medical treatment.

I. Content of the Insurance Policy

Under the insurance policy, the Insurance Company undertakes to provide coverage for the Insured risks set forth in these general conditions and pay the insurance benefit if an Insured event occurs and the insurance claim is grounded, while the Policyholder undertakes to pay the insurance premium.

II. General Provisions

II.1. Parties to the Insurance Policy (Insurance Company, Policyholder, Insured)

II.1.1. The **Insurance Company** is a legal entity which, in consideration of the payment of insurance premium, provides coverage for the insured risk and undertakes the obligation to reimburse the costs of the services set out in these general conditions.
II.1.2. The **Policyholder is also the Insured** (hereinafter: Insured or Policyholder/Insured)any natural person consumer whose health is covered under the insurance policy with respect to specific insured events, and who applies for the insurance coverage by completing the insurance application, while also agreeing to pay the insurance premium. (Consumer shall mean any natural person acting for purposes which are outside his/her trade, business or profession.)
II.1.3. Under this insurance product, the Insured may be any natural person of foreign citizenship temporarily resident in Hungary **who is between 18 and 65 years of age** as at the date when the insurance policy is concluded and whose health is covered under the insurance policy with respect to specific insured events, and who is enrolled as a student **during the policy term** at the university / educational institution specifically named on the insurance **Application and Policy** document.
For the purposes of this insurance, insured may also be a natural person of foreign citizenship between 18 and 65 years of age as at the date when the insurance policy is concluded who is a close relative of an insured person defined above, provided that such person is not insured under the national social insurance scheme in Hungary.

II.2. Conclusion and Modification of the Insurance Policy

II.2.1. The policy is concluded pursuant to the **written agreement** of the Policyholder/Insured and the Insurance Company whereby the Policyholder/Insured completes and signs the Application and Policy and pays the insurance premium specified on the Application and Policy document in respect of the first insurance period in one sum.
II.2.2. The Insurance Company is entitled to collect the premium payable for the first insurance period prior to the conclusion of the policy, which shall be regarded as an interest-free advance payment.
II.2.3. The Insurance Company issues a Health Insurance Card for the insured, which contains the most important information related to the insurance coverage. The Health Insurance Card is validated with a hologram for the given insurance period.

II.3. Commencement of the Insurance Coverage
The insurance coverage will commence at the time when the insured is added to the insurance policy, **at 0 a.m. of the day following the date** when the Policyholder/Insured **signs the Application and Policy** and pays the insurance premium to cover the first insurance period (if it is not the same day, then on the date when both conditions are met), **not to precede the first day of the insurance period**.

II.4. Coverage period

II.4.1. STUDIUM fee-for-service health insurance may be taken out **for a fixed coverage period, corresponding to the Insured's legal relationship as a student.**
II.4.2. The policy term is divided into policy years and insurance periods.
Policy year: 1 (one) year, corresponding to the academic year, **starting on September 01 of the given year and ending on August 31 of the subsequent calendar year.**
Insurance period: each policy year is divided into two insurance periods, **Period I from September 1 to February 28/29 and Period II from March 1 to August 31.**
II.4.3. The coverage in any one insurance period is certified by a hologram sticker placed on the Health Insurance Card.
II.4.4. The insured persons may not be covered under this insurance for a period shorter than 1 (one) month. An insured month is a calendar month for which the insurance premium has been paid, on the understanding that any insured month shall commence on the first (01) day of the calendar month and shall end on the last day of the same calendar month, provided that the commencement date of the insurance coverage during the first insured month corresponds to the commencement of the insurance.

II.5. Termination of the Insurance Policy

II.5.1. The policy shall terminate:
a) when the legal relationship of the student is terminated with the educational institution,
b) if the insurance premium is not paid by the due date set out in Clause IV.2;
c) at the end of the insurance period in which the Insured reaches the age of 65,
d) if the Insured dies, at the time of the death,
e) when the insurance policy is cancelled (for convenience) in accordance with Clause II.5.2.
f) if material conditions affecting the insurance policy have changed in accordance with Clauses II.2.4 and II.2.5.

II.5.2. The Policyholder/Insured may cancel the insurance policy in a written notice delivered at least 30 days before the end of the insurance period, with effect from the end of the insurance period.

II.6. Geographical limit of the insurance coverage

The insurance coverage and the reimbursement of costs under this insurance shall be **limited to** medical expenses associated with medical care and medical and health care service **received within the territory of Hungary**.

III. Insurance Premium

III.1. Insurance premiums shall be paid semi-annually under this policy, and the first premium of the insurance shall be due at the time when the policy is concluded, and any later premium shall be due on the first day of the period (insurance period) which it is payable for. The insurance premium payable for the first insurance period is specified in the **Application and Policy** document.
III.2. The Policyholder/Insured will have fulfilled his/her obligation to pay the insurance premium as of the day when the **insurance premium is credited to the account of the Insurance Company**.
III.3. The Policyholder/Insured agrees to pay the due insurance premium applicable to the particular insurance period (for the whole of its term) in one sum.
III.4. Irrespective of the date when the insurance is concluded in any given insurance period, the insurance premium must be paid in full for the then current insurance period.

IV. Consequences of premium payment default

IV.1. If the Policyholder/Insured fails to settle the insurance premium by the due date, the Insurance Company will send the policyholder a written payment reminder with at least an additional thirty-day (30-day) deadline including advice on the legal consequences of payment default.

IV.2. If the Policyholder/Insured fails to comply with his payment obligation **within the additional period**, the policy shall be terminated with effect to the date until premiums were paid.

VI.4. Modification of the insurance premium

IV.4.1. In order to preserve the fee-for-service feature of the insurance and by application of the principle of risk proportionate premiums, the insurance company may modify the insurance premium once every calendar year.

a) The insurance premium may be modified if the costs of the covered services, the range of the insurance benefits or the frequency of the receipt of services have changed.
b) The insurance premium may be modified by changing the applicable premium rate by a percentage value determined before effecting the modification.
c) The basis of the premium rate modification shall be the change of the Health Care Price Index published by the Central Statistical Office (hereinafter: KSH) in respect of the preceding calendar year, any change in the prices of covered health care services offered by the health care service provider contracted by the insurance company in comparison to the previous year, as well as any change in the services and benefits offered by the insurance company (e.g.: offering new services/benefits, etc.).
d) The insurance company will compare the claimed and calculated insurance benefits at least once a year. If this comparison reveals a difference larger than 2%, the insurance company will review all the applicable premium rates and will modify the insurance premium as required.

If the insurance premium is adjusted in line with the foregoing, the Insurance Company is required to notify the Policyholder/Insured in writing of the premium modification and its rate at least 30 days before the effective date of the modification (with particular regard to the commencement of the insurance period).

If the Policyholder/Insured does not wish to maintain the insurance with the proposed modifications communicated by the insurance company, he/she may cancel the insurance policy without a notice period with effect from the end of the then current insurance period.

In the absence of a cancellation notice, the Policyholder/Insured shall be required to pay the modified amount of the insurance premium with effect from the first day of the subsequent insurance period.

V. Insured Events, Insurance Benefits, Conditions for Benefit Payment

V.1. Insured event

IV.1.1. The insurance covers medical and health care services provided to the insured Policyholder/Insured by the **designated health care provider** or arranged for by, notified to and approved by the **designated medical care management company** (**hereinafter jointly: designated service provider**) during the coverage period to treat the insured's injuries due to an accident, or his/her illness or medical condition with no prior history relative to the commencement of the insurance coverage.
V.1.2. For the purposes of this clause, illness, medical conditions and accidents shall be unprecedented relative to the commencement of the insurance coverage if they are not in any way connected to the insured's illness, medical condition or accident which existed or which was diagnosed or treated before the commencement of the insurance coverage, nor with a previously established permanent impairment.
V.1.3. If the medical care which the Policyholder/Insured received was not provided or arranged for by the designated service provider, the Insurance Company will only reimburse the cost of such medical care, provided that the claim is otherwise grounded, if the Insured had a medical condition which did not allow him/her to be provided medical care by or under the arrangement of the designated service provider (emergency) and the designated service provider has been notified of the medical care within 48 hours of the beginning of the treatment.
V.1.4. **The insurance will not cover medical care which is delivered in urgent care centers if such medical care is or may be covered under the national health insurance scheme.**
V.1.5. The **date of the insured event** is the first day when medical care and/or health care services are received. For the purposes of these general conditions, **medical or health care services required for the treatment of the same trauma(s), medical condition(s) or illness(es), and received on the same day or within the framework of the same medical treatment, belonging to the same service category shall be treated as a single insured event**.

VI.2. General rules on the payment of insurance benefits

VI.2.1. **The insurance company shall reimburse the costs related to the medically justified health care treatment of the Policyholder/Insured, as defined in these policy conditions, provided that the Policyholder/Insured received such treatment from the designated health care provider or if the medical necessity of the treatment is properly evidenced by the Policyholder/Insured**.
VI.2.2. The insurance covers the costs of medical care specified in these policy conditions subject to the annual limit and pro rata limit specified in the Application/Policy, and by applying deductibles, if the insurance company applies deductibles.
VI.2.3. When an insurance claim is not grounded or only partly grounded pursuant to the insurance policy, and consequently the Insurance Company is not at all or only party required to reimburse costs, the Policyholder/Insured will be required to pay the part of the costs of the medical care the Insured received which is not covered under this insurance directly to the provider of the medical care or to the party which has issued the invoice.
VI.2.4. **Within the framework of the outpatient treatment**, the insurance will cover:
a) the costs of **primary medical care** (GP or similar services),
b) the costs of **specialty care services**, **including the costs of ambulatory surgeries**,
c) the costs of **physicians' house calls** (in acute cases, as defined in medicine, when the condition (high fever, immobility) of the Policyholder/Insured does not make it possible to see the physician in his/her office),
d) the costs of **laboratory and diagnostic tests** which the insurance company shall only cover if these are necessary for the diagnosis and treatment of the illness.
VI.2.5. The costs of **same-day surgery.**
VI.2.6. Within the framework of **inpatient treatment**, the Insurance Company shall pay for the costs of the hospitalization and medical treatment of the Policyholder/Insured. The insurance, in particular, covers:
a) the costs of medical treatments prescribed by a physician, (including necessary surgeries);
b) the costs of hospital treatment;
c) the costs of therapeutic, or medically-necessary abortion.

VI.2.7. The insurance shall cover the costs of **medications, bandage, medical equipment for temporary use (products officially listed as durable medical equipment) if required for the medical care, subject to and taking account of the annual limit, pro rata limit and deductible set out in the insured's statement.**
The cost of these products need to be prepaid by the Insured. The Insurance Company will only reimburse the costs to the Policyholder/Insured if an insurance claim for the reimbursement of costs is filed to the insurance company in accordance with Clause V.3. and Clause V.4. of these general conditions, and the event underlying the insurance claim is covered under the insurance policy.
VI.2.8. **Patient transport:** If the Policyholder/Insured is immobile and has a medical need for transport to the medical facility providing healthcare, the insurance covers the cost of patient transport without medical supervision within the territory of Hungary, if it is required for medical and health services which qualify as insured events pursuant to these general conditions.
VI.2.9. **Subject to the annual limit, the insurance covers the costs of repatriation (transport home) to the native country of the Policyholder/Insured, if it is medically necessary (pursuant to a written opinion of the physician) and recommended by the service provider designated by the insurance company for the** Policyholder/Insured **to be repatriated.**

VII.3. Conditions for the payment of insurance benefits

VII.3.1. **The Insurance Company shall pay the costs of medical care received from the designated service provider, or arranged by or delivered with the cooperation of the designated service provider directly to the designated health care service provider.**
VII.3.2. If the insured receives medical treatment in an emergency at a medical facility other than the designated service provider, or without the management of the designated service provider, the Policyholder/Insured may be required to prepay the associated medical costs.
VII.3.3. If the cost of **medical care is prepaid by the Policyholder/Insured**, or if the Policyholder/Insured purchases medication and medical equipment, the insurance claim for the reimbursement of the costs of the medical and health care service must be submitted to the **designated health care provider** (University of Debrecen, Primary Care Clinic, 4032 Debrecen, Egyetem tér 1.) within 15 days from the issue date of the invoice.
VII.3.3.1. The insurance claim for the reimbursement of the cost of medical care prepaid by the Policyholder/Insured, or of the cost of medication and medical equipment purchased by the Policyholder/Insured, must be accompanied by the following documents:
a) the original invoice specifying the delivered medical or health care service, issued to the name of the Designated Medical Service Provider (Debreceni Egyetem [University of Debrecen], 4032 Debrecen, Egyetem tér 1.) quoting the Insured's name, or issued to the name of the Insured quoting the Insured's address, which shall be requested from the service provider no later than on the last day of the provision of the services,
b) a copy of all medical documents related to the insured event (e.g.: outpatient records, hospital discharge summary, examination records, nursing and care documentation, test findings, laboratory records, images made during diagnostic or histology tests, prescriptions, referrals, etc.) including all related precedence medical documentation and the documents produced during the first medical treatment.
c) the Insured's declaration quoting the bank account number of his/her (HUF) current account in Hungary (signed and dated).
VII.3.3.2. **In addition to the documents specified in the previous Clause, the Insurance Company is entitled to require that a copy of the following documents verifying the existence of the legal ground for the claim and/or necessary for determining the amount of the insurance benefit payable shall also be submitted for the assessment of the insurance claim:**
a) if an official investigation was initiated in connection with the circumstances which resulted in an Insured event, all the documents produced or used in the proceedings, as well as the resolution closing the proceedings (in particular the resolution terminating the proceedings, or a binding court decision). A binding court decision made in criminal proceedings, or a binding resolution adopted in misdemeanor proceedings only if this is available when the insurance claim is notified;
b) To allow for a clarification of all the circumstances of the event which led to the Insured event, the Insurance Company may require the submission of the following documents (statement by the Policyholder/Insured and/or any other person involved in the insured event about the circumstances of the insured event, the autopsy report,

the driver's license and vehicle registration certificate, the accident & injury report made by the employer, educational institution, transportation company, expert opinions on the accident/consequences);
c) A standard form furnished by the Insurance Company and completed by the treating physician of the Policyholder/Insured or by the health care provider where the Policyholder/Insured was treated, with medical information related to the insured event, the insured's medical condition, and the Insured's medical history;
d) The medical documentation of the Policyholder/Insured produced in connection with the insured event and his/her medical history: the medical file issued by a general practitioner, a company physician, or a physician supervising the insurance policy portfolio, as well as documents produced during outpatient or inpatient care, and documents in proof of the administration of pharmaceuticals;
e) The documents managed by the social insurance body or another person or organization, containing data regarding the insured with respect to the insured event or a circumstance leading to such an event (pursuant to the entitled party's authorization for a release from the confidentiality obligation and for a request of data);
f) The sports club membership card of the Policyholder/Insured or a membership certificate relating to his/her sports activities, or an official match report;
g) An official certificate in proof of the date of birth of the Policyholder/Insured (birth certificate, identification card, passport, driver's license);
h) The Insurance Company may also require that all documents necessary for the assessment of the insurance claim but produced in a foreign language shall be translated into Hungarian at the cost of the claimant, and the official translations shall be submitted to the Insurance Company for decision making.
i) The Insurance Company may require that original copies of such documents are presented and that they are also submitted on a form of electronic media.
VII.3.4. The Insurance Company may obtain further documents for the assessment of the insurance claim.
VII.3.5. If the documents available do not prove to be sufficient for the assessment of the insurance claim, the Insurance Company shall be entitled to require a medical examination of the Policyholder/Insured by a physician (hereinafter: medical examination required for claim settlement) at the expense of the Insurance Company.
V.3.6. If the documents required by the Insurance Company are not submitted or are incomplete despite a reminder, or if the Policyholder/Insured fails to attend the medical examination required for claim settlement, the Insurance Company will assess the claim on the basis of the documents available.

VII.3.7. The Insurance Company shall not be obliged to pay the benefit if the Policyholder/Insured or the claimant fails to comply with the obligations set forth in these general conditions, particularly if the time limit for reporting an Insured event is not observed and as a result material conditions or circumstances may not be revealed.

VIII.4. Rules of the payment of insurance benefits

If the claim is grounded, the Insurance Company shall settle the insurance claim prepaid by the Policyholder/Insured or by a third party on behalf of the Policyholder/Insured, within 15 days upon receipt of all documents necessary for the assessment of the claim, in local legal currency, by wire transfer to a bank account held in a bank in Hungary pursuant to the invoice and subject to the applicable payment conditions and benefit limits.

IX. Cases when the Insurance Company is Relieved from Benefit Payment, Events Excluded from Coverage

IX.1. The Insurance Company will be relieved from the benefit payment if it can prove that the event which resulted in the insured event was caused unlawfully and willfully or unlawfully and in gross negligence by
a) the Policyholder/Insured; or
b) a relative living in the same household with them.
IX.2. The Policyholder/Insured shall be acting in gross negligence in particular if:
a) the Policyholder/Insured was verifiably intoxicated or under the influence of drugs or other stupefying agents at the time of the event which led to the Insured event, and this fact contributed to the occurrence of the Insured event.

If a blood alcohol test was administered, the person is legally intoxicated if his/her blood alcohol concentration exceeds 1.5‰ – or 0.8‰ while driving a motor vehicle,
b) the insured operated a motor vehicle without a valid vehicle registration certificate or the insured did not have a valid license required for driving such vehicle, and this fact contributed to the occurrence of the event which led to the insured event;
c) the Policyholder/Insured has committed at least two traffic offenses at the time of the event which led to the Insured event, and as such the event which led to the Insured event resulted directly from these actions.
IX.3. When an event underlying an insured event occurs, the Policyholder/Insured is required to act as generally and reasonably expected in the given situation, and as such promptly seek emergency assistance or medical care. If the Policyholder/Insured fails to comply with this obligation, the Insurance Company will not be required to pay the insurance benefits. The refusal of a medical procedure by the Policyholder/Insured – due to his/her autonomy or freedom to decide guaranteed by law – shall not be an breach of his/her duty to mitigate loss.
The above shall not be construed, however, as limiting or restricting the Policyholder/Insured in freely choosing a physician or a medical and health service provider.
IX.4. If the Policyholder/Insured infringe their obligation to disclose the required information or to report changes, the Insurance Company's obligation to pay the benefits shall not set in, unless they can prove that any of the following circumstances exist:
a) the concealed or undisclosed circumstance was known to the Insurance Company at the time when insurance policy was concluded, or
b) the concealed or undisclosed circumstance did not intervene in the occurrence of the insured event.
IX.5. Furthermore, the insurance does not cover events caused in whole or in part by:
a) ionizing radiation,
b) nuclear energy,
c) infection by HIV,
d) war, combat operations, hostile actions of foreign forces, civil disorders, coup d'état or attempted coup d'état, riots, civil war, revolution, rebellion, demonstrations, processions, labor acts, terrorist acts, workplace disorder, border conflicts, insurrection.
For the purposes of these conditions warlike events shall mean war (whether war be declared or not), border conflicts, insurrection, revolution, riots, coup d'état or attempted coup d'état, civil war.
IX.6. Notwithstanding the provisions set forth in Clause VI.5.d., the insurance covers any physical or mental impairment of the health of the Policyholder/Insured which results from his/her active participation in demonstrations, processions, or strike actions announced in advance and organized in accordance with the provisions of effective Hungarian regulations, provided that the Insured has fully complied with his/her obligation to prevent and mitigate the damage.
IX.7. The insurance does not cover events which arise from a failed suicide attempt of the Policyholder/Insured, not even in the event that the Policyholder/Insured was mentally incompetent at the time when attempted suicide.
IX.8. The insurance does not cover medical and health services related to any of the following:
a) the illness or medical condition of the Policyholder/Insured which is proven to have existed prior to the effective date of the insurance coverage, or which had been diagnosed prior to the effective date of the insurance coverage, or which required treatment during this time period, or any permanent physical or mental impairment of the Insured that had been diagnosed prior to the effective date of the insurance coverage,
b) medical care related to pregnancy (confirmation of pregnancy, antenatal care) or child birth, and associated costs incurred,
c) abortion of pregnancy (with the exception of therapeutic abortion necessary to save the life or health of the mother, or if abortion is performed to terminate a pregnancy which was the result of a criminal act, or therapeutic abortion which is medically necessary due to expected abnormalities of the foetus),
d) surgeries related exclusively to treating infertility, and medical treatments related to any form of artificial reproductive techniques,
e) sterilization surgeries and consequences,
f) sex reassignment surgeries,
g) treatments and surgeries for aesthetic (cosmetic) purposes, and their consequences

h) vision correction surgeries,
i) dioptric glasses/sunglasses, contact lenses and their accessories, and the costs of the medical examination required for the above,
j) hearing aid,
k) dental care and treatments (with the exception of cases which require immediate care: fillings, root canal treatments, treatment of abscess, dental extraction; as well as accident consequences)
l) medical care in relation to HIV infection,
m) tests and treatments performed in relation to the consumption of alcohol, narcotic drugs or other addictions,
n) convenience (V.I.P.) health care services (e.g. single bedroom),
o) acupuncture, acupressure treatment, oriental medicine, alternative and naturopathic medicine,
ö) psychological disorders and psychiatric disorders; psychiatric treatment and psychotherapy,
p) purchase of vaccine for immunization shots, reimbursement of costs,
q) treatment received in sanatoriums or in assisted accommodation,
r) rehabilitation or nursing of chronic illnesses (especially geriatrics, hospice care, special needs education, speech therapy, physiotherapy, physical therapy, bath therapy, weight loss therapy, infusion therapy to improve blood flow, pain management infusion therapy), excluding treatments which are for the purpose of diagnosing chronic illnesses, initiation of a therapy, the prevention of significant deterioration of acute conditions,
s) medical care that is not for the purpose of diagnosis of illness for the Insured, or for the prevention of deteriorating condition and rehabilitation of the Insured's health, especially screening tests not ordered or attended in relation to this insurance, or a parent having to stay at a hospital with his/her child, nor is the Insured's stay at a hospital for the purpose of nursing a parent,
t) treatment by a person who does not have medical certification and permit to practice medicine, and medical or other health care treatment made necessary as a result of treatments performed by such person.
IX.9. The insurance shall not cover insured events which have been caused by the Policyholder/Insured's engagement in sports activities with increased risks listed herein: scuba diving under 40 m, singlehanded and open sea sailing, white-water rafting, hydro-speeding, canyoning, surfing, mountaineering and rock-climbing on routes graded 5 or higher, high-mountain expeditions, caving and cave expeditions, bungee jumping, auto-motor sports (e.g. auto-crash, go-kart, motocross, motorboat sports, motorcycle sports, rally, ability competitions by car), quad, private flying/sports flying/aviation sports (e.g. paragliding, ballooning, motor sail plane, hang-gliding and ultra-light flying, hot-air ballooning, parachute jumping, free plane flying, stunt flying, base jumping).
IX.10. The insurance does not cover insured events which may have been directly caused by the Policyholder/Insured's engagement in or pursue of the following hazardous activities or occupations: stuntmen, circus artists, equilibrists, test pilots, flight test pilots, parachute jumpers, jet plane crew in the army, bodyguards, commando staff, foreign legionnaires, peacekeepers, secret agents, armed guards, armored car personnel, specialists or officers serving in the army who are exposed to high levels of risks during their activities (e.g. bomb experts, divers).

X. Miscellaneous Provisions

X.1.Limitation Period

X.1. The limitation period of claims enforceable under the policy shall be one (1) year.

VII.1.2. If the Policyholder/Insured prepaid the costs of the medical and health care services (medical bill), the limitation period with respect to the Insurance Company's benefit payment obligation will commence at the following points in time:

a) if the insurance claim is not notified to the Insurance Company, on the day following the last day when the medical and health care services are provided,
b) if an insurance claim is notified to the Insurance Company then on the day following the 15th day after the last document is received by the Insurance Company,
c) if an insurance claim is notified to the Insurance Company and if the documents or information required by the Insurance Company are not submitted or disclosed, on the day following the deadline of the document

submission or information provision set out by the Insurance Company, or in the absence of such a deadline, on the day following the 30th day of the issue date of the written communication served for that purpose.

X.2. Dispute resolution procedure

If the customer disputes the position of the Insurance Company in connection with an insurance claim, he/she may request a review of the decision in writing. The review shall be carried out by the competent organizational unit of the Insurance Company within 30 days upon receipt of all documents/data necessary for the assessment of the request and the decision shall be communicated to the customer.

X.3. Communication between the Insurance Company and the Insured, as well as notices addressed to the Insured persons shall be made both in Hungarian and in English, it being understood that the insurance policy is concluded in Hungarian and therefore in disputes or disagreement the Hungarian wording shall prevail.

XI. Standard terms of the general conditions that substantially differ from the provisions of the Hungarian Civil Code

This chapter summarizes the provisions of the General Terms and Conditions of STUDIUM Fee-for-service Health Insurance which substantially differ from the respective provisions of the Hungarian Civil Code.

XI.1. Within the meaning of Clause II.2.1 of these conditions, and by way of derogation from Section 6:443 (1) of the Civil Code, the insurance policy will be concluded pursuant to an **agreement executed in writing** by the Policyholder and the Insurance Company.
XI.2. The provision on the statute of limitations set out in Clause VII.1 of these conditions differs from the five (5) year limitation period prescribed in Section 6:22 (1) of the Civil Code. **The limitation period for claims arising under this contract shall be 1 (one) year.**