CONTRACTING TERMS AND CONDITIONS AND CUSTOMER INFORMATION OF GROUPAMA MEDICARE GROUP HEALTH INSURANCE

1. Contents of the terms and conditions

These contracting terms and conditions include the provisions that must be applied to the Groupama Medicare Group Health Insurance contracts of Groupama Biztosító Zrt. (hereinafter insurer) provided that the contract was concluded with reference to these CTC. The framework contract (hereinafter insurance contract or contract or insurance) contains all declarations relating to the contract and the contracting terms and conditions include all conditions of the agreement of the parties, and therefore any former agreement or declaration shall be repealed and shall not constitute part of this contract.

2. Definitions

2.1. ***Acute medical case:*** All acute medical conditions, even relating to chronic illnesses, where symptoms may be identified according to which medical care is required within 48 hours according to the medical standards.

2.2. ***Care****:* All care and nursing services and procedures that are aimed at improving the health condition, preserving and restoring health, stabilising the condition of the patient, preventing illnesses, easing suffering by preserving the human dignity of the patient and preparing the people around them and the environment for the tasks and involving them in the care.

2.3. ***Assistance line****:* A telephone service available for 24 hours on every day of the year, which provides health related information for 24 hours of every day of the year to the policyholder and arranges for health services for the policyholder as and when required between 8 a.m. and 8 p.m. In addition to Hungarian, the insurance company provides the service in at least English.

2.4. ***Accident:*** A sudden external event occurring outside the will of the policyholder as a result of which the policyholder dies within one year or develops final incapacity to work or a permanent health damage (disability) within 2 years and/or sustains an immediate short-term injury. For the purposes of these CTC, the following events are also classified as accidents if they occur suddenly, outside the will of the policyholder:

- drowning;
- burn injuries, scolding, strike of a lighting, impacts of electricity;
- inhaling of harmful gases and steams, poisonous or corrosive substances getting into the body.

An illness does not qualify as an accident, and infectious diseases may not be deemed the consequence of an accident.
Suicide and suicide attempt are not accidents.

2.5. ***Disease:*** According to the currently available and generally accepted position of the medical science, disease is an extraordinary physical or intellectual condition occurring in the health of the policyholder which does not stem from an accident and shows objective symptoms.

2.6. ***Patient transportation:*** Transportation of a patient in accordance with the conditions defined in the legal regulations based on an order of an authorised physician in order to provide access to the required medical care when the patient does not require any ambulance supervision but the medical service cannot be accessed in any other way given the health condition of the policyholder.

2.7. ***Insurance anniversary:*** The insurance anniversary of an insurance contract effective for more than one year is the day of the start of the insurance term in each year.

2.8. ***Card Network benefits:*** the following benefits are available on the Online Health Portal: making an appointment on the phone or online for a vaccination against influenza or for a screening test directly at the medical service provider within the framework of the Card Network service; the organisation of outpatient specialised care is a supplementary Card Network benefit.

2.9. ***Package type:*** The Groupama Medicare Group Health Insurance may be taken in specific packages according to these terms and conditions. The package type may be selected for each insured. The individual packages are different from each other in terms of the services and the service limits. The packages selected by the contracting party for the policyholder are stated in the framework insurance contract by the contracting parties. The contracting party informs the policyholder of the selected package types.

2.10. ***Diagnostic test***: A medical test ordered only by a physician to detect the cause of the complaint or clarify the condition of the policyholder, or to certify or preclude the existence of an illness, which itself is not aimed at changing the condition. The diagnostic tests are available within the framework of outpatient specialised care. According to these conditions, the diagnostic tests available within the framework of outpatient specialised care do not include CT, MR, PET CT and cardio CT.

2.11. ***Medical document:*** Any note, record or data captured in some other way based on Act CLIV of 1997 on Health Care and Act XLVII of 1997 on the Processing and Protection of Health and Related Personal Data (hereinafter legal regulation) and in compliance with the health and medical standards containing health and personal identification data relating to the treatment of a patient, obtained by the medical staff during the medical service, irrespective of its medium or form.
For the purposes of these conditions, the medical documents defined in the legal regulations include especially the following documents, also regulated in the legal regulations:
– outpatient medical record;
– hospital discharge report;
– description of the operation;
– examination sheet;
– care and service documentation;
– test result;
– physician's expert opinion;
– laboratory sheet, laboratory result;
– images of diagnostic or histological tests;
– prescription (copy);
– histological or pathological results;
– result of imaging diagnostic services;
– referral (copy).

2.12. ***Medical service organising partner***: Teladoc Hungary Kft. is the medical service organising partner of the insurer. (Registered office: 1092 Budapest, Köztelek utca 6.; Company registration number: 01-09-864388; Tax number: 13613781-2-42), to which the personal data of the policyholder are transferred for the purpose of organising care.

2.13. ***One-day surgery:*** It is a planned and programmed surgical intervention defined in the law which is performed by a medical service provider licensed for it, providing that the service is justified and may be performed according to the physician's expert opinion and the medical standards based on the choice of the policyholder opting for the service and the test results; following the intervention, the policyholder can leave the medical institution on their own feet, with a companion, based on the physician's expert opinion and following observation, within 24 hours from their admission to the institution. The services available within the framework of one-day surgery under these conditions are included in Annex 3 to these CTC. The one-day surgery definition effective when these contracting terms and conditions enter into force are included in the Decree of the Minister of Welfare 9/1993 (2 April) NM on certain issues of social security financing of specialised medical care.

2.14. ***Service organisation:*** It involves the management of the medical services of the policyholder, monitoring and controlling the medical services and the service paths, maintaining contact with the medical service provider caring for the policyholder, administration of the medical services used by the policyholder at or through the medical service organiser, in the organisation and with the awareness and approval of the service organiser.

2.15. ***Service organiser:*** The party organising the service. Our service organising partner is defined in section 2.12. of these contracting terms and conditions.

2.16. ***Preliminary disease:*** any symptom, injury, disease, alteration or permanent damage already established (diagnosed), within the period defined in section 17.3 of these contracting terms and conditions or not yet established (not diagnosed) prior to the inclusion in the group of insured (i.e., the start of risk coverage for the policyholder) which by nature developed prior to the start of the risk coverage according to the general medical standards and in relation to which the policyholder requested or used a medical service during the risk coverage period.

2.17. ***Inpatient care (hospital care):*** Inpatient care is provided to a person who is admitted to an inpatient medical institute (hospital) providing the medical care required as a consequence of an illness or accident and the patient spends each night at the institute between their admission to the inpatient medical institute and the date of discharge in relation to the medical care received. An admission to an inpatient medical institute is for a number of days when discharge from the inpatient medical institute takes place on a later date than the date on which the patient is admitted to the inpatient medical institute.

2.18. ***Inpatient medical institute (hospital):*** For the purposes of these CTC, an impatient medical institute (hospital) is an authorised inpatient care institute recognised by the National Public Health and Medical Officer Service, which is under permanent medical control and supervision providing that it offers permanent and continuous physician presence, is equipped with adequate diagnostic and therapy options and operates only according to the generally accepted methods of the medical science as well as keeps medical history. For the purposes of these contracting terms and conditions, sanatoria, rehabilitation institutes, thermal baths, therapeutic holiday facilities, old peoples' homes, medical institutes and clinics of mental patients, geriatric institutes, alcohol and drug rehabilitation institutions and the departments of inpatient medical institutes (hospitals) providing services similar to the ones defined in this paragraph are not considered inpatient medical institutes (hospitals).

2.19. ***VIP-level inpatient care (hospital service):*** High-quality inpatient service in an active or matrix-type hospital ward, in a room with one or two beds, satisfying the quality requirements of the insurer.

2.20. ***Consumer:*** Any natural person who proceeds outside the scope of their profession, occupation or business activity.

2.21. **General practitioner**: A physician co-ordinating the medical services of patients registered with them in compliance with the legal regulations and offering primary care for them.

2.22. ***Relative**:* Spouses, next of kin, adopted persons, stepchildren, foster children, adoptive parents, stepparents, foster parents, siblings, and domestic partners, spouses of the next of kin, spouse's next of kin and siblings, and spouses of siblings.

2.23. ***Outpatient specialised care***: A single or occasional specialist medical service provided by a specialist physician or a consultation of specialist physicians if it is not considered inpatient care or one-day surgery or continuous medical care or service applied in the case of a chronic illness and requiring inpatient specialist care.

2.24. ***Supplementary Card Network benefit for organising outpatient specialised care:*** a supplementary insurance service associated with the selected package types, available online or through the phone, with the help of which the policyholder can individually arrange for any medical service in addition to the basic services defined in Section 2.31., also within the framework of outpatient specialised care. With the help of the Supplementary Card Network benefit outpatient specialised care organisation service, the policyholder can organise for their own outpatient specialised care themselves, without the involvement of the service organiser.

2.25. ***Close relative:*** spouses, next of kin, adopted children, stepchildren, foster children, adoptive parents, stepparents, foster parents, and siblings;

2.26. ***Shared household**:* the community of natural person consumers registered at the same address and habitually living in an economic community.

2.27. ***Chronic disease***: Any diagnosed illness or condition established by a physician which requires permanent or periodical outpatient and/or inpatient care and hospital stay and which develops and/or lasts for a long time (at least 3 months) with even acute periods or reducing and easing symptoms in the meantime.

2.28. ***Laboratory test**:* Examination of human tissue parts (e.g., blood) and biological products (urine, stool, wound secretion, etc.) with physical, chemical and biological methods under laboratory conditions in order to establish the qualitative and quantitative composition, biological activity and infection of the samples.

2.29. ***Operation:*** An operation is a surgical intervention performed in an inpatient medical institute by a qualified physician in compliance with the medical rules and standards and is not excluded by the insurer according to these contracting terms and conditions.

2.30. ***High-value diagnostics***: A **CT, MR, PET CT and cardio CT** test, ordered only by a specialist physician in order to detect the cause of the complaint or clarify the condition of the policyholder, or to certify or preclude the existence of an illness, which itself is not aimed at changing the condition.

2.31. ***Online Health Portal:*** It is an online interface that can be used for organising insurance services, online basic services and Supplementary Card Network outpatient specialised care services. Basic services that may be used on the Online Health Portal: heart and vascular system online status assessment, heart and vascular system online calculator, BMI calculator, online and home dietician advice, training and locomotive organ advice online and on the phone, map finder and, within the framework of the Card Network service, it may also be used for a vaccination against influenza or making appointments for a screening test directly at the medical service provider either through the phone or online. Of the services of the online health portal, the appointment made with the medical service provider on the phone or online, i.e., the Supplementary Card Network outpatient specialised care organisation service may be attached to the basic services of the Online Health Portal as a supplementary service.

2.32. ***Rehabilitation**:* All health procedures and services that are aimed at the elimination of any developed loss of function (limitation of movement, speech disorder, reduced heart performance, etc.), restoration or substitution of the healthy condition or development of new abilities for compensation purposes.
The integrated parts of medical rehabilitation include especially infusion treatments aimed at improving circulation and/or reducing pain, physiotherapy, sport therapy, speech therapy, psychological care, occupational therapy, supply of medical aids and training for their use as well as services to mental patients in medical and clinical institutions, thermal baths, therapeutic holiday facility, geriatric institute, old people's home, alcohol and drug rehabilitation and other sanatorium-type rehabilitation institute service.

2.33. ***Specialist physician:*** A physician with a valid specialist certificate and operating licence other than physicians specialised in general physician practice, occupational medical practice or disaster related medical practice.

2.34. ***Service cover**:* all service components defined by the contracting party for the policyholder, which may be used by the policyholder on the basis of the insurance contract between the contracting party and the insurer and the provisions of these contracting terms and conditions. The summary table of the individual covers is included in Annex 1.

2.35. ***Service financing***: Reimbursement of the cost of a medical service in part or in full as an insurance service under the terms and conditions of the insurance contract.

2.36. ***Service limit**:* The upper limit of a service within one insurance period defined by the insurer which is lost and cannot be carried over to the subsequent insurance period if it is not used by the policyholder during the given period, i.e., it may not be accumulated.

2.37. ***Screening test:*** A medical test or series of tests that are aimed at health protection, an improvement in the quality and duration of life of the individual, through active search for, detection, identification and assessment of hidden or latent diseases or diseases without any symptoms, medical conditions prior to specific diseases or risk factors leading to an inclination for a disease at an early stage, presumably free of complaints.

2.38. ***Pregnancy care****:* All medical interventions, examinations and services that are classified as outpatient specialised care and are directly related to the health care during pregnancy.

2.39. ***Duty service:*** A prompt medical service in cases occurring outside the daily working hours and defined by the law through the continuous availability of certain medical services with the objective of examining and detecting the health condition of the individual requiring the service, performing occasional and immediately required interventions or referring patients to inpatient institutes for immediate care between the time of finishing the service according to the daily work schedule and the start of the working time according to the subsequent day's work schedule, as well as involvement of various procedures specified in separate legal regulations.

2.40. ***Waiting period****:* The period specified in the insurance contract, calculated from the date of establishment of the legal relationship relating to the policyholder as the cover period, during which the insurer provides limited cover for the policyholder.

2.41. ***Examination:*** An activity aimed at assessing the health condition and preserving the health of the policyholder, detecting diseases and their risks, defining a specific disease(s), establishing a prognosis and projecting changes and establishing the efficiency of medical treatment or the occurrence and cause of death.

3. Parties to the contract

3.1. **Insurer**
Groupama Biztosító Zrt., which covers the risk in exchange for the insurance premium, and undertakes to provide an insurance service in case the claim events defined in these contracting terms and conditions occur.

3.2. **Contracting party**
The contracting party is the party who enters into the insurance contract with the insurer for the policyholder, is obliged to issue legal declarations and undertakes to pay the insurance premium and to whom the insurer addresses its declarations. The contracting party shall notify the policyholder of the conclusion of the insurance contract, the insurance terms and conditions and services.

3.3. **Insured person**
A natural person belonging to the group defined by the contracting party whose health condition and physical health is involved in the claim event for which the insurance contract is established. A natural person of at least 18 but no more than 64 years of age at the time of the entry and establishment of the contract may be an insured. The contracting parties define the group of insured in the framework insurance contract.
A written declaration of the policyholder (declaration of the policyholder) is required for establishing the insurance cover.
The start of the insurance cover of the policyholder (hereinafter entry) is regulated in the provisions of section 6 of these contracting terms and conditions.
The insurer establishes the entry age of the policyholder at the time of the conclusion of the contract by deducting the year in which the policyholder was born from the year in which they join the insured group.
A new insured may be notified for the insurance at any time during the term of the framework contract. The contracting party shall report to the insurer any change in the number of the insured group during the term in the manner and within the deadline specified in the framework contract.
In the case of new insured entering the existing contract, the insurer establishes the entry age of any new insured by deducting the year in which the policyholder was born from the year in which they join the insured group.
The policyholder shall not have the right to replace the contracting party.

3.4. **Beneficiary**
The beneficiary is the person who is entitled to the insurer's service. Under the insurance contract established on the basis of these contracting terms and conditions, the policyholder is the beneficiary. The insurer pays the amounts stated in the invoices generated in relation to the use of the services as 'claim payments' to Teladoc Hungary Kft.

4. Conclusion of the insurance contract

This insurance is established with mutual written agreement between the contracting party and the insurer, with the signature of, and under the terms and conditions stated in, the framework contract. **The insurer does not issue a policy.**

5. Risk assessment

The insurer does not apply any risk assessment in relation to this contract.

6. Start date of cover by the insurer

6.1. The cover provided by the insurer shall commence at the time defined by the parties in the framework contract.
The Insurer's risk bearing for each Insured starts at 0:00 on the day following the complete completion of the Insurance Statement and its receipt by the Policyholder, but no earlier than February 1, 2023 - or if the Framework Agreement is signed by the Parties at a later date, then not earlier than the day of the signing of the Framework Agreement by the Parties - but no later than August 31, 2025.
The Insurer's risk-bearing is also conditioned on the fact that the Contracting Study Party annually verifies the insured's student status within the framework of the provision of data to the Insurer.

7. Waiting period

The insurer waives the waiting period in connection with this framework contract.

8. Removal of the policyholder from the insured group

When the following events occur, the insurer does not provide any further benefit to the particular policyholder and that particular policyholder will be removed from the insured group (hereinafter exit).
a. based on a request of the policyholder made in a written declaration, at 0 hour of the first day of the month that follows the receipt of the declaration by the insurer;
b. if the policyholder no longer belongs to the insured group and the contracting party requests the termination of the legal relationship of the policyholder at the insurer in writing by the deadline specified in section 14.1.4. of these CTC (the 20th day of the current month) at 0 hours of the first day of the month that follows the receipt of the request for the termination of the legal relationship by the insurer; if the request is received by the insurer after the deadline specified in section 14.1.4. of these CTC (after the 20th day of the current month), then the legal relationship of the policyholder shall be terminated at 0 hours of the first day of the 2nd month that follows the receipt of the request for the termination of the legal relationship by the insurer;
c. if the policyholder dies (including death in an accident), at the time of the death of the policyholder;
d. at 0 hours on the insurance anniversary that follows the 65th birthday of the insured person;
e. when the policyholder sustains 100% disability or health damage as a result of an accident, at the time of establishment of the health damage;
f. if the framework contract ceases to exist, at the time of cessation of the framework contract.

9. The insurance period

9.1. The insurance period is the period for which the insurer calculates the insurance premium and during which the contracting party shall pay the insurance premium.
9.2. The insurance anniversary date is the day when the insurance period starts each year.
9.3. By the entire insurance period, the parties understand the contractual period of 5 study semesters defined in the Framework Contract.

10. The insurance term

The insurance contract may be established for a definite term of 5 study semester.
The insurance term commences at the start of the cover period. The parties specify the start of the term in the insurance framework insurance contract.

11. Territorial and timely scope of the insurance

The insurer covers the risks only in the territory of Hungary in relation to the medical services used by the policyholder as a result of an accident or a presumed disease in Hungary during the cover period.

12. The claim event and the insurer's benefits

12.1. For the purposes of these CTC, a claim event is an accident of the policyholder during the cover period or, unless otherwise provided for, a presumed disease, medical condition or pregnancy of the policyholder that has no preceding events at the start of the cover period and is reported to the service organising partner of the insurer and based on which the policyholder needs to use a medical service, organised, reported to, previously approved by the service organiser, who is then actually involved in the organisation of the medical service (claim events, classified as indemnity insurance).

12.2. No preliminary disease of the policyholder defined in Section 2.16. of these CTC qualifies as a claim event unless the insurer provides otherwise the framework contract and in Annex 1. or Annex 2. of these contracting terms and conditions.

12.3. The insurer and the contracting party may agree that the insurer shall not apply any preliminary examinations and shall not check the diseases of the policyholder prevailing prior to the start of the cover. The respective agreement between the insurer and the contracting party is stated in this framework contract.

12.4. The claim event occurs on the day when the policyholder reports the claim event to the service organiser. In the case of appointments made by the policyholder individually online or on the phone (hereinafter Card Network services), the day of the claim event shall be the time of the appointment made with the medical service provider within the framework of the Card Network services.
The benefits provided by the insurer are included in Annex 1. and Annex 2. constituting part of these contracting terms and conditions.

12.5. Report of claim events
12.5.1. In the case of claim events defined in section 12.1., contact with the service organiser (in the case of online Card Network services making an appointment online with the medical service provider, i.e., contact with the medical service provider) is classified as reporting the claim event. The service organiser may request the presentation of documents referred to in section 12.6.5. for the certification and assessment of the need for the service.
12.5.2. The due date of the claim for the benefit is the date of reporting the claim event to the service organiser on the phone or, in the case of Card Network services, the appointment made with the medical service provider online or on the phone.
12.5.3. It is a condition of reporting the claim event on the phone or making an appointment online or on the phone by using the Card Network services that the policyholder provides the data stated in the declaration of the policyholder.
12.5.4. If the policyholder refuses the transfer of the medical documentation to the service organiser when they use a medical service, they shall cover the cost of the used medical service themselves.
12.5.5. If a medical service is not organised by the medical service organising partner but has been used under these terms and conditions, the insurer shall reimburse the respective cost or a specific part thereof to the policyholder subsequently, on the basis of the invoice proving the use of the service. The top limit of the subsequent reimbursement is the amount that the service would have cost if it had been organised by the medical service organising partner. If the amount stated in the invoice submitted by the policyholder is lower than that amount, then the insurer shall reimburse the cost of the used medical service up to the amount stated in the invoice submitted by the policyholder. A subsequent benefit claim can only be submitted through the Health Portal. When a subsequent benefit claim is submitted, the invoice issued for the previously used medical service and the health documents created during the use of the service must be uploaded to the Health Portal.

12.6. The insurer's benefits
12.6.1 The benefit components of the insurance by package are included in Annex 1. constituting part of these CTC. The organisation of the outpatient specialised care services within the framework of the Supplementary Card Network service may be attached to the individual benefit packages in compliance with Annex 1. The insurance benefits included in each insurance package and the benefits available with the outpatient specialised care organisation service with the Supplementary Card Network are defined in Annex 2., constituting an integrated part of these contracting terms and conditions.
The packages selected by the contracting party and the benefits are defined by the contracting party and the insurer in the framework contract.
12.6.2. The individual benefit components are presented in detail in Annex 2. constituting part of these CTC. The top limit of the reimbursement obligations relating to the individual benefit components of the insurer are included in Annex 1., constituting part of these CTC. The insurer makes a payment only for the services defined in Annex 1. and up to the limits specified therein.
12.6.3. If the insurer's cover for the policyholder has ceased to exist in compliance with the provisions of section 8. b. and f. but the policyholder had already reported a claim event to the insurer, either on the phone or online, and based on a claim reported on the phone the insurer's service organising partner had already begun to organise a service within the cover period, then the insurer shall undertake to organise and reimburse the cost of no more than one examination by a specialist physician within the framework of outpatient specialised care. In the case of a subsequent reimbursement claim, the insurer undertakes to reimburse the cost of no more than one examination by a specialist physician and only within the framework of outpatient specialised care when the policyholder can prove that the service for which the invoice was issued to them was already organised prior the cessation of the insurance cover.
12.6.4. In the course of the services organised by the service organiser, the medical service provider identifies the policyholder. The policyholder shall cover the cost of the service towards the medical service provider if the policyholder cannot be identified on the spot.
12.6.5. The service organiser may request the presentation of the following documents to prove and assess a request for a service:
– physician's referral or proposal;
– specialist physician's referral or proposal;
– documentation certifying the need for the medical service;
– invoice issued to the policyholder.
12.6.6. The service organiser checks the documents submitted in relation to the claim event and is entitled to review the health condition of the policyholder and the need for any medical service as well as the duration of the treatment. On the basis of these documents, the service organiser may refuse to organise the services when it is medically not justified or necessary.
12.6.7. The service organiser shall arrange for medical services primarily with medical service providers that have a contract with them. If the required service cannot be arranged with the contracted medical service provider, the service organiser may also arrange for the service at a different service provider with whom it does not have a contract. In that case the policyholder pays for the service on the basis of the invoice issued by the service provider. The service organiser reimburses the policyholder the eligible costs described in the contracting terms and conditions based on the service provider's invoice.
12.6.8. Prior to the organisation of a medical service, the service organiser informs the policyholder that the cost of the requested medical service or the number of occasions of the use of the service exceeds the limit defined in these CTC whenever necessary.
12.6.9. On the basis of the insurance cover established under these CTC, the policyholder is not entitled to any financial benefit.

12.6.10. The service organising partner of the insurer classifies the service used by the policyholder into the various special categories primarily on the basis of the physician who performs the particular service. (Example: interventions performed by a surgeon are classified under surgery.)

13. The insurance premium

13.1. The insurer calculates the insurance premium in the framework contract, taking into account the number of policyholders, the duration of the insurance and the type and amount of the benefits as well as the scope of the risks. The frequency and method of premium payment are also defined in the framework contract.

13.2. The pre-calculated annual insurance premium may be corrected by the parties on the basis of any change in the number of participants in the group during the year or any major change in the activity of the individual members of the group, in a manner specified in the framework contract, within the framework of subsequent premium settlement.

14. Rights and obligations of the parties to the contract

14.1. The disclosure and change reporting obligation of the contracting party and the policyholder

14.1.1. The contracting party and the policyholder shall inform the insurer and the service organiser in writing of all conditions that are importance in terms of the insurance cover that they were or had to be aware of, or in relation to which the insurer or the service organiser asked a question at the time of conclusion of the insurance contract and subsequently, during the term of the contract. In terms of the assumption of the health insurance risk included in the insurance contract established on the basis of these CTC, all questions are important questions in relation to which the service organiser or the insurer ask questions in the health declaration or request information from the contracting party and the policyholder, even on the phone.
The consent of the policyholder to the establishment of the health insurance cover under these CTC also means a commitment to allow the insurer and the service organiser to verify the disclosed data.
14.1.2. The contracting party and the policyholder shall satisfy their disclosure obligation by responding in writing with truthful answers to the questions asked by the insurer in writing. Leaving the questions unanswered shall not in itself constitute a violation of the disclosure obligation.
14.1.3. The contracting party and the policyholder shall report to the insurer any change in the important conditions included in the contract or disclosed in the declarations that occur during the term of the insurance within 5 working days.
14.1.4. Unless otherwise agreed, the contracting party shall inform the insurer of any change in the policyholders no sooner than 30 days prior to the change or not later than specified below, in writing: the data of any change in the policyholders taking place between the 16th day of the previous month and the 15th day of the current month (including the list of policyholders and the signed original declarations of policyholders) shall be submitted to the insurer by the 20th day of the current month. The insurer records the changes in the identity or data of policyholders following the receipt of the change report, by the 28th day of the current month.
14.1.5. The policyholder is not obliged to report any change in their health condition to the insurer.
14.1.6. In the event of any breach of the obligation of disclosure and notification of changes, the obligation of the insurer shall not take effect, unless
a. it is proven that the insurer was aware of the undisclosed condition when the contract was concluded or it did not contribute to the claim event;
b. five years have already passed between the conclusion of the contract and the occurrence of the claim event.
14.1.7. If the obligation of disclosure or reporting changes was violated only in relation to certain policyholders, the insurer may not refer to the violation of the obligation of disclosure or change reporting with regard to the other policyholders.
14.1.8. The obligation of disclosure and notification of changes applies to the contracting party and the policyholder both; neither of them shall be entitled to refer to any circumstance that either one had neglected to disclose or report to the insurance company though he must have known about it and should have disclosed or reported it.
14.1.9. The insurer's obligation shall not take effect if the contracting party or the policyholder fails to report to the insurer the occurrence of a claim event within the time limit specified in the contract, fails to provide the information necessary, or fails to facilitate verification of the information provided, and, as a consequence, circumstances which are considered material from the point of view of the obligation of the insurance company become undetectable.
14.1.10. The insurer, if it gains knowledge after the time of conclusion of the contract of any material circumstance that existed at the time the contract was concluded, shall be entitled to exercise the rights arising therefrom only during the first five years of the life of the contract. The insurer's obligation shall take effect notwithstanding an infringement of the disclosure obligation, if the claim event occurs more than five years after the conclusion of the contract.
The provisions set out in this subsections shall apply mutatis mutandis to the legal consequences on the infringement of the disclosure obligation relating to changes in the material circumstances provided for in the contract. The five-year period available for the insurer to exercise its related rights shall commence on the day following the disclosure deadline.

14.2. Insurer's rights when learning about important conditions or when changes in important conditions are reported to it

14.2.1. If the insurer becomes aware of any material circumstance regarding a contract, or any changes thereof, only after the contract has been concluded, 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 with 30 days' notice.
14.2.2. If the contracting party 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 30th day following the day of communicating the proposal for the amendment, if the insurance company warned the contracting party of this consequence when the proposal for amendment was made.

14.2.3. If the contract covers more than one policyholders concurrently, and the considerable increase in insurance risk applies to some of them only, the insurer shall not be able to exercise its rights under subsections 14.2.1. and 14.2.2., with respect to the remaining policyholders.
14.2.4. From the aspect of this contract, the possibility that the policyholder's health deteriorates with age due to natural causes shall not constitute a considerable increase in insurance risk.

14.3. If justified, the policyholder may modify the examination/operation appointment by 16:00 of the working day prior to the scheduled date. **If the policyholder indicates a request to modify or cancels the examination/operation date previously agreed with the service provider after 16:00 of the previous working day or if the policyholder fails to cancel the arranged examination/operation date and does not appear at the service provider at the arranged time, it shall be considered as if the policyholder took part in the examination/used the service and the insurer shall have the right to deduct the cost of the arranged service from the service limit (limit) established for the particular service. In that case, the requested service cannot be used for the subsequent 3 months. The service organiser shall modify the date of the cancelled medical service on one occasion.**

14.4. In the case of one-day surgery, the policyholder may modify or cancel the appointment by 16:00 of the working day prior to the date of the operation. In the agreement for the operation, established between the service organising partner and the insured the service organiser nay impose a penalty in case the policyholder fails to fulfil that amendment/cancellation obligation.

15. Benefit limits and cover replenishment

15.1. Pursuant to the insurance contract, the insurer establishes limits for the benefits available under the contract for each insurance period in compliance with Annex 1, which constitutes part of these CTC. The insurer provides benefits only up to the limit established for each benefit component in Annex 1., constituting part of these CTC.
The services used beyond the benefit limit established for one insurance period shall not constitute a claim event.

15.2. The cover replenishment rules do not apply to the insurance contract, and therefore if a particular policyholder has used up the insurance benefit limits established for the particular insurance period, they will not be entitled to any further benefit during the given insurance period.

15.3. If the service limits established in Annex 1 constituting part of these CTC are modified, the insurer shall inform the contracting party about it in writing no later than 60 days prior to the entry into force of the amendment (i.e., the insurance anniversary date).

16. Exemptions of the insurer

16.1. In the case of a claim event that is classified as indemnity insurance, the insurer shall be exempted from providing the benefit:
– if it can prove that the event constituting the basis of the claim event was caused by the policyholder or a policyholder's relative sharing the same household unlawfully, deliberately or with severely negligent conduct;
– if the contracting party or the policyholder violates the obligation to mitigate or prevent damages, unless the policyholder exercises the right of disposition granted by law and refuses the medical intervention.

16.2. For the purposes of these CTC, it shall be deemed a severely negligent conduct especially when the claim event occurs as a result of
- **a crime deliberately committed by,**
- **severely drunken state of (at least 2.51‰ blood alcohol level);**
- **the condition resulting from the consumption of intoxicating narcotic substances or other substances with a similar impact or as a result of the dependence on toxic substances of;**
- **driving without a valid licence or under the influence of alcohol by**

the persons defined in section 16.1.

16.3. If the health insurance was taken as indemnity insurance, it may not be deemed an event resulting in the exemption of the insurer that the policyholder exercises the right of disposition granted by law and refuses the medical intervention.

17. Events excluded from the insurance cover

17.1. The insurance cover does not extend to events which are the result, either in part or in full, of the following:
a. severely intoxicated state of the policyholder (2.51‰ or higher blood alcohol level);
b. ionising radiation;
c. nuclear energy;
d. care for a HIV infection or other sexually transmitted other diseases (STD);
e. war, military acts, aggressive acts of an alien power, disturbance, coup or attempt coup against the government, mutiny, civil war, revolution, rebellion, demonstration, procession, strike, terrorist act, disturbance at the workplace, fights on the border, uprising.

17.2. For the purposes of these CTC a terrorist action is any violent or potentially violent act which threatens human life, material or intangible assets or infrastructure for any declared political, religious, ideological or ethnical objective or is aimed at or is suitable for influencing a government or creating fear in society or any part thereof.

17.3. The insurer's cover does not extend to the events that are the direct consequence of the events listed below:
a. any illness or medical condition of the policyholder that provably prevailed for five years prior to the start of the insurance cover or was diagnosed within five years prior to the cover or required medical treatment during that period;
b. a permanent health damage of the policyholder established prior to the insurance cover.

17.4. The insurance cover does not extend to:
- **events that are the consequence of an attempted suicide of the policyholder even if the policyholder committed the suicide attempt in a disturbed state of mind;**
- **medical care and services falling within the scope of disaster management and public health defined by law, including the expenses of any mandatory or age and/or job related protective vaccination;**
- **rehabilitation programmes, medical care or service related to alcohol, drug or narcotic dependence or any other addiction as well as any other claim event which is the consequence of excessive alcohol or drug consumption and it can be proved medically.**

17.5. The insurance cover does not extend to events which are the result, either in part or in full, of the following:
- **medical services related to pregnancy, child birth and maternal care, except when pregnancy care is included in the covers of the policyholder;**
- **operations and interventions relating to the treatment and examination of infertility (including all forms of fallopian tube transferability examinations), with the exception of non-invasive infertility relation examinations;**
- **sterilisation upon request;**
- **artificial abortion (for reasons other than medical reasons);**
- **contraception.**

17.6. The insurer's cover does not extend to the following:
- **emergency care or examination (with the exception of outpatient care resulting from urgent need) elimination of threats to life;**
- **expert services, expert opinion medical aptitude examination, writing prescriptions, specialist physician's proposal, examination or care for the purpose of medical evidence;**
- **services related to inherited and congenital disorders;**
- **care and hospice care, life sustaining interventions, geriatric care, all types of long-term care without exception, services used in therapeutic holiday facility, sanatorium, chronic inpatient care institute, old people's home;**
- **treatment, maintenance and rehabilitation of chronic diseases defined in the law, including the regular oncology treatment of cancer patients, migraine treatment, epilepsy treatment and treatment of certain degenerative diseases of the spine (e.g. polydiscopathy), direct or indirect consequences, with the exception of the treatment of the acute phase and the establishment of the first diagnosis;**
- **therapeutic exercises, physiotherapy and other similar types of care, including manual therapy, tapeing, massage, bath cure, with the exception of Annex 1 and Annex 2 of these CTC;**
- **psychotherapy and psychiatric care;**
- **condition maintaining injections and infusion treatments (e.g., circulation improving treatments and vitamin cures without any acute symptoms) and other curative treatment;**
- **medical services belonging to organ and tissue transplant, including also services relating to preparation and follow-up care thereof;**
- **artificial kidney treatment;**
- **in gastroenterology care, the costs of sedation in the case of colonoscopy, with the exception of the Premium package and costs of virtual endoscopy and capsule endoscopy as well as IgG food intolerance tests;**
- **laboratory and diagnostic examinations relating to respiratory allergy, not even on the proposal of a specialist physician, with the exception of the Optimum and Premium packages;**
- **dental care and treatments;**
- **oral surgery interventions;**
- **vision improving ophthalmology operations;**
- **septal deviation treatment;**
- **treatment of varicose veins in the lower limb with injection, laser, radio frequency or other operation;**
- **medical treatment that started prior to the insurance cover;**
- **any physical or mental disease or condition that occurred prior to the start of the cover, in relation to which the policyholder received treatment or treatment was proposed;**
- **in the case of inadequate thyroid operation and insulin resistance, the treatments after the establishment of the diagnosis, with the exception of the Optimum and Premium packages;**
- **overnight sleeping tests somnography, polysomnography);**
- **protective vaccinations and treatment of the complications of protective vaccinations, with the exception of those defined in Annexes 1 and 2 of these CTC;**
- **medicine, bandage and medical aids, in the case of the later with the exception of those defined in Annexes 1 and 2 of these CTC;**
- **scientific medical research conducted on humans;**
- **aesthetic treatments, surgical interventions and the treatment of their complications, plastic surgery;**
- **medical services relating to corpses;**

- **treatments and interventions relating to birthmarks, unless they are medically justified (under these CTC, the excision of a birthmark is medically recommended if there is any alteration on its surface, when it has grown, been damaged or is exposed to irritation, other physical injury or if a complaint is associated with it: i.e., discharge is coming out of it; the reimbursement obligation of the insurer does not extend to the costs of birthmark excision when there is no alteration on the birthmark, it does not cause any complaint and no difference is detected during the regular screening examinations);**
- **of the non-conventional procedures defined in the law, the wellness services, speech therapy and logopedy treatment, bath cure, slimming diet, natural medical factors (e.g., mineral water therapy, thermal waters, sludge, sub-surface climate and all factors that provably have a favourable impact on the human body), services provided by baths and climatic therapeutic institutes and other treatment facilities;**
- **service needs relating to the following confirmed infectious diseases based on test sor clinic (symptoms): TBC, tetanus, polioviruses, measles, mumps, rubeola, hepatitis B, C virus infection, diphtheria, pertussis, tropical diseases such as malaria, yellow fever, cholera, Dengue fever, SARS, any other epidemic diseases (including pandemic diseases);**
- **for services performed in the interest of epidemiology (taking into account the current epidemiology protocols);**
- **vision improving devices, hearing devices and their accessories;**
- **prevention and other preventive treatments, screening examinations and status assessment specified by law, with the exception of the screening tests and examinations included in the service package;**
- **any service performed by an individual and/or institution without any medical qualifications and/or an operating licence;**
- **health damage occurring as a consequence of any health or medical service or treatment;**
- **rehabilitation treatments;**
- **costs of treatments not supported by medical professional protocols accepted in Hungary and generally applied by Hungarian medical service providers, disposable devices and medicinal drugs and biological therapy drugs subject to itemised settlement and costs of procedures, devices and medicinal drugs not accepted or financed by OEP;**
- **procedures described as experimental procedures;**
- **protheses, corrective aids and health equipment which are not required during an operation;**
- **purchase and implantation of any artificial equipment without any exception, also including heart transplant and artificial heart treatment;**
- **sex change, irrespective whether it is made for medical or other reasons;**
- **diseases based on subjective complaints that cannot be justified with objective medical methods;**
- **expert services provided in the framework of health care;**
- **pulmonology care;**
- **addictology care;**
- **occupational health care;**
- **acupuncture treatment;**
- **nail fungus removal with laser;**
- **incontinence devices or operation (e.g., intimate laser treatment);**
- **digital dermatoscopy;**
- **speech therapy treatment;**
- **intensive patient care;**
- **clinical oncology care;**
- **care for hepatitis C patients;**
- **any screening examination, unless it is included in the package applicable to the policyholder pursuant to Annex 1 of these CTC.**

17.7. The insurer's obligation does not apply in cases either when the professional medical regulations were not complied with in the course of the treatment and the repeated operations and treatment occurred as a result of that or some other claim event defined in these contracting terms and conditions occurred due to non-compliance with professional medical regulations (medical malpractice).

17.8. The insurance cover does not extend to the following events relating to sports activities: auto-motor sports (e.g., aurocrash or wreck vehicle sport, go kart, motocross, skill competitions with cars), any type of car racing, caving, cave expeditions, base jump, BMX cross, BMX and skate, speed bike, bungee jumping, diving with a respirator below 40 metres, one-hand and open-sea sailing, parachuting, wall climbing, hill climbing, rock climbing from degree V., heat ballooning, jet ski, air shipping, mountain expedition, motorboat sport, motorcycle sport, private/sports flight/flying sports (e.g., narrow paragliding, air shipping, paragliding, gliding and ultralight flying, acrobatic flying), parachute jumping, base jumping, quad, rally, wild-water rowing, water ski, hydrospeed, canyoning, surf, mountainboard, ski acrobatics, ski jumping, showboarding, pancration).

17.9. The insurer is not obliged to cover or provide any benefit and the insurer shall be obliged to reject any indemnification based on this insurance contract if such a benefit or indemnity payment is subject to any sanction, prohibition or restriction based on a resolution of the United Nations Organisation and/or are subject to any economic or trade sanctions introduced by the European Union, France, the United States of America or any national legislation.

17.10. The insurance cover does not extend to penalty which is imposed by the service partner on the policyholder pursuant to the agreement between them because in the case of one-day surgery the policyholder failed to cancel the operation or modify the date of the planned operation by 16:00 of the previous working day.

18. Cessation of the insurance contract

18.1. The insurance contract ceases to exist in the following cases:

a. If the contracting party ceases to exist without a legal successor, at the time of the cessation without a legal successor.
b. If the insurance term has expired because it was not extended by the parties, at 24:00 on the last day of the insurance term.
c. If the insured group ceases to exist, at the time of cessation of the group.
d. In the event of non-payment of the premium by the contracting party as due, the insurer shall dispatch a written request for payment to the contracting party in default - indicating the potential legal consequences - with a 30-day additional period from the date when the warning was dispatched. In the event of non-compliance within the additional period, the contract shall be terminated with retroactive effect to the original due date, except if the insurer forthwith moves to enforce its claim by judicial process. If the contracting party fails to pay the first premium as due, the insurance contract shall cease to exist on the 30th day from the due date without the commencement of the insurance cover. If contrary to the provisions of section 13.6. of the CTC, the insurer provided a benefit to the policyholder, the insurer shall have the right to reclaim the benefits from the contracting party in relation to the reported claim events.
e. With the termination of the insure pursuant to section 14.2. of these CTC, if there is a major increase in the insurance risk.
f. If the contracting party does not accept the premium amending proposal of the insurer described in section 13.3., at 24:00 hours at the end of the term.
g. Pursuant to section 23.1., if the insurer's service organising partner changes.

18.2. Cessation of the insurance cover

The insurance cover ends at 24:00 hours on the last day of the term or, if the insurance contract ceases to exist sooner, then at 24:00 hours on the date of cessation.
The insurance cover with regard to the individual policyholders shall cease the times defined in section 8. of these CTC.

19. Due date of the claim for benefits

Due date of the claim for a benefit is the day when the policyholder reports the claim event to the service organiser. In the case of the Card Network services, the claim is due at the time of the appointment made online or on the phone.

20. Limitation period

The time limit of the claims arising from an insurance contract is one year from the due date.

21. Legal declarations

The insurer sends its declarations to the contracting party in writing to the last notification address provided by the contracting party and known by the insurer. The insurer shall be obliged to consider legal declarations and notifications received from the contracting party as legally effective only if they were submitted in writing. A declaration is effective if it has been received by the insurer.

22. Residual rights and indexation

The insurance has no residual rights, it may not be premium exempted, or surrendered and shall not entitle the policyholder to any profit share. The insurer does not apply indexation.

23. Other provisions

23.1. The service organising partner may change during the term of the insurance.
The insurer shall arrange for the continuation of the organisation of the services without any disturbance in that case too. The insurer shall notify the contracting party of the change in writing. If the service organising partner changes during the insurance term, the contracting party shall have the right to terminate the insurance contract n writing with a 30-day notice period within 30 days from the receipt of the letter containing the information on the change. In that case, the insurance contract shall cease to exist on the 30th day from the date of receipt of the termination notice by the insurer.

23.2. Annexes 1, 2, 3 and 4 constitute inseparable parts of this contract. The insurance terms and conditions are effective only together with Annexes 1, 2, 3 and 4.

23.3. The insurance contract established on the basis of these CTC shall be governed by the Hungarian law. In matters not regulated in these contracting terms and conditions and in the insurance contract, Act V of 2013 on the Civil Code and the effective Hungarian legal regulations shall prevail.
In taxation law matters relating to the insurance contract, Act CXVII of 1995 on Personal Income Tax. Act LXXXI of 1996 on Corporate Tax and Dividend Tax. Act CL of 2017 on the Rules of Taxation; Act CLI of 2017 on the Rules of Tax Administration and other effective Hungarian legal regulations shall prevail.

23.4. The theoretical and practical information concerning personal data processing and the contact details of the insurer (postal address, telephone number, website address), information about the supervisory authority and consumer protection procedures relating to insurance contracts are included in a separate document prepared under the title of useful information, constituting part of these contracting terms and conditions.

23.5. Please note that the terms and conditions of the exemption of the insurer and the limitations of the insurer's benefit, as well as the exclusions applied in the insurance contract are contained in these contracting terms and conditions emphatically in bold.

24. Significant deviation from the previously applied conditions

We draw your attention to the fact that these terms and conditions differ from the terms and conditions applied by Groupama Biztosító Zrt. from August 15, 2019, as the insurance company has modified these Terms and Conditions in comparison with the previously applied Terms and Conditions as follows:
- clarified the definition of the scope of exclusions
- clarified the definition of online services and the definition of the use of screening tests.
- the name of the healthcare provider partner changed, which was modified in the condition.

We would like to draw your attention to the fact that the conditions for the insurer's exemption, the limitation of the insurer's service and the exclusions applied in the insurance contract are included in this contract condition in a bold font.The insurer's key data
Name: Groupama Biztosító Zrt.
Registered office: 1146 Budapest, Erzsébet királyné útja 1/C
Postal address: 1380 Budapest, Pf. 1049
Website: www.groupama.hu
Legal form: private limited company (established in 1987)
Company registration number: Cg. 01-10-041071
Our company was registered at the Court of Registration of the Budapest-Capital Regional Court

1. Annex 1: Summary table of service covers

The benefit amount and itemised limits defined in the table in this Annex 1 relate to one insurance period.

	Insurance package
Exclusion of antecedent illnesses	**yes, except medical primary care**
Waiting period	**the insurer does not apply**
Screening tests	**not included**
Total service limit	**HUF 2 000 000 Ft/insured/study semester**
Non-stop call center (in English)	**yes**
Health care organization (in English)	**yes**
Outpatient care *- medical primary care (English-speaking general practitioner care)* *- specialist care (including outpatient surgeries)* *- laboratory tests* *- diagnostic examinations* *- outpatient care resulting from urgent need* *- medical home visit (in medically justified acute cases)*	**up to the student semester limit**
One-day surgery	**up to the student semester limit**
Inpatient care *- surgical interventions* *- hospitalization*	**up to the student semester limit**
Costs of medical aids (without deductible)	**maximum HUF 100 000 (within the student semester limit)**
Costs of medicines and bandages (without deductible)	**maximum HUF 100 000 (within the student semester limit)**
Patient transport (in medically justified acute cases)	**up to the student semester limit**
Home delivery costs (in medically justified acute cases)	**up to the student semester limit**

Groupama Biztosító
Az OTP Csoport partnere

Annex 2: The insurer's benefits

1. Assistance benefits

1.1. Assistance line
1.1.1. Insurance benefit
24-hour medical call center and online consultancy
The insurer provides constant accessibility to its health insurance call center in the Hungarian language and addition at least in English through its health service organising partner, Europ Assistance Magyarország Kft(hereinafter service provider). Medical advice is available at the health insurance call center on each day of the year, for 24 hours a day, on the following phone number which is not charged at a premium rate:
+36 1 465-3764
On the designated telephone number the policyholder may receive information from qualified and practicing physicians on the following:
- explanation of medical terms and hospital discharge reports;
- explanation of the laboratory results and subsequent correlations;
- explanation of medical procedures;
- issues relating to the disease, the treatment and health preservation;
- composition and applicability, side effects of medicinal drugs, their substitutability and prices;
- medical, paediatric and dental duty services;
- pharmacies on duty;
- contact details of health institutions.

The medical call center is also available on the 'online medical advice' interface on the website http://egeszsegbiztositas.groupama.hu, where the parties eligible for the service may ask their questions in writing, and attach images and results if they wish, requesting a return call. The service provider sends a response to the e-mail address provided by the party eligible for the service within 24 hours from the question.
1.1.2. Insurance benefit limit
The service defined in section 1.1. may be used in each package on an unlimited number of occasions.
1.1.3. Use of the assistance line service
1.1.3.1. The assistance line service may be used by calling the telephone number defined in section 1.1.1. of Annex 2 of the contracting terms and conditions.
When the service is used, the service provider always identifies the policyholder. The policyholder identifies themselves and the contracting party with the following data:
- contracting party's name;
- policyholder's name;
- policyholder's place and date of birth;
- mother's name of the policyholder;
- policyholder's permanent address.

1.1.3.2. The information provided during the assistance line service is for information only and cannot substitute a personal medical examination.
1.1.3.3. The insurer shall not take any responsibility for the accuracy, reliability, erroneous use or erroneous interpretation of the information provided within the framework of the assistance line service, or for any financial and non-financial damage resulting from the lack of delay in the supply of the requested information, or any wrong or erroneous statement in the medical opinion.

1.2. Basic services available with the Online Health Portal:
1.2.1. Insurance benefits
1.2.1.1. Online cardiovascular status assessment
The service provider publishes an online questionnaire about lifestyle and cardiovascular risks on the http://egeszsegbiztositas.groupama.hu website. Following its completion, any party eligible for the service may print out or send via e-mail to any address the evaluation and the lifestyle advice prepared on the basis of the responses. Medical advice may be requested on the phone or online also in relation to the service defined in this section.
1.2.1.2. Cardiovascular calculator, BMI calculator
The insurer's service organising partner makes available a user friendly risk calculator for the risks of severe cardiovascular diseases and an ideal bodyweight BMI calculator for the parties eligible for the service on the http://egeszsegbiztositas.groupama.hu website.
1.2.1.3. Dietetic consultation online and on the phone
On the 'online dietetic consultation' interface of the http://egeszsegbiztositas.groupama.hu website, the dietetic experts of the insurer's service organising partner respond to the questions asked by the party eligible for the service on that topic. The service provider sends a response to the e-mail address provided by the party eligible for the service within 24 working hours from the question.
1.2.1.4. Training and other locomotor organ advice online and on the phone
Parties eligible for the service may ask fitness, training and sports habits related questions online at the http://egeszsegbiztositas.groupama.hu website on the 'training/locomotor organ advice' interface, where the experts of the insurer's service organising partner respond to the questions and give advice. The service provider sends a response to the e-mail address provided by the party eligible for the service within 24 working hours from the question or responds with a telephone advice in a returned phone call, if that was requested by the policyholder.
1.2.1.5. Premium discounts offered by the medical service providers, map finder
The insurer's service organising partner offers a map finder application to the parties eligible for the service online at the http://egeszsegbiztositas.groupama.hu website, with the help of which the medical service provider where the eligible party intends to use a medical service can be selected on the basis of geographic location, available medical services and diagnostic tests. This application also provides a detailed presentation of the medical service provider and the party eligible for the service can also download a certificate for discount, which

enables them to use the services of a medical service provider with a discount. Following the use of the service, the service provider runs a quality check.

1.2.1.6. Making an appointment on the phone or online for a vaccination against influenza or for a screening test directly at the medical service provider within the framework of the Card Network service

The policyholders can make an appointment for a protective vaccination against influenza and for screening tests individually, directly with the medical service provider within the framework of the basic services of the Online Health Portal in accordance with sections 5, 11 and 12 of this Annex 2.

1.2.2. Insurance benefit limit

The service defined in section 1.2.1. may be used on an unlimited number of occasions.

1.2.3. Use of the Online Health Portal services

1.2.3.1. The services defined in Section 1.2.1. of this Annex 2 may be used at the website defined in Section 1.2.1.

1.2.3.2. Within the framework of the Online Health Portal services defined in section 1.2.1., the insurer sends a welcome e-mail to the policyholder when the insurance contract is established. The e-mal contains a reference, where the policyholder can generate a password. While using the Online Health Portal services, the policyholder shall use that password to identify themselves in the course of each login.

2. Specialist physician examinations (outpatient specialised care)

2.1. Insurance benefits

2.1.1. Specialist physician examinations

Within the framework of outpatient specialised care, the insurer may provide the following services depending on the specific insurance package:

- specialist physician examinations;
- laboratory tests;
- diagnostic tests (except high-value diagnostics);
- pregnancy care;
- physiotherapy:
- home visit service in Budapest.

The services provided by the insurer in each package and the top limit of the reimbursement obligation for individual examinations and services under the packages are included in Annex 1.

If pursuant to the framework contract the insurance package also covers a preliminary disease, the Supplementary Card Network service can be used for organising outpatient specialised care ,within the framework of which outpatient specialised care may be organised by the policyholder individually with the medical service providers indicated on the Health Portal either online or on the phone in the following areas: internal medicine, dermatology, otolaryngology, gastroenterology, cardiology, gynaecology, surgery, ophthalmology, traumatology orthopaedics and urology. The examining specialist physician and the service organiser decide on the need for any further examinations.

Within the framework of the pregnancy care service, the insurer covers any kind of specialist physician examination. The insurer provides the pregnancy care service only with the Comfort, Optimum and Premium packages.

The insurer provides the physiotherapy service only with the Comfort and Premium packages.

Within the framework of outpatient specialised care, the insurance cover extends also to specialist physician examinations performed in relation to infertility not classified as an exclusion pursuant to section 17 of these contracting terms and conditions but required on the basis of the proposal of a physician.

2.1.2. Laboratory tests

The service organiser shall have the right to request a specialist physician's referral for laboratory tests in compliance with 12.6.5. of these CTC.

2.1.3. Diagnostic tests

The insurance benefit is a medical test ordered only by a physician to detect the cause of the complaint or clarify the condition of the policyholder, or to certify or preclude the existence of an illness, which itself is not aimed at changing the condition. The insurer does not cover high-value diagnostic tests within the framework of diagnostic tests defined in this section.

2.1.4. Home visit in Budapest

The claim event is the policyholder's need for a medical service within the framework of a home visit in a medically justified, acute case.

When a claim event occurs, the service organiser arranges for the medical service provider's physician to visit the policyholder in their home at the agreed address within the agreed time and provide a duty-type medical service to them or, if necessary, arranges for some other emergency or informative care.

The insurer provides this service only in Budapest in 24 hours every day of the year.

The notification of the claim event does not mean immediate availability. The insurer and the insurer's service provider agrees to implement the visit within 3 hours.

The home visit service cannot be used for treatment in communal or public areas (e.g., road, square, park, sports field, etc.).

Treatment within the framework of a home visit may be requested when

- **the policyholder's health condition has deteriorated unexpectedly;**
- **on the basis of the notification and the responses to the questions it may be assumed that the problem can be resolved in the policyholder's home without the involvement of a specialist physician (e.g., the complaint did not occur in relation to pregnancy or childbirth);**
- **no immediate medical intervention is required that cannot be delayed (thus, e.g., on the basis on the notification, the policyholder's condition does not justify an emergency service or immediate ambulance service).**

The insurer's home visit service may be used with the payment of 30% excess.

The home visit service may not be used with a subsequent reimbursement claim.

The insurer provides the home visit service only with the Comfort, Optimum and Premium packages.

2.2. Waiting period and history assessment

Within the framework of the outpatient specialised care defined in section 2 of this Annex 2, the insurer sets a 6-month waiting period for pregnancy care services, which is calculated from the establishment of the insurance cover. If the claim event occurs during the waiting period, the insurer does not provide any benefit.

Unless it is provided otherwise, the insurer's risk cover extends only to medical services used as a result of an accident occurring during the cover period or an illness that presumably occurs without any preceding event following the start of the cover period.

2.3. Date modification and cancellation

The policyholder can modify or cancel the appointment for the examination or treatment defined in this section 2 appointment by 16:00 of the working day which precedes the date of the examination or treatment. If the policyholder does not fulfil that obligation or does not appear at the medical service provider at the arranged time, it should be considered as if the policyholder used the service and therefore the cost of the service shall be deducted from the applicable annual service limit (limit). In that case, the requested service cannot be used for the subsequent 3 months. The service organiser shall modify the date of the cancelled medical service on one occasion.

3. High-value diagnostics

3.1. The insurer's benefit

A **CT, MR, PET CT and cardio CT test,** ordered only by a physician in order to detect the cause of the complaint or clarify the condition of the policyholder, or to certify or preclude the existence of an illness, which itself is not aimed at changing the condition.

The insurer's high-value diagnostic test service defined in this section 3 can only be used on the basis of a recommendation of a specialist physician's.

The top limit of the reimbursement obligation related to high-value diagnostic tests defined by the insurer are included in Annex 1.

3.2. Waiting period and history assessment

The insurer does not define a waiting period for its high-value diagnostic service defined in this section 3.

Unless it is provided otherwise, the insurer's risk cover extends only to medical services used as a result of an accident occurring during the cover period or an illness that presumably occurs without any preceding event following the start of the cover period.

3.3. Events excluded from the insurance cover

In addition to the exclusions defined in the contracting terms and conditions, in the framework of the services defined in this section 3, the insurance cover does not extend to the following treatment/event:

CT laser mammography test.

3.4. Date modification and cancellation

The policyholder can modify or cancel the appointment for the examination defined in this section 3 appointment by 16:00 of the working day which precedes the date of the examination. If the policyholder does not fulfil that obligation or does not appear at the medical service provider at the arranged time, it should be considered as if the policyholder used the service and therefore the cost of the service shall be deducted from the applicable annual service limit (limit). In that case, the requested service cannot be used for the subsequent 3 months. The service organiser shall modify the date of the cancelled medical service on one occasion.

4. One-day surgery

4.1. Insurance benefit

The insurance benefit extends to scheduled and programmed surgical interventions and operations of the policyholder that are defined in the law and satisfy the following criteria:

- it occurs during the cover period without any preceding event since the start of the cover period; and
- it is defined in the law and is performed by medical service provider licensed for it, providing that the service is justified and may be performed according to the physician's expert opinion and the medical standards based on the choice of the policyholder opting for the service and the test results; and
- following the intervention, the policyholder can leave the medical institution on their own feet, with a companion, based on the physician's expert opinion and following observation, within 24 hours from their admission to the institution (with the exception of leaving on their own responsibility and cases when the specialist physician believes that more than 24-hour hospital stay is required);
- furthermore, the insurance service applies only to services which may be used in a Hungarian medical service provider for payment.

Within the framework of one-day surgery, the insurance risk relates only to the interventions included in the list of operations in an Annex 3 of these CTC.

Within the framework of one-day surgery, the insurer also reimburses the cost of medicinal drugs, blood products, disposable devices, implants, used and directly required for the operation as well as the cost of the related hotel service provided by the medical service provider.
The insurer's service may be used subject to prior notification to the service organiser before the service is actually used.
The insurer's physician shall have the right to override the need for the treatment prior to the insurance pay-out.
The top limit of the reimbursement obligation relating to the one-day surgery service defined by the insurer are included in Annex 1.

4.2. Waiting period and history assessment

The insurer sets a 3-month waiting period for its one-day surgery service defined in this section 4. If the claim event occurs during the waiting period, the insurer does not provide any benefit.
The insurer covers the risks only in relation to the medical services used by the policyholder as a result of an accident or a presumed disease that occurs during the cover period without any preceding event.

4.3. Events excluded from the insurance cover

In addition to the exclusions defined in the contracting terms and conditions, in the framework of the services defined in this section 4, the insurance cover does not extend to the following:

- **Reimbursement of costs (e.g., travel costs) other than the cost of organisation of the treatment and the costs of the intervention, not listed in section 4.1. of this Annex 2.**
- **If any unforeseen complication occurs during the operation due to which the policyholder stays in the treating institution for more than 24 hours after the treatment or requires inpatient care, the insurer shall not reimburse any incurred additional cost.**

4.4. Date modification and cancellation

The policyholder can modify or cancel the appointment for the treatment defined in this section 4 appointment by 16:00 of the working day which precedes the date of the treatment. If the policyholder does not fulfil that obligation or does not appear at the medical service provider at the arranged time, it should be considered as if the policyholder used the service and therefore the cost of the service shall be deducted from the applicable annual service limit (limit). In that case, the requested service cannot be used for the subsequent 3 months. The service organiser shall modify the date of the cancelled medical service on one occasion.

5. Screening test

5.1. The insurer's benefit

Within the framework of the service defined in this section, the following screening packages can be used on one occasion during each insurance period as specified below:

Within the framework of the Comfort package:

- abdominal ultrasound;
- gynaecological screening test and cytology for ladies;
- urological screening test and PSA for gentlemen.

Within the framework of the Optimum package:

- abdominal ultrasound;
- chest X-ray;
- internal medicine screening test;
- laboratory test (faeces blood test too);
- gynaecological screening test and cytology for ladies;
- urological screening test and PSA for gentlemen.

Within the framework of the Premium package:

- abdominal ultrasound;
- chest X-ray;
- internal medicine screening test;
- mammography;
- breast ultrasound;
- pulmonology screening test (with spirometry);
- laboratory test (faeces blood test too);
- gynaecological screening test and cytology for ladies;
- urological screening test and PSA for gentlemen;
- dental screening (panorama X-ray and status assessment)
- dermatoscopic birthmark screening, which does not extend to any further service or treatment recommended on the basis of a specialist physician's proposal.

The tests of the screening test packages specified in this section may be used according to the choice of the policyholder in each insurance period, i.e., they may choose a complete screening package or specific tests.

If the insured wants to use only certain tests within a screening test package, the request for each screening test must be reported to the care provider at the same time, the request cannot be made in several details. Within 30 days of the request, the insurance provider's service organizing partner will inform the insured about the dates of the organized examinations. If the insured requires only a part of the screening tests at the same time within the package specified in this point, he is not entitled to use only those screening tests at a later time within the same insurance period.

In order to take part in a screening test, the policyholder may use the map finder service of the Online Health Portal to select the medical service provider which is the closest to their home address. The service may be requested by using the service provider's contact details available on the Health Portal online or on the phone. Within the framework of the Card Network services, the insurance cover may be certified with the virtual health card sent to the policyholder. If the policyholder cannot find an adequate medical service provider with the help of the online Health Portal map finder service, they may request the organisation of the screening test at the medical call center. If the policyholder does not wish to use the service provider recommended by the service organiser on the phone or through the online map finder, they may take part in the screening test at the medical service provider selected by them and submit the invoice for the service to the insurer online, through the Health Portal subsequently. Upon the policyholder's request the screening test results may be uploaded through the medical call center or online to the Health Portal, where they will be assessed by the insurer.

If the basis of the results further medical examinations are needed, the insurer shall organise them under the limit defined for each type of service in Annex 1.

5.2. Date modification and cancellation

Prior to screening tests defined in this section 5, the policyholder can modify or cancel the appointment by 16:00 of the working day prior to the date of the screening test. If the policyholder does not fulfil that obligation or does not appear at the medical service provider at the arranged time, it should be considered as if the policyholder used the service and therefore the cost of the service shall be deducted from the applicable annual service limit (limit). In that case, the requested service cannot be used for the subsequent 3 months. The service organiser shall modify the date of the cancelled medical service on one occasion.

6. International second medical opinion

The insurer undertakes to receive telephone calls from the policyholder on working days between 8:00 and 20:00 and provides a service pursuant to these contracting terms and conditions through its medical service provider partner Advance Medical Hungary Kft. (address: 1085 Budapest, Baross utca 22.; tax number: 13613781-2-42, hereinafter service provider).

Definitions

Life threatening illness or high-complexity intervention: Diseases and conditions when even following the treatments and interventions made according to the medical standards the condition of the policyholder remains so serious that despite adequate treatment the life threatening status still prevails when the need for the service is reported and the policyholder has been in inpatient care at the intensive department concurrently for more than 20 days. Highly complex surgical interventions include not only to the scheduled interventions due to diseases listed in the claim events in section 6.1., but also those that affect at least two organs or during the performance of which the abdominal and chest cavity are simultaneously open (open surgery) and other procedures which may not be performed in Hungary within the state health system but the National Health Fund allows and supports the performance thereof abroad. Interventions for diagnostic purposes do not qualify as highly complex interventions even if they involve the opening of a body cavity.

Life threatening cancerous disease (malignant tumour): In the case of a malignant tumour, the cells showing signs of histological atypology (malignant cells) multiply uncontrollably, and during the process the malignant cells spread breaking through tissue borders (invasion), there is a risk of establishment and multiplication of malignant cells in remote organs and the invasion of that organ (metastasis).

According to these contracting terms and conditions, the malignant diseases also include malignant tumours of blood generating tissues (leukaemia), reticuloendotelial tumours and tumours starting from the lymphatic system (lymphomas), malignant plasma cell disorders (plasma cell myeloma). The insurance cover does not extend to the following groups of malignant tumours:

– pre-cancerous (praecarcinoma) conditions;
– tumours that do not invade into the environment (in situ) (T1M0N0 status tumours according to the TMN categories);
– skin cancer, with the exception of malignant tumours of pigmented birthmarks (melanoma malignum);
– any tumour occurring with a HIV positive diagnosis.

Degenerative diseases of the neural system and demyelinisation: Irreversible distortion of the brain and the spinal cord as well as of the brain and spinal cord nerves, with predicted further progress on the basis of the examination and treatment neurology results. The diagnosis must be clearly supported with adequate diagnostic procedures.

Neurology and neurosurgery diseases, including a cerebrovascular disaster: Diseases of the brain and the spinal cord during the operation of which the intervention affects the brain or the spinal cord through the opened skull or spine. This category does not include the removal of a subdural haematoma or an operation on a herniated disc. For the purposes of these contracting terms and conditions, a cerebrovascular disaster is any pathological condition that develops within the skull (vascular rupture, full or partial vascular blockage as a result of a thrombosis or emboli) as a result of which the areas of the central nervous system supplied by the respective blood vessels die, sustain an infarct or the event leads to permanent organic or neural system damage (source symptom), i.e., the physical symptoms indicating the damage can clearly be detected even 30 days after the cerebrovascular disaster.

Organ transplants: Any surgical intervention during which a heart, heart and lung, liver or kidney is transplanted from the body of the donor into the body of the recipient and the institution performing the transplant declared the need for the organ transplant for some reason and the policyholder has been added to the waiting list for an organ transplant. Tissue and cell transplant does not fall within the definition of organ transplant and therefore pancreas, skin, bone, bone marrow transplant, cornea transplant and transfusion do not qualify as claim events.

Cardiac diseases, including cardiovascular surgery: The death of heart muscles (cardiac infarct) means that certain parts of the heart muscles die due to the inadequate blood supply in the dead area. Only such pathological conditions may be deemed as myocardial infarction where the size of the damaged area is such that it generates a pathological Q-wave, detectable also with ordinary ECG registration techniques, i.e., the myocardial infarction is transmural. For the purposes of these contracting terms and conditions, cardiovascular surgery includes open heart surgery involving the coronary arteries and operations on the aorta/the indication of such operations. The need for operation may only be declared by the physician making the intervention/institute eligible for examination based on the examination results of the institute eligible for performing the operation/examination. The possibility of an operation is not the same as the indication or need for an operation.

Diseases and problems resulting from renal failure: It is a type of chronic renal failure where the operation of both kidneys has reduced irreversibly and that reduction is such that without artificial kidney treatment or a kidney transplant that condition would become incompatible with life and which requires regular kidney treatment and control.

6.1. Claim event

A claim event is a diagnosed disease or detected medical condition of the policyholder during the insurance cover period that leads to the events included in the list below and in relation to which a second medical opinion may be requested in writing, in the Hungarian language. The insurer provides a second medical opinion referred to in these CTC only in relation to the following diseases:

– life threatening cancerous disease (malignant tumour);
– cardiac diseases, including cardiovascular surgery:
– organ transplants;
– neurological disease and neurosurgery, including cerebrovascular disasters;
– degenerative diseases of the neural system and demyelinisation:
– diseases and problems resulting from renal failure;
– life threatening illness or high-complexity intervention.

6.2. Insurer's benefit

For the purposes of these CTC, it is a medical analytical service within the framework of which a body consisting of qualified medical experts reviews the medical documentation of the policyholder (medical history, hospital discharge reports, examination results, etc.), and then a reputable

foreign medical expert of the given medical area with high-level professional experience issues a second medical opinion for the diagnosis concerned based on the detailed review analysis and assessment of the medical documentation.
While this service is used, the policyholder can consult an independent specialist physician to obtain an opinion on the adequacy of the previously established diagnosis and the planned or already pursued therapy.
The second medical opinion is not a requirement for treatment and it does not substitute the treating physician's expert opinion, only supplements it.
The insurer shall not take any responsibility for the erroneous interpretation of the second medical opinion or its consequences.
Conditions of the performance of the service
The request for the service must be reported through the phone during the cover period. When this insurance contract is concluded, the telephone number to be used is +36 1 461 1550.

- In relation to the request for the service, the complete medical documentation of the reported case (all documents generated during outpatient and inpatient care between the first treatment and the submission of the claim, including imaging tests and laboratory results, with the exception of the documents of medical treatments and services organised by the service organiser).
- In order to perform the service smoothly, the party providing the service may request further information for preparing the second medical opinion and may also maintain contact with the policyholder and the treating physician if required and then shall send the second medical opinion prepared by international experts about the diagnosed condition to the policyholder and, when requested, to the treating physician.
- The insurer shall have the right to have the health condition of the policyholder checked by the physicians defined by the insurer and to accept or reject the request for the service according to the result.
- The Policyholder is only entitled to request a second medical opinion when a physician in possession of an official license for medical practise in Hungary already examined the Insured for the illness constituting the subject matter of the requested expert opinion and prepared medical records of the examination and issued a written diagnosis.
- The insurer may specify a medical examination as the condition of the performance of the service. If that is required, the insurer's service does not fall due until the policyholder allows for the medical examination.

Conditions of use:

a. a second medical opinion may be requested in relation to a particular disease on only one occasion;
b. following completed interventions, only a proposal for subsequent treatment and care may be requested (no opinion can be issued on the completed intervention);
c. in the case of any need for urgent treatment obtaining an opinion is not recommended because of the time required (approximately 1 month);
d. no opinion may be requested for policyholders who do not take part in the experimental procedure or for procedures not authorised by the Hungarian health system;
e. the second medical opinion cannot be used in either a legal procedure or for other (e.g., scientific) purposes;
f. no second medical opinion may be requested in the case of hereditary or congenital diseases or disorders.

6.3. Waiting period and history assessment

The insurer waives the waiting period in relation to the supply of a second medical opinion defined in this section 6.
With regard to a second medical opinion defined in this Section 6, the insurance cover applies only to a disease or detected medical condition diagnosed within the cover period in compliance with section 61.

7. Cost reimbursement of operations

7.1. Claim event and the insurer's benefits

In case the policyholder has an operation specified in section 2.29. of the contracting terms and conditions due to an accident or illness that occurs during the cover period, the insurer shall organise the operation for the policyholder and reimburse the costs of inpatient medical institute treatment relating to it directly to the medical service provider up to the amount stated in Annex 1 based on an invoice issued by the inpatient medical institute.

If the medical service defined in this section was not organised by the insurer, then the insurer shall subsequently reimburse the costs of the service pre-financed by the policyholder to the policyholder based on the invoice issued by the inpatient medical institute.

The insurer's service defined in this section may be used only in relation to operations indicated in Annex 4.

7.2. Waiting period and history assessment

The insurer defines a 3-month waiting period for its reimbursement of the cost of operation service defined in this section 7. If the claim event occurs during the waiting period, the insurer does not provide any benefit.

The insurance cover extends only to medical services used as a result of an accident occurring during the risk assumption period or an illness that occurs without any preceding event following the start of the risk cover.

7.3. Date modification and cancellation

The policyholder can modify or cancel the appointment for the treatment defined in this section 7 appointment by 16:00 of the working day which precedes the date of the examination or treatment. If the policyholder does not fulfil that obligation or does not appear at the medical service provider at the arranged time, it should be considered as if the policyholder used the service and therefore the cost of the service shall be deducted from the limit for the service or the applicable annual service limit (limit). In that case, the requested service cannot be used for the subsequent 3 months. The service organiser shall modify the date of the cancelled medical service on one occasion.

8. Patient transportation

8.1. Insurance benefit

Transportation of the policyholder based on an order of an authorised physician in compliance with the legal regulations outside the state health service system to a domestic address specified by the policyholder or to a rehabilitation institute if the policyholder ordered it at the service organiser at least 24 hours in advance.
If the policyholder requests patient transportation due to an emergency (accident, sudden medical condition, fainting, etc.), then the central ambulance phone number must be called (104). The patient transportation is covered by the insurance only when the transportation is made to a specialist physician's examination.

8.2. Insurance benefit limit

The policyholder or his authorised party reports the need for the service at the service organising partner at least 24 hours prior to the planned hospital discharge or not later than by 16:00 hours of the day which precedes the date of discharge.
The insurer finances patient transportation for the policyholder on no more than 100 kilometre distance within one insurance period.
Reason for the stay in an inpatient medical institute in relation to which the insurer's service can be used:

- **operation on a lower limb or on both upper limbs;**
- **operation involving the opening of a bodily cavity (abdominal cavity, chest cavity);**
- **operation performed on the head or neck, as a result of which inadequate organ or neural system operation occurs even temporarily or there is some other sudden illness or condition which leads to severe restriction of movement of the policyholder where the policyholder can move around only by using or with the help of some aid device;**
- **the hospital stay did not involve a cure type or repetitive treatment;**
- **the transportation requires no more than a paramedic companion;**

8.3. Waiting period and history assessment

The insurer waives the waiting period in relation to the patient transportation defined in this section 8.
Unless it is provided otherwise, the insurer's risk cover extends only to medical services used as a result of an accident occurring during the cover period or an illness that presumably occurs without any preceding event following the start of the cover period.

8.4. Date modification and cancellation

The policyholder can modify or cancel the appointment for the service defined in this section 8 appointment by 16:00 of the working day which precedes the date of the service. If the policyholder does not fulfil that obligation or does not use the service at the arranged time, it should be considered as if the policyholder used the service and therefore the cost of the service shall be deducted from the limit for the service. In that case, the requested service cannot be used for the subsequent 3 months. The service organiser shall modify the date of the cancelled medical service on one occasion.

9. VIP hospital treatment with subsequent reimbursement

9.1. Insurance benefit

The insurer subsequently reimburses to the policyholder the costs of medical treatment in a Hungarian inpatient medical institute certified with an invoice issued by the inpatient medical institute that incurred outside the medical service (e.g., a room with higher comforts).

9.2. Insurance benefit limit

VIP-level inpatient service may be used for no more than 30 days in one insurance period, which the insurer covers up to the service limit defined in Annex 1 for each day. Any cost that exceeds the reimbursement indicated above shall be covered by the policyholder. The inpatient care could be a one-off treatment or an interrupted treatment.

9.3. Waiting period and history assessment

The insurer waives the waiting period in relation to the subsequent reimbursement of VIP hospital care service defined in this section 9.
The insurer's risk cover extends only to medical services used as a result of an accident occurring during the risk assumption period or an illness that presumably occurs without any preceding event following the start of the risk cover.

10. Financing of medical aids

10.1. Insurance benefit

The insurer subsequently reimburses to the policyholder the cost of a medical aid certified with an invoice, incurred in Hungary for the recovery of the policyholder in relation to an accident or disease occurring during the cover period or without any preceding event after the start of the cover period and pre-financed by the policyholder.

For the purposes of these contracting terms and conditions, the following do not qualify as medical aids and they are not included in the insurance cover:

- **glasses;**
- **contact lenses;**
- **hearing aid;**
- **braces;**
- **nappies.**

For the purposes of these contracting terms and conditions, medical aids include only the following devices defined in the applicable legal regulations as such:

- wheelchair;
- walking sticks;
- crutch;
- fastener.

10.2. Waiting period and history assessment

The insurer waives the waiting period in relation to its financing of medical aids service defined in this section 10.

The insurance cover extends only to medical services used as a result of an accident occurring during the risk assumption period or an illness that occurs without any preceding event following the start of the risk cover.

11. Anti-influenza protective vaccination free of charge

11.1. Insurance benefit

The insurer reimburses the cost of vaccination bought and pre-financed by the policyholder and the price of its injection on one occasion in each insurance period.

In order to use the service, the policyholder may select a medical service provider that is close to their address by using the map finder service of the Online Health Portal. The service may be requested by using the service provider's contact details available on the Health Portal online or on the phone. Within the framework of the Card Network services, the insurance cover may be certified with the virtual health card sent to the policyholder. If the policyholder cannot find an adequate medical service provider with the help of the map finder service of the online Health Portal, then they can request the arrangements for the protective vaccination through the medical call center. If the policyholder does not wish to use the service provider recommended by the service organiser on the phone or through the online map finder, they may also request the medical service provider selected by them to inject the vaccination and submit the invoice for the service to the insurer online, through the Health Portal subsequently online.

11.2. Waiting period and history assessment

The insurer waives the waiting period in relation to its anti-influenza protective vaccination free of charge service defined in this section 11.

The insurance cover extends only to medical services used during the cover period.

12. Online Card Network benefits

According to section 2.8. of the contracting terms and conditions, the appointment for an anti-influenza protective vaccination or screening test on the phone or online, available with the Card Network Service, is a service that can be used directly at the medical service provider as a basic service of the Online Health Portal, while the organisation for outpatient specialised care under the Supplementary Card Network service may be attached to the insurance packages defined in Annex 1. The online Card Network services are available within the Online Health Portal at http://egeszsegbiztositas.groupama.hu.

12.1. Insurance benefit

The insurer sends a virtual health card to the eligible persons by e-mail at the time of the establishment of the insurance contract to the e-mail address specified by the policyholder. The health card contains the name and individual ID number of the policyholder, with the help of which the policyholder can individually request medical services. The medical service provider where the treatment may be requested individually can be selected with the map finder available on the Health Portal. The service may be requested by using the service provider's contact details available on the Health Portal online or on the phone.

The party eligible for the service may make an appointment for personalised screening tests defined in section 5 of this Annex 2 in the online basic services category, for the anti-influenza protective vaccination defined in section 11 of this Annex 2 and, if the insurance also covers preliminary diseases, then in the following medical fields within the framework of the Supplementary Card Network service outpatient specialised care organisation, without any prior notification to insurer's service organiser partner: internal medicine, dermatology, otolaryngology, gastroenterology, cardiology, gynaecology, surgery, ophthalmology, traumatology, orthopaedics and urology. Within the framework of the outpatient specialised care under the Supplementary Card Network service, the medical service provider is entitled to initiate another medical service in the course of the originally requested medical service without any prior notification to the insurer's service organising partner.

Following the use of the medical service, the party eligible for the service receives the result; service provider sends the invoice issued for the used medical service directly to the insurer's service organising partner.

12.2. Insurance benefit limit

The service defined in section 12.1. may be used on an unlimited number of occasions after the occurrence of the claim event.

12.3. Use of the Card Network services:

12.3.1. The Card Network services are available at the website defined in this section in compliance with section 1.2.3. (e-mail address and individual password).

12.3.2. Within the framework of the Card Network services available on the Online Health Portal services defined in this section 12, the insurer sends a welcome e-mail to the policyholder when the insurance contract is established. The e-mal contains a reference, where the policyholder can generate a password. While using the Card Network services, the policyholder shall use that password to identify themselves in the course of each login.

Groupama Biztosító
Az OTP Csoport partnere

Annex 3: One-day surgery operations:

Otolaryngology
Maxillary sinus interventions, endoscopic interventions, minor salivary gland surgery

OENO code	Definition
52210	Maxillary sinus drainage (intranasal fenestration by Lothrop)
52220	Luc-Caldwell operation
52270	Endoscopic (microscopic) maxillary sinus surgery
52500	Excisio laesionis linguae
52600	Incision of salivary gland or salivary duct
52630	Reconstruction of salivary gland or salivary duct
52760	Resectio uvulae

Gastroenterology
Endoscopic esophagus, stomach, duodenum, gall bladder and colon intervention

OENO code	Definition
16361	Endoscopic sphincterotomy
16363	Endoscopic stone extraction
16367	Wirsungotomia endoscopica et dilatatio eadem
54490	Endoscopic polypectomy in the upper gastrointestinal tract
54523	Polypectomia colontos per colonoscopiam
54693	Polypectomia sigmae, sigmoidoscopic

Neurosurgery
Nerve compression syndromes treatment

OENO code	Definition
50432	Carpal tunnel release
50435	Other nerve compression syndromes surgery

Gynaecology
Laparoscopic uterus, tuba and ovary surgery, therapeurtic curettre, cervix surgeries, vaginal platic surgeries and other minor gynaecology surgeries

OENO code	Definition
16611	Falloposcopia laparoscopica
55433	Excisio endometriosis peritonei laparoscopica
55435	Ablatio endometriomae ovarii laparoscopica unilat.
55436	Ablatio endometriomae ovarii laparoscopica bilat.
56515	Cystectomia ovarii / parovarialis laparoscopica unilat.
56516	Cystectomia ovarii / parovarialis laparoscopica bilat.
56517	Cauterisatio ovarii laparoscopica (drilling)
56518	Resectio ovarii laparoscopica unilateralis
56519	Resectio ovariorum laparoscopica bilateralis
56521	Oophorectomia unilateralis laparoscopica
56531	Salpingo-oophoprectomia laparoscopica unilateralis
56541	Oophorectomia bilateralis laparoscopica
56552	Salpingo-oophorectomia bilateralis laparoscopica
56571	Adhaesiolysis laparoscopica
56592	Detorquatio ovarii laparoscopica
56602	Salpingostomia unilat. laparoscopica
56603	Salpingostomia bilat. laparoscopica
56611	Salpingectomia laparoscopica unilateralis
56622	Salpingectomia laparoscopica bilaterale
56651	Salpingectomia partiale laparoscopica
5666A	Salpingo-stomatoplastica laparoscopica
5666C	Adnexectomia laparoscopica
56672	Chromopertubatio laparoscopica
56710	Conisatio portionis uteri
56720	Excision of cervix lesion
56721	Kryoconisatio portionis
56722	Electroconisatio portionis
56723	Uterus polyp removal
56740	Cervix uteri surgical reconstruction
56741	Cervical plastic surgery
56742	Cerclage colli uteri
56812	Septum uteri excision (hysteroscop)

Surgery
Inguinal hernia and umbilical hernia surgery, treatment of hemorrhoid and anal fistulas

OENO code	Definition
54911	Exstirpatio fistulae ani
54913	Exstirpatio fistulae ani sec Hippokrates
54930	Haemorrhoidectomia
54931	Haemorrhoidectomia sec. Parks
54932	Haemorrhoidectomia sec. Milligan-Morgan
54933	Haemorrhoidectomia sec. Eisenhammer
54934	Haemorrhoidectomia sec. Langenbeck
54935	Haemorrhoidectomia sec. Whithead
55300	Hernioplastica inguinofemoralis
55310	Hernioplastica inguinofemoralis c. implant.
55311	Hernioplastica inguinofemoralis laparoscopica
55320	Herniotomia inguinofemoralis bilateral
55330	Hernioplastica inguinofemoralis bilat. cum implantationem
55340	Hernioplastica umbilicalis

Traumatology/Orthopaedic surgery
Arthroscopic interventions (knee, ankle, shoulder, elbow, wrist)

OENO code	Definition
16970	Arthroscopy
16971	Wrist arthroscopy
16972	Elbow arthroscopy
16973	Shoulder arthroscopy
58054	Arthroscopy
58055	Arthroscopic ligament reconstruction
58056	Arthroscopic ligament suture
58057	Arthroscopic mosaicplasty
58058	Arthroscopic retinaculum plasty
58059	Arthroscopic debridement of ankle, shoulder and hip joint
58322	Baker-cyst removal
58345	Dupuytren plantaris excisio

Urology
Endoscopic urinary bladder, urethra interventions, prostate surgeries, testicles and epididymis minor surgeries

OENO code	Definition
56011	Prostate TUR
56013	Transurethral prostata incisio
56015	Prostata transurethral spiral insertion
56059	Other alternative LASER operations on the prostate
56110	Bergmann f. hydrocele suregry
56111	Winkelmann f. hydrocele surgery
56112	Hydrocele suregry
56291	Appendix testis excision
56301	V.sperm.int.retroperitonealis ligatura (Palomo)
56302	Scrotal varicocelectomy
56303	Funiculocele resectio
56308	Ligatura v. spermaticae internae laparoscopica
56310	Epididymis cyst excision
56311	Spermatocele resectio
56330	Epididymectomy
56360	Vasectomy
56370	Vasovasostomy
56400	Circumcisio
56403	Phimotomy
86051	Thermotherapia prostatae

Groupama Biztosító
Az OTP Csoport partnere

Annex 4: Cost reimbursement of operations - List of operations

55118 Cholecystectomia laparoscopica
58040 Meniscectomia partialis, arthroscopos
56830 Uterus excision - abdominal
58149 Anterior cruciate ligament reconstruction
55310 Hernioplastica inguinofemoralis c. inplant.
58033 Flavotomy and lumbal discectomy
56550 Salpingo-oophorectomy-bilateral
52271 Endoscopic (microscopic) ethmoid sinus (FESS)
56530 Salpingo-oophorectomy-unilateral
5381E TEA carotis
55300 Hernioplastica inguinofemoralis
55340 Hernioplastica umbilicalis
56840 Uterus excision - vaginal
52270 Endoscopic (microscopic) maxillary sinus surgery
55731 TUR Resectio transurethral vesurin.therapeutic.
53844 Varicectomy
56723 Uterus polyp removal
56850 Uterus removal radical-abdominal (extended)
53002 Microlaryngoscopic operation
55110 Cholecystectomy
58620 Mastectomia con.lymphadenect. reg.
50432 Carpal tunnel release
56810 Myoma enucleatio
55311 Hernioplastica inguinofemoralis laparoscopica
5815E Hip prosthesis hybrid TEP
56611 Salpingectomia laparoscopica unilateralis
54930 Haemorrhoidectomy
55119 Cholecystectomy, converted after LC-treatment
56610 Salpingectomy-unilateral
55541 Nephrectomia radicalis
56816 Enucleatio myomae uteri laparoscopica
58030 Discectomia anterior cervicalis
56518 Resectio ovarii laparoscopica unilateralis
54932 Haemorrhoidectomia sec. Milligan Morgan
56011 Prostata TUR
51950 Tympanoplastica
56040 Prostatectomia radicalis
56302 Scrotal varicocelectomy
54688 Adhaesiolysis interintestinalis
58034 Lumbalis discectomy flaminectomy v.haemilaminect.at
54920 Exscisio fissurae ani
53957 Angioplastica arteriae subclaviae PTA
54931 Haemorrhoidectomia sec. Parks
50511 Sympathectomia lumbalis
55732 TUR Resectio transurethralis ves.urin.palliativa
56513 Ovariectomy, partial-unilateral
56570 Release of ovarium and tuba adhesions
55600 Ureterorendoscopic stone extraction
56531 Salpingo-oophoprectomia laparoscopica unilateralis
56520 Ovariectomy-unilateral
58041 Meniscectomia partialis, arthrotomia
58230 Aponeurectomia partialis manus
52150 Turbinectomia, conchotomia, operculumresectio

55435 Ablatio endometriomae ovarii laparoscopica unilat.
57064 Transabdominal suspension of vaginal stump
54933 Haemorrhoidectomia sec. Esenhammer
50435 Other nerve compression syndromes surgeries
5666C Adnexectomia laparoscopica
58031 Discectomia cervicalis anterior multiplex
51951 Tympanoplastica, cholesteatoma sanatioval
56540 Ovariectomy-bilateral (castratio)
55331 Hernioplastica inguinofem. bilat. laparoscopica
52850 Adenotomyy, readenotomy
58322 Baker-cyst excision
56817 Enucleatio myomae hysteroscopica
56510 Ovary local excision
57063 High suspension of vaginal stump
56620 Salpingectomy - bilateral
56012 Prostata TUR-radicalis
52820 Tonsillo-adenotomy
56821 Hysterectomia subtotalis laparoscopica.
58231 Aponeurectomia totalis manus
56112 Hydrocele surgery
53003 Microlaryngoscopic operation with LASER
58055 Arthroscopic ligament reconstruction
52121 Polypectomy without ethmoidectomy from nasal cavity
56622 Salpingectomia laparoscopica bilaterale
56020 Prostatectomia transvesicalis
5816C Collateral ligament reconstruction (knee)
50640 Thyreoidectomia substernalis
56514 Overiectomy, partial-bilateral
5681A Resectio myomae hysteroscopica
55330 Hernioplastica inguinofem. bilat. c. inplant.
56803 Hysterectomia laparoscopica
55436 Ablatio endometriomae ovarii laparoscopica bilat.
56600 Salpingotomy
55138 Cholecystectomia laparoscopica + cysticus drain
55131 Cholecystectomia choledochotomiamque+Kehr drainage
54560 Colectomy
56519 Resectio ovariorum laparoscopica bilateralis
52030 Mastoidectomy, atticoantrotomy
58042 Meniscus reinsertio, arthroscopic
56730 Cervix amputatio
57043 Posterior vaginal vault plastic surgery
55733 TUR Resectio transurethralis colli ves. urin.
56013 Transurethralis prostata incisio
56651 Salpingectomia partiale laparoscopica
56833 Hysterectomia totalis laparoscopica sec. Reich
55320 Hernioplastica inguinofemoralis bilateralis
56552 Salpingo-oophorectomia bilateralis laparoscopica
58691 Excisio gynecomastiae
58036 Discecto percutanea