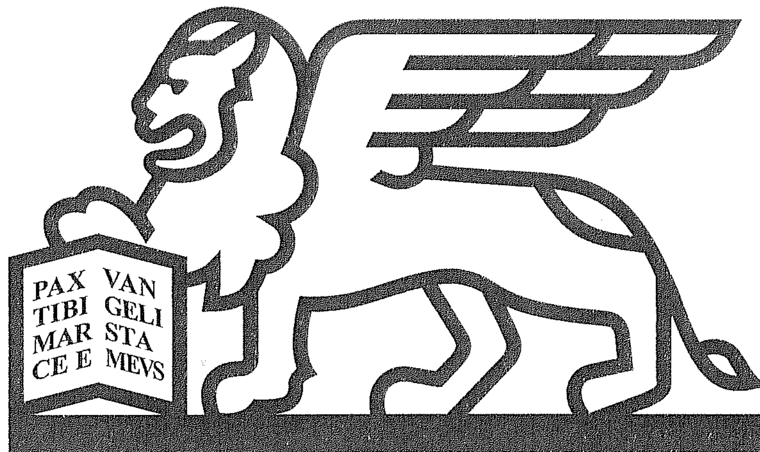

STUDIUM Fee-for-Service Health Insurance – Terms and Conditions (SZTE15)

Effective from 1st of September, 2015

Nysz.: 17973

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STUDIUM Fee-for-Service Health Insurance – Terms and Conditions (SZTE15)

These general terms and conditions of STUDIUM Fee-for-Service Health Insurance (SZTE15) (hereinafter: policy conditions or general conditions) set out the standard conditions for the fee-for-service health insurance concluded between Generali Biztosító Zrt. and the University of Szeged (hereinafter: insurance policy or policy) and shall be applicable to the coverage of students and researchers added to the insurance policy as insured persons. In the case of matters not regulated by these general conditions, the insurance policy shall be governed by the provisions of the Customer Information and General Provisions Governing Insurance Policies, as well as the applicable provisions of the **Civil Code** and **other effective Hungarian regulations.**

In the event of discrepancy between the Customer Information and General Provisions governing Insurance Policies, an integral part of the insurance policy, and these policy conditions, the provisions of the policy conditions shall prevail.

Under the insurance policy, the insurance company undertakes to provide coverage for the insured risks set forth in these general conditions and pay the insurance benefit if an insured event occurs and the insurance claim is grounded, while the policyholder undertakes to pay the insurance premium.

1. Terms and Definitions

1.1. **Disease (illness):** any deviation from or interruption of the normal structure or function of the human body.

1.2. **Accident:** one-time, external physical impact and/or chemical exposure which the insured suffers beyond his/her control or is unwillingly exposed to during the policy term, and as a result of which the insured suffers permanent physical or mental impairment or dies.

1.3. **Medical care:** any and all medical and health care activities pursued by the health care provider in possession of an operation permit issued by the health care supervisory authority, and which aims at examining and treating the insured, caring for, attending him/her, decreasing pain and suffering and for the purpose of the above, the processing of the patient's examination documents in order to preserve the insured person's health, as well as for the prevention, early recognition, establishment, treatment of illnesses, averting dangers of life, improving the condition occurred due to attaches, or as a consequence of accidents and for the purpose of preventing further condition deterioration.

1.4. Health care shall furthermore include activities related to medications, bandage, medical aids, medical care in accordance with effective legislation, and patient transport.

Primary healthcare: health care services which the Insured can receive without a physician's referral when he/she is in need of medical attention as a result of an accident or illness.

1.5. **Specialty healthcare**: health care services received by the insured pursuant to a referral of a primary care physician.

1.6. **Healthcare provider:** medical facility or company permitted by the medical authorities (Hungarian medical officer's and professional supervision) to provide health care services in accordance with effective legislation, and licensed to carry out operations in Hungary.

For the purposes of these policy conditions, health care service providers shall not include sanatoriums, rehabilitation institutes, thermal or hydro-mineral establishments, asylums and care centers for patients with mental disorders and other psychiatric diseases, geriatrics, chronic institutes, social homes, alcohol and drug detoxification institutes (hereinafter jointly referred to as: other health care institutions), even if these provide health care services, or departments of health care institutions which provide health care services in line with the operations of health care institutions as defined herein (for the purposes of this section, hereinafter: department), provided that the insured person has received services in line with the specialization of the other health care institution or of the department.

1.7. **Designated healthcare provider**: the healthcare service provider contracted with the Insurance Company to render health care services and specifically named on the Health Insurance Card by the Insurance Company.

1.8. **Outpatient care** includes the treatment of any person who, as a result of an accident or illness, receives primary medical or specialist care the duration of which does not exceed 24 hours, and which is not considered as inpatient care.

1.9. **Inpatient care** shall be provided for any person who, as a result of an accident or illness, is hospitalized in a medical facility for several days to receive medical care, and the person spends every night during his/her hospitalization between admission and discharge in such medical facility in connection with the medical treatment. The insured is hospitalized for multiple days if his/her discharge from the medical facility is on a later day than that of his/her admission.

1.10. **Urgent care (hereinafter: Emergency)** a medical emergency when as a result of sudden changes in the insured's medical conditions the insured's life could be in direct danger or the insured could suffer serious or permanent health impairment without immediate medical attention. In such a case, either the emergency services number (ambulance) must be called, or an emergency medical facility must be attended.

1.11. **Prepaid healthcare:** healthcare services provided by a person or institution duly authorized to render healthcare services, received by the insured in medically justified cases, where the costs have been prepaid to the service provider directly by a person or entity other than the insurance company.

1.12. **Insured's statement:** is a written document bearing a serial number which contains the insured's declarations with respect to the health insurance policy, and in particular information regarding the rights and obligations of the insured, the name of authorities and institutions which the insurer's confidentiality obligation shall not apply to, as well as the insured's Loss Payable Clause with respect to the payment of benefits, all forming an **integral part of the insured's statement** to which it is annexed. The insured's statement shall constitute a part of the insurance policy.

1.13. **Health insurance card:** A card bearing the same serial number as that of the insured's statement referred to in Clause 1.12 and issued by the insurance company containing the most important information related to the insurance coverage, which is designed to be proof of the insurance at the health care service provider.

1.14. **Annual (aggregate) limit:** the upper threshold (annual limit) of the insurance company's total benefit payment in relation with the insured's health care treatment during any given policy/fiscal year and with respect to the particular benefit types, as specified in the Product Information material, which is an integral part of the policy, above which the insurance company is not required to provide services (pay benefits).

1.15. **Deductible**: a lower benefit limit applicable to the payment obligation of the Insurance Company specified in the STUDIUM Product Information, an integral part of the insurance policy, which must be interpreted and applied by insured events and insured persons, and corresponding to an amount which the insured shall pay himself/herself with respect to the insured's medical care.

1.16. **Medication, dressings and bandages, durable medical equipment:** only those agents, accessories and means shall be deemed as medication, dressings and bandages, durable medical equipment which are registered and recognized in Hungary as medication, dressings and bandages, or durable medical equipment. Lenses for the correction of vision (glasses, contact lenses, glass for vision, etc.), tools for improve hearing and materials and means used in dental care (artificial teeth, prostheses, fillings, implants, braces, substances and tools to whiten teeth etc.) are not qualified as durable medical equipment. Medication does not include contraceptive pills, emergency contraceptive pills (morning after pills), condoms, etc.

1.17. Patient transport: if the insured is immobile and has a medical need for transport to the facility providing healthcare, the insurance covers the cost of patient transport without medical supervision within the territory of Hungary, if it is required for medical and health services which qualify as insured events pursuant to these general conditions.

1.18. House call: the costs of a physician's field-work (hereinafter: "house call") when the insured's condition does not make it possible to visit the physician in his/her office (provided that the Insured has paid the premium of the module providing this service). This service shall not replace any medical care provided in case of emergency.

1.19. Repatriation: The insurance company shall cover the costs of repatriation (transport home) to the insured's country of residence if the insured's condition so requires and/or makes it possible, provided that the medical service provider specified by the insurance company also recommends the treatment at home.

2. General Provisions

2.1. Parties to the Insurance Policy (Insurance Company, Policyholder, Insured)

2.1.1. In consideration of the insurance premium payment, the insurance company shall bear the insurance risk during the insured period specified in the policy, and undertakes the obligation to pay the insurance benefits set forth in these policy conditions.

2.1.2. Policyholder is **Szegedi Tudományegyetem [University of Szeged]**, which takes out the group insurance policy from the insurance company and agrees to pay insurance premiums.

2.1.3. Insured is a foreign natural person whose state of health is covered under the insurance policy with respect to specific insured events, and who is an enrolled student, lecturer or visiting researcher of the University of Szeged (SZTE) or the partner of SZTE during the policy term, **on the condition that the Policyholder has reported him/her as an insured to the insurance company and has paid the pertaining insurance premium. The Policyholder may report those natural persons as insureds who are enrolled students or researchers of the Policyholder during the policy period, and foreign nationals resident in Hungary between the age of 18 and 65, and who complete and sign the insured's statement in a separate document together with the Health Insurance Card to explicitly apply as insureds for insurance coverage under this insurance policy.**

2.2. Conclusion of the Insurance Policy

The policy is concluded pursuant to a written agreement by and between the policyholder and the insurance company, and may be amended at any time subject to the provisions stipulated in Section 132 of Act CVIII of 2011 on Public Procurement (hereinafter: "Public Procurement Act"). **The insurance policy may be modified without the consent of the insured.**

2.3. Adding Insured Persons to the Coverage

2.3.1. Insured may be added to the coverage of this group health insurance policy individually **by signing the insured's statement.**

2.3.2. In the insured's statement, the insured shall communicate correctly all circumstances to the insurance company in connection with which it has requested information in the form of questions or it has imposed an obligation to declare.

2.3.3. The insurance company issues a Health Insurance Card for the insured, which contains the most important information related to the insurance coverage. The Health insurance card may be issued for such time period concerning which the respective insurance premium has been prepaid.

2.4. Effective Date of the Policy

2.4.1. The insurance company does not stipulate a waiting period in the insurance policy.

2.4.2. The insurance policy will take effect: **at 0:00 am on 1st September 2015, except for Module II which shall come into effect at the time when the 24th month following the effective date of this policy has elapsed, in virtue of the unilateral request of SZTE 60 days prior to such date.**

2.5. Commencement of the Coverage

The insurance coverage pertaining to a **particular** insured shall commence **at 0:00 a.m. on the day following the day when this insured's statement is signed by the insured, but not before 1st September, 2015.**

With regard to the particular insured, the insurance policy may include the following insurance periods:

- **Annual from 01.09. to 31.08 + 1 month in consideration of annual premium**
- **any 3-month definite period during the policy period in consideration of a specified premium.**
- **1st semester from 01.09.-31.01 + 1 month in consideration of 6 months premium.**

2nd semester from 01.02.-31.08. + 1 month in consideration of 6 months premium.

2.6. Termination of the insurance coverage with respect to a particular insured:

2.6.1. a) on the date specified in the insurance policy or at the time when the definite period expires or
b) in case of non-payment of the premium, on the day following the last day of the period of due payment of the first non- paid premium.
c) if the insured dies or
d) by the termination of this policy,

2.6.2. This policy may terminate for the following reasons:
a) by the mutual agreement of the Parties,
b) by termination for convenience by either of the Parties,
c) by termination upon breach by either of the Parties,
d) by the dissolution without succession of either of the Parties.

2.6.3. Termination for convenience: The Parties agree that both **the Policyholder and the Insurance Company may terminate this insurance policy in writing at least 120 days prior to the renewal date of the policy.** The insurance policy concluded for an indefinite period shall not be cancelled for 2 years, during which period the policy may be terminated solely upon material breach of the policy by either of the parties.
Cancellation period shall commence at the time the written cancellation notice communicated by way of registered mail is delivered to the other party in a verifiable fashion. The Policyholder shall not enter any new Insured parties into the Insurance Policy during the cancellation period.
The Policy shall terminate at the time the cancellation period expires. The insurance coverage provided by the Insurer shall terminate with respect to any and all Insured persons at 24:00 pm on the expiration date of the cancellation period.

2.6.4. Termination upon breach: In the event of a material breach of the contract by the other party or in case the contract concluded between the health care service provider terminates without any fault on the part of the insurance company, the Parties may terminate the Policy with immediate effect by written notice supported by reasons given to the other Party.

2.6.4.1. Material breach of the Policyholder shall mean:
a) if its activity seriously and repeatedly affects adversely the interests of the Insurance Company,
b) if its activity seriously and repeatedly affects adversely the interests of the Insureds,
c) if the Policyholder fails to pay any overdue insurance premium,
d) if the Policyholder repeatedly and seriously fails to comply with its information obligations
under this Policy.

2.6.4.2. Material breach of the Insurance Company shall mean:
a) if its activity seriously and repeatedly affects adversely the interests of the Policyholder or the Insureds,
b) if concerning at least three cases within one calendar year the court establishes in its final judgment that the insurance company has refused to pay damages to the Insured in the absence of a legal basis.

2.6.4.3. It shall constitute a material breach by either of the Parties, and the other party may terminate the Policy with immediate effect if the defaulting Party fails to comply with any of its obligations of discretion and confidentiality.

2.6.4.4. **The Policy shall terminate at the time of receipt of the notice of termination with immediate effect. The insurance coverage provided by the Insurer shall terminate with respect to any and all Insured persons** at 24:00 pm on the 8th (eighth) day following the termination of the Policy upon breach.

2.6.5. The insured may not replace the policyholder in the insurance policy.

2.7. Geographical Limit of the Insurance Coverage

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

2.8. Insurance Premium

2.8.1. The insurance premium is received in consideration of the insurance coverage offered by the insurance company. The Insurance Company may claim the Insurance Premium for the whole period of the insurance coverage.

2.8.2. The policyholder undertakes to pay the insurance premium in due time, **in one sum and in advance for each insurance period.**

2.8.3. The Policyholder shall pay the premium to the above stated bank account of the insurance company via bank transfer. The policyholder will have fulfilled his/her obligation to pay the insurance premium as of the day when the **insurance premium is credited to the account of the insurance company.**

3. Insurance Coverage

3.1. Insured Events

3.1.1. It shall be considered an insured event when, during the period of insurance, as a result of a disease, pathological condition or accident which was unprecedented prior to the commencement of the coverage and arose in a sudden and acute manner, the insured receives health care services in a medically justified case from a health care service provider named (designated) on the Health insurance card in accordance with the conditions of the contract. The insurance company will only reimburse the cost of medical care in a facility other than the designated service provider, provided that the claim is otherwise grounded, if the insured had a medical condition which did not allow him/her to be provided with medical care by or under the arrangement of the designated service provider (case of emergency) and the designated service provider has been notified of the medical care within 48 hours of the beginning of the treatment.

3.1.2. For the purposes of this clause, a trauma, an illness or a medical condition shall have no prior history relative to the commencement of the insurance coverage if it is not in any way connected with a trauma, illness or medical condition of the insured which existed or was diagnosed or treated before the commencement of the insurance coverage, or with a previously determined permanent physical or mental impairment.

3.2. Insurance Benefit

3.2.1. The insurance company shall only reimburse those **health care services which are provided in Hungary at or organized by the designated health care service provider.**

3.2.2. **The costs of the insured events covered by the insurance company and specified in this policy shall always be subject to the annual limit and deductibles specified in this policy (if any), taking into account any exclusions and exemptions of the insurance company.**

3.2.3. Within the framework of the outpatient treatment, the insurance company shall pay for:
a) the costs of primary medical care,
b) the costs of specialty care, including ambulatory (same-day) surgeries,
c) the costs of a physician's field-work (hereinafter: "house call") arising from cases when the insured's condition does not make it possible to visit the physician in his/her office (in case the Insured has paid the premium of the module providing such service). This service shall not replace any medical care in case of emergency.
d) the costs of diagnostic tests required during the medical treatment (e.g. laboratory tests, X-ray diagnostics, ultrasound examination); which the insurance company shall reimburse only if required for the diagnosis and treatment of the illness.

3.2.4. Within the framework of inpatient treatment, the insurance covers the costs of the insured's hospitalization and medical treatment. This shall include:
a) the costs of medical treatments prescribed by a physician, (including necessary surgeries and same-day general surgeries);
b) the costs of nursing;

3.2.5. Financing any cases of emergency: in any cases of emergency the pre-financed cost of emergency medical care will be reimbursed subsequently by the insurance company, provided that the medical care constitutes an insured event.

3.2.6. The insurance company shall reimburse the costs of medications, bandage, medical equipment for temporary use (products officially listed as durable medical equipment) if required for the medical care, subject to the annual limit and deductible set out in this policy.

3.2.7. Patient transport: If the insured is immobile and has a medical need for transport to the medical facility providing healthcare, the insurance covers the cost of patient transport without medical supervision within the territory of Hungary, if it is required for medical and health services which qualify as insured events pursuant to these general conditions.

3.2.8. Repatriation The insurance company shall reimburse the costs of repatriation (transport home) **to the insured's country of residence** if the insured's condition so requires and/or makes it possible, provided that the medical service provider specified by the insurance company also recommends **the treatment at home** (if the insured has paid the premium of the module providing such service).

3.2.9. The insurance company bears the costs of operating a 24-hour telephone service (Call Center) in English language which provides health information and also organizes the care pathway between the SZTE Szent-Györgyi Albert Clinics , the Primary Care Provider and the Insured. The Call Center verifies the entitlement of the Insured to health care services and simultaneously entitles the Clinics to provide health care service.

3.3. Payment of Insurance Benefits

3.3.1. **The insurance company shall pay the costs of medical treatment constituting an insured event and received from, arranged by or delivered with the cooperation of the designated health care service provider directly to such designated health care service provider.**

3.3.2. If the insured receives medical treatment in an emergency at a medical facility other than the designated service provider, or without the management of the designated service provider, and also in case of Module III - Dental services, **the insured is required to prepay for such medical care.**

3.3.3. If the costs of the medical services are prepaid by the insured (prepaid medical care), or if the insured purchases medication, dressings and bandages, durable medical equipment, the insurance claim for the reimbursement of such costs must be submitted to the insurance company within 15 days from the issue date of the invoice.

3.3.4. The insurance claim for the reimbursement of the costs of prepaid medical care, or of medication, dressings and bandages, or durable medical equipment purchased by the insured, must be accompanied by the following documents:
a) the original invoice on the delivered medical treatment (health care services) issued on the last day of such treatment, or the original invoice on the purchase of medications or durable medical equipment on prescription by the treating physician requested in the pharmacy or the medical equipment shop, showing the name of the insured (as well as the Health insurance card number),
b) a copy of all medical documents related to the insured event,
c) the insured's declaration stating the account number of his/her (HUF) account in Hungary (signed and dated).

If the claim is grounded, the insurance company shall settle the insurance claim within 15 days upon receipt of all documents necessary for the assessment of the claim.

4. Exemption of the insurance company

4.1. The insurance company will be released from the benefit payment if it can prove that the event which resulted in the insured event was caused unlawfully and willfully or unlawfully and in gross negligence by:
a) the insured; or
b) a relative living in the same household with him/her.

4.2. The insured shall be acting in gross negligence in particular if:
a) the insured was verifiably intoxicated or under the influence of drugs or other stupefying agents at the time of the event which led to the insured event, and this fact contributed to the occurrence of the insured event. If a blood alcohol test was administered, the person is legally intoxicated if his/her blood alcohol concentration exceeds 1.5‰ – or 0.8‰ while driving a motor vehicle;
b) the insured operated a motor vehicle without a valid vehicle registration certificate or the insured did not have a valid license required for driving such vehicle, and this fact intervened in the occurrence of the insured event,
c) the insured has committed at least two traffic offenses at the time of the event which led to the insured event, and as such the event which led to the insured event resulted directly from these actions.

4.3. If the policyholder or the insured infringe their obligation to disclose the required information or to report changes, the insurance company's obligation to pay the benefits shall not set in, unless they can prove that any of the following circumstances exist:
a) the concealed or unreported circumstance was known to the insurance company at the time when insurance policy was concluded, or
b) the concealed or unreported circumstance did not contribute to the occurrence of the insured event.

4.4. When an event underlying an insured event occurs, the insured is required to act as generally and reasonably expected in the given situation, and as such promptly seek emergency assistance or medical care. If the insured fails to comply with this obligation, the insurance company will be relieved from the payment of insurance benefits. The insured's refusal of a medical procedure – due to his/her autonomy or freedom to decide guaranteed by law – shall not be an breach of his/her duty to mitigate loss.

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

5. Risks excluded from the insurance coverage

5.1. The insurance coverage provided by the insurance company shall not cover any insured events being directly or indirectly in connection with:
- active participation in any military acts or other warlike acts on the side of any of the acting parties,
- being an accessory in a crime against the state.

5.2. For the purposes of these terms and conditions war shall mean any war whether declared or not, border-incidents, insurrection, revolution, riot, coup or coup attempt against the government, civil war, military actions with limited purposes of a foreign country (e.g. air strike or sea strike only), commando attacks, acts of terror. (In case of commando attacks and acts of terror, it shall not constitute an active participation in a warlike act if the insured acts in the interest of the victims.)

5.3. For the purposes of this policy crime against terror shall mean any crime that the Criminal Code constitutes to be such, especially: rebellion, espionage, destruction.

5.4. The insurance company will not reimburse any of those damages which are in direct or indirect connection with any nuclear damage (nuclear fission or fusion, nuclear reaction, radiation of radioactive isotopes, ionizing radiation, laser radiation and the contamination thereof).

5.5. The insurance coverage provided by the insurance company shall not cover any insured events being directly or indirectly in connection with:
a) pregnancy or delivery, or any consequences of health damage occurring within one year of the delivery, except for any outpatient care provided in order to diagnose pregnancy and any necessary medical intervention in case of eccyesis;
b) any medical intervention the purpose of which is an aesthetic change or cosmetic treatment.

5.6. The insurance company shall not reimburse the costs of the following health care services and medications:
a screening tests,
b) occupational health examinations and other medical tests,
c) organ transplant,
d) the insured's such illness or medical condition which is proven to have existed prior to the effective date of the insurance coverage, or which had been diagnosed prior to the effective date of the insurance coverage, or which required treatment or medical control during this time period, or any permanent impairment of the insured that had been diagnosed prior to the effective date of the insurance coverage, such parts or organs of the body which had already been damaged, ill, injured or truncated prior to the effective date of the insurance for any reasons, and any consequences of such injuries, except for primary care services,
e) the insured's suicide or suicide attempt, even if it happened while the insured was in an altered mental status,
f) any medical care and medication costs in connection with rehabilitation, sanatorium treatment, physiotherapy, spa therapy, slimming therapy, any medical care or medication costs in connection with dialysis treatment, except for acute cases,
h) psychiatric treatment and psychotherapy, medication costs,
i) any treatment provided by acupuncture, naturopath, osteopath or alternative medicine, medication costs,
j) costs of contact lenses, dioptric glasses/sunglasses and any costs of health care service in connection with the prescription thereof.
k) any health care service in connection with contraception, medication costs,
l) abortion of pregnancy, unless termination of the pregnancy was necessary to preserve the life or health of the mother, or termination of the pregnancy was performed in a case where pregnancy was the result of a criminal act,
m) infertility examination and treatment, medication costs,
n) costs related to artificial reproductive techniques and its medication,
o) HIV infection treatment, medication costs,
p) treatment of sexually transmitted diseases, medication costs,
q) dental services, medication costs, except for those health care services which are provided under the module of dental services, provided that the insured has paid the premium of the module of such services,
r) sterilization surgeries and consequences,
s) sex reassignment surgeries,
sz) vision correction surgeries,
t) hearing aid,
u) tests administered and treatments performed in relation to the consumption of alcohol or narcotic drugs,
ü) convenience (V.I.P.) health care services (e.g. single bedroom),
v) purchase of vaccine for immunization shots, reimbursement of costs,
w) treatment received in assisted accommodation,
x) medical care that is not for the purpose of diagnosing the condition of the insured, or for the prevention of further deterioration of his/her health or rehabilitation as well as treatment by a person who does not have medical certification and permit to practice medicine, including medical care or other health care treatment made necessary as a result of treatments performed by such person.

5.7. The insurance does not cover events which may have been caused by the insured's engagement in sports activities with increased risks listed herein: scuba diving to a depth of 40 metres, singlehanded and open sea sailing, white water rafting, , riverboarding (hydrospeed), canyoning, surfing, mountaineering and rock-climbing on routes graded 5 or higher, high-mountain expeditions, caving and cave expeditions, bungee jumping, auto-motor sports (e.g. auto-crash, go-kart, motocross, motorboat sports, motorcycle sports, rally, ability competitions by car), quad biking, private flying/sports flying/aviation sports (e.g. paragliding, ballooning, motor sail plane, hang-gliding and ultra-light flying, hot-air ballooning, parachute jumping, free plane flying, stunt flying, base jumping).

6. Benefit Limits and Deductibles:

	Benefit/service	Aggregate LIMIT HUF 2 mn / policy year / insured	Deductible
Outpatient care	Primary health care (English speaking General Practitioners)	up to the limit	none
	Specialty care (including ambulatory (same-day) surgeries)	up to the limit	none
	Diagnostic and lab tests	up to the limit	none
Inpatient care (including surgeries and same day surgeries)		up to the limit	none
Financing of medications, bandage, medical equipment for temporary use (products officially listed as durable medical equipment) if required for medical care, subject to the applicable deductible. **The insured is required to prepay medical expenses.**		HUF 100 000 / policy year / insured (the insurance pays out maximum HUF 100 000 /policy year)	50%
Patient transport: if the insured is immobile and has a medical need for transport to the facility providing healthcare, within the territory of Hungary, if it is required for the medical treatment which qualifies as an insured event.		up to the limit	none
Emergency medical care: within the territory of the country, in cases which require immediate medical attention **in certain cases the insured is required to prepay medical expenses.**		up to the limit	none
Add-on Module I (if the insured has paid the premium of the module separately)	Costs of **Repatriation** if the insured's condition so requires and/or makes it possible, provided that the medical service provider specified by the insurance company also recommends the treatment at home and the repatriation of the insured to his/her country of residence.	HUF 3 000 000 / policy year / insured (the insurance pays out maximum HUF 1 500 000 / policy year)	50%
Add-on Module II (which takes effect after 24 months following the effective date, pursuant to a unilateral request submitted by SZTE 60 days prior to such date)	**House call:** visit by a general practitioner between 8:00 am and 4:00 pm on weekdays if the insured's condition does not make it possible to visit the physician in his/her office (shall not replace the treatment of emergency)	up to 200,000 HUF/ policy year/ insured	none
Add-on Module III (if the insured has paid the premium of the module separately)	**Dental services:** dental fillings, root canal treatments, treatment of abscess, dental extractions, treatments of the mouth cavity and accident consequences which come with strong pain and require immediate medical attention, up to the limit specified for dental treatments) **The insured is required to prepay medical expenses.**	400,000 HUF/ policy year / insured (up to 200,000 HUF/ policy year)	50%

7. Premium Payment

7.1. **Frequency of payment: in case of a definite policy period (min. 3 months): in one sum**

in case of an indefinite policy period: in two 6-month installments according to the order of tuition fee payment (01.09-31.01. + 1 month and 01.02.-31.08. + 1 month)

Insurance premium per policy period:
- **annual: HUF 68 000 / person**
- **3 months fixed policy period: HUF 30 000 / person**
- **semiannual: HUF 34 000 / person**

Add-on Module I - Annual premium: **HUF 10 000** / policy year / person
Add-on Module II - Annual premium: **HUF 75 000** / policy year / person
Add-on Module III - Annual premium: **HUF 85 000** / policy year / person

7.2. To payment, paragraphs (1) and (6) of Section 130 of the Public Procurement Act shall be applied accordingly.

The Policyholder shall pay the insurance premium to the Insurance Company with respect to each and every Insured (reported to the insurance company).

7.3. The Policyholder shall report to the insurance company each and every person (insureds) entering the group insurance as insured persons. **The Policyholder shall submit its first data report on 30th September, 2015, and subsequently until the last day of the first month of each half-year.** In case of any person insured for a 3-month period, the Policyholder is at all times obliged to submit a separate data report with respect to the given person within 2 working days of signing the insured's statement. The order of data reporting forming the basis of premium payment is stipulated in Annex 7.

7.4. The premium of the insurance shall be paid regularly on a half-yearly basis; the first insurance premium payment is due until the 90th day of the commencement of the coverage, and all subsequent premium payments are due until the 90th day of the first day of each and every policy period. The Insurance Company issues the invoice on the basis of the data report of the Policyholder set out in Cause 7.3, the payment deadline of which is the last day of the period of due payment. The 6-month insurance premium shall be calculated on the basis of the number of insureds.

7.5. The insurance company issues an invoice on the current insurance premium to the Policyholder (in the name of the Policyholder), which shall be sent to the insurance broker, who (after checking the invoice) shall forward it to the Policyholder. The Policyholder transfers the insurance premium to the bank account of the insurance company stated on the invoice according to the payment deadline of the invoice.

The Parties agree to settle accounts with one another on a half-yearly basis according to Section 58 of the Value Added Tax Act. The insurance company shall state on each and every invoice the legal title of performance, the period of performance and the number of the contract (policy number). The date of performance equals with the payment deadline on these invoices. The Policyholder is entitled to send back the invoice without payment and extending the payment deadline in case of non-compliance with the aforementioned conditions.

7.6. In case the Policyholder fails to pay the insurance premium, the insurance coverage terminates on the day following the last day of the period of due payment.

The insurance premium pertaining to the covered Insureds shall not be modified within the given policy period (as stated on the Health insurance card) until the 2-year long mark-up moratorium period elapses.

7.7. The Policyholder shall pay the consideration for the service with respect to the covered period against invoice via bank transfer according to paragraphs 1 to 3 of Section 6:130 of the Civil Code.

7.8. To the procedure, Section 36/A of Act XCII of 2003 on the Rules of Taxation shall be applied.

7.9. The policyholder will have fulfilled his/her obligation to pay the insurance premium as of the day when the **insurance premium is credited to the account of the insurance company.**

The policyholder undertakes to pay the insurance premium at the time when the insurance contract is concluded, or if payment deferment is applied, at the payment dates specified, **in one sum and in advance for each insurance period**.

8. Limitation Period

Any claims arising under this policy shall lapse after 1 (one) year of the date of occurrence of the harmful event.

If the insured prepaid the costs of the medical and health care services (medical bill), the limitation period with respect to the insurance company's benefit payment obligation will commence at the following points in time:

a) if the insurance claim is not notified to the insurance company, on the day following the last day when the medical and health care services are provided,
b) if an insurance claim is notified to the insurance company then on the day following the 15th day after the last document is received by the insurance company,
c) if an insurance claim is notified to the insurance company and if the documents or information required by the insurance company are not submitted or disclosed, on the day following the deadline of the document submission or information provision set out by the insurance company, or in the absence of such a deadline, on the day following the 30th day of the issue date of the written communication served for that purpose.

9. Miscellaneous Provisions

The insurance policy is concluded in Hungarian.

9.1. The policyholder is required to inform the insureds of all the legal statements it is delivered by the insurance company as well as of any modifications of the insurance policy. The insurance company provides the Policyholder with the statement and information material on the policy in English language.

9.2. The insurance company is entitled to charge any extra expenses over and above the insurance premium incurred during the contract period according to the following provisions:

Any expenses incurred in connection with the verification of insured events shall be borne by the party which intends to enforce the claim.

9.3. To the activities and liability of the health care service provider providing the medical care, the provisions of the Health Act shall be applied, and for damages arising out of the defective execution of medical care and attendance, the health care service provider shall be held responsible.

The insurance company forwards any complaints in connection with the quality and level of service provided by the health care service provider and any possible medical malpractice to the entity providing the medical care.

9.4. Detailed rules on data handling are set out in the Customer Information (Annex 8)

10. Provisions that substantially differ from the provisions of the Hungarian Civil Code

According to the agreement of the Contracting Parties, any issues not regulated in the present contract or its annexes shall be governed by the provisions of Act V of 2013 on the Civil Code, Act CXII of 2011 on Informational Self-determination, Act LX of 2003 on on Insurance Institutions and the Insurance Business and any other laws and regulations in force.

Provisions that substantially differ from the provisions of the Hungarian Civil Code are as follows:

10.1. Within the meaning of Clause 2.2 of these policy conditions, and by way of derogation from Section 6:443. (1) of the Civil Code, the insurance policy will be concluded pursuant to an **agreement executed in writing** by the policyholder and the insurance company.

10.2. Pursuant to Clause II.2 of the insurance policy, and by way of derogation from Section 6:475. of the Civil Code, **the consent of the insured is not required for amending the insurance policy.**

10.3. Pursuant to Clause 2.5 of the insurance policy, and by way of derogation from paragraph 2 of Section 6:447 (2) of the Civil Code, the policy period conforms with the period of the student attendance.

10.4. Within the meaning of Clause 2.6.3 of these policy conditions, and by way of derogation from Section 6:490. (2) of the Civil Code, this insurance contract may be cancelled by the Policyholder with 120 days notice and by the Insurance Company with 90 days notice by way of termination for convenience.

10.5. Within the meaning of Clause 2.6.5 of the insurance policy, by way of derogation from Section 6:451 (1) of the Civil Code and in line with Section 6:442 (3) of the Civil Code, **the insured may not replace the policyholder in the insurance policy.**

10.6. The provision on the statute of limitations set out in Clause 8 of this insurance policy differs from the five (5) year limitation period prescribed in Section 6:22 (1) of the Civil Code. **The limitation period for claims arising under this policy shall be 1 (one) year.**