UNION
VIENNA INSURANCE GROUP

# PrivateMed Next health insurance Policy Terms and Conditions

These Policy Terms and Conditions (hereinafter referred to as: Policy Terms and Conditions) are valid for PrivateMed Next health insurance policies of UNION Vienna Insurance Group Biztosító Zrt.

**Issues not regulated in these Policy Terms and Conditions, and the Specific and Supplemental Insurance Terms and Conditions shall be governed by the provisions of the Civil Code and the current applicable Hungarian laws.**

The parts of the customer information document prepared as prescribed by Annex 4 of Act LXXXVIII of 2014 on the Insurance Business (Insurance Act) are **in bold type**, while the conditions deviating from those included in the Civil Code and/or the general policy conclusion practices are *in italic type*.

## 1. Terms and definitions

1.1. **Primary care** means a long-term service based on a personal relationship that may be used in the insured person's place of residence or place of abode or in the vicinity of the same according to the insured's choice, in the scope of which continuous health care is provided irrespective of the gender and age of the insured or the nature of his/her illness (general practitioner services).

1.2. **Outpatient operation** means a diagnostic and/or therapeutic surgical intervention after which the patient does not need any inpatient institutional care, and where after necessary and sufficient observation following the intervention he/she may be discharged.

1.3. **General outpatient care** means one-off or occasional health care, including outpatient operation and house call, provided by a specialist physician on the basis of the referral of the physician responsible for the continuous care of the insured or on the basis of the insured's own application.

1.4. **Healthcare provider not contracted by the care organiser/ Insurer** means any healthcare provider that has not entered into a contract with the care organiser/Insurer.

1.5. **Healthcare provider contracted by the care organiser/Insurer** means any healthcare provider that has entered into a contract with the care organiser.

1.6. **Accident** means the sudden occurrence of an external stress outside of the insured's control which causes an acute change in the human anatomy that is evidenced by a medical specialist to lead to injury.

1.7. **Intervention** means any physical, chemical or biological procedure that serves preventive or diagnostic, or therapeutic, or other purposes, and brings or may bring about a change in the patient's organisation.

1.8. **Insurer** is a legal person that, after the acceptance of the insurance offer, provides coverage for the risks specified in the terms and conditions, and undertakes an obligation for the fulfilment of the services specified in the Specific Policy Terms and Conditions and Supplemental Insurance Terms and Conditions in respect of the insured events occurring after the inception date.

1.9. **Policy year** means the period between two consecutive policy anniversaries.

1.10. **Insured** is a natural person for whom the policy is concluded to cover the insured events related to this person's health condition and physical integrity, provided that he/she declares that he/she has accepted the terms and conditions of this health insurance policy and consents to the extension of the insurance coverage to them.

1.11. **Insured's Declaration** is the document stating the insured's declaration of consent to the extension of the policy's coverage to them.

1.12. **Insured event:** an event defined by the Specific and Supplemental Insurance Terms and Conditions as insured event, upon the occurrence of which the Insurer provides the services/benefits specified in these terms and conditions.

1.13. **Illness:** The disruption of the balance of a living organism's body, spirit and mind that impedes its life processes, everyday operation and participation in social life.

1.14. **Group insurance:** The insurance applies—under a single policy—to several insured persons, a group or groups of natural persons defined against objective criteria laid down by the policyholder in the insurance offer. Several groups of insured persons - defined by name - may be established in the policy concluded under these General Terms and Conditions. Objective grouping criteria may include the legal relationship between the insured persons and the policyholder, other types of relationship or belonging to an organisation. A group of insured persons may comprise insured persons eligible for the same insurance benefits. The policyholder shall clearly define the groups of insured persons when the proposal is made.

1.15. **Premium rates:** When defining the payable premium, the Insurer considers several factors and one of them is the premium rate.
The premium rate is the premium calculated for a certain service/service package, for a given age range, without discounts and aggravating factors of risk.
The premium rate is not identical to the payable premium, but a factor applied to define that.

1.16. **Medical documentation:**
The medical documentation includes all relevant data connected to the examination and medical treatment of the patient. The medical documentation should be kept so that it truthfully reflects the process of care.

a) The medical documentation shall contain:
- the personal identification data of the insured person,
- in the case of an insured person with capacity to act, the name, address and contact details of the person to be notified, in the case of a minor or an insured person under custody the name, address and contact details of the legal representative,
- the medical history,
- the results of the first examination,
- the examination results on which the diagnosis and the medical treatment plan are founded, and the dates of the examinations,
- the name of the illness justifying the care, the illness from which the illness has developed, any accompanying illnesses and complications, and the names of any other illnesses or risk factors that do not directly justify the care,
- the dates of the interventions, and their results,
- the medication and other therapies, and their results,
- data concerning the patient's drug hypersensitivity,
- the name of the health care worker making the entry, and the date of the entry,
- the content of the information given to the insured person (patient) or to other lawful recipients of such information,
- the fact of informed consent or rejection, and its date,
- any other data or fact that might influence the insured's recovery.

b) The following should also be retained as part of the medical documentation:
- the findings of the examinations,
- the documents generated in the course of medical treatment and consultation,
- the nursing documentation,
- the records of medical diagnostic imaging procedures, and
- the tissue samples taken from the insured's body, and their histological results.

At the end of complex care processes consisting of several sub-procedures or inpatient hospital care, a written summary report (discharge report) must be prepared, and delivered to the insured person.

1.17. **Expert activities performed in the scope of health care:**
any health expert service provided in the context of therapeutic and preventive care as well as in relation with application for social security services, including, in particular, the health assessment of and providing opinion on

a) medical fitness for work or for the relevant profession,
b) earning capacity,
c) the degree of disability and the measure and quality of the remaining ability for work, and the terms and conditions of further employment.

1.18. **Health care** means all health care activities related to the insured's health condition.

1.19. **Healthcare service** means collectively all health care activities that may be performed on the basis of an operating license issued by the health authority and that are directed at the preservation of the individuals' health, as well as the prevention,

early recognition, diagnosis and medical treatment of illnesses, the aversion of danger to life, the examination and treatment, care and healing of the insured person (patient) to improve the conditions that have developed as a result of illnesses or the prevention of the further deterioration of such conditions, the reduction of pain and suffering, and furthermore, the processing of the insured's (patient's) examination materials in view of the foregoing, including activities involving pharmaceuticals, medical aids, and medical care as per relevant laws.

1.20. **Healthcare provider** means any individual medical entrepreneur, legal person or organisation without legal personality, irrespective of the form of ownership or of the operator, that is authorised to provide health care service on the basis of an operating license issued by the health authority.

1.21. **Health risk assessment** means an activity of the Insurer whereby it assesses the health condition of the insured person before assuming an insurance risk.

1.22. **One-day surgery:** One-day surgery care is a foreseen or scheduled surgical intervention specified in the legislation, resulting in hospital inpatient care, that shall be performed by a healthcare provider which possesses official authorisation to perform such type of care according to the relevant legislation and medical opinion to a patient suitable for such type of care, and after which no more than 24 hours of hospital supervision is required.

1.23. **Care organiser** is an organisation that is authorised to organise healthcare services.

1.24. **Electrotherapy** is a type of physiotherapy which uses electricity for targeted muscle stimulation.

1.25. **Antecedent illnes**s means any symptom, illness, injury or permanent impairment that already existed before the conclusion of the insurance, and that is related to the illness or symptom surfacing during the life of the insurance.

1.26. **Annual benefit limit** means an annual limit of the amounts of services to be performed as defined by the Insurer in respect of this contract, for certain services of PrivateMed Next specified in the Specific and Supplemental Terms and Conditions, the measure of which is set out in the Benefit Limits form.

1.27. **Consumer** means any natural person acting outside the scope of their vocation, profession or business activity.

1.28. **Therapeutic massage** is a type of physiotherapy that is performed by an expert who has the relevant professional qualification.

1.29. **Corrective-gymnastic therapy** is a type of physiotherapy. A series of exercises selected after a precise medical check-up to achieve the targeted physical condition, that improves functions by generating an adequately fitting series of stimuli, and that is provided by an expert who is a qualified physical therapist.

1.30. **House call:** House call is a health service that can be used day and night at the patient's place of residence or place of abode, in Budapest and its 20 km vicinity, in emergency cases reported to the care organiser on the phone, in the scope of which the care organiser sends a physician providing on-call care to the insured person.

1.31. **Implant** is a prosthesis placed in the body or organism.

1.32. Beneficiary is the person entitled to use the services and identical to the insured person in respect of the General, Specific and Supplemental Terms add Conditions of PrivateMed Next.

1.33. **Treating physician** means the physician or physicians determining the examination and therapeutic plans related to the given illness or the health condition of the insured person, who perform(s) interventions in the scope of such plans, and is/are responsible for the insured's medical treatment.

1.34. **Hospital:** licensed institution recognised by professional supervisory bodies, that provides inpatient care under continuous medical control and supervision, and is assigned an adequate institutional code. Sanatoriums, day hospitals, psychiatric institutions, rehabilitation institutes, medical spas, health resorts, medical and care institutions for the mentally ill, institutions providing treatments for alcohol and drug addictions, hospices, care institutions, institutions providing chronic care for inpatients, geriatric institutions, nursing homes, and hospital departments providing the above-specified services do not qualify as hospitals.

1.35. **Reimbursement** means the reimbursement of actual costs incurred in connection with an insured event or the insurance service, up to the measure specified in the contract.

1.36. **Extracorporeal shockwave therapy** is a type of physiotherapy, where powerful longitudinal waves are used to treat musculoskeletal complaints.

1.37. **Surgery:** surgical intervention needed due to disease or accident performed on the insured person consistently with the rules governing the medical profession.

1.38. **Physician's recommendation** is a health document issued by a healthcare professional who possesses general practitioner, physician qualification, bearing the physician's stamp, that describes the examinations, interventions or treatment plan to be performed for the purpose of revealing the illness that causes the patient's symptoms, and preservation or rehabilitation of his/her health. In case of services subject to a physician's recommendation the Insurer performs the service based on the original physician's recommendation submitted in relation to the given service, and does not take any modified documents into account that have been issued in relation to the same event (physician's visit, diagnostic test, surgical intervention) but on a later date.

1.39. **Deductible:** The deductible is the amount that the Insurer deducts upon the reimbursement of the healthcare service used from the amount to be reimbursed, and that the insured person shall pay. The Insurer reimburses only the part of the cost of the healthcare service in excess of the deductible.

1.40. **Prosthesis:** an artificial instrument intended to replace a limb/body part or treat a dysfunction caused by accident, illness or congenital malformation.

1.41. **Specialised outpatient care** means health care organised for illnesses that require special expertise, or have special financial, material and professional prerequisites.

1.42. **Care arising from urgent need** means a degree of deterioration in health condition as a result of which – in the absence of immediate medical intervention – the patient's life would be directly endangered or the patient would suffer a severe or irreversible health damage.

1.43. **Policyholder** is a natural or legal person who makes an offer to conclude the insurance policy and undertakes an obligation to pay the insurance premium.

1.44. **Screening test** means an examination aimed at the early recognition of a potential illness or pre-disease state of symptom-free persons (including the recognition of risk factors that predispose the patient for specific illnesses) that is also suitable for determining the Insurer's risk assumption criteria.

1.45. **Ultrasound therapy** is a type of physiotherapy. It uses ultrasound waves to alleviate musculoskeletal complaints.

1.46. **Waiting period** means a contractual delay of the inception date or the limitation of insurance coverage for a specified period of time.

1.47. **Examination** means an activity aimed at the assessment of the health condition of the insured person, the preservation of his/her health, the detection of illnesses or their risks, the determination of concrete illness(es), the establishment of their prognosis or changes therein, the establishment of the effectiveness of the medical treatment, and of the occurrence and cause of death.

**2. Subjects of the health insurance policy**

2.1. **The Insurer is UNION Vienna Insurance Group Biztosító Zrt.**
**Registered office: 1082 Budapest, Baross u. 1.**
(1380 Budapest, Pf. 1075.; telephone: (+36-1) 486-4343)
**Company registration number: 01-10-041566**
**Name od Registry Court: Fővárosi Törvényszék, as Registry Court**
**Customer Service: 1134 Budapest, Váci út 33.**

2.2. Policyholder is a natural or legal person who makes an offer to conclude the insurance policy and undertakes an obligation to pay the insurance premium.

*2.3. The insured person shall be a natural person who is minimum 6 months, maximum 69 years of age at the time of entering the contract. For insureds below the age of 17 only Children's package can be taken.*
*For insureds entering the age of 18th in the year of entering the contract, the policy holder may decide whether to choose Children's package or any other package for the insured. For insured above the age of 18 Children's package cannot be taken.*

2.4. The insured person (beneficiary) is entitled to use the services provided by the Insurer.

**3. Conclusion of the insurance policy**

3.1. The offer for the conclusion of the insurance policy shall be made in writing by the policyholder in the standard offer form of the Insurer.

3.2. The policyholder is bound by its offer for 15 days, and in the

case of a health check for 60 days, after the date of the offer.

3.3. **Specific provisions applicable to insurance policies concluded in the framework of remote sales**
Specific provisions related to remote sales shall be applied to an insurance policy that is concluded between the Insurer and the consumer in the framework of remote sales, where the Insurer uses only telecommunications devices to conclude the contract. A telecommunications device means any device that is able to deliver a declaration for the conclusion of the contract in the absence of the parties.
The consumer shall have the right to terminate the insurance policy concluded in the framework of remote sales within 14 days from the date of policy conclusion. A written notice of termination shall be sent to the postal address and fax number of the Insurer's registered office. The insurance policy ceases on the day when the written notice of termination is delivered to the Insurer. In case the consumer exercised its right to terminate the contract, the Insurer shall have the right to require the consumer to pay only the proportionate value of the service performed as per the contract. The amount paid by the consumer shall not exceed the value of the performed service, and payable proportionately to the whole of the service specified in the contract, and cannot reach a measure where it would constitute a sanction. The Insurer shall reimburse to the consumer the amount in excess of the proportionate value of the premium after receiving the notice of termination at the latest within 30 days.

3.4. If the offer is accepted, the Insurer shall issue a certificate of insurance coverage (policy) on the contract. The contract is created on the date of issuance of the policy.

3.5. If the policy differs from the offer of the policyholder, and the policyholder fails to state its objection to such discrepancy immediately after receipt of the policy, the contract shall be created with the content specified in the policy. This provision can be applied to material discrepancies only if the Insurer calls the attention of the policyholder to the discrepancy in writing upon the delivery of the policy. In the absence of such warning, the contract shall be concluded consistently with the content of the offer.

3.6. If the Insurer rejects the offer in writing within 15 days of receipt, or within 60 days of receipt in the case of a health check (risk assessment period), the contract will not be concluded. The Insurer is under no obligation to provide the rationale for its rejection of the offer. If the policyholder is a **consumer** and the insured event materialises during the risk assessment period, the Insurer may only reject the offer if it has specifically called attention to this option on the offer form and the nature of the requested insurance coverage or the circumstances of cover clearly indicate the need for the individual assessment of the risk prior to accepting the offer.

3.7. If the policyholder is a **consumer**, the policy shall take effect even if the Insurer has failed to issue a declaration regarding the offer within 15 days of receipt or within 60 days if health check is necessary, provided that the offer was made on the Insurer's standardised proposal form, applying its premium schedule and in possession of the requisite information on the content of the legal relationship as defined in legislation. In this case, the policy takes effect retroactively to the date of transmission of the offer to the Insurer on the day following the lapse of the risk assessment period. If the policy having taken effect without the Insurer's explicit declaration contains a material discrepancy from these Terms and Conditions, the Insurer may propose an amendment of the policy consistent with these Terms and Conditions within 15 days of the insurance contract taking effect. If the policyholder does not accept the proposal or fails to reply within 15 days, the Insurer may terminate the policy within 15 days of receipt of the refusal or amendment proposal, providing 30 day's written notice.

3.8. If the policyholder is a consumer, and the policyholder and the insured person are different persons, the written consent of the insured person is necessary for the conclusion or amendment of the insurance policy.

3.9. On the date of the proposal, the Insurer has the right to collect the first premium of the insurance.

3.10. Before accepting the offer, the Insurer shall carry out a risk assessment, for which it may request the health declaration, medical examination and other statements of the insured person to be presented. The Insurer has the right to check such data.

3.11. **Specific rules of policy conclusion**

3.11.1. The Insurer shall notify the policyholder. The policyholder shall notify the insured persons about any provisions of the present agreement affecting them, the declarations received by the policyholder, and any changes in the contract.

*3.11.2. If the insured person is a minor, the parts of the policy pertaining to him/her do not require the approval of the guardianship office to become valid.*

*3.11.3. If the insured person is an adult restricted in his/her legal capacity or in terms of issuing legal declarations, or is legally incapacitated, the parts of the policy pertaining to him/her do not require the approval of the guardianship office to become valid.*

**4. The rules for the amendment of the insurance policy**

*4.1. In case the legal conditions entitling to tax allowance and tax credit in respect of the insurance policy change after the conclusion of the policy, the Insurer may propose the amendment of the insurance policy or these insurance terms and conditions having regard to the changed regulation within 60 days from the date when the change of legislation took effect, in order to have the content of the contract complied with the conditions entitling to tax allowance or tax credit.*

*4.2. If the policyholder does not refuse the amendment proposal within 30 days of the receipt of the information specified in Section 4.1, the policy shall be amended with the terms and conditions defined in the amendment proposal as of the date when the change of legislation takes effect.*

**5. Term of policy**

**5.1. The contract is concluded for a fixed term of 1 year. If neither party informs the other party in writing 30 days before the lapse of the term that it does not want the contract to be automatically prolonged, the contract shall be prolonged for another year.**

5.2. Unless agreed otherwise, the inception time and the starting time for premium payment shall be at 0:00 on the first day of the month following signature of the insurance offer.

**6. Insurance cover**

6.1. **Unless agreed otherwise, the insurance coverage shall start at 0:00 on the first day of the month following signature of the insurance offer**, provided that the policyholder has paid the first insurance premium to the Insurer.

6.2. Unless agreed otherwise, in case of the extension of the insurance coverage to a new insured person, the insurance coverage shall start **at 0:00 on the first day of the month following the registration of the new insured person as insured**, provided that the Insurer has not refused the offer related to the new insured person, and the policyholder has paid the relevant insurance premium to the Insurer.

6.3. Insurance coverage for specified insured persons shall cease in the following cases, unless agreed otherwise:

- **a) in case of the insured's death, on the day of his/her death,**
- **b) if the insured person has revoked his/her declaration of consent, on the last day of the month of revocation,**
- **c) if the insured person has reached the age of 70, at the first anniversary following his/her 70th birthday,**
- **d) upon the termination of the insured person's legal relationship or other relationship with the policyholder, as of the last day of the month of termination,**
- **e) if the insurance premium concerning the insured person has not been paid, at the end of the period covered by premium,**
- **f) upon the termination of the insurance policy,**
- **g) in the other cases regulated in the Specific and Supplemental Insurance Terms and Conditions.**

**7. Waiting period**

**7.1. The parties may stipulate in the contract that the Insurer provides coverage for the risk of an insured event starting only from a later date following the creation of the contract, or is entitled to decrease services if the insured event occurs within the waiting period. The waiting period may not exceed six months; any defined period in excess of this shall be null and void.**

**7.2. If some permanent illness of the person to be insured is known at the time of policy conclusion to all parties to the contract, the parties may stipulate a waiting period of maximum 3 years in the present agreement and in the Specific Insurance Terms & Conditions.**

**7.3. In case of the extension of the insurance coverage to a new insured person, the waiting period stipulated by the Insurer**

**shall be applied to the new insured person from the date specified in Section 6.2.**

**8. Cases for the termination of the policy**

**8.1. The insurance policy shall terminate in the following cases:**

**a) Unless it is prolonged, as of the 24th hour of the last day of the fixed term.**

**b) In the event of the policyholder natural person's death, as of the day of his/her death, if the insured person does not enter the contract.**

**c) In the event of termination of the policyholder legal person without succession, as of the day of termination.**

**d) Pursuant to Section 11.1 in the event of default on premium payment.**

**e) In case the number of insured persons reduces to zero, as of the last day of the month of the last insured person's withdrawal.**

*8.2. If the policyholder is a consumer, the insured person has the right to enter the contract upon termination of the contract.*

8.3. The policyholder shall notify the insured persons on the termination of the insurance coverage.

**9. Insurance premium**

9.1. The insurance premium is the amount to be mandatorily paid by the policyholder for the insurance coverage provided by the Insurer and for its obligation to provide benefits. The policyholder may pass on the premium paid by it to the insured person.

9.2. The policyholder shall pay the insurance premium for each insured person.

9.3. The insurance premium is the sum of the premiums of the basic insurance and the connected supplemental insurances.

**9.4. The insurance premium is defined by the Insurer for one policy year. The insurance premium may be paid in annual, semi-annual, quarterly or monthly instalment**s.

9.5. In case of a policyholder who is not a consumer, the Insurer calculates the insurance premium per insured based on the average age of the given group of insured persons. In case of a policyholder who is a consumer, the Insurer calculates the insurance premium for the given insured based on his/her average age at the time of entry into the policy. The Insurer calculates the age of the insured person by deducting the year of the insured person's birth from the year of the entry into the policy.

9.6. **The first premium of the policy falls due upon signature of the offer, unless agreed otherwise. All subsequent premiums fall due on the first day of the period to which they apply.** The policyholder shall pay the first premium on the policy following the first instance of data reporting, against the invoice issued by the Insurer, by the deadline stated on the invoice.

**10. Amendment of the insurance premium**

10.1. The insurance premium may be amended for the following reasons:

a) Change in the average age of the given group of insured persons.

b) Change in the service charges of private healthcare.

c) The unforeseen deterioration of claim experience.

**10.2. Amendment of the insurance premium due to a change in the average age of the given group of insured persons.**

**10.2.1. If the policyholder is not a consumer, in the event of the automatic prolongation of the policy, at the policy anniversary, the annual insurance premium per insured person is annually recalculated according to the actual average age of the group of insured persons, in case the composition of the group changed.**

*10.2.2. 50 days prior to an insurance anniversary at the latest the Insurer shall notify the policyholder in writing on the amendment of the premium. If the policyholder fails to respond to the amendment of the premium 30 days prior to an insurance anniversary at the latest, the Insurer shall consider the amended premium to be valid. If the policyholder refuses the amended premium 30 days prior to an insurance anniversary at the latest, the insurance policy shall terminate at the insurance anniversary.*

**10.3. Amendment of the insurance premium due to change in the service charges of private healthcare.**

10.3.1. The price index calculated by the Insurer is intended to reflect the average annual increase of the service charges in the Hungarian private healthcare.

10.3.2. When calculating the service price index, the Insurer takes into account the average prices of predefined private healthcare providers for a given calendar year.

10.3.3. When calculating the service price index, the Insurer takes into account the average charges of predefined types of private healthcare services in predefined ratios.

*10.3.4. The Insurer determines the service price index every year on 1 February in respect of the previous calendar year and discloses it on its website, first on 1 February 2020.*

**10.3.5. If the average growth rate of the prices of private healthcare services is more than 10%, thus the service price index reaches 110, the Insurer shall increase the insurance premium by the average growth rate.**

**10.3.6. If in a given policy year the service price index does not reach 110, and the Insurer does not increase the premium for the reason specified in Section 10.1. b), in the next policy year it will take into account the increase of service prices of two calendar year and will increase the premium by the rate of the service price index calculated based on those two years.**

**10.3.7. If the Insurer increases the insurance premium in accordance with Section 10.3.5., for the purpose of indexation it will simultaneously increase the limit values of basic service packages with limits defined in the Benefit limits document.**

*10.3.8. 50 days prior to an insurance anniversary at the latest the Insurer shall notify the policyholder on the amendment of the premium and the increase of the benefit limit (if any). If the policyholder fails to respond to the amendment of the premium and the limit 30 days prior to an insurance anniversary at the latest, the Insurer shall consider the amended premium and limit to be valid. If the policyholder refuses the amended premium and limit 30 days prior to an insurance anniversary at the latest, the insurance policy shall terminate at the insurance anniversary.*

*10.3.9. The Insurer shall have the right to apply a service price index officially published by an authority, professional forum or body instead of the service price index used as basis for the premium increase.*

**10.4. Amendment of the insurance premium due to the unforeseen deterioration of claim experience.**

**10.4.1. The Insurer is entitled to amend the insurance premium at the insurance anniversary if it is necessary for the protection of the risk pool and justified by the unforeseen deterioration of claim experience, i.e. a 10% higher than expected frequency of claims.**

*10.4.2. 50 days prior to an insurance anniversary at the latest the Insurer shall notify the policyholder in writing on the amendment of the premium. If the policyholder fails to respond to the amendment of the premium 30 days prior to an insurance anniversary at the latest, the Insurer shall consider the amended premium to be valid. If the policyholder refuses the amended premium 30 days prior to an insurance anniversary at the latest, the insurance policy shall terminate at the insurance anniversary.*

**11. Legal consequences of the non-payment of premiums**

11.1. If the policyholder fails to pay the insurance premium due, the Insurer shall issue a warning of the expected consequences and a written payment reminder to the policyholder, setting a 30-day extended payment deadline. If the extended deadline lapses and no payment is made, the policy shall terminate retroactively from the payment due date, except if the Insurer enforces its premium claim through judicial proceedings with no delay. The Insurer has the obligation to provide services for 30 days after the premium payment due date.

**11.2. The Insurer has the obligation to provide services for 30 days after the premium payment due date.**

*11.3. If the premium falling due has been partially paid and the Insurer has issued a payment reminder to the policyholder in line with Section 11.1 to no avail, the policy shall remain effective for the prorated period based on the premium paid.*

**12. Rights and obligations of the subjects of the insurance policy**

12.1. Rights and obligations of the policyholder

12.1.1. Obligation of disclosure: Upon the creation of the contract the policyholder and the insured shall disclose to the Insurer any and all circumstances that are relevant for the assumption of risk, and during the life of the insurance shall have the obligation to report changes in respect of the material circumstances specified in the contract, which disclosures are to be made in printed or electronic format.

12.1.2. The policyholder shall supply data to the Insurer if there have been changes in respect of the insured persons, in a manner

and with the content defined by the Insurer.

12.1.3. The policyholder is entitled to modify the basic service packages it selected for a given insured or group of insured persons at the insurance anniversary by selecting another service package from among the basic service packages determined by the Insurer. The policyholder shall notify the Insurer about the requested change 30 days before the insurance anniversary, on a form applied by the Insurer for this purpose.

12.1.4. On a monthly basis, the policyholder may make a proposal for involving new insured persons, or the termination of insurance coverage in respect of the insured persons identified by the policyholder (exiting insured persons).

12.2. Rights and obligations of the Insurer

*12.2.1. Before accepting the offer, the Insurer may carry out a risk assessment, for which it may request the declaration of the policyholder concerning the insured persons regarding the average number of sick pay days per person in the preceding year, and the health declaration, medical examination and other statements of the insured to be presented. The Insurer has the right to check such data, as well as to ask further questions for the purposes of the risk assessment.*

**12.2.2. If the actual health condition or lifestyle habits of the insured existing at the time of the policy fail to match those stated in his/her health declaration made in the scope of the risk assessment, the Insurer's obligation to perform will not enter in force, unless it is proven that such condition or habits did not influence the occurrence of the insured event, or at least five years have passed between the policy conclusion and the insured event.**

12.2.3. If the Insurer gains subsequent knowledge of any material circumstance already prevailing at the time of policy conclusion, it shall be entitled to exercise the rights arising therefrom during the first 5 years of the life of the policy.

*12.2.4. Despite any breach of the obligation of disclosure, the Insurer's obligation shall nevertheless apply if 5 years have passed between the date of the policy conclusion and the materialisation of the insured event.*

*12.2.5. The provisions of Sections 12.2.3 and 12.2.4 shall also apply to the consequences of violating the obligation to report changes in material circumstances as defined in the policy. The 5-year period available for the Insurer to exercise its related rights commences on the day following the expiry of the deadline for reporting the changes.*

**12.2.6. Upon a breach of the obligation of disclosure or the obligation to notify changes, the Insurer's obligation to perform shall not enter in force, unless the policyholder proves that the concealed or unreported circumstance was known to the Insurer at the time of the policy conclusion, or such circumstance did not contribute to the occurrence of the insured event, or if 5 years have already passed since the date of policy conclusion at the time of occurrence of the insured event, or since the day following the expiry of the change reporting deadline.**

12.2.7. The Insurer requires the insured persons to make a specific declaration on the exemption from medical confidentiality in respect of the Insurer's risk assessment and claim settlement units.

**13. Insured event**

**13.1. An insured event is the materialisation of any of the insured events defined in the Supplemental Insurance Terms and Conditions pertaining to the risks defined in the policy.**

13.2. Accumulated insured event: materialisation of an insured event defined in the Supplemental Insurance Terms and Conditions in respect of multiple insured persons in the context of a single policy. *Upon materialisation of an accumulated insured event, the Insurer shall provide indemnity up to the accumulated sums insured as defined in the policy, but no more than HUF 100,000,000 in respect of one insurance policy.*

**14. The Insurer's exemption**

**14.1. In the event of a breach of the disclosure or change notification obligation, the Insurer shall be exempted from its obligation to provide benefits, except if it is proven that the concealed circumstance was known to the Insurer upon the policy conclusion or that such circumstance did not contribute to the materialisation of the insured event.**

**14.2. The Insurer will be exempted from paying the sum insured if the insured event is the insured's death that was caused by the beneficiary's intentional behaviour or gross negligence.**

**14.3. The Insurer shall be exempted from paying the sum insured if the insured event materialised as a result of the insured's intentional grave criminal offence or in relation thereto.**

**14.4. The Insurer shall be exempted from its obligation to provide benefits if the insured has violated its obligation to prevent or mitigate damage.**

**14.5. The Insurer shall be exempted from paying the coverage amount if the insured event was unlawfully caused by the beneficiary intentionally, or if it occurred due to the unlawful gross negligence of the policyholder or the insured.**
**The insured commits gross negligence in particular if:**
- **a) there is a causative relationship between the insured event and regular consumption of alcohol or the insured being under the strong influence of alcohol (blood alcohol content of 0.0026 or higher),**
- **b) the insured event occurs as a consequence of the consumption of narcotics or substances with an effect of narcotics or medications, except when this latter was used as recommended and instructed by the treating physician.**

**14.6. The Insurer shall be exempted from performing the service if there is a causative relationship between the insured event and the insured's attempted suicide, even if the latter took place in the insured's confused state of mind.**

**15. Excluded risks**

**15.1. Insurance coverage does not apply to cases where the insured event is directly or indirectly connected with active participation in a combat or other act of war on either side, or in the context of participation in a criminal offence committed against the state. For the purposes of these terms, a war with or without declaration, a border clash, revolution, mutiny, coup d'état or attempted coup d'état against a government, civil war, military operation (e.g. airstrike or naval operation only) by a foreign country for a specific purpose, commando attack, and terrorist act will be considered as war. (In case of a commando attack or a terrorist act the insured person's acting in the interests of victims will not be considered as active participation in an act of war.) Under this contract, a criminal offence against the state is one that is defined as such by the Criminal Code, thus in particular riot, espionage and destruction.**

15.2. Insurance coverage does not apply to the case where the insured event is indirectly or directly connected with nuclear damage (nuclear fission or fusion, nuclear reaction, radiation of radioactive isotopes, ionising or laser radiation, or contamination caused by these).

**15.3. Insurance coverage does not apply to the case where the insured event took place due to the insured's inebriation, addiction arising from the consumption of intoxicating, narcotic or similar agents, or the regular consumption of toxic substances.**

**15.4. The Insurer does not perform services in cases where the insured event took place due to non-compliance with the medical standards (medical malpractice).**

**15.5. The Insurer does not cover the costs of treatments that become necessary due to health care, medical intervention, and harm suffered as a consequence thereof.**

***15.6. The event where the insured applies for health care without a physician's recommendation, except the consultation with specialist, shall not qualify as insured event.***

***15.7. The event where the insured applies for health care but the physician's recommendation does not feature the physician's stamp does not qualify as insured event either.***

***15.8. The care which was used without the involvement of the care organiser, i.e. it was used prior to consulting with the care organiser, does not qualify as insured event.***

**15.9. The Insurer shall not provide insurance cover for:**
- **a) care provided for the purpose of emergency reasons, in order to avert danger to life,**
- **b) expert activities performed in the scope of health care,**
- **c) care provided due to disasters,**
- **d) care administered for epidemiological reasons,**
- **e) pulmonology care,**
- **f) addictology care,**
- **g) alcohology care,**
- **h) drug patient treatment and care,**
- **i) employment health care,**
- **j) acupuncture treatment,**
- **k) alternative medical procedures,**
- **l) any care needed due to dental problems, complaints,**
- **m) laser treatments, interventions (nail fungus, vision correction, intimate laser surgery, varicose veins, etc.),**

**n) geriatric treatment and care,**
**o) eye lens implantation,**
**p) dialysis treatment,**
**q) injection treatment of varicose vein disease (sclerotherapy),**
**r) care and treatment that may become necessary after the diagnosis of a sexually transmittable disease,**
**s) tests carried out due to infertility,**
**t) genetic tests,**
**u) food intolerance (including IgG type food intolerance tests (FOOD test) and DAO-test as well),**
**v) psychiatric treatment, except the first consultation,**
**w) special education treatment,**
**x) physio- and motion therapy treatment (except if the insured person has a supplemental insurance package for motion rehabilitation),**
**y) injection therapy series (the first injection given during the first consultation to alleviate pain is covered, while all further injections including cartilage supplementary injections are not covered by the insurance)**
**z) intensive patient care,**
**aa) clinical oncology care,**
**bb) maintenance infusion and scheduled treatments including PRP and GUNA therapy,**
**cc) care of hepatitis C patients,**
**dd) anaesthesiology care, except if it becomes necessary in respect of ambulatory or one-day surgery,**
**ee) mandatory mother and child protection duties, including mandatory vaccination and screening required under the law,**
**ff) insured events occurring with pregnancy, childbirth and within one year after childbirth, in connection with childbirth, if the childbirth takes place within 270 days after the inception date**
**gg) applications for care related to contraception, infertility, artificial fertilisation,**
**hh) applications for care in connection with artificial termination of pregnancy, except if the pregnancy endangers the mother's life or if the embryo's health condition justifies such care,**
**ii) applications for care occurring in connection with aesthetic changes and cosmetic treatments, except the reconstructive interventions that may become necessary due to a disease or an accident, and the relating examinations,**
**jj) HIV infection of the insured, or any resulting applications for care,**
**kk) Applications for care related to the termination of alcohol or drug addiction,**
**ll) tele-consultation, meaning a medical consultation given not in a personal meeting, (except for the medical call center service of the PrivateMed Next health insurance),**
**mm) treatments that are not accepted and supported by the medical protocols accepted and applied in Hungary,**
**nn) microbiome stool test,**
**oo) immune therapy,**
**pp) psychotherapy,**
**qq) dietetic consultancy, except for cases when the insurance contract covers dietetic consultations as well.**

**16. The use of insurance services and benefits**

16.1. In respect of insurance services that include organising and financing of health care, the following procedure has to be followed:

16.1.1. The insured person indicates his/her application for care to the care organiser over the phone.

16.1.2. The care organiser shall be available to accept applications for care on working days between 8 a.m. and 8 p.m.

16.1.3. Telephone calls and online enquiries are recorded in a traceable form.

*16.1.4. If the care organiser deems the insured person's application for care justified, it arranges the first consultation between the insured and the physician within 5 working days — when arranging a screening test, within 30 days — of the date of requesting the care. It informs the insured on the place and date of care over the phone or via email. The deadline given to the care organiser applies only to the organising of the service, not to the providing of the service.*

16.1.5. If the physician orders further examinations, the insured may use these at the times and places arranged by the care organiser, provided that the care organiser also deems that the care is justified and the insured has not exhausted his/her annual benefit limit related to the given type of care.

*16.1.6. In the case of a service provider contracted by the care organiser, the Insurer—through the care organiser—reimburses the costs of the service to the service provider, up to the available annual limit. The medical documentation prepared by the healthcare provider concerning the care administered to the insured shall be a condition precedent for the Insurer's performance, which is sent by the service provider to the care organiser.*

16.1.7. If the amount available from the insured person's annual limit related to the given care does not cover the cost of the care, or the insured has already exhausted 90% of his/her annual limit related to the given care in the given policy year, the Insurer undertakes to organise health care only so that costs will be reimbursed to the insured subsequently, against invoices issued to the insured person's name, up to the annual limit.

16.1.8. **If the insured person wants to use the care at a service provider who is not contracted with the care organiser, the Insurer shall only reimburse the cost of the service to the insured subsequently, against an invoice issued to the insured person's name, provided that the care was carried out after a prior consultation with the care organiser, and only to the extent of the amount the given care would have cost at a contracted service provider recommended by the care organiser.** The care organiser shall inform the insured person about the extent of that amount upon application for the service.
**The information provided by the care organiser is preliminary information only, and does not qualify as an obligation undertaken by the Insurer.** The Insurer reserves the right to refuse the application after the receipt of the medical documentation sent after the care has been used, if it does not comply with the General, Specific or Supplemental Terms and Conditions. The option to subsequent reimbursement does not apply to screening, the Insurer does not reimburse invoices referring to screening tests subsequently.

16.1.9. Subsequent performance by the Insurer against an invoice is subject to the submission of the following documents:
a) the original invoice issued, to the insured person's name by the healthcare provider who provided the care, invoices issued to a health fund's name will not be reimbursed.
b) copies of the documents related to the care,
c) all documents, test results or medical documents required to establish eligibility, and that meet the requirements set out in Section 1 of these Policy Terms and Conditions,
d) the insured person's bank account number, where he/she wants to receive the reimbursement.

16.1.10. The documents must be sent to the address of the Insurer's care organiser partner.
Subsequent reimbursement, by taking the provisions of Section 16.1.8 into account, is performed within 15 days of the receipt in full of the documents specified in Section 16.1.9 at the latest.

***16.1.11. The insured shall have the opportunity to change the arranged date and time only once, 2 working days before the time of the examination at the latest, at the care organiser.***

***16.1.12. If the insured cancels or changes the date and time within 2 working days, or he/she does not appear to use the care on the agreed date and time, or the cancellation is not communicated directly to the care organiser, the Insurer will reduce the annual limit set for the given care available to the insured by 50% of the cost of the care planned, and the insured will become entitled to being provided with the same arranged intervention again after 3 months, except if he/she proves that he/she did not have the opportunity to cancel the care for a reason beyond his/her control.***

16.2. The Insurer does finance treatments happening after the end of the insurance term, in case the insured's need for the treatment has been announced to the care organiser within the insurance term.

16.3. The process of using other insurance benefits is described in the Specific and Supplemental Insurance Terms and Conditions.

**17. Coverage replenishment**
*In the scope of this contract, coverage may not be topped up.*

**18. This PrivateMed Next health insurance may not be reactivated, repurchased, exempted from premium payment or encumbered as collateral to loans.**

**19. Special rules for health insurance policies of non-consumers**

19.1. Notwithstanding Section 3.8 of these terms and conditions, unless the parties agree otherwise, the extension of the insurance

coverage to the given insured persons is subject to the written consent of the insured person (insured's declaration). The insured's declaration is a part of the policy. The policyholder shall retain the insured's declaration and provide it to the Insurer upon request. The insured shall complete the declaration providing accurate and complete information. The insured may revoke his/her consent to the conclusion of the policy and the establishment of his/her insured legal status in writing at any time.

*19.2. Without the insured's declaration, as is customary, the policyholder shall have the written consent of the insured persons to the processing of their personal data by the Insurer.*

*19.3. The written consent of the insured is not necessary for amending or terminating the insurance policy.*

19.4. The Insurer shall define the per capita premiums of the insured persons for each group of insured persons. The per capita premium for each insured person shall be the same within a group of insured persons. When calculating the premiums for the groups of insured persons, the Insurer takes into account the number of members, average age, profession/activity of the given group of insured persons and the selected insurance coverage.

19.5. The Insurer may also perform the risk assessment at group level.

**20. Deviation from normal contracting practice or the provisions of the Civil Code**

*The Policy Terms and Conditions of the PrivateMed Next health insurance materially diverge from the relevant provisions of the Civil Code in respect of the following elements:*

- *The Policy shall be renewed for another year unless, at least 30 days prior to the end of the original term, either party gives the other party written notice of its intent not to automatically renew the Policy. (Section 8.1.a)*
- *In case of an insurance policy of a non-consumer, the insured cannot enter into the policy (Section 8.2).*
- *In the scope of this contract, coverage may not be topped up. (Section 17)*
- *Claims arising from insured events occurring during the coverage period will lapse after one year following the occurrence of the insured event. (Section 24)*
- *if the insured is a minor or an adult restricted in its legal capacity or in terms of issuing legal declarations, or is legally incapacitated, the policy does not require the approval of the guardianship office to become valid (Sections 3.11.2 and 3.11.3)*
- *in case of an insurance policy of a non-consumer, if the policyholder and the insured are not the same person, the written consent of the insured is not necessary for amending or terminating the insurance policy. (Section 19.4)*

**21. Special rules pertaining to supplemental insurances**

21.1. Supplemental insurance cannot be concluded independently, but only connected to the basic insurance of PrivateMed Next health insurance.

21.2. The supplemental insurance can be concluded upon the conclusion of the basic insurance, or linked to an existing basic insurance at the insurance anniversary thereof, provided that the Insurer accepts the offer and the basic insurance remains valid after the anniversary with premium payment.

21.3. The supplemental insurance shall start on the starting date of the basic insurance, provided that it is concluded simultaneously with the basic insurance.

21.4. If the supplemental insurance is concluded during the life of the basic insurance, it shall start on the next anniversary of the basic insurance.

21.5. The policyholder shall pay the premium from the starting date of the supplemental insurance

21.6. In the cases described in Section 21.3 of this supplemental insurance, the inception date shall be identical to the inception date of the basic insurance. In the case described in the section of this supplemental insurance, the policy inception date shall be identical to the date of insurance anniversary of the basic insurance.

**21.7. Term of supplemental insurance**

**The term of the supplemental insurance is 1 year, which shall be automatically extended to each successive policy year, but only until the end of the term of the basic insurance, if the policyholder does not indicate in writing until the related insurance anniversary that it does not intend to prolong this supplemental insurance.**

**21.8. Supplemental insurance premium**

**21.8.1. The supplemental insurance premium is defined by the Insurer for one policy year. The insurance premium may be paid in annual, semi-annual, quarterly or monthly instalments.**

**21.8.2. The insurance premium is payable together with the premium of the basic insurance.**

21.8.3. The insurance premium related to a given insured person is calculated by taking into account the result of the risk assessment, the age of the insured person and the selected insurance package.

**21.9. Termination of the supplemental insurance**

**The supplemental insurance shall terminate in accordance with Section 8.1 of these terms and conditions.**

**22. Information on the processing of personal data and the confidentiality**

The data processing rules for the insurance customers' personal and insurance secrets information are set out in the Data Processing Information Document, which is also available on www.union.hu/adatvedelem.

**Data that is classified as an insurance secret is entitled to become acquainted with the persons or entities against whom the insurer has no obligation to hold an insurance secret in accordance with the provisions of the Insurance Act.**

A list of such organizations is contained in the first appendix of Data Processing Information Document. The insurer uses data processors and/or outsourced service providers in the context of the processing of such services in connection with the provision of contracts. The list of data processors and reinsurers, as well as the latest Data Processing Information Document is available on www.union.hu/adatvedelem. The content of the Data Processing Information Document and the list of data processing partners and reinsurer may vary depending on the changes in the legislation and the partnership agreements concluded by Insurer or to be entered into in the future.

**23. Legal statements**

23.1. The Insurer shall deliver its declarations in writing to the policyholder, or to the insured when claims for benefits are reported, to the most recent notification address provided by them to the insurer.

23.2. Any legal statements and reports sent to the Insurer shall be considered valid only if they are made in writing. Any legal statement will be effective upon its receipt by the Insurer.

**24. Limitation**

*The claim for benefits shall lapse after one year following materialisation of the insured event.*

**25. Language of communication and custormer notification**

All communication between the Insurer and the policyholder and notification of insured persons shall take place in Hungarian.

**26. Governing law and proceeding sourts**

**This insurance contract shall be governed by the provisions of Hungarian law.** The parties may apply to the court with general competence and jurisdiction for the adjudication of legal disputes arising out of the insurance contract and the legal relations between the parties. The language of the proceedings shall be Hungarian.

**27. Resolution of disputes**

27.1. The policyholder and the Insurer are bound to make every effort to settle any disagreements or disputes that may arise between them in the scope of or in connection with the contract amicably, by direct negotiation. The parties are bound to mutually inform each other of any independent circumstances arising subsequent to the conclusion of the contract that prevent the fulfilment of the contract.

27.2. Means of reporting complaints:

1. reporting verbal complaints:

a) personally:

– in our central customer service, during its opening times:
UNION Vienna Insurance Group Biztosító Zrt.
Central Customer Service
1134 Budapest, Váci út 33.
(the crossing of Dózsa György and Váci Street),

– or outside of the capital in our sales offices at the agency manager. The availability of our sales offices are published on our website: www.union.hu

b) by phone via our call center on the (+36-1) 486-4343 phone number in opening hours.

2. complaints in writing:

a) in person or by an authorized representative via a document handed over in a premise open for the clientele.
b) by post: (1380 Budapest, Pf. 1076);
c) by fax: ((+36-1) 486-4390);
d) via e-mail: ugyfelszolgalat@union.hu

The template used by Magyar Nemzeti Bank (Hungarian National Bank) for taking complaints is available on our website and the website of Magyar Nemzeti Bank on the following link:
https://www.mnb.hu/fogyasztovedelem/penzugyi-panasz

27.3. If any complaint concerning the insurance service is received by the policyholder, it shall direct the insured persons to the Insurer.

27.4. The Insurer shall send its position regarding the written complaint to the customer along with an explanation within 30 days of the communication of the complaint.

27.5. Insurer's supervisory authority: Magyar Nemzeti Bank (Hungarian National Bank)
1054 Budapest, Szabadság tér 8-9;
central phone number: (+35-1) 428-2500)

**27.6. Other forums for the enforcement of rights**

**If the consumer's complaint submitted to the Insurer have been refused, or**

- **have not been investigated as prescribed in the Insurance Act, or**
- **from the Insurer's response the insured person presumes circumstances violating the consumers' rights stipulated in the Insurance Act, or**
- **the Insurer has not responded to the complaint within the 30 days prescribed by the law for the investigation,**

**a) with complaints concerning inquiries into the violation of consumer protection provisions under Act CXXXIX of 2013 on the Hungarian National Bank, contact the Hungarian National Bank (mailing address: Hungarian National Bank, 1534 Budapest BKKP P.O.B. 777; Blue line with local charges: (+36-40) 203-776;**
**web: felugyelet.mnb.hu;**
**e-mail address: ugyfelszolgalat@mnb.hu);**

**b) with complaints concerning the issuance, validity, legal effects and termination of the policy, as well as breaches of contract and their legal effects, contact the Financial Arbitration Board (mailing address: H-1525 Budapest BKKP P.O.B. 172;**

**Telephone: (+36-1) 489-9100; e-mail: pbt@mnb.hu), or you may apply to any court of law according to the rules of civil procedure.**

27.7. Claims arising from or in relation to the insurance contract may also be enforced directly through judicial avenues. The resolution of complaints does not substitute litigation.

**28. Miscellaneous**

*In case of service financing risks, actual healthcare is provided by the healthcare provider defined in Section 1.1.15., whose activities and liabilities are governed by the provisions of the Act on Health; liability for losses arising from the faulty performance of medical and healthcare services shall be borne by the healthcare provider rather than the Insurer.*
*The Insurer shall forward complaints concerning the quality of the services provided by the healthcare providers, service standards and potential medical malpractices to the organisation providing the care, considering that the Insurer only pays the counter-value of such services, but the services themselves are not provided by the Insurer.*

**29. Miscellaneous provisions**

The Insurer will disclose its report on its solvency and financial situation on its website (www.unlon.hu) in the manner and at the time defined by the legal provisions.

**UNION Vienna Insurance Group Biztosító Zrt.**

Upon the entry into force of the Policy Terms and Conditions, Regulation 9/1993. (IV. 2) NM on certain aspects of social security financing of healthcare and Regulation 16/2002, (XII. 12.) ESzCsM on the professional conditions of one-day surgery and scheduled treatments