SPECIAL TERMS FOR THE COMPLEMENTARY HEALTH INSURANCE

ARTICLE 1 - SUBJECT MATTER OF INSURANCE

The Policy Holder's treatment expenses arising from a disease and/or accident in addition to the Health Insurance General Terms are covered within the coverage, limit, special and general terms specified in the policy. Insurance coverage is valid only for the persons included in the insurance policy, and others cannot benefit from the coverage. Pursuant to the Social Security and General Health Insurance Law, only those who benefit from health services can benefit from this insurance coverage.

ARTICLE 2 - DEFINITIONS

Explanations for the definitions used within the insurance policy are provided below.

IN-NETWORK PROVIDER: Healthcare providers where the insurance company offers policy holder beneficial service with and/or without charge within the frame of special agreements, and that serve within the special and general terms of the policy.

LIST OF IN-NETWORK PROVIDERS: The list of healthcare providers that serve within the special and general terms of the policy and the list where the insurance company introduces policy holder beneficial service with and/or without charge within the framework of special agreements. This list is updated by the insurance company and its final updated version is taken into consideration for all policies.

OUT-OF-NETWORK PROVIDER: These are the healthcare providers that do not have a contract with the insurance company

OUTPATIENT TREATMENT COVERAGE: It is the coverage including services within the scope of this policy and in the cases where hospitalization or treatment at the hospital, and being kept under observation is not required.

START DATE: Day, month and year in which the policy enters into force for the first time or upon each renewal. (12.00 at local time in Turkey)

WAITING PERIOD: It is the period that is applied by the insurer depending on the health status of the candidate policy holder during which certain medical situations are not covered.

END DATE: Day (12.00 at local time in Turkey), month and year in which this policy expires. Any expenses to be made after this date are excluded from coverage, regardless of their reason.

REMOVAL DATE: Day, month and year on which the policy holder is removed by the insurer from a policy under which more than one person is covered as policy holder and that continues for other policy holders, upon the request of the policy owner and/or in the case that the policy holder does not meet the conditions stated in the definition of Persons to be Insured. (12.00 at local time in Turkey) In the case that the policy holder is removed for rescission or termination, provisions and periods stated in Article 8, General Terms apply.

GENERAL TERMS: Written rules which are determined by the Insurance and Private Pension Regulation and Supervision Agency, the application of which is obligatory in health insurances by all insurance companies.

LOSS RATIO: It is the ratio of total paid and pending indemnities of the policy holder within the policy period to the premium

ADDITIONAL FEES: Foundation universities and private health institutions and organizations contracted with the Social Security Institution; extra fees requested from people based on amounts that may be invoiced to the Institution on condition that they do not exceed the rate determined by the Institution over all costs of healthcare services included in SUT and its appendices.

CANCELLATION DATE: Day, month and year on which the policy is canceled upon a written request by the policy owner or a rescission or termination due to the matters specified in the General Terms by the insurer. (00.01 at local time in Turkey)

CONTRIBUTION SHARE: It is the amount to be paid for examination by the general health policy holder or the persons whom they are obliged to look after, to benefit from healthcare services in the Social Insurances and General Health Insurance Law No. 5510

RED ZONE: Life-threatening cases requiring urgent evaluation and treatment along with a fast and aggressive approach. In such cases, the patient is taken to the red zone without waiting. In addition, they are cases with a high probability of being life-threatening, which should be evaluated and treated within 10 minutes.

OCCUPATIONAL DISEASE: Temporary or permanent physical or mental disease that results from a recurring cause due to the nature of the policy holder's occupation or occurs at the time of performing such work. (e.g. asbestosis, silicosis, silicotuberculosis).

NETWORK (IN-NETWORK PROVIDER TYPE): Refers to the grouping of In-Network Providers by MAPFRE Sigorta A.Ş. The network type of the valid in-network provider is specified on each policy. Even if the providers outside the scope of the relevant network are MAPFRE In-Network Providers, they are considered as out-of-network providers for the relevant policy. All entities included in the In-Network Providers list constitute the general network of MAPFRE Sigorta A.Ş.

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SPECIAL TERMS: Terms prepared by the insurance company in addition to the Health Insurance General Terms and which state mutual rights and liabilities, coverages and validity terms and which are effective until the end date of this policy

PERSONNEL: A person actually working in an entity having a legal personality permanently and full time (at least 35 hours a week), who is complying with insurance conditions

SCOMMUNIQUE ON HEALTHCARE PRACTICES (SUT): The communique containing the principles and procedures of benefiting from healthcare services, travel, daily allowance and attendant expenses financed by the Social Security Institution for the persons with general health insurance, and their dependents, whose healthcare benefits are covered by the Social Security Institution, and the fees to be paid for the said services, set by the Healthcare Services Pricing Commission.

SAGMER: The insurance oversight center aiming at making public oversight-audit more effective, increasing the trust on insurance system, creating reliable statistics, preventing misuse, making sound pricing, ensuring practice uniformity in the sector, performing insurance business in a more comprehensive and effective way by gathering data in the health insurance branch in one center.

POLICY OWNER: A person or legal person applying for the insurance policy, whose application is accepted by the insurer, and being the responsible party within the scope of this insurance policy, acting in favor of themselves and the persons to be insured.

INSURANCE POLICY: Any document including an insurance certificate, which bears a company stamp and authorized signatures, issued by the insurer in a special format and includes matters such as term, special and general terms, limits, exclusions, as well as application information and payment conditions for the policy and which guarantees the payment of claims within the specified limits of the coverage, if the required conditions are fulfilled.

INSURER: Insurance company registered and holding an operating license in the country where the insurance policy is issued. The term "insurer" stands for MAPFRE Sigorta A.Ş. in this policy.

POLICY HOLDER: The person stated in the health insurance application of policy owner and the persons to be insured, accepted by the insurer and included in the policy coverage.

STANDARD EXCEPTIONS: General exceptions which are specified in special terms and apply to all coverages and policy holders.

COVERAGE: It is the scope of health expenses that the insurer undertakes to pay within the limit stated in the policy within the framework of special and general terms of insurance policy.

ANNUAL TOTAL LIMIT: The maximum amount that the policy holder may use from their coverage specified annually during the period of insurance policy.

RENEWAL: The case where the policy owner contacts the insurer 15 days before or after the expiration date of the existing insurance policy to execute a contract again and the insurer and the policy owner agree on the conditions of the new insurance policy upon which the new contract remains in force without interruption.

RENEWAL DATE: The start day, month and year of the new insurance policy, which is the same as the expiration date of the previous insurance policy. (12.00 at local time in Turkey)

MAPFRE CUSTOMER SERVICES: It is the hotline through which the policy holders can convey their suggestions, requests and complaints and receive various services such as ambulance and medical advice by dialing 0 850 755 0 755.

ARTICLE 3 - SUBJECT AND SCOPE OF COVERAGE

This insurance guarantees to pay additional fees that may arise while the persons with general health insurance and the ones they are obliged to look after, who are included in the coverage by the Social Security Institution are receiving healthcare services from the healthcare providers contracted/having a protocol with the Social Security Institution as determined by MAPFRE Sigorta A.Ş. within the annual total limit in accordance with Health Insurance General Terms and these special terms

This policy coverage is applicable for occasions covered by the Social Security Institution except the cases stated in Special Terms Article 5.

According to the provisions of the Social Insurances and General Health Insurance Law, the contributions that beneficiaries of healthcare services are obliged to pay shall not be covered by this policy. Coverage stated in the policy is only applicable for the persons whose names are included in the policy and shall not be applicable for any other person.

The coverage that may be given under this policy is specified below:

3.1. Inpatient Treatment Coverage

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In relation to disorders that occur after the commencement date of the policy holder, on condition that it is required medically and the doctor specifies this reason in his/her report in detail; the expenses for the policy holder's internal and/or surgical hospitalizations, emergency medical condition that may cause a life-threatening danger, and minor interventions are covered in accordance with special and general terms

In the case that the policy expires and it is not renewed while the hospitalization continues for medical conditions informed to and accepted by the insurer during the insurance period, the treatment expenses after the expiry of policy are not paid by the insurer.

3.2. Outpatient Treatment Coverage

Doctor examinations, analyses, radiology, modern diagnosis methods (diagnostic endoscopic procedures) and physical therapy and rehabilitation expenses for disorders occurring after the commencement date of the policy holder are considered within the scope of outpatient treatment.

In the cases where Outpatient Treatment Coverage is purchased, treatment expenses are met by this coverage in line with the limit stated in the policy and in accordance with special and general terms. Treatment expenses that exceed the upper limit of outpatient treatment are not covered by policies. Outpatient treatment coverage cannot be provided alone, but can be purchased together with the Inpatient Treatment Coverage.

3.3. Medical Equipment Coverage

As part of the treatment applied due to an accident or illness occurring during the policy term, the following items used externally for support to the body and solely for medical purposes are covered within the policy under the "Medical Supplies" coverage limit and payment percentage specified: portable, personalized orthoses (such as braces, active ankle bone spur pads), elastic bandages, orthopedic shoes, insoles, corsets, neck braces, knee braces, wrist supports, elbow braces, arm slings, seat cushions, rollators, walkers, crutches, plaster slippers, nebulizers, ventilators, compression stockings, aerochambers, wheelchairs (if permanent disability is documented by a doctor's report), crutches, urostomy bags used during hospital stays or home care, colostomy bags, and covering materials used for burn or wound treatment. Medical supplies not covered under General Health Insurance (GHI) and used during inpatient treatment or surgery in hospital are covered under this coverage provided that the necessity is documented by a doctor's report and approved by the Insurer. If medical supplies are prescribed after the examination performed using the General Health Insurance (GHI), payment is made within the coverage limit and payment percentage for the medical supplies within the scope (only limited to those mentioned above).

3.4. Check-Up Coverage

Regardless from insured policy's contracted health institutions type, check up service expenses covered 100% at Mapfre Sigorta's contracted health institutions once a year. You can reach the details of check up service and contracted health institutions from www.mapfre.com.tr

Other services provided by contracted/non-contracted health institutions will not be evaluated by this coverage.

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3.5. Dental Package

It is valid in the institutions contracted for this service within the scope determined for the Dental Package, and it is required to make an appointment to benefit from this service. In the event that the policy holder performs the transactions on their own, this service will be out of the scope. The package includes dental examination, scaling (lower and upper jaw), and dental x-ray.

The relevant coverage applies to individual policies and is provided in return for an additional premium upon the request of the policy owner for group policies. It is indicated in the policy coverage table if the relevant coverage is included in the policy. The contact information for appointment is provided in your policy

3.6. Maternity Coverage

Maternity Coverage is valid for female insureds aged 18 and over, who are themselves or their spouse, if there is outpatient treatment coverage in the policy and if this coverage is added as an additional coverage. Normal delivery, cesarean section, complications related to childbirth and pregnancy (medical abortion, curettage performed due to medical necessity, and/or miscarriage), and routine newborn expenses (initial examination and care costs) will be covered under the maternity coverage limit and payment percentage specified in the policy for all related treatments. Periodic physical medical examinations related to pregnancy, pre-pregnancy TORCH and follow-up and examinations during pregnancy (TORCH, amniocentesis, NST, Down triple screening, etc.), pregnancy routine controls are valid with outpatient coverage limit and payment percentage. This coverage, which is taken as additional coverage, is valid after the completion of the 12-month waiting period. After the 12-month waiting period, the maternity coverage is activated regardless of the pregnancy start date. In the event that the maternity coverage is not added to the policy during the renewal period and the coverage is interrupted, the waiting period for the re-added coverage will be activated again. For the insured who will switch from another company, even if there is maternity coverage in the previous insurance company, the 12-month waiting period from the inclusion of the relevant coverage in the policy will be re-activated in Mapfre Sigorta. Maternity and Pregnancy Routine Checks are valid only in the contracted institution network defined in the policy. The relevant coverage is invalid in non-contracted institutions.

3.7. Home Care and Treatment

Provided that the medical treatment plan requested to be applied at home by the treating physician after the inpatient treatment of the insured is approved by the Insurer when the insured is discharged from the hospital, the medical home care service expenses applied by the healthcare personnel from the date of discharge and the medical device rental expenses indicated as necessary by the doctor's report are covered with this coverage limit and payment percentage. The insured's inability to perform daily living activities independently, incontinence or immobility, needing assistance with feeding, taking medication orally, requiring full bathing assistance or being able to bathe with help, having a urinary catheter, living alone at home, and having a chronic illness requiring social support are not covered under the Home Care Services coverage. This coverage is only valid at institutions that have an agreement with Mapfre Sigorta for home care coverage.

3.8. Artificial Limb

The prostheses and the maintenance of these prostheses installed to replace the lost limb of the insured as a result of an accident or illness occurring during the insurance period are covered within the scope of this coverage limit and payment percentage. Artificial limb coverage is only for the material used. The replacement or maintenance of the artificial limb must take place within the relevant policy period. Artificial limbs used or to be renewed for disabilities existing before the insurance start date are not covered by the policy. Artificial limb expenses (additional fees) above the SUT price covered by the SSI and artificial limb expenses not covered by the SSI are considered within the scope of this coverage.

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ARTICLE 4 - WAITING PERIOD

This policy includes an initial waiting period of 3 months as of the date of purchase of the coverage for all procedures within the scope of Inpatient Treatment (except for the Red Zone cases) and all physical therapy and rehabilitation expenses, regardless of such services are outpatient or inpatient services. If maternity coverage is taken as additional coverage, the first 12 months waiting period will apply

ARTICLE 5 - CASES THAT ARE NOT COVERED

The exceptional cases stated below are excluded from the coverage for all coverage types of this policy: However, policy holders who have a renewal guarantee for individual policies before 01.11.2022 will be exempt from the exceptions between Articles 18 and 53. As of 01.11.2022, all exclusions stated below will be valid for policy holders switching from group to individual policy or switching from another insurance company. All the following exclusions will apply to policy holders in group policies.

1. Any kind of health expense arising from a diagnosis given, treatment received and/or treatment recommended due to a complaint and/or disease existing before the commencement date of the policy and related recurrences and complications are not included in the policy coverage, even if declared in the application form,

2. Health expenses arising in the period when the General Health Insurance provided by Social Security Institution is inactive for the reasons such as leave of employment, non-payment of insurance premium are not included in the policy coverage,

3. Procedures whose method, type, quantity, usage period are determined by Social Security Institution, materials that are permitted to be supplied from medical institution and paid by Social Security Institution within the rules in inpatient treatments and medical services not provided by Social Security Institution except materials used in the scope of protocol made with in-network providers in the cases where Social Security Institution makes payment on equivalent material prices are not included in the policy coverage,

4. Health expenses regarding treatments to be provided out of In-Network Service Provider and/or Providers written in the Policy including emergency are out of policy coverage,

5. Outpatient treatment expenses exceeding the number of use and/or coverage limit written in the policy are out of policy coverage,

6. Within the scope of outpatient treatments including Green Zone application, all kinds of medication expenses, materials and contrast materials used for examinations, material costs and vaccination expenses are excluded from the policy coverage,

7. Tests and/or treatments that may be performed after examinations out of the In-Network Provider(s) written in the policy They are out of policy coverage, even if they are performed in the In-Network Provider(s) written in the policy,

8. All expenses related to examinations, teeth and dental-gum treatments and jaw treatments performed by dentists and maxillofacial surgeons, expenses for toothpaste, oral and dental care preparations, etc.,

9. Eyeglasses, glass, frame and lens expenses and all the costs regarding them,

10. All treatments to be made and medicine to be used abroad, and all medicine to be imported are out of policy coverage,

11. Expenses for out-of-network local or interprovincial ambulance services

12. Travel expenses, daily allowance, second attendant expenses, suite room differences and special expenses,

13. Abortion which is not medically required, infertility, low sterility research and all examination, treatment and complication expenses to maintain the pregnancy (in vitro fertilization, follicle follow-up, microinjection, tuboplasty, etc.), hysterosalpingography (HSG), spermiogram, adhesiolysis expenses,

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14. Specialist physician reports, medical board reports, reports requested before starting a sport, prior to marriage, or before employment, and the related expenses,

15. All pregnancy-related expenses and maternity expenses, if not covered as additional coverage,

16. Any kind of health expenses regarding epidemics officially announced by the Ministry of Health or epidemics announced as phase 5 and above anywhere in the world by the World Health Organization,

17. All expenses related to circumcision and phimosis even if it is a medical requirement,

18. Treatment expenses incurred by dentists related to dental/genioplasty surgery resulting from traffic accidents/judicial accidents and replacement of teeth (provided that the accident report issued by official institutions is submitted) are paid from the Inpatient Treatment Coverage),

19. Expenses related to refractive defects (myopia, etc.) treatments, amblyopia, all kinds of diagnosis, examination and treatment expenses for toric and multifocal lenses, the problem of strabismus,

20. Congenital and genetic diseases, which are diagnosed after the start date of the policy even if they occur at an advanced age, and expenses for premature babies unless a contract is made otherwise,

21. Spinal curvature disorders such as scoliosis, kyphosis, etc.,

22.Expenses related to tests and treatments for pes planus, hallux valgus/rigidus, etc.,

23. Diagnosis or treatment of dementia caused by old age, Alzheimer's, Parkinson's, and epilepsy, and antipsychotic, anxiolytic, anticonvulsant and all psychotropic medicines used in the treatment of these diseases,

24. Mental diseases and psychological disorders that require psychiatric treatment, neuropsychiatric tests, examinations and treatment, all types of psychotherapies,

25. Nasal septum and concha operations,

26. Expenses related to nasal valve surgery unless it occurs as a result of a judicial accident,

27. Treatments of strabismus, otosclerosis, keratoconus, and ptosis,

28. Tests related to research and screening of all kinds of genetic diseases/conditions, genetic disease treatments,

29. Any kind of routine and specific examination and treatment expenses related to structural disorders, motor mental development and growth disorders (growth and development retardation, acromegaly, early/late puberty, etc.),

30. All types of illnesses and expenses related to accidents that may occur due to unlicensed vehicle use (the driver's license must be suitable for the class of the vehicle used by the policy holder),

31. Alcoholism, alcohol addiction (regardless of the BAC level), drugs, stimulants, hallucinogens and other substances, any illness and expenses that are related to accidents occurring after the use of these substances,

32. Expenses arising from all hazardous sports activities and/or hazardous activities including but not limited to (mountaineering, diving with breathing apparatus, airplane and glider piloting, parachuting, parapant, delta wing flying, horseback riding, electric motorcycles, electric scooters, skiing, motorcycle riding even if it is for transportation purposes, etc.) whether for amateur or hobby purposes, and all expenses arising from professional and/or licensed sports activities are excluded. Expenses arising from all kinds of professional and/or licensed sports activities are excluded from the coverage, and only expenses related to skiing, motorcycle and ATV use for transportation purposes and with a driver's license will be covered within the scope of the policy limit and coinsurance rates with additional premium unless the risk occurs,

33 Regardless of the institution where they are performed, alternative treatment methods (acupuncture, homeopathy, osteopathy hypnosis, yoga, mesotherapy, aromatherapy, neural therapy, chiropractic treatments, ayurveda, spa and mineral water treatments, etc.), anti-aging applications, and treatments performed by centers operating without the license of the Ministry of Health, and spa and thermal centers, sanatorium, nursing home, nursing home preventorium and rehabilitation centers,

34. All examination, testing and treatment expenses at aesthetics and beauty centers,

35.Expenses related to examinations such as coronary artery calcium scoring, coronary VCT angio, EBT (Electron Beam Tomography) for screening purposes, virtual angio and virtual colonoscopy,

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36. All expenses made for the removal of the special exception of the policy holder,

37. Unless it occurs as a result of a judicial accident or illness (cancer, burn, etc.) that occur during the validity period of the policy, expenses related to plastic and reconstructive surgery, all kinds of aesthetic and cosmetic procedures, treatments for telangiectasia, skin hemangiomas, gynecomastia, antiperspirant treatments and related examinations and procedures, rhinoplasty, hair loss (diagnosis and treatment, excluding alopecia areata), all types of reduction and augmentation mammaplasty,

38. Expenses related to weight loss and weight gain programs related to weight and appetite disorders, diagnosis or treatments of obesity and surgery,

39. Snoring treatment, sleep disorders, examinations and treatments for sleep apnea (polysomnography, sleep EEG), and any appliances used for sleep apnea,

40.All kinds of examination, analysis and treatment expenses, regardless of the area of expertise of the health center and/or doctors applying a balanced diet, diet-exercise programs,

41. Voice and speech therapies;

42. Expenses related to cord cyst, hydrocele and any kind of hernia for children below 7,

43. Medical supplies which are not considered within the scope of auxiliary medical supplies coverage, CPAP device, its calibration and monitoring, home humidifiers, externally worn devices (hearing aid, cochlear implant, etc.), sanitary items such as oral and dental care apparatus, thermometers and temperature probes, ice packs, hot water bags or gels, heated blankets, diapers, baby bottles, milking pumps and apparatus, pacifiers, injectors not received with medicine, other expenses not required for treatment such as tapes, telephone, TV, cafeteria, administrative service, paramedical service and service fee, and all kinds of (external) prostheses and support prostheses (those that cannot be considered within the Inpatient Treatment Coverage),

44. Varicocele expenses, whether related to infertility or not (except for people under 18 years of age),

45. Expenses of all examinations and treatments related to gender reassignment operations, impotence, peyronie's, penile chordee, vaginismus, sexual function disorders (including penile prosthesis) and birth control costs,

46. Regardless of how they spread, anogenital condylomas, HIV, AIDS, and all examination and treatment costs related to these,

47. Expenses related to sclerotherapy, laser, radiation, massage, socks, etc. applied for superficial varicose treatment,

48. Expenses related to donor in organ, tissue and blood transfusion,

49. Expenses related to the collection and storage of cord blood and stem cells,

50. Healthcare expenses for occupational diseases and occupational accidents,

51. The contribution shares that the policy holders are obliged to pay in accordance with Article 98/2 of the Social Insurance and General Health Insurance Law No. 5510,

52. Coverages not preferred in the policy and all kinds of medical expenses not included in the coverage descriptions specified in the policy,

53. Research, check-ups and non-diagnostic tests ordered without any symptoms and/or complaints or due to a general complaint,

ARTICLE 6 - GEOGRAPHICAL SCOPE

Coverages written in this policy are valid in the in-network providers written in the policy, within the boundaries of the Republic of Turkey. Overseas treatment expenses are not included in this policy coverage.

ARTICLE 7 - INDEMNITY PAYMENT

Expenses that may occur while the policy holder is receiving healthcare services from in-network provider(s) written in the policy shall be paid to the in-network provider directly after provision to be given to the provider when the policy is considered within coverage. Invoices and papers regarding the provision shall be sent to the insurer by the in-network provider. Invoices regarding the expenses that the policy holder makes on their own for the procedures for which provision is not received shall not be considered within the coverage

All expenses out of the policy coverage shall be paid by the policy holder.

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ARTICLE 8 - RENEWAL OF THE CONTRACT AND GIVING RENEWAL GUARANTEE

8.1. Renewal of the Contract

The policy holder may apply to the insurer for a new contract (policy) 30 days after the expiry date of the existing individual policy at the latest. If 30 days or more have passed since the renewal date, a new application form shall be prepared for the policy holder as if they were a new policy holder, and they shall be included in the insurance like a new policy holder.

The insurer reserves the right to apply additional premium or discount as per the loss ratio, not renew the policy as per the loss ratio and/or risk acceptance criteria and to apply conditional acceptance such as exemption, contribution share, limit, additional premium for policy holders who have no Lifetime Renewal Guarantee in the individual policy renewal period.

8.2. Lifetime Renewal Guarantee

Lifetime Renewal Guarantee is given under the conditions to be determined as a result of a risk analysis evaluation to be conducted for policy holders who have health insurance policies, provided that the policy holder continues their insurance with the Fark Yok Health Insurance product for an uninterrupted three years at MAPFRE Sigorta A.Ş. and that their three-year loss ratio average is below 80%.

In group policies, there is a requirement to be covered before the age of 55.

For the policies to be transferred from another insurance company to MAPFRE Sigorta A.Ş. Fark Yok Health Insurance product, risk analysis shall be made of policy holders and practices such as limit, contributions, additional premium, exemption shall be valid, whether there is a renewal guarantee or not.

The right of renewal guarantee gained in the previous company shall be considered according to MAPFRE Sigorta A.Ş. criteria, and the policy holder's right of renewal guarantee shall continue with existing special terms of the insurer within the framework of specifications to be determined. In the case that it is transferred from other products of our company to the Fark Yok Health Insurance product, the right of Renewal Guarantee shall be reserved without Making Risk Reassessment of Policy Holder which has already been made. However, in the case there is a request for transfer from Fark Yok Health Insurance product to a different product, risk analysis is made by the insurer once again. The insurer may require medical examinations to assess the health status of the policy holder applying for a Lifetime Renewal Guarantee. The insurer may, in accordance with the current risk acceptance regulations, reject or conditionally accept the application (limits, additional premiums, contributions, waiting period, etc.) or offer an unconditional Lifetime Renewal Guarantee according to the applicant's health status.

The last product used by the policy holder entitled to have Lifetime Renewal Guarantee is renewed with another product in line with the coverage in the previous policy and in-network provider network or a closest product, if the product is removed by the company and/or due to legal legislation amendment during renewal or force majeure. In such a case, policy holder reserves the right to their current Lifetime Renewal Guarantee. Renewal guarantee is personal and it belongs to the entitled policy holders. "Lifetime Renewal Guarantee" offered by the insurer to the policy holder is indicated on the policy of each policy holder.

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The insurer has no right to perform a risk analysis assessment in situations other than those that are stated in Articles 6 and 7 of the General Terms of Health Insurance and apply a new additional condition such as an additional premium, exclusion, limit or an additional premium based on claims/premium ratio for medical conditions of a policy holder who was granted a Lifetime Renewal Guarantee, which occur after the date that the renewal guarantee was provided.

The insurer reserves the right to review the Lifetime Renewal Guarantee if the policy holder wishes to expand their coverage during this period. The health policy the insurer offers to its policy holders to whom it gives renewal guarantee is subject to the special terms applicable on the date when the policy is granted the right of renewal guarantee. However, the insurer has the right to make changes in the network of in-network providers.

Nevertheless, the renewal guarantee for policy holders insured for the first time before 23.04.2014, entitled or not yet entitled to a renewal guarantee shall be continued to be provided under the phrase "Renewal Guarantee Provided without a New Risk Assessment". The insurer has no right to perform a risk analysis assessment in situations other than those that are stated in Articles 6 and 7 of the General Terms of Health Insurance and apply a new additional condition such as an additional premium, exclusion, limit and contribution for medical conditions of such policy holders, which occur after the date that the renewal guarantee was provided. Such policy holders shall be charged with the additional premiums mentioned in the information form and special terms depending on their claim/premium ratio. The criteria for the assessment of the renewal guarantee, which are explained in the relevant article, shall be applied in the same way for these policy holders.

ARTICLE 9 - DETERMINING THE PREMIUM

9.1. Premium Calculation for Individual Policies

In accordance with the insurer's Risk Acceptance Regulation, the premiums of the applicant are calculated by taking into account the health risk plan, coverage, age and gender of the policy holder, health inflation, indemnity premium rate. If spouse or children are requested to be included after the policy start date, this request of the policy holder is processed using the premium tariff in force at the time of request, provided that the insurer reserved the right not to accept the relevant request. Premiums and payment due dates, and plan details such as coverages, limits, contributions, etc. for the policy holders under the policy are indicated on the front page of the policy.

Policy premium is calculated based on the age on the start date of the insurance (calculation of difference between start date and date of birth as day/month/year). Actuarially calculated tariff base premiums can be updated periodically by taking into account the overall portfolio performance, health inflation and medical inflation variables. Variables of medical inflation include the changes in the Consumer Price Index, Producer Price Index, and coefficients of the Price Tariff of Turkish Medical Association, changes in exchange rates, and the current prices to be applied to our company by healthcare institutions. The increase in tariff base premiums is limited to a maximum 300% increase of the previous tariff premium, provided that it is not below the health inflation rate.

The policy premium is determined within the place of residence, age, gender and coverage criteria of the policy holder. Premiums vary in Istanbul and other provinces. The policy premium is determined within the place of residence, age, gender and coverage criteria of the policy holder. Premiums vary in Istanbul and other provinces.

The policy premium is calculated on the basis of the age on the insurance start date (calculation of the difference between the start date and the date of birth as day/month/year).

The mode of payment, terms, and amounts for the insurance premium are stated on the application form and the policy. The policy holder shall make all the premium payments via a credit card in line with the payment plan included in the policy.

9.2. Premium Calculation for Group Policies

The insurer determines the Group Health Insurance premiums taking into consideration the criteria such as the size of the group, previous usage, age/gender of the policy holders, insurance period, coverage type, coverage limit, and inflation rate. Instead of determining the premiums on an individual basis, premiums can be determined based on the number of the policy holders in the group, as well as the age and gender distribution. In addition, the changes in the Health Service Tariff (Turkish Medical Association minimum fee tariff, SUT units and coefficients, HUV units and coefficients) are considered as health inflation in the evaluation. If the implementations in the Health Service Tariff change, a reevaluation is made.

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Policy premium is calculated based on the age on the start date of the insurance (calculation of difference between start date and date of birth as day/month/year).

9.3. The No-Claim Discount;

(NCD) system consists of an entry level and a total of 7 discount levels, making a total of 8 levels. New policyholders and policyholders who transfer their policy start at the entry level (1st level) in this application. Based on the **"Claims"/"Health Net Premium" (C/H) ratio** and the policy level for the current policy period, the level for the next year's renewal policy is determined. For policyholders who have entered the policy on a day basis and have a duration of less than 6 months, the starting level will be 1 The level of the renewal policy is determined based on the current policy period level and the **"Claims"/"Health Net Premium" (C/H) ratio**. The renewal policy...

- If the Claims/Premium ratio is less than 25%, the policy will move up one level.
- If the Claims/Premium ratio is between 25.01% (inclusive) and 70% (inclusive), the policy will remain at the same level.
- If the Claims/Premium ratio is between 70.01% (inclusive) and 150% (inclusive), the policy will move down one level.
- If the Claims/Premium ratio is between 150.01% (inclusive) and 350% (inclusive), the policy will move down two levels.
- If the Claims/Premium ratio is 350.01% or higher, the policy will be renewed at three levels lower.

The discount rate for each tier is as follows:

DI SCOUNT	1	2	3	4	5	6	7	8
EACH TI ER (%)	0	15	25	35	40	50	55	60

SPECIAL TERMS FOR THE COMPLEMENTARY HEALTH INSURANCE

ARTICLE 10 - NEW ENTRY PROCEDURES

10.1. Insurance Term and Acceptance for Insurance

The insurance period is 1 year and shall cover the period between the start and end dates specified in the policy. Insurance coverages enter into effect with the acceptance of the application and issuance of the policy by the insurer, and the payment of the down payment. This insurance contract shall cover the citizens of the Republic of Turkey. The policy holder must be under the age of 60 (sixty) as of the starting year of the policy for the contract between the policy holder and the insurer to be concluded. The individual policy shall not be renewed after the age of 60 if the policy holder is aged 56 and above on the first date of inclusion in the policy. The policies of the persons who are insured for the first time within the scope of Fark Yok Health Insurance policy at the age of 55 and before may be renewed after the age of 60, if they continue without interruption. The age is calculated based on the difference between the insurance start date and the date of birth as day/month/year.

Children between 0-6 years of age can be included in the coverage as family, and/or for the same product held by at least one legally dependent person. If requested, dependent, unmarried and student (must be documented) children of the policy holder can be included in the policy coverage until they are 24 years of age. Children older than 14 days and younger than the age of 6 can only be insured within the scope of the product for which one of the parents is insured. Children between the ages of 7-18 can be insured individually, provided that the policy owner is over the age of 18. Within the scope of the policy, those who reside within the borders of the Republic of Turkey are accepted for insurance.

10.2. Applications

For individual policy, initial and all other subsequent applications of the policy owner/policy holder candidates must be made by application forms provided by the insurer and declaration sections related to the persons to be insured should be filled in completely and accurately. All applications and/or change requests to be made for an insurance policy must be in writing and bear a wet signature. Any amendment or scratch on the application form is not accepted.

If the policy holder authorizes the insurer to access their medical history information, a doctor's opinion, examination, etc. may be requested by the insurer to determine the health status of the policy holder. In such a case, the expenses related to these procedures are covered by the insurer. However, if the necessary documents cannot be obtained from the relevant institutions despite the authorization given by the policy holder to access health information, the costs related to doctor's opinion, examination, etc. shall be covered by the policy holder and/or the policy owner. If the policy holder does not give authorization to access health history information, the costs related to the doctor's opinion, examination, etc. shall be covered by the policy holder and/or the policy owner. The policy holder must apply to the insurer in every policy renewal period, even if the policy holder has received a renewal guarantee

The insurer's right to decline, or to apply conditional acceptance (limit, additional premium, contribution shares, waiting period, etc.) for the policy holder who is not given renewal guarantee in line with the Risk Acceptance Regulation in effect and/or state of health is reserved.

10.3. Liability of the Policy Owner

If the policy is canceled, or if the policy holder is excluded from the policy coverage, documents that were issued in the name of these persons excluded must be returned to the insurer. This responsibility rests with the policy owner. Losses that shall be incurred because the documents were not returned in full shall be claimed from the policy owner in recourse. The Policy Owner/Policy Holder is obliged to correctly answer the questions asked in the application form and complementary documents and to declare the information that constitutes the subject of the risk and/or that will be effective in its assessment.

If the declaration of the Policy Holder/Policy Owner is false, incomplete or incorrect, the provisions of Article 6 of the General Terms of Health Insurance will be applied. According to Article 6, reserving the rights of the insurer, the insurer is entitled to evaluate the diseases that were not declared by the policy holder/policy owner, and to include them in the coverage conditionally (out of scope, additional premium, etc.).

SPECIAL TERMS FOR THE COMPLEMENTARY HEALTH INSURANCE

The insurer has the right to collect from the policy holder and/or the policy owner the expenses that are against the Health Insurance General and Special Terms of the policy and the payments made outside the scope of the coverage.

ARTICLE 11 - SWITCHING TO ANOTHER POLICY AND EARNED RIGHTS

11.1. Switching Procedures from Other Insurance Companies

The insurer may, without prejudice to the provisions of the Lifetime Renewal Guarantee, request individuals switching from a different insurance company to provide proof of their health status, additional medical tests and, where necessary, a medical examination report and decide to offer limited/conditional coverage (limits, additional premiums, contribution shares, waiting period etc.). For policy holders who switch with a Lifetime Renewal Guarantee straight from another company, the provisions of the Lifetime Renewal Guarantee in our company shall apply

Diseases declared by the applicant in their previous insurance policy with another insurance company and/or diseases identified as preceding the first insurance date are not counted as acquired rights unless they have been declared in the application form. Such conditions are not covered.

Acquired rights refer to the removal of waiting times specified in the special terms and rights carried over from previous policies. Rights that come with the special terms/coverages of the previous policy but are not included in the special terms/coverages for the new period do not count as the "acquired rights" of the policy holder. However, rights that come with the Special Terms for the new period but are not included in the previous Special Terms also apply to the policy holder.

The original policy start date of the policy holder is taken into account when delivering acquired rights. The policy holder must apply within 30 days at the latest from the insurance end date for the original policy start date to be taken into account.

11.2. Applications for Switching from a Group Policy in MAPFRE Sigorta A.Ş. to an Individual Policy

If an employee, insured within the scope of the group policy with no renewal guarantee, applies individually (individual policy) at the latest within 30 days as of the date he/she leaves the contract coverage and provided that he/she selects a coverage that is the same or less than his/her last insurance policy, the insurer's right to decline, or to apply standard terms or conditional acceptance (additional premium, limit, contribution shares, exception, etc.) in line with the risk analysis evaluation made is reserved.

If the insured personnel, who have renewal guarantee under the group policy in our company with the condition of continuing their insurance for at least 6 months uninterruptedly, leave the scope of the Group Health Insurance policy (due to retirement, dismissal or resignation), they are required to apply for an individual policy within 30 days at the latest with their dismissal declaration.

The continuation of the policy shall be provided by a product equivalent to the Group Health Insurance product previously owned by the policy holder, or one of the individual tariffs with the closest plan. If the policy holder, who is insured within the scope of the group policy, applies for an individual policy without exiting the group, a risk analysis shall be performed in the transition to individual policy, regardless of whether the policy holder has a lifetime renewal guarantee

SPECIAL TERMS FOR THE COMPLEMENTARY HEALTH INSURANCE

ARTICLE 12 - PRINCIPLES OF INSURANCE CONTRACT EXPIRY

12.1. Cancellations

If the policy owner/policy holder makes a cancellation request within 30 days following the drawing up of the policy, the policy is canceled as of its start date, if no risks have materialized, and the paid-in premiums are fully refunded to the policy holder.

For requests delivered after 30 days but approved by the insurer, the insurer is entitled to collect premium based on the number of days, from the start date of the policy to the cancellation date. The amount to be returned to the policy owner/policy holder due to cancellation is calculated based on days by taking paid indemnity into consideration.

If the indemnity payments made to the policy holder do not exceed the premium amount earned by the insurer, the insurer deducts the paid-in premiums due to them and refunds the remaining sum to the policy holder. If indemnities paid to the policy holder exceed the premium amount the insurer is entitled to, but do not exceed the premium amount that the insurer collects, the insurer deducts the indemnity amount from collected premium amount and returns the remaining premium to the policy holder

If the indemnity amount paid to the policy holder exceeds both premium amount that the insurer is entitled to have and the premiums paid by the policy holder, cancellation is done without refunding the premiums. Even if the premiums are not due yet when the risk occurs, the portion corresponding to the indemnity amount that the insurer is obliged to pay becomes due and payable.

The policy owner will go into default if they fail to pay any of the premiums, whose exact due dates and amounts are indicated in the policy, before the maturity date. The provisions of Article 1434 of the Turkish Commercial Code shall apply if the premium is not paid on time.

If the insurer detects that the policy owner/policy holder is acting in bad faith (making persons not covered by the policy benefit from the policy coverages, misrepresentation of health expenditures as costs incurred by other policy holders, discovery of medical conditions known to the applicant before the insurance start date but deliberately not reported to the insurer, etc.), the insurer is entitled to claim back the health expenses paid, and/or to cancel the policy without returning premium.

12.2. Death of the Policy Owner or the Policy Holder

In the event of the death of the policy owner and/or the policy holder, the insurer proceeds depending on the following circumstances. In the event of the death of the policy owner, the insurer must be furnished with written approval of lawful heirs of the policy owner if the policy owner/policy holder(s) on the policy are different and if the policy holders wish to continue on the same policy by revising the policy owner. In this case, the policy continues by changing the policy owner. In the cases where the approval of lawful heirs is not received, the procedures are applied in line with the cancellation criteria stated above and the premium, if any, is refunded to lawful heirs.

A one-party policy in which the policy owner and the policy holder are the same person shall become null if the policy owner dies. The policy owner's policy is processed in accordance with the cancellation criteria set out above upon the written request of his lawful heir and the premium, if any, is refunded to the lawful heir.

In cases where more than one person is insured, in the event of the death of one of the policy holders, the person who has passed away is excluded from the policy as of the date of death. The premium, if appropriate, is reimbursed to the policy owner in the policy in accordance with the above cancellation criteria.

ARTICLE 13 - SAGMER (INSURANCE OVERSIGHT CENTER) NOTIFICATION

The policy and health information of the policy holders in this insurance policy will be transferred to SAGMER (Insurance Oversight Center), and the policy and health information of the policy holders will also be able to be obtained from SAGMER and other public institutions.

The General Terms of Health Insurance published by the Insurance Association of Turkey is available on www.tsb.org.tr.

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GENERAL TERMS FOR THE COMPLEMENTARY HEALTH INSURANCE

Please click here to access the health insurance general terms published by the Insurance Association of Turkey.

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INFORMATION FORM FOR THE COMPLEMENTARY HEALTH INSURANCE

This document consists of three copies and has been prepared for the purpose of providing Policy Owners and other individuals covered by the policy with information on their rights, obligations, the subject of the contract, its execution and other significant changes and developments as per the Regulation on the Disclosure Obligation of Insurance Companies published on 28.10.2007.

A - SUBJECT AND SCOPE OF COVERAGE

This insurance guarantees to pay additional fees that may arise (the part which has not been covered by the Social Security Institution) while the persons with General Health Insurance and the ones they are obliged look after, who are included in the coverage by Social Security Institution are receiving healthcare services from the healthcare providers contracted/having a protocol with Social Security Institution as determined by MAPFRE SİGORTA A.Ş. in accordance with Health Insurance General Conditions and these special conditions. This coverage is valid for all cases covered by the Social Security Institution, except for the cases specified under Article 2 of Special Conditions.

According to the provisions of Social Insurances and General Health Insurance Law, the contributions that beneficiaries of healthcare services are obliged to pay shall not be covered by this policy. Coverage stated in the policy is only applicable for the persons whose names are included in the policy and they do not cover any other person.

B - POLICY PREMIUM ACCOUNT

The health plan and coverage chosen based on the Insurer's Risk Acceptance Regulation. Considering age and gender of the Policyholder, inflation in health industry and damage/premium ratio of the portfolio, premium tariffs are specified by the company and announced to sales channels. Calculation is made according to this tariff

Policy premium is calculated based on the age in the insurance commencement date (calculation of difference between commencement date and date of birth as day/month/year). The Insurer can apply a discount and/or additional premium for policies meeting the following conditions.

Policy payment schedule can be implemented as a down payment, or with installments. No discount is applied for down payment.

In the case that the person who is not actively employed subject to Social Security Institution premium on the commencement of the policy is Policyholder with employee premium and this case is determined in the policy period, the required premium difference is accrued with an addendum.

The No-Claim Discount;

(NCD) system consists of an entry level and a total of 7 discount levels, making a total of 8 levels. New policyholders and policyholders who transfer their policy start at the entry level (1st level) in this application. Based on the **"Claims"/"Health Net Premium" (C/H) ratio** and the policy level for the current policy period, the level for the next year's renewal policy is determined. For policyholders who have entered the policy on a day basis and have a duration of less than 6 months, the starting level will be 1 The level of the renewal policy is determined based on the current policy period level and the **"Claims"/"Health Net Premium" (C/H) ratio**. The renewal policy...

- If the Claims/Premium ratio is less than 25%, the policy will move up one level.
- If the Claims/Premium ratio is between 25.01% (inclusive) and 70% (inclusive), the policy will remain at the same level.
- If the Claims/Premium ratio is between 70.01% (inclusive) and 150% (inclusive), the policy will move down one level.
- If the Claims/Premium ratio is between 150.01% (inclusive) and 350% (inclusive), the policy will move down two levels.
- If the Claims/Premium ratio is 350.01% or higher, the policy will be renewed at three levels lower.

The discount rate for each tier is as follows:

DI SCOUNT	1	2	3	4	5	6	7	8
EACH TI ER (%)	0	15	25	35	40	50	55	60

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INFORMATION FORM FOR THE COMPLEMENTARY HEALTH INSURANCE

Policyholders who have changed their product are not subject to the entitled discount or additional premium rate of the current product, but to the no claims discount and additional premium application of the new purchased product

C - GENERAL INFORMATION AND WARNINGS

1. The Policy Owner/Policyholder must submit their insurance request after filling out the Application Form fully and accurately. Application forms must be filled out fully and bear wet signature. Applicants are also obliged to provide details of any circumstances known to them that may have an impact on the likelihood of the risk materializing even if there are no specific questions in the Application Form to that end. Any change in circumstances following the making of the contract should be immediately reported to the Insurer. Please refrain from providing any missing or inaccurate information as doing so may result in your right to indemnity being revoked or generate negative consequences in terms of your policy. Fields left blank in the Application Form will be assumed to have been answered as NO.

2. The Insurer may request the applicant to have a medical examination to assess the health status of the Policyholder. As per the Regulation on Risk Acceptance, the Company reserves the right to refuse or offer a conditional acceptance of the application depending on the applicant's health status. If the application is denied the Application and Information Form becomes void.

3. Policy cancellations are processed upon the written application of the policy owner. The information form attached to the Application Form loses its validity as of the start date of the supplementary document

4. Provisions of the Code of Obligations shall apply in the event of a default in the payment of insurance premiums in accordance with Article 8 of the General Conditions of Health Insurance.

5. Insurance premiums are tax deductible. Please consult your Insurer regarding this matter.

6. If any of the Policyholders covered by the policy are engaged in an attempt that conflicts with the general terms and application principles of policy and which intentionally aims at getting benefits, the policy of all the Policyholders shall be immediately terminated.

7. Insurance company is entitled to request information and records related to the health background of the Policyholder, from all doctors who have treated the Policyholder, from health entities and third persons, before and after the insurance period. If the Policyholder will not allow this in good faith, the insurer can reject to pay indemnity, or can terminate the agreement.

8. At renewal times, the insurer specifies coverage, limits, and premiums associated with coverage reasonably, and is entitled to change the policy special conditions. This change will be effective as of the renewal date for each Policyholder.

9. For more information on the insurance please carefully read the Fark Yok (No Extra Fee) Special Conditions and the Health Insurance General Conditions attached to the policy.

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INFORMATION FORM FOR THE COMPLEMENTARY HEALTH INSURANCE

10. Policies start, unless otherwise agreed, at 12:00 on the policy start date and end at 12:00 on the policy end date, and when the risk materializes in any case.

11. The Policy Owner is obliged to inform the Policyholder to reply all the questions asked completely and accurately, and advise all conditions that may require the company not to execute the agreement, or to execute the agreement with more severe conditions. If the company requires doctor's opinion or some tests to be carried out at the application stage or throughout the insurance term, expenses of these will be paid by the Policy Owner/Policyholder.

12. In order for us to reach you more easily in case of any changes in your information such as identity, address, phone number, etc. found on our system, please contact info@mapfre.com.tr or the fax number 0212 334 90 19.

13. If the contract of one or several In-Network Health Care Providers written in the policy with the Social Security Institution expires within the policy term and no other provider in-network with the Social Security Institution and written in the policy remains in the region where the Policyholder resides, this policy is annulled automatically. The insurer shall be entitled to receive premiums depending on the time elapsed between the commencement date of the terminated policy to the cancellation date

D - EXCEPTIONS

Please refer to exceptions in the General Conditions for Health Insurance and Special Conditions for Fark Yok (No Extra Fee) Health Insurance to find out more about conditions that are not covered by the policy.

E - WAITING PERIOD

İşbu poliçede Yatarak Tedaviler kapsamında (Kırmızı Alan durumları hariç olmak üzere) tüm işlemler ve ayakta veya yatarak olmasına bakılmaksızın tüm fizik tedavi ve rehabilitasyon ile ilgili giderler için teminatın alındığı tarih itibarıyla ilk 3 ay bekleme süresi bulunmaktadır.This policy includes an initial waiting period of 3 months as of the date of purchase of the coverage for all procedures within the scope of Inpatient Treatment (except for the Red Zone cases) and all physical therapy and rehabilitation expenses, regardless of such services are outpatient or inpatient services.

F - LIFETIME RENEWAL GUARANTEE

"Lifetime Renewal Guarantee" is given within the conditions to be determined as a result of risk analysis assessment to be made for Policyholders having Health insurance policy, on condition that the Policyholders continues to the insurance with Fark Yok (No Extra Fee) Health Insurance product for 3 years in MAPFRE SİGORTA A.Ş. without interruption and his/her average Damage / Premium ratio is under 80% for the last three years.

INFORMATION FORM FOR THE COMPLEMENTARY HEALTH INSURANCE

For the policies to be transferred from another insurance company to MAPFRE SİGORTA A.Ş. Fark Yok (No Extra Fee) Health Insurance, risk analysis shall be made to Policyholders and practices such as limit, share, additional premium, exemption shall be valid, whether there is a renewal guarantee or not. The renewal right acquired with the previous company shall be subject to a review by MAPFRE SİGORTA A.Ş. whereby the Policyholder may be allowed, following a risk assessment, to retain his/her renewal right subject to the special terms of the Insurer.

In the case that it is transferred from other products of our company to the Fark Yok (No Extra Fee) Health Insurance product, the right of Lifetime Renewal Guarantee shall be reserved. However, in the case that it is requested to be transferred from Fark Yok (No Extra Fee) Health Insurance product to a different product, risk analysis is made by the Insurer once again. The Insurer may require medical examinations to assess the health status of the Policyholder applying for a 'Lifetime Renewal Guarantee'. The Insurer may, in accordance with the current risk acceptance regulations, reject or conditionally accept the application (limits, additional premiums, contributions, waiting period etc.) or offer an unconditional "Lifelong Renewal Guarantee" according to the applicant's health status. The Policyholder may apply to the Insurer for the purpose of extending the scope of the coverage in the Insurance Policy and/or adding a different product, network, coverage during policy renewal even if a Lifetime Renewal Guarantee is possessed. In such a case, the Policyholder's existing right to Lifelong Renewal Guarantee shall be reserved.

The Renewal Guarantee is personal, and cannot be passed on to third persons. The phrase "Lifelong Renewal Guarantee has been granted" provided to the Policyholder by the Insurer is stated in the certificate of each Policyholder.

Insurer does not have right to make risk analysis assessment and apply a new additional condition such as additional premium, exception, limit due to diseases occurring after the date that renewal guarantee is given for a Policyholder who has "Lifetime Renewal Guarantee" except the situations stated in the article 6 and 7 of Health Insurance General Conditions. The Insurer may decide to review his/her decision to issue a "Lifelong Renewal Guarantee" if the Policyholder wishes to expand his/her coverage during this period. The health policy offered by the Insurer to their Policyholders, to whom they have undertaken to provide a renewal guarantee, is subject to the Special Conditions on the date that the policy was granted the renewal guarantee right. The Insurer has the right to make changes to the group of in-network providers

Nevertheless, the renewal guarantee for Policyholders insured for the first time before 23.04.2014, entitled or not yet entitled to a renewal guarantee shall be continued to be provided under the phrase "Renewal Guarantee Provided Without a New Risk Assessment". Excepting cases outlined in Article 6 and 7 of the Health Insurance General Conditions, the Insurer may not perform a risk analysis or add additional terms such as additional premiums, exceptions, limits and contribution rates due to illnesses arising after the issuance of the Lifelong Renewal Guarantee. Such Policyholders shall be charged the additional premiums mentioned in the information form and special terms depending on their claim/premium ratio. The criteria for the assessment of the renewal guarantee, which are explained in the relevant article shall be applied in the same way for these Policyholders.

G - CANCELLATIONS

For the requests approved by the Insurer, the Insurer is entitled to collect premium on days basis, from the start date to the cancellation date. The amount to be returned to the Policy Owner/Policyholder due to cancellation is calculated based on days by taking paid indemnity into consideration. If the indemnity payments made to the Policyholder do not exceed the premium amount earned by the Insurer, the Insurer deducts the paid-in premiums due to them and refunds the remaining sum to the Policyholder. If indemnities paid to the Policyholder exceed the premium amount the Insurer is entitled to, but do not exceed the premium amount that the Insurer collects,

Insurer deducts the indemnity amount from collected premium amount and returns the remaining premium to the Policyholder. If the indemnity amount paid to the Policyholder exceeds both premium amount that the Insurer is entitled to have and the premiums paid by the Policyholder, cancellation is done without refunding the premiums. When the risk occurs, the part of indemnity amount that the Insurer is obliged to pay becomes due, even if the premiums are undue.

In the requests for reactivating policies after policy cancellation, Application Form is filled out again and risk reassessment is made.

INFORMATION FORM FOR THE COMPLEMENTARY HEALTH INSURANCE

If the Insurer catches the Policyholder/Policy Owner acting in bad faith (making persons not covered by the policy benefit from the policy's warranties, misrepresentation of health expenditures as costs incurred by other Policyholders, discovery of medical conditions known to the applicant before the insurance start date but deliberately not reported etc.). The Insurer has the right to receive health expenses that he/she has paid with their interests and costs and/or cancel the policy without premium return.

If the contract of one or several In-Network Health Care Providers written in the policy with the Social Security Institution expires within the policy term and no other provider in-network with the Social Security Institution and written in the policy remains in the region where Policyholder resides, this policy is annulled automatically. However, if the contract of the health institution with the Social Security Institution is terminated for any reason whatsoever while the Policyholder's required inpatient treatment is ongoing, the expenses to be incurred until the completion of the treatment shall be within the scope of the policy coverage. The insurer shall be entitled to receive premiums depending on the time elapsed between the commencement date of the terminated policy to the cancellation date. In the event of the death of the Policyholder, the policy shall be null and void. Where the Policyholder and Policy Owner are different in the policy and the Policy Owner becomes deceased, the Policyholders may continue the policy by changing the Policy Owner. In this case, the policy continues by changing the Policy Owner. In the cases where the approval of legal successors is not received, the procedures are applied in line with the cancellation criteria stated above and the premium return is made to legal successors, if any.

H - CONTRACT RENEWAL

The Policyholder may apply to the Insurer for a new contract (policy) 30 days after the expiry date of the existing policy at the latest. If 30 days or more have passed since the renewal date, a new Application Form shall be prepared for the Policyholder as if he/she is a new Policyholder, and he/she shall be included in the insurance like a new Policyholder.

During the policy renewal period, the Insurer reserves the right to apply additional premiums or discounts according to the Damage/Premium rate for the Policyholder that has not received a Lifetime Renewal Guarantee, not renew the policy according to damage premium ratio and/or risk acceptance criteria, and make conditional acceptance practices such as exemption, share, limit, additional premium.

I - SAGMER (INSURANCE SURVEILLANCE CENTER) NOTIFICATION

By signing the relevant documents, persons covered or to be covered by the policy consent to their health information, insurance records and other details being taken from the Insurance Information and Surveillance Center (SBGM), Social Security Institution, Ministry of Health, health institutions and organizations and insurance companies and the concerned data and records held by the company to being shared with the Insurance Information and Surveillance Center, insurance companies and authorities authorized by the relevant legislation, for accurate risk assessment or to help finalize indemnity claims.

J - INDEMNITY PAYMENT

Expenses that may be incurred by the Policyholder while receiving health services from the In-Network Provider and/or Providers included in the Policy shall be paid directly to the in-network provider after the authorization to be provided to the provider following the confirmation that the expenses are covered by the policy coverage. Invoices and documents related to the authorization shall be sent to the Insurer by the In-Network Provider. In case of unauthorized transactions, the invoices for the Policyholder's own expenses shall not be considered to be within the scope of the Policy. All expenses out of the policy coverage shall be paid by the Policyholder.

K - OTHER INFORMATION

The insurer is not a member of the Insurance System of Arbitration.

L - COMPLAINTS AND REQUESTS FOR INFORMATION

1- Please contact us on the following numbers or write to us at the following address for more details on your insurance policy, including its negotiation and drawing up, any technical issues, insurance transactions performed or to be performed, the warranties offered by the contract and how the policy works, as well as any information requests and complaints. The insurer must respond to requests within 15 business days following receipt of the claim

2- Contact our Customer Service Center on 0850 755 0 755 if you still have not received your policy agreement or rejection letter within 30 days from the date of your application.