STUDIUM Fee-for-Service Health Insurance – Terms and Conditions (STUDIUM22)

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The official language of this document is Hungarian. In the event of any inconsistency between the Hungarian version and the translated English version, the Hungarian version shall prevail.

These general terms and conditions of STUDIUM Fee-for-Service Health Insurance (STUDIUM22) (hereinafter: Policy Conditions or General Conditions) set out the standard conditions for STUDIUM Fee-for-Service Health Insurance offered by Generali Biztosító Zrt. (hereinafter: insurance company), provided that the insurance policy (hereinafter: Insurance Policy or Policy) has been concluded by reference to these general conditions. In the case of matters not regulated by these general conditions, the insurance policy shall be governed by the provisions the Customer Information (Customer Information and General Provisions Governing Insurance Policies), as well as the applicable provisions of the **Civil Code** and **other effective Hungarian regulations.**

In the event of discrepancy between the Customer Information and General Provisions Governing Insurance Policies, an integral part of the insurance policy, and these policy conditions, the provisions of these policy conditions shall prevail.

Under the insurance policy, the Insurance Company undertakes to provide coverage for the insured risks defined in these general conditions and pay out the insurance benefits if an insured event occurs and the insurance claim is grounded, while the Policyholder undertakes to pay the insurance premium.

SECTION 1 DEFINITIONS

1.1. **Application and Statements (hereinafter: Declarations):** is a written document bearing a serial number which contains the Policyholder's declarations about their intention to conclude the insurance contract, 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 Insured's declaration concerning the payment of benefits, all forming an integral part of the insured's declaration to which it is annexed. The Application and Declarations document shall constitute an integral part of the STUDIUM insurance policy.

1.2. **Disease (illness):** any deviation from or interruption of the normal structure or function of the human body.

1.3. **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.

1.4. **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.

1.5. **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.

1.6. **Specialty health care:** health care services received by the insured pursuant to a referral of a primary care physician.

1.7. **Health care service provider (medical facility):** 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.

1.8. **Designated health care service provider:** the health care service provider contracted with the Insurance Company to render health care services and specifically named on the Health Insurance Card by the Insurance Company.

1.9. **Outpatient care** includes the treatment of any person who, as a result of an accident or illness, receives primary medical or specialist care which does not qualify as neither same-day surgical care or inpatient care.

10. **Same-day surgery:** an elective, scheduled surgical procedure within the meaning assigned to it by law performed in a duly licensed medical facility, which does not require an overnight hospital stay and the patient may be escorted home after an observation period of no longer than 24 hours, provided that on the basis of the patient s medical test results – and pursuant to a medical expert opinion in accordance with the rules of the medical profession – such a surgery is necessary and may be performed.

1.11. **Inpatient care** shall be provided for any person who, as a result of an accident or illness, is hospitalized in a medical facility for more than one days to receive medical care, and the person spends every night during his/her hospitalization between admission and release in such medical facility in connection with the medical treatment. The insured shall be hospitalized for multiple days if his/her release from the health care institution is on a later day than that of his/her admission.

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1.12. **Emergency care** provided in the event of a sudden change in the Insured's health or condition as a consequence of which the Insured's life would be at direct risk, or could suffer severe or permanent injury to health without receiving immediate medical attention. In such a case, the emergency services number must be called.

1.13. **Emergency out-of-hours service:** medical facilities that are established and operated within the public health care system for the treatment of cases which require urgent care, and that provide continuous availability of medical care outside daily working hours.

1.14. **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.

1.15. **Health insurance card:** A card bearing the same serial number as that of the Application and Declarations document referred to in Clause 1.1, issued by the insurance company containing the most important data related to the insurance coverage, which is designed to be proof of the insurance to be presented to the Health care service provider.

1.16. **Annual Limit:** The upper threshold of the Insurance Company's total benefit payment obligation in relation with the Insured's health care treatment during the whole term of the insurance coverage (max. 12 months) applicable to the Insured and with respect to the particular benefit types (annual limit), as specified in the Application and Declarations document and in the STUDIUM Insurance Product Information Document, all integral parts of the policy, in excess of which the Insurance Company is not required to pay additional benefits.

1.17. **Pro rata limit:** the upper limit of the Insurance Company's benefit payment obligation specified in the Application and Declarations document and in the STUDIUM Insurance Product Information Document as a part of the annual limit in respect of certain named benefit types included in the Insured's medical care during the particular period of insurance, provided that the Insurance Company applies such limits.

1.18. **Deductible:** A lower benefit limit applicable to the payment obligation of the Insurance Company specified in the Application and Declarations document and in the STUDIUM Insurance Product Information Document, which must be interpreted and applied for each insured event and each Insured person separately, and which corresponds to an amount that the Insured is required to pay himself/herself with respect to the Insured's medical care, provided that the Insurance Company applies deductibles.

1.19. **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.

1.20. **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: outpatient records, hospital discharge summary, operative report, examination records, nursing and care documentation, test findings, medical expert opinion, laboratory records, images made during diagnostic or histology tests, prescriptions (copy), referrals (copy).

1.21. **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. Medication does not include contraceptive pills, emergency contraceptive pills (morning after pills), condoms, etc.

1.22. **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.

1.23. **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.

1.24. **Medical case management:** the arrangement and coordination of medically necessary health care services (in particular, elective outpatient and inpatient care) for the insured. Medical case management includes the coordination of the provision of medical and health care services to the insured, the monitoring and checking medical and health care services and their routes, communication with the medical facilities or service providers treating the insured, administration of medical and health care services arranged or notified to and approved by the medical management company.

1.25. **Fee for Service insurance:** 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..

SECTION 2 GENERAL PROVISIONS

2.1. Parties to the Insurance Contract

2.1.1. The insurance company is Generali Biztosító Zrt (hereinafter: insurance company) which shall, in consideration of the insurance premium payment, bear the insurance risk during the insurance period specified in the policy (in the Application and Declarations document), and undertakes the obligation to **reimburse the costs** of the services set forth in these policy conditions.

2.1.2. 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.)

2.1.3. For the purposes of these policy conditions, the **Insured** may be any natural person of foreign citizenship – over age 18 but under age 65 – temporarily resident in Hungary whose health is covered under the insurance policy with respect to specific insured events, **and who is actively enrolled as a student (and has a validated student ID card) at the educational institution specifically named in the STUDIUM Insurance Product Information Document at the time when the insurance policy is concluded and throughout the term of the insurance coverage applicable to the Insured.**

2.1.4. **The beneficiary of this insurance is the insured person.**

2.2. Conclusion of the Insurance Policy

2.2.1. The insurance policy is concluded pursuant to the written agreement between the Policyholder/Insured and the Insurance Company whereby **the Policyholder/Insured completes and signs the Application and Declarations document, and after the insurance policy is validly concluded, the Insurance Company issues the Health Insurance Card, which evidences the conclusion and validity of the coverage.**

2.2.2. This insurance policy is a single premium insurance contract. The insurance premium shall be stated in the Application and Declarations document (defined in Clause 1.1.). Insurance premium shall become due at the time when the insurance policy is taken out, and therefore the Policyholder/Insured shall pay the insurance premium when the contract is concluded.

2.2.3. The Insurance Company does not carry out underwriting at the time when the insurance policy is concluded.

2.2.4. The insurance company issues a Health Insurance Card which contains the most important information related to the insurance coverage.

2.3. Commencement of the insurance coverage, waiting period

2.3.1. With respect to the particular Insured person, the insurance coverage shall commence at 0 a.m. of the day following the day when the Application and Declarations document signed by the Policyholder/Insured is received by the Insurance Company, but no sooner than the first day of the insurance period, provided that the insurance premium for the period of insurance stated in the Application and Declarations document has been paid to the Insurance Company in full (if these two conditions are met on different dates, the coverage shall commence at 0 a.m. of the day following the day when both conditions have been met).

The Policyholder 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.

2.3.2. The insurance company does not stipulate a waiting period in the insurance policy.

2.4. Policy Period

2.4.1. The STUDIUM fee-for-service health insurance policy shall be concluded for the period of insurance stated in the Application and Declarations document, as well as on the Health Insurance Card, on the understanding that the period of insurance may not be longer than one year (12 months).

2.4.2. If the period of insurance is one year, the period of insurance shall start on the 1st of September of the current year and shall end on the 31st of August of the subsequent calendar year.

2.4.3. The period of insurance shall be stated in the Application and Declarations document (defined in Clause 1.1.).

2.5. Termination of the Insurance and the Insurance Coverage

2.5.1. The insurance coverage for the particular Insured terminates:

a) at the end of the period of insurance stated in the Application and Declarations document/on the Health Insurance Card, or
b) at the end of the period of insurance in which the insured reaches the age of 65, or
c) if the insured's enrollment with the educational institution named in the Product Information Document terminates for whatever reason, at the end of the current period of insurance.
d) if the insured dies, at the time of his/her death.
e) if the insurance premium is not paid, pursuant to the following: if the Policyholder/Insured fails to settle the single premium by the due date (at the time when the policy is concluded), the insurance company will send the policyholder a written payment reminder stipulating at least an additional 30 (thirty) day deadline, including advice on the legal consequences of payment default. If the policyholder fails to comply with his payment obligation within the additional period, the policy shall be terminated with effect to the date when the insurance policy was concluded, except if the insurance company forthwith moves to enforce its claim by judicial process.

2.6. Geographical Limit

The insurance coverage is limited to the territory of Hungary, and applies to medical care as well as medical and health care services received in Hungary, subject to the provisions of these policy conditions.

2.7. Rights and Obligation of Parties to the Insurance Policy

2.7.1. The Policyholder/Insured are required to comply with their obligation to disclose information and notify changes.

2.7.1.1. **The duty of the policyholder and the insured to disclose information**

Pursuant to their duty to disclose information, when taking out the insurance or when filing an insurance claim under the insurance policy, the policyholder/insured is required to disclose every matter known to them or that they know to be relevant to the insurance company's decision to accept the risk or assess the claim. By giving complete and true answers to the written questions of the insurance company, and by making true and accurate declarations on the standard forms of the insurance company and/or voice recordings, parties shall have complied with their obligation to provide information.

2.7.1.2. The obligation of disclosure and notification of changes equally apply to the Policyholder and the Insured. Neither of them shall be entitled to refer to any circumstance that either one had neglected to disclose or report to the Insurance Company though it must have known about it and should have disclosed or reported it.

2.7.2. **The duty of the policyholder and the insured to communicate change**

While the insurance policy is in force, the policyholder/insured is required to notify the insurance company in writing of any change in any relevant condition stated on the insurance application or included in the insurance policy within 5 workdays following such change.

Relevant material circumstances shall be all circumstances which the Insurance Company raised questions about, and which the policyholder/insured is required to disclose information about, including particularly the policyholder's/insured's name, address, mailing address, as well as their email address if electronic communication has been selected.

The insured shall not be required to communicate any changes in his/her health or medical conditions to the insurance company.

2.7.3. The insurance company's right to terminate or amend the insurance policy if new, relevant material circumstances arise or if the insured risk significantly increases

2.7.3.1. If the insurance company becomes aware of certain material circumstances or is advised of a change to material circumstances regarding the policy only after the policy has been concluded, and these circumstances bring about a considerable increase in the insured risk, within fifteen (15) days of gaining knowledge of the new circumstances the insurance company shall be entitled to propose that the policy be amended or that the policy – or if there are multiple insured persons, the applicable insurance coverage – be terminated by serving a thirty (30) day written cancellation notice.

If the insurance company fails to exercise this right, the insurance policy shall remain in force on the original terms.

2.7.3.2. If the policyholder does not accept the proposed modification or does not respond to it within 15 days of its receipt, the insurance policy or the provisions proposed to be modified will terminate on the 30th day after notification of the proposal for modification was given, provided that the insurance company has advised the insured of this legal consequence when sending out the notification.

2.7.4. Under the health insurance policy, the Insurance Company undertakes to reimburse health care services organized for the Insured persons (in Hungary) by the Designated health care service provider named in the Application and Declarations document.

2.7.5. With the exception of medical emergencies, the Insured shall receive all health care services directly from, or arranged by, or notified and approved by the Designated health care services provider.

2.8. Insurance premium

2.8.1. The Policyholder undertakes to pay the insurance premium in **one sum and in advance for the period of insurance specified in the** Application and Declarations (for the whole term of the policy) at the time **when the insurance policy is concluded.**

2.8.2. The policyholder 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.

2.8.3. Irrespective of the date when the insurance is concluded in any given period of insurance, the insurance premium must be paid in full for the current period of insurance.

SECTION 3 INSURANCE COVERAGE

3.1. Insured events

3.1.1. The insurance covers medical and health care services provided to the insured by the Designated health care provider named on the Health Insurance Card, or arranged for by, notified to and approved by the same 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.

3.1.2. **For the purposes of this clause, illness, medical conditions and accidents shall be unprecedented relative to the commencement of the insurance coverage of the particular insured if they are not in any way connected to the insured's any such 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 health impairment.**

3.1.3. If the Insured's medical treatment was not provided or arranged for by the Designated service provider, the Insurance Company will reimburse the costs of such treatment – provided that the claim is otherwise grounded – only 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 had been notified of the treatment within 48 hours of the beginning of the treatment.

3.2. General provisions on the payment of insurance benefits and cases of limited benefit payment

3.2.1. The Insurance Company's obligation to pay an insurance claim arising from an insured event means the obligation to **reimburse the medical expenses** related to only such medical, health care and other services which are specifically defined in this section.

3.2.2. The Insurance Company's service provision obligation **is limited to the reimbursement of the costs of medical care or health care services provided and received in Hungary.**

3.2.3. The insurance company shall reimburse the costs of the insured's duly notified, medically reasonable and justified health care treatment, as specified in these policy conditions, provided always that the health care treatment is covered under the insurance and its necessity is evidenced by the insured. The Insurance Company shall only reimburse these costs **if the tests and examinations are necessary for the diagnosis or treatment of the illness, and they are performed pursuant to the referral/recommendation of the physician.**

3.2.4. **The Insurance Company shall reimburse the medical expenses incurred in relation to health care services specified in these policy conditions, subject to the annual limit, pro rata limits and deductibles defined in these policy conditions.**

3.2.5. 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 pay the insurance benefit, the 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.**

3.2.6. Within the framework of the outpatient treatment, the insurance company shall pay for:
a) the costs of **primary medical care,**
b) the costs of **specialized health care** treatment,
c) **the costs of laboratory and diagnostic tests** (e.g.: blood and urine tests, X-ray diagnostics, ultrasound examination).

3.2.7. **The insurance company will reimburse the costs of same-day surgeries (1.10.).**

3.2.8. **Within the framework of inpatient treatment,** the insurance pays for the costs incurred from the insured's hospitalization and medical treatment. The insurance, in particular, covers:
a) the costs of medical care prescribed by a physician, (including necessary surgeries);
b) the costs of nursing.

3.2.9. The Insurance Company shall reimburse the **costs of medications, dressings, bandages, and durable medical equipment** (products officially listed as durable medical equipment) **necessary for outpatient care** up to the annual limit (1.15.), and subject to the pro rata limit (1.16.) and the deductible (1.17.) stated in the Application and Declarations document.

The costs of medications, dressings, bandages, and durable medical equipment required for outpatient care must be prepaid (1.11) by the Insured. The Insurance Company shall only reimburse the prepaid medical expenses within the meaning of this paragraph, if the Insured duly **submits an insurance claim** for the settlement of such medical expenses in accordance with these general conditions, and **in accordance with the Insurance Product Information Document.**

3.2.10. **Patient transport** If the insured is immobile, or has a medical need for transport to the premises 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.

3.2.11. Subject to the annual limit, the insurance covers the costs of a **one-time repatriation** (transport home) if it is medically necessary (as evidenced in the written opinion of the physician) and also recommended by the Designated service provider for the Insured to be repatriated back and continue treatment in his or her country of residence.

3.3. Payment of insurance benefits

3.3.1. **The Insurance Company shall pay the costs of medical care received from the Designated health care provider, or arranged by or delivered with the cooperation of (notified to and approved by) the Designated service provider directly to the Designated service provider.**

3.3.2. If the Insured receives medical treatment at a medical facility other than the Designated service provider, or without the coordination of the Designated service provider, or in an emergency at an emergency department or emergency room, the **Insured may be required to prepay such medical expenses (1.14).**

3.3.3. The Insurance Company shall only reimburse the medical costs of any treatment received in an emergency by an emergency care provider other than the Designated service provider if the Designated service provider has been duly consulted about the treatment – provided always that the claim is grounded.

3.3.4. If the costs of the medical services are prepaid by the insured (prepaid medical care), the insurance claim for the reimbursement of such costs must be submitted to the insurance company within 15 days from the issue date of the invoice.

3.3.4.1. To assess insurance claims arising out of pre-paid medical treatments and health care services, the Insurance Company may 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 benefit payable shall be submitted.

a) the invoice issued about the delivered medical treatment (health care services), showing the name and address of the Insured (as well as the policy number);
b) a copy of all medical documents related to the insured event;
c) the Insured's declaration quoting the bank account number of his/her (HUF) current account in Hungary (signed and dated);
d) if an official investigation was initiated in connection with the circumstances which resulted in an insured event, all the documents produced or referred to during the proceedings, as well as the resolution closing the proceedings (in particular the resolution terminating the proceedings, or a binding court decision);
e) documents necessary for a detailed investigation of the particular circumstances of the insured event (statement by the insured and/or any other person involved in the insured event about the circumstances of the insured event, the vehicle registration certificate, the accident & injury report made by the employer, educational institution, transportation company/police, experts opinions on the accident/consequences);
f) a standard form furnished by the Insurance Company and completed by the Insured's treating physician or by the health care provider where the Insured was treated, with medical information related to the Insured event, the Insured's medical condition, and the Insured's medical history;
g) the Insured's medical documentation produced in connection with the insured event and the insured's medical history: the medical file issued by a general practitioner or a company physician, as well as documents produced during outpatient or inpatient care;
h) 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);
i) 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;
j) 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 chosen by the customer;
k) The Insured or the Beneficiary is also entitled to prove his/her claim for the service with other documents in accordance with the general rules of proof in order to enforce his/her claim. Thus, for example, he/she is also entitled to submit a final decision in criminal proceedings and infringement proceedings to the insurer.

3.3.6. 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 Insured by a physician (hereinafter: medical examination required for claim settlement) at the expense of the Insurance Company.

3.3.7. If the documents required by the Insurance Company are not submitted or are incomplete despite a reminder, or if the 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.

3.3.8. The Insurance Company shall not be obliged to pay the benefit if the 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.

3.3.9. Pursuant to a request initiated within 15 days upon receipt of the insurance claim by the insurance company, the insurance company is entitled to obtain additional documents for the assessment of the insurance claim, which it will communicate to the customer.

3.4. Rules of the payment of insurance benefits

If the insurance claim is grounded, the prepaid medical expenses shall be reimbursed within 15 days upon receipt of all the documents which are necessary for the assessment of the insurance claim, by wire transfer in local legal currency, in respect of covered services and subject to the benefit limits.

When documents are obtained, the insurance company is required to pass a decision about the claim within 120 days after receiving the insurance claim, and shall communicate the decision to the customer.

3.5. Exclusions

3.5.1. **The insurance does not cover medical and healthcare services or events partly or entirely arising out of or related to any of the following, or any associated costs incurred:**

- **a) the Insured's illness or medical condition 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 contraception, pregnancy (confirmation of pregnancy, antenatal care) or child birth (including postpartum care),**
- **c) medical abortion of pregnancy, unless termination of the pregnancy was necessary to preserve the life or health of the mother, or if termination of the pregnancy was performed in a case where pregnancy was the result of a criminal act,**
- **d) medical procedures and surgeries related exclusively to diagnosing and treating infertility and related to human reproduction, as well as medical treatments related to any form of artificial reproductive techniques,**
- **e) sterilization surgeries and consequences,**
- **f) sex reassignment surgeries, and any associated costs incurred,**
- **g) consequences of treatments and surgeries performed for aesthetic (and/or cosmetic) purposes,**
- **h) vision correction surgeries performed on the cornea,**
- **i) dioptric glasses/sunglasses, contact lenses and their accessories, and the medical examination required for the above,**
- **j) hearing aids and accessories,**
- **k) dental treatments and dental surgery, with the exception of cases requiring emergency care (root canal treatments, treatment of abscess, dental extractions),**
- **l) health care treatment in relation to HIV infection,**
- **m) health care treatments and services (tests, treatments, detox and withdrawal treatments) performed in relation to the consumption of alcohol, narcotic drugs or other addictions (e.g.: the abuse of narcotic substances or medicine),**
- **n) convenience (V.I.P.) health care services (e.g. single or V.I.P. bedroom, V.I.P. meals, other special convenience services which are available for extra fees),**
- **o) acupuncture, acupressure treatment, oriental medicine, alternative and naturopathic medicine,**
- **ö) psychological disorders and psychiatric disorders; psychiatric treatment and psychotherapy (psychological therapy) and care,**
- **p) bodily injury caused intentionally by the insured person to himself/herself, even if the insured person did it while he/she was in a state of altered level of consciousness,**
- **q) costs of the vaccine for immunization shots and their administration,**
- **r) treatment received in sanatoriums or in assisted accommodation,**
- **s) transplantation, dialysis, the oncology treatment, nursing and control examinations related to malignant tumors, other treatments required to treat the consequences of malignant tumors (e.g.: bowel obstructions, surgical treatment of bone metastases),**
- **t) 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, injection administered into a joint), with the exception of treatments which are for the purpose of diagnosing chronic illnesses, or of initiating a therapy,**
- **u) 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,**
- **v) treatment by a person who does not have medical certification and permit to practice medicine, as well as medical care or other health care treatment made necessary as a result of treatments performed by such person,**
- **w) 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.**
- **x) medical research on human subjects, treatments related to experimental diagnostics and therapy, treatments which are not approved under the clinical protocols, standards and guidelines adopted by Hungarian medical facilities, the costs of treatments, instruments not approved or not financed by the National Health Insurance Fund of Hungary (NEAK/OEP), as well as procedures subject to individual NEAK/OEP funding, and any associated costs incurred, as well as procedures subject to individual NEAK/OEP funding,**
- **y) insurance claims related to contagious diseases (e.g.: Tuberculosis, tetanus, hepatitis B and C), tropical diseases (malaria, yellow fever, Cholera, Dengue fever, Severe Acute Respiratory Syndrome) and sexually transmitted diseases (STDs),**
- **z) medical care and health care services related to disaster management and public health as specified in the legislation, including the costs relating to any compulsory vaccination shots required at a certain age or for an occupation.**

3.5.2. **The insurance does not cover events which occurred while the insured is covered under the insurance (during the coverage period) and medical services which arise out of or caused in whole or in part by such event, as well as the associated costs incurred if**

- **a) the event occurred in relation to Insured's consumption of alcohol, abuse of drugs, administration of stupefying agents or pharmaceuticals, unless the latter was administered as prescribed by the treating physician;**
- **b) the Insured was verifiably under the influence of alcohol or drugs, stupefying agents or medication at the time of the event. If a blood alcohol test was administered, for the purposes of this paragraph, the person is 'under the influence of alcohol' if his/her blood alcohol concentration exceeds 1.5‰ – or 0.8‰ while driving a motor vehicle,**
- **c) the Insured was driving a motor vehicle without a valid driver's license or vehicle registration certificate as well at the same time also committed other traffic violations.**
- **d) the Insured was driving a motor vehicle under the influence of alcohol when the insured event occurred and at the same time also committed other traffic violations.**

3.5.3. **Furthermore, the insurance does not cover events which were 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.

3.5.4. **Notwithstanding the provisions set forth in Clause 3.5.3.d above, the insurance covers any injuries to the Insured's health 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.**

3.5.5. **The insurance does not cover events which arise from the Insured person's attempted suicide, not even in the event that the Insured was mentally incompetent at the time when attempted suicide.**

3.5.6. **The insurance does not cover events which may have been caused by the Insured's engagement in sports activities with increased risks listed herein: scuba diving to a depth of 40 metres, singlehanded and open sea sailing, white water rafting, , riverboarding (hydrospeed), 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 sport, motorboat sports, motorcycle sports, rally, ability competitions by car), quad biking, 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).**

3.5.7. **The insurance does not cover events which may have been directly caused by the 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).**

3.6. Exemptions

3.6.1. **The insurance company will be released 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 insured; or
b) a relative living in the same household with them.

3.6.2. **When an event underlying an insured event occurs, the insured is required to act as generally and reasonably expected in the given situation, and as such promptly seek emergency assistance or medical care (duty to mitigate loss).**

The insured's refusal – in exercising the right of disposition to which he is entitled by virtue of law – to a medical procedure shall not constitute an infringement of the obligation to mitigate damages. The insured must act as generally expected in the given situation to prevent the occurrence of an insured event.

If the Insured fails to comply with this obligation, the Insurance Company will be exempt from the benefit payment.

3.6.3. **Nothing in the above shall be construed, however, as limiting or restricting the insured in freely choosing a physician or a medical and health care service provider.**

SECTION 4 MISCELLANEOUS PROVISIONS

4.1. Limitation period

4.1.1. **The limitation period of claims enforceable under the policy shall be two (2) year.**

4.1.2. If the insured has prepaid the costs of the medical and health care services (Clause 3.3.4.), 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,
d) in other cases, at the date when the claim falls due.

4.2. 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. 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.

4.3. Policy Provisions that substantially differ from the provisions of the Hungarian Civil Code or standard contractual practice

4.3.1. **This chapter summarizes the provisions of the General Terms and Conditions of STUDIUM Fee-for-service Health Insurance (STUDIUM22) which substantially differ from the respective provisions of the Hungarian Civil Code (hereinafter also: Ptk) or from standard contractual practice.**

4.3.2. Within the meaning of Clause 2.2.1 of these policy 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.

4.3.3. The provision on the statute of limitations set out in Clause 4.1.1. of these policy 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 two (2) year.**

4.3.4. Pursuant to point e) of Clause 2.5.1 of these policy conditions, and by way of derogation from Section 6:449 (1) of the Civil Code, the insurance company will send the policyholder a written payment reminder with **at least an additional thirty (30) day deadline stipulated** if the policyholder fails to settle the insurance premium by the due date.