General Terms and Conditions of Generali Private Care Health Insurance (GPC-ÁSZF/2025_EN)

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Contents

General Terms and Conditions of Generali Private Care Health Insurance (GPC-ÁSZF/2025_EN)

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

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

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

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 services set forth in the related special policy conditions.

II.1.2. **Policyholder** is the party who takes out an insurance policy from the insurance company and agrees to pay insurance premiums. The policyholder may be a consumer or a person or organization who is not a consumer within the meaning assigned to it by law. Consumer shall mean any natural person acting for purposes which are outside his/her trade, business or profession.

II.1.3. **The insured may be a natural person** who is designated in the insurance policy as insured, and **whose life or health is covered under the insurance policy with respect to specific insured events.** The insured must be over 18 but under 69 years of age as of the inception date of the insurance policy or as of the day when the insured is added to the coverage of an in force policy.

II.1.4. In respect of a family insurance policy (within the meaning of Clause VII.5), a person over 1 but under 18 years of age may also be insured provided that such child is a close relative of an insured within the meaning of Clause II.1.3 of these general conditions, living in the same household with the insured. If a family insurance policy is taken out, only close relatives may be insured under the same insurance policy.

II.1.5. If the policyholder and the insured are different persons, **the insurance policy may only be concluded or the respective insurance coverage may only be modified if it is consented by the insured person in writing.**

II.1.6. If the policyholder and the insured are different persons, the policyholder is required to inform the insured of all the legal statements he/she is delivered as well as of any modifications of the insurance policy.

II.1.7. The insured may withdraw his/her consent to the conclusion of the insurance policy any time in a written notice.

As a result, the insurance policy – or if several persons are insured under the policy, only the coverage applicable to the particular insured, – shall terminate as of the end of the policy year, save for the case when the insured enters the policy as the new policyholder.

II.1.8. **The insured may enter** the insurance policy **as a new policyholder.** The insured may initiate the replacement of the policyholder in the policy by sending a written notice to the insurance company. The modification of the policyholder will take effect at the earliest on the day when the Insurance Company receives such written notice.

If the insured enters the insurance policy as the policyholder, the liability for the payment of premiums due in the current policy period shall lie with the insured and the original policyholder jointly. The insured who enters the insurance policy as a new policyholder is required to repay to the original policyholder all costs incurred by the original policyholder in connection with the insurance policy, including the insurance premium.

When the insured replaces the original policyholder in the insurance policy, he/she will assume all the related rights and obligations therewith.

II.1.9. **No professional athlete or competing athlete may be added to the insurance coverage of this policy as insured. The definitions of professional and competing athletes are set forth in Section VII.4. (Qualification of the Insured's sports activities) of these general terms and conditions.**

II.1.10. **The Beneficiary** is the person who is entitled to receive the covered services. 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.1.10.1. **The designation of a beneficiary shall be repealed** if the beneficiary dies or is dissolved without succession before an insured event occurs.

II.1.10.2. 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 of the Insurance Policy, Modifications

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

II.2.2. **Before approving the policyholder's insurance application the insurance company will carry out underwriting,** and in that context it may put questions to the policyholder and the insured, and require that the insured give a medical history statement or attend a medical screening, medical tests, a health check, or complete other written declaration forms. The insurance company may require the insured to give a medical

history statement over the phone at a prearranged point of time, or to complete a printed medical history form. 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 any claim may be enforced under the insurance policy, or as long as it is required by law.

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 medical service provider in accordance with the Act on Healthcare.

II.2.3. The findings of the underwriting procedure will determine whether the insurance company approves or denies the insurance application. The insurance application may be accepted by the insurance company's delivering a document which certifies the insurance coverage (hereinafter: certificate of coverage) containing terms identical to or different from those specified on the insurance application, or by the insurance company's implicit conduct (tacit contract). **If the certificate of coverage is issued with terms identical to those specified on the insurance application, the insurance policy will be concluded as of such issue date.**

II.2.4. 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 at the time when the certificate of coverage is issued.** 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.2.5. **The policy shall be concluded – by the insurance company's implicit conduct – on the terms of the application also if the insurance company fails to respond to the insurance application within sixty (60) days of its receipt.**

The policy shall be concluded – by the insurance company's implicit conduct – if the application was made on the insurance company's own standard application form for the type of policy in question, upon receipt of the relevant statutory information, containing the premium rates applicable. **In that case, the insurance policy will be concluded on the day following the end of the 60-day underwriting period, with retroactive effect to the date when the insurance company was delivered the insurance application.**

II.2.6. If a policy which is concluded without the express statement of the insurance company derogates in material conditions from these general conditions, the insurance company will have fifteen (15) days of the conclusion of the insurance policy to propose that the policy be modified to be in line with these general conditions. **If the policyholder refuses the proposed modification or fails to respond to it within 15 days, the insurance company may terminate the policy giving a 30-day written notice within 15 days upon receipt of the notification of the refusal or modification.** (Subsequent termination of a policy concluded by implicit conduct (tacit contract)).

II.2.7. The policyholder is bound by the insurance application for 15 (fifteen) days – or for 60 days if medical underwriting is required – of the date of the application's submission.

II.2.8. 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.2.9. **Policy Amendments Subject to Underwriting**

II.2.9.1. If the policyholder applies for a change of the Insurance Plan selected under the insurance policy to another Insurance Plan with a more extended range of services while the insurance policy is in force, or if a new insured person is requested to be added to the insurance coverage, the insurance company **may carry out underwriting or may deny the application without having to give reasons.**

II.2.9.2. Based on the findings of the underwriting procedure, the insurance company is entitled to approve or deny the modification request submitted with respect to the insurance policy. The insurance company shall send **written notification to the policyholder** about the approval of the modification request and the related conditions, or about the denial of such request.

If the insurance company approves the policy modification requested by the policyholder, the modification shall become effective as of the first policy renewal date following the date of the approval.

II.2.10. **The conclusion and the modification of the insurance policy, and the removal of an insured person from the insurance coverage requires the consent of the insured concerned.**

II.2.11. **If the Insurance Plan is modified, the exclusion set out in Clause VI.4 will be applicable to the new covered services included the new Insurance Plan 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. An insured person may be added to the coverage only if the insured concerned has signed the insured's statement, the policyholder has paid the first insurance premium and the insurance company has accepted the insurance application.

II.3.2. **The insured may withdraw his/her insured's statement any time in writing.** As a result of the withdrawal, the insurance coverage applicable to the particular insured shall terminate at 0 am of the insurance renewal date following the day when the withdrawal has been received by the insurance company.

II.3.3. The policyholder and the insured **are required to disclose information and notify changes. The insured is not required to communicate any changes in his/her health or medical conditions to the insurance company.**

II.3.4. **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 the whole duration of the coverage. 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.3.5. If the birth year of an insured person was misstated and it is confirmed 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. 6.4, or may challenge the insurance policy.

II.3.6. 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.3.7. **Relevant condition** shall be everything that the insurance company requires 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; as well as documentary evidence of the insured's valid social security coverage in Hungary (valid social security number (TAJ)).

II.4. Commencement and Termination of the Insurance Coverage; Waiting Period

II.4.1. The insurance coverage shall commence at 0 am on the first day of the month following the month in which the policy is concluded, provided that the policyholder has paid the insurance premium applicable to the particular insured to the insurance company.

II.4.2. The insurance company **stipulates a waiting period** in the insurance policy, the duration of which is **3 (three) months from the inception date of the insurance policy.** If the insurance policy is modified, the waiting period applicable to the new services included in the new Insurance Plan, or to the new insured person added to the coverage, shall commence at the effective date of the policy modification.

II.4.2.1. **The insurance company will limit the provision of covered services in accordance with the following rules:**

a) accident related acute care and elective procedures are provided in accordance with the content of the Insurance Plan applicable to the insured, and

b) in acute care cases which are not related to accidents, only outpatient care, basic laboratory tests and basic diagnostics tests are covered in accordance with the content of the selected Insurance Plan.

II.4.2.2. **In respect of the risk of the international medical second opinion, the insurance does not cover any diagnosed disease or morbidity found during the waiting period.**

II.4.2.3. **In respect of the risks of the oncology diagnostics and malignant tumours, the insurance does not cover insured events which occur during the waiting period.**

II.5. Term of the Insurance Policy

The insurance policy may be concluded for a fixed term of one or two years.

II.6. Termination of the Insurance Policy

II.6.1. **The insurance policy – and under a family policy the coverage of a particular insured – will terminate**

a) at the end of the term specified in the certificate of coverage,
b) at the end of the policy year in which the insured reaches 70 years of age,
c) if the insured dies, at the time of the death,
d) if the policyholder dies or the policyholder entity is terminated without legal succession, at the date of such event, save for the case if the insured replaces the policyholder in the insurance policy,
e) if the premiums are not paid, in accordance with Clause III.3. of these general conditions,
f) in the event of the subsequent termination of a policy concluded by implicit conduct (tacit policy) (Clause II.2.6.), or if if the insured risk significantly increases, by the insurance company's termination in accordance with Clause II.6.4. of the general conditions,
g) if the insured – unless the insured is also the policyholder – withdraws his/her written consent to the conclusion of the insurance policy with effect from the end of the policy year,
h) 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. The family policy will terminate at the end of the current policy period if on the last day of that period only a person under 18 years of age remains insured under the insurance policy for whatever reason.

II.6.3. **Cancellation of the Insurance Policy**

a) the policyholder may cancel the insurance policy in a written notice delivered to the insurance company at least 30 days before the end of the policy year with effect from the policy renewal date;
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.6.4.

II.6.4. **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**

II.6.4.1. 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.

II.6.4.2. **If the policyholder does not accept the proposed modification** or does not respond to it within 15 days of its receipt, the insurance policy or the provisions proposed to be modified, will terminate on the 30th day after notification of the proposal for modification was given, provided that the insurance company has advised the insured of this legal consequence when sending out the notification.

II.6.4.3. In respect of a family policy, if the considerable increase of the insured risk only applies to certain insured persons, the insurance company may not exercise the rights set out in the foregoing with respect to the other insured persons.

II.7. Geographical Limit of the Insurance Coverage

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

III. INSURANCE PREMIUM

III.1. Calculation of 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 is **required to be paid by the policyholder.**

III.1.2. The insurance premium shall be calculated pursuant to the insurance company's Premium Rates Schedule, in particular on the basis of the **insured's age, medical conditions, occupation** (profession, job), **his/her valid social security coverage in Hungary** (valid Hungarian social security number (TAJ)), as well as on the basis of the **Insurance Plan** and the **policy term** selected by the policyholder.

III.1.3. 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 takes effect.

III.2. Payment of Insurance Premiums (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 paid 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 decides the payment frequency at the time when the insurance application is completed, but he/she may request that the original frequency be modified any time during the policy term by completing a modification request form made available by the insurance company, with effect from the first day of the month following the month in which the modification request is submitted.

III.2.3. The first insurance premium is due at the date agreed by the parties, and in the absence thereof, at the date when the insurance policy is concluded. All later premiums are due on the first day of the premium payment period (year, half-year, quarter, month) which they are 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. Any insurance premium (or premium instalment) 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.2.6. **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. If the policyholder fails to settle the regular insurance premium by the set due date, the insurance company will send the policyholder a written payment reminder with at least an additional thirty-day deadline including advice on the legal consequences of payment default. If the policyholder fails to comply with his payment obligation within the additional period, the policy will be terminated with retroactive effect to the due date, except if the insurance company forthwith moves to enforce its claim by judicial process.

III.3.2. **If only a part of the due premium is paid, and the insurance company's reminder – issued in accordance with the provisions on premium payment default – sent to the policyholder requesting the payment of the sum outstanding has proved unsuccessful, the policy shall remain in force for a term to which the premium paid corresponds.**

III.3.3. The policyholder may, within 120 days of the due date of the first unpaid insurance premium, request that the **insurance policy terminated** due to the payment default **be reinstated (reactivation)** provided that all unpaid insurance premiums have been settled. In that case the insurance company shall be entitled to carry out underwriting once again, and conditionally, accept or reject the application without giving reasons.

III.3.4. In such a case the insurance coverage is reinstated as at 0 am 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.4. Rules of Modifying 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 once a 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 outpatient treatment price index (KSH code: 06.2) published by the Central Statistical Office (hereinafter: KSH) for February of the current year and for 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.

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.

III.4.2. **If the policyholder is not a consumer, then notwithstanding the provision set out in Clause III.4.1, the insurance premium will also be modified if the insurance company proposes the policyholder to modify the insurance premium with effect from the next policy renewal date, and the policyholder approves the proposed modification by paying the first modified premium due after the renewal date in accordance therewith.**

The insurance company will communicate its proposal for the modification of the insurance premium to the policyholder in writing and at least 30 (thirty) days prior to the next renewal date of the policy.

IV. INSURED EVENT, COVERED SERVICES AND THE CONDITIONS FOR PERFORMANCE

IV.1. Insured Event

The event specified in the special conditions upon the occurrence of which the insurance company is required to deliver the covered services.

IV.2. Covered Services

If an event that is defined as an insured event in the special conditions occurs, the insurance company shall offer the covered services specified in the special conditions. Any costs incurred in connection with notifying an insurance claim may only be 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 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 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);
c) 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.
d) 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;
e) The documents managed by the social insurance body or another person or organization, containing data regarding the insured with respect to the insured event or a circumstance leading to such an event (pursuant to the entitled party's authorization for a release from the confidentiality obligation and for a request of data);
f) The insured's sports club membership card or of the membership certificate relating to his/her sports activities, the official match report;
g) An official certificate in proof of the insured's date of birth (birth certificate, identification card, passport, driver's license);
h) It is also required that all documents necessary for the assessment of the insurance claim but produced in a foreign language shall be translated into Hungarian at the cost of the claimant, and the official translations shall be submitted to the Insurance Company for decision making;
i) 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 is entitled to obtain additional documents for the assessment of the insurance claim.

IV.4. Rules of Delivering the Covered Services

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 deny the insurance claim.

IV.4.3. **The insurance company shall not be required to provide the covered services 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 notifying 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 PERFORMANCE

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 deliver the covered services 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.6.4 of these general conditions to amend or cancel 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 performance if it can prove that the event which resulted in the insured event was caused unlawfully and willfully or unlawfully and in gross negligence by:

a) by the policyholder or the insured; or

b) a relative living in the same household with them.

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 contributed to 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 assistance or medical care. If the insured fails to comply with this obligation, the insurance company will be relieved of performance.

The insured's refusal to a medical procedure – when exercising the right of disposition to which he is entitled by virtue of law – shall not constitute an infringement of the obligation to mitigate damages.

Nothing in the above shall 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) HIV infection,

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) above, 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 the direct results of the following cases:

a) the 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's health that had been diagnosed prior to the effective date of the insurance coverage.

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 medical and health care services related to any of the following:

a) pregnancy, childbirth and postpartum care,

b) special procedures aimed at human reproduction (including artificial insemination and any of its form, as well as health care and medical procedures related to confirming and treating infertility, and procedures aimed at testing and manipulating male reproductive capacity), and procedures to facilitate pregnancy, as well as 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 surgery.

VI.8. The insurance does not cover medical and health care services related to any of the following:
a) rehabilitation of chronic illnesses (especially geriatrics, special needs education, speech therapy, physiotherapy /e.g.: physical therapy, manual therapy, bath therapy/, weight loss therapy, infusion therapy to improve blood flow, pain management infusion therapy), prescription of medication, dressings and bandages, durable medical equipment as a part of the rehabilitation therapy, nursing and hospice care; life sustaining procedures, treatments,
b) rheumatology treatments (physiotherapy including manual therapy) not including electrotherapy and physical therapy if they are specifically indicated in the Insurance Plan selected for the insured.
c) oncology treatment, nursing and control examinations related to malignant tumours, other treatments required to treat the consequences of malignant tumours (e.g.: bowel obstructions, surgical treatment of bone metastases),
d) 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, the costs of treatments, instruments and drugs not approved or not financed by the OEP (the National Health Insurance Fund of Hungary), as well as the costs of examination, tests and procedures related to the above, and procedures subject to individual OEP funding including the related costs,
e) biological therapies, as well as the costs of related examinations, and the costs of medication used in biological therapies,
f) medical research on human subjects, treatments related to experimental diagnostics and therapy and their costs,
g) 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 defined in legislation,
h) treatment performed by a person who does not have medical certification and a permit to practice medicine,
i) pharmaceuticals (including infant formula), dressings and bandages and durable medical equipment, unless they are used during the covered treatment provided in a medical facility (e.g.: local anaesthesia, needles, syringes, surgical disinfectants, surgical sutures, sticking plasters), but not including joint injections, injusion and the related tools together with the medication administered,
j) injection or infusion therapy (including at least 3 treatments) and the related medical control examinations,
k) purchase of vaccine for immunization shots, reimbursement of costs, administration of the shot, unless it is specifically indicated in the Insurance Plan selected for the insured,
l) treatments or procedures performed for aesthetic purposes, cosmetic surgery and its consequences,
m) the removal of benign skin lesions, virus induced warts (in the absence of a histology test, all abnormalities are considered benign),
n) vision correction surgery or procedure performed on the cornea, and vision correction aids, hearing aid and accessories,
o) general anesthesia or sedation during endoscopic procedures,
p) capsule endoscopy,
q) 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,
r) psychological disorders and psychiatric disorders,
s) medical care related to organ transplantation and heteroplasty, including pre-care and after-care procedures,
t) purchase of prosthetic parts or the implantation of artificial, corrective or prosthetic implants,
u) dialysis,
v) dental treatments and procedures, oral surgery,
w) sleep studies (somnography, polysomnography),
x) health care services related to deceased persons,
y) alcohol, drug or narcotic substance abuse treatment programs, other addiction treatments, and related medical and health care,
z) 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,
aa) 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 (STD),
ab) medical care related to disaster management and public health within the meaning assigned to it by law, including the costs relating to any compulsory vaccination shots required at a certain age or for an occupation,
ac) all claims and costs related to medical expert opinions, unless these are specifically included in the Insurance Plan selected for the insured,
ad) prevention within the meaning specified in the legal act, as well as other types of preventive treatments, screenings, tests, with the exception of screening tests included in the Insurance Plan,
ae) 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.

Sports 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: in particular, skiing, downhill, slalom skiing, giant slalom skiing, biathlon, snowboarding, freestyle skiing, ski jumping, luge/skeleton, bobsled, speed-skating, ice dancing, figure skating, ice 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 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, and/or if the insured event is the delivery of health care services, 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

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.3. Procedure to Settle Disputes or Disagreement

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

VIII.4. Qualification of the Insured's Sports Activities

VII.4.1. For the purposes of these conditions the insured shall qualify as a **professional athlete** if he/she entered into employment or other work-related legal relation with a sports association, or is engaged in 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 shall qualify as a **recreational athlete** if he/she is engaged in sports activities as a non-professional and non-competing sportsman.

VII.5. Terms and Definitions

24-hour Health Direct Line/Consultancy: Generali Medi24 Direct Line – 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).

Primary Care (availability of health care services or physicians): generally available basic (not specialty) medical and health care services, which are required to treat illness or accident consequences: GP or similar services.

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.

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.

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

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).

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

Patient Transport: transport of a patient if prescribed by a duly authorized physician, in accordance with the requirements defined in legislation, in order to provide him/her access to the required elective medical care in cases which do not require ambulance nursing supervision but when the availability of a medical and health care cannot otherwise be provided due to the patient's condition.

Insurance Coverage: medical and health care services and service types which the insured is eligible to receive partially or entirely free of charge during the term of the insurance policy concluded with the insurance company, subject to the provisions of the policy conditions.

Family Policy: an insurance policy with at least two insured persons covered under the insurance, one of them being an adult, and the insured persons are close relatives - within the meaning set out in the Civil Code - and have the same mailing address.

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. Diagnostics also includes imaging and laboratory tests, histology and cytology tests.

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

Medical Records, Medical Documentation: records, charts or data recorded otherwise, containing medical information and personal identification data related to the treatment of the patient, prepared under current regulations and in compliance with health care and medical professional requirements, disclosed to health care staff in the course of providing medical and health care services, regardless of data carrier or form. For the purposes of the general terms and conditions, medical and health care documents within the meaning defined in legislation shall particularly include the following documents also partially specified in legislation: outpatient records, hospital discharge summary, operative report, examination records, nursing and care documentation, test findings, medical expert opinion, laboratory records, images made during diagnostic or histology tests, prescriptions (copy), referrals (copy).

Medical and Health 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.

Healthcare Profession: medical and health care services which may only be provided by qualified medical professionals in medical facilities where certain conditions (personnel and material conditions) required by law are met, and which have a National Provider Identifier (NPI).

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.

Medical Facility (institution): any private health care entrepreneur, legal entity or organization without a legal personality, regardless of ownership and maintenance arrangement, which is entitled to provide medical and health care services under current legal regulations in possession of a license of operation issued by a public administrative body of health care 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.

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.

Electrotherapy: e.g.: transcutaneous electrical nerve stimulation (TENS), iontophoresis, interference, selective current stimulation, diadynamic therapy.

Healthcare Management: see Medical Case Management.

Healthcare Manager: see Medical Management Company.

Life-sustaining Medical Treatment: 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 Procedure: emergency medical procedure required to be performed in a suddenly developed condition threatening life to save the insured's life.

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.

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.

Physiotherapy: e.g.: balneotherapy, electrotherapy, massage, physical therapy, manual therapy, phototherapy.

Generali Medi24: see: 24-hour Health Direct Line/Consultancy

Medical Care: see treatment.

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 (including infant formula), 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.

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.

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

House Call: if a claim is notified through the 24-hour Health Direct Line/Consultancy, a house call a healthcare service available at the insured's place of residence/ temporary residence (home) – at certain locations – in acute care cases if such attention is medically reasonable and necessary, whereby a physician providing general practitioner type care services is sent to the insured. A House Call shall not substitute Emergency Care. The service is offered with deadlines applicable to acute care cases.

For information about towns and cities where the house call service is currently available, please call Generali Medi24 Direct Line.

Hospice Care: see terminally ill patient care.

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.

Treatment: A group of activities performed by special healthcare personnel aimed to cure diseases or to stabilize a patient's condition using diagnostic results.

Hospital: 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.

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 (of at least 3 months), possibly including acute periods or reduction or abatement of symptoms in the meantime.

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

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

Rescue: urgent care, within the meaning defined in legislation, 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.

Medical Profession: medical and health care services which may only be provided by qualified medical professionals in medical facilities where certain minimum conditions (personnel and material conditions) defined in legislation are met, and which have a National Provider Identifier (NPI).

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 relieve 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.

Rheumatology Treatment: see Physiotherapy

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 that require urgent care, and which provide continuous availability of medical care outside daily working hours.

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).

Fee for Service insurance: payment of the costs of medical and health care services, partially or entirely, in the form of insurance benefits, within the framework of an insurance policy subject to the terms and conditions set out and stipulated therein.

Insurance Plan: see insurance coverage.

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

Medical Management Company: 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 Company 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 Insurance Plan selected under the insurance policy.

Tissue: Group of cells of similar shape and function. Tissue does not include blood and blood components.

Childbirth and Postpartum Care: a group of medical and health care 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.

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.

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.

Therapy: see treatment.

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

Transplantation: see organ transplantation and heteroplasty.

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.

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.

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.

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 Private Care Health Insurance which substantially differ from the respective provisions of the Hungarian Civil Code (Ptk).

VIII.1. Conclusion of the Insurance Policy

Pursuant to Clause II.2.4. 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. of these policy conditions – and by way of derogation from Section 6:444 (1) of the Civil Code – the insurance policy will be concluded by the insurance company's implicit conduct **even if the policyholder is not a consumer.**

VIII.2. Additional Payment Deadline

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 company will send the policyholder a written payment reminder stipulating **at least** an additional thirty-day deadline if the policyholder fails to settle the insurance premium by the due date.

VIII.3. 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 No. 1
Insurance Plans of the Generali Private Care Health Insurance

The service types shown in this table may be received on medical advice only, subject to the content and limitations specified in the Insurance Plan, in accordance with the provisions of the general and special conditions of the insurance.

Benefits		Insurance Plans			
		EXCLUSIVE	COMPLEX	PLUS	START
Generali Medi24		•	•	•	•
Annual preventive screening test (health checkup)		extra preventive	standard preventive		
Basic Care	**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, 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.	•	•	•	
	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.	•	•	•	
Ambulatory surgeries		•	•	•	
One-day surgery		•	•	one procedure/ person/policy year	
International medical second opinion		•	•		
Vaccination against the flu with reimbursement of the price of the flu shot		•	•		
Patient Transport (with a paramedic)		•	•		
House call: in medically reasonable and necessary acute cases, home care for adults in Budapest and in certain towns in the country		•			
Physiotherapy		max. 12 occasions/ person/policy year			
Inpatient care in a hospital (healthcare treatment, surgeries, accommodation in VIP facilities)		max. HUF 4 000 000 / person/policy year			
Oncology diagnostics check-up, oncology opinion, treatment plan, consultations for one year		•			
Malignant tumour fixed-sum coverage		HUF 2 000 000			

Schedule No. 2
Hazardous Occupations

This Schedule No 2 shall form an integral part of the general terms and conditions of the Generali Private 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:** shotfirers 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. **Stuntmen**