STUDIUM Fee-for-Service Health Insurance – Terms and Conditions (STUDIUM22_2)

These general terms and conditions of STUDIUM Fee-for-Service Health Insurance (**STUDIUM22_2**) (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.

1. Definitions

1.1. The **Insured's Declaration** is a numbered written document which contains the Insured's legal statements and declarations with respect to the health insurance policy, as well as 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, and a loss payable clause with respect to the payment of benefits, which forms an integral part of the Insured's Declaration to which it is annexed. The Insured's Declaration constitutes an integral part of the 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 coverage period, and as a result of which the insured suffers permanent health 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 (non-specialist) medical and health care: treatment by a general practitioner or similar, which is generally available and necessary as a result of illness or accident.
1.6. Specialized medical 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 healthcare provider: the healthcare 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: the medical treatment of the insured required as a result of an accident or illness, and provided by a physician or specialist, unless such medical care qualifies as same-day surgical care or inpatient care (hospitalization).

1.10. 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 following the patient's admission to the treating facility, 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.

1.12. Emergency care is 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 insured's declaration referred to in Clause 1.12, issued by the insurance company containing the most important data related to the insurance, which shall be proof of the insurance coverage at the Health Care Service Providers.

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 STUDIUM Insurance Product Information Document, an integral part of the policy, in excess of which the Insurance Company is not required to pay additional benefits. The Contracting Parties expressly agree that, notwithstanding the provisions of Section 6:461 of the Civil Code, the Insurance Company may apply the reduction of the cover pursuant to this clause without advising the Policyholder thereof and without notifying the fee for maintaining the amount of insurance cover at the same time as the service is provided.

1.17. Pro rata limit: the upper limit of the Insurance Company's benefit payment obligation specified in health insurance policy 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 (policy period), provided that the Insurance Company applies such limits. The Contracting Parties expressly agree that, notwithstanding the provisions of Section

6:461 of the Civil Code, the Insurance Company may apply the reduction of the cover pursuant to this clause without advising the Policyholder thereof and without notifying the fee for maintaining the amount of insurance cover at the same time as the service is provided.

1.18. Deductible: a lower limit of the Insurance Company's benefit payment obligation set out in the STUDIUM Product Information Document, which is to be applied and understood separately to every insured event and insured person, and which corresponds to an amount which the insured shall himself/herself cover with respect to the insured's medical care.

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 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).

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. Contraceptives, emergency contraceptive pills (morning after pills), condoms, etc. are not considered medication.

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 administration of medical and health care services arranged by 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 – under the coverage of an insurance policy subject to the terms and conditions set out and stipulated therein.

2. General Provisions

2.1. Parties to the insurance policy (Insurance Company, policyholder, insured and beneficiary)

2.1.1. The insurance company is **Generali Biztosító Zrt** (hereinafter: Insurance Company) which shall, in consideration of the insurance premium payment, cover the insured risks during the insurance period specified in the policy, and undertakes the obligation to **reimburse the costs** of services set forth in these policy conditions.

2.1.2. The **Policyholder** may be an educational institution which takes out the insurance policy from the Insurance Company and agrees to pay the insurance premiums. **The policyholder of the insurance policy concluded pursuant to these policy conditions is not a consumer.** Consumer shall mean any natural person acting for purposes which are outside his trade, business or profession.

2.1.3. The **Insured** may be a natural person whose life or health is covered in the insurance policy with respect to specific insured events.
2.1.4. An insured person may be a natural person of foreign nationality who is over 18 years of age and under 65 years of age at the time when the insurance contract is concluded and whose health is covered under the insurance policy with respect to specific insured events, and is in active enrolment (with a valid student card sticker) with the Policyholder at the time when the insurance contract is concluded and throughout its entire duration, provided that the Policyholder has declared the insured person to the Insurance Company and has paid the insurance premium applicable to him/her.

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

2.2. Conclusion of the insurance policy and the insurance coverage
2.2.1. The insurance policy is concluded by execution of a written agreement by and between the policyholder and the Insurance Company.
2.2.2. In order to add new insured persons to the coverage of the insurance policy **(extension of coverage)**, **a written consent of the particular insured needs to be obtained**. This may be done so if the new insured duly completes and signs the Insured's Statement (hereinafter: Insured's Statement) as well as the Health Insurance Card. The Insured's Declaration constitutes an integral part of the insurance policy. The Insured is required to complete all the prescribed declarations with complete and true information.
2.2.3. The Insurance Company does not carry out underwriting.
2.2.4. Any insurance premium paid by the Policyholder prior to the conclusion of the insurance policy or the extension of coverage shall be deemed as an advance premium, which the Insurance Company will handle free of interest.
If the insurance policy or the extension of coverage is concluded, the advance premium shall count in full against the insurance premium. If the insurance policy or the extension of coverage is not concluded, the Insurance Company shall refund the advance premium to the policyholder.
2.2.5. **The policyholder may propose** the amendment or modification of the insurance policy or the coverage options, and may add or remove insured parties to or from the insurance coverage. **The insured's consent is not required for the conclusion, amendment, modification or termination of the insurance policy.**
2.2.6. Pursuant to the agreement of the Policyholder and the Insurance Company, each insured person may only have one STUDIUM cover for any one period of insurance.

2.3. Commencement of the insurance coverage, waiting period
2.3.1. The insurance coverage of the particular insured shall commence at 0 a.m. of the day following receipt of the duly and fully completed Insured's Insured's Declaration by the Insurance Company. provided that the Policyholder has paid the insurance premium in respect of the particular Insured in full to the Insurance Company.
2.3.2. The Insurance Company does not stipulate a waiting period in the insurance policy.

2.4. The policy period and the term of the insured's coverage
2.4.1. The health insurance policy is concluded by and between the Policyholder and the Insurance Company for a fixed period.
2.4.2.The insurance cover of any one insured shall be for a fixed term, up to the duration of the group health insurance policy concluded between the Policyholder and the Insurance Company, on the understanding that the duration of the insurance cover shall correspond to the duration of the active enrolment of the Insured with the Policyholder. This insured's coverage will commence at the time specified in Clause 2.3.1. and will be terminated in the cases and at the dates specified in Clause 2.5.1. The period of insurance is specifically indicated on the insured's declaration.

2.5. Termination of the insurance and the insurance cover of the insured

2.5.1. The insurance cover for the particular Insured terminates:

a) upon termination of the insurance policy between the Policyholder and the Insurance Company for any reason, or

b) **in the event of non-payment of the premium, after 30 days from the due date of the premium payable for the particular insured person, without a separate payment reminder to this effect sent by the Insurance Company, including the setting of a grace period,** or

c) if the insured's active enrollment with the Policyholder terminates for any reason, at the end of the current period of insurance.

d) at the end of the period of insurance in which the insured reaches the age of 65, or

e) if the insured dies, at the time of his/her death.

2.6. Geographical limit

2.6.1. 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 the parties to the insurance policy

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 agree to cover the risk or in the assessment of 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 policyholder and the insured are equally bound by the duty to disclose information and notify changes; Neither of them shall be entitled to refer to any circumstance that either one had neglected to disclose or report to the Insurance Company although 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 is not required to communicate 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.

2.8. The Insurance Company may also use the services of a medical management company to arrange healthcare services provided by the Designated Healthcare Provider under the insurance policy concluded with the Policyholder. With the exception of medical emergencies, the Insured is obliged to receive all health care services arranged by, or notified to and approved by the Designated Healthcare Provider or the medical management company.

2.8. Insurance premium

2.8.1. The insurance premium is received in consideration of the insurance coverage offered by the Insurance Company. The Insurance Company may claim the insurance premium for the whole period of the insurance coverage.

2.8.2. **The insurance premium is required to be paid by the Policyholder.**

2.8.3. The policyholder will have fulfilled his/her obligation to pay the insurance premium **at the time when the insurance premium is received on the account of the Insurance Company**.

2.8.4. The **method and schedule of payment of the insurance premium shall be determined by the Policyholder and the Insurance Company in the health insurance policy**.

2.8.5. Parties hereby agree that if the Policyholder fails to pay the insurance premium, the health insurance policy shall terminate on the 30th day following the due date of the insurance premium, **even without a written payment reminder sent by the Insurance Company, setting an additional deadline for the payment.**

2.8.6. In the event that the insurance policy is terminated due to the non-payment of premiums, the Insurance Company is entitled to claim the insurance premium in proportion to the actual duration of the insurance coverage.

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 Healthcare Provider named on the Health Insurance Card, or arranged 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, **a trauma, an illness or a medical condition shall have no prior history** relative to the commencement of the insurance coverage if it is not in any way connected with a trauma, illness or medical condition of the insured which existed or was diagnosed or treated before the commencement of the insurance cover of the particular insured, or with a previously determined permanent health impairment.

3.1.3. If the insured's medical treatment was not provided or arranged by the designated healthcare 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 healthcare provider (emergency), and the designated healthcare provider had been notified of the treatment within 48 hours of the beginning of the treatment.

3.1.4. The date of the insured event is the first day when medical care is received. For the purposes of these general terms and conditions, health care services attributable to the same injury, impairment, illness, cause or health problem which occur on the same day or in the course of the same health care treatment and which belong to the same type of service shall be considered as a single insured event.

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 settle an **insurance claim arising out of an insured event means the obligation to reimburse the costs of medical, healthcare and other services specifically stated in the insurance policy, in accordance with the provisions set out in these policy conditions (Clause 3.2.).**
3.2.2. The Insurance Company's obligation to cover the costs of healthcare **is limited to the reimbursement of the costs of medical or health care services** arranged by the Designated Healthcare Provider or the medical management company**, 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. Insurance Company shall only reimburse these costs if the tests and examinations are necessary for the exploration or treatment of the illness, and these are performed pursuant to the referral / recommendation of the physician.
3.2.4. **Pursuant to Clauses 1.16, 1.17 and 1.18, 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 cost of **specialist medical care**,
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 (within the meaning of Clause 1.10.).**
3.2.8. The Insurance Company will reimburse the costs of the insured's hospital stay and treatment in the context of inpatient care. The insurance, in particular, covers:
a) the costs of medical care prescribed by a physician, (including necessary surgeries);
b) the costs of nursing;
c) the costs of therapeutic abortion performed for medical reasons.
3.2.9. The Insurance Company will reimburse the costs of medications, dressings, bandages, and durable medical equipment (products officially listed as durable medical equipment) necessary for medical treatment, taking into account the annual limit, the pro rata limit and the deductible stated in the insured's declaration, if such a benefit is included in the insurance policy.
The costs of medications, dressings, bandages, and temporary durable medical equipment required for health care must be prepaid by the insured. The Insurance Company will only reimburse the costs of the prepaid services referred to above to the insured if an insurance claim for the reimbursement of costs is filed to the Insurance Company in accordance with Clause 3.3.4.1. of these general conditions, and the event underlying the insurance claim is covered pursuant to the policy conditions.
3.2.10. Patient transport. If the insured becomes immobile or cannot get to a health care institution, the Insurance Company will reimburse the cost of patient transport – not requiring ambulance supervision – within the national borders, if it is necessary to receive healthcare services that are defined as insured events according to the 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 healthcare provider for the insured to be repatriated back and continue treatment in his or her country of residence.

3.3. Payment of Claims

3.3.1. The Insurance Company shall pay the costs of medical care received from the designated healthcare provider, or arranged by or delivered with the cooperation of (notified to and approved by) **the designated healthcare provider directly to the designated healthcare provider.**
3.3.2. If the insured receives medical treatment at a medical facility other than the Designated Healthcare Provider, or without the coordination of the Designated Healthcare Provider/medical management company, or in an emergency at an emergency department or emergency room, the insured may be required to prepay such medical expenses.
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 healthcare provider only if 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) copies of all medical documents relating to the insured event;
c) a statement (signed and dated) containing the Insured's Hungarian (HUF) bank account number;
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;
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 shall be entitled to evidence its insurance claim by other documents and receipts according to the general rules of providing evidence in order to be able to enforce such claim. For instance, the insured is also entitled to submit to the Insurance Company the final court decision adopted in criminal proceedings and in infringement proceedings.
3.3.5. 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 Insured by a physician (hereinafter: medical examination required for claim settlement) at the expense of the Insurance Company.

3.3.6. If the documents required by the Insurance Company are not submitted or are incomplete despite a reminder, or if the insured person fails to attend the medical examination required for claim settlement, the Insurance Company will assess the claim on the basis of the documents available.
3.3.7. 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.
3.3.8. The Insurance Company is entitled to obtain additional documents for the adjustment of the insurance claim if such documents are requested within 15 days of receipt of the insurance claim and the request is communicated to the customer.

3.4. Rules of the payment of insurance claims

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 health 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,
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 oral 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 or intoxicating substance 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) ***physical injuries deliberately inflicted by the insured to himself/herself, even if the insured person did so while he/she was in a state of impaired 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,
ü) 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,
v) 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,
w) 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 occurrences while the insured is covered under the insurance (during the coverage period) and the associated costs incurred, if
a) the event occurred in relation to Insured's consumption of alcohol, abuse of drugs, administration of intoxicating substance or pharmaceuticals, unless the latter was administered as prescribed by the treating physician;
b) the insured was demonstrably under the influence of alcohol or drugs or any other intoxicating substance 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. The insurance does not cover, furthermore, 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.
3.5.4. Notwithstanding the provisions set forth in Clause 3.4.3.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 related causally to the insured's attempted suicide, even if the insured committed the suicide attempt in a state of impaired consciousness.
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 its obligation to pay the claim if the Insurance Company 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.

4. Miscellaneous Provisions

4.1. Limitation period

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

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_2) which substantially differ from the respective provisions of the Hungarian Civil Code (hereinafter also: Ptk) or from standard contractual practice.
4.3.1.1. 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.
4.3.1.2. Pursuant to Clause 2.2.5., and by way of derogation from Section 6:475. of the Civil Code, **the consent of the insured is not required for concluding, amending and terminating the insurance policy.**
4.3.1.3. Pursuant to Clause 2.5.1., and by way of derogation from Section 6:449 (1) of the Civil Code, if the **insurance premium** for a particular insured is not paid by the due date, the respective insurance coverage shall **terminate on the 30th day following the first missed due date**, **without an additional deadline set for the payment.**
4.3.1.4. Within the meaning of Clause 2.7.1.2 of these policy conditions, and by way of derogation from Section 6:451. (1) of the Civil Code, the **insured may not replace the policyholder in the insurance policy**.

4.3.1.5. Pursuant to Clause 2.8.4., and by way of derogation from Section 6:449 (1) of the Civil Code, if the **Policyholder fails to pay the insurance premium**, the health insurance policy shall terminate on the 30th day following the due date of the insurance premium, **without an additional deadline set for the payment.**
4.3.1.6. 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 insurance policy shall be 2 (two) years.**
4.3.1.7. The Parties expressly agree that, notwithstanding the provisions of Section 6:461 of the Civil Code, the Insurance Company may apply the reduction of the limit and pro rata limit without advising the Policyholder thereof and without notifying the fee for maintaining the amount of insurance cover at the same time as the service is provided.