General Terms and Conditions for Medicare Biztosító Zrt's Individual Service Financing Health Insurance

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The **General Terms and Conditions for Individual service financing Health Insurance** of **Medicare Biztosító Zrt.** (hereinafter: **GTC**) **shall apply** – unless otherwise agreed – to those service financing **Insurance Contract** of Medicare Biztosító Zrt. (registered seat: 1134 Budapest, Váci út 29-31., Hungary; company registration number: 01-10-142557; VAT number: 32409336-4-44; primary business activity: 6512'25 Non-life insurance; authorized representatives: Ildikó Horváthné Kürthy and István Gonda, members of the Board of Directors; contact address of board members: 1134 Budapest, Váci út 29-31., Hungary; registration number: 32409336; hereinafter: **Insurer**) that is concluded with reference to these GTC. The provisions other than those of the applicable Civil Code, including its amendments, are highlighted in **bold**, while the customer information components of Annex 4 to Act LXXXVIII of 2014 on Insurance Activities (hereinafter: "Insurance Act") are highlighted in *Italics*.

Terms and Definitions

For the purpose of these GTC, the following terms shall have the following meaning:

Accident: single and abrupt external, physical and/or chemical impact beyond the Insured's control, which occurs during the insurance term, and as a result of which the Insured suffers a physical injury or health impairment within 7 days after the accident date or dies. For the purpose of these GTC, heart attack, stroke and fainting (collapse) are not considered an accident.

Accidental stabilization dental care: stabilizing dental care that has become necessary as a result of an accident.

Advance diagnostics: advanced diagnostic procedures using equipments (including imaging) complying with the effective laws relating to such care, are performed by a medical specialist become necessary due to an illness or an accident that are defined in the List of Benefits which form an integral part of these GTC, and which the patient needs as ordered by a medical specialist and as evidenced by medical documentation, primarily for the purpose of the early diagnosis, detection, establishment, identification, location or finding the origin of an illness, injury or health impairment, or determine the treatment to be used, the monitoring of the efficiency of a therapy or of a medical treatment, or for the confirmation of the pathological anatomical abnormalities, size, structure or position differences of organs by using such equipment providing a high degree of spatial detail.

Basic care (health or medical availability): health care becoming necessary due to an illness or an accident, complying with the effective legal regulations related to basic medical care and treatment given by general practitioners.

The first visit at the internal medicine unit, gynecology unit, pediatric unit and, as part of this, medical consultation, examination and counseling during office hours are also considered basic care. Internal, gynecological and pediatric examinations that are intended to check health status or the efficiency or success

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of medical treatment, further, second and later visits are not considered basic care but outpatient care. For the purpose of these GTC, the following are also regarded as basic care: ECG examination, immediate blood sugar test and urine test, examinations for driving license, vaccination against the flue and other infections and illnesses.

Call Center: a telephone service available by calling the pre-published telephone number(s) during the announced periods of time (business day, extended working hours), intended to check or make an appointment for elective or programmed health services.

Care for dying patient: such nursing (mostly palliative) care for a dying person which is not only aimed at pain relief but also includes the physical and emotional care of patients with a long illness leading to death, improving their life quality, easing their suffering and help maintain their human dignity until death.

Cases requiring immediate (medical) care (Acute Cases) include:

a) sudden health injury, illness or accident requiring immediate health care on the basis of the applicable health, medical and legal regulations

b) emergency as defined by law (including cases requiring lifesaving procedures) and threatening conditions,

c) conditions considered acute according to the rules of the health and medical profession, including those related to chronic illness, with symptoms that require medical treatment within 48 hours according to the rules of the medical profession (particularly including high fever, convulsive pain, diarrhea, vomiting, acute infection, loss of conscience, inability to sleep, bleeding, deep or extensive open wounds, unexplained high or extremely low blood pressure and/or heart rate, sudden and considerable worsening of sensing abilities).

Chronic care: any and all health services related to the patient's chronic disease, also including such continuous health service or care by a specialist applied in the case of chronic diseases specified by the effective laws and requiring no specialist inpatient care that constitutes specialist outpatient care as defined by the effective laws.

Chronic disease: such diagnosed disease or condition classified by a physician that requires permanent or periodical outpatient and/or inpatient care or hospitalization and is characterized by a slow onset and/or long-term course (at least 3 months) with our without interim acute periods or the improvement or relief of symptoms.

Client: the Policyholder, the Insured, the Beneficiary, other persons entitled to receive benefits from the Insurer, and a person making a claim for benefit; for the purposes of the data protection regulations, Client also means a person who makes a proposal to the Insurer for the conclusion of the Insurance Contract.

Clinical psychology: health care activity defined by law that is intended to maintain and restore emotional health, diagnose and examine emotional disorders and identify their reasons, further, the execution of

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psychodiagnostic examinations necessary for diagnosis, and the correction of emotional disorders by psychological methods.

Congenital: a malformation, biochemical or functional disorder that develops during fetal life, as a result of internal and/or external environmental factors, and is detected at birth (or prenatally or after birth).

Consumer: a natural person acting outside the scope of their profession or independent occupation or business activity.

Course of treatment: curative treatment procedures that require an inpatient care background, are carried out at a predetermined time and in a predetermined number of treatments, and form a series of interrelated treatments.

Cover change: Change of insurance cover, package for the Insured under the Insurance Contract, typically on the day after the end of the insurance period, that is, as from the Insurance Contract anniversary day.

Death (biological): when the irreversible decomposition of the human body starts due to the complete cessation of breathing, circulation and brain activity.

Dental care (acute):dental and oral surgical treatment that is medically justified, is not intended for aesthetic purposes, complies with the applicable laws, arises from acute treatment case, is intended for the stabilization or restoration of condition, and satisfies the relevant professional conditions (particularly including tooth extraction and tooth preservation (specialist) care: tooth filling, root canal treatment, abscess treatment, identification of root cause of disease, cleaning of inflamed tooth and treatment for inflammation, insertion of dental crown and tooth bridge, further, if tooth replacement is covered by the Contract, implanting, insertion of implants, excluding dental jewelry, golden teeth and materials that are not medically justified; preparation of false teeth and dentures, scale removal).

Dental care for stabilization: such emergency, dental, tooth and oral surgical, tooth preservation specialist care, tooth extraction (tooth filling, cleaning of inflamed tooth and initial treatment for inflammation) that is intended for stabilization, is medically justified, is not intended for aesthetic purposes, complies with the current provisions of law, and does not exceed the minimum medical requirements.

Diagnostics: medical examination intended to establish the reason for the patient's complaint.

Elective health or medical care: see: planned health or medical care.

Embryo: living human being under development after fertilization up to 12 weeks of gestation.

Emergency care: Such care that cannot be planned or scheduled in advance, in other words, cases when the absence of care or the provision of the care in a scheduled manner entails the risk of damage to health (worsening of condition, permanent health injury or intolerable pain).

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Emergency department: An organizational unit of a health institution (typically hospital) that is not linked to a medical profession but is intended to treat patients with a condition requiring immediate intervention, typically in the case of emergency.

Emergency medical care: health care as defined by law, in cases of emergency occurring outside the normal daily business hours, that ensures continuous access to certain health care and is intended to examine persons in need of care in the period between the end of the health care providers' daily working hours and the start of their working hours on the next day, detect any health problem, apply occasional and immediate emergency interventions and care, give emergency referral to inpatient (medical) institutions, and participate in certain procedures defined by law.

Enrollment (entry):an action having a legal effect, in the course of which the Policyholder submits a written application to the Insurer for the extension of the scope of Insurance Contract to a person to be insured, which constitutes a proposal in respect of the Insured. **Enrollment** means when the Insurer has accepted the proposal for the Insured and the Insured becomes covered by the Insurance Contract, thereby creating the Insured relationship and risk bearing by the Insurer for the Insured.

Examination (medical): a health activity intended to survey the patient's health condition and preserve their health, detect any illness and risk of illness, injury, health impairment, consequences of an accident, diagnose an illness, determine its prognosis and any change in it, determine the efficacy of medical treatment, and establish death and its cause.

Expatriate: an individual whose permanent domicile is outside Hungary and who does not legally stay in Hungary for at least 183 days or has no valid social insurance or equivalent health cover in Hungary.

Eye examination: health test that is medically justified, is not intended for aesthetic purposes, and is intended for testing visual ability and the prescription of visual correction devices and accessories.

E-doctor: one of the most common forms of telemedicine, centered on telephone consultations, the purpose of which is

- to conduct a preliminary screening,
- assessing the need for in-person care, ordering additional tests necessary for a more accurate assessment of the patient's condition, initiating medical treatment,
- monitoring the patient's condition,
- prescribing medication or writing a referral, and
- providing follow-up care and aftercare following previous in-person care

E-prescription (writing): a digital health care service that allows for the prescription of medicine(s) that a

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patient takes on a regular basis without the patient (insured) having to visit his/her doctor in person, thereby ensuring continuous medication therapy.

Fetus: human being developing in the womb, from the 12th week of gestation.

Frequency of premium payment: the premium payment period is either monthly, quarterly, semiannual or annual, as determined by the parties in the proposal or through a separate agreement amending the insurance contract. The Policyholder is entitled to change the premium payment frequency on the anniversary date of the insurance contract, provided that the Policyholder notifies the Insurer of the change request no later than 30 days before the anniversary date.

General practitioner: physician coordinating health care for the patients registered with him/her, in line with the relevant laws, and providing base care to them.

Geographical scope: the geographical area in which the insured events occurs and in respect of which the Insurer bears the risk under the Insurance Contract, particularly including these GTC.

Health activity: any activity that is part of a health service, except activities which do not require a health care professional qualification, or the professional supervision of a health care professional.

Health care personnel: physician, dentist, pharmacist, other person with post-secondary health qualifications, persons with specialist health qualification, and persons without health qualification, involved in health care activities.

Health care provider (institution):regardless of their ownership form and operator, any and all individual health entrepreneurs or legal persons or organizations without legal personality that are entitled to provide health services under the effective laws and have an operating license issued by the health administrative bodies for Hungary. For the purposes of these GTC, spa and climatic medical institutions, and health resorts, sanatorium, spas, health resorts, psychiatric institutions, social homes, alcohol and drug rehabilitation institutions (hereinafter commonly referred to as “other health care institutions”) are not considered health care providers for the purposes of the GTC, even if they provide health care services. For the purposes of these GTC, the departments or units of institutions - entitled to provide health care services - which provide such health care to the patient or the Insured that correspond to the type of other health care institutions are neither considered health care providers.

Health care: any and all medical activities related to the patient’s health status, provided and documented in compliance with the rules of the medical and health profession and the effective health laws.

Health document, documentation: any and all notes, records, or information recorded in another way on any carrier in any format which include health and personal identification data related to the patient’s treatment

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that become known to the health care personnel during health services, , and are prepared in accordance with the effective legal regulations, in compliance with the rules of the health and medical profession. For the purposes of these GTC, the following documents, in particular, are defined by law as medical documents: outpatient records, hospital discharge reports, examination records, nursing or care records, test reports, laboratory reports, diagnostic test images, prescriptions (copies), referrals (copies).

Health impairment (permanent): any adverse change to the body structure or functions, affecting the whole body, that develops due to an illness or an injury or an inherited, congenital or acquired abnormal condition. Permanent health impairment means such health condition of the Insured which can be regarded as medically developed and final.

Health profession: any and all health services that are provided by health professionals, in line with the statutory professional (human and physical) minimum conditions, and are included in the registry of health professional codes.

Health service: all health care activities that may be carried out under an operating license issued by a public health administration agency or, in cases specified by law, on the basis of registration by a public health administration agency, which are aimed at the patient's examination and treatment, care, nursing, medical rehabilitation, the reduction of pain and suffering, and the processing of patient's medical records in the interest of the above for the purposes of preserving the patient's health, the prevention, early detection, diagnosis, treatment of diseases, the elimination of life-threatening conditions, the improvement of conditions resulting from a disease and the prevention of the further deterioration of a condition,. Health services for the purposes of these GTC include activities under special legislation relating to medicines, medical aids and medical care, as well as rescue and patient transport, obstetric care, special procedures for human reproduction, and activities relating to the examination of the dead, medical procedures relating to the dead, including the transport of the dead in connection herewith, under special legislation.

Home visit: health service that is available in certain pre-determined towns, villages and areas to patients at their domicile or residence (in their home) in acute cases upon a request made by calling the 7/24 hour health counseling line, when a physician or pediatrician providing care equivalent to general practitioner services is sent to the patient's home to perform medical examination and provide medical indication (recommendation or referral) in order to ensure access to health care, if visit to the patient's home is justified and supported according to the rules of the medical profession, and it would be difficult for the patient to directly visit the health care provider and so the patient requests this service by calling the 7/24 hour health service or when this is recommended by the health personnel.

Hospice: see Care for dying patients.

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Hospital: a health care provider (institution) that provides specialist inpatient care as defined by law, is acknowledged and registered by the competent regulatory body, and operates under permanent medical management and control.

Illness: a physical or mental condition generally recognized as abnormal according to the current state of the health and medical science.

Infertility: sterility or inability to conceive.

Inherited: genetically encoded or chromosome-linked.

Injury: health impairment when an organ, organ system or tissue or complexity of tissues of the patient becomes injured directly as a result of an accident.

Inpatient care: health service with diagnostic or medical treatment purposes provided on the basis of a referral by a physician who provides the patient's continuing healthcare, physician in charge or another person authorized to issue a referral, or at the patient's request, at an inpatient medical institution or hospital complying with the provisions of the effective laws relating to specialist inpatient care to a hospitalized person, or at certain times of the day, or a single procedure or a procedure performed as a course of treatment after which observation for a certain period is needed and during which immediate health care is available as needed. Thus, inpatient care means surgery (including its pre- and post-operative phases) performed on a patient in an in-patient medical institution or hospital for diagnostic or therapeutic purposes, especially if the patient is admitted to the in-patient medical institution or hospital for several days for the purpose of health care to be provided to him/her. Admission to a health care provider's institution is for more than one day if the patient spends all nights in the institution in connection with his/her health care between the day of admission and the day of discharge, and the day of discharge from the institution is later than the day of admission.

Insurance anniversary: the first day of the insurance period(s) within the term, by which the insurance period or new insurance period begins.

Insurance Contract (hereinafter: Insurance Contract or Contract): an individual health insurance contract made between the Policyholder and the Insurer with reference to the specified insurance terms and conditions, in which case the Insured is the Policyholder or a third-party natural person designated by the Policyholder who meets the conditions applicable to the Insured. The conclusion of an Insurance Contract is initiated by the Policyholder by means of an insurance proposal, and the conclusion of such contract is evidenced by a document (typically a policy) certifying the insurance cover. The Insurance Contract means the set of documents that form an integral part of the Insurance Contract, which are as follows: Proposal Documentation, Medicare Insurer's General Terms and Conditions for Individual Service Financing Health Insurance, List of Benefits, Insurance Product Information Document, Customer and Product Information (as set forth in these

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Terms and Conditions), Insured's Statements, Policyholder's Statement, Privacy Policy, as amended from time to time, and any supplementary Clause(s), if applicable based on a separate agreement between the Insurer and the Policyholder. The Insurer's general terms and conditions for individual service financing health insurance in force at the time of conclusion of the Insurance Contract shall apply to the insurance relationship of the Policyholder and the Insured, throughout the term of the Insurance Contract. Under the Insurance Contract, the Insurer undertakes to provide the services specified in the Insurance Contract in the event of the Insured becoming ill. The Insurer's services may include the reimbursement of costs incurred when a healthy individual uses the health services specified in the Insurance Contract.

Insurance cover: health services and types of services to which the Insured is entitled under the extension of the scope of the Insurance Contract to him/her and the provisions of the GTC and the contents of the List of Benefits.

Insurance interest: An insurance contract can be concluded by a person who is interested in avoiding an insurance event based on a financial or personal legal relationship, or who concludes the contract in favor of such interested person.

Insurance package: see insurance cover.

Insurance period (year): one year from the day of insurance anniversary until the day before the next anniversary, or in case of an expiring Insurance Contract, the period(s) from the day of the anniversary before the expiry date until the expiry date, within the term of the Insurance Contract. The Parties can agree on a shorter or a longer insurance period.

Insurance proposal: the Policyholder's statement initiating the conclusion of the insurance contract, submitted to the Insurer on the Insurer's proposal form and in accordance with the relevant rates, which can be submitted to the Insurer after its completion with accurate and true data.

Insured categories: groups used to determine insurance rates, into which the Insurer classifies the persons to be insured based on various characteristics of the insured, in particular age at the time of enrollment or entry into the insurance period, gender, occupation, (sports) activities and their nature, possibly place of residence, as well as the term of the insurance and the content and parameters of the insurance coverage, the various possibilities for applying discounts or surcharges, and possibly the frequency and method of premium payment.

Insured Event: the use of a healthcare service for which the Insured scheduled an appointment with the Insurer's service provider partner after the insurance contract was concluded, indicating at the time of booking that the Insured wishes to use the service at the expense of the insurance, and which the Insured uses during the risk bearing period for the Insured, by the Insured due to his/her illness - without any precedent to the period of start of the period of cover for the Insured - or accident, at a health care provider fulfilling the rules of the Insurance

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Contract, according to the Insurance Contract for the Insured, on the basis of the List of Benefits. A screening examination specified in these GTC, in particular in the List of Benefits forming an integral part thereof, which the Insured person takes, by its content, for preventive purposes at a health care provider who complies with the rules of the Insurance Contract, is also considered an insured event.

Only the use of health care services that are provided by Medicare Egészségközpont Zártkörűen Működő Részvénytársaság (registered office: 1134 Budapest, Váci út 29-31. company registration number: 01-10-042382; VAT number: 10895986-4-41) or its successor as a health care provider, or through it or organized by it, and with the knowledge and consent of it, is considered an insured event. The date of the insured event is the day of receiving health care or, in the case of continuous care for several days, the first day of care.

Insured: A natural person who qualifies as a Consumer and who has been designated by the Policyholder, with the consent of the Insured or the Insured's legal representative, as the Insured in the insurance contract, and for whom the contract is concluded in connection with events related to his or her health, and to whom the Insurer's risk bearing extends in accordance with the provisions of these GTC and the List of Benefits.

Insured's Statement: a written legal statement made by the Insured in relation to the Insurance Contract, which contains, in particular a reference to the information on the rights and obligations of the Insured (the person to be insured), a waiver of the obligation of confidentiality applicable to the institutions and persons handling the personal and health data of the Insured, and the Insured's assignment statement related to the performance of the service, and the Insured's consent to the processing of his/her personal, insurance and health data.

Intervention (health or medical): removal of organs or tissues to prevent illness or health deterioration or unstable health condition or for therapeutic or rehabilitation or other purposes, conforming to the current medical practice, or other physical, chemical, biological or psychiatric procedure that leads to or can lead to a change in the patient's body. **Invasive** intervention means physical intervention penetrating into the patient's body through the skin, mucous membrane or a body orifice, excluding interventions the risk of which is medically insignificant for the patient.

Lifesaving intervention: a health care activity aimed at saving the patient's life in emergency.

Life-sustaining intervention: a health care activity intended to artificially maintain the patient's life or replace certain life functions.

Limit: the maximum of the Insurer's liability to refund the cost of the services subject to a limit, related to the Insured in connection with insured events within an insurance period, specified in the Insurance Contract. Therefore, the limit belongs to the insurance cover and the types of service included in it, and is applicable per insurance period and per Insured.

Medical profession: any and all health services that can be provided by medical professionals, subject to the

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statutory professional (human and physical) minimum conditions, and are included in the registry of health professional codes.

Medical treatment: see 'treatment'.

Medicines, bandages and medical aids: medicines, bandages and medical aids that are medically justified, comply with the relevant effective laws, are prescribed, ordered or – on the basis of these GTC – approved by a (specialist) physician. Only those substances, accessories and devices considered to be medicines, bandages and medical aids that are registered and approved in Hungary as medicine, bandage or medical aid. Vision aids (spectacles, contact lenses, glasses, etc.), hearing aids and materials and appliances used in the context of dental care (false teeth, dentures, fillings, implants, braces, whitening materials and devices, etc.) are not considered medical aids.

Medicare health centers: Medicare Zrt.'s own health service sites.

Medicare service points: Medicare health centers and other health care providers with which Insurer has a cooperation agreement.

Non-conventional procedures: any and all health care and services intended to cure a person or improve his quality of life that are based on a different approach for health and illness and on methods arising from an approach different from the conventional, scientifically proven ones, and that constitute procedures, as defined by law, which complement the conventional curing methods, or may even replace them under medical supervision, or help improve way of life, provided that they are intended to have a positive impact on health, prevent illness and enable protection against factors threatening or damaging health.

Nursing: any and all nursing and care services and procedures defined by law that are intended for health improvement, preservation and restoration, the stabilization of the patient's condition, illness prevention, the mitigation of suffering by safeguarding the patient's human dignity, including the preparation of the patient's environment for participation in nursing tasks and their involvement in such tasks.

Obstetrical care and confinement: health care provided to a mother and her baby during childbirth, labor and postnatal care at the health care provider providing the care in connection with the birth.

One-day surgery: elective and programmed surgical procedure (including its pre- and post-operative phases) defined by law which is provided by a specialist health care provider in accordance with the law, provided that the need for such treatment is justified by medical opinion and the rules of the profession, and can be performed on the basis of the patient's choice and examination findings, and upon the performance of which, with or without anesthesia, the patient can leave the health care institution, after post-surgery monitoring, within 24 hours either on their own or accompanied by someone else.

Organ: part of the human body that is a complexity of tissues having a certain structure, and which the human

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body is unable to regenerate if completely removed.

Organ and tissue transplantation: removal of organ and tissue from the human body (donor) and its implant into the body of another live person (recipient).

Outpatient care: single or occasional specialist care or health service with diagnostic or medical treatment purposes or specialist consultation, all performed by a specialist based on referral from a physician who provides the patient's continuing healthcare or at the patient's request, in line with the effective provisions of law concerning specialist outpatient care, provided that such are not considered inpatient care or one-day surgery or continuous health care or service requiring specialist in-patient care performed by a specialist used in case of chronic disease.

Outpatient surgery: a surgical procedure in outpatient settings (including its pre- and post-operative phases), after the completion of which the patient can be discharged without requiring any special monitoring (for several hours) at the site of the procedure, and which constitutes neither inpatient care nor one-day surgery. The outpatient surgeries covered by the insurance are included in the List of Benefits for outpatient surgeries in force, as amended, which is part of the Insurance Contract.

Patient transport: transport of the patient upon the doctor's order, in line with the statutory conditions, in order to ensure access to health care for the patient in cases requiring no monitoring by an ambulance nurse and access to health care cannot be ensured in any other way; further, the transport of a patient discharged from a medical institution to his/her home can also be initiated in cases where the provisions of Section 97(3) of Act CLIV of 1997 on Health Care are fulfilled.

Patient: a person using or receiving health care.

Planned health and medical care: health (medical) care that is justified by the criteria of the health and medical profession and is not considered an acute case, and the performance of which does not require health or medical care within 24 hours and so can be scheduled and programmed.

Policy: Document certifying the insurance cover.

Policyholder: the natural person (consumer) who submits a proposal for insurance and undertakes to pay the premium.

Premium: the amount payable by the Policyholder to the Insurer for the risk assumed and taken by the Insurer on the basis of the Insurance Contract.

Premium adjustment: a premium adjustment that the Insurer can implement with effect from the insurance anniversary date of the Insurance Contract in order to maintain the cost-covering capacity of the insurance and to apply the principle of risk-based premiums.

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Premium payment period: period(s) of time depending on the frequency of premium payment, typically annual, semiannual, quarterly or monthly, within the insurance period and the term of the insurance, for which the premium(s) payable in line with the frequency of premium payment fall due.

Premium-level health (hospital and hotel) services: a service in kind that is operated as an integral part of the services provided by the health care provider (hospital), ensures health care for patients (inpatients) to standards that are higher than those considered average or normal (for hospital and hotel services) in Hungary, is organized and provided based on a protocol for each health care provider (hospital), and includes the organization of the individual's health (hospital) examination, medical treatment and care, and the ensuring of a staff and a health care environment that provides high-quality care.

Prenatal care; pregnancy care: any and all health interventions, tests and services that are considered outpatient care and are directly related to health care during pregnancy.

Preventive procedure (treatment): health care as defined by the effective laws that is intended for the prevention and early diagnosis of diseases, including contagious diseases, and includes preventive specialist outpatient care as defined by the effective laws.

Professional sportsperson: the term defined by the current Sports Law as a person who, under an employment contract or a contract of assignment with a sports organization, professionally pursues sports activities for gain.

Programmed health and medical care: See: elective health and medical care.

Proof of insurance cover: a document issued by the Insurer, certifying the existence of the Insurance Contract and the main conditions of the Insurance Contract (e.g. policy).

Psychiatric institution: any and all health care providers that provide, or also provide, health services, ensure the care, supervision and nursing of psychiatric patients 24 hours a day as needed for their psychiatric condition, regardless of any other services provided by, the operator and the name of the institution, including institutions providing community psychiatric care under special legislation. Also considered as a psychiatric institution a psychiatric institution providing outpatient specialized care for psychiatric patients, a home or a rehabilitation institution for psychiatric patients, including a temporary institution.

Psychiatric patient: a patient diagnosed by their treating physician as having a mental and behavioral disorder or intentional self-harm, as defined by the effective laws.

Psychotherapy: therapeutic procedure as defined by law, which is based on various methods, is scientifically proven, is applied for mental and psychosomatic disorders, in individual or group forms, in several therapeutic sessions each lasting a certain period of time, the execution of which requires physician or psychologist qualification or qualifications entitling their holder to conduct psychotherapeutic procedures.

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Rates: a summary including the rates, allowances, surcharges, possible term, payment methods and frequency of premium payment, other conditions, requirements, limitations, regulations and conclusion conditions for the insurance.

Rehabilitation (medical, health): any and all medical and health activities applied in a manner tailored to each patient, in a scheduled manner and with the patient's active participation in order to assist patients with impaired health and/or disability, by using the means of the health science and by the development (improvement) and replacement of their abilities so that they can regain their independence as fully as possible, and become capable of fitting in the family, at work (possibly by regaining their working ability in their own field of specialization), and in other communities. Rehabilitation (medical, health) particularly includes the rehabilitation-purpose outpatient and inpatient specialist care defined by law, further, as an integral part of or given in addition to such care, physiotherapy, sport therapy, speech therapy, psychological care, occupational therapy, supply with therapeutic equipment and teaching of their use, provided that they are applied in order to maintain basic life functions and/or replace lost functions, and thus improve the patients' ability to maintain themselves, their quality of life and ability to work.

Removal (withdrawal): a measure with legal effect whereby the Policyholder initiates the termination of the extension of the Insurance Contract's coverage to the Insured as of the end of the insurance period (year), by submitting a written request to the Insurer no later than 30 days before the insurance anniversary date. **Withdrawal** means that the Insurer accepts and acknowledges the above request related to the Insured and thus risk bearing by the Insurer for the Insured terminates.

Rescue: emergency care, as defined by law, given to a patient requiring prompt health care at the place of discovery, by a licensed rescue organization, further, if necessary, the transport of the patient to the closest health care provider capable of giving treatment to the patient suitable for his health condition, and the treatment of the patient during transport.

Risk assessment: an activity carried out by the Insurer before the conclusion of the Insurance Contract or the extension of the scope of that to the Insured in order to check the conclusion of the insurance in accordance with the insurance conditions, rates and regulations, and – in cases where the Insurer carries out risk evaluation and risk survey or risk estimation related to health condition – to survey the health of the Insured (person to be insured) by using a health statement and the results of the screening examinations and any other medical examinations required or accepted by the Insurer so as to make a decision about the assumption of risk for the Insured.

Screening: a medical examination or series of examinations intended to protect health, improve quality of life and increase life expectancy by detecting hidden, latent or asymptomatic diseases, pre-disease conditions and predisposing risk factors in a timely manner, at an early, preferably symptom-free stage, by active search,

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detection, identification and mapping, and in the case of identified diseases, health examination for the identification of associated diseases and/or comorbidities as part of health care.

Secondary prevention: detecting of early-stage, asymptomatic diseases, and taking early care of detected diseases. Its methods include screening and care for the detected diseases.

Service financing: partial or full refund of the cost of the health services under and in accordance with the conditions of the Insurance Contract as an insurance service.

Service organization: the organization of medically justified health services for the patient (particularly including elective outpatient and inpatient care). For the purpose of these GTC, service organization means: the management of the Insured's health care, the monitoring and inspection of health care and the route of health care, communication with the health care providers providing care to the Insured, and the administration of health services used by the Insured at Medicare Zrt. as health care provider or through, in the organization of, with the knowledge and approval of the latter. Based on these GTC, service organization includes the ordering and prescription of medicines, bandages and medical aids within the framework of health care received from Medicare Zrt. as health care provider or through, in the organization of, with the knowledge and approval of same, the receiving and checking of the relevant invoices, in particular, with regard to the service limits.

Service organizer: regardless of its ownership form and operator, any such party that – pursuant to a contract with the Insurer - is entitled and obliged to organize health services that can be used by the Insured under, and are financed by, the Insurance Contract, in particular, those available in a scheduled manner, and to check the health services given to the Insured from a quality and a professional point of view. For the purposes of these GTC, the Service organizer is Medicare Zrt. as health care provider. The Service organizer shall, wherever possible, by itself or through a health care provider contracted by the Insurer, provide the health services which the Insured can use under the cover provided by and at the expense of the Insurance Contract.

Specialist qualification: qualification entitling their holder to pursue a certain activity, obtain in Hungary or acquired abroad and accepted in Hungary, acquired in acknowledged basic, secondary and post-secondary specialist education, or university or college-level basic education, or in post-secondary specialist training of health care workers having a university or college degree.

Specialist: a qualified physician with a valid specialist qualification in a medical specialty or subject.

Standard diagnostics: standard diagnostic procedures complying with the effective laws relating to such care, are performed by a medical specialist, become necessary due to an illness or an accident, that are defined in the List of Benefits which form an integral part of these GTC and the Insurance contract, , , and which the patient needs as ordered by a medical specialist and as evidenced by medical documentation, due to the patient's illness or accident, primarily for the purpose of the early diagnosis, detection, establishment, identification,

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location, or finding the origin of an illness, injury or health impairment, or the determination of the medical treatment to be applied, the monitoring of the efficiency of a therapy or the monitoring of a medical treatment, and are not considered advanced diagnostic procedures.

Start day of premium payment: the date specified in the proposal or in the Policy as the start day of premium payment.

Surgery: diagnostic or curative/therapeutic medical intervention using devices, in compliance with the rules of the medical profession, which is (mostly) performed under general or local or conductive anesthesia.

Surgical operation: see: surgery.

Tariff: the basic fees payable for insurance packages and for insurance covers with renewed contents, by insured category, and the conditions and parameters of determining the insurance premium.

Telemedicine: a healthcare service provided not in person, but via information and communication technologies (phone, video call, app); its most common and direct form is a **live video conference with a specialist**, the purposes of which include:

- a professional assessment of the patient's health,
- the detection of diseases and the risks associated with them,
- identification of specific disease(s),
- ordering additional tests necessary for a more accurate assessment of the patient's condition, initiating medical treatment
- monitoring the patient's condition
- a preliminary screening intended to assess the need for in-person care,
- prescribing medication or writing a referral,
- follow-up and aftercare following prior in-person care.

Term (period of risk bearing): *The Insurance Contract* ***is entered into for an indefinite period based on the agreement of the parties.***

Therapy: see treatment.

Threatening condition: a health condition which, without prompt action, would lead to a situation directly threatening the physical intactness or health of the person having such condition or another person or would directly threaten their environment.

Tissue: any part of the human body, excluding sperm, egg, embryo, fetus, blood and blood components.

Total limit: The maximum amount defined in the Insurance Contract as the Insurer's obligation to reimburse the Insured or Insureds for the services in relation to all insured events in the insurance period. The total limit applies

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to the insurance package, per insurance period, and per Insured and the Insurance Contract as a whole.

Transplant: see organ and tissue transplant.

Treating physician: physician or specialist responsible for the patient's health and proper health care, determine the diagnostic, test and therapeutic procedures in connection with the patient's illness, injury, health impairment or the survey of his/her health condition, further, performing interventions or providing health care or services within these cares.

Treatment: diagnostic, test or therapeutic procedure connected with the patient's illness, injury or health impairment, further, intervention or health care or service provided within the framework of these, which are provided by a (specialist) physician or by (specialist) physicians as treating physician(s).

Urgency: an abrupt change in health in the cases of which the absence of prompt health care leads to direct danger of death, or a deterioration of condition leading to direct danger of death in the absence of intervention; or serious and/or permanent health injury; or permanent pain socially qualified as intolerable.

Vaccine: vaccines (and their administration) approved according to the effective laws that contain active ingredients suitable for giving active or passive protection against contagious diseases and so, if administered, the spread of contagious diseases can be prevented, or in the case of illness, recovery can be facilitated and the development of chronic complications avoided.

Vision correction devices: glasses, contact lenses and their accessories.

Waiting period: the waiting period is the initial duration of the time scope applies to the Insured during which the Insurer's risk bearing for the Insured is limited, before the insurance coverage becomes comprehensive. The Insurer is not obligated to cover the costs of services or claims submitted by the Insured during the waiting period.

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I. General provisions

1.1. Parties to the Insurance Contract, their rights and obligations

1.1.1. Insurer means the Party that assumes the insurance risk against a premium during the term specified in the Contract and renders insurance services upon an insured event.

1.1.2. Policyholder means the natural person who submits a proposal for insurance and who undertakes to pay the premium, or with whom the Insurer enters into the Insurance Contract and who, at the same time, undertakes to pay the premium.

1.1.3. Insured means the Policyholder or a natural person designated by same, who has given his/her consent, or whose legal representative has given consent, to the extension of the coverage of the insurance contract to him/her, and for whom the insurance contract is concluded in connection with events related to his/her state of health, and to whom the Insurer's risk bearing extends as set forth in these GTC and the List of Benefits as of the date of conclusion of the insurance contract. If the Policyholder and the Insured are different persons, the written consent of the Insured or the Insured's legal representative is required for the insurance contract to be concluded and for any amendment to that part of the contract pertaining to that Insured. If the Policyholder and the Insured are different persons, the Policyholder is required to inform the Insured of any statements addressed to the Policyholder and of any changes to the contract. The Insured may revoke his/her consent to the conclusion of the insurance contract, in writing at any time. If the Insured revokes his/her statement of consent, the Contract shall terminate with respect to the Insured at the end of the current insurance year, unless the Insured becomes a party to the Contract.

1.1.4. An Insured that is not the Policyholder can enter the Insurance Contract as the policyholder. Entry is subject to the notification of the Insurer by same in writing. A change in the identity of the Policyholder takes effect no earlier than the date on which the Insurer receives notification of such change. If the Insured enters the insurance contract as the policyholder, the Insured shall be jointly and severally liable with the policyholder for premiums due during the current insurance period. The Insured replacing the Policyholder is obliged to reimburse the Policyholder for the costs incurred by same in connection with the Insurance Contract, including the premium. Upon such entry, all rights and obligations of the contracting party will be transferred to the Insured.

1.1.5. *For the purposes of the Contract, the Insurer shall assume no risk in respect of individual having the following occupation or pursuing the following activities: acrobat, artiste, peacekeeper, armed guard, intelligence agent, legionnaire, stunt man, commando, money transporter, bodyguard, person doing military service as a professional/based on a contract in the army.*

1.1.6. *For the purposes of the Contract,* ***the Insurer shall assume no risk in respect of individuals who are professional sportspersons****.*

1.1.7. Within the framework of the Insurance Contract, the Insurer has no obligation to assume any risk in

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connection with any such person to be insured who is covered by another effective service financing health insurance plan concluded with the Insurer, which is in effect on the enrollment day specified in the proposal.

1.1.8. The Insured is obliged to submit a properly completed and signed Insured's Statement that is truthful and consistent with the Insured's identification documents, no later than before receiving medical care covered by the insurance contract.

1.1.9. The Policyholder may propose a Contract amendment aimed at the naming, enrollment and removal of another Insured in addition to the insured persons already covered by the Contract. The Policyholder may exercise this right by providing notice by the anniversary date of the Insurance Contract, no later than 30 days prior to such date.

1.2. The establishment of the Insurance Contract and the insurance relationship, start of risk bearing

1.2.1. Prior to the conclusion of the insurance contract, the Insurer will provide advice to the customer based on a product description about the insurance product being sold, and make a recommendation to the customer on the selection of a specific insurance product or products.

1.2.2. Before the acceptance of the proposal for the conclusion of the Insurance Contract, the Insurer may carry out a risk assessment and, as part of this, may ask the Insured to answer questions, and may require submission of the Insured's health statement, the execution of other medical examinations as necessary for screening and risk survey, and require submission of other legal statements by the Insured. The Insurer is entitled to check any data obtained in this way.

1.2.3. The Insured's statements and, where applicable, the Insured's responses to the questions from the Insurer, form part of the Contract and the proposal.

1.2.4. The Insurer may choose to accept the proposal or enrollment proposal or submit a modification proposal, or reject them within 15 days – or 60 days if health examination is necessary for the procession of the proposal – of receiving the proposal or enrollment proposal. If the Insurer rejects the proposal or submits a modification proposal, the Insurer has no obligation to justify its rejection or modification decision.

1.2.5. *For the Insured enrolled at the time of conclusion of the Insurance Contract, risk bearing by the Insurer shall commence on the date indicated by the Policyholder and the Insurer in the proposal or the contract documents, or in the Policy.*

1.2.6. If the proposal to conclude the Insurance Contract is accepted, the Insurer shall enter into an Insurance Contract with terms and conditions identical to those of the proposal, and shall issue a policy to certify the scope of the insurance coverage.

1.2.7. The Insurance Contract or the insured relationship shall take effect for the Insured also in case if the Insurer fails to respond to the proposal within 15 days or, if a health examination is needed for processing the proposal, within 60 days of receiving it or its delivery to the Insurer's representative, provided that the proposal

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was made in possession of the statutory information about the nature of the legal relationship, on the proposal form provided by the Insurer and in accordance with the rates provided by the Insurer.

1.2.8. If the policy evidencing the coverage deviates from the Policyholder's proposal or the written agreement of the Parties, and the Policyholder does not object to the deviation without delay after receiving the proof of cover, the Contract or the insured relationship for the Insured will be made with the contents included in the policy evidencing the coverage. This provision shall apply to material deviations only if the Insurer has drawn the Policyholder's attention to the deviation in writing when delivering the policy evidencing the coverage. Otherwise, the Contract will be made in accordance with the contents of the proposal.

1.2.9. If the Insurance Contract which was created without the Insurer's express statement or that part of it which applies to the insured relationship deviates from the regulations set forth in these GTC in any material respect, within fifteen days of the effective date of the Contract the Insurer may recommend the amendment of the Contract in line with these GTC. If the Policyholder does not accept this recommendation or fails to respond to it within 15 days, the Contract may be terminated by the Insurer within 15 days of receiving the modification proposal, on 30 days' written notice.

The Policyholder is bound by their proposal for 15 days after the submission of the proposal. Unless otherwise provided in these GTC, the Contract may be amended only by a mutual written agreement between the Policyholder and the Insurer.

1.2.10. The insurance contract is deemed to have been concluded once the Policyholder has paid the first premium and the Insurer has accepted the proposal. The Insured may revoke his/her insured's statement in writing at any time. As a result of such withdrawal, the Insurer's risk bearing for the insured in question shall cease as of 0:00 a.m. on the insurance anniversary date following the Insurer's receipt of the withdrawal notice. If the Policyholder fails to pay the first premium by the due date, the contract will not take effect. In the event of failure to pay the renewal premium, the application of Section 6:449(2) of the Civil Code of 2013 (Ptk.) shall not apply; that is, in connection with a contract terminated due to non-payment of the renewal premium, the policyholder cannot request the Insurer to reinstate coverage.

1.2.11. *If the Insurer becomes aware of any material circumstance regarding a Contract, or any changes thereof, only after the conclusion of the insurance Contract, and these circumstances bring about a considerable increase in the insurance risk, the insurance company shall be entitled to make a written proposal within 15 days after gaining knowledge thereof to amend the Contract or may terminate the Contract in writing on 30 days' notice.* If the Policyholder does not accept the proposal for amendment or fails to respond to it within 15 days from the time of receipt thereof, the Contract shall be terminated on the thirtieth day following the day of communicating the proposal for the amendment, if the Insurer warned the Policyholder of this consequence when the proposal for amendment was made. A significant increase in risk is deemed to exist, in

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particular, if the Insurer, based on material circumstances that have come to its attention, would normally apply a surcharge, exclusion, or rejection with respect to the contract. If the Insurer does not exercise this right, the contract remains in effect with its original content.

1.2.12. ***If the insurance risk has increased significantly with respect to an Insured, the Insurer is entitled, without providing a reason, to terminate the relationship of the Insured in question with immediate effect*****, but this shall not affect the insurance coverage of the other insureds named in the Insurance Contract.**

1.2.13. During the term of the Insurance Contract, the Insurer may carry out risk assessment upon the Policyholder's request for a service package that offers a broader range of services than the one selected under the Policy, or may reject such request without providing a reason. The Policyholder must notify the Insurer of any request to amend the contract as specified in this section, no later than 30 days prior to the insurance anniversary date. Depending on the outcome of the risk assessment, the Insurer is entitled to either approve or reject a request to amend the Insurance Contract. The Insurer shall notify the Policyholder in writing about the fulfillment of a request for amendment to the Insurance Contract, the terms and conditions thereof, or the rejection of such request. If the Insurer accepts a request for contract amendment initiated by the Policyholder, the amendment to the Contract shall take effect as of the policy anniversary date following the acceptance. The consent of the Insured concerned is required for entry into or the amendment of the Insurance Contract.

1.3. Term, insurance anniversary, insurance period

1.3.1. *The Insurance Contract* ***is entered into for an indefinite term based on the agreement of the parties.***

1.3.2. *Within the term, the insurance anniversary shall be that day in each calendar year which is shown in the proposal or the Contract/Policy as the initial date of premium payment (start of risk bearing).*

1.3.3. Unless otherwise agreed, *the insurance period is one year*, which commences at 00:00 AM on the day of the insurance anniversary in each year and lasts until the end of the day before the next insurance anniversary.

1.4. Cover change, package increase

1.4.1. Based on a separate agreement between the Policyholder and the Insurer, with reference to the Insurance Contract (policy number) and to the Insured, a request to modify the insurance cover – whether to a broader or narrower coverage package – can be submitted to the Insurer in writing, with effect from the anniversary date of the Insurance Contract, no later than 30 days before the anniversary date, provided that the Policyholder requests the modification of the cover applicable to the Insured; in other words, the Policyholder requests that instead of the individual health insurance package currently used for the Insured, another package from among the basic individual health insurance packages specified in the insurance contract be applied.

For the insurance period following the effective date of the modification, the Policyholder is obliged to pay a

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premium corresponding to the premium for the insurance package containing the revised cover.

1.4.2. Unless otherwise agreed, if a change of cover or a package increase is made possible by the agreement between the Insurer and the Policyholder, the **change of cover and package increase may be requested only with effect from the insurance anniversary date, after the first insurance period of the Insurance Contract.**

1.4.3. Unless otherwise agreed, **a request for change of cover will be considered a proposal at the same time**, and has to be sent to the Insurer in writing before the insurance anniversary at the latest, in such a way that the request is received by the Insurer at least 30 days before the insurance anniversary.

1.4.4. The Insurer will issue a proof of cover document for the Policyholder's request for change of cover and package increase; even if this is not done, the request will still be valid if the Policyholder has paid the premium corresponding to the change of cover or package increase to the Insurer within the payment deadline specified in the Contract and the Insurer has not rejected the request in writing before the anniversary date of the Insurance Contract.

1.4.5. The change of cover or package increase does not create a new Insurance Contract or insured relationship; the Contract or the insured relationship is modified.

1.4.6. The cover cannot be topped up in respect of the Insurance Contract; in other words, the Insurance Contract cannot be construed as allowing the premium to be topped up in the event that the sum insured for a given period of insurance is reduced by the amount paid out in respect of an insured event occurring in the same period of insurance.

1.5. Expiry and termination of the Insurance Contract or the insured relationship

1.5.1. The Insurance Contract, and thus risk bearing with respect to the insured in question, shall terminate:

a) at the end of the insurance year in which the Insured reaches the age of 70,

b) in case of the Insured's death, with respect to that Insured as of the date of death, which the Policyholder is required to report to the Insurer

c) in case of the Policyholder's death, as of the date of death, unless any of the Insureds joins the Contract as a Policyholder,

d) if the premium is not paid, as specified in Section 3.3 of these GTC,

e) in case of the subsequent termination of an insurance contract created through conduct indicating such intent (by implication), or in the event of a significant increase in the insured risk, by termination by the Insurer as specified in sections 1.2.11 and 1.2.12 of these GTC,

f) by the Insured, if he or she is not the Policyholder, through the written withdrawal of his or her consent to the conclusion of the Insurance Contract, as of the end of the current insurance period.

1.5.2. Termination or expiration of the Insurance Contract:

In the event of change in material circumstances affecting the Insurance Contract, or a breach of the

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obligation to disclose information and report changes, the Insurer may terminate the contract in accordance with Section 1.2.12. of these GTC.

1.5.3. *The Insurance Contract may be terminated by the Policyholder. The Policyholder may terminate the Insurance Contract in writing without providing a reason, effective at the end of the relevant insurance period. Notice of termination must be given to the Insurer no later than 30 days before the end of the relevant insurance period.*

1.5.4. *If the Policyholder fails to pay the due premium, the Insurer shall, with a warning of the consequences, issue a written notice for payment to the Policyholder, allowing a 30-day grace period from the date of sending the notice. If the grace period has expired without result, the Insurance Contract shall be terminated with retroactive effect to the due date, unless the Insurer enforces the claim for premiums in court proceedings without delay.* ***Within 4 months of the expiry of the grace period for premium payment without result, claim enforcement by the Insurer in litigation or non-litigation proceedings shall be deemed to be claim enforcement without delay.***

1.5.5. *In the event of the expiry or termination of the Insurance Contract for any reason, the insurance relationship of the Insureds shall also terminate at the same time as the termination of the Insurance Contract.*

1.5.6. *If the Policyholder rejects the premium amendment or the premium adjustment in accordance with Section 3.4.6, the Contract shall terminate on the last day of the applicable insurance period.*

1.6. Geographical scope of the Insurance Contract

1.6.1. Risk bearing by the Insurer *covers* the area of Hungary, *health care and services received in Hungary*.

II. Rights and obligations of the parties to the Contract

2.1. Obligations specific to the Insurer, the Policyholder and the Insured

2.1.1. The Insurer is obliged to inform the Policyholder in writing about the Insurer's main data and the main characteristics of the Insurance Contract before the conclusion of the Insurance Contract, in accordance with the Insurance Act. Accordingly, the Insurer shall provide the Policyholder, prior to the conclusion of the Insurance Contract, with the GTC forming part of the Insurance Contract, explaining the characteristics of the Insurance Contract, the Insurance Product Information Document, the List of Benefits, the Customer and Product Information (as set out in these GTC). The Insurer has to inform the Policyholder, while the Policyholder is obliged to inform the Insureds about the statements made to the Policyholder and any changes in the Insurance Contract.

2.1.2. Based on the information provided by the Insurer in its Customer and Product Information forming part of these GTC, in accordance with Section 152 of the Insurance Act, the Policyholder is obliged to inform the Insured in writing prior to his/her entry into the Insurance Contract about the Insurer's main data, and the

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characteristics of the Insurance Contract on the basis of these GTC and the Product Information.

2.1.3. In connection with his/her enrollment and during the fulfillment of the Insurance Contract, the Insured is obliged to cooperate with the Insurer and the Policyholder, particularly in respect of the assessment of any claim for benefit or risk. Based on his/her obligation to cooperate, the Insured is obliged to provide the data necessary for the procession of the claim, for risk survey and risk assessment, and enable the inspection of the reported data.

2.2. Obligation of the Policyholder and the Insured to notify and report changes

2.2.1. The Policyholder and the Insured are obliged to fulfill their obligation to notify and report changes.

2.2.2. The notification obligation means that at the time of proposal making, contract conclusion and enrollment, the Policyholder and the Insured are obliged to inform the Insurer of any and all circumstances that are known or should be known to them and are material to the acceptance of insurance. This obligation will arise upon conclusion of the Contract and remain in effect throughout the entire insurance relationship.

2.2.3. The parties will comply with their notification obligation by replying the Insurer's written questions truthfully, and by making the statements on the form provided by the Insurer for insurance purposes completely and in a trustworthy manner. Failure to answer questions and incomplete data supply shall not in themselves be considered breach of the notification obligation.

2.2.4. The Insurer may check the answers and data received. If an insured's year of birth is incorrectly recorded and it is determined that, based on the actual year of birth, the insurance relationship should not have been established, the Insurer shall, with respect to that insurance relationship, proceed as set forth in section 1.2.11. or may contest the contract.

2.2.5. The parties agree that the Insured and the Policyholder are obliged to notify the Insurer in writing and within a reasonable time about any change in material circumstances stated in the Insurance Contract (hereinafter "obligation to report changes"). Unless otherwise agreed, on the basis of the obligation to report changes, the Policyholder and the Insured are obliged to report in writing, within 8 days during the insurance term, any change in material circumstances stated under the Contract or in their statements.

2.2.6. Material circumstances are such circumstances that are regulated in the Insurance Contract and for which the Insurer asks a question in writing, further, in respect of which the Insurer has prescribed the obligation of the Policyholder and the Insured to make a statement. Material circumstances particularly include the Policyholder's and the Insured's name, bank account data, home address or residence, further, the address and mailing address of their registered seat, their citizenship, sex, contact data (telephone number, e-mail address), and the Insured's occupation, sport activities or their competition or professional nature, and, if there is any change in the Contact Person named by the Policyholder, the name, telephone number(s) and e-mail address of the Contact Person and, if applicable, the existence of the Insured's social security coverage (social security

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number) valid in Hungary.

2.2.7. The Insured has no obligation to inform the Insurer of the changes in his/her health condition.

2.2.8. *If the obligation to notify or report changes is not fulfilled, the Insurer's obligation to provide services shall not apply, save where it is proven by the Contracting Party that the Insurer was aware of the concealed or unreported circumstances at the time of the contract conclusion or such circumstances did not contribute to the occurrence of the insured event. The Insurer's obligation to provide services will neither apply in cases where the Insured fails to fulfill his/her notification obligation*, in particular, when the Insured fails to meet the deadline for notification and the submission a claim for benefit, and thus it becomes impossible to reveal material circumstances.

2.2.9. If the Insurer becomes aware of material circumstances that existed at the time of the contract conclusion after the contract conclusion, the Insurer may exercise the related rights during the first 5 years of the term of the Insurance Contract.

The Insurer's obligation applies despite any breach of the notification obligation if and when 5 years have elapsed between the conclusion of the Insurance Contract and the occurrence of the insured event.
The provisions of this section are applicable as appropriate to the consequences of any failure to meet the obligation to report any change in material circumstances defined in the Insurance Contract. The five-year period during which the Insurer can exercise its related rights commences on the day after the expiry of the deadline for reporting changes.

2.2.10. If the breach of the obligation to notify or report changes only occurs in relation to an individual Insured, the Insurer may not invoke the breach of the obligation to notify or report changes in relation to the other persons.

2.2.11. Both the Policyholder and the Insured are liable to fulfill the obligation to notify and report changes; none of them may make reference to any circumstances that either of them has failed to report to the Insurer although they should have been aware of it and should have been obliged to disclose or report it.

III. Premium

3.1. Determination of the premium

3.1.1. The premium is the consideration payable for the services of the Insurer, in particular, its risk bearing. **Calculation of the premium, i.e., the determination of the annual premium, is performed per Insured person, taking into account the service package and premium payment frequency selected by the Policyholder, based on the Insurer's rates**.

3.2. Premium payment, premium payment frequency, due date of premium payment

3.2.1. Unless otherwise agreed, the Insurance Contract concluded by applying these GTC is subject to

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regular annual premium. ***For Insurance Contracts with regular annual premiums, the annual premium can be paid on a monthly, quarterly, semiannual or annual basis. If the premium payment frequency differs from monthly payments, the Insurer will apply a discount as follows: for semi-annual premium payments, an amount equal to 3% of the annual premium; for quarterly premium payments, an amount equal to 2% of the annual premium, and for annual premium payments, an amount equal to 5% of the annual premium.***

3.2.2. *The first premium installment is due on the date of conclusion of the Insurance Contract as a condition for the conclusion of the Contract; after this, premium is due on the first day of the period to which the premium relates.*

3.2.3. The premium shall be paid as regulated in the Insurance Contract/Policy/Accounting document, in the manner, in the amount and at the time specified in it.

3.2.4. If the Insured's insured relationship terminates due to death during the insurance period, within 30 days of the termination the Insurer shall refund to the Policyholder the portion of the premium for the Insured's cover period that exceeds the portion proportional to the actual period of risk bearing during that period, without any interest. Any transaction and conversion fees will be borne by the Policyholder.

3.2.5. The obligation to pay the premium will be considered fulfilled when the premium is credited to the Insurer's account. Any premium (or premium installment) paid by the Policyholder to the Insurer before the conclusion of the Insurance Contract will be considered an advance premium, which the Insurer shall hold without any interest payment. If the Contract is concluded, the Insurer will include the advance premium in the premium. If the contract is not concluded, the Insurer will refund the advance premium to the Policyholder.

3.2.6. Regardless of the method of premium payment, the name of the Policyholder or such data that is suitable for identification of the Insurance Contract, particularly including the proposal/policy number or the identifier of the Contract in respect of which the premium is paid, must be indicated each time when premium is paid (e.g. as a note).

3.2.7. The Insurer shall set off payment made as premium against any past due debt of the same premium payer.

3.2.8. Method of premium payment

In view of the use of the "recurring payment" payment method, the Policyholder is required to pay the first premium installment under the Contract, as advance premium, immediately upon submission of the proposal. If the Insurer accepts the proposal, it will treat the advance payment as a premium; if the proposal is rejected, it will refund the advance premium to the Policyholder in accordance with these GTC. Recurring credit card payment is an automatic payment transaction in which, based on prior authorization, the Insurer deducts the premium at the intervals specified in the Contract (e.g., monthly, annually) by charging the credit card provided by the Policyholder. If, during the insurance period, the Policyholder cancels his/her credit card previously

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provided for recurring premium payments and fails to provide another valid credit card, issued in his/her name, by the due date of the next premium installment, then the Policyholder will be required to pay the unpaid premium for the remaining term of the insurance period in one sum within 15 days of the card's cancellation date, by transferring the amount to the bank account listed on the Insurer's website, and indicating the policy number of the insurance contract in the payment reference.

In this case, the insurance contract will terminate at the end of the insurance year, unless the Parties agree otherwise.

3.3. Consequences of the failure to pay premium

3.3.1. If the due renewal premium has not been paid by the Policyholder, the Insurer shall be entitled to refuse to fulfill the request for a service claim notified under the Insurance Contract and make it conditional on pre-financing by the Insured concerned (i.e. the Insurer suspends the fulfillment of the Insurance Contract). If the Policyholder pays the due premium within the additional time limit, he or she will be entitled to submit a subsequent request to the Insurer in respect of the medical care received on a pre-funded basis, and the Insurer will be obliged to reimburse the fee for such care to Policyholder/Insured if such care is covered by the insurance. If the Policyholder fails to pay the regular premium by the due date,, the Insurer shall, with a warning of the consequences, issue a written notice for payment to the Policyholder, allowing a 30-day grace period from the date of sending the notice. If the grace period has expired without result, the Insurance Contract shall be terminated with retroactive effect to the due date, unless the Insurer enforces the claim for premiums in court proceedings without delay. **Within 4 months of the expiry of the grace period for premium payment without result, claim enforcement by the Insurer in litigation or non-litigation proceedings shall be deemed to be claim enforcement without delay.**

3.3.2. If only a portion of the premium due on a continuing basis has been paid, and in accordance with the rules governing failure to pay premiums, the Insurer has unsuccessfully requested the Policyholder to pay the remaining balance, the contract will remain in force for a period proportionate to the premium paid.

3.3.3. If an insured event occurs or the Insurer has benefit payment obligation or pays benefit during the period of risk bearing by the Insurer, the Insurer is entitled to deduct from the amount of benefit(s) payable by it any premium due but not paid until the occurrence of the insured event or its benefit payment obligation or the benefit payment; further, in respect of the services covered by insurance, the Insurer may order a pre-financing obligation.

3.3.4. If, due to the Policyholder's failure to pay the premium, the Insured uses health services during the period while risk bearing by the Insurer does not apply, the health care provider is entitled to claim the fee of the service used directly from the Insured.

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3.4. Rules for premium adjustment and premium modification

3.4.1. The Insurance Contract can always be concluded on the basis of the product version and tariffs in force on the day when the Insurer received the proposal from the Policyholder, and the health insurance package applied for during the term of the Insurance Contract can be provided, unless otherwise agreed, according to the product version and tariffs version in force on the first day of the insurance period covered by the application.

3.4.2. For the purpose of premium indexation, the Insurer shall take into account the health care services and consumer price indices published by the Hungarian Central Statistical Office (hereinafter: KSH), which are calculated separately as follows: a price change percentage is obtained by multiplying the monthly price indices for the same range of the 12 months preceding the 2 months before the entry into force of the premium modification. The non-lower of these is the indexation percentage, by the amount of the indexation percentage the Insurer will increase the premium for the insurance period following the current insurance period.

The Insurer is ***entitled to apply indexation with the above specified value to its existing Insurance Contracts****, i.e. to modify the premium by such amount with effect from the insurance anniversary (hereinafter referred to as* ***premium modification for indexation)****. Unless otherwise agreed,* ***if the Insurer has not applied any premium modification for indexation for the premium applicable to the Contract in the current insurance period, it will be entitled to modify the premium with effect from the next insurance anniversary within the framework of premium modification for indexation, by applying the combined effect of the retrospective indexation values,*** *retrospectively for several years of up to 3 years or, if smaller, the number of consecutive years in which no indexation was applied to the premium of the Contract.*

3.4.3. The Insurer is entitled, with effect from the insurance anniversary date*, unless otherwise agreed* ***– with or without the application of the indexation premium modification described in section 3.4.2 – to adjust the premium based on the insurance cover applicable to the Insurance Contract and the Insureds, in order to maintain the cost-covering capacity of the insurance policies and to apply the principle of risk-proportionate premiums (hereinafter: premium adjustment).*** *When assess the development and change in the volume and/or frequency of use of health benefits covered by the insurance is the reference primarily is the data of the Insurer's own risk community, data for specific contracts, data on the risk measures characterising the package(s) within the contracts and their changes, but the Insurer may also use statistical data from the KSH.*

If the Insurer does not send a premium modification proposal to the Policyholder, the Contract will continue to be in effect with the same premium.

3.4.4. ***If the premium is modified because of premium modification for indexation under section 3.4.2 with***

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effect from the insurance anniversary date, the Insurer shall inform the Policyholder of any change in the premium in writing on the 30th day before the insurance anniversary.

3.4.5. If the premium is modified because of premium adjustment under section 3.4.4. with effect from the insurance anniversary date, the Insurer shall inform the Policyholder of any change in the premium in writing on the 30th day before the insurance anniversary. If the Policyholder does not reject the extent of premium adjustment under section 3.4.4 and the related premium modification in writing within 15 days of receiving the relevant notification, the Contract will remain effective from the insurance anniversary with contents corresponding to the premium modification. If the Policyholder rejects the extent of the premium adjustment under Section 3.4.4 and the related premium modification in writing within 15 days of receiving the relevant notification, then – based on the Insurer's decision and written notice – the Insurance Contract will terminate on the last day of the relevant insurance period or, if the Policyholder has not exercised its right of termination within the specified time limit, it will remain in effect with the premium amount without the adjustment, provided that the risk remains acceptable to the Insurer even at the unchanged premium, of which the Insurer is required to inform the Policyholder.

IV. Insured event

4.1. *Insured event means the use of a healthcare service for which the Insured scheduled an appointment with the Insurer's service provider partner after the conclusion of the insurance contract, indicating at the time of booking the appointment that he or she intends to use the service at the expense of the insurance and which the Insured uses during the risk bearing period for the Insured, by the Insured due to his/her illness - without any precedent to the period of start of the period of cover for the Insured - or accident. A screening examination specified in these GTC, in particular in the List of Benefits forming an integral part thereof, which the Insured person takes, by its content, for preventive purposes at a health care provider who complies with the rules of the Insurance Contract, is also considered an insured event. The Insurer or the Service Organizer is entitled to request additional documents from the Insured to establish that the use of the requested health care is related to an illness or accident or is requested for preventive purposes.*

4.2. *The screening examination can be used in any insurance period according to the content of the laboratory packages detailed in the health care provider Medicare Zrt. Screening Protocol in force (i.e. in force at the time of use), which may vary depending on gender, age and insurance package. The Screening Protocol will be made available by the Insurer.*

4.3. ***Only the use of such health services is considered an insured event which the Insured received at Medicare Zrt as health care provider or through it as service organizer, in the organization of, with the knowledge and approval of the same.***

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4.4. *The date of the insured event is the day of receiving health care or, in the case of continuous care for several days, the first day of care. For the purposes of these GTC, health services that are attributable to the same reason or reasons for injury, to health impairment or illness or to one and the same health problem will be regarded as one insured event, provided that such services are given on the same day or as part of the same health care, and belong to the same service type.*

4.5. The Contracting Parties may agree differently from what is stated in section IV in respect of the insured event.

V. Benefits provided by the Insurer, conditions for and due date of performance

5.1. General rules for the provision of benefits by the Insurer

5.1.1. *Upon the occurrence of an insured event, the Insurer's obligation to provide benefits shall cover the organization of the provision of medical, health and other services specified in the Insurance Contract/Policy and in these GTC, in particular in the List of Benefits forming an integral part thereof, at the health care provider specified in these GTC, and the reimbursement of the costs thereof, in accordance with the content and service limits of the insurance cover applicable to the Insured and subject to the provisions of these GTC.*

5.1.2. *The benefits provided by the Insurer, the limits for benefit and other limitations set forth in the Insurance Contract, and the other detailed rules of the provision of benefits are regulated jointly by the Insurance Contract/Policy, these GTC, and the List of Benefits forming a non-severable part of these GTC.*

5.1.3. The benefit limits shall be applicable in accordance with the content of the Insurance Contract in effect at the time when the insured event occurs.

5.1.4. The Insurer has discretionary powers in relation to the organization or refusal of services and the use of health services at the expense of the insurance, and has medical discretion in assessing the legal basis of the claim for benefits covered by the insurance.

5.1.5. The Insurer assumes no responsibility for the professional quality of any health care services provided by health care providers and for any harm caused by them to the Insured.

5.1.6. *Medicare Zrt, as Service Organizer, cannot organize services in cases where any of the relevant conditions set forth in the Insurance Contract, in particular, in these GTC and its part entitled "List of Benefits" is not satisfied.*

5.1.7. *The Insurer may request medical documents from the Insured, in particular, but not limited to, outpatient records, hospital discharge reports, examination records, nursing or care documentation, test reports, laboratory reports, diagnostic test images, prescriptions (copies), referral letters (copies), treatment plans, in order to verify the insurance cover prior to the fulfillment of a claim for benefits.*

5.1.8. If the Insured has more than one service financing health insurance plans in force at the Insurer at the same time, the Insurer will provide benefits only and exclusively on the basis of the Insurance Contract that

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provides the broadest cover or the cover with the highest total limit at the time of the insured event.

5.1.9. The Insured is obliged to comply with the health care provider's current regulations at the time of benefits and in relation to examinations organized by the Service organizer.

5.1.10. ***If the Insured fails to attend the scheduled examination or treatment and does not cancel it at the Service Organizer within 2 working days, or 3 working days in the case of endoscopic examinations, before the booked date of treatment through his/her own fault, and this results in the Insurer's obligation to reimburse the health care provider, in this case the Insurer shall not be obliged to reimburse the missed examination or treatment again if it is taken by the Insured, within 1 year of the date of such failure, on the basis of an unchanged medical reason.***

In connection with the cancellation or modification of appointments, the current cancellation and modification policy of the health care provider shall be taken into account; therefore, if the current cancellation policy of the provider is not in accordance with the provisions of this section, the provisions of the current policy of the provider shall apply. If a cancellation fee is paid by the Client to the health care provider, the previous paragraph of this section shall not apply.

5.1.11. ***In the event that the Insured cancels the booked surgery appointment within 2 weeks prior to the date of appointment for any reason (not including confirmed illness, other reason stated by medical opinion or change / resolution of symptoms), Medicare Zrt. shall be entitled to 100% of the fee paid to Medicare Zrt., as the health care provider performing the planned surgery, up to the date of cancellation, as default penalty. If the Insured cancels the booked surgery appointment more than 2 weeks prior to the date of appointment, Medicare Zrt. as the health care provider performing the planned surgery will be entitled to 50% of the fee paid to Medicare Zrt., up to the date of cancellation, as forfeit money. The provisions of this section shall apply also in cases where the Insured has not fully completed the required tests by the requested date or the required control test is not done for reasons for which the Insured is responsible.***

The provisions of this section shall be documented by Medicare Zrt. in the framework of the legal relationship between the Insured and Medicare Zrt. as the health care provider, following the booking of health care. If the other documents forming part of the legal relationship established by the booking of health care differ from those set out in this section, the documents provided by the health care provider shall apply.

5.2. Use of health services and assignment

5.2.1. In the case of an Insurance Contract concluded in accordance with these GTC, by an express written statement made in his/her Insured's Statement, assigns the amount of the insurance benefit to the party issuing the invoice for the health services received by the Insured and serving as the basis for the insurance benefits, in particular, to Medicare Zrt as health care provider, provided that Medicare Zrt has provided the health services that serve as a basis for the insurance benefits to the Insured or has paid their cost directly to the party providing

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them.

5.2.2. *The Insured is obliged to directly pay the cost of any health service provided by a health care provider not contracted by the Insurer to such provider, unless otherwise jointly agreed by the party providing the service and the Insurer in cases where the cost is covered by the insurance and the Contract, and the party providing the services settles the cost with the Insurer directly against an invoice and upon receiving the documents necessary for payment by the Insurer (hereinafter "direct invoicing"). If the Insurer and the health care provider do not use direct invoicing, the Insurer will reimburse the Insured for the costs subsequently, if a claim for benefits is submitted to the Insurer for the purpose of settling the costs, and the Insurer's obligation to provide benefits arises under the Insurance Contract. As a condition for this, any health service should be used as a service organized by or with the knowledge and consent of the Service Organizer.*

5.2.3. ***If the legal basis for the payment of insurance benefits does not exist under the Insurance Contract – including in particular: failure to pay premiums; the reason of the examination provided during the coverage review was not substantiated by the medical records* – and so the Insurer is not or not fully obliged to provide insurance benefits, *the Insured shall pay the cost of that part of the health care received by same in such cases that is not covered by the insurance to the party providing the health services and issuing the invoice for them*.**

5.3. Rules of and deadline for reporting an insured event or a claim for benefit

5.3.1. *The use of health services that constitute an insured event and are directly received by the Insured from Medicare Zrt do not have to be separately reported to the Insurer.*

5.3.2. *If* the Insured or someone else on his/her behalf other than the Insurer has paid the cost of the health service received to the health care provider providing such care, contracted by the Insurer, and thus the occurrence of the insured event *gives rise to a* subsequent *claim for reimbursement of costs* to the Insurer, and if the Insurer does not reimburse the costs to the health care provider directly, then *the occurrence of the insured event must be reported to the Insurer in writing within 15 days of the last day of the use of the health care or service*, the necessary information must be provided and the verification the content of the report and the information must be made possible.

If the Insurer has made the fulfillment of a claim for benefits notified under the Insurance Contract as set out in these GTC, *subject to pre-financing by the Insured concerned and the Insurance Contract has not been terminated due to the payment of the arrears, the Insurer shall reimburse the Insured's expenses against an invoice submitted by the Insured during the relevant insurance period*.

5.3.3. *If the Insured has paid the cost of health care under section 5.3.2 and the care is covered by the Insurance Contract, the Insured must submit the following for reimbursement of the health service costs:*

a) The original invoice for the health service issued in the Insured's name, which should be requested from the

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provider on or before the last day of receiving such service.

b) All health and medical documents of the health service provided in relation to the insured event (particularly including the outpatient form, hospital discharge report, examination sheet, nursing and care documentation, medical findings, laboratory form, any diagnostic images, (copies of) prescriptions and (copies of) referrals, treatment plan).

c) Apart from sections a) and b), the Insurer may require the submission of such documentation for the assessment of a claim for benefit without which such claim cannot be judged, particularly including the accident report if the claim for benefit is related to an accident and such report was raised.

d) If the claim for benefit cannot be judged on the basis of the available documentation, the Insurer may order that the Insured be medically examined at the Insurer's expense (hereinafter: medical examination necessary for claim judgment).

5.3.4. *If the documents required by the Insurer are not submitted despite a request or are submitted incompletely again, or if the Insured does not appear for the medical examination necessary for claim judgment, the Insurer will assess the claim for benefit on the basis of the available documents, and may refuse the claim by giving a reason.*

5.3.5. *The Insurer will pay cost refund benefits, if their legal basis exists, within 15 days of the submission of all necessary documents,* by credit transfer to a bank account kept at a financial institution, in the statutory domestic currency, *on the basis of the invoice and the services, subject to any benefit payment limits.* Any cost of conversion will be charged on the Insured.

5.3.6. *The Insurer's obligation will not apply in cases where the obligations specified in these GTC is not fulfilled, in particular, when the deadline for notification is not fulfilled and thus it becomes impossible to reveal material circumstances.*

5.3.7. Other provisions related to the provision of benefits by the Insurer are included in the List of Benefits forming an integral part of these GTC.

5.3.8. *The cost of health services* provided by a health care provider contracted by the Insurer (Medicare service points) and *covered by the Insurance Contract will be paid by the Insurer directly to the party providing such services if the health service used was organized by, with the knowledge and approval of Medicare Zrt.* and the service provider issues an invoice for such care to the Insurer.

VI. Exclusions

6.1. *Except if and to the extent that the List of Benefits provides otherwise, i.e. specifically stated to be covered by the insurance, risk bearing by the Insurer shall not cover the following events or events which are caused directly or indirectly, in whole or in part by*:

a) induced abortion (except for abortion necessary in order to save the mother's health or life, and cases of

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abortion necessary because of a crime, and for such interventions made because of the expected abnormalities of the fetus that medically justify the termination of pregnancy),

b) special procedures aimed at human reproduction, as defined by law, research involving embryos, eggs and sperms, surgical sterilization, further, examinations, treatment and surgeries related exclusively to the cessation of sterilization and any examinations, treatments and procedures related to any form of artificial insemination,

c) health services aimed at sex reassignment,

cs) health services qualifying as organ and tissue transplant as defined by law; the acquisition or implanting of prostheses, artificial and correction medical aids; dialysis,

d) prenatal care, childbirth (obstetric care),

e) events causally related to congenital, hereditary and acquired immunodeficiency conditions, e.g. events due to immunodeficiency, HIV, AIDS and sexually transmitted disease (STD),

f) dental care and treatment, other than dental care intended to stabilize condition upon an accident; if the dental care is specifically listed in the cover for the Insured, the following services will not be covered even in this case: tooth whitening, dental care related to dental jewelry, airflow (salt polishing), flour treatment, APF gel treatment, tooth sensitivity treatment, dental curettage treatment,

g) treatment and surgery for aesthetic purposes, capillary treatment by injection, radiofrequency or laser (known as sclerotherapy), further, endovascular varicose vein surgery, including glue, clarivein, laser or radiofrequency or conventional varicose vein surgeries (crossectomy, stripping),

gy) outpatient care, outpatient surgery, inpatient care and one-day surgery, unless specifically stated to be covered by the insurance (List of Benefits); if covered, inpatient care and one-day surgery not intended to diagnose the patient's illness, prevent the deterioration of his/her condition or restore his/her health, in particular, hospital stay by a person to take care of a person receiving health care, in particular, hospital stay of a parent because of his/her child.

h) treatment, care, rehabilitation of chronic diseases, including laboratory, imaging, advanced diagnostic tests and imaging follow-up of specific/known non-symptomatic conditions, except for the diagnosis of chronic diseases, initial setting of their treatment, acute care for their acute phases,

i) claims for benefits related to genetic diseases, chronic renal failure (stage IV, V, dialysis), autoimmune diseases (in particular but not exclusively rheumatoid arthritis, ankylosing spondylitis, myasthenia gravis, multiple sclerosis), inflammatory bowel diseases, neurological diseases (epilepsy, Parkinson's disease, dementia), insulin resistance,

j) care for patients requiring nursing and for dying patients (hospice), life-sustaining interventions, geriatric care, oncological diseases, including routine chemotherapy and radiotherapy for cancer patients, additional tests recommended by the oncologist, and tests, molecular diagnosis and staging (except staging before the first surgery) establishes the basis for the therapy of oncological diseases,

k) infusion treatments (e.g. circulatory treatments, vitamin therapies, etc.), medical research on humans as defined by law,

l) interventional radiology procedures (in particular, but not limited to stenting, thrombectomy),

ly) imaging procedures with specific radiopharmaceuticals or contrast agents (in particular, but not limited to liver-specific Primovist, octreotide),

m) rheumatological treatment, except when aimed at stopping the acute worsening of condition,

n) home visit, patient transport, home transport, further, health services related to the examination of the dead and to dead persons as defined by law, and transport of the dead, unless specifically stated to be covered by the insurance ,

ny) such healthcare services and to such extent that are financed or covered by social security or any other plan, such as private health insurance, particularly including health care from a health care provider financed by social security,

o) emergency care, planned health care not covered by the List of Benefits, rescue, emergency medical care,

p) health care and services qualifying as disaster and public health care tasks and services as defined by law, including failure to fulfill compulsory and age-related and/or job-related vaccination obligations

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stipulated by law and in medical recommendations,

q) detoxification, health care or health service due to alcohol, drug or addictive disorders,

r) sleep analysis (somnography, polysomnography, except respiratory pulse oximetry), medical treatment and care of psychiatric patients and illnesses, psychotherapy, clinical psychology (in particular: psychoanalysis, mental, depressive or psychological tests and treatments), mental disorders and illnesses,

s) non-conventional procedures, biological therapy, natural therapeutic treatment, physical therapy, therapeutic massage, acupuncture, alternative medicine, wellness services, therapeutic education, speech therapy, physiotherapy, physicotherapy, spa therapy, weight loss therapy, natural remedies, spa and climatic medical institutions, health resorts, treatment provided by a person without a medical or health professional qualification and license, and the activities of a health expert, as defined by law,

sz) claims for services connected with the following contagious diseases: tuberculosis, tetanus, polioviruses, measles, mumps, rubella, hepatitis B, C, D virus infections, diphtheria, pertussis, infectious diseases caused by previously unknown new pathogens, introduced tropical diseases such as malaria, yellow fever, cholera, dengue fever, leishmaniasis, West Nile fever, chikungunya virus, Crimean-Congo blood fever, SARS, Lyme disease,

t) visual correction surgery or procedure on the cornea, visual correction devices and eye test not performed by an eye specialist, hearing aid and accessories, and acquisition, administration and refund of vaccines

ty) medicines, bandages and medical aids, unless they form an inseparable and direct part of health care, medical treatment or procedure covered by the insurance package.

u) secondary prevention, prevention defined by law, and other kinds of preventive care, screening examinations and medical examinations, except for screening examinations forming part of health survey ordered or offered by the Insurer,

v) the insured event is directly related to the Insured's attempted suicide, regardless of whether or not the Insured committed the suicide attempt while having a disturbed state of mind for any reason,

w) events, risks, health benefits excluded on the basis of and as a result of the risk assessment, listed in detail in the Contract.

6.2. *Further, risk bearing by the Insurer does not cover events that are partly or fully due to ionizing radiation, nuclear energy, war, acts of war, hostile acts by foreign power, disturbance, coup or attempted coup against the government, revolt, civil war, revolution, riot, terrorist acts, workplace disorder, frontier incidents, rebellion or protest meeting, demonstration and strike, except for participation in a protest meeting, demonstration or strike that has been notified in advance and is conducted in accordance with the provisions of the effective laws, if the Insured has fulfilled its obligations to prevent and mitigate damage.*

For the purposes of these GTC, in addition to the cases stated in the applicable Criminal Code, including its amendments, terrorist act means, in particular, violent acts or acts threatening with violence that endanger human life, material and immaterial goods or the infrastructure, and either supports political, religious, ideological or ethnic purposes or is aimed at or is suitable for influencing the government or provoking a state of terror in society or a part thereof.

6.3. The Insurer *excludes* from risk bearing *any such events that are partly or completely due to the Insured's accident before his/her entry (the extension of the insurance cover to him/her) or his/her illness or suspected illness in case of which evidence is available that it existed within 3 years before the Insurer's start of risk bearing for the Insured and was diagnosed before the start of risk bearing, or was diagnosed or required health care or caused a health complaint or required the use of health services within 3 years before the Insurer's start of*

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risk bearing for the Insured. Further, risk bearing by the Insurer will not cover events caused, in part or in full, by the Insured's inherited (genetic) or congenital disease or his/her permanent health impairment diagnosed before the start of risk bearing by the Insurer.

6.4. *For the purpose of these GTC, risk bearing by the Insurer shall not cover events of which occurrence is related to the Insured's pursue of the extreme sport activities defined by the relevant law, and in particular the following sport activities: car-motor sports (e.g. car-crash or wrecked car sports, go-kart, motocross, rally), caving, cave expeditions, base jumping, BMX cross, BMX and skate, bungee jumping, diving with aqualung under 40 meters, one-hand and open-sea sailing, parachuting, wall climbing, any kind of car race, speed cycling, mountain climbing, rock climbing from grade V, hot air ballooning, jet-ski, airship, high-mountain expedition, motorboat sport, any kind of motorcycle race, stunt-flying, quilt gliding, quad, hang-gliding and ultralight gliding, paragliding, sport flying, wild rafting, water ski, sailplaning, light sport aviation, canyoning, mountainboard, ski acrobatics, ski-jumping, all-in wrestling.*

VII. Exemption

7.1. *The Insurer shall be exempted from its obligation to provide benefits if it can prove that the insured event or the loss was caused by the unlawful or intentional conduct or gross negligence of the Insured or the Policyholder or a relative living in the Insured's household.*

7.2. *The person causing the insured event or the loss has acted with gross negligence, in particular, if*

a) *evidence is available that at the time of the insured event, he or she was in a drunken state or under the influence of illicit drugs, psychoactive or narcotic substances or medication taken by ignoring the instructions or with no medical reason at all, and this fact played a role in the occurrence of the accident or the health injury.*

If a blood alcohol test has been done, a person is considered to have an alcoholic condition if he/she has alcohol in his/her system from the consumption of a spirit drink capable of causing a blood alcohol concentration of more than 0.50 grams per liter or an air alcohol concentration of more than 0.25 milligram per liter.

b) *he/she drove a vehicle with no valid vehicle license or for which he/she had no valid driving license and this played a part in the occurrence of the insured event.*

c) *the Insured has breached at least two traffic regulations or occupational health and safety regulations at the time of the insured event, or the Insured has breached any occupational health and safety regulations at the time of the insured event and this fact is causally linked to the occurrence of the insured event.*

d) *the insured event is associated with regular alcohol consumption or the consumption of illicit drugs, psychoactive or narcotic substances or the taking of medication by ignoring the instructions or with no medical reason at all.*

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7.3. In the interest of loss prevention, *the Insured is obliged to act as generally expected under the given circumstances*, in particular, in the event health complaint and when using health services.

Upon the occurrence of an accident or illness which is the basis of an insured event, the Insured is required to immediately seek medical attention, continuously fulfill the instructions of the treating physician or health personnel until the end of treatment, and *act as generally expected under the given circumstances in the interest of loss mitigation. To the extent of the Insured failing to fulfill these obligations, the Insurer will be relieved of its obligation to provide benefits, on the understanding that on the one hand, in the course of applying the rules related to the loss mitigation obligation, it will not be regarded as a reason leading to the Insurer's relief if the Insured, by exercising his/her legal rights, does not consent to a medical intervention and, on the other hand, upon the occurrence of an insured event, the Insured has no obligation to take action to maintain condition.* However, the Insured's right to choose a doctor and health care provider cannot be restricted.

7.4. *The Insurer shall be exempted from providing the service in all cases expressly provided for in these GTC, and also in cases where the Insured is covered by other insurance under which insurance benefit has been paid for the insured event occurred (with the exception of such claims arising from the occurrence of the insured event that are not covered by any other Insurance Contract).*

7.5. The validity of the circumstances and facts related to such exemption must be proven by the party making reference to it.

7.6. The Insurer's obligation will not apply in cases where the obligations specified in the GTC is not fulfilled, in particular, when the deadline for notification is not fulfilled and thus it becomes impossible to reveal material facts.

VIII. Handling complaints, difference of opinions

8.1. *Complaints about the conduct, activity or omission of the Insurer, an agent employed or engaged by the Insurer or a person involved in supplemental insurance mediation engaged by the Insurer for a product, in relation to the Contract, insurance product or insurance mediation must be reported in writing to the Insurer at the following address: H-1134 Budapest, Váci út 29-31. Customer service, by telephone: +36-1-465-3188, or electronically by using the complaint form posted on the Insurer's website.*

8.2. *The Insurer is obliged investigate complaints reported to it in writing, and inform the party making the complaint about the result of the investigation in writing within 30 days of receiving the complaint.*

8.3. *If an insurance related complaint is rejected by the Insurer or not answered by the Insurer within 30 days of the receipt of the complaint by the Insurer, consumers can turn to the customer service of the National Bank of Hungary (Magyar Nemzeti Bank) established to receive inquiries on Financial Consumer Protection (mailing address: 1534 Budapest, BKKP Pf.: 777, telephone: (+36-80)-203776, e-mail: ugyfelszolgalat@mnb.hu), or to the*

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Financial Arbitration Board (Pénzügyi Békéltető Testület) (mailing address: 1525 Budapest, Pf.: 172, telephone: (+36-1)-489-9700, (+36-80)-203-776, website: *www.penzugyibekeltetotestulet.hu*, place of hearing: *1133 Budapest, Váci út 76.), or can turn to the competent courts. Customers that do not qualify as consumers can turn to the court for legal remedy.*

8.4. *The Insurer publishes its current complaint handling policy on the medicarebiztosito.hu website.*

8.5. If the Customer disputes the Insurer's decision about a claim for benefits or any other issues related to the Contract, he/she may submit a written application for the revision of such decision using the contact details indicated in section 8.1.

IX. Supervisory bodies of the Insurer

9.1. The professional supervision of the Insurer is exercised by the National Bank of Hungary (registered office: 1013 Budapest, Krisztina körút 55., postal address: 1850 Budapest).

9.2. *Insurance contracts created by applying these GTC shall be governed by the Hungarian laws, and any legal disputes arising from the Insurance Contract shall be submitted to the Hungarian courts.*

9.3. The Insurer represents that it wishes to resolve any dispute rising out of or in connection with Contracts created subject to these GTC amicably, by direct negotiation with its customers.

9.4. Issues referred to and matters not regulated in these GTC shall be governed by the Hungarian law, the effective Hungarian legal regulations, particularly including Act V of 2013 on the Hungarian Civil Code and Hungarian Act CLIV of 1997 on Health.

9.5. The Insurer shall publish its annual solvency and financial condition report on its website.

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X. Miscellaneous

10.1. ***Claims enforceable under the Contract will lapse 2 years after the occurrence of the insured event.***

10.2. When a policy (document verifying insurance cover) has been lost or destroyed, at the request of the Policyholder or the Insured or premium payer, the Insurer will issue a new policy with the same contents as the effective original one and send it to the Policyholder or the Insured, and the relevant costs shall be borne by the Policyholder or Insured making the request.

10.3. Legal statements are valid only if made in writing. Communication between the Insured and the Policyholder at the e-mail address provided by them on the separate statement for communication shall be deemed to be made in writing. As a rule, communication will be via the contact e-mail addresses indicated in a separate statement, so the Insurer and the Policyholder will consider the legal statement made in this way as legally binding communication.

10.4. The language of the Insurance Contract is Hungarian.

10.5. In the event of disputes related to the Contract, the Hungarian version of the contract documentation (if the Contract has a bilingual part), will prevail.

10.6. The notification of the Proposal and the Policyholder's Statement and the Insured's Statement shall takes effect when brought to the attention of the Insurer.

10.7. The legal statement sent by the Insurer to the contact e-mail address of the Policyholder or the Insured indicated on a separate statement shall be deemed to have been delivered on the working day following the dispatch of the electronic mail. The Insurer's sending of a payment reminder to the email address provided by the Policyholder as the delivery address for invoices regarding the insurance premium shall be deemed a valid notification.

10.8. In the event of a change of e-mail address, the Policyholder and the Insured must notify the Insurer of the new contact details within 3 working days of the change. In the event of failure to do so, information and legal statements sent by the Insurer to the Policyholder or the Insured to the e-mail address provided by them shall be deemed to be legally binding and communicated. The defaulting party is responsible for the consequences of failing to notify the change in accordance with this section.

10.9. The Insurer and the Policyholder shall consider electronic signatures provided by trust service providers, or other electronic signature solutions and technologies (in particular, but not exclusively, the following providers and solutions: DocuSign, DÁP, eSignature, Microsec, Netlock, Adobe Acrobat Sign, FaceKom) adopted by mutual agreement of the Parties, as valid and legally binding signatures on the contractual documents.

XI. Distance selling information

11.1. If the insurance contract that the Policyholder intends to enter into is concluded without the simultaneous

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physical presence of the consumer and the service provider, the provisions of Act XXV of 2005 on Contracts for Financial Services Concluded by Distance Selling (hereinafter: the "Distance Selling Act") shall apply.

11.2. Pursuant to Section 3(2)(ca) and Section 6 of the Distance Selling Act, a policyholder who qualifies as a consumer under the said act may, with immediate effect and without giving a reason, terminate the contract within 14 days of the date of its conclusion (or, if concluded by implication, of the date of making the proposal), provided that the contract was concluded between the Insurer and the Policyholder classified as a consumer within the framework of organized distance selling in such a way that for the conclusion of the Contract, the Insurer used exclusively a means of distance communication as defined in Section 2(1)(g) of the Distance Selling Act. The Policyholder does not have the right of termination in the case of insurance policies with a term of no longer than one month. The Policyholder may terminate the contract with immediate effect within fourteen days of the date of its conclusion, without giving a reason.

11.3. The notice of termination must be sent by the Policyholder in writing to the Insurer by email to ugyfelkapcsolat@medicarebiztosito.hu . The right of termination shall be deemed to have been exercised in a timely manner if the Policyholder sends his/her relevant notice by email in a verifiable manner before the deadline specified in paragraphs (1) through (8) of Section 6 of the Distance Selling Act to the Insurer's email address specified in this section.

11.4. The Insurance Contract terminates on the date the written notice of termination is received by the Insurer. Before the expiry of the period within which notice of termination may be given, the Insurer may only begin providing services under the contract after the Policyholder's explicit consent. If the Policyholder enters into the contract with a risk bearing start date that falls within the period within which notice of termination may be given, the Insurer will also consider this as consent to the start of providing services.

11.5. Pursuant to Section 8 of the Distance Selling Act, if the policyholder exercises the right of termination as described above, the Insurer may only claim the proportionate consideration for the services actually provided in accordance with the contract, that is, the proportionate consideration for the risk borne up to the date of contract termination. The amount to be paid by the policyholder is therefore the amount proportional to the services already provided (risk bearing) relative to the total benefits specified in the contract. Compensation for services related to the contract conclusion may be claimed only to the extent proportionate to the other benefits actually provided under the contract. If the contract is terminated as described above, the Insurer will be obliged to refund to the Policyholder, immediately upon receipt of the notice of termination but no later than 30 days thereafter, the portion of any premium already paid by the Policyholder that exceeds the amount proportional to the risk bearing provided up to the date of termination.

11.6. There will be no additional cost for the consumer from the use of the telecommunications device.

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XII. Rules for electronic contracting and electronic communication

12.1. Technical steps for contract conclusion, confirmation of the insurance proposal

After registration at the electronic sales platform of Medicare Zrt. as a tied agent fo the Insurer at online.medicare-group.hu and submission of the insurance proposal, the data is automatically processed in the Insurer's IT system. The insurance contract is concluded electronically on the online.medicare-group.hu website after the Policyholder has registered and provided the required information and submitted the proposal. The steps of contract conclusion are displayed on the platforms and can be tracked. Upon receipt of the proposal, the Insurer will send a confirmation email to the email address provided in the proposal, in which it will send the Policyholder the Contract Documents, issue a policy confirming the contract conclusion, and forward to the Policyholder an accounting document containing information about the premium.

12.2. The written form, language, recording of the contract and making it available constitutes a written insurance contract concluded electronically as specified in paragraph 1. The language of the insurance contract and all communications is Hungarian. The details of contracts concluded electronically, as well as the Contract Documents, will be sent to the Policyholder in electronic form.

12.3. If you find an error in the proposal after its submission, please contact our staff by email at ugyfelkapcsolat@medicarebiztosito.hu.

XIII. Data management and other provisions

13.1. Processing of the Customers' personal data

Detailed information about the processing of personal data, particularly including the purpose, legal basis, period of processing by the Insurer, the recipients and about the data subjects' rights are included in the applicable Privacy Information forming a non-separable part of these GTC (published at the medicarebiztosito.hu website).

13.2. Rules concerning the processing of personal data constituting insurance secret

13.2.1. *Pursuant to the Insurance Act, the insurer is entitled to process those data of its customer constituting an insurance secret that are related to the insurance contract, its conclusion, registration, and the service provided. The purpose of data processing is restricted to purposes necessary for the conclusion of the insurance contract, its amendment and maintenance and the judgment of claims arising from the insurance contract, or other purposes set forth in the Insurance Act.*

Processing for purposes other than those set out above may be carried out by the insurer only with the prior consent of the customer. The customer may not suffer any disadvantage by refusing to give such consent, nor may he or she be offered any inducement to give it.

The health data relating to the health of the customer, as defined in the Act on the processing and protection

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of health and related personal data, may be processed by the insurer for the purposes set out above, in accordance with the provisions of the said Act, only with the express consent of the data subject. Unless otherwise provided by law, the Insurer's owners, executives, employees and all those who have had access to any insurance secret in any way during their activity connected with the Insurer are obliged to keep such information confidential without any time limit. The insurer uses processors and providers engaged in outsourced activities for data processing, on the basis of agreements that comply with the relevant legal requirements.

13.2.2. *Insurance secret may be disclosed to third parties only if the Insurer's Customer or the Customer's legal representative has consented to this in writing by accurately specifying the insurance secret that can be disclosed, or if no confidentiality obligation applies according to the Insurance Act or if it is learnt during a certification procedure through a certification body assigned by the Insurer, or if the Insurer's interest requires this for the sale of its claim against the Customer or for the enforcement of its claim.*

13.2.3. *The obligation to hold insurance secret in confidence does not apply, in particular, to disclosure to*:

a) the National Bank of Hungary as Supervision Body acting in its competence as such,

b) the body conducting the preparatory procedure, the investigation authority and the public prosecutor's office, as well as the police, as well as the police acting in their capacity as the authority responsible for the prosecution of offences, and the National Tax and Customs Administration,

c) the proceeding court and the expert assigned by the court in criminal cases, civil court or out-of-court or administrative procedures, the independent bailiff acting in execution cases, the administrator in bankruptcy proceedings, the provisional or extraordinary administrator in liquidation proceedings, the main creditor acting in a natural person's debt settlement procedure, the Family Insolvency Service (Családi Csődvédelmi Szolgálat), the family administrator, the courts,

d) the notary public acting in estate cases and the expert assigned by same,

e) the tax authority in the cases stipulated by law,

f) the national security service acting in its competence as such,

g) the Office of Economic Competition (Gazdasági Versenyhivatal) acting in its competence as such,

h) the court of guardians acting in such competence,

i) the health administration body in the cases specified in section 108(2) of Act CLIV of 1997 on Health,

j) the body authorized to collect confidential information upon existence of the conditions set forth in the applicable laws,

k) co-insurers, another member of the group, and, in the case of joint insurance, the insurers assuming the risk,

l) the insurance policy registration body keeping insurance policy records in respect of the transfer of data

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as governed by law,

m) the recipient Insurer in respect of Insurance Contracts handed over upon the transfer of the contract stock, in accordance with the relevant agreement,

n) the organization managing the Indemnification Account and the Indemnification Fund, the National Office, the correspondent, the Information Center, the Indemnification Organization, the loss adjustment officer and the loss representative in respect of the data necessary for loss adjustment and the enforcement of a claim for refund and their transfer among one another, further, the person causing the loss if, based on his or her right of self-determination, he or she wishes to have access to the repair data of the other vehicle involved in the accident, included in the loss statement report raised during loss adjustment upon a road accident,

o) the party to which an activity has been outsourced in respect of the data necessary for the execution of such activity, and the auditor in respect of the data necessary for fulfilling the auditor's tasks,

p) a commissioner of basic rights acting in his/her competence as such,

q) the National Authority for Data Protection and Freedom of Information acting in its competence as such,

r) the authority registering the liquidation bodies

if approached in writing by a body or person listed in paragraphs a) through j), n) and r) above, and such written request contains the customer's name or identifies the Insurance Contract, the type of data requested, and the purpose and legal basis of the data request, on the understanding that the body or person listed in paragraphs p) and q) above only has to identify the type of the requested data and the purpose of and legal ground for such request.

Making reference to the provision of law giving entitlement to acquire the data in question is also accepted as verification of the purpose and legal ground.

13.2.4. *The obligation to hold insurance secret in confidence does not cover disclosure to the tax authority when, in tax matters, the Insurer has a statutory obligation to make a statement upon the tax authority's request, or if the Insurer has a statutory obligation to supply data about payment subject to tax payment obligation, made under an Insurance Contract.*

13.2.5. *The obligation to hold insurance secret in confidence does not apply to the financial institutions specified in the Act on Credit Institutions and Financial Enterprises in respect of Insurance Contracts related to claim from financial services if the financial institution approaches the Insurer in writing and such request contains the customer's name or identifies the Insurance Contract, the type of the data requested, and the purpose, legal basis of the data request, and the purpose.*

13.2.6. *The insurance secret shall not be considered breached if the data supply by the Insurer to the tax authority is limited to the fulfillment of the obligations stipulated in sections 43/B-43/C of Act XXXVII of 2013 (hereinafter Administrative Cooperation Act) on the rules of international administrative cooperation related*

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to tax and other public charges pursuant to Act XIX of 2014 on the promulgation of the Agreement on the facilitation of international tax compliance between the Government of Hungary and the Government of the United States of America and the implementation of the FATCA regulation, and the amendment of related acts (hereinafter the FATCA Act). It will not be regarded as breach of insurance secret if data supply by the Insurer to the tax authority is limited to the fulfillment of the obligations set forth in section 43/H of the Administrative Cooperation Act and, pursuant to the FATCA Act, in sections 43/B and 43/C of the Administrative Cooperation Act.

13.2.7. *The obligation to hold insurance secret in confidence also applies to the employees of the above bodies outside the framework of the procedure.*

13.2.8. *Further, at the written request for data supply or other written request of the national security service, the body performing the preparatory procedure, the investigation authority, the district attorney or the court, the Insurer is obliged to provide prompt written information if it is suspected that the insurance case is associated with*

a) abuse of drugs, abuse of new psychoactive agents, terrorist act, the unlawful use of explosives or blasting materials, the unlawful use of gun or ammunition, money laundering, criminal act committed in complicity or criminal organization as defined in Act IV of 1978 which was in effect until 30 June 2013,

b) abuse of new psychoactive substanceds under the Criminal Code which was in effect until 15 June 2025, or

c) illicit drug trading, possession of illicit drugs, arousal of addiction or facilitation of the preparation of illicit drugs, abuse of mind-altering substances,, terrorist act, failure to report a terrorist act, the financing of terrorism, unlawful use of explosives or blasting materials, unlawful use of gun or ammunition, money laundering, criminal act committed in complicity or criminal organization, as defined in the act on Criminal Code.

Insurance secret and business secret shall not be considered breached when the group inspection report is disclosed during supervisory inspection to the executive member of the financial group.

13.2.9. *The obligation to hold insurance secret in confidence does not apply in cases where the Insurer fulfills its obligation to notify as set forth in the act concerning the implementation of financial and property restrictive measures ordered by the European Union and the UN Security Council.*

13.2.10. *The obligation to hold insurance secret in confidence does not apply to disclosure to*:

a) a Hungarian criminal investigation body – acting on the basis of an international commitment, in the interest of fulfilling a written request made by a foreign criminal investigation body – submit a written request for the supply of information constituting insurance secret,

b) a regulatory authority acting as a financial information unit submits a written request for information

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constituting insurance secret within its competence specified in the act on the prevention and combating of money laundering and the financing of terrorism or in the interest of the fulfillment of a written request from a foreign financial information unit.

13.2.11. *Data transfer by the Insurer to an insurer, reinsurer in a third country or a data processing body in a third country will not be regarded as a breach of insurance secret if:*

a) if the customer of the Insurer (hereinafter referred to as the "data subject") has given his/her written consent or, in the absence of the data subject's consent, if the transfer

b) meets the requirements for the transfer of personal data to a third country.

When data constituting insurance secret is forwarded to another member state, the rules relating to forwarding data within Hungary are applicable.

13.2.12. *Insurance secret shall not be considered breached by*

a) the supply of aggregate data from which the person or business data of the individual customers cannot be traced back,

b) transfer of data not constituting personal data to the competent minister for the purpose of data supply for legislation and the execution of impact studies,

c) data transfer in the interest of fulfilling the provisions set forth in the act on the supplementary supervision of financial conglomerates.

The Insurer may not refuse to provide the data specified in this paragraph by making reference to the protection of insurance secret.

13.2.13. *The personal data included in the data transfer records shall be deleted 5 years after their transfer, and transferred data constituting sensitive data or criminal personal data shall be deleted, 20 years after their transfer.*

13.2.14. *The Insurer may process personal data during the period of the insurance or agency relationship and during the period in which a claim can be enforced in connection with the insurance or agency relationship.*

13.2.15. *The Insurer may process personal data connected with an insurance contract that has not been concluded as long as the claim connected with the failure of contract conclusion can be enforced.*

13.2.16. *The Insurer is obliged to completely delete such personal data connected with its customers or former customers or with contracts that have not concluded, in the case of which the data processing purpose no longer exists or that are not covered by the consent of the person to whom they apply, or the processing of which lacks a statutory basis.*

13.2.17. *The provisions of law relating to the processing of personal data are applicable to the processing of the data of deceased persons. In respect of data that can be associated with a deceased person, the rights of such person may be exercised by his or her heir and the beneficiary named in the Insurance Contract.*

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13.2.18. *In order to protect the interests of the risk community, in performing its statutory or contractual obligations, the Insurer (for the purpose of this section, the approaching Insurer) may approach another Insurer (for the purpose of this section, the approached Insurer) in the interest of the fulfillment of services in accordance with the relevant laws or contract and the prevention of unlawful action related to insurance contracts as defined by law by such Insurer, in respect of the data managed by taking into account the characteristics of the insurance product, provided that the relevant authority of the approaching Insurer was specified in the insurance contract. The approached Insurer is obliged to submit the data requested in accordance with the relevant laws to the approaching Insurer by the deadline stated in the request or, in the absence of such deadline, within fifteen days of receiving the request.*

The approaching Insurer may request the following data in connection with the fulfillment of a contract pertaining to the accident, disease and life insurance branch:

a) the data of the Policyholder, the Insured and the beneficiary;

b) data about the insured person's health at the time of the data recording, related to contractual risks;

c) data of the person specified in paragraph a) about previous insured events related to a contract belonging to the branch defined in this paragraph;

d) data necessary for the survey of risk related to the conclusion of the contract with the approached Insurer; and

e) data necessary for examining the legal basis of the benefits to be provided under the contract concluded with the approached Insurer.

Any such request should contain the data necessary for the identification of the person, property or property rights covered by the request, the type of the data requested, and the identification of the purpose of the request for data supply. The request and its fulfillment do not constitute a breach of insurance secret. The approaching Insurer is responsible for the existence of the entitlement to approach. The approaching Insurer may manage the data learned as a result of the request for ninety days after their receipt. If the data learned by the approaching authority as a result of the request is necessary for the enforcement of the legitimate interests of such Insurer, the period of data processing will be extended until the completion of the procedures initiated for the enforcement of such interests. If the data learned by the approaching Insurer as a result of the request is necessary for the enforcement of the legitimate interests of such Insurer, and the procedures is not started within a year after learning such data, the data can be managed for one year after learning them. The approaching Insurer will inform the customer affected by the request about the request and its fulfillment, and the data covered by it, at least once during the insurance period. If the customer requests access to his or her personal data, and the requesting insurer no longer processes the data covered by the request, the applicant must be informed of this. The requesting insurer may not link the data obtained as a result of the request to

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any other data not relevant to the insured interest, learned or managed by it, for any purposes other than those defined in this section.

The requested Insurer is responsible for the correctness and accuracy of the data provided upon the request.

13.2.19. *When processing data, the Insurer shall comply with the relevant EU and Hungarian data protection regulations, the provisions of Act LXXXVIII of 2014 on Insurance Activities and any other applicable legislation.*

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