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 contracts 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 in Annex 4 of the Act LXXXVIII of 2014 on the Insurance Business (Insurance Act) are shown in **bold type**, while the terms and conditions deviating from those included in the Civil Code and/or the general contracting practices are displayed in *italics*.

1. Terms and definitions

1.1. **Basic insurance package** means a basic benefit package that is specified in the document entitled PrivateMed Next health insurance Benefit Limits. It is mandatory to choose this package and it is possible to complement it with supplemental insurance products.

1.2. **Primary care:** means a long-term service based on a personal relationship that may be used in the Insured'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 person or the nature of their illness (general practitioner services).

1.3. **Outpatient operation** means a diagnostic and/or therapeutic surgical intervention performed as a part of outpatient care, after which the patient does not need any inpatient institutional care, and where, after necessary and sufficient observation following the intervention, they may be discharged.

1.4. **Outpatient specialist care** means one-off or occasional healthcare, including outpatient surgery, teleconsultation and prenatal care, non-conventional activities and the house call service 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.

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

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

1.7. **Accident** means a one-off external impact affecting the human body that occurs irrespective of the will the insured, either suddenly or during a relatively short period of time, inflicting injury, causing poisoning or other bodily health-related harm.

1.8. **Intervention:** means any physical, chemical or biological procedure performed by a doctor that serves preventive or diagnostic, or therapeutic or other purposes, and brings or may bring about a change in the patient's body.

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

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

1.11. **Policy anniversary** means the annual cut-off date of insurance's risk bearing (the inception date).

1.12. **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. In the case of a private person policyholder, a close relative stipulated in Section 1 8:1(1)(1) of the Civil Code, and living in the same household with the policyholder, may be an Insured person.

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

1.14. **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.

1.15. **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.

1.16. **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. In the contract concluded under these Terms and Conditions, several groups of insured persons – specified by name – may be established. 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.

1.17. **Premium rates:** When defining the payable premium, the Insurer considers several factors and one of them is the premium rate.

Premium rate means the premium calculated for a certain service/service package for a given age range, without discounts and aggravating risk factors.
The premium rate is not identical with the payable premium, but a factor applied to define thereof.

1.18. **Medical documentation:**
The medical documentation includes all relevant data connected to the examination and medical treatment of the patient. The medical documentation contains the insured's identification data, and it should be kept so that it reflects the process of care truthfully as well as showing the reasonableness of the intervention/examination.
The medical documentation shall contain:
- 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 underlying illness from which it 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 number of the physician's stamp.

1.19. **Expert activity performed in the framework of healthcare** means 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) examinations to establish medical fitness for work or for the relevant profession or other kind of medical fitness required by the law,
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.

1.20. **Healthcare:** means all healthcare activities related to the insured's health condition.

1.21. **Healthcare service** collectively means all healthcare activities that may be performed on the basis of an operating license issued by the health authority and that are aimed 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 (patient) in view for the improvement of 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 for the foregoing, including activities involving pharmaceuticals, medical aids, and medical care as per relevant laws.

1.22. **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.

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

1.24. **Same-day surgery** Same-day surgery care is a foreseen and elective 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.

1.25. **Care organiser** means an organisation that is authorised to organise healthcare services and patient transports. The Insurer shall provide information about the identity and contact details of the care organiser or any changes thereof on its website. In the case of changes, such information shall be given no later than on the 30th day prior to the occurrence of the changes.

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

1.27. **Antecedent illness** means any symptom, illness, injury or permanent impairment that had already existed and been diagnosed by a specialist physician before the inception date or the existence of which was already suspected based on medical documentation prior to the inception date and that is clearly related to the illness or symptom surfacing during the term of the insurance.

1.28. **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. The annual benefit limit is set for the policy year.

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

1.30. **Care:** ongoing healthcare with the purpose of maintaining healthy or asymptomatic condition, supporting rehabilitation.

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

1.32. **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.

1.33. **House call** means a health service that can be used at the patient's place of residence or place

of abode, in Budapest and its 20 km vicinity, in emergency cases which do not require institutional care or the elimination of direct risks to life and are reported to the care organiser over the phone, in the scope of which the care organiser sends a physician providing the Insured with on-call care.

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

1.35. **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.

1.36. **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.

1.37. **Supplemental insurance** means an insurance package that can be taken out only with a basic insurance package but not independently.

1.38. **Control examination:** By control examination the Insurer means the regular monitoring of current health condition generated by an existing illness, and not required by a complaint, the control of the efficiency of the treatment, and if needed, the change of the treatment based on the patient's condition.

1.39. **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, and neither do obesitology and lipidology departments.**

1.40. **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.

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

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

1.43. **Non-conventional activities**
In the context of these Policy Terms and Conditions, non-conventional activities mean activities set out in **Annex 1 to Decree No. 11/1997 (V.28.) of the Ministry of Welfare that can be performed only by doctors holding a valid operating licence in Hungary**, including manual therapy procedures, traditional Chinese medicine and neural therapy methods, together with all other non-conventional procedures and methods for the training of which a medical university organises a course and examination, or which are accredited by such a university.

1.44. **Physician's recommendation** is a health document issued by a healthcare professional who possesses general practitioner or physician qualification, bearing the physician's stamp number, where such document describes the examinations, interventions or treatment plan to be performed for the purpose of revealing the illness that causes the patient's symptoms and for the preservation or rehabilitation of their health. Where the services are subject to a physician's recommendation, the Insurer performs the service based on the physician's initial 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. In the absence of a written medical recommendation, the care organiser's doctor may also give medical recommendations for the organisation of outpatient specialist care and they also have the right to override the medical recommendation submitted by the insured.

1.45. **Deductible:** Deductible means an amount that the Insured holding a deductible-based basic insurance package must pay directly before making an appointment. The Insurer reimburses only the part of the cost of the healthcare service in excess of the deductible.

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

1.47. **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, or need that, in accordance with the rules of the medical profession, makes it necessary to provide the patient with healthcare services within 24 hours.

1.48. **Policyholder** means a natural person or a person/economic operator (not qualifying as a consumer, hereinafter: legal person) who/that makes a proposal to conclude the insurance contract and undertakes an obligation to pay the insurance premium.

1.49. **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).

1.50. **Teleconsultation:**
Outpatient care realised by way of a not-in-person meeting between the patient and the doctor. The consultation may take the form of over-the-phone or video consultation with the observation of applicable medical rules and regulations.

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

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

1.53. **Examination** means an activity aimed at the assessment of the health condition of the Insured, the preservation of his/her health, the detection of illnesses or their risks, the determination of specific illness(es), the establishment of their prognosis or changes therein and the evaluation of the effectiveness of the medical treatment.

2. Subjects of the insurance contract

2.1. The Insurer is UNION Vienna Insurance Group Biztosító Zrt.
Registered office:
H-1082 Budapest, Baross u. 1, Hungary
(H-1380 Budapest, Pf. 1076;
telephone: +36 (1) 486-4343)
Company registration number: 01-10-041566
Name od Registry Court: Fővárosi Törvényszék, as Registry Court
Customer service: H-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.
On behalf of an Insured person under the age of 18, only a Kid package can be taken out.
No Kid package can be taken out on behalf of an Insured person aged 18 or over.

2.4. The Insurer uses the following formula to calculate compliance with the condition applicable to the minimum age of entry: date (year/month/day) of joining minus the year of birth (year/month/day). In other cases: the year of joining minus the year of birth.

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

3. Conclusion of the insurance contract

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

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. The deadline for risk assessment starts from when the offer is delivered to the Insurer. If a tied insurance intermediary (agent, multi-agent) was involved in the contracting procedure, the day of offer delivery is the day when the offer is signed and delivered by the policyholder to the insurance intermediary or has electronically activated it. If an independent insurance intermediary (broker) was involved in the contracting procedure, the day of offer delivery is the day when the offer was received by the Insurer.

3.4. **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. The termination must be delivered to the postal address 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 the consumer for the premium amount in excess of the proportionate value of the service/benefit provided or the duration of risk bearing (i.e. the period of time that has passed since the inception date), following the receipt of the declaration of termination but in no more that 30 days.

3.5. 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.

3.6. 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.

3.7. 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.

3.8. 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 contract (having taken effect without the Insurer's explicit declaration) materially deviates from these Insurance Terms and Conditions, the Insurer may propose (within 15 days of the insurance contract taking effect) an amendment to the contract to render it consistent with these Insurance Terms and Conditions. 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.

3.9. 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.

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

3.11. The Insurer may carry out a risk assessment prior to accepting the offer and may also request the insured person to submit their health declaration, medical examination and other declaration. The Insurer has the right to check such data.

3.12. **Specific rules of policy conclusion**

3.12.1. 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.

3.12.2. 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.

3.12.3. 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 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. The rejection of the amendment proposal by the policyholder cannot serve as a ground for the insurer to terminate the contract.

5. Term of the insurance

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. If insurance coverage was extended to a new Insured, the insurance coverage applicable to such Insured shall start – unless agreed otherwise – **at 0:00 on the first day of the month following the registration of the new insured person as Insured in accordance with Section 12.1.2. of this Insurance Condition**, 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) upon the insured's death, as of the day of his/her death,**
- **b) if the insured has revoked their declaration of consent, on the last day of the month in which the notice of revocation by the Insurer is received, and (provided that the insured is over 70 years of age) on the first anniversary after the Insured has reached this age,**
- **c) if the insured has reached the age of 70, at the first anniversary following his/her 70th birthday,**
- **d) If the Insured holds a Kid Package, on the first policy anniversary following the Insured's 18th birthday,**
- **e) upon the termination of the Insured's legal relationship or other relationship with the policyholder as of the last day of the month in which the notice of revocation is received by the Insurer,**
- **f) if the insurance premium concerning the insured person has not been paid, at the end of the period covered by premium,**
- **g) upon the termination of the insurance policy,**
- **h) 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 to all parties to the contract at the time of policy conclusion, the parties may stipulate a waiting period of maximum 3 years.

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.

7.4. If the insurance relationship of an Insured terminates, but the same person concludes a new PrivateMed Next insurance contract within one month after the termination, the Insurer shall not apply the waiting period.

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 instalments.

9.5. The Insurer may provide a discount on the insurance premium depending on the number of the insured persons specified at the time of the offer. Any change in the headcount during the insurance period does not affect the rate of such discounts.

9.6. 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.

9.7. 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.

9.8. The insurance premium shall be paid in accordance with the method specified in the course of making the offer. However, this can be amended and changed to any other method of premium payment that is made available by the Insurer from time to time.

10. Amendment of the insurance premium

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

- a) Change in the service charges of private healthcare.
- b) The unforeseen deterioration of claim experience.

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

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

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

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

10.2.4. 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.

10.2.5. The Insures increases the insurance premium in accordance with the rate of the service price index.

10.2.6. If the Insurer increases the insurance premium in accordance with Section 10.2.5., for the purpose of indexation, simultaneously it will also increase the current values of benefit packages.

10.2.7. **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.

10.2.8. **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.

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

10.3.1. The Insurer is entitled to amend the insurance premium on the insurance anniversary date, provided this is necessary to protect the risk pool and is justified by the unforeseen deterioration of claim experience.

10.3.2. 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 premium falling due, the Insurer shall issue a warning of the expected consequences and a written payment reminder to the insured, setting a 30 day extended payment deadline. If the extended deadline lapses and no payment is made, the contract terminates retroactively as of the due date, unless the Insurer enforces its premium claim through judicial avenues without delay.

11.2. The Insurer has the obligation to provide services for 30 days after the premium payment due date. If the insurance terminates retroactively as of the due date, and a benefit claim was submitted during the 30 days thereafter which was fulfilled by the Insurer, the Insurer may subsequently demand that the Policyholder reimburse the costs of such benefits.

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.

11.4. Payment of the insurance premium cannot be suspended.

12. Rights and obligations of the subjects of the insurance contract

12.1. Rights and obligations of the policyholder

12.1.1. Obligation of disclosure: Upon the conclusion of the contract, the policyholder and the insured shall disclose to the Insurer any and all circumstances that are relevant to the assumption of risk and, during the term of the insurance, shall be obliged to report changes in and to material circumstances specified in the contract, which disclosures shall be made either in a printed or in an 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 requested change must be reported to the Insurer 30 days before the policy anniversary.

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

12.1.5. If the insurance relationship of the Insured terminates, they shall be entitled to enter into the same insurance contract only as of the following policy anniversary. In such cases, the waiting period applicable to the new insured's insurance relationship shall enter into force.

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 is entitled to check such data and to ask further questions for the risk assumption.

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.

12.3. Entry of an insured in the contract

If the policyholder is a consumer, the insured (provided the contract was not concluded by them) may become party to the contract at any time, by delivering a written declaration to the insurer; the consent of the insurer is not necessary to join the contract.

Upon joining the contract, all rights and obligations of the policyholder shall pass on to the insured.

In such cases, the insured and the policyholder shall be jointly and severally liable for the payment of the premium due. The insured person that becomes a party to the contract shall reimburse the policyholder for all contract-related expenses, including the insurance premium.

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. 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.

14.2. The Insurer shall be exempted from the obligation to provide benefits if it is able to prove that the insured event was caused by the unlawful, wilful or grossly negligent conduct:

a) of the policyholder or the insured;

b) relative of the insured residing in the same household.

14.3. During the classification of the conduct, all circumstances of the case shall be assessed individually. Conduct may be classified as gross negligence, in particular when:

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 occurred as a consequence of the consumption of narcotics or substances with an effect of narcotics or medications, except when the latter was used as recommended and instructed by the treating physician

c) the person responsible for the occurrence of the insured event was performing an activity subject to authorisation without holding the relevant authorisation.

14.4. The above rules also apply to the violation of loss prevention obligation and damage mitigation obligation.

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 combat or in other acts of war on either side, or in the context of participation in a criminal offence committed against the state. For the purposes of these Insurance Terms and Conditions, a war with or without declaration, a border clash, a revolution, a mutiny, a coup d'état or an attempted coup d'état against a government, a civil war, a focused military operation (e.g. airstrike or naval operation only) by a foreign country, SWAT raid, and terrorist act shall be considered as war. (In the case of a SWAT raid or terrorist act, the insured's involvement in the victims' interest will not be considered as active participation.) 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 cases 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 will 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 medical treatment, medical intervention, and harm suffered as consequence thereof.

15.6. Events where the Insured applies for medical care without a physician's recommendation, except the medical examinations conducted by specialist physicians listed in the Specific Insurance Terms and Conditions, shall not qualify as insured events.

15.7. Similarly, where the physician's recommendation does not bear the physician's stamp or stamp number, the Insured's request for medical care shall not qualify as an insured event.

15.8. Care used without the involvement of the care organiser, i.e. it was used prior to consulting with the care organiser, shall not qualify as an insured event.

15.9. Care that becomes necessary due to an accident/ pre-existing illness or condition prior to the applicable inception date (Antecedent Illness), except for outpatient specialist care and diagnostic tests, shall not qualify as an insured event.

15.10. Care that becomes necessary within 15 days of the applicable inception date, or in connection with which the Insured consulted with a doctor within 15 days of the applicable inception date, shall not qualify as an insured event.

15.11. The Insurer does not provide any service in the case of a claim for a high value diagnostic test, if the recommendation for the high value diagnostic test is not issued by a specialist physician. A recommendation/referral issued by a general practitioner/a physician not of the medical speciality presumed by the suspected diagnosis shall not be accepted by the Insurer even if the general practitioner is authorised to pursue specialist tasks as well.

15.12. The Insurer shall not provide insurance cover for:

a) care arising from an urgent need,
b) expert activities performed within the scope of healthcare, in particular examinations, tests and medical findings for the issuance of sports medical fitness certificates, licences for driving land, water or aircraft or medical fitness certificates required by law,
c) care provided due to disasters,
d) care provided due to an epidemic, including tests, diagnostic tests, or control/screening examinations without complaints, or care relating to illnesses classified as an epidemic by the competent authority,
e) pulmonology care,
f) addictology care,
g) psychological consultations,
h) dietetic consultations,
i) employment healthcare, general practitioner, general paediatrician primary care,
j) acupuncture treatment,
k) alternative medical procedures, not even upon a physician's recommendation, except if the insured holds such basic package that (according the provisions of the Benefit Limits document) also covers and extends to non-conventional activities,
l) any care needed to treat dental problems or complaints, including any care necessary for dental treatment,
m) the following laser treatments, interventions: nail fungus, vision correction, intimate laser surgery,
n) geriatric treatment and care,
o) eye lens implantation,
p) dialysis treatment,
q) treatment of varicose veins of lower extremities with injection, laser, etc.,
r) care and treatment that may become necessary after the diagnosis of illness caused by the following pathogens:
   – Treponema pallidum (syphilis)
   – Neisseria gonorrhoeae
   – Chlamydia trachomatis
   – Ureaplasma urealyticum
   – Mycoplasma hominis/genitalium
   – Herpes simplex virus 1, 2
   – Trichomonas vaginalis
   – Haemophilus ducreyi (ulcus molle, chancroid)
   – Calymmatobacterium granulomatis (Granuloma inguinale, donovanosis)
s) examinations and interventions performed in relation to reproductivity (fertility),
t) genetic tests,
u) food intolerance tests (including IgG-type food intolerance tests; FOOD tests; DAO tests; coeliac tests; lactose, fructose, sorbitol tests) as well as lactulose-intolerance tests,
v) psychiatric treatment and care, except for the first consultation after the diagnosis,
w) special education treatment,
x) physio- and motion therapy treatment (except if the insured person holds the Move supplemental insurance package),
y) injection therapy series (including injections or injection series to joints for the purpose of cartilage regeneration, except for the first injection to alleviate pain only locally, including an injection administered in the framework of non-conventional activities),
z) intensive patient care,
aa) oncological treatment,
bb) maintenance infusion and scheduled treatments, including PRP treatment 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 of childbirth, in connection with childbirth, unless the childbirth is expected to take place later than on the 270th day after the inception date. If the childbirth is expected to take place later than on the 270th day after the inception date, the Insurer shall cover, within the framework of outpatient care, 2 gynaecological examinations (with traditional ultrasonography, i.e. excluding

3D, 4D, 5D, foetal, genetic and foetal heart ultrasound examinations, genetic ultrasonography) with healthy prenatal care indication to which a 6-month waiting period shall apply.

gg) requests for care related to contraception, infertility, artificial fertilisation,

hh) requests 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) requests 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) diagnosed HIV infection of the insured, or any resulting requests for care,

kk) nasal septum surgeries,

ll) treatments not supported by generally applied medical protocols accepted in Hungary,

mm) stool genomics tests,

nn) applications for care related to the planning and execution of immunotherapy of tumours.

pp) benefits relating to excluded events that are outlined in this section shall also not qualify as insured events.

15.13. The insurance cover provided by the Insurer does not comprise examinations and care conducted abroad, one-day and outpatient operations, except for the Operation coverage risk in the supplemental Operation package.

15.14. The (Re)Insurer shall not provide insurance coverage, not make claims payments and not provide a service/benefit, if by providing such coverage or making such claims payments the (Re)Insurer would violate any sanction, provision or resolution stipulated in a decision of the United Nations, or the commercial, financial embargoes or economic sanctions, laws or resolutions of the European Union, Hungary or the United States of America (provided that these do not violate any regulation or specific national law applicable to the (Re)Insurer).

16. Use of insurance services and benefits

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

16.1.1. The Insured indicates their need for care to the care organiser over the phone, via email or online, indicating also the reason for care and the relevant health complaint.

16.1.2. The online appointment interface of the care organiser is available 24/7. 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, emails and online enquiries are recorded in a traceable form.

16.1.4. For the assessment of the claim for benefits, the care organiser may request:

- a physician's recommendation
- previous medical documentation relating to the complaint, antecedent (existing condition).

16.1.5. **The Insurer's obligation to provide benefits may only arise if the Insured makes the data required for the assessment of the claim, necessary for the commencement of obligations and the determination of the amount, as well as the documents available in full to the Insurer/care organiser. If the care organiser deems the Insured's request for care justified, it arranges the first consultation between the Insured and the physician within 5 working days (or in the case of screenings and one-day surgical interventions, within 30 days) after the receipt of the report, all the required physician's recommendations and previous healthcare documents.** *It informs the insured on the place and date of care over the phone or via email. The time available for the care organiser applies to reserving the appointments, to providing relevant information to the Insured, but it does not apply to organising the given care.*

16.1.6. 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 the care justified and that the insured has not exhausted his/her annual coverage limit related to the given type of care.

16.1.7. **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.

16.1.8. If the amount available from the Insured's annual limit related to the given care does not cover the cost of the care, or if the Insured has already exhausted 90% of their annual limit (that is denominated in HUF) related to the given care in the given policy year, the Insurer undertakes to organise care provided that the costs are reimbursed to the Insured subsequently, against an invoice issued to the Insured's name, up to the annual limit.

16.1.9. **If the Insured wants to use the care at a service provider who is not contracted with the care organiser or the requested service is not available at the contracted partners of the Insurer, the Insurer shall only reimburse the cost of the service to the Insured subsequently, against an invoice issued to the Insured'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 Insured can request information about the rate of this amount from the care organiser, when applying for the benefit.

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. In respect of screening tests, the Insurer does not provide an opportunity for subsequent reimbursement.

16.1.10. Retrospective payment by the Insurer against an invoice is subject to the submission of the following documents:

a) the original invoice made out to the insured's name by the healthcare provider which provided the care, or the scanned or photo version thereof,
b) **we are not in a position to reimburse invoices made out to the name of a health fund,**
c) copies of the documents describing the care,
d) 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,
e) the number of the HUF bank account of the insured kept with a Hungarian financial services provider, where they request the reimbursed amount to be transferred.

16.1.11. The documents are to be sent to the address of the Insurer's care organiser partner no later than within one year following the date of receiving care.

Subsequent reimbursement, by taking the provisions of Section 16.1.10 into account, is performed within 15 days of the receipt in full of the documents specified in Section 16.1.11 at the latest.

16.1.12. The Insured may change the agreed date and time with the care organiser only once, no later than two business days before the time of the examination.

16.1.13. If the Insured cancels or changes the date and time within two business days, or does not appear on the date and time agreed for the care, or does not cancel or change the appointment with the care organiser, the Insurer does not refund the already paid deductible and reduces the annual limit set for the given care available to the Insured by the cost of the care planned. In the case of limitless risks, the Insured will become entitled to being provided with the same arranged intervention again after 3 months, except if the Insured proves that they did not have the opportunity to cancel the care for a reason beyond their control. If the Insured cancels or changes the date and time within two working days prior to the date and time agreed for all or any elements of a Screening package or does not appear at the examination, or does not cancel at the care organiser, the Insurer deems the examinations in the Screening package as used; therefore the Insured shall not be entitled to use them again in the policy year concerned.

16.2. The medical expert of the Insurer shall have the right to supersede the eligibility for care.

16.3. The Insurer's service includes the financing of care for which the reporting of the relevant request has been made before the end of the coverage period, but the care was used following the end of the coverage period.

16.4. 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 replenished.

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 contracts with non-consumers

19.1. Unless the parties agreed otherwise, the extension of the insurance coverage to individual insured persons requires the written consent of the insured person (insured's declaration). The Insured's declaration is 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.

19.6. Rules of Premium Payment

19.6.1. Unless the Parties agree otherwise, if the Policyholder is a legal entity, the insurance policy shall be settled on an annual basis.

19.6.2. Annual settlement shall mean that, throughout the policy year, the policyholder shall pay the flat rate premium established at the beginning of the policy year in accordance with the premium mode agreed.

19.6.3. The Insurer reserves the right to modify the flat rate insurance premium under Section 19.6.2. unilaterally from the day of breach of the 20%

limit if, at any time within a policy year, the change in the number of insured persons exceeds 20% of the opening headcount as at the beginning of the policy year. The policyholder shall be charged the new flat rate premium from the day of breach of the 20% limit; however, payment of the new premium shall become due only from the next premium payment made in accordance with the premium mode. After the new flat rate premium has come into effect, the basis of the 20% limit shall be the number of insured persons taken into account for the calculation of the new flat rate premium.

19.6.4. The insurer shall apply a headcount tolerance for the purposes of annual settlement. The rate of headcount tolerance shall depend on the opening headcount as at the beginning of the policy year, as follows:

Opening headcount	Rate of the headcount tolerance
1 to 50 persons	10%
51 to 250 persons	5%
over 250 persons	2.5%

19.6.5. As of the end of the policy year, the insurer shall make an annual settlement in consideration of the reports on changes in the number of insured persons delivered on a monthly basis.
It shall determine the average monthly number of insured persons taken into account as the basis of the flat rate premium paid for the given policy year (a). It shall determine the average monthly number of insured persons based on the headcount reported by the Policyholder for the given policy year (b).
It shall determine the relative difference of the two values: (b–a)/a.
Where the latter exceeds the tolerance rate specified in Section 19.6.4, the Insurer shall determine the premium for the given policy year based on the actual number of insured persons in that policy year, and issue an accounting document for the difference of the flat rate premium paid by the policyholder and the premium payable for the policy year based on the actual headcount. As long as the headcount change remains within the tolerance rate specified in Section 19.6.4, the Insurer shall not charge for the difference.

19.7. Claims ratio based premium refund

19.7.1. Should the Policyholder be a legal entity, the Insurer shall provide a claims ratio based premium refund provided that the following terms and conditions are all met:
a) The monthly average number of insured persons in the relevant policy year (the total actual number of insured persons in each month of the relevant policy year divided by 12) was at least 20 persons,
b) The first premium refund may be made after one full policy year, i.e. 12 months.
c) The claims ratio for the policy year concerned may not exceed 30%.

19.7.2. Depending on the claims ratio, the premium refund shall be the following:
a) If the claims ratio is 10% or less, the premium refund shall be equivalent to 10% of the annual premium paid for the policy year being settled;
b) If the claims ratio is over 10% but no more than 30%, the premium refund shall be equivalent to 5% of the annual premium paid for the policy year being settled.

19.7.3. Definition of the claims ratio: the ratio of the claim expense taken into account in respect of the insured persons covered by the Policy in the policy year being settled to the insurance premium for the policy year being settled.
The claim expense is the sum of the following items: claim payments made during the given policy year; the difference between the value of the claim reserves for the policy as at the end and as at the beginning of the policy year.

19.7.4. The Parties agree that the Insurer shall deduct the amount of the premium refund from the insurance premium payable for the next policy year unless the Policyholder requests in writing to be reimbursed for the premium refund, and provides its bank account number.

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 5.1)*
- *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 replenished. (Section 17)*
- *Claims arising from insured events occurring during the coverage period will lapse after two years 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 3.12.2 and 3.12.3)*
- *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 19.3)*
- *The (Re)Insurer shall not provide insurance coverage, not make claims payments and not provide a service/benefit, if by providing such coverage or making such claims payments the (Re)Insurer would violate any sanction, provision or resolution stipulated in a decision of the United Nations, or the commercial, financial embargoes or economic sanctions, laws or resolutions of the European Union,*

Hungary or the United States of America (provided that these do not violate any regulation or specific national law applicable to the (Re)Insurer). (Section 15.14)

– *In case of benefit financing risks, actual healthcare is provided by the healthcare provider defined in Section 1.22, whose activities and liabilities are governed by the provisions of the Healthcare Act; 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. (Section 28)*

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 policyholder sends their request by the 30th day prior to the anniversary to the Insurer at the latest, 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 Section 21.4. of the 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 30th day before 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 Insurance Terms and Conditions.

22. Information on the processing of personal data and confidentiality

Data processing regulations applicable to the personal data and confidential insurance information of the insurer's customers are set out in the Privacy Notice which is also available on the website www.union.hu/adatvedelem. **Furthermore, data classified as confidential insurance information may be disclosed to persons or organisations to whom the insurer's obligation to keep confidential insurance information does not apply pursuant to the provisions of the Insurance Act. The list of such organisations is included in Appendix 1 of the Privacy Notice.** For the purpose of data processing, the Insurer employs data processors as well as service providers performing outsourced activity within the framework of service agreements concluded to this end. The list of data processors and reinsurers as well as the most up-to-date Privacy Notice are available on the website https://union.hu/adatvedelem. The content of the Privacy Notice and the list of data processor and reinsurer partners and may change subject to statutory amendments or partner contracts concluded or to be concluded by the insurer.

23. Representations

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 made in writing and sent by post or via email. Any legal statement will be effective upon its receipt by the Insurer.

24. Limitation

The claim for benefits shall lapse after two years of the occurrence of the insured event or, in the case of other claims, from their due date.

25. Language of communication and customer notification

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

25.2. Means of contact:

During the course of communication with the

insurer, the policyholder/insured may use any of the following options for contact:
- by phone:
- in person (Customer Service)
- in writing (by post or via e-mail).

26. Governing law and proceeding courts

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 shall 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 shall mutually notify each other of any independent circumstances arising subsequent to the conclusion of the contract that may prevent the performance thereof.

The Insurer makes it possible for the client and consumer advocacy bodies to lodge complaints against the conduct, activity or omission of the agent (who/that is either employed or contracted by the Insurer) performing supplemental insurance intermediary activity. Such complaints may be lodged either verbally (personally or over the phone) or in writing (by way of a document delivered personally or via another person, by mail, fax or in electronic mail).

27.2. Methods of lodging complaints:

1. Lodging verbal complaints:

a) in person:

Complaints may be filed verbally, in person:
- **During opening hours at our Company's Central Customer Service Office. Address of the Central Customer Service Office: 1134 Budapest, Váci út 33 (Corner of Dózsa György út – Váci út),**
- **or with the office managers of our regional sales offices outside of Budapest. The contact details of regional sales offices are available on our website at www.union.hu.**

b) by phone:

You can also lodge your complaints through the telephone customer service of our Company by calling (+36-1) 486-4343 during opening hours.

2. Written complaints:

a) by submitting a document in person or by way of a representative at the premises open to customer traffic;

b) by post (H-1380 Budapest Pf.: 1076);

c) by fax (+36-1-486-4390);

d) by e-mail sent to: ugyfelszolgalat@union.hu

The complaint template used by the National Bank of Hungary is available on our Company's website and on the website of the National Bank of Hungary, at the following link: https://www.mnb.hu/fogyasztovedelem/penzugyi-panasz

27.3. 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.

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

27.5. Insurer's supervisory authority:
Magyar Nemzeti Bank
(H-1013 Budapest, Krisztina körút 55;
central phone number: (+36-1) 428-2600)

27.6. If the consumer's complaint submitted to the Insurer
- has been refused, or
- has not been investigated as prescribed in the Insurance Act, or
- from the Insurer's reply the insured presumes circumstances violating the consumers' rights stipulated in the Insurance Act, or
- the Insurer has not replied to the complaint within the 30 days prescribed by law for the investigation,

a) they may apply to the Financial Arbitration Board (in the case of legal disputes relating to the conclusion, validity, legal effects, termination or breaches of the contract and the legal effects thereof).

In the absence of an agreement on the merits of the case, the Financial Arbitration Board:
- adopts a binding resolution if the claim is substantiated and the Insurer has accepted the decision of the Financial Arbitration Board as binding, or
- makes a recommendation if the claim is substantiated, but the Insurer has stated that it does not accept the decision as binding, or has not made any statements on the acknowledgement of the decision.

In the absence of an agreement, the Financial Arbitration Board may adopt a binding resolution even if the Insurer makes no declaration on submission, but the claim is substantiated and the claim intended to be enforced by the consumer does not exceed one million Hungarian forints either in the claim request or the binding resolution.

Contact details of the Financial Arbitration Board:
postal address:
H-1525 Budapest, Pf: 172
telephone: +36-80-203-776,
customer service:
H-1122 Budapest, Krisztina krt. 6
email: ugyfelszolgalat@mnb.hu);

b) or they may turn to the Consumer Protection Centre of the National Bank of Hungary (in the case of violation of consumer protection regulations, mailing address:
H-1534 Budapest, P.O.Box: 777,
telephone: +36-80-203-776,
customer service:
H-1122 Budapest, Krisztina krt. 6
email: ugyfelszolgalat@mnb.hu);

c) **they may turn to the court 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 benefit financing risks, actual healthcare is provided by the healthcare provider defined in Section 1, whose activities and liabilities are governed by the provisions of the Healthcare Act; 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 consideration for such services, but the services themselves are not provided by the Insurer.

29. Miscellaneous provisions

29.1. The Insurer discloses its report on its solvency and financial position on its website (www.union.hu) in the manner and by the deadline defined by law.

29.2. Financial Navigator, the consumer protection website of the MNB, is available at: www.mnb.hu/fogyasztovedelem.

30. The care organiser partner of the Insurer is UNION-Érted Ellátásszervező Kft., the contact details of which are available on their website (www.union.hu). The Insurer shall provide information about the identity and contact details of the care organiser or any changes thereof on its website; such information shall be given no later than by the 30th day prior to the occurrence of the changes.

UNION Vienna Insurance Group Biztosító Zrt.