Generali Company Care Health Insurance

General Terms and Conditions (GCC-ÁSZF/02016)

Effective from: August 1, 2016

Nysz.: 19542

Contents

Generali Company Care Health Insurance

General Terms and Conditions (GCC-ÁSZF/02016)

These general terms and conditions (hereinafter: general conditions or policy conditions) set out standard conditions for **Generali Company Care Health Insurance policies (hereinafter: policy)** offered by **Generali Biztosító Zrt. (hereinafter: insurance company),** provided that the policy has been concluded by reference to these general conditions.

All matters not regulated by these general conditions will be governed by the provisions of the **Hungarian Civil Code** or the provisions of other **effective Hungarian legislation.**

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

I. Content of the Insurance Policy

Under the insurance policy, the insurance company undertakes to provide coverage for the insured risks set forth in these general and special conditions, and to pay the insurance benefits if an insured event occurs; the policyholder, in turn, undertakes to pay the insurance premium.

II. General Provisions

II.1. Parties to the insurance policy (insurance company, policyholder, insured and beneficiary)

II.1.1. **Insurance company** is a legal entity which, in consideration of the payment of insurance premium, provides coverage for the insured risk and undertakes the obligation to deliver insurance services (pay insurance benefits) set forth in the related special policy conditions.

II.1.2. **Policyholder** may be a **person or organization who is not a consumer** and takes out an insurance policy from the insurance company and agrees to pay insurance premiums.

Pursuant to these general conditions, the policyholder of the insurance policy cannot be a sports federation, sports association, sports club, sports community or sports undertaking employing or contracting with professional and competing athletes as defined in Clauses VII.4.1 and VII.4.2. of these general conditions.

II.1.3. Unless otherwise agreed by the parties, **the insured may be a natural person employed by the policyholder whose health is covered under the insurance policy with respect to specific insured events,** and who is more than 18 but not yet 69 years of age on the date when he/she is added to the insurance coverage as insured (entry date).

II.1.4. An insurance policy may be taken out to cover multiple **insured groups.** Each insured group may contain insureds who are exposed to identical occupational risks and are eligible for identical insurance benefits. In terms of occupational risk, the insurance company shall differentiate between average and hazardous occupations. The list of hazardous occupations are contained in Schedule 2 of these general terms and conditions.

Insured groups may only be defined on the basis of the job, place of work, or position in the organizational hierarchy. When completing the insurance application and the insured's statement, the policyholder or the insured is required to clearly define the insured group based on the respective job, place of work, or position in the organizational hierarchy. If several types of business activities are pursued at the place of work specified in the employment contract, the exact place of the job activities shall also be specified.

II.1.5. **Beneficiary** is the person who is entitled to receive the insurance benefit. In respect of fixed sum covers, subject to the written consent of the insured, the policyholder can designate a beneficiary in a written notice addressed and delivered to the insurance company. The designation may be withdrawn or modified (and a new beneficiary be named) in the same manner any time prior to the occurrence of an insured event.

II.1.5.1. **Designation of a beneficiary shall be repealed** if the beneficiary dies or is dissolved without succession before an insured event occurs.

II.1.5.2. A beneficiary may be designated and the designation may be modified at the time when the insurance is taken out and/or any time during the policy period prior to the occurrence of an insured event.

II.2. Conclusion and modification of the insurance policy

II.2.1. If the policy is not concluded by the parties in writing, the insurance company shall issue a document to certify insurance coverage.

II.2.2. If the certificate of coverage is issued with terms which differ from those on the insurance application, and this difference is **not contested** by the policyholder without delay, or **within a maximum of 15 days,** the policy will take effect on the different terms. If the policyholder rejects (contests to) the derogation, the insurance policy shall not be concluded. **The insurance company shall warn the policyholder of any material derogation in writing at the time when the certificate of coverage is delivered.** In the absence of this warning, the policy will enter into force with the terms specified on the application.

II.2.3. The policyholder is bound by the insurance application for 15 (fifteen) days – in the event of medical underwriting for 60 days – of the date of the application's submission.

II.2.4. Unless otherwise stipulated in these policy conditions, the insurance policy may only be modified in writing by mutual consent of the policyholder and the Insurance Company.

II.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 conclusion and the modification of the insurance policy, and the removal of the insured person from the insurance coverage does not require the consent of the insured.**

II.2.6. If the benefit package is modified, the exclusion set out in Clause VI.4. will be applicable to the new benefits and services included the new benefit package as of the date of the policy modification.

II.3. Conclusion of the insurance coverage, its content, the rights and obligations of the parties

II.3.1. The policyholder is entitled to initiate the addition of insured persons to the coverage of the insurance policy by obtaining from all persons insured under the insurance policy a signed copy of the **insured's statement** completed with true and accurate information, and unless otherwise agreed by the parties, to **submit one original copy to the insurance company** no later than within 3 workdays after the insured's statement is signed. **The insurance coverage will take effect by the acceptance of the insurance company.**

II.3.2. **The insured may withdraw the insured's declaration any time in a written statement.** As a result of the withdrawal, the insurance coverage applicable to the particular insured shall terminate at 0 hours of the first day of the month following the day when the withdrawal has been received by the insurance company.

II.3.3. Before approving a request to add a new insured into the insurance coverage, the insurance company **may carry out medical underwriting** in the course of which it may put questions to the insured, and require that the insured should give a medical history statement or other written declarations, or attend medical examinations. The insurance company may require the insured to complete a paper-based medical history statement form, or to make such statement over the phone at a prearranged point of time. If the medical history statement is given over the phone, the telephone conversation is recorded, and the voice recording is retained by the insurance company for as long as a claim may be enforced under the insurance policy, or as long as it is required by law. The insurance company will have not more than 60 days to complete the medical

underwriting procedure. **The insurance company shall be entitled to verify any data so obtained.**

The insured may look into the results of the medical examinations at the healthcare service provider in accordance with the Act on Healthcare.

II.3.4. The findings of the underwriting procedure will determine whether the insurance company approves or denies the request for adding a new insured person to the coverage, or proposes a modification. The insurance company is not required to give reasons for the denial of the insurance application or for any proposed amendments.

II.3.5. The **policyholder is required** to inform the insured persons of the content of the policy conditions and of any amendments made thereto.

II.3.6. **The insured may not replace the policyholder in the insurance policy.**

III.3.7. The policyholder and the insured are required to comply with their **obligation to disclose information and notify changes. The insured shall not be required to communicate any changes to his/her health or medical conditions to the insurance company.**

II.3.8. **The obligation to disclose information means** that the policyholder and the insured are required to declare to the insurance company all circumstances which may be relevant for underwriting purposes, and which they were or must have been aware of. The parties are bound by this obligation when the insurance is taken out or when an insured person is added to the coverage, and throughout its whole duration. Parties have complied with their obligation to provide information if they make the required declarations and statements, answer all questions asked by the insurance company, provided that such answers are complete, true and accurate; they are also required to notify any changes in such data and information. Attending the medical examination shall not exempt the insured person from his/her disclosure obligation. The insurance company shall be entitled to verify any data or information disclosed by the insured on the statement.

II.3.9. If the birth year of an insured person was misstated and it is established that the insurance coverage could not have been offered on the basis of the actual year of birth, the insurance company will follow the procedure set out in Clause II. 6.3, or may challenge the insurance policy.

II.3.10. The **duty to notify changes means** that during the coverage period the policyholder and the insured are required to give **written notification** of any change in any relevant condition which have been disclosed on the insurance application or on the insured's statement or which have been specified in the policy, within 5 workdays following such change.

II.3.11. **Relevant condition** shall be everything that the insurance company has required to be stated, in particular, the policyholder's and the insured's name, permanent or temporary residence, or registered seat, mailing address, the insured's job, job activities, sports activities, participation in competitions, if the reference person named by the policyholder changes, the name, telephone numbers, fax number and email address of the reference person.

Unless otherwise agreed by the parties, **the policyholder is required to inform the insurance company if the persons insured under the insurance policy change, preferably 30 days before the effective date of such change but no later than within 8 days after the change.**

II.4. Commencement and termination of the insurance coverage and the waiting period

II.4.1. If the insurance company **does not carry out medical underwriting, the insurance coverage with respect to the particular insured shall commence at 0 am on the first day of the month following the month in which the insured's statement is received by the insurance company, provided that the policyholder has paid the insurance premium applicable to the particular insured to the insurance company.**

II.4.2. If the insurance company **carries out medical underwriting,** and as a result, agrees to **accept the risk,** the insurance coverage with respect to the particular insured shall commence at 0 am on the first day of the month following the month in which the underwriting is closed, provided that the policyholder has paid the insurance premium applicable to the particular insured to the insurance company.

II.4.3. **With respect to the particular insured persons, the insurance coverage will terminate in the following cases:**

a) if the insured dies, at the time of the death,
b) if the insurance is cancelled by the insurance company (Clause II.6.3)
c) if the insured withdraws the insured's statement,
d) in a unilateral written statement by the policyholder,
e) at the end of the policy period in which the insured reaches the age of 70,
f) if the insurance coverage applicable to all insured parties is terminated **in the event of termination of the insurance policy for whatever reason,** at 0 hours of the day following the date of the termination.

II.4.4. The policyholder may initiate the cancellation of the insured's coverage any time in a written notice addressed to the insurance company **without the insured's consent.** The insurance coverage applicable to the particular insured shall terminate at 0 am of the first day of the month following the day when the request is received by the insurance company.

II.4.5. **The insurance company does not stipulate a waiting period.**

II.5. Term of the insurance policy

This insurance policy is concluded for an indeterminate period of time.

II.6. Termination of the insurance policy

II.6.1. The insurance policy will terminate

a) if the insurance premium is not paid by the due date, at 24pm on the last covered day;
b) if the policyholder entity is terminated without legal succession, at the date of its termination without legal succession;
c) if the number of the insured persons drops below 10 for any reason, at 0am on the last day of the month in which the insurance company has learned of the above fact, unless otherwise agreed by the parties;
d) at the date when the insurance company's cooperation agreement with the medical management service provider terminates if the insurance company is no longer able to deliver the medical management services for unforeseen reasons beyond its control.

II.6.2. Termination of the insurance policy

a) the policyholder and the insurance company may terminate the insurance policy in a written notice delivered at least 30 days before the end of the policy year with effect from the renewal date (insurance anniversary).
b) if material circumstances affecting the insurance policy change or if the obligation to disclose information and notify changes is breached, the insurance company shall be entitled to cancel the insurance policy in accordance with Clause II.6.3.

II.6.3. 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

If the insurance company becomes aware of **material circumstances regarding the policy, the insurance coverage of an insured or a change thereof only after the policy has been concluded, and these circumstances bring about a considerable increase in the insured risk,** the insurance company shall be entitled to **complete underwriting** with respect to the particular insured person(s), and as a result the **insurance company may propose within fifteen days after gaining knowledge thereof that the policy be amended or may cancel the coverage – with respect to the particular insured – in writing with thirty days' notice.**

A **considerable increase in the insured risk** shall, in particular, include cases when had the insurance company known about the material circumstance, it would have applied a surplus premium, an exclusion from coverage, or it would have denied the coverage.

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

If the policyholder notifies the insurance company within 15 days of receipt of the proposed amendment that he does not accept the proposed amendment, the policy or the provisions applicable to the particular insured will terminate on the 30th day after the notification of the amendment was served.

If the policyholder fails to respond to the proposal for amendment within fifteen (15) days from the time of receipt thereof, the policy shall be amended in accordance with the proposal on the thirtieth (30th) day following the day of communicating the proposal for the amendment, provided that the insurance company warned the policyholder of this consequence when the proposal for amendment was made.

If the considerable increase of the insured risk only applies to certain insured persons, the insurance company may not exercise its rights set out in the foregoing with respect to the other insured persons.

II.7. Geographical limit of the insurance policy

Unless otherwise stipulated in the special conditions, the insurance provides coverage in Hungary.

III. Insurance Premium

III.1. Determining the insurance premium, entry age of insured persons

III.1.1. The insurance premium **is received in consideration of the insurance coverage offered by the insurance company.The insurance premium shall be paid by the Policyholder.**

III.1.2. The insurance premium shall be determined pursuant to the insurer's premium rates schedule on the basis of the **number of insured persons, their jobs,** and – if the insurance company has carried out underwriting – their medical conditions, as well as the **benefit package selected** by the policyholder.

III.1.3. The insurance company shall determine the insurance premium per insured for each insured group separately. Within any one insured group, the insurance premium per insured shall be identical.

III.1.4. If the number of the insured persons change, the insurance company will modify the insurance premium set for the insured group taking into account the premium defined in Clause III.1.2, in accordance with the modified number of insured persons. The starting date of the modified premium shall be the commencement of coverage when new insured persons are added to the coverage, and the termination of the coverage when insured persons are removed from coverage.

III.1.5. The insurance company shall determine the entry age of the insured by deducting the insured's year of birth from the calendar year in which the insurance coverage with respect to the particular insured will take effect.

III.2. Insurance premium payment (payment frequency, due date of premium payment, policy period and renewal date)

III.2.1. The **annual premium** applicable to the policy year may be settled in monthly, quarterly, or semi-annual installments **(premium payment frequency).** The insurance company may offer a premium discount for any payment frequency other than monthly payment.

III.2.2. The policyholder will specify the premium payment frequency when completing the insurance application, which may be modified with effect from any insurance renewal date if the intention to make a modification is communicated to the insurance company in a written notice at least 60 days before the policy's renewal date.

III.2.3. The first premium of the insurance policy is due at the time when the policy is taken out. Subsequently, the insurance premium is due on the first day of the insurance period (year, half-year, quarter, month) which it is payable for.

III.2.4. The policyholder will have fulfilled his/her obligation to pay the insurance premium as of the day when the insurance premium (premium installment) is received by the tied insurance intermediary (agent) against receipt or in other cases when it is credited on the insurance company's account.

III.2.5. The policyholder agrees to pay the insurance premium applicable for all the insured persons - in accordance with the due dates of the premium (premium installment) - in one sum.

III.2.6. Any insurance premium (or premium installment) paid by the policyholder prior to the conclusion of the insurance policy shall be deemed as an advance premium, which the insurance company will handle free of interest. If the insurance policy is concluded, the advance premium shall count in full against the insurance premium. If the insurance policy is not concluded, the insurance company shall refund the advance premium to the policyholder.

III.2.7. **The policy period shall be one year,** its starting date being the first day of the calendar month following the inception date of the policy (technical commencement), and it shall last for one year from then on (hereinafter: policy year). **The starting date of the policy period shall also be the renewal date (anniversary) of the insurance policy.**

III.3. Consequences of premium payment default, reactivation

III.3.1. The insurance policy will terminate after the 30 days from the due date of the insurance premium if by that time, the premium arrears have not been settled or the policyholder has not been permitted to defer premium payment, or the insurance company has not claimed payment in litigation.

III.3.2. **Reactivation** is the reinstatement of the insurance coverage of a policy which was terminated due to a premium payment default, on the original policy terms.

III.3.3. If an insurance policy is terminated due to a premium payment default, the policyholder may request the reactivation of the insurance coverage in writing within 120 days after the termination date of the policy (Clause III.3.1.). In such a case, the insurance company shall be entitled to carry out an underwriting procedure and to approve the request or deny it without giving reasons.

III.3.4. The terminated coverage will be reactivated with identical content if the insurance company approves the reactivation request, and sends written notification to the policyholder of such fact, and the policyholder pays all the unpaid and due premiums within 8 days following the approval of the reactivation request.

In such a case the insurance coverage is reinstated as at 0 hours of the day following the day when the unpaid and due premiums (premium installments) are settled, with retroactive effect to the date when the policy was terminated. As a result of the reactivation, the insurance coverage shall be continuous.

III.3.5. Reactivation may be requested **no more than twice** within the coverage period.

III.4. Rules of adjusting the insurance premium

III.4.1. **In order to preserve the fee-for-service feature of the insurance and by application of the principle of risk proportionate premiums, the insurance company may modify the basic premium rate for benefit packages, once every calendar year as per the following:**

a) modification of the insurance premium if the price index changes The insurance company may modify the insurance premium on the basis of the health care price index published by the Central Statistical Office (hereinafter: KSH) for February of the current year and February of the preceding year. The modification rate may not exceed the price index referred to herein.

b) Premium Adjustment
While the insurance policy is in force, the insurance company may modify the insurance premium rate, taking account of significant changes in risk factors, in particular a significant, at least 4%, change in the frequency of receiving medical care services covered under the insurance, based on the statistical data produced by the KSH and the insurance company's own risk pool data in the calendar year following the inception date of the policy, or changes in social charges on insurance. Premium rates may be adjusted in proportion to the said changes in risk factors but by a maximum of 100%, with effect from the next renewal date of the insurance policy.

c) notwithstanding the provision set out above, the insurance premium will also be modified if the insurance company

proposes to the policyholder the modification of the insurance premium with effect from the next policy renewal date.

If the insurance premium is adjusted in line with the foregoing, the insurance company is required to notify the policyholder in writing of the premium adjustment and its rate at least 30 days before the effective date of the adjustment.

If the policyholder does not wish to maintain the insurance with the proposed modifications communicated by the insurance company, the policyholder may cancel the insurance policy without a notice period – prior to the policy renewal date – with effect from the policy renewal date.

In the absence of such termination, the policyholder is required to pay the modified amount of the insurance premium with effect from the insurance policy's renewal date.

IV. Insured Events, Insurance Benefits, Conditions for the Payment of Insurance Benefits

IV.1. Insured event

For the purposes of insurance policies concluded pursuant to these general conditions and the related special conditions, insured events shall be events defined as such in the special conditions.

IV.2. Insurance benefits

If an event that is defined as an insured event in the special conditions occurs, the insurance company shall pay the insurance benefit specified in the special conditions. The costs incurred in connection with reporting an insurance claim are only reimbursed by the insurance company if the insurance company expressly undertakes this obligation in the special conditions.

IV.3. Documents required for the assessment of an insurance claim

IV.3.1. In order to settle an insurance claim, the insurance company will require the submission of all documents specified in the special conditions.

IV.3.2. The insurance company is entitled to require that a copy of the following documents verifying the existence of the legal ground for the claim and/or necessary for determining the amount of the insurance benefit payable shall also be submitted for the assessment of the insurance claim:

a) If administrative proceedings were initiated in connection with the circumstances leading to an insured event, all the documents produced or used in the proceedings, as well as the resolution closing the proceedings (in particular, the resolution terminating the proceedings, or a binding court decision) shall be submitted. A binding court decision made in criminal proceedings, or a binding resolution adopted in misdemeanor proceedings only if this is available when the insurance claim is filed;

b) To allow for a clarification of all the circumstances of the event which led to the insured event, the insurance company may require submission of the following documents (statement by the insured and/or any other person involved in the insured event about the circumstances of the insured event, the autopsy report, the driver's license and vehicle registration certificate, the accident & injury report made by the employer, educational institution, transportation company, experts opinions on the accident/consequences);
A standard form furnished by the insurance company and completed by the insured's treating physician or by the health care service 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.

c) 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, a company physician, or a physician supervising the insurance portfolio, documents produced during outpatient or inpatient care, and documents in proof of administration of pharmaceuticals;

d) 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);

e) The insured's sports club membership card or of the membership certificate relating to his/her sports activities, the official match report;

f) An official certificate in proof of the insured's date of birth (birth certificate, identification card, passport, driver's license);

g) It is 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;

h) It may also be required that original copies of such documents are presented and that they are submitted on a form of electronic media.

IV.3.3. The insurance company may obtain further documents for the assessment of the insurance claim.

IV.4. Rules of the payment of insurance benefits

IV.4.1. If the claim is grounded, the Insurance Company shall reimburse the costs of health care services prepaid by the Insured or by a third party on behalf of the Insured and pay out the fixed sum insurance benefits within 15 days upon receipt of all documents necessary for the assessment of the claim, in local legal currency, by wire transfer to a bank account held in a bank in Hungary pursuant to the invoice and subject to the applicable payment conditions and benefit limits.

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.

IV.4.2. If the documents required by the insurance company are not submitted or are incomplete despite the insurer's reminder, or if the insured fails to attend the medical examination required for claim settlement, the insurance company shall be entitled to assess the claim on the basis of the documents available and may reject the payment of benefits.

IV.4.3. **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 and special conditions, particularly where the time limit for reporting an insured event is not observed and as a result material conditions or circumstances may not be revealed.**

V. Cases when the Insurance Company is Relieved of Payment of Insurance Benefits

V.1. If the policyholder or the insured infringe their obligation to disclose the required information or to notify changes, the insurance company's obligation to pay the benefits shall not set in, unless the policyholder proves that any of the following circumstances exist:

a) the concealed or unreported circumstance was known to the insurance company at the time when insurance policy was concluded, or

b) the policyholder and/or the insured infringed their duty to communicate changes, but the concealed or unreported circumstance has come to the knowledge of the insurance company during the coverage period prior to the insured event, and the insurance company failed to exercise its rights set forth in Clause II.6.3 of these general conditions to amend or terminate the insurance policy within 15 days, or

c) the concealed or unreported circumstance did not contribute to the occurrence of the insured event.

V.2. The insurance company will be relieved of the payment of accident insurance benefits if the insurance company can prove that the event which led to the insured event was caused unlawfully and willfully or unlawfully and in gross negligence by the insured.

V.3. The insured shall be acting in gross negligence in particular if:

a) the insured operated a motor vehicle without a valid vehicle registration certificate or the insured did not have a valid license required for driving such vehicle, and this fact inter-

vened in the occurrence of the event which gave rise to the insured event;
b) the insured has committed at least two traffic offenses at the time of the event which led to the insured event, and as such the event which led to the insured event resulted directly from these actions.

V.4. 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 or medical care. If the insured fails to comply with this obligation, the insurance company will be relieved of payment of the insurance benefit.

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 above shall not be construed, however, as limiting or restricting the insured in freely choosing a physician or a medical and health service provider.

VI. Events Excluded from the Insurance Coverage

VI.1. The insurance will not cover claims which in part or in whole arise from any of the following:
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, work misbehavior, border conflicts, insurrection.

VI.2. For the purposes of these policy conditions, terrorist activities shall in particular mean unlawful acts involving violence or the threat of violence which endanger human life, tangible or intangible assets or the infrastructure, in support of political, religious, ideological, ethnic purposes or which are intended to influence any government or to create fear and terror in the whole or a part of society, or which are suitable for the above.

VI.3. Notwithstanding the provisions set forth in Clause VI.1.d, the insurance covers any physical or mental impairment of 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.

VI.4. The insurance coverage shall not apply to events which are direct results of the following cases:
a) such illness or pathological condition of the insured that has been proven to have existed during any time in the 3 (three) years prior to the commencement of the insurance coverage, or any disease that had been diagnosed during any time in the 3 (three) years prior to the commencement of the insurance coverage, or any illness that required treatment or medical control during this time period,
b) any permanent impairment of the insured that had been diagnosed prior to the commencement of the coverage period.

VI.5. The insurance does not cover events which arise from the insured's failed suicide attempt, not even in the event that the insured was mentally incompetent at the time when attempted suicide.

VI.6. The insurance does not cover the events which take place during the coverage period, if
a) the event was the result of the insured's regular alcohol consumption, recreational drug use, or there was a direct connection between the event and the abuse of narcotic substances or medical drugs, unless these latter were prescribed by a physician, and were taken in the recommended manner,
b) the insured was verifiably intoxicated or under the influence of drugs, stupefying agents or medication at the time of the event, and this fact contributed to the occurrence of the event. If a blood alcohol test was administered, the person is legally intoxicated if his/her blood alcohol concentration exceeds 1.5‰ – or 0.8‰ while driving a motor vehicle,
c) the insured operated a motor vehicle without a valid driver's license or vehicle registration certificate as well at the same time also committed other traffic violations, and the event resulted directly from these actions,
d) the insured operated a motor vehicle while under the influence of alcohol when the event occurred and at the same time also committed other traffic violations, and the event resulted directly from these actions.

VI.7. The insurance does not cover healthcare services related to the cases set out below, or in respect of fixed sum covers, the events caused in whole or in part by:
a) pregnancy, childbirth and postpartum care, except under fixed sum coverage, if the number of days between the commencement of the insurance coverage applicable to the insured and the expected delivery date recorded in the official supporting documentation (ex: Medical record of pregnancy booklet) is more than 285 days,
b) special procedures aimed at human reproduction (including artificial insemination and any of its form, or events related exclusively to treating infertility) human embryo and reproductive research,
c) abortion of pregnancy (with the exception of therapeutic abortion necessary to save the life or health of the mother, or if abortion is performed to terminate a pregnancy which was the result of a criminal act, or therapeutic abortion which is medically necessary due to expected abnormalities of the foetus),
d) sterilization,
e) sex reassignment,
f) hospital inpatient care or same day surgery 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, 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,
g) rehabilitation or nursing of chronic illnesses (especially geriatrics, special needs education, speech therapy, physiotherapy, physical therapy, bath therapy, weight loss therapy, infusion therapy to improve blood flow, pain management infusion therapy), terminally ill patient care and nursing (hospice care), life-sustaining medical procedures, regular oncology treatment of cancer patients, with the exception of treatments which are for the purpose of diagnosing chronic illness, the initiation of a therapy, acute care of the significant deterioration of acute conditions under fixed sum covers, and the administration of medications ordered as a part of the medical treatment, as well as electrotherapy and physical therapy, if specifically indicated in the Benefit Package selected for the insured,
h) treatment performed by a person who does not have medical certification and a permit to practice medicine,
i) treatment for aesthetic purposes, cosmetic surgery and its consequences,
j) psychological disorders and psychiatric disorders,

VI.8. The insurance does not cover medical and health services related to any of the following:
a) rheumatology treatments, excluding therapies which are for the purpose of the prevention of significant deterioration of acute conditions,
b) medical care related to organ transplantation and heteroplasty, including pre-care and after-care procedures,
c) purchase of prosthetic parts or the implantation of artificial, corrective or prosthetic implants,
d) dialysis,
e) dental treatments and procedures,
f) sleep studies (somnography, polysomnography),
g) purchase of vaccine for immunization shots, reimbursement of costs, administration of the shot, unless it is specifically indicated in the Benefit Package selected for the insured,
h) medication, dressings and durable medical equipment, unless it is the part of the treatment provided in the medical facility and is covered under the benefit package,
i) human medical experiments,

j) **all claims and costs related to medical expert opinions, unless it is specifically indicated in the Benefit Package selected for the insured,**
k) **health care services related to deceased persons,**
l) **medical care 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,**
m) **alcohol, drug or narcotic substance abuse treatment programs, other addiction treatments, and related medical care or health services,**
n) **treatments which are not approved under the clinical protocols and guidelines authorized in Hungary and adopted by Hungarian medical facilities, the costs of disposable medical instruments, controlled drugs and biological therapies, as well as the costs of treatments, instruments and drugs not approved or not financed by the OEP (the National Health Insurance Fund of Hungary),**
o) **non-conventional treatments, naturopathic medicine, acupuncture, alternative medicine, wellness services, special needs education, speech therapy, bath therapy, weight loss therapy, natural healing treatments, services of spas and climatic health resorts, as specified in legislation,**
p) **insurance claims related to the following contagious diseases: TBC, tetanus, poliovirus, measles, mumps, rubella (German measles), hepatitis B, C, diphtheria, Pertussis (whooping cough), tropical diseases such as malaria, yellow fever, dengue fever, Severe Acute Respiratory Syndrome, and sexually transmitted diseases,**
q) **vision correction surgery or procedure performed on the cornea, and vision correction aids, hearing aid and accessories,**
r) **anesthesia during endoscopic procedures,**
s) **pre and post-operative examinations, unless the insurance covers/covered the costs of the one-day surgery or inpatient care to which they are required for,**
t) **prevention as specified in legislation, and other types of preventive treatments, screenings, tests excluding screening tests included in the benefit packages,**
u) **conditions and events listed on the certificate of coverage as a result of the findings of the underwriting procedure (itemized exclusions).**

VI.9. The insurance does not cover events arising from the insured's engagement in any of the following sports activities: auto-motor sports (e.g. auto-crash, Kart racing, moto-cross racing, ability competitions by car), any form of automobile racing, caving, cave expeditions, BASE jumping, BMX-cross racing, BMX and skate racing, speed biking, bungee jumping, scuba diving under 40m, one-arm and open sea sailing, parachuting, indoor rock climbing, mountaineering, rock climbing from grade 5 upwards, hot-air ballooning, jetskiing, flying an airship, high mountain expeditions, power-boat racing, motorcycle racing, private and sport flying, aviation sports (parascending, travelling by airship, paragliding, motor-assisted gliding, soaring, hang-gliding and micro-light flying, gliding, aerobatics), parachute jumping, BASE jumping, quad racing, rally, whitewater rafting, waterskiing, hydrospeed, canyoning, surfing, mountainboard, aerial skiing, ski jumping, snowboarding, wrestling.

VI.10. Exclusion of sport injuries only in respect of the fee-for-service health insurance coverage

If at the time when the insured's statement is completed or at least for 3 years prior to that, the insured was doing any of the sports listed below as a professional athlete or a competing athlete within the meaning of Clause VII.4. of these general conditions, and has finished competing within 5 years, or the insured does any of the sports listed below as a professional athlete or a competing athlete any time while the insurance policy is in force, the both knees, ankles, shoulders and backbone of the insured are excluded from the insurance coverage, with the exception of claims arising from a fracture or crack of bones.

Sport activities

Ball games: table tennis, tennis, badminton, baseball, squash, rugby, volleyball, korfball, American football, basketball, handball, (association) football, footbag, floorball, foot shuttlecock, futsal, footballtennis.

Combat sports: wrestling, boxing, martial arts, especially: judo, karate, aikido, kung fu, iaidō, taekwondo, kenpō, kendo, kickbox, entertainment wrestling, sumo, capoeira, tai chi chuan, muay thai, hapkido.

Winter sports: especially skiing, downhill, slalom, giant slalom, biathlon, snowboard, aerial skiing, ski jumping, luge/skeleton, bobsled, speed-skating, ice dancing, figure skating, hockey.

Other: rope-jumping, competitive dancing, acrobatic Rock & Roll, aerobics, fitness, rhythmic gymnastics, gymnastics, track & field events, pentathlon, heptathlon, decathlon, speedwalking, running, orienteering, triathlon, fencing, roller-blading, skate-boarding, skate, caving, cave expeditions, mountain climbing, mountain expeditions, rock climbing from level V, mountainboard, canyoneering, bungee jumping.

VII. Miscellaneous Provisions

VII.1. Period of limitation

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

The limitation period with respect to the insurance company's benefit payment obligation will commence at the following points in time:

a) if an insured event is not notified to the insurance company, then at the time when the insured event occurred, if the insured event is the delivery of a health care service, upon the last day of the service delivery,
b) if an insured event is notified to the insurance company, then on the day following the 15th day of the date when the last document was received by the insurance company,
c) if an insured event 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.

VII.2. Loss or destruction of the certificate of coverage, loss and replacement of the Generali Company Care Card

VII.2.1. If the certificate of insurance coverage is lost or destroyed, the insurance company shall, at the request of the policyholder, issue a new certificate with the same content as that of the valid original.

VII.2.2. If the Generali Company Care Card is lost or destroyed, the insurance company shall, at the request of the policyholder, issue a card with the same content as that of the effective original, the cost of which shall be borne by the policyholder.

VII.3. Procedure to settle disputes or disagreement

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

VII.4. Qualification of the insured's sports activities

VII.4.1. For the purposes of these general conditions the insured is classified as a **professional athlete** if he/she is employed or otherwise contracted by a sports association (sports federation) to perform sports activities, or performs sports activities under a sports contract, or is licensed as a professional athlete by a foreign sports federation.

VII.4.2. For the purposes of these general conditions the insured shall qualify as a **competing athlete** (hereinafter: competing athlete) if he/she is engaged in sports activities as a non-professional athlete but he/she participates in competitions (championships, matches) irrespective of the nature of such competition (whether they are local, district, county, regional, national, international competitions, and whether they are friendly games or for a prize etc.).

For the purposes of these general conditions, a competing athlete can be a **top competing athlete, and an athlete who competes at regional level, or an athlete who competes at local level:**

a) the insured shall qualify as a top competing athlete if he/she enters international and national competitions,
b) the insured shall qualify as an athlete who competes at regional level if he/she enters competitions organized for participants from several counties, provided that he/she is not a top competing athlete,
c) the insured shall qualify as an athlete who competes at local level if he/she is not a top competing athlete or an athlete who competes at regional level.

VII.4.3. For the purposes of these general conditions the insured is classified as a **recreational athlete** if he/she does not perform sports activities as a professional athlete or a competitive athlete.

VII.5. Definitions

24-hour phone-in healthcare duty service / consultancy: Generali Medi24 hotline – a non-stop phone-in service operated 24 hours a day without interruption, through which professional consultancy is provided by staff with healthcare qualifications and information can be requested about healthcare services; in addition, claims can be submitted in connection with healthcare services.

Acute care services (Acute cases): acute conditions – as accepted by the healthcare / medical profession –, even in connection with any chronic disease, are states when on the basis of the symptoms identified medical care is required within 48 hours according to the rules of the medical profession (including, in particular: high fever, convulsive pain, diarrhoea, vomitus, peracute infection).

Accident: a sudden, one-time, external physical and/or chemical impact that the insured is exposed to beyond his/her control during the coverage period, and as a result of which the insured suffers physical injuries. For the purposes of these policy conditions, accidents shall not include myocardial infarction, cerebrovascular accident (stroke) and fainting (collapsus).

Advanced hospital and lodging service: services in kind, organized and provided as an integral part of a hospital, ensuring in-patient care for the insured at higher levels than the average or standard of services in Hungary based on a protocol specified for each hospital individually, and extending to arrangements for individuals' hospital treatment and care as well as to securing staff to provide high quality care in a high-standard care environment.

Ambulatory surgery: a surgery performed in the framework of outpatient care after which, following the surgical procedure and observation, the patient can be released to go home on the very day of the surgery, and which is not qualified as in-patient care and one-day surgery.

Benefit Package: its content is set out in Schedule No 1.

Cases of urgent care: a collective name for medical services including rescue operations, life-saving interventions and emergency care (including emergency treatment due to accidents).

Childbirth and postpartum care: a group of medical and health services during labor and delivery and within 6 weeks of childbirth, including postpartum control checks and newborn care provided to the mother and her child by the medical and health service provider in connection with delivery and birth.

Chronic disease: any diagnosed disease or any state qualified by a physician which requires permanent or temporary outpatient and/or in-patient care or hospitalization, characterized by slow development and / or a long course (at least 3 months), possibly including acute periods or reduction or abatement of symptoms in the meantime.

Disease: an abnormal bodily or mental state; the absence of feeling healthy.

Diagnostics: a medical examination to explore the cause of the insured's complaint, to clarify status, to verify or exclude the existence of any disease, which, in itself, is not aimed to change status, including imaging and laboratory tests, histology and cytology tests. Including imaging and laboratory tests, histology and cytology tests.

Elective medical procedure or treatment: health care (medical) procedures which are medically necessary but do not require urgent care or emergency treatment, therefore the date of the procedure may be delayed and scheduled in advance. The medical management service provider will most probably arrange for the required treatment within 14 days.

Emergency: any change in medical conditions which would directly threaten the patient's life or as a consequence of which the patient would suffer serious or permanent health impairment in the absence of instant medical attention.

Emergency out-of-hours service: medical care providers established and operated within the public healthcare system for the treatment of cases which require urgent care, and which provide continuous availability of medical care outside daily working hours.

Fee-for service: payment model where the fees for medical and health care services are fully or partially covered under an insurance policy – and paid for in the form of insurance benefits – subject to the policy conditions.

Foetus: a human being developing within the uterus from the week 12 of the pregnancy.

Generali Medi24: see: 24-hour phone-in healthcare duty service / consultancy

General practitioner: a physician coordinating the medical care of patients registered in his/her medical practice and providing primary medical care under Hungarian law.

Healthcare personnel: physician; dentist; any other person with a tertiary qualification specialised in healthcare; and any person with a special healthcare qualification.

Healthcare 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 terms and conditions, healthcare documents specified by law shall particularly include the following documents also partially regulated by law: outpatient records, hospital discharge report, 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).

Healthcare profession: a group of medical or health services allowed to be provided in possession of a special healthcare qualification and in compliance with the minimum professional (personal and material) conditions set out by law, which are included in the code register of healthcare professions.

Healthcare service: a group of healthcare activities performed by the healthcare service provider in possession of the licence of operation issued by the public healthcare administration authority.

Healthcare service provider (institution): any private healthcare entrepreneur, legal entity or organisation without a legal personality, regardless of ownership and maintenance arrangement, which is entitled to provide healthcare services under current legal regulations in possession of a licence of operation issued by a public administrative body of healthcare in respect of Hungary.

For the purposes of these conditions, healthcare service providers shall not include sanatoriums, rehabilitation establishments, spas, spa resorts, therapeutical and nursing establishments for the mentally deranged, geriatry care centres, welfare homes, alcohol and drug detoxication establishments, nursing homes, other establishments providing "chronic" in-patient care, not even if healthcare services are provided therein; nor any departments or sections, providing such types of services, of institutions recognized by a professional supervisory authority and providing licensed healthcare services (e.g. hospitals, clinics).

Healthcare activity: any and all activities forming part of the healthcare services, except for those not requiring special healthcare qualification or professional supervision by a person with a special healthcare qualification.

Healthcare management: see medical and health services management.

Healthcare manager: see medical management service provider.

Hospice care: see terminally ill patient care.

Hospital shall mean institutions providing in-patient care and operating under permanent medical attendance and control recognized and licensed by the Hungarian medical officer service and professional supervision.

Hospital shall not mean sanatoriums, rehabilitation centers, thermal or hydromineral establishments, psychiatric hospitals or psychiatric wards, geriatric nursing institutes, social homes, alcohol and drug detoxification institutions, nursing institutes, other "chronic" care institutes, and hospital departments providing the above services, even if they offer hospitalized in-patient care, provided that the Insured receives services in line with the specialization of such department.

House call: a healthcare service available at the insured's place of residence/ temporary residence (home) in acute care cases if such attention is medically reasonable – after the claim is reported through the 24-hour phone-in healthcare duty service/consultancy hotline, at certain locations – in the course of which a physician providing general practitioner type care services is sent to the insured.

The insurance company provides information through Generali Medi24 about which settlements the house call service is currently available.

Infertility: state of inability to procreate / to be conceived.

In-patient care: a person is provided in-patient care if he/she is admitted to a medical facility (hospital) for several days for the treatment (medical care) of an illness of trauma (due to an accident), and the person spends every night during his hospitalization, between the admission and the discharge, in such institution in connection with the medical care. Admission to a medical facility is for several days if such person is discharged from the institution at a later date than being admitted.

Life-sustaining medical procedure: when applied to the patient by the medical and health service provider, would serve to prolong the patient's life artificially by replacing or supporting ailing bodily function.

Life saving medical procedure: emergency medical procedure required to be performed in a suddenly developed condition threatening life to save the insured's life.

Medical care: health care and medical procedures delivered to treat the insured's medical condition, performed and documented in accordance with the regulations and standards of the medical profession as well as the provisions of effective healthcare legislation.

Medical care: see treatment.

Medical History Statement over the telephone: a list of questions and statement used by the insurance company to survey the medical condition of the insured, answered by phone, recorded and stored for a period in compliance with the applicable legal regulations, which is intended to assess any existing medical conditions, diseases, injuries, and health issues of the person to be insured, as well as to identify and map any latent diseases of such person, not producing symptoms of any disease, injury or health impairment, or any medical condition or pre-pathological state capable to deteriorate, as well as any risk factors making them susceptible for any disease.

Medical management service provider: an entity, irrespective of its ownership structure and operator, authorized and obligated under a contract concluded with the insurance company, to manage medical and health services covered under the insurance policy of the insured, in particular elective procedures and care, and to supervise the quality and professional aspects of the medical and health services delivered to the insured. The medical management service provider itself shall – or procure that the contracted medical and health service providers – perform the medical or health services available for the insured on the basis and to the debit of the benefit package selected under the insurance policy.

Medical profession: a group of healthcare services subject to special medical qualification and professional (personal and material) conditions stipulated by law and included in the code register of healthcare professions.

Medical services management: the arrangement and coordination of medically required health care services (in particular, elective outpatient and in-patient care) for the insured. For the purposes of these general conditions, medical services management shall mean the following: managing the provision of medical and health services to the insured, monitoring and checking medical and health services and their routes, liaison with the medical facilities or service providers treating the insured, administration of medical and health services arranged or notified to and approved by the medical management service provider.

Medication, dressings and durable medical equipment: only those agents, accessories and means shall be deemed as medication, dressings and durable medical equipment which are registered and recognized in Hungary as medication, dressings and 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.

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.

One-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.

Organ: groups of tissues specialized to a certain activity both anatomically and functionally.

Organ transplantation and heteroplasty: removal of any organ or tissue from a human body (donor), and implantation thereof into the body of another living person (recipient).

Out-of-hours service: medical and health services provided under national law in cases which require urgent care out of daily working hours, and which aim to ensure the continuous availability of certain medical and health care services, intended to examine, detect the medical condition of the person requiring care, to perform one-time and urgent procedures and/or to hospitalize the patient for urgent care from the end of the daily working hours of medical and health service providers until the beginning of the next day's working hours; as well as to participate in procedures set out in special regulations.

Outpatient care: special medical care or medical specialist counsel provided once or occasionally by a medical specialist, unless it is qualified as in-patient care, one-day surgery, or ongoing healthcare service provided by a medical specialist requiring special in-patient care applied in case of a chronic illness.

Patient transport: as prescribed by an authorized physician, to transport the patient – in accordance with the terms and conditions set out by law – in order to provide access to the required, elective medical and health services in a case not requiring ambulance nursing supervision when the availability of a medical and health services cannot be provided otherwise due to the patient's condition.

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.

Rehabilitation (medical, healthcare): healthcare procedures and medical services with the general intent to restore or supplement any loss of function (limitation of motion, speech disorder, reduced heart performance, etc.) and/or to develop new compensatory abilities.

Medical rehabilitation particularly includes infusion treatments, physiotherapy and sports therapy to improve circulation and / or relie-

ve pain, speech therapy, psychology care, occupational therapy, provision of therapeutical aids and training for their use, as well as care services in therapeutical and nursing establishments for the mentally deranged, spas, spa resorts, geriatry care centres, welfare homes, alcohol and drug detoxication establishments, and other sanatoriums and rehabilitation facilities.

Rescue: urgent care, as defined by law, delivered to a patient who requires immediate care at the original location, performed by an organization authorized for rescue, as well as the related transportation of such patient, if required, to the nearest medical facility capable of providing the required medical care to the patient in line with the patient's condition, also including the medical services provided during such transport.

Screening test: a medical test or series thereof intended to protect health, to increase the individual's life quality and length of life by active search and detection, identification and mapping of hidden, latent, and asymptomatic diseases, pathological states preceding certain diseases, and any risk factors conducive thereto in due time, at an early stage, possibly in a stage without complaints.

Terminally ill patient care = Hospice care: (mainly palliative) care service for a terminally ill person, not merely aimed to relieve pain but to provide physical and mental care to a patient suffering from a long, terminal illness, to improve their life quality, to relieve suffering and to preserve their human dignity until the time of their death.

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.

Therapy: see treatment.

Tissue: Group of cells of similar shape and function. Not including blood and blood components.

Transplantation: see organ transplantation and heteroplasty.

Treatment: A group of activities performed by special healthcare personnel aimed to cure diseases, to stabilize a patient's condition, and to relieve pain (or other complaints) using diagnostic results.

Vaccination: any vaccine licensed by current legal regulations (and administration thereof), which includes agents suitable for developing active / passive protection against infectious disease(s), thereby the spread of infectious diseases can be prevented, recovery can be assisted when falling sick, and chronic complications can be prevented by vaccination.

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

This chapter summarizes the provisions of the General Terms and Conditions of the Generali Company Care Health Insurance which substantially differ from the respective provisions of the Hungarian Civil Code.

VIII.1. Conclusion of the insurance policy

Pursuant to Clause II.2.2 of these conditions, and by way of derogation from Section 6:443 (2) of the Civil Code, if the certificate of coverage is issued with terms which differ from those of the insurance application, this difference may be contested by the policyholder without delay, or **within a maximum of 15 days.**

Pursuant to Clause II.2.5, and by way of derogation from Section 6:475 of the Civil Code, **the consent of the insured is not required for amending the insurance policy.**

Pursuant to Clause II.6.2. of these conditions, and by way of derogation from Section 6:490 (2) of the Civil Code, the insurance company is entitled to **terminate** the insurance policy **by notice.**

Pursuant to Clause II.6.3 of these conditions, by way of derogation from Section 6: 446 (2) of the Civil Code, if the policyholder **fails to respond to the proposal for amendment** within fifteen (15) days from the time of receipt thereof, **the policy shall be amended in accordance with the proposal on the thirtieth (30th) day following the day of communicating the proposal for the amendment,** provided that the insurance company warned the policyholder of this consequence when the proposal for amendment was made.

VIII.2. Consequences of premium payment default

Pursuant to Clause III.3.1. of these policy conditions, and by way of derogation from Section 6:449 (1) of the Civil Code – **the insurance policy will terminate after the 30 days from the due date of the insurance premium** if by that time, the premium arrears have not been settled or the policyholder has not been permitted to defer premium payment, or the insurance company has not claimed payment in litigation.

VIII.3. The insurance company's rights arising from the infringement of the duty of disclosure

Pursuant to Clause V.1. of these policy conditions, and by way of derogation from Section 6:482 (1) of the Civil Code, the insurance company shall be entitled to exercise the rights arising from the breach of the obligation to disclose information and report changes **without limitation.**

VIII.4. Conditions of the insurance company's release from benefit payment

The provision on the insurance company's release from benefit payment set out in Clause V of these policy conditions differs from the condition stipulated in Section 6:464 (1) of the Civil Code, inasmuch as it is only **the insured's** unlawful and willful or unlawful and grossly negligent conduct that will result in the insurance company's release from benefit payment.

VIII.5. Period of limitation

The provision on the statute of limitations set out in Clause VII.1 of these conditions differs from the five (5) year limitation period prescribed in Section 6:22 (1) of the Civil Code. The limitation period for claims arising under this insurance policy shall be **2 (two) years.**

Schedule 1

Benefit Packages available under Generali Company Care Health Insurance

The service types shown in this table may be received subject to the content and limitations specified in the benefit package, in accordance with the provisions of the general and special conditions.

Service/Insurance Benefit			Benefit Packages			
			EXCLUSIVE	PREMIUM	STANDARD	START
Fee-for-Service Components (health care services)		**Generali Medi24**	●	●	●	●
		Annual preventive screening test (health checkup)	extra preventive	extended preventive	standard preventive	
	Basic Care	**Internal medicine**	●	●	●	●
		Outpatient care: internal medicine, otorhinolaryngology, ophthalmology, gynaecology, urology, dermatology	●	●	●	●
		Laboratory tests: basic blood tests, urine analysis, fecal test, basic infection tests, gynaecological cytology test, for men: screening for prostate cancer (PSA)	●	●	●	●
		Diagnostic tests: ECG, ultrasound, X-ray, mammography, Doppler and arteriographic vascular tests, audiometry, naevus checks, allergy tests, central bone density test, optometric and vision tests, perimetry	●	●	●	●
	Extended Care	**Outpatient care:** allergology, cardiology, orthopedics, rheumatology, electrotherapy, pulmonology, neurology, gastro-enterology, oncology, dietetics, ambulatory surgeries, etc.	●	●	●	
		Laboratory tests: immunology tests, hormone tests, screening for tumorous diseases, HIV tests and screening for other sexually transmitted diseases, genetic tests, intoxication tests, etc.	●	●	total of HUF 200 000/person/ policy year and PET CT one occasion/person/ policy year	
		Diagnostic tests: cytology and histology tests, isolation of allergens from blood, endoscopic-reflective tests, MRI, CT, PET CT, tests for electrical activity of muscles, nerves and the brain (EEG, EMG, ENG), cardiovascular tests and angiography, enterography, radioisotopic tests, articular pinprick tests, respiratory function tests, etc.	●	●		
		Physiotherapy	max 12 occasions/person/ policy year	max 6 occasions/ person/ policy year		
		Reimbursement of the price of the vaccination against the flu	●	●		
		Patient Transport (with a paramedic)	●	●		
		House call: in professionally justified acute cases, home care for adults in Budapest and in certain towns in the country.	●	2 occasions/person/ policy year		
		One-day surgery	●	two procedures/ person/policy year	one procedure/ person/policy year	
		Inpatient care in a hospital (healthcare treatment, surgeries, accommodation in VIP facilities up to HUF 4 000 000/insured/policy year)	●			
International medical second opinion			●	●		
Oncology diagnostics			check-up, oncology opinion, treatment plan, consultations for one year	check-up, oncology opinion, treatment plan		
Fixed-sum coverage		**Accidental permanent disability to an extent of at least 30%**	HUF 10 000 000	HUF 7 000 000	HUF 5 000 000	HUF 3 000 000
		Fracture of bones	HUF 100 000	HUF 75 000	HUF 50 000	HUF 50 000
		Fixed-sum hospitalization benefit, with an 8-day elimination period	HUF 100 000	HUF 60 000	HUF 40 000	
		40 critical illness coverage	HUF 2 000 000	HUF 1 000 000		
Medical assistance abroad		**Emergency medical assistance services abroad (EUB Travel Insurance):** Generali Medi24: 24-hour assistance in Hungarian: medical advice over the phone information about the contact details of local medical facilities, ambulance services, pharmacies, arranging the repatriation of the patient	●	●	●	●
		Health insurance coverage abroad (EUB Travel Insurance): (reimbursement of emergency medical treatment and rescue costs, arrangement of the repatriation of the patient, reimbursement of costs)	●	●		

Schedule 2

Hazardous Occupations

This Schedule 2 shall form an integral part of the general terms and conditions of the Generali Company Care Health Insurance and shall be read together with the provisions set out therein.

Hazardous Occupations

1. **Workers of aviation services other than civil aviation:** workshop pilots, advertising airplane pilots, pest control aircraft pilots, aircraft photographers, helicopter rescue, helicopter police, construction by helicopter, helicopter transportation, helicopter pest control.
2. **Army flight crew:** piston engine aircraft crew in the army, army cargo aircraft crew, helicopter crew, flight instructors, student pilots, test pilots, parachute jumpers, jet plane crew in the army.
3. **Mine workers:** mining operators, mining technicians, sink miners, mine supervisors, mine operators, loader operators, splitters, cutters and carvers, oil miners, cement, stone and other mineral products machine operators.
4. **Metal processing and finishing plant workers:** metal processing and finishing plant operators, metal processing technicians, metal processing plant workers, coating machine operators, ferrous and non-ferrous smelters, tinsmiths.
5. **Workers dealing with explosives and highly flammable substances:** shot-firers and blasters, pyrotechnists, industrial alpinists, industrial divers.
6. **High voltage engineering workers:** high voltage engineering technician, skilled and trained workers.
7. **Industrial alpinists**
8. **Industrial divers**
9. **Occupations in the armed forces:** bodyguards, commando staff, foreign legionnaires, secret agents, armed guards, armed guards in prison services, prison supervisor, prison guards, security guards, security guards with a self-defence weapon, armored car personnel, contractors working in the army or persons in conscription (who pursue increased danger activities: bomb experts, divers)
10. **Peacekeepers**
11. **Radioactive decontamination apparatus operator**
12. **Stuntman**

Schedule 3

Disability Table – Permanent Physical Impairment

The Benefit Table referred to in the special conditions of the accidental permanent disability insurance and the insurance for permanent disability arising from a road accident.

The purpose of this table is to illustrate the concept of how insurance benefits are determined.
The extent of the permanent impairment shall be determined by a physician assigned by the insurance company, in accordance with the following:

Injury to body parts, sensory organs	**% degree of impairment**
total loss of arm at shoulder joint, or its permanent loss of function	70%
total loss of arm above elbow joint, or its permanent loss of function	65%
total loss of arm at elbow joint, or total loss of hand, or its permanent loss of function	60%
total loss of thumb or its permanent loss of function	20%
total loss of index finger or its permanent loss of function	10%
total loss of any other finger or its permanent loss of function	5%
total loss or disability of one leg from thigh joint or the total disability of the thigh joint	70%
partial amputation of one leg above knee joint or the permanent loss of function of the knee joint	60%
partial amputation of a leg below knee joint	50%
total loss of a foot at ankle joint or its permanent loss of function	30%
total loss of a great toe or its permanent loss of function	5%
total loss of any other toe or its permanent loss of function	2%
complete loss of vision in both eyes	100%
complete loss of vision in one eye	35%
complete loss of vision in one eye, if the insured has already lost vision in the other eye before the occurrence of the insured event	65%
complete loss of hearing in both ears	60%
complete loss of hearing in one ear	15%
complete loss of hearing in one ear, in case the insured has already lost hearing in his other ear before the insured event	45%
complete loss of smell (anosmia)	10%
complete loss of sense of tasting	5%

The effective date of these general conditions shall be: August 1, 2016

Travel Insurance Coverage in Generali Company Care Health Insurance

The summary below is for information purposes only. The detailed conditions of the insurance are set out in EUB2016-06EG General and Special Conditions!

Subject of the insurance

Pursuant to a written application to join, any insured added to the insurance coverage of a **Generali Company Care Health Insurance** policy taken out from Generali Biztosító Zrt, may be entitled to claim the travel insurance benefits and services specified in detail in the Policy Conditions marked EUB2016-06EG under the group insurance policy concluded between Generali Biztosító Zrt. and Európai Utazási Biztosító Zrt, as long as the **travel insurance policy** is in force.

Travel insurance coverage is provided by Európai Utazási Biztosító Zrt. (hereinafter: EUB, H-1132 Budapest, Váci út 36-38., phone: (06-1) 452-3580, www.eub.hu) to the policyholder pursuant to EUB2016-06EG Travel insurance conditions.

Insured

Any insured person under Generali Company Care Health Insurance, provided that he/she is covered under the statutory health insurance scheme in his/her country of residence or is otherwise eligible to covered health care, and has not turned 70 years of age at the time when he/she is added to the insurance coverage.

Travel insurance benefits

In the event of a sudden illness or accident during a foreign trip, the insurance company shall cover the costs of rescue and emergency medical care up to the limit specified in the benefit table below; in addition, the insurance company shall arrange and cover medically reasonable repatriation of the patient or injured party (by an ambulance car or plane), or in the event of death, the repatriation of the deceased.

The operators of the 24-hour Assistance Helpline (Generali Medi24) of the insurance company will check the details of the medical care with foreign physicians and hospitals, including the settlement of costs.

Geographical limit of the travel insurance coverage

The following countries within geographical Europe: Albania, Andorra, Austria, Belgium, Bosnia and Herzegovina, Bulgaria, Czech Republic, Denmark, United Kingdom Estonia, Belarus, Finland, France, Greece, the Netherlands, Croatia, Ireland, Iceland, Kosovo, Poland, Latvia, Liechtenstein, Lithuania, Luxembourg, Macedonia, Malta, Moldova, Monaco, Montenegro, Germany, Norway, Italy, Portugal, Romania, San Marino, Spain (including the Canary Islands), Switzerland, Sweden, Serbia, Slovakia, Slovenia, the Ukraine, Vatican City; and the whole territory of the following countries: Cyprus, Turkey.

Scope of the travel insurance coverage

The travel insurance coverage will take effect on the commencement date of the coverage of Generali Company Care Health Insurance at th earliest, and will be valid for an unlimited number of foreign trips of maximum 30 days long each, in respect of each insured person. On the day when the Generali Company Care health insurance coverage terminates, this travel insurance coverage shall also terminate. Other cases when the insurance coverage terminates are described in the travel insurance policy conditions marked EUB2016-06EG.

Restrictions to the coverage of the travel insurance

The travel insurance coverage linked to the Generali Company Care health insurance policy covers traditional tourist trips, so it does not cover e.g. physical work, driving occupation, hazardous sports or the trips of professional athletes. Restrictions and limitations are set forth in detail in the travel insurance policy conditions marked EUB2016-06EG.

Notifying travel insurance claims

In the event of illness or accident, the notification shall me made to **Generali Medi24,** specifying the insured's name and date of birth, as well as the telephone number of the person making the notification (where he/she may be contacted later) and the summary of the event.

Telephone number of Generali Medi24: +36 1 465 3777. The **Generali Medi24** 24-hour service is available in Hungarian with outsourcing partners in many countries of the world so the insured persons can rely on help at numerous places from people who know local conditions well. If someone's life is in danger, please first call the local emergency hotline and ask for help! (Universal emergency hotline in the European Union: 112) Please make sure you request a detailed incident report.

For further information about the travel insurance coverage and claims settlement, please read the policy conditions marked EUB2016-06EG which is available at www.generali.hu under Letölthető dokumentumok" (Download documents) and at http://eub.hu/aktualis-biztositasi-feltetelek (policy conditions).

EUB Customer Service: Európai Utazási Biztosító Zrt., 1132 Budapest, Váci út 36-38., Tel.: 452 35 80, Fax: 452 3312, ugyfelszolgalat@eub.hu, opening hours: Monday-Friday: 8:00-16:00; Thursday: 8:00-17:00.

Notification of complaints related to the travel insurance coverage

If you have any complaint about the conduct, operations or any omission on behalf of Európai Utazási Biztosító Zrt. or its employees, you may lodge your complaint either in writing or orally. Oral complaints may be made in person at the address of the customer service office specified above during opening hours; complaints may also be made over the telephone during the same opening hours - with the exception of Thursday, when between 8am and 8pm - by calling the number of the customer service. Please note that calls are recorded in accordance with the law. You may deliver a written complaint in person or by a third party at EUB's customer service office, or you may send it by post to the mailing address of EUB, by fax to fax number +36 1 452 3312, or in an email to the email address ugyfelszolgalat@eub.hu. EUB's operations are supervised by: National Bank of Hungary (customer service address: 1013 Budapest, Krisztina krt. 39.).

Processing personal data

EUB and Generali Biztosító Zrt shall handle the personal particulars of insured persons as well as the data pertaining to their policies as confidential insurance information and may only disclose them to a third party in possession of an express written consent of the data subject. Pursuant to Act LXXXVIII of 2014 on the Insurance Business, the insurance company is allowed to release data classified as confidential insurance information to the organizations and bodies in the cases specifically listed in the law. Europ Assistance Kft. (H-1134 Budapest, Dévai u. 26-28.), as the contracted agent of Európai Utazási Biztosító Zrt., provides assistance services relating to insurance claim settlement under an outsourcing agreement. In this respect, EUB may, under the authority referred to it by law, disclose data and information concerning insurance claims to Europ Assistance.

Benefit limits applicable to packages available under Generali Company Care health insurance (HUF, unless otherwise indicated)	START and STANDARD	PREMIUM	EXCLUSIVE
A) Emergency Medical Assistance and Insurance			
Medical and rescue costs – total: Including: – rescue by relief helicopter, mountain and water rescue – patient transfer by ambulance – urgent dental treatment – telephone, taxi and interpreter costs because of an illness or accident – hospitalization daily allowance for the insured if hospital costs are recovered under EHIC or any other insurance plan (HUF / hospitalization night)	–	25 000 000 5 000 000 2 500 000 € 300 25 000 5 000	50 000 000 10 000 000 5 000 000 € 400 50 000 10 000
Arrangement of Repatriation, with associated additional expenses (including air ambulance transport if medically required)	–	no limit applied	no limit applied
Emergency Medical Assistance Services	24-hour assistance in Hungarian – medical advice over the phone – information about the contact details of local medical facilities, ambulance services, pharmacies – arrangement of the repatriation of a patient		
Arrangement of the repatriation of the deceased and associated expenses	–	no limit applied	no limit applied