„STÚDIUM" Fee-for-Service Health Insurance – Terms and Conditions

The present general insurance terms and conditions shall, unless otherwise agreed by the parties hereto, be applicable to the fee-for service health insurance contracts of Generali-Providencia Biztosító Zrt., provided that the insurance contract referred to herein (hereinafter: contract) has been concluded with reference to the present conditions.

As regards issues not regulated under these terms and conditions, provisions of the Hungarian Civil Code and effective Hungarian regulations shall prevail.

Section 1 Definition of Terms

1.1. Illness: abnormal physical or mental condition known in generally acknowledged medicine.
1.2. **Accident:** a sudden, one-time, external physical or chemical impact occurring during the period of insurance, independently of the will of the insured and resulting in a permanent injury to the health of the insured, or the death of the insured.
1.3. **Health care:** any and all health care activities that can be pursued in possession of an operation permit issued by the health care authority (the Hungarian medical officer's and professional supervision), which aims at examining and treating the patient, 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, as well as rescue and patient transport.
1.4. Primary health care: health care services which can be freely received by the insured person at his/her own discretion, without the physician's order.
1.5. Specialized health care: health care used by the insured person upon the physician's order.
1.6. Health care service provider: an organization which is recognized by the medical authorities (Hungarian medical officer's and professional supervision), is entitled to provide health care services in accordance with effective legislation, and whose operation is authorized in Hungary.
For the purposes of the present conditions, **health care service provider 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.

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1.7. 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.
1.8. Outpatient care shall be provided for any person who, as a result of an accident or illness, receives primary medical or specialist care the duration of which does not exceed 24 hours, and which is not considered as inpatient care.
1.9. Inpatient care shall be provided for any person who, as a result of an accident or illness, is hospitalized in a health care service provider institution for several days to receive medical attention, and the person spends every night during his/her hospitalization, between admission and release, in such institution 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.
1.10. Emergency: a sudden change in health conditions as a consequence of which the insured person's life would be at direct risk, or could suffer severe or permanent injury to health without receiving immediate medical attention.
1.11. Pre-financed 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 are settled to the service provider directly by a person or entity other than the insurance company.
1.12. Proposal/policy/statements (insured's statement): is a written document which contains the insured's declarations with respect to the health insurance contract, and in particular information regarding the rights and obligations of the insured, the name of authorities and institutions which the insurer's secrecy obligation shall not apply to, as well as the insured's Assignment with respect to the payment of benefits, forming an integral part of the insured's statement to which it is annexed. The insured's statement shall be an integral part of the Stúdium contract to which it is annexed. An insured's statement referred to above shall be completed and signed by the insured every time when insurance is taken out.
1.13. Health insurance card: A numbered card with an embedded hologram issued by the insurance company containing the most important data related to the insurance, the insurance period for which the insurance premium has been paid and the reference number of the proposal/policy/statement, which is designed to be proof of the insured status before the Health care service provider. A Health insurance card shall be issued for any one insured only once, when the first insurance is concluded. If the insured takes out insurance once again after the first insurance period is over by completing and signing a new Proposal/policy/statement form referred to above in Section 1.12, the health insurance card, which has been issued before, shall be validated with a hologram that contains the period of the particular insurance as well as the number of the signed Proposal/policy/statement.
1.14. Annual limit: the upper threshold of the Insurance Company's total benefit payment specified in the Stúdium Product Information material which is an integral part of the contract, in relation with the insured's health care treatment during a given insurance/fiscal year and with respect to the particular benefit types, above which the Insurance Company shall not be bound to provide services (pay benefits).
1.15**. Pro rata limit**: a part of the annual limit pro rata temporis for the services specified in the Stúdium Product Information material, in relation with the insured's health care treatment and with respect to the particular benefit types in a given insurance period.
1.16. Deductible (or excess): a lower threshold of the Insurance Company's benefit payment obligation specified in the Stúdium Product Information material, which is an

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integral part of the contract, construed and applied by insured events and by insureds. This is the amount which the insured shall cover himself/herself in relation with the insured's health care treatment.

Section 2 General Provisions

2.1. Parties to the insurance contract (insurance company, policyholder, insured)

2.1.1. Generali-Providencia Biztosító Zrt. (hereinafter: insurance company) shall, in consideration of the insurance premium payment, bear insurance risk during the period of insurance specified in the contract, and undertakes the obligation to pay the insurance benefits set forth in these general terms and conditions.
2.1.2. Policyholder also Insured: a party that enters into the insurance contract by signing the Proposal/policy/statements (insured's statement) in a consolidated structure and undertakes to pay the insurance premium.
2.1.3. **Insured:** any natural person whose health is covered under the insurance contract with respect to specific insured events, and **who is a student at the University of Debrecen (registered seat: H-4032 Debrecen, Egyetem tér 1.) during the term of the insurance.**
2.1.4. For the purposes of the present terms and conditions, insured can be a natural person with foreign citizenship **who is not less than 16 and not more than 65 years of age** as at the date when the insurance contract is concluded, and is not insured under the national social insurance scheme in Hungary.
2.1.5. Furthermore a natural person who has not yet reached the age of 18 and is a close relative (by definition of the Hungarian Civil Code) to an insured as defined in the foregoing (Section 2.1.4) may be insured under this insurance provided that he/she is not insured under the national social insurance scheme in Hungary.
2.1.6. For the purposes of this insurance contract, insured shall not be engaged in the following occupations, nor shall pursue the following activities:
stuntmen, circus artists, equilibrists, test pilots, parachute jumpers, jet plane crew in the army, bodyguards, commando staff, foreign legionnaires, peacekeepers, secret agents, armed guards, armored car personnel, contractors working in the army or persons in conscription who pursue increased danger activities (e.g. bomb experts, divers).

2.2. Execution of the insurance contract:

2.2.1. The contract shall be concluded by execution of a written agreement by and between the policyholder and the insurance company.
2.2.2. The consolidated version of the insurance 'proposal/policy/statements', as defined in Section 1.12, shall be an integral part of the contract to which it is annexed.
2.2.3 The insurance may be taken out (the insurance contract concluded) for any one insurance period by the insured completing and signing a form that includes the insurance proposal/policy/statement. When the insurance is first taken out, a Health insurance card referred to in Section 1.13 is issued for the Insured, which is validated by a hologram and must be signed by the Insured. The insurance will automatically terminate at the end of the insurance period for which the insurance premium has been paid, but the insured shall be entitled to renew the insurance for a subsequent insurance period by once again completing and signing the proposal/policy/statements

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form that is referred to herein. When the insurance is renewed for a second or subsequent insurance period, no new Health insurance card is provided, but the Health insurance card referred to in Section 1.13 which was issued when the insurance was first taken out shall be validated by placing a self-adhesive hologram label on the Health insurance card which shows the policy number of the proposal/policy/statement as well as the insurance period for which the insurance premium has been paid.
2.2.4. The insurance company shall be entitled to collect advance premium in the amount of the first premium or single premium of the contract, which shall be regarded as an interest-free advance payment.
If the contract is concluded, the insurance company shall include the premium advance in the insurance premium. In case the contract is not concluded, the insurance company shall refund the advance premium to the policyholder.
2.2.5. Before concluding the contract, the insurance company is entitled to carry out underwriting and for that purpose may require a statement of health (pre-conditions), medical tests or other written declarations from the insured. The insurance company shall be entitled to verify the data so obtained.
2.2.6. In the medical statement, as well as in all other written declarations, all data or circumstances explicitly requested by the insurance company in the form of questions or in a statement must be true and accurate.

2.3. Effective date of the contract, commencement of coverage

2.3.1. The insurance company shall be entitled to set out a waiting time in the contract, the duration of which shall be a maximum of 6 months from the entry into force of the contract. The term of the waiting period, if stipulated by the insurance company, is indicated by the insurance company on the endorsement of the contract and/or the policy. During the waiting period, the insurance coverage shall be partial, and it shall only apply to accidents and insured events in direct causal relationship with accidents.
2.3.2. The insurance coverage for the particular insured shall commence, taking into account the waiting period if one is stipulated by the insurance company in the contract and/or policy, at the time when the insurance contract is concluded **at 0 hours on the day following the day when the proposal/policy/statements are signed**, provided that the premium for the particular insurance period has been credited to the bank account of the insurance company.
2.3.3. If the insurance contract is concluded and the insurance company does not complete underwriting for the particular insured, the insurance company shall cover the particular insured from the day following the day when the insured's statement is signed, subject to the provisions on the waiting period.

2.4. Term of coverage, technical commencement of premium payment

2.4.1. This health insurance contract is concluded for a definite period corresponding to an insurance period.
2.4.2. Insurance year/fiscal year: 1 (one) year starting on 1st January of the current year and ending on 31st December of the current year.
2.4.3. The insurance/fiscal year can be divided into two insurance periods. These insurance periods are aligned to the semesters of the school year in accordance with the following.

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Insurance period I: from 1st September of the current year to 28th February of the year following the current year.
Insurance period II: from 1st March of the current year to 31st August of the current year.
Insurance periods shall be specified on the insurance proposal.
2.4.4. The **technical commencement** of the insurance is the first day of the particular insurance period.

2.5. Termination of the contract, termination of the insurance coverage

2.5.1. The contract shall terminate:
a) at the date specified in the contract (at the end of the insurance period), or
b) in the case of non-payment of premium, after 30 days from the due date of the first missed premium, or
c) at the end of the insurance/fiscal year in which the insured reaches the age of 65, or
d) if the insured dies.

2.6. Geographical limit of the insurance

2.6.1. The insurance coverage shall only be applicable in the territory of the Republic of Hungary.

2.7. Rights and Obligations of the Parties to the Contract

2.7.1. Any amendment of the contract shall be subject to a written consent from the insured.

2.8. Obligation of the policyholder and the insured to disclose data and report changes

2.8.1. The policyholder and the insured shall comply with their obligation to disclose data and report changes.
2.8.2. Obligation to disclose data shall mean that when making an insurance proposal the policyholder and the insured person shall declare to the insurance company all circumstances which may be relevant for underwriting and which they are or must have been aware of. Parties shall comply with their obligation to disclose data by answering the written questions of the insurance company provided that such statements and answers are true and accurate.
2.8.3. Obligation to report changes shall mean that during the insurance period the policyholder and the insured shall give written notification of any change in any relevant condition specified or included in the contract within 15 days following such change. Relevant condition shall include everything that the insurance contract provides for or which the insurance company has asked or which was required to be stated.
2.8.4. The insurance company shall be entitled to verify any disclosed data.
2.8.5. If the obligation to disclose data and report change is infringed, the insurance company shall be exempt from payment of the insurance benefit, save for the case when it is proven that the undisclosed or undeclared condition was known or must have been known to the insurance company at the time when the insured event occurred.

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2.8.6. The occurrence of any of the above cases shall be evidenced by the party that refers to it.
2.8.7. If the insurance company becomes aware of any relevant condition after the conclusion of the contract, it may initiate the amendment of the contract within 15 days after obtaining such information, or if it does not accept the risk under the new circumstances, it may terminate the contract in writing giving 30 days notice.
2.8.8. If the policyholder (insured) does not accept the recommended modification or does not respond within 15 days from its receipt, the contract shall terminate on the 30th day after notification of the modification was given (for the particular insured), provided that the insurance company has advised the insured of this legal consequence when sending notification of the modification.

2.9. Insurance premium

2.9.1. For all issues in relation to the payment of the insurance premium, the consolidated version of the insurance proposal/policy/statements shall apply.
2.9.2. The policyholder shall fulfill 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.
2.9.3. The policyholder undertakes to pay the insurance premium at the time when the insurance contract is concluded, or if payment deferment is applied, at the payment dates specified, in one sum and in advance for each insurance period.
2.9.4. If the contract is terminated as a result of a default on premium payment, the insurance company shall be entitled to claim insurance premiums in proportion to the actual period in which coverage was provided.

Section 3 Insurance coverage

3.1. Insured Event

3.1.1. The insurance covers events when, during the period of insurance, the insured receives health care services in a medically justified case as a result of an accident or illness from a health care service provider named (designated) on the Health insurance card in accordance with the conditions of the contract. Health care services received in other institutions shall only be covered if the condition of the insured did not make it possible to be treated in the designated institution.

3.2. **Services of the insurance company**

3.2.1. The insurance shall cover health care services provided in Hungary only.
3.2.2. The insurance shall cover costs related to the insured's medically justified health care treatment as defined in these conditions provided that their justified use is properly supported by the insured.
3.2.3. The insurance benefit the insurance company shall pay to cover the costs of health care services under this insurance contract, shall be limited to the annual limit and pro rata limit as specified in the consolidated version of the proposal/policy/statements, and shall be reduced by the deductible, if the insurance company applies deductibles.

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3.2.4. Within the framework of the outpatient treatment, the insurance company shall pay for:
a) the costs of primary health care services,
b) the costs of specialized health care treatment,
c) the costs of a physician's field-work incurred when the insured's condition does not make it possible to visit the physician in his/her office (e.g. case of emergency),
d) the costs of special tests (e.g. laboratory tests, X-ray diagnosis, ultrasound examination); which the insurance company shall only cover if these are necessary for the exploration or treatment of the illness.)
3.2.5. Within the framework of inpatient treatment, the insurance company shall pay for the costs incurred from the insured's hospitalization and medical treatment. The insurance company, shall in particular pay for:
a) the costs of medical treatments prescribed by a physician, (including necessary surgeries);
b) the costs of nursing;
c) the costs of medically justified abortion.
3.2.6. The insurance shall cover the costs of medications, bandage, temporary medical aids (products officially listed as medical aids) if required for the health care treatment, subject to and taking account of the annual limit, pro rata limit and deductible set out in the consolidated version of the proposal/policy/statements.
3.2.7. Costs of travel or transport to a physician are covered by the insurance if they are within the territory of the country and such transport to the hospital (in an ambulance, taxi) is medically justified.
3.2.8. The insurance company shall cover the costs of repatriation (transport home) if the condition of the insured so requires or makes it possible and the medical service provider specified by the Insurance Company also recommends repatriation.

3.3. Payment of Insurance Services

3.3.1. The insurance company shall pay the costs of medical treatment received from, arranged by or delivered with the cooperation of the designated health care service provider directly to the designated health care service provider.
3.3.2. The Insurance Company shall pay the costs of emergency health care services received from other than the designated health care service provider in an emergency after consultation between the designated health care SP, the affected health care SP and the insured.
3.3.3. If the cost of a **pre-financed health care treatment is settled by the insured**, the insurance claim for recovering the costs of the health care service must be filed to the insurance company within 15 days from the issue of the invoice.
3.3.3.1. To enforce an insurance claim for covering the costs of any health care service, the following documents shall also be submitted to the insurance company:
a) original invoices certifying payments, issued to the name and address of the Service Provider
b) a copy of all medical documents related to the insured event.
3.3.3.2. If the claim is grounded, the designated service provider shall settle the insurance claim within 15 days upon receipt of all documents necessary for the assessment of the claim.

3.4. Exclusions

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3.4.1. The insurance shall not cover:
a) any illness or pathological condition of the insured which has been proven to have existed prior to the effective date of the insurance cover, or any permanent health damage of the insured which has been diagnosed prior to the effective date of the insurance coverage.
b) hospitalization related to pregnancy, child birth,
c) 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) surgeries related exclusively to treating infertility, and medical treatments related to any form of artificial reproductive techniques,
e) sterilization surgeries and consequences,
f) sex reassignment surgeries,
g) treatments and surgeries exclusively for aesthetic (cosmetic) purposes,
h) eye correction surgeries,
i) dioptric glasses/sunglasses, contact lenses and their accessories,
j) hearing aid,
k) dental treatments, with the exception of acute conditions, cases of emergency and accident consequences,
l) health care services in relation to HIV infection,
m) tests taken and treatments performed in relation to the consumption of alcohol or narcotic drugs,
n) convenience (V.I.P.) health care services (e.g. single bedroom),
o) acupuncture, acupressure treatment, oriental medicine,
ö) psychiatric treatment,
p) immunization shots,
q) treatment received in sanatoriums or in assisted accommodation,
r) rehabilitation or nursing of chronic illnesses (especially geriatrics, hospice care, special needs education, speech therapy, physiotherapy, physical therapy, bath therapy, weight loss therapy), excluding treatments which are for the purpose of diagnosing chronic illnesses, initiation of a therapy, the prevention of significant deterioration of acute conditions,
s) medical care that is not for the purpose of diagnosis of illness for the insured, or for the prevention of deteriorating condition and rehabilitation of the insured's health, especially screening tests not ordered in relation to this insurance, or a parent having to stay at a hospital with his/her child, nor is the insured's stay at a hospital for the purpose of nursing a parent,
t) treatment by a person who does not have medical certification and permit to practice medicine, and medical or other health care treatment made necessary as a result of treatments performed by such person.
3.4.2. Furthermore, the insurance will not cover events which are in part or in whole caused by any of the following:
a) mental abnormality,
b) HIV infection
c) ionizing radiation,
d) nuclear energy,
e) warlike event, or a crime against the state.

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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.
3.4.3. The insurance shall not cover insured events which may have been caused by the insured's engagement in sports activities with increased risks listed herein: scuba diving under 40 m, one-arm and open sea sailing, white-water rafting, hydrospeed, canyoning, surfing, mountaineering and rock-climbing from peg 5, high-mountain expeditions, caving and cave expeditions, bungee jumping, auto-motor sports (e.g. auto-crash, go-kart, moto-cross, motorboat sports, motorcycle sports, rally, ability competitions by car), quad, private flying/sports flying/aviation sports (e.g. paragliding, ballooning, motor sail plane, hanggliding and ultra-light flying, hot-air ballooning, parachute jumping, free plane flying, stunt flying, base jumping).

3.5. Exemptions

3.5.1. The insurance company shall be exempt from payment of the insurance benefit if the insured event was caused by an unlawful and willful behavior of the policyholder or the insured or unlawfully and in gross negligence by them.
3.5.2. The insured shall act in gross negligence, in particular, if
a) the insured event occurred in relation to regular alcohol consumption, drug consumption, the administration of stupefying agents or medications by the insured, unless the latter was administered as prescribed by the attending physician,
b) the insured was verifiably in an alcoholic condition at the time of the insured event, or was under the influence of drugs or stupefying agents and this fact intervened in the occurrence of the insured event. If a blood alcohol test was performed, blood alcohol concentration exceeding 1.5‰ – or 0.8‰ during driving a vehicle – shall be deemed as an alcoholic condition.
c) the insured drove a motor vehicle without a valid traffic license or the insured did not have a valid driving license required for driving such vehicle, and this fact intervened in the occurrence of the insured event.
d) the Insured has committed at least two traffic offences violating the traffic regulations effective in the particular country at the time of the occurrence of a traffic accident.
3.5.3. If the policyholder or the insured infringe their obligation to disclose or to report changes, the insurance company's obligation to pay the benefits shall not set in, unless it is proven that any of the following circumstances exist:
a) the concealed or unreported circumstance was known to the insurance company at the time of concluding the contract; or
b) the policyholder or the insured infringed their obligation to report changes, but the insurance company was made aware of such concealed or unreported circumstance during the term of insurance, before an insured event, and the insurance company did not exercise its rights to amend or terminate the contract within 15 days, or
c) the concealed or unreported circumstance did not intervene in the occurrence of the insured event.
3.5.4. Should an insured event occur, the insured must act as generally expected in the given situation; accordingly, the insured must have recourse to prompt medical assistance and must keep to the instructions of the acting physician on an on-going basis until completion of the therapeutic procedure. The insurance company shall be exempt from its obligation to pay benefits to the extent that the insured did not comply

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with this obligation. This provision shall not affect the insured's right to a free choice of a physician.
3.5.5. The verity of the circumstances listed must be evidenced by the party referring to them.

Section 4 Miscellaneous provisions

4.1. Legal statements, notices

4.1.1. All notifications and statements given to the insurance company shall be addressed to the insurance company and executed in writing, unless otherwise provided for herein.

4.2. Filing Complaints

4.2.1. Complaints in connection with the insurance contract can be reported to the insurance company by telephone calling the Generali TeleCenter at 06-40 200 250, in writing sending an email to generali@generali.hu, or a fax message to 06-1-452-3927, or in person at the Customer Relationship Division of Generali-Providencia Insurance Ltd. (42-44 Teréz Blvd., Budapest H-1066).

4.2.2. The insurance company will investigate all filed complaints and shall give a written notice to the complainant on the findings of such investigations within 30 days of the date when the complaint came to the attention of the insurance company.

4.3. Limitation

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

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