Fee-for-Service Health Insurance – Terms and Conditions (STUDIUM14)

These general terms and conditions of STUDIUM Fee-for-Service Health Insurance (STUDIUM14) (hereinafter: policy conditions or general conditions) set out the standard conditions for STUDIUM Fee-for-Service health insurance offered by Generali Biztosító Zrt. (hereinafter: Insurance Company), provided that the insurance policy (hereinafter: insurance policy or policy) has been concluded by reference to these general conditions. In the case of matters not regulated by these general conditions, the insurance policy shall be governed by the provisions the Customer Information (Customer Information and General Provisions Governing Insurance Policies), as well as the applicable provisions of the **Civil Code** and **other effective Hungarian regulations**.

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

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

Section 1 Definitions

1.1. Illness (disease): any deviation from or interruption of the normal structure or function of the human body.

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

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

Health care shall furthermore include activities related to medications, dressings and bandages, durable medical equipment**,** medical care in accordance with effective legislation, and patient transport.

1.4. Primary care (availability of a physician or health care services): basic (not specialty) medical and health care services generally available, required to treat illness or accident consequences: GP or similar services.

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

1.6. Health care service provider (medical facility): any private healthcare entrepreneur, legal entity or organization without a legal personality, regardless of ownership and maintenance arrangement, which is entitled to provide medical and health care services under current legal regulations in possession of a license of operation issued by a public administrative body of healthcare in respect of Hungary. For the purposes of these policy conditions, health care service providers shall not include sanatoriums, rehabilitation institutes, thermal or hydro-mineral establishments, asylums and care centers for patients with mental disorders and other psychiatric diseases, geriatrics, chronic institutes, social homes, alcohol and drug detoxification institutes (hereinafter jointly referred to as: other health care institutions), even if these provide health care services, or departments of health care institutions which provide health care services in line with the operations of health care institutions as defined herein (for the purposes of this section, hereinafter: department), provided that the Insured person has received services in line with the specialization of the other health care institution or of the department.

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

1.8. Outpatient care includes the treatment of any person who, as a result of an accident or illness, receives primary medical or specialist care the duration of which does not exceed 24 hours, and which is not considered as inpatient care.
1.9. Inpatient care shall be provided for any person who, as a result of an accident or illness, is hospitalized in a medical facility for several days to receive medical care, and the person spends every night during his/her hospitalization between admission and release in such medical facility in connection with the medical treatment. The Insured is hospitalized for multiple days if his/her discharge from the medical facility is on a later day than that of his/her admission.
1.10. Emergency: the deterioration of the Insured's medical condition as a result of which the Insured's life would be in direct danger or the Insured would suffer serious or permanent health impairment without immediate medical attention. In such a case, the emergency services number must be called.
1.11. **Prepaid health care:** health care services provided by a person or institution duly authorized to render health care services, received by the Insured in medically justified cases, where the costs have been prepaid to the service provider directly by a person or entity other than the Insurance Company.
1.12. Application and Policy (containing the insured's statements): a numbered written document which is the standard Application Form of the Insurance Company and is also used as a certificate of coverage (Policy), so it evidences that the application has been approved and the insurance has taken effect. (The insurance application is a unilateral written statement which the policyholder may complete to apply for insurance coverage and request the conclusion of the policy.) The Application and Policy contains the Insured's declarations with respect to the health insurance policy, and in particular information regarding the rights and obligations of the Insured, the name of authorities and institutions which the insurance company's confidentiality obligation shall not apply to, with respect to the payment of benefits, all forming an integral part of the Insured's statement to which it is annexed. The Application and Policy shall constitute an integral part of the STUDIUM insurance policy.
1.13. Health insurance card: A card bearing the same serial number as that of the Insured's statement referred to in Clause 1.12 and issued by the Insurance Company containing the most important information related to the insurance coverage, which is designed to be proof of the insurance at the health care service provider.
1.14. Total limit: the upper threshold of the Insurance Company's total benefit payment in relation with the Insured's health care treatment during the period of the insurance coverage (max. 9 months) applicable to the Insured and with respect to the particular benefit types (total limit), as specified in the **health insurance policy**, above which the Insurance Company is not required to make benefit payments.
1.15. Pro rata limit: the pro rata total limit applicable to the coverage relating to the Insured's medical care during the period of the insurance coverage (max. 9 months) applicable to the Insured and specified in the **health insurance policy**.
1.16. Deductible: a lower benefit limit applicable to the payment obligation of the Insurance Company specified in the **health insurance policy**, which must be interpreted and applied separately to insured events and Insured persons, corresponding to an amount which the Insured shall pay himself/herself with respect to the Insured's medical care.
1.17. Nursing: a group of care services and procedures of nursing directed to improve health status, to preserve and reinstate health, to stabilize patient status, to prevent diseases by preserving the patient's human dignity, and by preparing and involving the patient's surroundings in nursing tasks.
1.18. Healthcare (medical) document, documentation: records, registers or data recorded otherwise, containing healthcare and personal identification data related to the treatment of the patient, prepared under current regulations and in compliance with healthcare and medical professional requirements, disclosed to healthcare staff in the course of providing healthcare services, regardless of data carrier or form. For the purposes of the general conditions, healthcare documents specified by law shall particularly include the following documents also partially regulated by law: outpatient records, hospital discharge summary, surgery description, examination records, nursing and care documentation, test findings, medical expert opinion, laboratory records, images made during diagnostic or histology tests, prescriptions (copy), referrals (copy).
1.19. Medication, dressings and bandages, durable medical equipment: only those agents, accessories and means shall be deemed as medication, dressings and bandages, durable medical equipment which are registered and recognized in Hungary as medication, dressings and bandages, or durable medical equipment. Lenses for the correction of vision (glasses, contact lenses, glass for vision, etc.), tools for improve hearing and materials and means used in dental care (artificial teeth, prostheses, fillings, implants, braces, substances and tools to whiten teeth etc.) are not qualified as durable medical equipment. Medication does not include contraceptive pills, emergency contraceptive pills (morning after pills), condoms, etc.

1.20. Treatment: medical activities performed by special healthcare staff aimed to cure diseases, stabilize a patient's medical condition, and to relieve pain (or other complaints) using diagnostic results.
1.21. Test (medical): a healthcare activity aimed to survey the Insured's medical conditions, to preserve his/her health, to test for diseases, injuries, health impairments, consequences of accidents and/or any risks thereof, to diagnose specific disease(s), to establish prognosis and any change thereof, and to check the effectiveness of medical treatment.

2.1. Parties to the Insurance Contract
2.1.1. In consideration of the payment of the insurance premium, the **Insurance Company – Generali Biztosító Zrt** (hereinafter: insurance company) – shall bear the insured risk throughout the duration of the insurance specified in the policy, or during the insured period selected for the particular insured and specified on the Insured's Statement, and undertakes the obligation to pay the insurance benefits set forth in these policy conditions.
2.1.2. The **Policyholder is also the Insured (hereinafter: Insured or Policyholder/Insured**): any **natural person consumer** whose health is covered under the insurance policy with respect to specific insured events, and who applies for the insurance coverage by completing the insurance application, while also agreeing to pay the insurance premium. (Consumer shall mean any natural person acting for purposes which are outside his/her trade, business or profession.)
2.1.3. For the purposes of these policy conditions, the Insured may be any natural person of foreign citizenship temporarily resident in Hungary who is between 18 and 65 years of age as at the date when the insurance policy is concluded and whose health is covered under the insurance policy with respect to specific insured events, and who is enrolled as a student during ***the policy*** **term at BMC School Budapest.**

2.2. Conclusion of the insurance policy
2.2.1. The policy is concluded pursuant to the written agreement of the **Policyholder/Insured and the Insurance Company whereby the Policyholder/Insured completes and signs the Application and Policy and pays the insurance premium in respect of the insurance period specified on the Application and Policy document in one sum**.
2.2.2. The Insurance Company is entitled to collect the premium payable for the agreed insurance period prior to the conclusion of the policy, which shall be regarded as an interest-free advance payment.
2.2.3. The insurance company issues a Health Insurance Card which contains the most important information related to the insurance coverage.

2.3. Commencement of the insurance coverage, waiting period
2.3.1. With respect to any one insured person, the commencement of the insurance coverage will be 0 hours of the day following the day when the Application and Policy as well as the insured's statement are signed by the policyholder/insured, ***and the Insured's Statement has arriving to the Insurance Company,*** but no sooner than the first day of the insurance period, provided that the insurance premium for the insurance period specified on the insured's statement has been paid to the insurance company.
2.3.2. The insurance company does not stipulate a waiting period in the insurance policy.

2.4. Policy Period
2.4.1. STUDIUM fee-for-service health insurance **may be taken out for a fixed period corresponding to the insurance period specified on the insured's statement** but for a maximum of one insured year.
2.4.2. Policy year (insurance periods): in respect of the particular insured, 1 (one) year starting on September 01 of any given year and ending on August 31 of the subsequent calendar year.
2.4.3. The insured persons may not be covered under this insurance for a period shorter than 1 (one) month. An insured month is a calendar month for which the insurance premium has been paid, on the understanding that any insured month shall commence on the first (01) day of the calendar month and shall end on the last day of the same calendar month, provided that the commencement date of the insurance coverage during the first insured month corresponds to the commencement of the insurance.

2.5. Removal of the Insured from the insurance coverage, termination of the insurance coverage
The insurance coverage for the particular Insured terminates:
a) at the end of the insurance period specified on the Insured's statement,
b) at the end of the calendar year in which the Insured has become 65 years old, or

c) if the Insured dies, at the time of the death.

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

2.7. Rights and obligations of the parties to the insurance policy
2.7.1. The policyholder/insured are required to comply with their obligation to disclose information and notify changes.
2.7.2. While the insurance policy is in force, the policyholder and the insured are required to notify the Insurance Company in writing of any change in any relevant condition stated on the insured's statements or included in the insurance policy within 5 workdays following such change.
2.7.3. Relevant material circumstances shall be all circumstances which the insurance company raised questions about, and which the policyholder or the insured are required to disclose information about, including particularly the policyholder's and the insured's name, address, mailing address and telephone number.

2.8. Insurance premium
2.8.1. The policyholder undertakes to **pay the insurance premium in one sum and in advance** for the insurance period specified in the insured's statement (for the whole duration of the policy) at the time **when the insurance policy is concluded**.
2.8.2. The policyholder will have fulfilled his/her obligation to pay the insurance premium as of the day when the insurance premium is credited to the account of the insurance company.
2.8.3. **Irrespective of the date when the insurance is concluded in any given insurance period, the insurance premium must be paid in full for the then current insurance period.**

Section 3 Insurance Coverage
3.1. Insured events
3.1.1. The insurance covers medical and health care services provided to the Insured by the designated health care provider named on the Health Insurance Card, or arranged for by, notified to and approved by the same during the coverage period, to treat the Insured's injuries due to an accident, or his/her illness or medical condition with no prior history relative to the commencement of the insurance coverage.
3.1.2. For the purposes of this clause, a trauma, an illness or a medical condition shall have no prior history relative to the commencement of the insurance coverage if it is not in any way connected with a trauma, illness or medical condition of the Insured which existed or was diagnosed or treated before the commencement of the insurance coverage, or with a previously determined permanent physical or mental impairment.
3.1.3. If the medical care which the Insured received was not provided or arranged for by the designated service provider, the Insurance Company will only reimburse the cost of such medical care, provided that the claim is otherwise grounded, if the Insured had a medical condition which did not allow him/her to be provided medical care by or under the arrangement of the designated service provider (emergency) and the designated service provider has been notified of the medical care within 48 hours of the beginning of the treatment.
3.1.4. **The insurance coverage will not apply to medical treatments delivered in urgencies if such treatment is or should be covered under the national health insurance scheme.**
3.1.5. The date of the insured event is the first day when medical care and/or health care services are received. For the purposes of these general conditions, medical or health care services required for the treatment of the same trauma(s), medical condition(s) or illness(es), and received on the same day or within the framework of the same medical treatment, belonging to the same service category shall be treated as a single Insured event.

3.2. General rules on the payment of insurance benefits
3.2.1. The Insurance Company's obligation to settle an insurance claim arising from an insured event (within the meaning of Clause 3.1) means the obligation to reimburse the costs of medical, health care and other services specifically defined in this section.
3.2.2. The insurance shall cover costs related to the Insured's medically justified health care treatment as defined in these conditions provided that their justified use is properly evidenced by the Insured.

3.2.3. The insurance covers the costs of medical treatment specified in these policy conditions subject to the total benefit limit and pro rata limit specified in the health insurance policy and in the STUDIUM Product Overview, and also subject to deductibles.
3.2.4. When an insurance claim is not grounded or only partly grounded pursuant to the insurance policy, and consequently the Insurance Company is not at all or only party required to pay the insurance benefit, the Insured **will be required to pay** the part of the costs of the medical care the Insured received **which is not covered under this insurance directly to the provider of the medical care or to the party which has issued the invoice.**
3.2.5. **Within the framework of the outpatient treatment, the Insurance Company shall pay for**:
a) the costs of **primary medical care**,
b) the costs of **specialized health care treatment**,
c) the **costs of tests** (e.g. laboratory tests, X-ray diagnosis, ultrasound scan), which the Insurance Company shall only cover if these are **necessary for the diagnosis or treatment of the illness**.
3.2.6. The costs of **same-day surgery.**
3.2.7. Within the framework of **inpatient treatment**, the Insurance Company shall pay for the costs of the Insured's hospitalization and medical treatment. The insurance, in particular, covers:
a) the costs of medical care prescribed by a physician, (including necessary surgeries);
b) the costs of nursing;
c) the costs of therapeutic or medically-necessary abortion.
3.2.8. The insurance shall cover the costs of **medications, dressings and bandages, or medical equipment for temporary use** (products officially listed as durable medical equipment) if required for the medical care, subject to and taking account of the total limit (1.14.), pro rata limit (1.15.) and deductible (1.16.) set out in the Insured's statement.
The costs of medications, dressings, temporarily used durable medical equipment (products officially listed as durable medical equipment) required for the health care treatment must be prepaid by the Insured (1.11). The Insurance Company will only reimburse the costs of the prepaid services referred to above if an insurance claim for the reimbursement of costs is filed to the designated health care provider in accordance with Clause 3.3.4.1. of these general conditions, and the event underlying the insurance claim is covered pursuant to the policy conditions.
3.2.9. Patient transport If the Insured is immobile, or has a medical need for transport to the premises providing healthcare, the insurance covers the cost of patient transport without medical supervision within the territory of Hungary, if it is required for medical and health services which qualify as Insured events pursuant to these general conditions.
3.2.10. Subject to the total limit, the insurance covers the costs of repatriation to the country of origin (transport home) if it is medically necessary (as evidenced in a written opinion of the physician) and also recommended by the designated service provider for the Insured **to be repatriated back to the country of the Insured's permanent residence**.

3.3. Conditions for the payment of insurance benefits
3.3.1. The Insurance Company shall pay the costs of medical care received from the designated health care provider, or arranged by or delivered with the cooperation of (notified to and approved by) **the designated service provider directly to the designated service provider.**
3.3.2. If the Insured receives medical treatment in an emergency at a medical facility other than the designated service provider, or without the engagement of the designated service provider, the **Insured is required to prepay the costs of such medical care (1.11)**.
3.3.3. The Insurance Company shall pay the costs of medical services received in an emergency from a service provider other than the designated service provider only after the designated service provider has consulted the treating medical facility and the Insured.
3.3.4. If the costs of the **medical services are prepaid by the Insured** (prepaid medical care), or if the Insured purchases medication, dressings and bandages, durable medical equipment, the insurance claim for the reimbursement of such costs must be submitted to the Insurance Company within 15 days from the issue date of the invoice.
3.3.4.1. **The insurance claim for the reimbursement of the costs of prepaid medical care, or of medication, dressings and bandages, or durable medical equipment purchased by the Insured, must be accompanied by the following documents:**

a) the original invoice on the delivered medical treatment (health care services) issued on the last day of such treatment, or the original invoice on the purchase of medications or durable medical equipment on prescription by the treating physician requested in the pharmacy, showing the name of the Insured (as well as the policy number),
b) a copy of all medical documents related to the insured event,
c) the Insured's declaration quoting the bank account number of his/her (HUF) current account in Hungary (signed and dated).
3.3.5. In addition to the documents specified in Clause 3.3.4., the Insurance Company is entitled to require that a copy of the following documents **verifying the existence of the legal ground for the claim and/or necessary for determining the amount of the insurance benefit** payable shall also be submitted for the assessment of the insurance claim:
a) if an official investigation was initiated in connection with the circumstances which resulted in an Insured event, all the documents produced or used in the proceedings, as well as the resolution closing the proceedings (in particular the resolution terminating the proceedings, or a binding court decision). A binding court decision made in criminal proceedings, or a binding resolution adopted in misdemeanor proceedings only if this is available when the insurance claim is notified;
b) to allow for a clarification of all the circumstances of the event which led to the Insured event, the Insurance Company may require the submission of the following documents (statement by the Insured and/or any other person involved in the Insured event about the circumstances of the Insured event, the autopsy report, the driver's license and vehicle registration certificate, the accident & injury report made by the employer, educational institution, transportation company, expert opinions on the accident/consequences);
c) a standard form furnished by the Insurance Company and completed by the Insured's treating physician or by the health care provider where the Insured was treated, with medical information related to the Insured event, the Insured's medical condition, and the Insured's medical history.
d) the Insured's medical documentation produced in connection with the Insured event and the Insured's medical history: the medical file issued by a general practitioner, a company physician, or a physician supervising the insurance policy portfolio, as well as documents produced during outpatient or inpatient care, and documents in proof of the administration of pharmaceuticals;
e) the documents managed by the social insurance body or another person or organization, containing data regarding the Insured with respect to the Insured event or a circumstance leading to such an event (pursuant to the entitled party's authorization for a release from the confidentiality obligation and for a request of data);
f) the Insured's sports club membership card or membership certificate relating to his/her sports activities, or an official match report;
g) an official certificate in proof of the Insured's date of birth (birth certificate, identification card, passport, driver's license);
h) the Insurance Company may also require that all documents necessary for the assessment of the insurance claim but produced in a foreign language shall be translated into Hungarian at the cost of the claimant, and the official translations shall be submitted to the Insurance Company for decision making.
i) the Insurance Company may require that original copies of such documents are presented and that they are also submitted on any form of electronic media.
3.3.6. The Insurance Company may obtain further documents for the assessment of the insurance claim.
3.3.7. If the documents available do not prove to be sufficient for the assessment of the insurance claim, the Insurance Company shall be entitled to require a medical examination of the Insured by a physician (hereinafter: medical examination required for claim settlement) at the expense of the Insurance Company.
3.3.8. If the documents required by the Insurance Company are not submitted or are incomplete despite a reminder, or if the Insured fails to attend the medical examination required for claim settlement, the Insurance Company will assess the claim on the basis of the documents available.
3.3.9. The Insurance Company shall not be obliged to pay the benefit if the Insured or the claimant fails to comply with the obligations set forth in these general conditions, particularly if the time limit for reporting an Insured event is not observed and as a result material conditions or circumstances may not be revealed.

3.4. Rules of the payment of insurance benefits
If the claim is grounded, the Insurance Company shall settle the insurance claim prepaid by the Insured or by a third party on behalf of the Insured, within 15 days upon receipt of all documents necessary for the assessment of the claim, in local legal currency, by wire transfer to a bank account held in a bank in Hungary pursuant to the invoice and subject to the applicable payment conditions and benefit limits.

3.5. Exclusions

3.5.1. The insurance does not cover medical and health services related to any of the following:

a) the Insured's illness or medical condition which is proven to have existed prior to the effective date of the insurance coverage, or which had been diagnosed prior to the effective date of the insurance coverage, or which required treatment during this time period, or any permanent physical or mental impairment of the Insured that had been diagnosed prior to the effective date of the insurance coverage,

b) medical care related to pregnancy (confirmation of pregnancy, antenatal care) or child birth, and associated costs incurred,

c) abortion of pregnancy (unless termination of the pregnancy was necessary to preserve the life or health of the mother, or if termination of the pregnancy was performed in a case where pregnancy was the result of a criminal act),

d) surgeries related exclusively to treating infertility, and medical treatments related to any form of artificial reproductive techniques,

e) sterilization surgeries and consequences,

f) sex reassignment surgeries,

g) treatments and surgeries for aesthetic (cosmetic) purposes, and their consequences,

h) vision correction surgeries,

i) dioptric glasses/sunglasses, contact lenses and their accessories, and the costs of the medical examination required for the above,

j) hearing aid,

k) *dental treatments, with the exception of cases requiring immediate care (emergency cases of root canal treatments, treatment of abscess, dental extractions) and accident consequences,*

l) medical care in relation to HIV infection,

m) tests and treatments performed in relation to the consumption of alcohol, narcotic drugs or other addictions,

n) convenience (V.I.P.) health care services (e.g. single bedroom),

o) acupuncture, acupressure treatment, oriental medicine, alternative and naturopathic medicine,

p) psychological disorders and psychiatric disorders; psychiatric treatment and psychotherapy,

q) purchase of vaccine for immunization shots, reimbursement of costs,

r) treatment received in sanatoriums or in assisted accommodation,

s) rehabilitation or nursing of chronic illnesses (especially geriatrics, hospice care, special needs education, speech therapy, physiotherapy, physical therapy, bath therapy, weight loss therapy, infusion therapy to improve blood flow, pain management infusion therapy), excluding treatments which are for the purpose of diagnosing chronic illnesses, initiation of a therapy, the prevention of significant deterioration of acute conditions,

t) medical care that is not for the purpose of diagnosis of illness for the Insured, or for the prevention of deteriorating condition and rehabilitation of the Insured's health, especially screening tests not ordered or attended in relation to this insurance, or a parent having to stay at a hospital with his/her child, nor is the Insured's stay at a hospital for the purpose of nursing a parent,

u) treatment by a person who does not have medical certification and permit to practice medicine, and medical or other health care treatment made necessary as a result of treatments performed by such person.

3.5.2. Furthermore, the insurance does not cover events caused in whole or in part by:

a) ionizing radiation,

b) nuclear energy,

c) infection by HIV,

d) war, combat operations, hostile actions of foreign forces, civil disorders, coup d'état or attempted coup d'état, riots, civil war, revolution, rebellion, demonstrations, processions, labor acts, terrorist acts, workplace disorder, border conflicts, insurrection.

For the purposes of these conditions warlike events shall mean war (whether war be declared or not), border conflicts, insurrection, revolution, riots, coup d'état or attempted coup d'état, civil war.

3.5.3. Notwithstanding the provisions set out in Clause 3.4.2.d., the insurance covers the physical or mental impairment of the Insured which results from his/her active participation in demonstrations, processions, or strike actions announced in advance and organized in accordance with the provisions

of effective Hungarian regulations, provided that the Insured has fully complied with his/her obligation to prevent and mitigate loss or damage.
3.5.4. The insurance does not cover events which arise from the Insured's failed suicide attempt, not even in the event that the Insured was mentally incompetent at the time when attempted suicide.
3.5.5. The insurance does not cover events which may have been caused by the Insured's engagement in sports activities with increased risks listed herein: scuba diving to a depth of 40 metres, singlehanded and open sea sailing, white water rafting, , riverboarding (hydrospeed), canyoning, surfing, mountaineering and rock-climbing on routes graded 5 or higher, high-mountain expeditions, caving and cave expeditions, bungee jumping, auto-motor sports (e.g. auto-crash, go-kart, motocross, motorboat sports, motorcycle sports, rally, ability competitions by car), quad biking, private flying/sports flying/aviation sports (e.g. paragliding, ballooning, motor sail plane, hang-gliding and ultra-light flying, hot-air ballooning, parachute jumping, free plane flying, stunt flying, base jumping).
3.5.6. The insurance does not cover events which may have been directly caused by the Insured's engagement in or pursue of the following hazardous activities or occupations: stuntmen, circus artists, equilibrists, test pilots, flight test pilots, parachute jumpers, jet plane crew in the army, bodyguards, commando staff, foreign legionnaires, peacekeepers, secret agents, armed guards, armored car personnel, specialists or officers serving in the army who are exposed to high levels of risks during their activities (e.g. bomb experts, divers).
3.5.7. The Insured shall be acting in gross negligence in particular if:
a) the Insured was verifiably intoxicated or under the influence of drugs or other stupefying agents at the time of the event which led to the Insured event, and this fact contributed to the occurrence of the Insured event, if a blood alcohol test was administered, the person is legally intoxicated if his/her blood alcohol concentration exceeds 1.5‰ – or 0.8‰ while driving a motor vehicle;
b) the Insured operated a motor vehicle without a valid vehicle registration certificate or the Insured did not have a valid license required for driving such vehicle, and this fact intervened in the occurrence of the Insured event,
c) the Insured has committed at least two traffic offenses at the time of the event which led to the Insured event, and as such the event which led to the Insured event resulted directly from these actions.

3.6. Release from benefit payment

3.6.1. The Insurance Company will be released from the benefit payment if the Insurance Company can prove that the event which resulted in the insured event was caused willfully or in gross negligence by:
a) the Insured; or
b) a relative living in the same household with them.
3.6.2. The Insured shall be acting in gross negligence in particular if:
a) the Insured operated a motor vehicle without a valid vehicle registration certificate or the Insured did not have a valid license required for driving such vehicle, and this fact intervened in the occurrence of the Insured event,
b) the Insured has committed at least two traffic offenses at the time of the event which led to the Insured event, and as such the event which led to the Insured event resulted directly from these actions.
3.6.3. If the Policyholder or the Insured infringe their obligation to disclose the required information or to report changes, the Insurance Company's obligation to pay the benefits shall not set in, unless they can prove that any of the following circumstances exist:
a) the concealed or undisclosed circumstance was known to the Insurance Company at the time when insurance policy was concluded, or
b) the concealed or undisclosed circumstance did not intervene in the occurrence of the Insured event.
3.6.4. When an event underlying an insured event occurs, the Insured is required to act as generally and reasonably expected in the given situation, and as such promptly seek emergency assistance or medical care. If the Insured fails to comply with this obligation, the Insurance Company will be relieved from the payment of insurance benefits. The Insured's refusal of a medical procedure – due to his/her autonomy or freedom to decide guaranteed by law – shall not be an breach of his/her duty to mitigate loss.
The above shall not be construed, however, as limiting or restricting the Insured in freely choosing a physician or a medical and health service provider.

Section 4 Miscellaneous Provisions

4.1. Limitation period

4.1.1. The limitation period of claims enforceable under the policy shall be one (1) year.

4.1.2. If the Insured has prepaid the costs of the medical and health care services (Clause 3.3.4.), the limitation period with respect to the Insurance Company's benefit payment obligation will commence at the following points in time:

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

4.2. Dispute resolution procedure

If the customer disputes the position of the Insurance Company in connection with an insurance claim, he/she may request a review of the decision in writing. The review shall be carried out by the competent organizational unit of the Insurance Company within 30 days upon receipt of all documents/data necessary for the assessment of the request and the decision shall be communicated to the customer.

4.3. Standard terms of the general conditions that substantially differ from the provisions of the Hungarian Civil Code

4.3.1. This chapter summarizes the provisions of the General Terms and Conditions of STUDIUM Fee-for-service Health Insurance (STUDIUM14) which substantially differ from the respective provisions of the Hungarian Civil Code (hereinafter also: Ptk).

4.3.1.1. Within the meaning of Clause 2.2.1 of these policy conditions, and by way of derogation from Section 6:443. (1) of the Civil Code, the insurance policy will be concluded pursuant to an **agreement executed in writing** by the policyholder and the insurance company.

4.3.1.2. The provision on the statute of limitations set out in Clause 4.1.1. of these policy conditions differs from the five (5) year limitation period prescribed in Section 6:22. (1) of the Civil Code. **The limitation period for claims arising under this contract shall be 1 (one) year.**