MAPFRE GENEL SİGORTA A.Ş.
SPECIAL TERMS FOR HEALTH INSURANCE POLICIES OF FOREIGN NATIONAL RESIDENTS

These special terms are valid for the Insured who have a Health Insurance Policy for Foreign National Residents as of 08.07.2015.

The Insurance Policy that was prepared in line with the conditions that have been mutually agreed on by Mapfre Genel Sigorta A.Ş. (referred to hereafter as Insurer) and the Insurant/Insured; is comprised of the Application Form and Insured Information Form which is filled out and signed by the Insurant/Insured and accepted by the Insurer, the Health Insurance General Conditions and Special Conditions, Certificate, User Manual and Booklet of Health Institute with which an agreement is established and if any, the Supplement Protocol, all of which are an inseparable part of the policy.

ARTICLE 1- SUBJECT OF THE INSURANCE

In addition to the Health Insurance General Conditions, if an insured member becomes ill and/or injured in an accident the expenses necessary for their inpatient /outpatient treatment at any Ministry of Health licensed private or official health organization, will be covered in line with coverage, limit and co-payment rates specified in the certificate attached to the policy within the scope of the special and general conditions.

This policy covers the minimum coverage structure that is specified in the Notice regarding private health insurances to be obtained in the scope of residence permits dated 06/06/2014 and numbered 9.

The insurance coverage is only valid for the individuals on the Insurance Policy, others may not benefit from the coverage.

ARTICLE 2- DEFINITIONS

The definitions used in the scope of the Insurance policy are as follows.

EMERGENCY: Situations which require medical attention within 24 hours following an incident in which sudden illness, accident, injury or similar situation occurs and situations in which the risk of losing life and/or integrity of health may occur since medical intervention has not been performed urgently or the patient is transferred to another health organization.

JUDICIAL INCIDENT: Unexpected sudden incidents that result in the Insured becoming physically injured within the policy period and that need to be or are pursued and investigated by judicial authorities. They are documented by the authority conducting the investigation.

IN-NETWORK PROVIDER: The hospitals, clinics, laboratories, diagnosis and treatment centers, pharmacies and doctors that are on the (Eko) In-Network Provider list in the attachment of the policy that the Insurer has made an agreement with so that the Insured can benefit from their services free of charge according to the conditions of the policy.
The limit and coverage percentages applied at the In-Network Providers have been specified on the Certificate. Since this list is updated regularly, the Insurance Company should be asked whether their agreement is still valid with that service provider before receiving services.

NON-NETWORK PROVIDER: The hospitals, clinics, laboratories, diagnosis and treatment centers, pharmacies and doctors that the Insurance Company does not have an agreement with. If Doctors who work at an In-Network hospital but issue bills based on their own fees do not have a special agreement with the Insurance Company, the bills of this doctor will be handled as if they are from a non-network provider.

OUTPATIENT COVERAGE: This is the Coverage in the scope of this policy which includes services that do not require hospitalization or treatment in the hospital and being kept under observation.

START DATE: The date that the policy goes into force for the first time or each first day of its renewal (At 12:00 local time in Turkey), month and year.

WAITING PERIOD: This is the period that starts with the Registration Date of the Insured, in which certain medical conditions that are specified in the Policy's diseases with a waiting period section are not covered, and the period without coverage that is applied by the Insurer according to the health status of the Insured.

UNDECLARED PRE-EXISTING MEDICAL PROBLEM: Any complaint, symptom or disease that existed during or before application for this Policy that was not declared to the Insurer on the application form.

EXPIRATION DATE: The day, month, years that the term of this Policy expires (at 12:00 local time in Turkey). All expenditures that are made after this date regardless of the reason shall be excluded from coverage. However, the expenses of a patient who is still in the hospital as of the Policy expiration date will be covered for an additional 10 days on the condition that they never left the hospital as of the expiration date.

EXTRACTION DATE: The day, month and year (at 12:00 local time in Turkey) that an Insured individual is removed from a Policy, under which more than one person is covered, as per the Insurant's request and/or because the Insured is not compliant with the status that is defined in the Individuals to be Insured definition; and which is continued by the Insurer for the other Insured. If the Insured is extracted due to default or termination, the matters and periods specified in article 8 of the General Conditions shall apply.

DOCTOR: An individual licensed by the T.R. Ministry of Health who has an official medical doctor title and certificate according to the laws that are enforced in their geographical area.

GENERAL CONDITIONS: The written rules that are set forth by the T.R. Prime Ministry Treasury Undersecretary and required to be complied with in health insurance by all insurance companies.

UNNECESSARY TREATMENTS: Carrying out treatments, examinations and procedures by hospitalizing the Insured although such treatments, examinations and procedures are accepted by impartial doctors to be applicable without having to admit the patient in a hospital unless the Insured's health is jeopardized.

TOTAL LIMIT PER DISEASE / COVERAGE: The maximum of health expenditures to be determined by the Insurer per illness and/or coverage under the conditions of this policy, which is specified on the insured individual's certificate and in compliance with general conditions.

HOSPITAL: The public or private institution that has an official Hospital license in connection with its field of operations and provides medical services to ill and injured patients. Clinics that provide outpatient services, sanatoriums, physical therapy centers, health clubs, hospices, nursing homes, etc. and establishments that specialize in substance abuse (drugs, alcohol) are not in the scope of Hospitals.

HOSPITALIZATION: Situations in which a Hospital stay of at least 24 hours is necessary for medical conditions that cannot be treated outside of the hospital and are covered by this Insurance Policy.

MAD (Medical Practice Database): This is a schedule that shows the fees and principles of application for doctors practicing their profession within the borders of the Republic of Turkey, which has been announced by the Association of Turkish Physicians.
The fee in the schedule is calculated by multiplying the "unit value" set forth for each medical procedure with the general coefficient that is determined every year separately for each province.

CANCELLATION DATE: The day, month, year (at 00:01 local time in Turkey) that the Policy is cancelled per the request of the Insurant or by the Insurer for default or termination reasons specified in the General Conditions.

ACCEPTABLE COMPENSATION: The amount that is determined taking into account the percentage of health expenditures, limits and exemptions that are in the scope of Coverage that is specified in the Insured's Health Insurance general Conditions and this Insurance Policy; and paid by the Insurer.

REGISTRATION DATE: The day (at noon at 12:00 local time in Turkey) that the Insured is first taken under Coverage with the Insurance Policy or taken under Coverage with the first renewed Insurance as defined.

ACCIDENT: An unexpected sudden incident that results in the physical injury of the Insured which can be proved medically.

CONGENITAL DISEASE: Physical and/or metabolic irregularities and/or disorders that are present from birth.

CHRONIC ILLNESS: A disease that does not have a sudden beginning, that develops and/or progresses gradually, recurs from time to time and causes a constant health problem.

SMALL PROCEDURE COVERAGE: This coverage includes small procedures and observations that are specified in the Minimum Fee Schedule published by the MPD up to 199 units (including unit 199).

SPECIAL CONDITIONS: Conditions prepared in addition to the Health Insurance General Conditions by the Insurance Company, which determine the corresponding rights and obligations of the parties, the Coverage and validity terms and the conditions that are valid until the expiration date of this Policy.

PERSONNEL: Individuals who actively work as an employee in a legal entity workplace constantly and full time (at least 35 hours a week) and are suitable for being insured.

ADDITIONAL RISK PREMIUM: The additional premium application specified in the Policy that is provided in the annex of the Policy and only applicable to the relevant insured. The applied additional premiums shall be stated in the certificate of the concerned insured along with the reasons and rate.

CERTIFICATE: The table that shows the domestic and foreign group of coverage that the Insurant has chosen on their application form and agreed on with the Insurer, the In-Network Provider type, copayment rates, coverage limits if any and exemptions if any; and is an inseparable part of the Policy.

VALIDITY: The state of the insurance policy being valid and in force.

INSURANT: The responsible party who has applied for an Insurance Policy, whose application has been accepted and is in the scope of this Insurance Policy; the individual or legal entity acting on their own behalf and on behalf of Individuals to be Insured.

INSURANT/INSURED COPAYMENTS: The percentage of the Acceptable Expenditures that will be paid by the Insurant/Insured at the rate that is specified in the Certificate that is provided in the annex of the Policy.

INSURER SHARE: The percentage of the Acceptable Expenditures that will be paid by the insurer at the rate that is specified in the Certificate that is provided in the annex of the Policy.

INSURANCE POLICY: All the documents that are prepared in a special format by the insurer, that contain the term of the policy, application information like special and general conditions, limits, exemptions and payment terms; that guarantee payment, within the set limits, of coverage if the specified conditions occur, that contain the company stamp and signature and include the insurance certificates.

INSURER: The Insurance Company that is registered in the country where the policy is issued and has an operation license. In this policy the title of Insurer has been used for Mapfre Genel Sigorta A.Ş.

INDIVIDUALS TO BE INSURED: The Insurant themselves or their Personnel, their spouse, children under 18 years old or children under 25 who are unmarried or attending university full time and are not employed in a freelance or salary provided job.

INSURED: The person and/or persons that are specified in the health insurance application of the Insurant and the Individuals to be Insured, or that are added on later and accepted by the Insurer or taken under coverage in the Policy or by a later amendment.

TOTAL EXEMPTION PER INSURED: The portion of exemption belonging to the Insured, which is applied for the maximum and/or minimum coverage in the scope of the policy to be undertaken by the Insurant throughout the Insurance Policy validity period from the Acceptable Expenditures; and within the limit that is specified in the Certificate.

SPECIAL EXCEPTIONS FOR THE INSURED: Acceptances of special conditions (additional premium, exception, participation, etc.) unique to the Insured that have been decided by the Insurer to be applied on the Insurance Policy and exceptions to be applied for the Insured. These are specified on the certificate that is provided in the annex of the insurance policy.

STANDARD EXCEPTIONS: All general exceptions that are valid for all coverage and insured and have been specified in the special conditions.

IMPARTIAL PHYSICIAN: A medical doctor that makes decisions and notifies opinions according to impartial medical rules.

HEALTH INSURANCE PATIENT INFORMATION FORM: The form that is provided in the User Manual for the Insured to be able to benefit from the policy coverage within the validity period of the Insured's Policy and filled out by the doctor that the insured applies to. Since there are no forms available at non-network institutions, the insured must have the form that is provided to them in the policy form with them. This form is required in order for health expenses to be evaluated. It can be reproduced by photocopy**.**

COVERAGE: The scope of the health expenditure that the Insurer has undertaken to pay within the framework of the Insurance Policy's special and general conditions, outside of the limits, exceptions, waiting period and exemptions that are specified on the certificate.

RENEWAL: The Insurant applying to the Insurer 30 days before or 30 days after the Insurance Policy Expiration Date to renew the existing contract and the new contract, continuing without interruption, after the Insurer and Insurant have agreed on the new Insurance Policy conditions.

RENEWAL DATE: The Day (12:00 noon local time in Turkey) month and year of the new Insurance Policy Start Date that is the same as the Expiration Date of the existing Insurance Policy.

YEARLY TOTAL LIMIT: The maximum yearly amount that the Insurer can use within the Insurance Policy term specified yearly within the conditions of this Insurance Policy.

ARTICLE 3. COVERAGE

3.1. IN PATIENT TREATMENT COVERAGE

The Inpatient Treatment Coverage covers medically necessary internal and/or surgical admissions, expenditures for emergency health conditions that could endanger the insured's life and small procedures in accordance with special and general conditions as long as the physician explains the reasons in detail in their report. The treatments of the insured that require a hospital stay of over 24 hours will be assessed in the scope of this coverage.

In cases requiring planned admissions and/or surgery, other than emergencies, the "special health insurance patient information form" (found in all in-network institutions) must be filled out 48 hours before by the doctor who will perform the operation and be submitted by the concerned institution to the Medical Processing Center. After the insurance company makes the necessary assessment, it will be notified as to whether or not the stay and/or surgery costs will be paid in the scope of the policy.

- Daily room (limited to the room fee for a standard single bed room), food, companion,
- Doctor, medication, operation room, anesthesiologist, operator, anesthetic nurse (limited to standard nurse fee), intensive care,

- All consumable supplies expenses,

- Chemotherapy (Including the “interferon and peg interferon alpha” used in the treatment of Hepatitis C), Radiotherapy, Dialysis and the expenses for the physical therapy and rehabilitation provided during the hospital stay in connection with the illness under Coverage

will be assessed in the scope of this coverage and provided in line with the coverage limit and copayment rates that are specified in the certificate and in accordance with the Special and General Conditions.
The expenses for treatment by dentists in connection with dental/jaw surgery as a result of a traffic accident and replacing teeth (on the condition that the accident report prepared by authorities is presented) is paid from this coverage.

Coronary angiography, breaking kidney stones (ESWL), kidney, brain, bone marrow and liver biopsies, ectopic pregnancy, molahydatidiforma and photo therapy will be evaluated under this coverage limit and the copayment rates.

If the insured becomes deceased during treatment their morgue expenses will be evaluated under this coverage limit and the copayment rates.

The prostheses that are required during surgery (heart valve, pacemaker, hip prosthesis, etc) will be evaluated under this coverage limit and the copayment rates.

The period of staying in intensive care in hospital stays is limited to 90 days unless specified otherwise in the Policy and a total of 180 days throughout the policy term will be evaluated within the hospital stay period. In the event that these periods are used, the main coverage in the policy will be ceased until the expiry date of the policy. The specified day limits for intensive care stays and daily stay periods will be evaluated starting over for each renewed policy period.
Also as of the first day that the Insured obtains health insurance, the hospital stay for life period is limited to 720 days.

The authorizations that are obtained for treatment to be conducted in in-network institutions are valid if they are completed within 7 days. A new authorization must be obtained for procedures that are not carried out within this period. Mapfre Genel Sigorta A.Ş reserves the right to reject procedures which have not been completed in the 7 days and for which a new authorization has not been obtained.

In the event that the policy expires and is not renewed while the Insured is getting treatment within the Insurance period for a condition that has been notified to the Insurer and accepted, the treatment expenses for 10 days after the policy expiration date will be paid by the Insurer.

If, in the same session or with different incisions, more than one surgical procedure is performed and there are some treatments that are NOT COVERED among them, the amount to be paid is found by rating total bill (including DOCTOR fee) according to MPD.

3.1.a. Operator Doctor Fee

The expenses for inpatient treatments performed at Mapfre Genel Sigorta A.Ş. in-network Health Institutions where the insurance policy is valid, will be paid according to special and general conditions in line with the coverage, limits and copayment rates that are specified on the certificate.

If the doctor performing the procedure (anesthesia and assistant doctors will also be considered in this scope) is not a staff doctor or a non-staff part time doctor at the in-network institution, the treatment fee will in any case be paid by the Insured and then sent to the Insurer for assessment. The relevant bills must be in the form of freelance professional receipts and/or a POS slip issued in accordance with the Tax Procedure Law (TPL).

Anesthesia and assistant doctor fees cannot be included on the same freelance professional receipt/ POS slip issued in accordance with the Tax Procedure Law (TPL); documents that are issued otherwise shall not be processed by the Insurer.

Regardless of whether the treatment was provided at an In-Network or Non-Network institution, the doctor fee for a Non-Network doctor (on staff or not working temporarily part time) shall not exceed the general level for the region in which the service is provided and in any case the MPD tariff.

The doctor fee is paid according to special and general conditions in line with the coverage, limits and copayment rates that are specified on the certificate. The Doctor fees that are not specified on the MPD Tariff or about which there is a conflict shall be consulted with MPD.

3.1.b. Coverage for Small Interventions

Small interventions specified in MPD up to 199 units (including unit 199) and all small procedures like dressing, injections, serum, ear cleaning, all cast applications (including those over 199 units), administering oxygen, abscess drainage, gastric lavage, enema, catheter attachment, nail extraction, any kind of cauterization, probe curettage, fractional curettage and curettage with dilatation even for treatment purposes, cryotherapy applications, interventions for all treatment of pain, injections to joints and removing all benign skin tumors regardless of size and number that are done with local or general anesthesia, will be paid from this coverage according to special and general conditions in line with the coverage, limits and copayment rates that are specified on the certificate as long as the necessity of the treatment is documented by a doctor and approved by the Mapfre General Insurance Processing Center (MPC).

3.1. c. Home Care

In order for the Insured to benefit from Home Care coverage they must have a tracheostomy, need frequent orotracheal aspiration, enteral nutrition or TPN / IV fluid support, be dependent on a ventilator, have advanced respiratory failure, be an advanced oncology patient and have pain protocol applied.

If the doctor treating the Insured deems it necessary and the Insurer approves, the organization and generated expenses of the Home Care for the Insured will paid according to special and general conditions in line with the coverage, limits and copayment rates that are specified on the certificate, unless specified otherwise to be limited to 60 days within the term of the policy.

3.1. d. Ambulance

The expenses for the Insured to be moved with a licensed land ambulance from where they are located to the nearest fully equipped hospital, from hospital to home or from home to hospital due to an illness or injury in the scope of coverage, or if the doctor treating the insured deems it necessary and it is approved by the Mapfre General Insurance Medical Processing Center (MPC); the expenses for land and/or air ambulance for transport from the province and hospital they are located to another province and hospital will be paid from this coverage according to special and general conditions in line with the coverage, limits and copayment rates that are specified on the certificate .

Emergency situations shall be taken as the basis for ambulance services.

3.1.e. Auxiliary Medical Materials

The medical materials comprised of portable, customized braces (orthez, brace, active ankle, bon spur pad), walker, elastic bandage, arm sling, corset, varicose vein socks, neck brace, knee brace, ankle brace, special sitting cushion and cane which are used only for medical purposes to provide support from the outside of the body of the insured as part of their treatment for an accident or illness that occurred after the Insurance started, aero chamber and covering materials used in burn and injury treatment are covered in the scope of the policy within the yearly limits and payment percentages.

3.2. OUTPATIENT TREATMENT COVERAGE

Doctor examination, diagnosis/advanced diagnosis examinations, prescription medication and sessions of outpatient treatment expenses in connection with illnesses that developed after the start sate of the insurance are assessed in the scope of outpatient treatment.

In situations where Outpatient Treatment Coverage is obtained, the treatment expenses are paid in line with the limits and copayment rates that are specified in the certificate and in accordance with special and general conditions from this coverage. Treatment expenses that exceed the maximum limit for Outpatient Treatment in the policies will not be paid.

Outpatient Coverage is not provided on its own, it can only be received together with Inpatient Treatment Coverage.

3.2.a. Doctor Examination

The examination fees in the scope of Outpatient Treatment documented with the Health Insurance Patient Information form by doctors on duty at hospitals or clinics licensed by the T.R. Ministry of Health or authorized to open private clinics, are paid with the limit, copayment, exemption and coverage percentages specified in the policy and within the special and general conditions.

Since the examinations done by the same doctor until the 10th day in connection with the diagnosis of the first examination are follow-ups, the expenses for treatment that are billed as such are not paid.

The expenses for examinations by on staff doctors / non-staff doctors not working temporarily at in-network institutions shall be paid by the Insured in any case and then they will be sent to the Insurer for assessment. The relevant bills must definitely be in the form of freelance professional receipts and/or POS slips in accordance with TPL (Tax Procedure Law).

3.2.b. Prescription Medication

Medications documented to be in the scope of outpatient treatment by doctor prescription, preventive vaccination expenses (rabies, tetanus, for children aged 0-6; Ministry of Health vaccination schedule) are evaluated in the scope of this coverage and paid within the limit specified in the policy, the coverage percentage and the framework of special and general conditions.

Expenses for medications approved by the T.R. Ministry of Health are not paid without the original prescription and bill and/or cashier receipt.

In terms of taking medication, our application for dose limitation has been set at 1 month doses.
However, after the prescription has been written, the medication must be purchased within 7 business days. Medications that are purchased after 7 business days will not be paid by Mapfre Genel Sigorta A.Ş.

When medication is necessary for chronic illnesses the insured must apply to the insurer with a physician report including their illness, the history of their illness and the planned treatment. In the event that the chronic illness medication is approved, it will be sufficient for the insured to go to the in-network pharmacy for the necessary medication throughout the treatment period, within the term of the policy, with their “first doctor report and/or copy of the prescription”. The approved medications that are demanded throughout the treatment period are paid according to the copayment rates and limits specified in the policy as long as the cashier receipt/bill is presented.

3.2.c. Examinations for the Purpose of Diagnosis

The expenses for the tests, x-rays, hearing tests, USG, Doppler, EEG, EMG, EKG, EKO and holter performed within the policy period and deemed medically necessary by the physician for diagnosis and treatment and specified in the Health Insurance Patient Information Form; and the medication, anesthesia and doctor fees that are required for these diagnosis methods are paid according to the copayment rates and limits specified in the policy.
In procedures focused on diagnosis the Health Insurance Patient Information Form must be filed out in full by the doctor and every diagnosis procedure that needs to be done by the doctor must be specified on this form. The tests that are done until the insured is diagnosed shall be considered the use of one right.

3.2.d. Examinations for Advanced Diagnosis

The expenses for the BT, MR, PET-CT, nuclear medicine and scintigraphy (thallium. etc.), endoscopic procedures [gastroscopy, colonoscopy (including biopsy), bronchoscopy, etc.], angiographies (except cardio angiography), biopsies and urodynamics deemed medically necessary by the physician for diagnosis and treatment and specified in the Health Insurance Patient Information Form; and the medication, anesthesia and doctor fees that are required for these diagnosis methods are paid according to the limits, coverage percentage and special and general conditions specified in the policy.

In procedures focused on diagnosis, the Health Insurance Patient Information Form must be filed out in full by the doctor and every diagnosis procedure that needs to be done by the doctor must be specified on this form.

3.2.e. Outpatient Treatment in Sessions

The expenses for Physical Therapy and Rehabilitation, PUVA (UVA), Hyperbaric 02, ESWT, PRP (Platelet Rich Plasma), etc. that is deemed medically necessary by the physician for treatment of an illness in the scope of coverage and approved as session / day by the Mapfre Genel Sigorta A.Ş. Medical Processing Center(MPC) are paid according to the limits, coverage percentage and special and general conditions specified in the policy**.**

ARTICLE 3.3 GENERAL LIMITS

Annual Total Limit: In the Certificate that is provided in the Annex of the Insurance Policy there are specified limits which can vary per illness and/or according to coverage, the process is carried out by deducting the copayment, if any, from the coverage based on these limits.

Annual Exemption Limit: The total annual limit that is provided in the Insurance Policy Annex which can vary on the certificate according to coverage and the Insurer is not obligated to pay it.
In order for the health expenses payments to start being paid on a Policy in which only Inpatient and Outpatient Treatment has been received, the exemption amount will first be deducted from the coverage (Inpatient and Outpatient) in which the bill will be evaluated and the amount over the exemption will be paid according to the limit, copayment, special and general conditions specified in the policy.

Inpatient Treatment Lifelong Total Day Limit: The total number of days the Insured can benefit for Inpatient treatment lifelong is 720 days and this is valid for the years that the insured renews their policy without interruption. For this purpose each day that is spent in the Hospital shall be considered one day. If the Inpatient Treatment Lifelong Total Number of Days Limit is filled, the Coverage of the insured will automatically end on the day the limit is filled. If the lifelong limit (720 days) is exceeded the insured will have the right not to renew the policy.

Inpatient Treatment Annual Total Day Limit: The total number of days the insured can stay in the hospital during a policy period is 180 days, a maximum of 90 days of this limit is used for intensive care. For this purpose each day that is spent in the Hospital shall be considered one day. The limits will start over for each renewed policy period.

Hospital Stay Limit continuing After the Policy Expiration Date: The Hospital treatment expenses that start when the insurance policy is in force and continue without interruption until a date that is after the Insurance Policy Expiration Date, are covered up to 10 days after the Policy Expiration Date if the insurance expires and a new contract is not made. If the insurance policy is cancelled or the Insured is removed from Insurance Policy Coverage or the Coverage Plan is changed, the hospital treatment expenses after the removal or plan change shall not be covered under any condition.

ARTICLE 4. STANDARD WAITING PERIODS

The following situations have all been excluded from Coverage Scope throughout the relevant waiting period, as of the Registration Date of the Insured as long as they have not resulted from a judicial incident. If the Insurance Policy is repeated and continued according to the renewal conditions and no special exception is placed by the Insurer for one of the situations listed below by the Insurer, the Insured, who have completed a 12 month period of being insured without interruption and been given

an additional waiting period by the Insurer and completed this waiting period, shall not be given the standard Waiting Period listed below and will be included in the Coverage.

Situations with a 12 month waiting period as long as they have not been caused by a judicial incident

1. All hernias,
2. Anorectal disorders (hemorrhoid, anal fistula and fissure, anal abscess, etc.) pilonidal sinus (cist dermoid sacral),
3. Tonsillectomy, adenoid vegetation surgery, ear drum surgery and tube application, sinus surgery,
4. Cancer, all kinds of tumors, expansive lesions, polyps and hyperplasia, etc.
5. Thyroid and parathyroid disorders,
6. Diseases and operations concerning the cervix, uterus, ovaries and tubes, endometriosis, cyctorectocele
7. Spine and disc disorders, all joint disorders (knee, shoulder, etc. trigger finger, ligament and tendon disorders, carpal tunnel, tarsal tunnel
8. Ischemic heart diseases, hyperlipidemia, hypertension and complications, (acute myocardia emergency treatments that start with infarction in the year are not considered in this scope), varicose and vein thrombosis
9. Urinary system stone disorders, prostate biopsy and surgeries
10. All endoscopic, laparoscopic procedures and angiography (other than those for diagnosis purposes)
11. Cataract, glaucoma, corneal graft,
12. Gall bladder and bladder tract diseases,
13. All chronic disease treatment and home care for chronic diseases (hypertension, ulcer, reflux, inflammatory intestine diseases (ulcerative colitis, crohn etc.) KOAH, asthma, diabetes, demyelinating diseases, sarcoidosis, nephrite and rheumatoid diseases, joint tissue diseases,

ARTICLE 5. STANDARD EXCEPTIONS

Other than the situations Excluded from Coverage that are specified in the Health Insurance General Conditions Article 2, the following situations have been excluded from all Coverage under this Policy.

1- **Health expenses for a complaint and/or disease that existed before the policy start date and relapses and complications in connection with this**
2- Congenital and genetic diseases that emerge after the policy start date, even if they emerge at middle age, premature baby expenses
3- Scoliosis, lordosis, kyphosis, pes planus, hallux valgus/rigidity test and treatment expenses,
4- Operations for nasal septum and concha
5- Age related dementia and Alzheimer, Parkinson, Epilepsy and the Antipsychotics, Anxiolytic and Anticonvulsants used in the treatment of these disorders and all Psychotropic medications
6- All genetic diseases/status research, screening and related tests, structure disorders, motor mental development and growth disorder (growth and development deficiency/ progression, early/late puberty, etc.) related routine and specific test and treatment expenses
7- Mental and psychological disorders that require psychiatric treatment, all psychotherapies,
8- All disorders that could develop after unlicensed vehicle use, alcoholism, alcohol, drug, stimulant, hallucinogen and other substance addiction and expenses resulting from related accidents,
9- All expenses generated by dangerous sports activities whether done professionally, as an amateur or hobby and/or dangerous activities not limited to these (hiking, scuba diving, airplane and glider piloting, parachuting, parapant, flying with delta wings, horseback riding, kayaking, motorcycling even for transportation, etc.) and expenses generated by any kind of professional and/or licensed sports activities
10- Alternative treatment methods (acupuncture, homeopathy, hypnosis, yoga, mesotherapy, ayurveda, hot springs treatment, etc.) and centers that operate without a

Ministry of Health license, sanatoriums, preventorium and rehabilitation center treatments,

11- Treatment without scientific proof, experimental treatment and all expenses related to medication and materials that have not been approved by the American FDA (Food and Drug Administration)
12- Procedures/treatment with no correspondence on the MPD,
13- All expenses for examination, tests, treatments in aesthetic and beauty centers, eye examinations, testing and treatments in lens and optic centers, all procedures by individuals who are not Medical Doctors, dentists or Ministry of Health Licensed centers
14- Bills issued by 1st degree relatives of the Insured,
15- Expenses related to the Unnecessary Treatments in Hospitals in the Definition Section and without any clear complaint and/or illness or not related to a complaint (Checkup, routine control, etc.),
16- Unless it is generated by a judicial accident or illness within the term of the policy (cancer, burn, etc.); plastic and reconstructive surgery, all manner of aesthetic and cosmetic procedures, telangiectasia, treatment for skin hemangioma, gynecomastia, testing and treatment procedures to prevent perspiration, acne, nevus, hair loss (diagnosis and treatment), any breast reduction and enlargement operation expenses, weight loss and weight gain programs for weight and eating disorders and diagnosis and treatment expenses related to these,
17- Hearing loss operations (except attaching tubes, tympanoplasty, chronic otitis sequel, etc.) and all diagnosis and treatment expenses related to these, voice and speech therapy,
18- All expenses related to hernia procedures for children under 7,
19- All examinations, tests and treatment in connection with dental and/or gingival and/or jaw surgery,
20- Treatment expenses for vision problems, ptosis, keratoconus, cross eyes, diplopia, lazy eye, all diagnosis, testing and treatment for toric and multifocal lenses,
21- Products not accepted as medication, all substances and chemicals that are licensed by the Ministry of Agriculture, all medications that have not been officially imported (not found in Turkey and no equivalent in Turkey, other than pharmaceuticals that are imported with the permission of the Ministry of Health), vitamin and mineral combinations that are used to fulfill the body's daily requirement and/or to maintain good health and/or nutrition regulating preparations,
22- Medical materials that are not considered to be in the scope of auxiliary materials defined in Article 3.1, CPAP device calibration and monitoring, moisturizers used at home, devices attached to the body from the outside (hearing aid, cochlear implant, etc.), injections not taken with medication, tapes, glasses-lens, lens solution, toothpaste and dental care preparations, related expenses, other miscellaneous expenses not necessary for treatment like telephone, TV, cafeteria, administrative expenses, paramedical services, pick-up services, all external prostheses (not considered in the Inpatient Treatment Coverage)
23- Vaccinations for asthma and allergies, allergy tests, skin prick test, food intolerance tests, all immune-therapies (except for those done for treating metabolic and autoimmune disorders),
24- All curettage, infertility, sterility, miscarriage research, all testing, treatment and complication expenses for achieving pregnancy (in-vitro fertilization, follicle tracking, microinjection, tobuplasty etc.), hysteron salpingography (HSG), spermiogram, adhesiolysis, impotency, peyronie, vaginismus, all testing and treatment in connection with sexual disorders (including penile prosthesis) and birth control (pills, condoms, etc.), varicosele whether it is related to infertility or not, gender changing operations, regardless of how it has been contracted sexually transmitted diseases, syphilis, gonorrhea chancroid, lymphogranuloma venereum, granuloma inguinale diseases, genital condylomas, AIDS and all related diagnosis and treatment expenses and all expenses related to circumcision even if medically necessary,
25- Surface varicose treatment (sclerotherapy, laser, radiation, massage, socks, etc.),
26- Expenses related to the donor in organ and blood transplants,
27- Officially announced epidemics and maliciously started epidemics
28- All procedures for disease prevention, rabies, tetanus and all vaccinations except the ones approved for 0-6 year old children on the Ministry of Health schedule (including pre vaccination or post vaccination tests and vaccination fees) ,
29- Special nursing expenses (outside of homecare coverage) not approved by the Medical Processing Center (MPC) and ambulance expenses other than emergencies (explained in Article 2 Definitions),

30- Health expenses to be incurred outside of the country,
31- All procedures done with Robotic surgery
32- Pregnancy, pregnancy related routine check-ups, normal or cesarean birth, miscarriages and all related complications
33- Fees for companions of inpatient patients over 16 years of age throughout their hospital stay,
34- Expenses related to menopause, andropause, osteoporosis, and complications,
35- All expenses related to artificial limbs,
36- All expenses related to testing and treatment for sleeping disorders (sleep apnea, uvuloplasty, sleep walking, snoring therapy, etc.),
37- All expenses related to spermatocele, varicosele, hydrocele, cord cist and epididymis cist,
38- Unless there is a condition to the contrary; expenses related to diseases that are medically considered vocational and develop in direct relation with the person's vocation (asbestosis, pneumoconiosis, silicosis, etc.),

ARTICLE 6. GEOGRAPHICAL SCOPE

This applies to all foreign nationals residing within the borders of Turkey. All national coverage in the policy is valid for all of Turkey.

ARTICLE 7. COVERAGE APPLICATION PRINCIPLES

The principles for applying the coverage have been explained in Article 3 of the "Coverage" section.

ARTICLE 8. PAYMENT OF COMPENSATION

After submitting the originals of bills related to health expenditures incurred by the Insured at non-network institutions outside of the In-network institutions, and all other documents (doctor report, test results, etc.), in full to the Insurer, payment will be made to the Insured's TL account in Turkey within 5 business days.

If a risk occurs in a policy that is being paid in insurance premium installments, the remaining installments will become due and be deducted from the compensation to be paid to the insured.

In order for the payment for health expenditures to be started on a Policy that has been purchased only for Inpatient or inpatient and outpatient care; regardless of which coverage the bill is from (inpatient, outpatient) first the exemptions will be deducted and the amount exceeding the exemption amount will be paid in accordance with the limit, copayment, special and general conditions specified on the policy.

After any health treatment it is necessary for you to see the bill and check the figures for yourself, and especially after hospital stays the hospital discharge bill must be checked and signed.

In order for payments in the scope of Inpatient Treatment to be paid, the following documents need to be submitted to the Insurer.

1- Itemized hospital bills signed by the insured, report showing reason for hospital stay,
2- Detailed surgery report for surgical procedures (if a biopsy has been taken, the pathology results report must be included),
3- When necessary, an observation file, traffic accident record, forensic report, forensic record, alcohol report, insured declaration,
4- Epicrisis (flow summary) report,
5- When necessary laparoscopic / arthroscopic / endoscopic operation tapes.

In order for payments in the scope of Outpatient Treatment to be paid, the following documents need to be submitted to the Insurer in the attachment of the Health Insurance Patient Information Form:

Doctor examinations;

1- A bill or freelance professional receipt showing the doctor's fee (the Dr. stamp and branch must be included) (cashier receipts are not valid)
2- If an ultrasound was taken during the examination an original printout or report (medical record when necessary)

In medication expenditures;

1- Original of concerned doctor's prescription (and doctor's report when necessary),
2- Cashier's receipt or bill,
3- When necessary the name of the medication and the print and barcodes that show the price,
4- A doctor's report for medication that is used constantly

In Examinations for Diagnosis and Advanced Diagnosis;

1- Doctor request letter / transfer slip or report,
2- Bills that show related expenditures,
3- Examinations results, reports, medical record when necessary.

In Physical Therapy;

1- Results of imaging that require treatment (MR, Ultrasound, etc.),
2- Doctor request letter, detailed report showing the treatment they have planned (the treatment necessary for each session and the total number of sessions must be specified).

ARTICLE 9. RENEWAL OF CONTRACT

This insurance is valid for 1 year at the most. However, after the expiration of the insurance a new policy can be issued at the request of the insured/insurant within the principles determined by the insurer.
The Insurer will decide on whether to renew the policy by examining the health status of the insured within the period that they were insured and/or the Damage/Premium ratio. The Insurer reserves the right to cover the insured with conditions in accordance with the Risk Acceptance Regulation (limit, additional premium, copayment, waiting period, etc.) or to not renew the policy.

If the illnesses of the Insured from the previous period and/or ongoing illnesses are in the conditional acceptance to be valid in the new contract, these conditional acceptances will be valid as long as the policy is renewed and it is not decided by the parties that they are no longer applicable.
The policies may be renewed with the same plan and the premium, tariff and special conditions that are current on the policy renewal date.

The Insured may apply to the Insurer up to 30 days before or after the policy expiration date for a new contract (policy).

If more than 30 days or more has passed since the renewal date, the insured will apply as if they are a new client and will join the insurance as a new insured. The rights they had earned in their previous policy will no longer be applicable, the waiting periods will apply again and all illnesses before the date in question will be excluded from coverage.

The Insurer's right to not cover the risks that occur in the period that passes until a new policy is prepared, to cover with conditional acceptances in accordance with the Risk Acceptance Regulation (limit, additional premium, copayment, waiting period, etc.) and remove the validity of renewal rights are reserved.

The Insured must comply with the Health Insurance General Conditions Article 6 during renewal and the Turkish Commercial Code article 1435 in complying with the obligation to declare.

A lifelong renewal guarantee shall not be given to the individuals insured under this policy.

ARTICLE 10. APPLICATIONS

The Insurer has the right to request information and documents from the individuals and institutions treating the Insured with the written consent of the Insured.

In situations where the Insured has given the Insurer authority to access the health history of the Insured, the Insurer may request doctor opinions, tests, etc. if deemed necessary to determine the state of the Insured's health. In this case the expenses for the procedures in question will be covered by the Insurer. However, if it is not possible to obtain the necessary documents from the concerned institutions despite the consent of the Insured, the necessary doctor opinion, test, etc. expenses will be covered by the Insured and/or Insurant.

The Insured must apply to the Insurer in every renewal period.
In line with the Insured's health status and/or the risk acceptance regulation in force, the Insurer reserves the right to reject Insured applications, to accept with the application of conditional acceptances (limit, additional premium, copayment, waiting period, etc.). Previously earned rights will not be maintained in transfers from other companies or transfers from one product to another within our company. The applicant will be treated as a new insured in transfers. The waiting periods applied in the first year shall be applied.

Newborn babies can be covered 14 days after application date and birth date at the earliest.

ARTICLE 11. SAGMER (INSURANCE MONITORING CENTER) NOTIFICATION

The policies and health information belonging to the Insured in this Insurance Policy will be transferred to Sagmer (Insurance Monitoring Center) and the policy and health information of Insured individuals can be obtained from Sagmer and other public agencies.

ARTICLE .12 DETERMINATION OF PREMIUM

ARTICLE 12.1 CRITERIA FOR DETERMINING PREMIUM

The Insured premiums of plans and coverage chosen for health risks are calculated in accordance with the Insurers Risk Acceptance Regulation, taking into account the Insured's age and gender, health inflation and coverage premium rates. The premiums and terms of Insured in the scope of the Policy are on the front of the policy and the coverage, limits, copayments, etc. plan information are specified on the certificate table.
The policy premium is calculated based on the age of the insured on the insurance start date (the calculation in day/month/year format of the difference between start date and birth date).

ARTICLE 12.2 ARRANGEMENTS CONCERNING THE PREMIUM

<u>Discounts and additional premiums to be applied according to Coverage / Premium rate</u>;

The discount rate which is "paid coverage / net premium rate" for Insured	To be applied to total insured premium
%0	%10

"paid coverage / net premium rate" for Insured	To be applied to total insured premium Additional premium rate
%101- %150	%75 Additional premium
%151- %200	%100 Additional premium
%201 -%300	%150 Additional premium
%301 and over	%200 Additional premium

ARTICLE 12.3 PREMIUM PAYMENTS

How, in what period and amounts the insurance premium is to be paid is specified on the application and/or the premium payment form. The Insured makes all the premium payments specified on the policy in line with the written payment plan in cash or blocked installments from a credit card.

ARTICLE 13. NEW ENTRY PROCEDURES

ARTICLE 13.1 TERM OF INSURANCE AND ACCEPTANCE TO INSURANCE

The term of the insurance is 1 year and it will stay in force between the start and expiration dates specified on the policy. The insurance coverage will go into effect when the application is accepted by the Insurer, the policy is issued and the prepayment is made.

The insurance policy will cover babies over 14 days old and individuals less than 60 years of age upon first entry to our company. The Insurant must be over 18 years of age.
Children between 0-18 years of age may be covered in the scope of a family and/or at least one person that is legally obligated to care for them.

Unless specified otherwise by the Insurer, foreign nationals who live within the T.R. borders will be accepted by the insurance.

ARTICLE 13.2 THE RESPONSIBILITIES OF THE INSURANT

If the policy is cancelled or the Insured leaves the scope of the policy, the Insurant is responsible for returning the documents issued in the name of these individuals to the Insurer. Recourse for any losses due to the documents not being returned in full will be taken against the Insurant.

If the Insured's / Insurant's declaration is not true, incomplete or incorrect, the Health Insurance General Conditions Article 6 provisions shall apply. On the condition of the Insurer's rights according to Article 6 being reserved,

the Insurer has the right to assess and cover with conditional acceptance (excluded from scope, additional premium, etc.) illnesses that the Insured/Insurant does not declare.

The Insurer has the right to collect the expenses that are against the Health Insurance General Conditions and payments that are made outside of the coverage from the Insured and/or Insurant.

ARTICLE 14. PRINCIPLES FOR ENDING THE INSURANCE CONTRACT

ARTICLE 14.1 CANCELLATIONS

If the Insured/Insurant requests cancellation after the date that the policy is issued; the following conditions must take place to complete the cancelling process,

a) A new private health insurance covering the term of residence must be presented to the insurance company,
b) A letter from an official authority showing the cancellation of the residency permit must be submitted,
c) A document showing that they are covered by General Health Insurance in accordance with the Social Security and General Health Insurance Law No 5510 must be presented.

In the event that a risk does not take place, the Insurer will earn a premium in connection with the time that has passed since the policy start date. The amount that will be returned to the Insured/Insurant for cancellations will be calculated based on days.

If there is a compensation paid to the Insured and it exceeds the amount premium that the Insurer has earned, the premium will be cancelled without reimbursement. When a risk occurs, even if the premiums are not due yet, the portion up to the compensation that the Insurer is obligated to pay becomes due.

If the Insurant does not pay any one of the premiums, for which the definite terms and amounts are specified on their policy, by the due date they will have lapsed into default. If the premium due is not paid on time the provisions of Turkish Commercial Code Article 1434 shall apply.

If the Insurer determines that the Insured/Insurant has acted maliciously (Uninsured individuals being enabled to benefit from the insurance coverage and health expenses being arranged in the name of other insured members, the detection of pre-existing conditions that the Insured knew about and/or had symptoms before the insurance start dated and did not declare this to the Insurer, etc.) the Insurer shall have the right to collect the paid health expenses and/or cancel the premium without refund.

ARTICLE 14.2 THE DEATH OF AN INSURANT OR INSURED

In the event of an Insurant's and/or Insured's death, the Insurer will proceed as follows.
In the event of the Insurant's death; if the Insurant and the insured/ several insured on the policy being different from the Insurant and the insured wishing to change the insurant and continue the policy, the written consent of the insurant's legal heirs must be submitted to the Insurer. In this situation the insurant will be changed and the policy will continue. If the consent of the legal heirs cannot be obtained the policy will be cancelled according to the cancellation criteria provided above and if there are any premium refunds they will be given to the legal heirs.

In a policy where the Insurant and insured are the same and in single person policies, the policy will become invalid if the insurant becomes deceased. If the legal heirs of the Insurant submit a written

request, the above mentioned cancellation procedure shall be applied and any premium refunds will be given to the legal heirs

In policies where more than one person is insured, if one of the insured becomes deceased the deceased insured will be removed from the policy effective on the date of death. If there is a premium refund in accordance with the cancellation criteria specified above, it will be refunded to the Insurant on the policy.