UNION BIZTOSÍTÓ
VIENNA INSURANCE GROUP

PrivateMed Pro group health insurance

Specific Insurance Terms & Conditions

These Specific Insurance Terms & Conditions shall concern UNION Vienna Insurance Group Biztosító Zrt.'s PrivateMed Pro group health insurance contracts, provided that the contract is concluded with reference to these terms.
As regards any issues that are unregulated in these Specific Insurance Terms & Conditions, the Policy Terms & Conditions of the insurer's PrivateMed Pro group health insurance (the "Policy Terms and Conditions") shall be governing as applicable.

1. Basic services

1.1. Outpatient care
An insured event shall be the emergence of the need for medical care due to an unforeseen and unexpected illness of the insured as compared with the inception date during the risk-bearing period related to the insured, which care is implemented in the scope of outpatient care or house call, where medically justified and necessary, as well as the prescription of the medication necessary in the scope of such care. **In the case of symptoms and illnesses that are connected to illnesses existing at or before the inception date, the insurance shall provide coverage for the costs of specialist examinations only. The insurance does not cover the costs of laboratory, imaging or other diagnostics and medical treatment that are necessary due to such illnesses and symptoms.** Use of the house call service is bound to loss retention. The amount of loss retention is 30% of the costs of the house call, subject to a minimum of HUF 5,000. The amount of the loss retention shall be paid by the insured after the service to the service provider proceeding in the course of the house call. The insured has no other payment obligations in connection with the use of the service.

1.2. One day surgery
An insured event shall be a plannable and planned medical intervention that has become necessary due to an unforeseen and unexpected illness of the insured as compared with the inception date during the risk-bearing period related to the insured, which intervention is to take place depending on the insured's selected ambulatory surgery and examination criteria in an institution designed for this purpose and having all other required conditions, provided that the insured does not stay in the given institution for longer than 24 hours.

1.3. Medical diagnostic imaging procedures
An insured event shall be any of the diagnostic procedures detailed in the paragraphs below which is to be carried out in view for the further healing of the patient, and that has become necessary due to an unforeseen and unexpected illness of the insured as compared with the inception date during the risk-bearing period related to the insured and is diagnosed by a specialist and documented through examination findings.

1.3.1. **PET-CT (positron emission tomography—computed tomography)**
A medical diagnostic examination necessitated by the insured's illness that primarily serves the early recognition of malignant tumours, heart diseases and various illnesses of the central nervous system, as well as to determine the therapies to be used and monitor their effectiveness.

1.3.2. **Cardio-CT (computed tomography)**
A medical diagnostic examination necessitated by the insured's illness that is suitable to detect illnesses (as well as their origin) that cardiology examinations (e.g. stress ECG) are unable to show without doubt. It has a significant role especially in the detection of coronary artery diseases.

1.3.3. **MR (magnetic resonance imaging)**
A medical diagnostic examination necessitated by the insured's illness that primarily assists the diagnosis of diseases of the skull, the spine, the joints, abdominal and pelvic organs, the blood vessels and the heart.

1.3.4. **CT (computed tomography)**
A medical diagnostic examination necessitated by the insured's illness by which pathological alterations of organs, or changes in their size, structure or position may be identified in high spatial detail.

2. Extension of basic services
The basic services listed in Section 1 may be supplemented with the following risks:

2.1. Screening tests
The insured may use the tests included in the selected screening package once a year. In view for the assessment of the health conditions of insureds over 18 years of age, the insurer makes the following screening tests:
The policyholder may select one per insurance group from the following screening packages:
a) Medium screening package
- examination by internal specialist
- ECG at rest
- lab tests: complete blood count, blood glucose, cholesterol, triglycerides, complete urinalysis and sediment test

b) Customised screening test package (only in the case of basic services with double annual limit or without limit)
The content of this screening package may be composed by the policyholder from the following elements:
- Examination by internal specialist
- ECG at rest
- Ultrasound scan of abdomen and pelvis
- Chest X-ray (unidirectional)
- Lab tests: complete blood count, blood glucose, cholesterol, LDL-cholesterol, HDL-cholesterol, triglycerides, GPT, GOT, GGT, bilirubin, uric acid, creatinine, urea, potassium, sodium, complete urinalysis and sediment test
- Gynaecological screening
- Urological screening
- Dental screening test (Budapest only)

2.2. Children package
The insurance may as well be concluded for children between 6 months and 18 years of age, if the policyholder of the insurance is a natural person, and the insured child is the biological, adopted or foster child of the natural person policyholder (consumer) or of his/her spouse or partner. For children between 6 months and 18 years of age, the basic service as per Section 1 may only be concluded at an annual limit of HUF 250,000.

3. Services provided by the insurer

3.1. It is a condition precedent for the arrangement of the services and cost reimbursement by the insurer that the insured—where necessary in view for the further examination of his/her health condition or the preservation of his/her health as indicated by an examination carried out by his/her primary care physician, or private physician or other specialist—should have a (specialist's) recommendation necessary for his/her further care. The insurance covers the organisation of the service as well as the examination, if the insured so requires, and the insurer accepts a general practitioner's referral as well. It is a further condition precedent for the service of the insurer that the insured's claim for medical care should be qualified by the care organiser as eligible in accordance with these Specific Insurance Terms & Conditions.

3.2. The following services may be used without a physician's recommendation as well: ophthalmology, laryngology, dermatology, urology, general surgery, gynaecology and pulmonology.

3.3. If the insured applies for any of the services described in Section 1, the insured—having the medical recommendation at his/her disposal—shall report his/her need for further care on the phone to the care organiser, who is available on working days, and who shall within 5 working days of the call arrange the first contact between the insured and the physician.
If the physician subsequently orders further examinations, the insured may use these at the times arranged by the care organiser, provided that the care organiser also deems that the care is justified and the insured has not exhausted his/her annual limit concerning the given risk. Telephone calls are recorded in a traceable form.

3.4. In the case of a service provider contracted by the care organiser, the insurer—through the care organiser—fully reimburses the costs of the service to the service provider, up to the available annual limit.

3.5. In the course of the telephone conversation mentioned in Section 3.3, the care organiser shall inform the insured of the amounts available from the annual limits concerning the given care.

3.6. If the insured has already exhausted 90% of his/her annual limit concerning the given care, the insurer undertakes to organise health care only so that costs will be reimbursed to the insured

in retrospect, against invoices, up to the annual limit.

3.7. Within the outpatient care risk, the insurer reimburses laboratory tests up to HUF 50,000 per policy year, and dermatology care up to HUF 100,000 per policy year, irrespective of the selected service package.

3.8. If there is no contract between the care organiser and the health care provider, the insurer shall—subject to the prior approval of and up to the amount determined by the care organiser—reimburse the costs of the medical care to the insured in retrospect, against invoices.

3.9. In the case of screening tests, the care organiser arranges the carrying out of the tests for the insured or the insured group, and notifies the policyholder of the place and time of the tests.

4. Documents necessary for the insurer's performance

It is a precondition for performance that the person applying for medical care should be eligible for the care in accordance with the contract. The documentation of adequate content prepared by the health care provider concerning the care administered to the insured shall be a condition precedent for the insurer's performance. Payment shall take place immediately after the documentation has been received in full, but within 15 days at the latest, in accordance with Section 3.

5. Risks excluded from coverage

5.1. The insurer shall not arrange health care, and shall not reimburse its costs, in the following cases:

- **if the insured applies for health care without a physician's recommendation, except for the cases listed in Section 3.2,**
- **if the recommendation is not furnished with the stamp of the physician,**
- **if the recommendation for the medical diagnostic imaging examination is not issued by a clinical physician. A recommendation / referral issued by a general practitioner shall not be accepted by the insurer even if the general practitioner is authorised to pursue specialist tasks as well,**
- **if the care was not used through the care organiser,**

5.2. The insurer shall not provide coverage if the medical care takes place on account of the following:

- **for emergency reasons, in order to avert danger to life,**
- **due to expert activities performed in the scope of health care,**
- **due to disasters,**
- **care administered for epidemiological reasons,**
- **pulmonology care,**
- **addictology care,**
- **alcohology care,**
- **drug patient treatment and care,**
- **employment health care,**
- **acupuncture treatment,**
- **dental care,**
- **laser toenail fungus removal,**
- **geriatric treatment and care,**
- **dialysis treatment,**
- **digital dermoscopy,**
- **injection treatment of varicose vein disease (sclerotherapy),**
- **venereal disease care,**
- **tests carried out due to infertility,**
- **psychiatric treatment,**
- **special education treatment,**
- **physio- and motion therapy treatment,**
- **intensive patient care,**
- **clinical oncology care,**
- **care of HIV patients,**
- **care of hepatitis C patients,**
- **in the scope of anaesthesiology care.**

5.3. The following care services are not included in the coverage provided by the insurer in connection with the insured events "Outpatient care" and "Medical diagnostic imaging":

- **mandatory mother and child protection duties, by which mandatory vaccination and screening required under the law is meant,**
- **during pregnancy, the insurer reimburses 4 gynaecological examinations altogether, including the related ultrasound scans, up to the annual limit at maximum.**

5.4. The insurer shall not provide coverage if one day surgery takes place on account of the following:

a) Sterilisatio laparoscopica feminae
b) Laparoscopic sterilisation with clips
c) Laparoscopic sterilisation with rings
d) Laparoscopic sterilisation with monopolar electrode
e) Laparoscopic sterilisation with bipolar electrode
f) Laparoscopic surgery of extrauterine gravidity
g) Laparoscopic aspiration of embryos from salpingotomy
h) Termination of pregnancy with intra-amniotic medication
i) Termination of pregnancy with extra-amniotic medication
j) Termination of ectopic pregnancy with injection, laparoscopic interruption with vacuum
k) Interruption by Hegar dilator and curettage
l) Interruption by laminaria dilation
m) Termination of medicated interruption
n) Interventions related to infertility
o) Artificial fertilisation
p) Plastic surgery for aesthetic reasons.

6. Other services

6.1. Second medical opinion

For the purposes of this agreement, second medical opinion is defined as teleexpertise provided by an internationally acknowledged medical expert who is highly experienced in the field concerned in response to a medical question asked by the insured from the care organiser concerning his/her severe disease.

6.1.1. This service includes the following:

Access to the expertise of international medical experts, where using the international network of acknowledged medical experts and hospitals the care organiser selects in each case recognised foreign specialists for the purposes of providing second medical opinion.

Selection and recommendation of leading experts in any country for the purposes of teleexpertise.

Selection and recommendation of leading hospitals in any country for the purposes of teleexpertise.

The care organiser assigns a case manager in each case, who obtains from the insured the medical findings and information necessary for the preparation of the second medical opinion, and keeps contact with the patient and his/her treating physician as needed.

6.1.2. The second medical opinion described in these terms is provided by the care organiser in respect of the following illnesses:

- life endangering cancer (malignant tumour);
- cardiac diseases, including cardiovascular surgery;
- organ transplants;
- neurological and neurosurgical diseases, including strokes;
- congenital diseases and disorders;
- degenerative illnesses of the nervous system and demyelinisation;
- illnesses and problems resulting from renal failure;
- life endangering illnesses or highly complicated interventions.

In the case of illnesses other than those specified above, the care organiser shall take decision regarding the provision of the second medical opinion or refusal of the same in its sole discretion.

For the use of this service, the insurer does not stipulate any waiting period as compared with the entry in force of the contract.

6.2. Use of medical call centre

Under these terms, the insurer provides for the insured through its health care provider partner (Advance Medical Hungary Kft., hereinafter "the service provider") a call centre service accessible 24 hours a day, 7 days a week.

The purpose of the service is that specialists provide information meant for lay people over the phone in connection with the preservation of health to customers. In the health care call centre, specialists answer incoming calls, and provide information in respect of the following issues:

a) questions related to the preservation of health and lifestyle,
b) information concerning the ingredients, application, side-effects, substitution and price of medicines,
c) information on medical, pediatrics and dentistry stand-by services,
d) information on pharmacies on duty,
e) information on the contact details of health care institutions.

Customers may use this service 24 hours a day on any day of the year during the entire lifetime of the coverage. As it is impossible to set up an accurate diagnosis and select the right treatment on the basis of a telephone call, medical consultation over the phone cannot substitute a personal visit to the physician or the examination of the insured. Neither the insurer, nor the service provider shall be liable for any losses arising from the misinterpretation or misuse of the information provided on the phone. The service provider does not give prescriptions, or referrals to hospitals or outpatient care, and does not examine

patients in-person. The service provider shall treat the personal data and information it becomes aware of in the course of the telephone conversations confidentially, use the same only and exclusively for the purpose of answering the questions of the caller, and shall not forward the same to third parties.

7. Liability of the care organiser

From medical point of view, the care organiser has the exclusive right of consideration concerning the evaluation of the legitimacy of the need for health care covered by the insurance.

Exercising this right of consideration, the care organiser may refuse to arrange the service in the cases where it is deemed unnecessary and thus unjustified from medical point of view.

These cases include in particular the examinations or interventions intended to be executed repeatedly, within an unreasonably short period of time as compared with the previous similar intervention. They also include the interventions where the recommending physician is unable to justify the necessity of the intervention. The care organiser may also refuse to arrange the care in the cases where although a medical recommendation is not needed for the use of the specialist care, but the care organiser deems the care is unjustified from medical point of view.

The care organiser shall not be liable for cases that in the opinion of the insured's treating physician are justified professionally in the given moment and for the evaluation of the demand for the related care where the service is not covered by the insurer. In such cases it is the responsibility of the insured to use the health care provided by social security.

The liability of the care organiser does not comprise the professional performance of the service providers, or any losses that might be caused by the service providers to the insured in the course of performance.

UNION Vienna Insurance Group Biztosító Zrt.