UNION BIZTOSÍTÓ
VIENNA INSURANCE GROUP

UNIMED Health Insurance INSURANCE CONDITIONS

1. VALIDITY OF CONDITIONS

These conditions shall be valid for UNION Vienna Insurance Group Biztosító Zrt's (hereinafter: Insurer) health insurance policies.

2. SUBJECTS OF THE HEALTH INSURANCE POLICY

2.1. Insurer

The insurer is a legal entity which provides cover after the acceptance of the insurance proposal and undertakes the obligation to provide the benefits. In respect of this policy it is UNION Vienna Insurance Group Biztosító Zrt seated at 1082 Budapest, Baross u. 1.

2.2. Policyholder

The policyholder is a natural person who makes a proposal to conclude the insurance policy and undertakes an obligation to pay the insurance premium.

2.3. Insured

2.3.1. The insured is a natural person and the policy is concluded to cover insurance events related to this person's health and physical integrity. The insured can be a Hungarian or foreign national residing in the territory of Hungary. **The age of the insured can be between 14 and 65 years at the time of concluding the contract.** The insured's age must be determined by subtracting the insured's birth year from the first year of the insurance.

2.3.2. The insurance contract can also be concluded concurrently for multiple insured persons, and for the close relatives (spouse, parent, children) of the contracting party residing in Hungary.

2.4. Beneficiary

The insured is entitled to use the benefits specified in the insurance policy.

3. TERM OF POLICY, POLICY PERIOD

This insurance policy is effective for a fixed term - either 3 or 6 months or 1 year - in respect of the individual insured persons.

4. TERRITORIAL SCOPE

The insurance shall cover **insured events occurring in Hungary only**.

5. INSURANCE PREMIUM

5.1. The insurance premium is the consideration payable for the insurer's cover and its obligation to provide benefits.

5.2. The premium is payable annually, semi-annually or once. The first premium of the insurance is due upon the signing of the offer.

5.3. The policyholder must pay the insurance premium within 30 days of the date on which it is due.

5.4. If the policyholder fails to pay the premium due, the insurer shall issue a warning of the expected consequences and a written payment reminder to the policyholder, setting a 30-day extended payment deadline. If the extended payment deadline lapses and no payment is made, the contract shall terminate retroactively as of the due date, except if the insurer enforces its premium claim through judicial avenues without delay.

5.5. An insurance that has been terminated due to premium non-payment may not be reactivated.

6. INSURANCE COVER

6.1. The insurance coverage will start from 00.00 hrs of the day following the signing of the offer.

6.2. The insurer does not stipulate a waiting period from the entry into effect of this policy in respect of its cover.

6.3. The insurance coverage will be terminated in respect of a particular insured in the following cases:

a) on the day of the insured's death,

b) upon expiry of the term related to the insured,

c) pursuant to Section 5.4 in the event of default on premium payment,

d) termination of the insurance.

6.4. The termination of the insurer's cover will not affect the appraisal of current or pending losses sustained as a result of insurance events occurring prior to the termination of the policy.

7. COVERAGE LIMITS

In order to provide healthcare services to the insured based on the insurance policy, the insurer sets coverage limits for the insurance events specified in the insurance policy. The coverage limits and the deductibles payable by the insured are specified in the Appendix on Coverage Limits of these insurance conditions. After the coverage limit has been depleted the insurer will not provide benefits to the insured in the current insurance period.

8. INSURED INCIDENTS

An insurance event is the **emergence of the need for medical care due to the unforeseen, unexpected and acute deterioration of the insured's state of health compared to the commencement of cover during the coverage period related to the insured.** These benefits can be as follows:

8.1. Primary care provided by a general practitioner

Medical service in non-emergency cases as part of primary care provided by a general practitioner. The benefit covers the costs of one vaccination per year (the cost of the vaccine is not covered).

8.2. Outpatient specialist care

Medical service in non-emergency cases as part of outpatient specialist care if medically justified and deemed necessary.

8.3. Inpatient care

Medical service which cannot be performed as part of primary and outpatient specialist care and without which the insured's state of health would further deteriorate.

8.4. Emergency care

A degree of deterioration of the state of health in which case the absence of immediate medical intervention would directly threaten the insured's life or the insured would suffer severe or irreversible health deterioration.

8.5 Patient transport

If due to his or her health condition the insured cannot reach a medical institution or cannot return to his or her home from a medical institution, he or she can use a patient transport service prescribed by a medical practitioner, provided that the insured's health condition allows. The time and method of patient transport (Appendix 2) will be agreed between the care organiser and the medical practitioner providing the treatment. This benefit only applies to the use of services delivered by a patient transport organisation which possesses a license issued by a professional supervisory body. Patient transport does not apply to emergency care.

9. SERVICES PROVIDED BY THE INSURER

9.1. Organisation of services arising from insurance events

9.1.1. To deliver its services, the insurer hires a care organiser to organise medical care in the case of the occurrence of insurance events listed in Section 8. The care organiser's data are contained in Appendix 2 to this insurance condition. Upon the occurrence of the insurance event listed in Section 8, the care organiser's activities will cover the following:

a) organisation of care by a general practitioner;

b) organisation of outpatient specialist care;

c) organisation of inpatient care;

d) organisation of patient transport if the insured is unable to walk;

e) information provided to the insured about the availability of doctors on call or inpatient care institutions near the insured's place of residence.

9.2. Accounting for services arising from insurance events

9.2.1. If in the course of the services listed in Section 8 a medical practitioner prescribes medication or a medical aid on an official drug prescription form (National Health Insurance Fund (OEP) prescription form), the insurer will cover the price of drugs - up to the amount specified in the Coverage Limits table - against the medical document justifying drug prescription and the pharmacy receipt. The insurer will combine the cost of medication invoices and refund it by HUF 5,000. The insurer will not refund any amount lower than that.

9.3. Payment for services arising from insurance events

9.3.1. After appraising the legitimacy of care, the care organiser will make arrangements for the refund of the costs of care up to the coverage limits listed in Appendix 1.

a) if the insured has paid for medical care, the care organiser will transfer the cost of care to the insured's bank account, or in the absence of one, to his or her address of residence in Hungary;

b) if the insured did not pay for medical care, the care organiser will settle with the medical service provider administering medical care;

c) the care organiser will transfer the cost of prescription drugs to the insured's Hungarian bank account, or in the absence of one, to his or her address of residence in Hungary.

As a precondition of refunding the costs of services, the insured must report in writing his or her claim on the Sickness Claim Form (Appendix 2) to the care organiser's address. In every case, the photocopies of documents proving medical care (medical practitioner report, discharge report, outpatient treatment report and other medical documentation) and the original copy of the invoice of the costs paid by the insured must be attached to the form.

9.3.2. The insurer will refund the cost of services within 15 days of the receipt of the last document.

9.4. Obligations of the insured

A need for medical care must be reported to the care organiser immediately. If the insured's condition or circumstances did not allow immediate reporting to the care organiser, the need for medical services must be reported within no later than 48 hours of the occurrence of the insurance event.

10. THE INSURER'S EXEMPTION

10.1. The insurer will be exempted from paying the insured amount if the insurance event was caused by the beneficiary unlawfully by design, or due to the unlawful gross negligence of the policyholder or the insured. The insured commits gross negligence in particular if:
a) there is a causative relationship between the insured event and regular consumption of alcohol or the insured being under the strong influence of alcohol (blood alcohol content of 0.0026 or higher),
b) the insured event occurs as a consequence of the consumption of narcotics or substances with an effect of narcotics or medications, except when this latter was used as recommended and instructed by the treating physician.
10.2. The insurer will be exempted from paying the coverage amount if:

a) there is a causative relationship between the insured event and the insured's attempted suicide, even if the latter took place in the insured's confused state of mind,

b) the insured event is caused by a serious criminal offence committed by the insured intentionally or in connection with such an offence.

11. EXCLUSIONS

11.1. Insurance coverage does not apply to cases where the insured event is directly or indirectly connected with:

– the insured's active participation in combat events or other acts of war on either side,

– or the insured's participation in a criminal offence against the state.

11.2. For the purposes of these conditions, a war with or without declaration, a border clash, revolution, mutiny, coup d'état or attempted coup d'état against a government, civil war, focused military operation (e.g. airstrike or naval operation only) by a foreign country, commando attack, and terrorist act will be considered as war. (In the case of a commando attack or terrorist act, the insured's involvement in the victims' interest will not be considered as active participation.)

11.3. Under this contract, a criminal offence against the state is one that is defined as such by the Criminal Code, thus in particular riot, espionage and destruction.

11.4. The insurer will not cover losses indirectly or directly connected with nuclear damage (nuclear fission or fusion, nuclear reaction, radiation of radioactive isotopes, ionising or laser radiation, or contamination caused by these). 11.5. The insurer does not cover costs in cases (except for services provided by the medical service provider contracted by the insurer) where medical malpractice during treatment led to the repeated operations in question or to other insurance events specified in this policy. Under this policy, medical malpractice occurs when the provider of medical services violates, ignores or overlooks legal regulations, professional guidelines and customs pertaining to the particular field of healthcare and medicine.

11.6. Insurance coverage does not apply to cases where the insured event is directly or indirectly
connected with:

–pregnancy or childbirth and the consequences of health deterioration occurring within one year after childbirth, except outpatient care meant to establish pregnancy and interventions related to ectopic pregnancy;
–medical interventions designed to make aesthetic changes or provide cosmetic treatment.

11.7. The insurer does not cover the following medical services and related medication expenses:

a) screening tests,

b) occupational health and other medical aptitude tests,

c) transplantation,

d) treatment received as a consequence of a health condition already existing at the time of concluding this policy, except for critical lifesaving interventions,

e) treatment received due to attempted suicide,

f) rehabilitation, sanatorium treatments, physiotherapy

g) dialysis, except acute cases,

h) care due to psychiatric illness, except: emergency care to establish a diagnosis or in response to mental problems,

i) acupuncture, naturopathic and chiropractic treatments,

j) cost of contact lenses,

k) medication costs related to birth control,

l) care and medication costs in connection with abortion, except in medically justified cases,

m) examinations, treatments and medication costs in connection with infertility,

n) care and medication costs related to in-vitro fertilisation,

o) HIV infection,

p) medication costs of sexually transmitted diseases, except: trichomoniasis and chlamydia infection,

q) dental care (mandibular orthopedic treatment, orthodontics, periodontal care, depuration, final root canal treatment, prosthodontic treatment, crown, bridge), except: emergency dental care, direct palliative care, and temporary root canal treatment for maximum two teeth. The insurer's coverage limit extends up to HUF 50,000.

11.8. Any body parts or organs impaired, diseased, injured or truncated prior to the inception date and the subsequent consequences of these conditions are excluded from insurance.

12. LEGAL STATEMENTS

The insurer will have an obligation to consider valid any legal statements and reports sent to it, provided that they are submitted in writing to its unit authorised to issue this policy. Any legal statement will be effective upon its receipt by the insurer. The
insurer will send its legal statements to the person concerned in the insurance policy in writing.

13. COVERAGE REPLENISHMENT

In the scope of this contract, coverage may not be topped up.

14. DATA PROCESSING AND CONFIDENTIAL INSURANCE INFORMATION

Personal data is defined as data and conclusions drawn from data that may be associated with a specific (identified or identifiable) natural person (hereinafter "the data subject").

Personal data concerning health, addiction or sexuality constitute special data pursuant to the existing legislation and may be processed only with the written consent of the data subject. Data reporting is voluntary, but disclosure of certain personal data is essential for the conclusion of the insurance contract.

14.2. The insurer has the right to process customer data, including special data, legitimately brought to its knowledge in accordance with the provisions of Act CXII of 2011 on the Right of Informational Self-Determination and on Freedom of Information (hereinafter "the Information Act") and Act LXXXVIII of 2014 on the Insurance Business (hereinafter "the Insurance Act").

14.3. The insurer may process data related to the customer's health condition for the purposes of Section 14.5 only subject to the written consent of the data subject pursuant to Act XLVII of 1997 on the Processing and Protection of Healthcare Data and Associated Personal Data.

14.4. Data subject to banking secrecy may be processed by the insurer as required for the provision of insurance benefits. Data may be transferred in the manner defined in the Insurance Act with the consent of the customer/accountholder.

14.5. The insurer will process the personal data of the policyholder, the insured and the beneficiary in connection with the conclusion and administration of the insurance policy and the performance of insurance benefits, or for other purposes defined in the Insurance Act.

14.6. The insurer may process personal data—including special data—during the period of insurance as well as during the period in which a claim may be made in connection with the insurance. In connection with insurance contracts which were not realised, the insurer may process data brought to its knowledge as long as claims may be enforced in connection with the failure of the realisation of the contract. With complaints managed over the phone, the telephone communication between the service provider and the customer will be recorded by the service provider, and the recording will be retained for 5 years. The insurer shall delete all personal data relating to its customers, former customers or unrealised contracts where the purpose of data processing no longer exists, where the data subject's consent to processing is not available, or where there are no statutory legal grounds for processing.

14.7. Data relating to deceased persons shall be processed subject to the legal provisions for the processing of personal data. In respect of data that may be associated with a deceased person, the rights of the deceased person may also be exercised by the heir of the deceased person or the beneficiary named in the insurance contract.

14.8. Customer data may only be disclosed to the insurer's authorised staff, insurance intermediaries or persons and organisations providing data processing or outsourced activity to the insurer under specific contracts, within the scope determined by the insurer and to the extent required for their activities. The insurer undertakes to have appropriate data protection technology and records in place to ensure the protection of confidential insurance information.

14.9. The insurer is bound to retain information brought to its knowledge and treat it as confidential insurance information pursuant to the Insurance Act. Confidential insurance information is information at the insurer's disposal that contains no classified information and pertains to the personal circumstances, wealth or financial management of individual customers, or their contracts with the insurer.

14.10. With regard to confidential insurance information, unless otherwise provided for by law, the insurer's owners, managers, employees and all other persons that have access to such information in their activities relating to the insurer, are bound by non-disclosure obligation for an indefinite period of time.

14.11. Where as part of outsourced activities, the insurer forwards the personal data of its customers to the persons performing the outsourced activities, the persons performing the outsourced activities shall be considered as the insurer's data processors and shall be subject to non-disclosure obligation. Third parties may only process data under an agency agreement as part of outsourced activities.

14.12. The insurer may transfer the data subject's personal and special data and their confidential insurance information to third parties only with the written consent of the data subject or their legal representative, except where data is provided to entities specified in the Insurance Act as part of a request or mandatory data reporting provided for by law.

14.13. The non-disclosure obligation shall not apply to the following:

a) the Supervisory Authority acting in an official capacity,

b) after the ordering of the investigation, the investigating authority and the prosecutor's office,

c) courts of law in connection with criminal or civil litigations or non-litigated cases, courts acting during the judicial review of public administration resolutions, experts appointed by the court, and the independent court bailiff acting in a case of judicial enforcement, the major lender acting in the debt

settlement proceeding of natural persons, the family insolvency proceeding service, family receivers, courts,

d) public notaries and the experts appointed by them in connection with probate cases,

e) the tax authority in connection with tax matters where the insurer is required by law to disclose specific information to the tax authority upon request and/or to disclose data concerning any payment made under an insurance contract that is subject to tax liability,

f) the National Security Service when acting in an official capacity,

g) the Hungarian Competition Authority acting in an official capacity,

h) guardianship authorities acting in an official capacity,

i) the public health authority referred to in Section 108 (2) of Act CLIV of 1997 on Health,

j) the agencies authorised to use secret service means and to conduct covert investigations if the conditions set forth in the specific legislation are met,

k) providers of reinsurance and co-insurance (when insurance coverage is provided jointly by several insurers),

l) the office maintaining central policy records with respect to data transferred pursuant to the Insurance Act,

m) the receiving insurer with respect to insurance policies received under an insurance portfolio transfer according to the provisions of the relevant agreement,

n) the body operating the Claims Security Account and the Claims Security Fund, the National Office, the Correspondence Centre, the Information Centre, the Claims Organisation and the claims agent, as well as the claims representative with respect to the information required for the settlement and enforcement of compensation claims and to the transfer of such information between one another, and the party responsible for the claim if, by exercising his/her right to self-determination, he/she requires access to data of repairs of the other vehicle from a claims settlement report taken in connection with a road accident,

o) persons performing outsourced activities, in respect of data necessary for performing such outsourced activities, and the auditor in respect of the data required for carrying out his/her tasks,

p) third-country insurance companies, insurance brokers and consultants in respect of their branch offices, if they are able to satisfy the requirements prescribed by Hungarian law in connection with the management of each data item and the country in which the third-country insurance company is established has legal regulations on data protection that conform to the requirements stipulated by Hungarian law,

q) the Commissioner for Fundamental Rights when acting in an official capacity,

r) the National Authority for Data Protection and Freedom of Information when acting in an official capacity,

s) the insurer with respect to information concerning a customer's individual claims history and no-claim discount classification in the cases as set forth in the ministerial decree on the issuance of claim history certificates, the bonus-malus system (no claims bonus) and the classification of customers therein, upon receipt of a written request from an agency or person referred to in points a)–j), n) and s) indicating the name of the customer or the description of the insurance policy, the type of data

requested and the purpose and grounds for requesting data. The bodies or persons referred to in points p)–s) are required to indicate only the type of data requested and the purpose and grounds for requesting it. An indication of the statutory provision granting authorisation for requesting data shall be treated as verification of the purpose and legal grounds.

14.14. The insurer shall delete transferred personal data after 5 years following the data transfer, except for data relating to the health condition of the customer or classified as special data under the Information Act, which shall be deleted after 20 years.

14.15. Upon written request by investigative authorities, the National Security Service or public prosecutor's offices, the insurer or the policyholder shall also be required to promptly provide information if evidence is found substantiating that the insurance transaction may be related to:

a) drug abuse, abuse of new psychoactive substances, acts of terrorism, misuse of explosives and blasting agents, criminal misuse of firearms and ammunition, money laundering, organised crime or crime committed in participation in a criminal organisation, as defined in Act IV of 1978, in force until 30 June 2013,

b) drug trafficking, possession of drugs, incitement to the use of narcotics or the promotion of illegal drug production, abuse of new psychoactive substances, acts of terrorism, failing to report terrorism, financing of terrorism, misuse of explosives and blasting agents, criminal misuse of firearms and ammunition, money laundering, organised crime or crime committed in participation in a criminal organisation, as defined in the Criminal Code of Hungary.

14.16. The insurer may not inform the customer if data is transferred to investigative authorities, prosecutor’s offices, the National Security Service and, subject to conditions set out in specific legislation, to agencies authorised to use secret service means and to conduct covert investigations.

14.17. The duty to retain insurance information in confidence does not apply if the insurer, insurance intermediary or consultant is required to comply with its reporting obligation under the Act on the Implementation of Financial and Asset-related Restrictive Measures Ordered by the European Union.

14.18. The duty to retain insurance information in confidence shall not apply furthermore if:

a Hungarian law enforcement agency — acting in response to the written request of a foreign law enforcement agency pursuant to an international agreement — requests confidential insurance information from the insurer in writing,

b) an authority operating as a national financial intelligence unit—acting within its powers conferred under the Act on the Prevention and Combating of Money Laundering and Terrorist Financing or in response to the written request of a foreign financial intelligence unit—requests confidential insurance information from the insurer in writing.

14.19. The duty of confidentiality is not breached:

a) in the event of disclosure of summarised information from which the identity of customers or the specifics of their business cannot be identified,

b) in the case of a branch office, the data transfer necessary for the supervisory authority as per the registered office (headquarters) of the enterprise with a registered office abroad if it complies with the agreement between the foreign and the Hungarian supervisory authority,

c) in the event of disclosure of information, other than personal data, to the competent minister for legislative purposes or in connection with the completion of feasibility studies,

d) data transfer in order to comply with the provisions of the act on the supplementary supervision of financial conglomerates.

14.20. Data transfer by the insurer to a third-country insurer, reinsurance company or a third-country data processing agency shall not qualify as a breach of insurance secret if:

a) the customer of the insurer has given written consent, or

b) if, in the absence of the customer's consent, the data transfer has the scope, purpose and legal basis defined in the legislation and the adequate level of protection of personal data is ensured in the third country in compliance with the provisions set out in Section 8 (2) of the Privacy Act.

14.21. When transferring confidential insurance information to another Member State, the provisions governing data transfer within the domestic territory shall be applicable.

14.22. The data subject may exercise the following rights in respect of its data being processed by the insurer:

– request for information,

– corrections,

– deletions,

– classification,

– public disclosure.

14.23. Where the insurance contract requires the prospective customer to undergo medical examination, the customer may obtain the results of such examinations from the medical service provider pursuant to Act CLIV of 1997 on Health.

14.24. Under the Privacy Act, in the cases specified therein, the data subject may object to the processing of their personal data. The insurer as controller shall examine such requests as required by law and inform the applicant in writing. In the event of the infringement of their rights, the data subject may take court action against the controller. The insurer as controller shall also indemnify the data subject for any proven damage which it caused by unlawful data processing or failure to comply with the requirements of technical data protection.

14.25. Data transfer by the insurer to the tax authority for the purposes of fulfilling the obligation included in Sections 43/B-43/C of Act XXXVII of 2013 on Certain Rules of International Public Administration Cooperation Related to Taxes and Other Public Duties (hereinafter: the "Aktv.") based on Act XIX of 2014 on Announcing the Agreement between the Government of Hungary and the Government of the United States of America to Improve International Tax Compliance and to Implement FATCA and the amendments of certain related laws (hereinafter: "FATCA Act") shall not qualify as a breach of insurance secret.

14.26. In order to protect the interests of the risk pool, in the course of the performance of its obligations, the insurer may contact other insurers for the purposes of performing the services in accordance with the law and the contract, and preventing abuses connected to insurance contracts, in respect of the following data managed by those insurance companies:

a) personal identification data of the policyholder, the insured and the beneficiary;

b) data on the health condition of the insured at the time of data registration, relevant to the policy risk;

c) data on earlier life, accident and sickness insurance events involving the person defined in point a);

d) data required to assess the risk arising from the policy concluded with the contacted insurer, and

e) data required to assess the legal grounds of the benefits to be provided based on the policy with the contacted insurer.

Making contact and its fulfilment do not qualify as the breaching of insurance secrets. The insurance company initiating the contact may manage the data it became aware of as a result of the enquiry during the period defined by the Insurance Act. The insurance company will notify the customer in question of the aforementioned enquiry, the affected data and the fulfilment of the enquiry at least once a year, and at the request of the customer, it will notify the customer in the way defined in the Information Act.

14.27. The insurer's data management registration number is: NAIH-57651/2012

15. LEGAL STATEMENTS

15.1. The insurer shall deliver its declarations in writing to the policyholder, or to the insured when claims for benefits are reported, to the most recent notification address provided by them to the insurer.
15.2. Any legal statements and reports sent to the insurer shall be considered valid only if they are made in writing. Any legal statement will be effective upon its receipt by the insurer.

16. LIMITATION

Claims arising from insured events occurring during the coverage period will lapse after one year following the occurrence of the insured event.

17. LANGUAGE OF COMMUNICATION AND CUSTOMER NOTIFICATION

All communication between the insurer and the policyholder and notification of insured persons shall take place in Hungarian.

18. GOVERNING LAW AND PROCEEDING COURTS

This insurance contract shall be governed by the provisions of Hungarian law. The parties may apply to the court with general competence and jurisdiction for the adjudication of legal disputes arising out of the insurance contract and the legal relations between the parties. The language of the proceedings shall be Hungarian.

19. RESOLUTION OF DISPUTES

19.1. The policyholder and the insurer are bound to make every effort to settle any disagreements or disputes that may arise between them in the scope of or in connection with the contract amicably, by direct negotiation. The parties are bound to mutually inform each other of any independent circumstances arising subsequent to the conclusion of the contract that prevent the fulfilment of the contract.

19.2. Please report any complaints concerning the insurer's service to the insurer:

a) in writing or by telephone to:

UNION Vienna Insurance Group Biztosító Zrt.

(1082 Budapest, Baross u. 1, tel.: (+36-1) 486-4343)

b) or in person at the following address:

UNION Vienna Insurance Group Biztosító Zrt.

Central Customer Service Office (1134 Budapest, Váci út 33)

The insurer will publish on its website any changes to the above contact information occurring after the conclusion of the contract.

19.3. If any complaint concerning the insurance service is received by the policyholder, it shall direct the insured persons to the insurer.

19.4 The insurer shall send its position regarding the written complaint to the customer along with an explanation within thirty days of the communication of the complaint.

19.5. The insurer's supervisory authority is: National Bank of Hungary (1054 Budapest, Szabadság tér 8-9;
central phone number: (+36-1) 428-2600)

19.6. Other forums for the enforcement of rights

In the case of disagreement with the response to their complaint made with the insurer, the insured may

a) with complaints concerning inquiries into the violation of consumer protection provisions under Act CXXXIX of 2013 on the National Bank of Hungary, contact the National Bank of Hungary (mailing address: Magyar Nemzeti Bank, 1534 Budapest BKKP PO Box: 777; blue line with local charges: (+36-40) 203-776; website: felugyelet.mnb.hu; e-mail: ugyfelszolgalat@mnb.hu);
b) with complaints concerning the issuance, validity, legal effects and termination of the policy, as well as breaches of contract and their legal effects, contact the Financial Arbitration Board (mailing address: H-1525 Budapest BKKP Pf. 172; Phone: (+36-1) 489-9100; email: pbt@mnb.hu), or apply to any court of law according to the rules of civil procedure.

19.7. Claims arising from or in relation to the insurance contract may also be enforced directly through judicial avenues. The resolution of complaints does not substitute litigation.

20. Deviation from normal contracting practice or the provisions of the Civil Code

– An insurance that has been terminated due to premium non-payment may not be reactivated.
– In the scope of this contract, coverage may not be topped up.
– Claims arising from insured events occurring during the coverage period will lapse after one year following the occurrence of the insured event.

21. Miscellaneous

21.1. Actual healthcare is provided by the healthcare provider, whose activities and liabilities are governed by the provisions of the Act on Health; liability for losses arising from the faulty performance of medical and healthcare services shall be borne by the healthcare provider rather than the insurer. The insurer will forward complaints concerning the quality of the services provided by the healthcare providers, service standards and potential medical malpractices to the organisation providing the care, considering that the insurer only pays the counter-value of such services, but the services themselves are not provided by the insurer.

21.2. From 2017, the insurance company will disclose its report on its solvency and financial situation on its website (www.unionbiztosito.hu) in the manner and at the time defined by the legal provisions.

UNION Vienna Insurance Group Biztosító Zrt.

These insurance conditions are valid with **Appendix 1** setting out the benefits of the "UniMed Health Insurance" and **Appendix 2** containing the care organiser's data.

UNIMED Health Insurance - INSURANCE CONDITIONS

Appendix 1

Table of benefits

The insurer's annual coverage limit for a fixed-term one-year policy: HUF 2,000,000; for a fixed-term 6-month policy: HUF 1,000,000. This coverage limit will be reduced by every benefit that has been used. Medical care, with the exception of emergency care, is always provided in Pécs.

COVERAGE	LIMIT		DEDUCTIBLE
	ANNUAL	QUARTERLY / SEMI-	

		ANNUAL	
Outpatient primary care (provided by English-speaking general practitioners)	HUF 2,000,000	HUF 1,000,000	none*
Outpatient specialist care			none
Emergency outpatient care			none
Inpatient care (including emergency care)			none
Patient transport			50%
Cost of medications and medical aid	HUF 100,000	HUF 50,000	50%

UNIMED Health Insurance - INSURANCE CONDITIONS

Appendix 2

Care Organiser's Data

Advance Medical Hungary Kft.

1085 Budapest, Baross u. 22

Care Organiser's 24-hour contact number: **+36 1 461-1590**