



Terms and Conditions

Foreign Visiting Students

Group Sickness Insurance

Valid from: 1 January 2018

Customer information

Dear Customer,

Please **read carefully** the Insurance Product Profile, this Customer Information leaflet and the detailed terms and conditions of the related insurance product, i.e. the Insurance Terms and Conditions, **prior to the insurance quote**.

I. Insurance company:

- name: **UNIQA Biztosító Zártkörűen Működő Részvénytársaság**
- registered seat: 1134 Budapest, Róbert Károly körút 70–74.
- activity: insurance activity

II. Supervisory body

The supervisory body of the Insurer: **National Bank of Hungary (MNB)**

III. Report on solvency and financial situation

The report is available on the website of the Insurer (www.uniqa.hu).

IV. Advising

With respect to the insurance product stipulated in this Customer Information and the related insurance terms and conditions, the Insurer provides

- advice if the insurance is sold through a tied insurance mediating agent.

If the insurance product stipulated in this Customer Information and the related insurance terms and conditions is mediated to you by an independent insurance mediating broker or a tied insurance mediating multi-agent, please consult the insurance mediating (customer) information leaflet of such broker, multi-agent whether they provide consultancy services..

V. Remuneration paid to contributors

Non-insurance broker contributors of the Insurer sell insurance products within the framework of employment for which they receive remuneration typical for labour law relationships.

VI. Further important information on the insurance product:

- the insurance **period and term are defined** in Sections 5 to 13 of the Insurance Terms and Conditions;

- the **commencement date of the Insurer's risk** are set out in Sections 15 to 21 of the Insurance Terms and Conditions;
- the **insured event** are defined in Sections 64 to 67 of the Insurance Terms and Conditions;
- the terms and conditions of **premium payment** are set out in Sections 95 to 99 of the Insurance Terms and Conditions;
- the Insurer's **services, the time and manner of performance thereof** and the options are stipulated in Sections 68 to 92 of the Insurance Terms and Conditions
- information on **the termination of the insurance policy** are stipulated in Sections 22 to 24 of the Insurance Terms and Conditions;
- the terms and condition of **terminating the policy** are stipulated in Section 22.1 of the Insurance Terms and Conditions;
- the Insurer's release and the **unacceptable (excluded) risks** are regulated in Sections 105 to 111 of the Insurance Terms and Conditions,
- the detailed terms and conditions of the Insurer's service limitations (e.g. excess, indemnification limit) are set out in Appendix 1 of the Insurance Terms and Conditions;
- the manner and rate of **indexation** are regulated in Sections 101 to 105 of the Insurance Terms and Conditions.

VII. Other important information stipulated by the law

- The Insurer shall ensure that **complaints** of the Insured and the consumer representative bodies, **if any**, regarding the conduct, activity or failure of the Insurer, the tied insurance mediating agents employed or commissioned by it, or the person mediating insurances upon assignment by the Insurer, may be submitted orally (in person, by telephone) or in writing (delivered in person or by others, by post, fax or electronic mail) pursuant to the provisions of Section 119 of the Insurance Terms and Conditions.
- Information related to **insurance secret, data processing** by the Insurer and **data transfer** are defined in Sections 113 to 117 of the Insurance Terms and Conditions.
- The insurance policy is governed by **Hungarian law**.
- **Provisions deviating** from the law and the standard contractual practice are set out in Section 112 of the Insurance Terms and Conditions.

Terms and Conditions of the Foreign Visiting Students Group Sickness Insurance 001

Unless stipulated otherwise herein, these terms and conditions apply to sickness insurance policies of **UNIQA Biztosító Zrt.** (1134 Budapest, Róbert Károly krt. 70–74), hereinafter: **Insurer**, that have been concluded with a reference to these terms and conditions.

Issues not regulated herein shall be governed by the applicable Hungarian laws.

GENERAL INFORMATION RELATED TO THE INSURANCE CONTRACT

SUBJECTS OF THE INSURANCE CONTRACT

1. The **INSURER** undertakes to deliver the services specified in the **Group Sickness Insurance Master Contract** and **these terms and conditions** in exchange for the payment of an insurance premium..
2. The **POLICYHOLDER** is a person who makes a proposal to conclude the insurance contract and undertakes an obligation to pay the insurance premium.
 - 2.1. Providing the legal statements relevant to the contract is the right and responsibility of the policyholder.
 - 2.2. Any legal statements and notifications sent to the insurer shall only be considered legally effective if they have been sent to one of its organisational units **in writing**.
 - 2.3. The insurer shall send its declarations to the policyholder, who is then responsible to inform the insured person(s) of the contents of said declarations, and of any current or planned changes affecting the contract.
3. **Insured:** shall mean the natural person with respect to events related to whose health the insurance policy is concluded. The Insured may be a private individual of foreign nationality between the age of 18 and 65 who is a student of the Policyholder staying in Hungary, and provided that by signing the Insured's Declaration this person expressly requests as Insured the application of these insurance terms and conditions to be extended to it.
 - 3.1. **The following may not be insured persons:**
 - a) persons who have reached the age of 65 in or before the year of the start of applicable coverage,
 - b) persons who, before the start of applicable coverage have already retired, are on disability pension, are already receiving accident annuity or accidental disability pension, rehabilitation benefit, disability benefit, or have already submitted a request to the current competent authority for the purpose of establishing reduced capacity for work..
 - 3.2. Due to the restrictions applicable to the person of the Policyholder, Insured persons may not replace the Policyholder.
4. **BENEFICIARY:** the services stipulated herein may at all times be used by the Insured to whom the insured event occurs.

CONCLUSION AND TERMINATION OF THE INSURANCE CONTRACT

CONCLUSION OF THE INSURANCE CONTRACT

5. The insurance contract consists of the **Group Sickness Insurance Master Contract** concluded by and between the Insurer and the Policyholder, these **Terms and Conditions** and the **data reports** and other **declarations stipulated in the Group Sickness Insurance Master Contract**.
6. Insurance services shall provided by the Insurer pursuant to these terms and conditions subject to the Group Sickness Insurance Master Contract concluded by and between the Policyholder and the Insurer.
7. The insurance contract may be concluded for a **definite** or **indefinite term**.
8. The **commencement date** and **expiry** of the insurance contract shall be the days stipulated as such in the Group Sickness Insurance Master Contract.
9. The insurance contract shall be concluded for a **definite term** if both the commencement and the expiry date are defined.
10. The insurance contract shall be concluded for an **indefinite term** if only the commencement date is defined.
11. Insurance anniversary shall mean the anniversaries of the month and date of the insurance contract commencement date during the term of the insurance contract. Among others, the right of termination, settlement of the insurance premium, modification of the content of the contract, and the indexation, if any, are all connected to the policy anniversary dates.
12. For definite term insurance policies the insurance term shall be the period between the insurance commencement date and the expiry.
For **indefinite term** insurance policies the **insurance term** shall be the period of one year calculated from the insurance anniversary dates.
13. For **indefinite term** insurance policies if neither the policyholder nor the insurer notifies the other in a written declaration to the contrary at least 30 days before the anniversary, the insurance contract will be extended for **one additional insurance period** in accordance with the last data report and the content of the insurance policy.

EFFECTIVE DATE

14. The insurance policy shall come into effect from 0:00 hours on the day after the day the Policyholder has made the payment of the **first premium** to the Insurer's account, or when an agreement has been concluded on the deferred

payment of the insurance premium, provided that the insurance contract has already been concluded or will be subsequently concluded..

START DATE OF THE RISK, "INITIAL" AND "NEW" INSURED PERSONS

15. The Insurer's risk shall commence on the effective date of the insurance policy.
16. The extension of the scope of the policy to the relevant Insured shall be subject to that Insured's written consent made by the Insured by duly completing and signing the Insured's declaration attached to the Group Sickness Insurance Master Contract (hereinafter the Insured's Declaration).
17. The Policyholder shall obtain the Insured's Declaration completed and signed by the Insured which then shall be sent to the Insurer. The Policyholder shall report the Insurer the number of Insured before the date stipulated in the Group Sickness Insurance Master Contract.
18. With respect to Insured who have duly made and delivered the Insured's Declaration, the risk of the Insurer shall commence on the day following the date of the Insured's Declaration, provided that the Policyholder has paid the Insurer the total one-off premium for that Insured after the accounts are settled.
19. The risk of the Insurer with respect to that Insured shall be for a definite term, always for an academic half year. The commencement date and end date of the academic half year or years shall be agreed in the Group Sickness Insurance Master Contract.
20. The risk term applicable to each Insured shall be the period with respect to which the Policyholder has paid the Insurer the group insurance premium of that Insured.
21. The insurance shall cover insured events in Hungary, however the reason causing such insured events may occur in any country of the world. The insurance shall apply for 24 hours a day. Pursuant to this insurance policy the Insurer shall provide the **sickness insurance services within the territory of Hungary**.

TERMINATION OF THE INSURANCE POLICY AND THE RISK-BEARING

22. The **insurance contract** – and with it the insurance cover provided by the insurer to the insured person – **will terminate** in any of the below cases:
 - 22.1. if the policyholder or the insurer notifies the other in writing of their intent to terminate the insurance contract at least 30 days before the policy anniversary date, with effect from the end of the day preceding the policy anniversary date;;
 - 22.2. in the case of premium non-payment (Section 99);
 - 22.3. for definite term insurance policies on the expiry date of the insurance policy;

- 22.4. if a resolution is adopted about the dissolution of the Policyholder without a legal successor, on the earlier of the following: the last day of operation stipulated in the resolution or the last day of the period for which premium has been paid.

23. **The insurance cover of an insured person will terminate** in any of the below cases::
 - 23.1. upon the date of death of the insured person;
 - 23.2. upon the expiry of the risk term applicable to the Insured (Section 19);
 - 23.3. at the end of the day prior to the insurance anniversary following the 65th birthday of the Insured.
24. The termination of the Insurer's risk shall not affect the assessment of the pending and continuing damage related to insured events arising before the termination.

COMMUNICATION AND CHANGE REPORTING OBLIGATION

25. The Policyholder and the Insured shall have a joint and several **disclosure obligation** according to which they are required to disclose all circumstances that they are aware or should be aware of as material to the Insurer's acceptance of insurance risk, on the date of the insurance contract or on the date the Insured enters the insurance contract. The parties comply with their disclosure obligation by duly and properly answering the Insurer's written questions. Based on the information disclosed the Insurer has the right to set insurance policy terms and conditions other than the insurance terms and conditions (including, but not limited to a surcharge, restricting the scope of risk or excluding certain risks).

The disclosure obligation shall apply to the factors affecting the extent of the Insurer's risk even if the insurance **policy is amended**, including the review of the insurance policy related to the insurance anniversary..
26. The insurer is entitled to check the disclosed data, and with a view to this, may ask further questions pertaining to the health condition, activities, and circumstances of the insured person, and require that the insured person undergo medical examination.
27. The policyholder and the insured person hereby authorise the insurer to verify the disclosed data. By appending their signature the Insured authorises their treating physicians, the hospitals and healthcare institutions providing treatment, the National Health Insurance Fund Manager, and the social security payment offices to provide the Insurer, upon request, with any information they have on record – pertaining to the assumption of insurance risk, occurrence of an insured event, and the health status of and healthcare services used by the Insured.
28. During the term of the insurance policy the Policyholder and the Insured shall notify the Insurer in writing within 15 days about all changes in the studies, job of the Insured materially affecting the risk undertaken (e.g. risk of accident).

29. If the Insurer only becomes aware of material circumstances that had existed prior to the entry into force of the insurance contract, and which could affect the acceptance of the insurance risk after the insurance contract has already been concluded, and furthermore, if it is notified of any changes in the material circumstances specified in the contract, it may put forward a recommendation in writing for the amendment of the contract within 15 days, or if according to the conditions it is unable to assume the risk, it may terminate the insurance contract in writing with a notice period of 30 days. If the Policyholder does not accept the amendment proposal or fails to reply within 15 days, the insurance contract will terminate on the 30th day after the receipt of the amendment proposal.
30. The Policyholder shall notify the Insurer in writing of any changes in its data, legal status included in the insurance contract within 5 business days. Any legal consequences of failing to do so shall be borne by the policyholder.
31. The Policyholder shall notify the Insured electronically (in e-mail) about all material changes in the person or data of the Insured (in particular upon entry, i.e. the delivery of the insured's declaration / exit, i.e. termination of the student status, and changes in the name and other identification data of the Insured recoded in the insurance contract) within five (5) business days from the change requiring disclosure.

TERMS RELATED TO INSURED EVENTS

32. **BASIC SERVICE** (health care or medical availability): general "basic" (non-specialised) health care or general medical services required due to a sickness or accident.
33. **OUTPATIENT OPERATION**: operation performed within the framework of outpatient services where after the intervention the person operated on may return home on the day of the intervention, and such service shall not be deemed hospital inpatient care, nor a one-day surgery.
34. **CARE**: care services, processes the purpose of which is to improve, preserve and restore health, to stabilize the condition of the patient, to prevent illnesses, to relieve pain, to maintain the human dignity of the patient by preparing and involving their surroundings for their participation in care services and activities.
35. **ACCIDENT** shall be mean a sudden external impact arising beyond the control of the Insured during the term of the risk undertaken with respect to the Insured, which results in the death, bodily injury, or permanent accidental disability of the Insured.
36. **ILLNESS** shall be mean an abnormal state of the body, organs, psyche, or an abnormal psychological state, presenting with objective symptoms, in accordance with the generally accepted principles of medical science.
37. An **INSURED EVENT** is an event defined as such in the insurance terms and conditions.
38. **INSURANCE SERVICE** shall mean the obligation of the Insurer arising upon the occurrence of an insured event. If the conditions are met, the service of the Insurer only applies to the reimbursement of the price of the health inspection and cure provided by health care service providers (Section 43), or that of the medications and medical devices.
39. **INSURED'S DECLARATION** shall mean the numbered written document containing the express declaration of the Insured that it accepts the scope of the insurance contract between the Policyholder and the Insurer to be extended to it, and that includes a reference to the information on the Insured's rights and obligations, and also a waiver of the confidentiality of the institutions, people processing the Insured's personal and health data, and also the Insured's assignment related to the performance of the service.
40. **DIAGNOSTIC EXAMINATIONS** shall mean for the purpose of these insurance terms and conditions the diagnostic examinations listed in Appendix 3.
41. **HEALTHCARE DOCUMENT, DOCUMENTATION** shall mean notes, records and any other recorded data, notwithstanding the media or the format, that contain healthcare and personal identification data communicated to the healthcare personnel during the healthcare service pursuant to the applicable laws and healthcare, medical regulations. Healthcare documents shall in particular include the following documents stipulated by the law as well: outpatient records, hospital discharge summary, description of operation, examination records, care and benefit documentation, examination findings, medical opinion, laboratory test findings, diagnostic or histological test records, prescription (copy), referral (copy).
42. **HEALTHCARE SERVICE** shall mean healthcare activities performed by a healthcare service provider subject to an operating permit issued by a healthcare authority which aim at examining and treating, caring for patients, relieving their pain and suffering with the purpose of maintaining health, preventing, detecting illnesses early, diagnosing and treating them, preventing threat to life, improve conditions caused by illnesses or accidents or to prevent further deterioration. Healthcare service shall also include activities, patient transport related to medicines, bandages, medical devices, medical services under the applicable law.
43. **HEALTHCARE PROVIDER**: a natural or legal person entitled to provide health care services, or persons considered as such by the healthcare authority (National Public Health and Medical Officer Service in Hungary), whose operation is authorised within the territory of Hungary. For the purpose of these terms and conditions healthcare provider shall not include the following, not even if they provide healthcare services as well: sanatoria, rehabilitation institutes, spas, convalescent homes, psychiatric care institutes for the mentally ill an other psychiatric patients, geriatrics, chronic care institutions, care homes, alcohol and drug rehabilitation institutions (hereinafter jointly referred to as other healthcare institutions), or wards of medical services institutions providing other healthcare institution services

- (hereinafter the ward), provided that the Insured uses services within the scope of the other healthcare institution or the ward.
44. **ONE-DAY SURGERY** shall mean pursuant to the law a foreseeable and schedules surgical intervention which is performed subject to the law by a healthcare provider specialised to do so, provided that such service is necessary based on the medical opinion and the rules of the profession, and may be performed subject to the intention of the patient and their examination findings, and after which the patient is released to its own home on its own feet with a companion following a 24-hour medical observation from the time of its admission to the institution.
 45. **CARE ORGANISER SERVICE PROVIDER (HEREINAFTER COSR)** shall mean an organisation which, pursuant to a separate agreement concluded with the Insurer, is entitled to organise care provision activity (Section 46) in respect of the Insured within the framework of this insurance.
 46. **CARE ORGANISING:** shall mean organising healthcare services required for medical purposes (particular foreseeable outpatient care) for the benefit of the service users. For the purpose of these terms and conditions care organising shall include in particular the following: managing, handling, monitoring healthcare service and patient journey, and administering healthcare services organised by or through and known to and also with the consent of the COSR.
 47. **ILLNESS WITHOUT PRECEDENT** shall mean an illness that is not in a causal relationship with an illness that had existed or had been diagnosed prior to the start of the insurance cover, or with an illness, accident, or diagnosed permanent disability that had required treatment. Healthcare services used by the Insured during the term of the risk-bearing in casual relationship with the Insured's illness without precedent shall only qualify as an insured event if the Insurer was informed of that illness during risk assessment prior to conclusion of the insurance policy or in some other verifiable manner, and the Insurer has not excluded such related service claims from the scope of the risk-bearing, and undertook the risk..
 48. **PRE-FINANCED HEALTHCARE SERVICE** shall mean medically justified healthcare services provided by a person or institution authorised to provide healthcare services, and used by the Insured, the costs of which are paid to the service provider directly by a person other than the Insurer.
 49. **SEMI-ANNUAL LIMIT:** with respect to certain Insured the Insurer may apply limits for services stipulated herein, and the rate of such limits shall be set out in the insurance policy (Appendix 1). Semi-annual limits shall apply to each insurance period separately (Clause 19).
 50. **MEDICINE, BANDAGE AND MEDICAL DEVICES** shall only mean drugs, equipment, devices that are registered and approved as medicine, bandage or medical devices in Hungary. Sight correction devices (glasses, contact lenses, corrective glasses, etc.), hearing correction devices and materials, devices used in dental services (artificial teeth, dentures, fillings, dental fittings, braces, whitening materials and devices, etc.) shall not qualify as medical devices. Medicine shall not be interpreted to include contraceptives, morning-after pills, condoms, etc.
 51. **OUTPATIENT SERVICES** shall, for the purpose of these insurance terms and conditions, mean the examinations, control tests, performed as specialist services provided by medical professions listed in Appendix 2, small operations, treatments defined as such by the law.
 52. **OUTPATIENT THERAPY** shall, for the purpose of these insurance terms and conditions, mean therapies required as a result of some illnesses or accidents, approved by professional bodies defined by the competent ministry and the currently effective law, medically justified and used within the framework of healthcare services provided that such therapy does not qualify as inpatient hospital treatment and one-day surgery.
 53. **THERAPY** shall mean activities performed by healthcare professionals with the purpose of curing illnesses, stabilising conditions, relieving pain (or other symptoms) based on the findings of diagnostics.
 54. **DESIGNATED HEALTHCARE PROVIDER** shall mean a healthcare provider identified as such by the Insurer in the Group Sickness Insurance Master Contract.
 55. **HOSPITALISATION:** shall mean all medically justifiable medical procedures and treatments performed and provided at a hospital, as recognised by the competent ministry and the professional bodies set out in effective legal regulations, which require continuous hospital stay for at least 24 hours; which procedures and treatments are aimed at the direct examination, treatment, care and medical rehabilitation of the Insured for the purpose of diagnosing and treating an illness, and maintaining or improving the deterioration of health arising as a result of the illness.
 56. **HOSPITAL** shall mean any licensed institution recognised by the medical officer and professional supervisory authorities of the country in which the healthcare service is provided (in Hungary by the Hungarian Medical Officer Service) that provides inpatient care, operates under continuous medical control and supervision, provided that round-the-clock medical supervision is ensured, it is equipped with the appropriate diagnostic and therapeutic means, and operates solely on the basis of the methods generally accepted by medical science, and keeps medical history records. For the purposes of this insurance, sanatoriums, rehabilitation institutes, medical spas, health resorts, alcohol and drug addiction treatment institutions, psychiatric institutions, geriatric institutions, nursery homes, and hospital departments providing the above-specified services do not qualify as hospitals, even if inpatient treatment is provided in them.
 57. **LABORATORY EXAMINATIONS** shall mean for the purpose of these insurance terms and conditions the laboratory examinations listed in Appendix 3.

58. **HUNGARIAN PRIVATE HOSPITALS** shall mean healthcare institutions licensed by the Hungarian Medical Officer Service and classified as a hospital admitting inpatients which are under permanent medical management and supervision, and the costs of healthcare services of which are not financed either in whole or part by the National Health Insurance Fund of Hungary as social security body (NEAK).
59. **SPECIALISED MEDICAL CARE** shall mean healthcare services used by the Insured upon a doctor's prescription.
60. **(MEDICAL) EXAMINATION** means an activity aimed at the assessment of the health condition of the insured person, the preservation of their health, the detection of illnesses, injuries, health deterioration, consequences of accidents, and their risks, the determination of concrete illness(es), the establishment of their prognoses or changes therein, the establishment of the effectiveness of the medical treatment.
61. **PARTIAL LIMIT** shall mean the own reimbursement limit stipulated in Appendix 1 hereto, agreed for each specified service type in relation to the healthcare services used by the Insured and with respect to that Insured for the duration of risk-bearing (one academic term) (Section 19), which at the same time is included in the semi-annual limit.
62. **Emergency care:** the medical treatment of a deterioration in state of health, in the absence of which the patient's life would be directly endangered or would suffer severe or permanent health damage. In such cases ambulance shall be immediately notified.
63. The **CONTENT OF THE SERVICES** shall be defined in Appendix 1. The content of the service, the service limit may be amended during the term of the insurance policy in the cases and manner regulated in the terms and conditions.

INSURED EVENT, RULES APPLICABLE TO THE INSURER'S SERVICES

INSURED EVENT

64. Insured event shall mean healthcare services that are used by the Insured under the supervision or with the approval of the COSR due to an illness, pathological condition or accident that occurred during the term of the risk, but was otherwise without precedent before the commencement date thereof.
65. If the healthcare service is not used by the Insured under the supervision of the COSR, the costs of the service shall only be paid by the Insurer, subject to a legal basis, if the condition of the Insured did not allow for using the service provided under the supervision of the COSR (emergency), and also the Insured notifies the COSR within 48 hours from the commencement of such service.
66. Healthcare services related to emergency care shall not qualify as an insured event if they are funded or fundable by the social security system.
67. The date of the insured event shall be the first day on which the healthcare service is used. Healthcare services that relate to the same injuries, health damages, illnesses or health problems and are provided on the same day or within the framework of the same medical care activity and belong to the same type of service shall be deemed to be one and the same insurance event.

GENERAL TERMS AND CONDITIONS OF THE INSURER'S SERVICES

68. If an insured event occurs, the Insurer's service obligation shall only apply to the reimbursement of the costs of the medical, healthcare and other services stipulated in Clauses 72 and 73.
69. The Insurer shall reimburse the costs related to the medically justified medical care provided to the Insured and stipulated in Clauses 72 and 73 if the Insured proves the justified use of such care services.
70. Within the semi-annual service limit and partial limit stipulated in Appendix 1 hereof, the Insurer shall reimburse the costs related to the healthcare services.
71. If the legal basis of the insurance service does not exist or only exists in part under these insurance terms and conditions, and as a result the Insurer is not obliged or is only obliged in part to perform the insurance service, only the part of the costs of the healthcare services used by the Insured covered by the insurance shall be reimbursed by the Insurer to the healthcare provider or the party issuing the invoice thereof, or to the person who has paid the price of such healthcare services and verifies it with invoices.
72. Within the scope of outpatient services the following shall be reimbursed:
- a) costs of basic medical care,
 - b) costs of specialised medical care,
 - c) the doctor's call-out charges (medically justified acute cases) if the Insured's condition did not allow a visit to the doctor's office (e.g. high fever, inability to move),
 - d) costs of separate examinations (e.g. laboratory tests, X-ray diagnostic, ultrasound), which are only reimbursed by the Insurer if they are required for identifying, curing the illness,
 - e) the costs of one-day surgical care.
73. In case of inpatient care, the Insurer shall pay the Insured's costs of hospital stay and treatment. Within this the following shall be reimbursed:
- a) the costs of healthcare services prescribed by the doctor (including the necessary operations);
 - b) the costs of nursing;
 - c) the costs of abortion performed for medically justified health related reasons.
74. The Insurer shall reimburse the costs of medicine, bandage, medical devices required for the healthcare services (products listed on the official list of medical devices) subject to the semi-annual limit, partial limit stipulated in Appendix 1 hereof.

The costs of medicine, bandage, temporary medical devices required for the healthcare services shall be pre-financed by the Insured. The costs under this paragraph shall be reimbursed by the Insurer to the Insured in arrears if the Insured submits the service claim to the Insurer to settle the costs pursuant to Clauses 83 and 84 herein, and as a result the Insurer's service obligation arises.

75. Should the Insured become unable to move, and the Insured is incapable of visiting a healthcare institution, the costs of patient transport not requiring paramedical attendance within the country shall be reimbursed by the Insurer if transport is required for using healthcare services qualifying as insured event under the general terms and conditions.

76. The Insurer shall reimburse the costs of returning the Insured to the country of origin subject to the semi-annual limit if the written opinion by the caring doctor recommend return to home based on the health condition of the Insured and the COSR approves the Insured being transported to the country of its residence. This service is only available to each Insured once during the term of the insurance policy.

PROVISION OF INSURANCE SERVICES

REPORTING OF THE INSURED EVENT

77. The Insured (*Section 3*) shall report the **insured event** to the Insurer or the service organiser (*Section 45*) **within 8 days** from occurrence **in writing**, as well as providing the necessary clarifications, and shall allow for the verification of the contents of the report and the clarifications.

TERMS AND CONDITIONS OF PROVIDING BENEFITS

78. If the legal basis exists, the Insurer shall perform the services within 15 days from the receipt of all the documents necessary for assessing the claim.

79. The costs of the healthcare services which is organised or supported by COSR (with its knowledge and approval) shall be directly paid by the Insurer to the healthcare provider.

80. The Insured shall have a pre-financing obligation with respect to healthcare services organised by the COSR and used in case of emergency.

81. The costs of healthcare services or care not organised by COSR, but used in case of emergency shall be paid by the Insurer subject to consultation between the COSR, the Insured and the relevant healthcare provider if the use of the services were justified.

82. In case of healthcare services pre-financed by the Insured, and in case of the purchase of medicines, bandages and medical devices, the service claim for cost reimbursement related to the healthcare services shall be filed within fifteen (15) days from the date of the invoice.

83. To enforce service claim for cost reimbursement related to healthcare services pre-financed by the Insured, and in case of the purchase of medicines, bandages and medical devices, the following documents shall be submitted:

- a) an invoice made out for the name of the Insured shall be requested on the last day of the healthcare service used with respect to the performance of the healthcare service (medical care), or in the pharmacy about the costs of the medicine, medical device purchased as prescribed by the doctor performing medical care,
- b) a copy of all medical documents related to the insured event,
- c) a declaration containing the Insured's Hungarian (HUF) bank account number (duly signed and dated).

84. In addition to the documents listed in Section 83 the Insurer may, for assessing the service claim, request a copy of all other documents which prove the existence of the legal basis of the service claim and/or are required for establishing the amount of the claim:

- a) if authority proceedings are launched in connection with the circumstances on which the insured event is based, the documents generated during the proceedings or included in the documentation of the proceedings together with the resolution closing the proceedings (including in particular the resolution terminating the proceedings or the final and valid court order) shall be submitted. The final and valid resolution adopted in criminal proceedings and in infraction proceedings shall only be submitted if they are available on the filing date of the service claim;
- b) documents required to clarify the closer circumstances and consequences of the event on which the insured event is based (the declaration of the Insured and other persons affected by the insured event about the circumstances of the insured event, postmortem report, driving licence and vehicle registration, incident report/resolution recorded by workplace, educational institution, transport company, the expert opinions related to the accident/its consequences);
- c) the form provided by the Insurer and completed by the doctor treating the Insured or the healthcare provider serving the Insured, which contains medical information related to the insured event, the health condition of the Insured and the medical history of the Insured;
- d) the Insured's medical documents related to the insured event and the medical history data: medical records kept by the GP or workplace doctor or staff medical executive, documents generated during inpatient and outpatient care, and also the documents certifying the use of medicines;
- e) documents containing the data of the Insured which are processed by the social security body or other person, organisation and which relate to the insured event or the circumstance on which it is based (subject to the authorisation required for the release of the beneficiary from confidentiality and for a request of data);
- f) membership certificate of the Insured related to its sports activity, document verifying legal relationship, the minutes of the match;

- g) official document proving the Insured's date of birth (birth certificate, identification card, passport, driving licence);
- h) the Insurer may request all foreign language documents required for adopting a decision on the claim to be officially translated at the costs of the person submitting the service claim;
- i) the Insurer may request the original of the documents above to be presented and submitted on any media.

85. The Insurer may obtain further documents for assessing the service claim.

86. If the service claim cannot be assessed based on the documents available, the Insurer may order the Insured's personal medical examination (hereinafter the medical examination required for the assessment of the service) at the costs of the Insurer.

87. If the documents requested by the Insurer are not submitted or are submitted incompletely, or if the Insured fails to appear at the medical examination required for the assessment of the service, the Insurer shall assess the insurance claim on the basis of documents available.

88. The Insurer shall make the payments that have been delayed on account of the late submission of the claim or the late submission of documents needed for the assessment of the claim without any additional interest.

89. The service obligation of the Insurer shall arise if the Insured fails to comply with its obligations stipulated herein, in particular if the submission date (Section 77) is not observed, and as a result the material circumstances cannot be clarified and identified.

90. The insurer has no benefit provision obligations if performance is prevented or hindered by force majeure.

91. The Insurer provides the benefits undertaken in the insurance contract in line with the contractual terms and conditions in force at the time of the occurrence of the insured event, on the basis of the **latest data disclosure** available in respect of the service. In order to verify the existence of risk-bearing relating to the given Insured, the Insurer requests the necessary data from the Policyholder and is also entitled to retroactively verify the data of the group of Insured.

92. The claims arising from the insurance shall lapse after 1 year from the day of the occurrence of the insured event.

RIGHTS OF THE INSURER TO OVERRIDE

93. The insurer is entitled to involve its **own medical expert** to assess the insurance claim. The Insurer's medical expert has a right to **override** in respect of the insured events.

94. The **findings of the insurer's medical expert are independent** of the findings of all other medical or social security organs or bodies or other medical experts, and the in-

surer takes the opinion of its own medical expert into account when assessing the insurance claim.

INSURANCE PREMIUM

95. The insurance premium shall be the consideration payable for the insurer's risk-bearing and service obligation. The Insurer shall be entitled to the Premium for the whole term of the risk.

96. The premium shall be paid semi-annually. The premium shall be due and payable on the date the Insured's Declaration is signed by the Insured.

97. The Insurer shall be entitled to the premium applicable to the Insured for the whole insurance period (academic term) (Section 19) even if risk-bearing only covers a part of the insurance period (academic term) (Section 19).

98. The premium shall be paid by the Policyholder to the Insurer within 30 days from the due date.

99. Should the Policyholder fail to comply with its premium payment obligation, the Insurer's risk shall terminate after the expiry of the thirtieth (30th) day from the due date of the premium if the Insurer delivered a request to this effect containing a grace period and such grace period was frustrated, then thirty (30) days after the delivery of the request.

SETTLEMENT BETWEEN THE PARTIES, DATA DISCLOSURE, REPORTING CHANGES

100. The detailed rules of settlement, data and change reporting between the parties, the rules pertaining to communication in writing as well as any other agreements between the parties shall be set out in the Group Sickness Insurance Contract concluded by and between the Policyholder and the Insurer.

PREMIUM ADJUSTMENT, INDEXATION

101. With the start of the insurance period, the Insurer is entitled to review the insurance premium on account of the change in market prices of the provided services, as well as on account of the frequency of insured events measured in the risk pool, and to determine a new premium on an actuarial basis.

102. Should the risk conditions of the insurance change, including, but not limited to the average life expectancy, the frequency or value of the service use, then at the beginning of each insurance period the Insurer has the right to adjust the premium accordingly.

The Insurer shall notify the Policyholder about the adjustment of the premium not later than 45 days before the insurance period. Should the Policyholder refuse the adjustment of the premium due to a change in risk conditions in writing within 30 days, or fails to pay the premium increased accordingly, the Insurer is entitled to reduce or amend the scope of the services accordingly, or terminate the insurance contract.

103. The policyholder is entitled to refuse the premium raise until the 30th day before the entry into force of the amended premium. If the policyholder refuses the premium amendment, the insurance contract shall terminate on the day before the entry into force of the amended insurance premium.

RESIDUAL RIGHTS

104. The insurance contract concluded on the basis of these insurance conditions provides for no remaining **residual rights** (repurchase, waiver of premium) for the event of premium non-payment or the termination of the contract without payment of the sum insured; insurance **policy loans** may not be applied for and no **bonus-sharing** is provided.

INSURER'S EXEMPTION, EXCLUSIONS

THE INSURER'S EXEMPTION

105. If the Policyholder or the Insured violates its data or change reporting obligation, the Insurer's service obligation shall not arise, unless any of the following circumstances are proven to exist:

- 105.1. the circumstances withheld or not reported were known to the Insurer on the date of the insurance contract, or
- 105.2. the circumstances withheld or not reported did not contribute to the occurrence of the insurance event.

106. The insurance contract shall be terminated without the payment of the sum insured or the provision of any other potential benefits, if the illness, accident or deterioration of health was caused by the **wilful or grossly negligent conduct** of the Insured or the beneficiary.

- 106.1. **The insured event is deemed to be caused through grossly negligent conduct**, in particular, if it occurs in a direct relation to
- a) a wilfully committed criminal offence
 - b) grave drink driving by the persons listed above (blood alcohol being at least 2.5 permille)
 - c) a state caused by the consumption of alcohol, intoxicating, narcotic or similar agents, or from addiction caused by the regular consumption of toxic substances
 - d) the driving of a vehicle without a valid licence or without a valid registration card or under the influence of alcohol.

107. The Insurer shall be released from its service obligation if

- there is proof that the Insured was under the influence of alcohol, drug or narcotic substances or medicine at the time of the event, and this contributed to the occurrence of the event. There was a blood alcohol test, alcoholic intoxication means a blood content of 1.5 permille, blood alcohol concentration exceeding 0.8 permille while driving,
- if according to the medical expert of the Insurer, the medical care is unnecessary.

108. In the event of the Insurer's **release**, the Policyholder, the Insured **shall not be entitled to any reimbursements** from the insurance premium.

EXCLUSIONS

109. The healthcare services related to the following shall not be covered by the Insurer's risk:

- 109.1. the Insured's illness or pathological condition which is proven to have existed before the commencement date of the Insurer's risk, or which was identified prior to the Insurer's risk-bearing, or which required therapy or medical attendance during that time, and the Insured has some permanent health damage identified prior to the risk-bearing of the Insurer;
- 109.2. medical care, costs incurred in connection with contraception, pregnancy (establishing existence thereof, prenatal care) and birth (post-natal care);
- 109.3. induced abortion (not including abortion for the purpose of preserving mother's health, save mother's life, or interventions required by the expected disorders of the baby that medically justify abortion, and abortion of pregnancy caused by a criminal act), the related costs;
- 109.4. care, operations that are only aimed at investigating, terminating infertility, or medical care related all types of artificial insemination, the related costs;
- 109.5. sterilisation and consequences, the related costs;
- 109.6. sex re-assignment surgery, the related costs;
- 109.7. therapy and surgery performed for aesthetic (cosmetic) purposes, the consequences thereof, the related costs;
- 109.8. sight correction surgery, and the related costs;
- 109.9. the diopter glasses/sunglasses, contact lenses (and accessories), and the costs of the medical examination required to manufacture these, the related costs;
- 109.10. hearing aid and accessories, the related costs;
- 109.11. dental and oral surgery therapy, and services due to accidents, and the related costs, not including emergency cases (direct painkilling therapy, temporary root canal treatment, abscess treatment, tooth extraction);
- 109.12. medical care required by HIV infection, and the related costs;
- 109.13. examinations, treatments, detoxication related to the consumption of alcohol, drug or narcotic, or other addiction, and the related costs;
- 109.14. VIP medical care (e.g. single bed room), the related costs;
- 109.15. acupuncture, acupressure, eastern medicine, alternative therapy, naturopathy, the related costs;
- 109.16. procurement, reimbursement of vaccine for immunisation, and the related costs;
- 109.17. services in sanatoria or nursing homes, and the related costs;
- 109.18. chronic illness rehabilitation, care (in particular geriatric, hospice care, special education, logopedics, physiotherapy, spa therapy, diet, circulation enhancer or painkilling infusion, injection into joints), not including the identification of chronic illnesses, treatments related to the first definition of medical care, and the related costs;

- 109.19. medical care the purpose of which is to identify the illness of the Insured, the prevention of health deterioration, restore health, in particular screening tests ordered or used not in connection with the insurance, parent or Insured staying in medical institution on account of own child or own parent, and the related costs;
- 109.20. therapy performed by a person with no medical certificate or operating permit, and medical or other healthcare services that later become necessary as a consequence of such therapy, the related costs;
- 109.21. extremely dangerous hobby, sport, extreme sports (including, but not limited to speleology, diving, rock, wall and mounting climbing, bungee jumping), and events occurring during sports involving the use of engine driven land vehicles, watercrafts, and aircrafts with or without an engine, and other sports causing extreme stress and presuming knowledge;
- 109.22. events related to flying (including parachuting, hang gliding), not including participation in organised air passenger services as passenger, pilot, staff;
- 109.23. psychological, psychotherapeutic and psychiatric treatments;
- 109.24. illnesses with subjective symptoms that cannot be proven with objective medical methods, furthermore migraine, degenerative illnesses of the spine (in particular polydiscopathy), including the direct and indirect consequences;
- 109.25. events occurring during competitive sport, training;
- 109.26. events occurring due to the Insured's suicide or the attempt thereof, and self-harm;
- 109.27. rheumatologic treatment, not including those performed with the purpose of preventing acute deterioration of condition;
- 109.28. events occurring in causal connection with the Insured's insanity or derangement;
- 109.29. toxication, injury caused by the intentional consumption of solid, liquid or gas form substances, including drug, narcotic;
- 109.30. events occurring while the Insured performed armed services, or while the Insured carried or used a weapon, and events occurring in connection with above.
110. Furthermore, the Insurer's risk shall not cover events are caused, in whole or in part, by:
- 110.1. HIV infection and other sexually transmitted diseases (STD);
- 110.2. the effect of radioactive nuclear energy or ionising radiation (not including therapeutic medical care);
- 110.3. war, military actions, belligerent acts of foreign powers, riots, coupe or attempt against government, civil war, revolution, uprising, demonstration, procession, strike, terrorist activity, workplace disturbance, border conflicts, revolt.
111. The following **shall be excluded** by the Insurer as **accidents** or events cause by accidents:
- 111.1. all forms of straining caused by lifting heavy weight;
- 111.2. disc damage, sprain, dislocation, strain, abrasion, bruise, and bleeding caused by other than accident.

DEVIATION FROM THE CIVIL CODE AND PREVIOUS CONTRACTUAL PRACTICE

112. The contractual terms and conditions applicable to Group Sickness Insurance deviate from the Civil Code and the previous contractual practice in the following:
- a) insurance contract may be concluded in writing;
- b) if the first premium is not paid, the Insurer's risk shall not commence;
- c) the limitation period is 1 year, unlike the average limitation period of 5 years;
- d) the limitation period shall not be interrupted by any written request to comply with demand.

MISCELLANEOUS PROVISIONS

RECORDING OF DATA

113. Data related to this insurance contract are processed by the Insurer based on the customer's consent and pursuant to Sections 135 and 136 of Act LXXXVIII of 2014 on Insurance Activity (hereinafter the Insurance Act).
- The insurer is entitled to comprehensively process – in a manner compliant with legal regulations – the personal, health-related and business data it becomes aware of in relation to the insurance contract, as well as the establishment, recording and services thereof. The Insurer shall treat such information as insurance secret and retain it without any limitations in time, and it shall ensure confidentiality with respect to its employees, the COSRs and co-operators. The following shall be allowed to act as data processors on behalf of UNIQA Biztosító Zrt.: UNIQA Software Service GmbH (A-1029 Wien, Untere Donaustrasse 21.), medical experts engaged by the Insurer, and persons, COSRs performing outsourced activities in connection with the insurance contract. The data shall be made accessible to these persons in accordance with the provisions of the applicable laws.
- Customers may request information from UNIQA Biztosító Zrt, after presenting proof of their identity, they may request the correction of their data, deletion, blocking of their data with the exception of data falling under the scope of mandatory data processing, may object to the processing of their data, and may file suit against the data processor at a court of law, if their rights have been violated. A suit may also be brought at a court of law competent at the place of permanent or temporary residence of the customer or at the Budapest-Capital Regional Court. UNIQA Biztosító Zrt will provide the necessary information regarding data processing within 25 days of submitting the request. Requests for information may be sent to info@uniqa.hu or the address of UNIQA Biztosító Zrt.: 1134 Budapest, Róbert Károly krt. 70–74.
114. **Insurance secret** shall mean all data, not containing any privileged information, in the possession of the Insurer, reinsurer, or insurance brokers that pertain to the personal circumstances and financial situation, or business affairs of their customers (including the injured party), and the contracts of customers with the insurer and/or the reinsurer. The insurer is entitled to process the data handled by it during the term of the insurance as well as during the period

in which a claim may be made in connection with the insurance relationship, unless otherwise provided by a relevant act of legislation. The Insurer shall delete all data relating to its customers, former customers or unrealised insurance contracts where the purpose of data processing no longer exists, where the data subject's consent to processing is not available, or where no legal grounds for processing exist.

115. The insurer can forward the **data of its customers** without violating its secrecy obligation – in the cases stipulated by law – **to the following bodies and organisations:** Supervisory Authority acting in its scope of authority, the investigative authority and the prosecutor's office, the court, experts engaged by the court, court appointed executors, principal creditors acting in the debt settlement proceedings of natural persons, Family Insolvency Service, official family administrator in insolvency proceedings, notary public acting in estate proceedings, experts engaged by a notary public acting in an estate proceeding, the tax authority, the national security services, the Hungarian Competition Authority, the public guardianship authority, government health care agencies, agencies authorised to use secret service means of collecting information, the reinsurer, and in the case of joint underwriting (coinsurance): the participating co-insurers, in the case of portfolio assignment: the receiving insurer, partners performing outsourced activities for the insurer, auditors, in the case of branch offices: third country insurers, insurance brokers, and the Commissioner of Fundamental rights, the National Authority for Data Protection and Freedom of Information, to an authority acting as financial information unit or a Hungarian law enforcement agency acting within its scope of responsibility specified in the Act on the prevention and combating of money laundering and the prevention of terrorist financing, or acting on the basis of international commitments.

The reporting obligation under the Act on the Implementation of Financial and Asset-related Restrictive Measures Ordered by the European Union shall also be exempted from the obligation of keeping insurance secrets confidential. The disclosure of the group audit report to the governing member of the financial group during a supervisory audit proceeding shall not constitute a breach of insurance or business secrets. In the case and after the period set out in Section 147 of the Insurance Act, the documents containing business secrets may be used for the purposes of archives research. The data provision obligation set out in the Act on the publication of data of public interest and public data on the grounds of public interest shall also be exempted from the obligation of keeping business and insurance secrets confidential..

116. By signing the Group Sickness Insurance Master Contract, the Policyholder and by signing the Insured's Declaration the Insured consent to the Insurer transmitting their data to third country (re)insurers, third country data processing organisations, and to institutions that can be potentially used for their medical treatment under this contract.
117. With a view to protecting the interests of its risk pool, as part of the compliant fulfilment of its statutory or contractual obligations, the Insurer may contact other insurers in

the interest of providing benefits in line with legislation and the policy, of preventing insurance fraud; and moreover, at the enquiry of another Insurer in line with legal regulations, it shall transfer the requested data to the enquiring Insurer by the deadline set out in such enquiry, or in the absence thereof, within fifteen days from the receipt of such enquiry. Enquiry and the fulfilment thereof do not qualify as a breach of insurance secrets.

Enquiry and transfer of data may apply to data specified in Section 149 of the Insurance Act. The insurer is entitled to process the data it becomes aware of as a result of the enquiry during the period defined by the Insurance Act. The enquiring insurer shall notify the customer in question of the enquiry, the affected data and the fulfilment of the enquiry at least once during the insurance period, and at the request of the customer, it will notify the customer in the way defined in Act CXII of 2011 on Informational Self-Determination and Freedom of Information.

OTHER PROVISIONS

118. Medical care is provided by healthcare providers (*Section 43*) the activity of which is regulated by the provisions of the Health Act.

The service provider shall be liable for damages arising from the faulty performance of medical and healthcare activities, and not the Insurer. The Insurer forwards complaints regarding the quality of services provided by healthcare service providers as well as the standard of services and medical malpractices to the organisation providing care, and contributes to the medical service provider in investigating the complaint and informs the submitter of the complaint on the results of the investigation.

SUBMITTING COMPLAINTS

119. The Customer may submit their complaint relating to the conduct, activity or any alleged infringement of UNIQA Biztosító Zrt. **verbally** (in person, by telephone) or in **writing** (delivered in person or by others, by post, fax or electronic mail) according to the following:

- a) **in person verbally or in writing** at the insurer's customer service office (1134 Budapest, Róbert Károly krt. 70–74) during business hours,
- b) **electronically** (via email to panasziroda@uniqa.hu),
- c) **by telephone** (via the insurer's Call Center on the following numbers: +36-1/20/30/70/544-5555, short number: 1418),
- d) **by fax** (to: +36-1/238-6060),
- e) **by mail** (to the following address: 1134 Budapest, Róbert Károly krt. 70–74.

On complaint submissions, please indicate Complaint Handling as the recipient. **Information on the detailed rules of the complaint handling procedure [Complaint Handling Policy] is available at the www.uniqa.hu website**, and the text of the Policy is also available from the Customer Service Office operating at the insurer's registered office.

If the complaint is rejected by the insurer and it is related to the conclusion, validity, legal effects, termination of the insurance contract, or relates to breach of contract and the

legal effects thereof, the customer may contact the following organisations:

- a) the **Hungarian Financial Arbitration Board** (hereinafter the PBT, mailing address: 1525 Budapest Pf. 172, telephone : +36-40-203-776, fax: +36-1-489-9102, e-mail: ugyfelszolgalat@mnbn.hu) or
- b) a **court of law** according to the rules of Civil Procedure.

If the complaint rejected by the insurer is aimed at the investigation of a violation of a consumer protection provision of Act CXXXIX of 2013 on the National Bank of Hungary (hereinafter: MNB Act), the customer may initiate the consumer protection proceeding of the **MNB** [1534 Budapest BKKP Pf. 777; Phone: +36-40-203-776, email address: ugyfelszolgalat@mnbn.hu].

The initiation of the proceedings of both the PBT and the MNB are conditional upon the customer qualifying as a consumer in accordance with the provisions of the MNB Act, and that prior to the initiation of the legal remedy proceedings the customer has attempted to settle the dispute with the insurer directly. According to the provi-

sions of the MNB Act, a **consumer** is a natural person acting in the interest of goals outside their independent profession and trade. In terms of complaints handling the **following shall not qualify as a consumer**: e.g. business associations, trade associations, condominiums, law firms, or any other organisations with legal personality; furthermore, any insurance brokers, and/or persons acting on behalf of or employed by an insurer or an insurance broker.

If, according to the provisions of the MNB Act, the customer does not qualify as a consumer, the customer may bring a civil suit against the decision of the insurer rejecting their complaint at a competent court of law as defined by the rules of Civil Procedure.

120. The insurer's supervisory authority:

National Bank of Hungary

Registered seat: 1054 Budapest, Szabadság tér 9.

Customer service: 1013 Budapest, Krisztina krt. 39.

Mailing address: 1534 Budapest, BKKP Pf.: 777

Internet site: www.mnb.hu/felugyelet

The Foreign Visiting Students Group Sickness Insurance service package

(Additional information on the various services are available in the specific terms and conditions of Foreign Visiting Students Group Sickness Insurance.)

SERVICE	Semi-annual limit: HUF 2 million/six month/Insured
Outpatient care for acute and foreseeable cases (not including emergency care)	
a) Outpatient general practitioner like basic service	within limit
b) Specialised care (including outpatient operations as well)	within limit
c) Laboratory and diagnostic tests required during therapy	within limit
One-day surgical care	within limit
Inpatient care	within limit
Medical device (upon doctor's prescription) cost reimbursement	Partial limit: HUF 100,000/ six months
Medicine, bandage (upon doctor's prescription) cost reimbursement	Partial limit: HUF 100,000/ six months
Emergency care/on-call duty cost reimbursement	within limit
Patient transport	within limit
The Insurer shall, subject to the semi-annual limit, reimburse the costs of returning the Insured to the country of origin subject to the semi-annual limit if the written opinion by the caring doctor recommend return to home based on the health condition of the Insured and the COSR approves the Insured being transported to the country of its residence. This service is only available to each Insured once during the term of the insurance policy.	within limit

Valid from: 1 January 2018 until withdrawn.

Medical Experts with Outpatient Services

The Foreign Visiting Students Group Sickness Insurance shall only cover the medical outpatient services listed in this appendix.

Medical area
Allergology
Angiology
Traumatology
General medicine
Dermatology & Sexually Transmitted Diseases
Diabetology
Endocrinology
Cardiovascular surgery
Otorhinolaryngology
Gastroenterology
Hematology
Neurosurgery
Infectology
Cardiology
Hand surgery
Nephrology
Neurology
Oncology
Orthopaedics
Pathology
Rheumatology
Surgery
Ophthalmology
Gynaecology
Pulmonology
Urology

List of laboratory and diagnostic tests

The Foreign Visiting Students Group Sickness Insurance shall only cover the laboratory and diagnostic tests listed in this appendix.

Laboratory and diagnostic tests
Blood test (haematopoiesis, ESR (We), blood sugar, cholesterol/total cholesterol, HDL, LDL/ triglyceride, blood coagulation test, TSH, FT3, FT4, PSA, hgA1c, INR, uric acid, CK, ions, crp)
Comprehensive urinalysis
Stool test: bacteriological stool test, immune blood test
Infection test
Pregnancy screening
Hematology
Serology - immune test (prescribed by an immunologist)
PCR
Hormone test
Tumor and cancer markers
Toxicology tests
Genetic tests
Biopsy
Endoscopy (without anaesthesia)
H2 breath test
Urease test
Mammography
Isotope tests
Ultrasound
Standard X-ray tests
ABPM
Arteriograph
Osteoporosis test
ECG (12 lead)
Holter-monitoring
Exercise ECG
Pathology
Epicutan allergy test
Dermatoscopic test
Audiology test
Vaginal cytology
Scintigraphy
Spirometry
Contrast medium x-ray screening
Neurology electrophysiology tests
CT, PET-CT
MRI