# 3S HEALTH INSURANCE SPECIAL CONDITIONS

These special conditions are valid for the Insured who have MAPFRE Health Group Insurance Policy as of 01.11.2023.

## ARTICLE 1- SUBJECT OF INSURANCE

MAPFRE Sigorta A.Ş. ("Insurer") guarantees the health expenses of the Insured, which may arise as a result of accident and/or illness/discomfort during the period the insurance contract is in force, in line with the coverage, limits, participation rates, exclusions (general and special exclusions) and network coverage specified in the Policy, within the framework of these Special Terms and Conditions and the General Terms and Conditions of Health Insurance attached hereto and the Regulation on Private Health Insurance, Turkish Commercial Code, legal regulations including insurance health legislation. The insurance coverage is valid only for the persons included in the Insurance Policy and other persons cannot benefit from the coverage.

## ARTICLE 2- DEFINITIONS

Explanations regarding the definitions used within the scope of the Insurance Policy are attached.

**EMERGENCY SITUATION:** Situations requiring medical intervention within the first 24 hours following the occurrence of the event in cases of sudden illness, accident, injury and similar situations, and situations where it is accepted that there is a risk of loss of life and / or health integrity in the absence of immediate medical intervention or transfer to another health institution.

**1. Drowning in water:**
In cases of respiratory or cardiac arrest or where the patient's general condition is such that water is entering the lungs to the extent that drowning may occur.

**2. Traffic accident:**
Acute conditions with spinal injuries and haemorrhagic fractures. Severe chest, abdominal or head trauma that may cause internal bleeding, even if it does not affect the patient's condition at the time. Cutting and penetrating injuries caused by vehicle parts that cause major haemorrhage in the body.

**3. Terrorism, sabotage, shootings, stabbings, fights, etc.** (Applicable in cases where he/she was not the instigator or party to the incident and was accidentally exposed).

**4. Falling from a height:**
Acute conditions with spinal injuries and haemorrhagic fractures. Severe chest, abdominal or head trauma that may cause internal bleeding, even if it does not affect the patient's condition at the time. Cutting and penetrating injuries caused by vehicle parts that cause major haemorrhage in the body.

**5. Serious occupational accidents, amputations:**
In addition to the situations in article 2, emergencies specific to the work performed. For example: Inhalation of poisonous gases, drinking or spilling of chemicals, partial or complete amputation of fingers, hands, feet, arms or legs.

**6. Electric shock:**
Severe electric shocks that can cause burns, organ damage or disrupt heart rhythm.

**7. Frostbite, cold stroke:**
Exposure to cold that may lead to shock that may affect vital functions and cause gangrene in the limbs.

**8. Heat stroke:**

Exposure to the sun or a hot environment that affects the heart rhythm, blood pressure or state of consciousness.

**9. Severe burns:**
Burns from fire, chemicals, electricity, etc. that are extensive enough to cause massive fluid loss, organ loss or skin damage. Inhalation of smoke or hot air that may cause narrowing of the respiratory tract.

**10. Severe eye injuries:**
Severe sharp or piercing injury, blunt trauma or chemical contact that may cause damage to the eye.

**11. Poisoning:**
Ingestion of substances that have impaired vital functions at the time of the incident or are likely to do so in the following hours, skin contact with chemical substances or inhalation of toxic gases.

**12. Anaphylactic shock:**
Severe allergies or low blood pressure that may lead to heart rhythm disturbance, obstruction of the respiratory tract.

**13. Spine and upper and lower extremity fractures due to trauma:**
Life-threatening or potentially life-threatening fractures of the spine, arms and legs in the absence of intervention.

**14. Heart attacks, hypertension crises:**
Heart attack in progress, types of heart rhythm disorder requiring urgent treatment, elevated blood pressure that can lead to serious conditions such as cerebral haemorrhage.

**15. Acute respiratory problems:**
Drowning, foreign body ingestion, allergic reaction, respiratory burns, which may lead to severe respiratory failure.

**16. Any organic defect causing loss of consciousness:**
Conditions such as fainting, cardiac trauma that may cause deterioration in the person's state of consciousness.

**17. Sudden paralyses:**
Loss of mobility or sensation in the limbs or the whole body due to brain haemorrhage, spinal injury, etc.

**18. Severe general condition disorder:**
Deterioration of a person's health to a degree that may be dangerous in general terms due to nutritional deficiency, inadequate care, prolonged severe illness, etc.

**19. High fever above 39.5:**
A rise in body temperature due to poisoning, infectious diseases, heatstroke, etc. that may lead to convulsions (convulsions) or heart rhythm disorders. 39.5 °C and above.

**20. Diabetic and uremic coma:**
Conditions that may start from blurred consciousness caused by diabetes (diabetes) and kidney failure to complete loss of consciousness (coma).

**21. Acute abdomen:**
The occurrence of diseases related to intra-abdominal organs that require urgent surgical intervention, such as perforation of hollow organs such as the stomach and intestines, intestinal

obstruction or knotting, obstruction of the bile ducts due to stones or inflammation, serious organ inflammation such as appendicitis, pancreatitis, blockage of intestinal or peritoneal arteries, etc.

**22. Acute massive haemorrhages:**
Life-threatening internal or external bleeding, usually as a result of trauma.

**23. Meningitis, encephalitis, brain abscess:**
Inflammatory, infective diseases of the brain and the membrane surrounding the brain, which can lead to changes in the state of consciousness that can affect the functions of the nervous system and thus vital functions.

**24. Renal colic:**
A condition of severe pain caused by kidney stones, which may lead to urinary tract or kidney damage if it progresses.

**FORENSIC ACCIDENT:** An unexpected sudden event that results in bodily injury to the Insured during the policy validity period and that requires and/or has already been followed up and investigated by the judicial authorities. It is documented by the organisations conducting the investigation.

**CONTRACTED HEALTH INSTITUTION:** These are the hospitals, clinics, laboratories, diagnostic and treatment centres, pharmacies and doctors who are licensed by the Ministry of Health of the Republic of Turkey and authorised by the Ministry of Health of the Turkish Republic of Northern Cyprus, who are qualified for diagnosis, treatment and surgical intervention, and with whom the Insurer has an agreement for the insured to benefit from health services in accordance with the Policy Terms. The limits and coverage percentages valid in Contracted Institutions are specified in the Policy. You can access the list of contracted organisations at www.mapfre.com.tr and MapfreGo application. Since this list is subject to continuous updating, it must be confirmed before receiving service. The insurer reserves the right to make changes to the "Contracted Health Institutions List" during the policy period.

**NON-CONTRACTED HEALTH INSTITUTION:** Hospitals, clinics, laboratories, diagnostic and treatment centres, pharmacies and doctors who do not have a contract with the Insurance Company. Doctors who do not accept MAPFRE contract terms even if they work as a permanent staff in the contracted institution are considered as "Non-Contracted Institution".

**BEGINNING DATE:** The day (12:00 noon Turkey time), month and year on which the Policy comes into force for the first time or each subsequent renewal, if any.

**END DATE:** This Policy expires on the day (12:00 noon Turkey time), month and year. All expenses incurred after this date are excluded from coverage regardless of the reason. However, the expenses of an Insured who is being treated in a hospital are covered up to 10 days after the Policy End Date, provided that he/she has never left the hospital.

**WAITING PERIOD:** The period starting from the date of registration of the Insured and the medical procedures/interventions specified as a waiting period in the Policy are not covered.

**UNDECLARED PRE-EXISTING HEALTH PROBLEM:** Failure to declare to the Insurer any complaint, symptom, disease/discomfort or complications arising from these, regardless of whether they are diagnosed or not, existing and known at the time of application for this Policy or before.

**DECLARATION OBLIGATION:** The Policy Owner/Insured is obliged to give correct answers to the questions asked to him/her at the stage of application for the insurance contract or during the continuation of the insurance contract and to inform the Insurer about the matters that constitute the subject matter of the risk/which will be effective on the assessment of the risk, which are known to him/her.

**DOCTOR:** A person who has been granted a work licence by the Ministry of Health of the Republic of Turkey and who has been officially given the title and certificate of medical doctor within the framework of the laws applicable in the geographical region where health services are provided.

**GENERAL CONDITIONS:** These are the written rules determined by the Republic of Turkey Prime Ministry Undersecretariat of Treasury and compulsory to be applied by all insurance companies in health insurance.

**UNNECESSARY TREATMENT PROCEDURES:** Although the Insured does not require hospitalisation, the tests and treatments planned by the doctor are performed by hospitalisation.

**HOSPITAL:** A public or private institution providing medical services to sick and injured persons, which has an official hospital licence for its field of activity. Outpatient clinics, sanatoriums, physiotherapy centres, health clubs, nursing homes, nursing homes, etc. and institutions specialised in substance (drug, alcohol) addiction are not included in the scope of hospitals.

**HUV (Physician Practices Database):** This tariff is published by the Turkish Medical Association and shows the fees and principles of practice for doctors practising their profession within the borders of the Republic of Turkey.
The fee in the tariff is calculated by multiplying the "unit value" determined for each medical procedure in the HUV (Physician Practices Database) by the general coefficient determined once a year for each province.

**CANCELLATION DATE:** The day, month and year on which the Policy is cancelled due to the written request of the Policy Owner or the withdrawal or termination of the Policy by the Insurer due to the issues specified in the General Terms and Conditions.

**REGISTRATION DATE:** The day (12:00 noon Turkey time), month and year on which the Insured is covered by the Insurance Policy or covered by the first Contract repeated under the conditions specified in the renewal definition.

**ACCIDENT:** An unexpected, sudden event that causes the Insured to suffer bodily injury that can be medically proven.

**COMPLICATION:** Unwanted effects of a disease, disorder or medical treatment.

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

**CHRONIC DISEASE:** A disease that does not have a sudden onset, develops and/or progresses slowly, recurs from time to time or causes a permanent health problem.

**MEDICAL OPERATIONS CENTRE:** It is a unit consisting of specialists who evaluate the payment of health expenses of the Insured who apply to contracted health institutions within the scope of the Policy Conditions and provide 24/7 service within MAPFRE Sigorta.

**REINSTATEMENT:** In case the Insurance Policy is cancelled, the Policy is reinstated after the evaluation to be made by the Insurer. For applications to be made within 1 month as of the date of cancellation, the reinstatement process can be evaluated. For this evaluation, the Insurer has the right to request an application

form from the Insured, to apply special exception and/or additional risk premium to the Insured whether or not the Insured is entitled to Lifetime Renewal Guarantee (LRG), and to reject the request for reinstatement.
**NETWORK (CONTRACTED ORGANISATION TYPE):** It refers to the grouping of health institutions contracted by MAPFRE Sigorta A.Ş. The valid contracted organisation network type is indicated on each Policy. Institutions outside the scope of the relevant network are considered as Non-Contracted Institutions for the relevant Policy even if they are MAPFRE Contracted Institutions. All entities listed in the Contracted Entity list constitute the MAPFRE Sigorta A.Ş. network. MAPFRE Sigorta A.Ş. has the right to change the Contracted Organisations determined for the network within the policy period or to exclude the relevant Contracted Organisation from the contracted network completely.

**SPECIAL CONDITIONS:** These are the terms prepared by the Insurance Company in addition to the General Terms and Conditions of Health Insurance, stating mutual rights and obligations, guarantees and conditions of validity and valid until the End Date of this Policy.

**PROVISION:** It is the insurer's assessment that informs whether or not or under what conditions the expenses of health services (internal hospitalisation, surgical hospitalisation, examination, diagnostic procedures, etc...) to be performed in contracted health institutions valid under the Policy of the Insured will be covered.

**PERSONNEL:** A person who works continuously and on a full-time basis (at least 35 hours per week) in a workplace with legal personality and who meets the conditions to be insured.
**RISK:** The occurrence of any disease/illness that may create an indemnity obligation for the insurer.

**SUPPLEMENTARY PREMIUM FOR RISK:** This is the additional premium application related to the disease risks specified in the Policy attached to this Policy and to be applied only for the relevant Insured. The additional premiums applied are stated in the relevant Insured Policy together with the reason and rate.

**POLICY OWNER:** The person or legal entity who applies for the Insurance Policy, whose application is accepted by the Insurer and who is the responsible party within the scope of this Insurance Policy and acts in favour of himself/herself and the Persons to be Insured.

**INSURANCE POLICY:** It is a document issued by the insurer within the framework of a special format and contains issues such as maturity, special and general conditions, limits, exclusions, application information and payment conditions related to the Policy; if the conditions are fulfilled, it guarantees the payment of the guarantees within the specified limits; all documents bearing the authorised signatures of the company.

**INSURER:** An Insurance Company registered and licensed in the country where the Insurance Policy is issued. In this Policy, the title of Insurer is used for MAPFRE Sigorta A.Ş.

**INSURED:** The person and/or persons specified in the health insurance application of the Policy Owner and the Persons to be Insured or added subsequently and accepted by the Insurer and included within the scope of the Policy either in the Policy or with a subsequent addendum.

**SPECIAL EXCEPTIONS FOR THE INSURED:** The exclusions to be applied for the Insured, which have been decided to be applied by the Insurer in the Insurance Policy, are stated on the Insurance Policy.

**STANDARD EXCEPTIONS:** These are the general exclusions valid for all Coverages and Insureds and specified in the special conditions.

**HEALTH INSURANCE PATIENT INFORMATION FORM:** The form filled in by the physician to whom the Insured applies in order for the Insured to benefit from the Policy coverage during the validity period of the Policy. Since this form is not available in Non-Contracted Institutions, the Insured must obtain

the Patient Information Form from the Insurer and keep it with him/her. This form is required for the evaluation of medical expenses.

**CERTIFICATE:** The table, which is an integral annex of the Policy, showing the domestic and international coverage group, Contracted Institution type, participation rates, coverage limits, if any, and exemption amounts, if any, selected by the Policy Owner in the application form and agreed upon with the Insurer.

**COVERAGE:** It is the scope of health expenses that the Insurer will undertake to pay within the framework of the special and general terms and conditions of the Insurance Policy, except for the limit exception, waiting period and exemption specified in the policy.

**RENEWAL:** It is the application of the Policy Owner to the Insurer for a new contract 30 days before or 30 days after the Expiry Date of the existing Insurance Policy and the continuation of the new contract uninterruptedly by the agreement of the Insurer and the Policy Owner on the conditions of the new Insurance Policy.

**RENEWAL DATE:** The Start Date (12:00 noon Turkish time), month and year of the new Insurance Policy, which is the same as the End Date of the pre-existing Insurance Policy.

**ANNUAL TOTAL LIMIT:** This is the annual gross maximum amount that the Insurer may use during the Insurance Policy period specified annually in the terms and conditions of this Insurance Policy. Participation shares and/or exemption amounts to be paid by the Insured are also included in the gross amount.

**MAPFRE CUSTOMER SERVICES:** The telephone line 0850 755 0 755, where insured persons can communicate their suggestions, requests and complaints, and receive various services such as ambulance and medical counselling.

**MAPFRE SİGORTA GO:** MAPFRE Sigorta mobile application. Policy coverage conditions, claims management and all kinds of detailed information can be obtained by our insured through the mobile application.

**MAPFRE SİGORTA WEBSITE:** MAPFRE Sigorta corporate web site. Policy special conditions, contracted organisations and detailed information can be accessed via www.mapfre.com.tr.

## ARTICLE 3. COVERAGES

**3.1. Inpatient Treatment Coverage**

Inpatient Treatment Coverage covers internal, surgical and intensive care hospitalizations, emergency medical expenses that may cause a life-threatening situation, minor interventions, chemotherapy, radiotherapy and dialysis treatment expenses in accordance with the special and general conditions, provided that it is medically necessary and the doctor states this reason in detail in his/her report. Treatments of the Insured requiring hospitalization exceeding 24 hours are covered under this coverage.

In cases requiring a planned hospitalization and/or surgery, other than emergencies, the "Private Health Insurance Patient Information Form" completed by the doctor who will perform the surgery or internal hospitalization and the results of the examinations must be submitted to the Medical Operations Center by the relevant institution at least 48 hours before the hospitalization.

The insurance company decides whether the treatment expenses will be paid within the scope of the Policy after making the necessary examination.

In addition, the lifetime hospitalization period is limited to 720 days from the first date the Insured has health insurance. In the event of exceeding this period, if there is no lifetime renewal guarantee in the

Policy, all coverage in the Policy will cease and the Policy will not be renewed. The lifetime hospitalization limit does not apply to Insureds with lifetime renewal guarantee.

**3.1.1 Internal Hospitalization Coverage**
All non-surgical hospitalizations and phototherapies, emergency medical expenses that may cause a life-threatening situation of the Insured are covered under this coverage, provided that the treatment expenses to be incurred by hospitalization exceeding 24 hours are medically necessary and the doctor states this reason in detail in his/her report.
Physical therapy and rehabilitation expenses that are medically obligatory to be performed on an inpatient basis for a condition within the scope of the coverage are evaluated with the limit and contribution share of the Rehabilitation Coverage specified in the Policy.

**3.1.2 Surgical Hospitalization Coverage**
All surgical interventions performed for the purpose of treatment, provided that the medical necessity of the Insured to be hospitalized for more than 24 hours is stated in detail in the doctor's report, and emergency health expenses that may cause a life-threatening situation of the Insured are covered by this coverage.
Coronary angiography, kidney stone crushing (ESWL), kidney, brain, bone marrow and liver biopsies are considered within the limits and participation rates of this coverage.
Ectopic pregnancy and mole hydatiform, which are pregnancy complications, are evaluated within the limits and participation rates of this coverage without any waiting period.
In the event that more than one surgical procedure is performed in the same session with the same or separate incisions and there is a treatment that is not covered, the total invoice (including all hospitalization and doctor's fee) is proportioned according to the HUV Tariff to determine the amount to be paid. In the proportioning to be made, proportioning is made over the total procedure score calculated without applying the incision rule in the HUV Tariff for surgical procedures.

**3.1.3 Room-Companion Coverage**
In all cases requiring inpatient treatment, room and board (limited to 1 person) expenses for each full day are covered under this coverage within the limits specified in the Policy and the special and general terms and conditions of the Policy. Luxury room or suite room expenses are not covered, the coverage is limited to the cost of a standard single-bed room.

**3.1.4 Intensive Care Coverage**
Services provided in the intensive care unit are covered under this coverage. Unless otherwise stated in the Policy, the duration of intensive care hospitalization is limited to 90 days and is considered within the total 180-day hospitalization period during the Policy period. If these periods expire, the coverage for the procedures requiring hospitalization in the Policy will cease until the expiry of the Policy.
The day limits specified for the said intensive care hospitalization period and daily hospitalization period are evaluated starting again in each renewed Policy period.

**3.1.5 Operator and Doctor Expenses**
For all procedures covered under the Inpatient Treatment Coverage, if the treating physician (anesthesia and assistant physicians will also be considered within this scope) is a contracted physician with MAPFRE Sigorta A.Ş. or a permanent physician of the contracted institution, the physician's fee is evaluated with the contracted institution limit and contribution rates specified in the Policy. If the treatment is performed by a non-contracted doctor (permanent or non-permanent temporary doctor) in a contracted/non-contracted organization, the non-contracted limit and participation rates specified in the Policy shall apply for the doctor's fee. The Insured's invoice for a procedure performed by a non-contracted doctor within the scope of inpatient treatment will be evaluated with this coverage limit and participation rates.

The non-contracted doctor's fee paid by the insured is sent to the Insurer for evaluation together with the Patient Information Form and its annexes. The relevant invoices must be in the form of e-invoice, self-employment receipt and/or POS slip issued in accordance with the Tax Procedure Law ("TPL"). Operator doctor, anesthesiologist and assistant fees must be invoiced separately. These fees cannot be included together in the same e-invoice, self-employment receipt / POS slip issued in accordance with the TPL; documents arranged otherwise will not be processed by the Insurer.
The opinion of the Turkish Medical Association shall be taken for physician fees for procedures that are not specified in the HUV's tariff or for which there is a dispute.

**3.1.6 Minor Intervention Coverage**

Minor interventions up to 199 units (including 199 units) specified in the HUV (Physician Practice Database) tariff published by the Turkish Medical Association, as well as dressing, all injection applications, insertion of serum, ear washing; all kinds of plaster application (including those above 199 units), oxygen administration, abscess drainage, gastric lavage, enema, catheter insertion, nail pulling, all kinds of cauterization, endometrial curettage, probe curettage, fractionated curettage and dilated curettage even if it is for treatment purposes, cryotherapy application; all kinds of interventions for pain treatment and all minor interventions such as removal of all benign tumors of the skin regardless of their size and number, provided that the treatment is documented by a doctor's report showing that the treatment is necessary and approved by MAPFRE Sigorta Medical Transaction Center (MIM), in accordance with the special and general conditions in line with the coverage, limits and participation rates specified in the Policy.

**3.1.7 Ambulance**

Expenses incurred for the transportation of the Insured from the province and hospital where he/she is located to the nearest full-fledged hospital by a locally licensed land ambulance due to an illness or accident within the scope of the coverage, or from the province and hospital where he/she is located to another province and hospital by land and/or air ambulance, if deemed necessary by the treating physician and approved by MAPFRE Sigorta Medical Transaction Center (MIM), are covered in accordance with the special and general conditions in line with the relevant coverage, limits and participation rates specified in the Policy. Non-contracted ambulance expenses are evaluated in accordance with the limits and participation rates specified in the Policy.
Air ambulance is valid within the borders of the Republic of Turkey, provided that it is approved by the Insurer.
Emergency cases are taken as basis for ambulance services.

**3.1.8 Chemotherapy, Radiotherapy, Dialysis Coverage**

Expenses related to chemotherapy and radiotherapy (doctor, room and board, medication, venous port opening), blood tests required for these two procedures before chemotherapy and radiotherapy, blood tests for the evaluation of complications that may occur after chemotherapy and radiotherapy and treatment of complications are covered under this coverage in accordance with the special and general terms and conditions of the Policy. Apart from cancer treatments, drugs with the active ingredient "interferon alpha" (Roferon-A or Intron-A) and drugs with the active ingredient "peginterferon alpha" (Pegasys or Pegintron) used in the treatment of Hepatitis C are paid from the chemotherapy coverage.
Expenses related to examinations and tests performed to evaluate the course of the disease before and after chemotherapy and radiotherapy are paid from outpatient coverage, but not from chemotherapy coverage.
In the event that chemotherapy drugs that are not licensed in Turkey are FDA approved for the current health condition of the Insured and invoiced by the Turkish Pharmacists Association, the related expenses are evaluated within the contracted institution co-payment and limit specified in the Policy.
For chemotherapy/radiotherapy performed at a contracted health institution by an external physician who is not a staff physician of that health institution, the fee to be paid to the non-staff physician will

be paid up to the Non-Contracted Physician Expense as stated in Article 3.1.5 of the special conditions of the Policy.

**3.1.9 Accidental Dental Coverage**
Treatment expenses incurred by dentists related to dental/jaw surgery resulting from traffic accidents/forensic accidents and replacement of teeth (provided that the accident report issued by official institutions is submitted and the treatment is performed within 90 days following the accident) are paid from the surgical hospitalization coverage. Precious metals that can be used in interventions to be performed within this scope and materials such as implants and coatings will be considered outside the scope of the Policy.

**3.1.10 Medicine and Consumables Coverage**
Expenses for medicines and consumables used during inpatient treatment are covered by this coverage within the limits specified in the Policy and the special and general terms and conditions of the Policy.

**3.1.11. Artificial Limbs/Prostheses**
Support prostheses approved by the MAPFRE Sigorta Medical Operations Center, which are documented by a doctor to be necessary to be used as a result of an operation and/or a forensic accident after the insurance start date, prostheses implanted externally to the body even if they are compulsorily applied during surgery, artificial limb (eye, hand, arm, leg) expenses are covered from this coverage in accordance with the special and general conditions in line with the limits and participation rates specified in the Policy.
Breast/testicular prosthesis expenses that may arise after cancer treatments are paid from the artificial limb coverage in accordance with the limits, special and general conditions specified in the Policy.
Any prosthesis applied for aesthetic purposes other than those mentioned above are not covered.

**3.1.12 Home Medical Care**
In order for the Insured to benefit from Home Medical Care coverage, he/she must have a tracheostomy, frequent orotracheal aspiration requirement, enteral nutrition requirement, TPN/IV fluid support requirement, ventilator dependency and respiratory failure, advanced oncology patient and pain protocol must be applied.
If deemed necessary by the physician treating the Insured and provided that the Insurer approves, the Insured's Home Medical Care Treatment organization and the expenses incurred are covered from this coverage in accordance with the coverage, limits and participation rates specified in the Policy, in accordance with the special and general terms and conditions, limited to 90 days during the term of the Policy unless otherwise stated. The relevant day limit is not deducted from the annual 180-day hospitalization limit defined for Inpatient Treatment Coverage in the Policy.

**3.1.13 Auxiliary Medical Equipment**
Used as part of the treatment applied to the Insured as a result of an accident or illness occurring after the insurance start date, to support the body externally and for medical purposes only; portable, personalized splint (orthosis, brace, active ankle, bon spur pad), rum walker, walker, nebulizer, elastic bandage, arm sling, corset, orthopedic boot, insoles, elbow brace, compression stockings, neck brace, knee brace, wrist brace, sitting wheelchair, plaster slippers, colostomy bag, urostomy bag; wheelchair (in case of permanent disability documented by a doctor's report), crutches, aerochamber and covering materials used in burn or wound treatment are covered under this coverage within the annual limit and payment percentage specified in the Policy.

**3.1.14 Physical Therapy After Hospitalization**
In the event that the doctor treating the Insured deems it compulsory and the MAPFRE Sigorta Medical Operations Center approves it, the related physical therapy expenses are paid at the limit and participation share rate specified in the Policy, provided that they support the treatments performed after surgical hospitalization or intensive care for a condition covered by the coverage and provided that they are performed within 3 months. After the 3rd month, physiotherapy sessions, if any, will be covered under outpatient coverage.

**3.1.15 Rehabilitation Coverage**
This coverage is activated when the Insured needs inpatient physical therapy with an indication for hospitalization. Within the scope of the coverage, rehabilitation expenses that are medically mandatory to be performed inpatient for a condition are considered as mandatory by the physician treating the Insured and approved by MAPFRE Sigorta Medical Operations Center; at the limit and contribution rate specified in the Policy. Apart from this limit, other coverage such as room and board, doctor follow-up, etc. do not come into force.

**3.1.16 Emergency Diagnosis Coverage**
Expenses for the examination and initial diagnosis of the emergency health condition that caused the Insured to apply to the hospital are covered under this coverage within the limit and participation rate specified in the Policy.
Diagnosis and examination procedures that do not require intervention, even if performed in the emergency departments of health institutions, are considered within the scope of Outpatient Treatment Coverage.

**3.1.17 Robotic Surgery Coverage**
In the event that the treatment is performed with the Robotic Surgery method (such as Da Vinci) deemed appropriate by the doctor and the robotic surgery is approved by MAPFRE Medical Operation Center (MIM) for the relevant diagnosis, the Robotic Surgery coverage specified in the Policy is covered in accordance with the special and general conditions in line with the limits and participation rates.
All kinds of material expenses specially used in this method and all hospital expenses incurred during Robotic Surgery (room, accompanying fees, operator doctor fees, etc.) are paid with this coverage limit and contribution rates.
Regardless of whether the treatment is at a Contracted or Non-Contracted Institution, the doctor's fee for procedures to be performed by a non-contracted doctor (permanent or non-permanent temporary non-employee) is covered in accordance with the limits and participation rates specified in the Policy and in accordance with the special and general conditions. The opinion of HUV shall be taken for the Doctor's fees for the procedures that are not specified in HUV's tariff or for which there is a dispute.

**3.2. Outpatient Treatment Coverage**
Outpatient Treatment Coverage is valid if it is included in the Policy.
Medical examination, diagnostic/advanced diagnostic examinations, prescription medication and session outpatient treatment expenses related to conditions that occur after the insured's start date are considered as outpatient treatment.
In cases where Outpatient Treatment Coverage is obtained, treatment expenses are covered from this coverage in accordance with the limits and participation rates specified in the Policy and in accordance with the special and general conditions. Treatment expenses exceeding the Outpatient Treatment upper limit in the policies are not paid.
Examination, examination and treatment procedures of the insured in any health institution are covered only if approved by MAPFRE Sigorta Medical Transaction Center (MIM) in accordance with the special and general conditions in line with the outpatient treatment coverage, limits and participation rates specified in the Policy.

Outpatient Treatment Coverages cannot be provided alone, but can only be taken together with Inpatient Treatment Coverage.

**3.2.1. Doctor Examination**

Physical examination expenses within the scope of Outpatient Treatment documented with the Health Insurance Patient Information Form and performed by physicians working in hospitals and clinics licensed by the Ministry of Health of the Republic of Turkey or licensed to open private practices are evaluated within the limits, co-payment, exemption and coverage percentages specified in the Policy and special and general conditions.

Since the examinations performed by the same physician up to the 10th day in relation to the diagnosis in the first examination are control examinations, the treatment expenses invoiced in this way are not paid.

In the event that the physicians included in the MAPFRE Sigorta A.Ş. Contracted Physician List perform the authorization process through online systems, the related examination amount will be evaluated 100% within the coverage limits specified in the Policy, taking into account the special conditions.

Expenses related to examinations performed by doctors who do not work as permanent/non-permanent temporary staff at contracted organizations will be paid by the Insured in any case and sent to the Insurer for evaluation. The relevant invoices must be in the form of self-employment receipts and/or POS slips issued in accordance with the Tax Procedure Law.

MAPFRE Sigorta reserves the right to make partial payment or not to make payment for invoices of some doctors/organizations as a result of the evaluation and legal investigations to be made by MAPFRE Sigorta.

If you prefer a non-contracted doctor in our outpatient policies, you should contact MAPFRE Insurance Customer Services, MAPFRE Go and our Corporate Website to confirm the validity of the relevant doctor.

**3.2.2. Prescription Medicine**

Within the scope of outpatient treatment, medications documented with a doctor's prescription, preventive vaccination expenses (rabies, tetanus, influenza, pneumococcus for people over 65 years of age, rotavirus, meningococcus for children aged 0-6 years in addition to the Ministry of Health vaccination calendar) are considered within the scope of this coverage and are covered within the limits, coverage percentage and special and general conditions specified in the Policy.

Expenses for medicines approved by the Republic of Turkey Ministry of Health will not be paid without the original prescription and invoice and/or cash receipt. Our practice for dose limitation in drug purchase is organized as 1 monthly dose. However, the medication must be taken within 7 working days after the prescription is written. After 7 working days, the medication will not be paid by MAPFRE Sigorta A.Ş.

When it is necessary to use medication for chronic diseases, the Insured must apply to the Insurer with a physician's report including the condition, the history of the condition and the planned treatment. If the use of chronic medication is approved, it will be sufficient for the Insured to apply to the contracted pharmacy with the "first doctor's report and/or a copy of the prescription" for the necessary medication during the treatment period within the Policy period. Approved medications requested during the treatment period will be paid within the participation rate and limit specified in the Policy upon presentation of a cash receipt/invoice.

**3.2.3. Diagnostic Examinations**

For conditions within the scope of the coverage, which the medical doctor deems medically necessary for diagnosis and treatment and specified in the Health Insurance Patient Information Form, and which occur within the validity period of the Policy; Expenses for tests, X-rays, hearing tests, USG, Doppler, EEG, EMG, ECG, ECHO, holter and similar diagnostic methods including but not limited to the aforementioned diagnostic methods, medication, anesthesia and physician fees required for the application of these diagnostic methods and other expenses related to the diagnostic procedure are

covered within the limits, coverage percentage and special and general conditions specified in the Policy.
For diagnostic procedures, the Health Insurance Patient Information Form must be filled out completely by the Doctor and each diagnostic procedure deemed necessary by the Doctor must be specified in this form.

**3.2.4. Advanced Diagnostic Examinations**
Any medical procedures deemed medically necessary by a medical doctor for diagnosis and treatment and specified in the Health Insurance Patient Information Form; CT MRI PET-CT and scintigraphies (thallium etc.) endoscopic procedures [gastroscopy colonoscopy (including biopsy) bronchoscopy etc.] angiographies (except coronary angiography) biopsies urodynamics expenses and similar diagnostic methods including but not limited to these specified diagnostic methods medication anesthesia and doctor's fees required for the application of these diagnostic methods other expenses related to the diagnostic procedure are covered within the framework of the limit coverage percentage specified in the Policy and special and general conditions. For diagnostic procedures, the Health Insurance Patient Form must be filled out completely by the Doctor and each diagnostic procedure deemed necessary by the Doctor must be indicated on this form.

**3.2.5. Sessional Outpatient Treatment Procedures**
Physical Therapy and Rehabilitation, PUVA (UVA), Hyperbaric O2, ESWT, etc. expenses deemed necessary by a physician for the treatment of a condition covered by the coverage and approved by MAPFRE Sigorta Medical Operations Center in sessions/day are covered in accordance with the limit, coverage percentage and special and general conditions specified in the Policy. If the treatments to be applied are applied to more than one body region, each region will be treated as one session.

**3.3. Support Outpatient Treatment Coverage**
Support Outpatient Treatment Coverage is valid if it is included in the Policy.
For inpatient treatments resulting in surgery and/or inpatient treatments resulting in a forensic accident, all Outpatient Treatment expenses related to the same case 30 days before and 30 days after the date of hospitalization are covered from this coverage in accordance with the special and general conditions in line with the coverage, limits and participation rates specified in the Policy.
Support Outpatient Treatment Coverage cannot be provided on its own, but can be taken together with Inpatient Treatment Coverage.

**3.4. Maternity Coverage**
Maternity Coverage is only available if it is included in the preferred plan.

**3.4.1. Standard Maternity Coverage**
Hospital expenses for the mother during and after labor and delivery, medical abortion, curettage or miscarriage due to medical necessity and/or any complications caused by pregnancy, and if the Insured has outpatient treatment coverage within the plans determined by the company; All kinds of diseases, routine controls and examinations (amniocentesis, non-invasive prenatal test, TORCH panel, etc.) that may occur during and after the detection of pregnancy are covered under the Maternity Coverage in accordance with the special and general conditions within the annual limit, participation and coverage percentage of the coverage.
Newborn routine infant expenses (first examination and care expenses) are covered within the Maternity Coverage limit, participation and coverage percentage.
Maternity Coverage cannot be provided on its own, but can be taken together with Inpatient Treatment Coverage.
All expenses related to pregnancy and childbirth abroad will be covered within the limits and coinsurance of this coverage.

#### 3.4.2. Family Planning

Non-recurrent family planning methods (sterilization, tubal ligation, spiral applications, etc.) can be paid up to 20% of the Maternity Coverage limit (within the Maternity Coverage limit) under the conditions and coverage specified in the Policy.
Frequently repeated family planning methods (birth control pills, condoms, etc.) are not covered.
In order to benefit from family planning methods, the waiting period for Maternity Coverage must be exceeded.

#### 3.5. Control Mammography and Control PSA Coverage

Mammography expenses of female Insureds aged 40 years and over for control purposes and PSA examination expenses of male Insureds aged 40 years and over for control purposes are paid once a year at 100% for Insureds with inpatient and/or outpatient treatment plans, provided that they are performed at our company's checkup contracted institutions, unless otherwise stated in the Policy.
You can find the details of the contracted organizations that are valid for these examinations within the scope of the Policy at www.mapfre.com.tr.
Costs of mammography/PSA and, if necessary, breast ultrasonography for control purposes performed at other contracted/non-contracted health institutions will not be paid under the Policy.

### 3.6. Dental Treatment Coverage

Dental examinations, panoramic x-rays, fillings, resin, plastic and temporary fillings, tooth extractions, gum diseases, gingivitis (gingivitis), compulsory bridge costs in case of tooth loss, total and partial dentures, detertraj (tooth cleaning) are covered.
Orthodontics, cosmetic dental expenses, night plaque, metal, gold or other precious veneers and routine dental check-ups, Orthodontic appliances (treatments applied to correct irregularities in the teeth or teeth in the wrong position or to prevent such formations) are not covered.
For dental claims, it is mandatory to submit a dental diagram in the invoice attachment.

Dentist prescriptions are paid from dental coverage.  Dental and maxillofacial surgeries will be paid from the dental coverage.
If the relevant coverage is added to the policy, it is indicated in the policy coverage table.

### 3.7. Eye Treatment Coverage

The eye coverage covers prescription glasses lenses and frames, non-cosmetic contact lenses and lens solutions up to the annual maximum limit upon the written recommendation of an ophthalmologist. Eyeglass prescription will be valid for 1 year.

Cosmetic lenses, sunglasses, voluntary lens replacement without a doctor's recommendation and voluntary spectacle frame expenses are not covered.

For the assessment of compensation, it is mandatory to submit a spectacle diagram and accompanying spectacle warranty certificate in the invoice attachment. For the payment of lens invoices, the prescription must be sent with the invoice.
The insured's microbial and viral infections and other eye-related conditions (whether optical or not) during the period will be paid from the doctor's visit in the outpatient coverage at the diagnosis stage and will not be included in the eye coverage.

If the relevant coverage is added to the policy, it is indicated in the policy coverage table.

**3.8. Overseas Treatment Coverage**

The Insured's inpatient treatment expenses incurred overseas after the inception date of the insurance, which require internal/surgical hospitalization and are covered under the coverage (as defined in the Domestic Inpatient Treatment Coverage) are covered under this coverage in accordance with the limit, participation and coverage percentage specified in the Policy and in accordance with the special and general terms and conditions.
Expenses for medical examinations, medication, diagnostic and advanced diagnostic examinations and physiotherapy expenses related to the Insured's illnesses that occur overseas after the inception date of the insurance are covered under this coverage in accordance with the limit, participation and coverage percentage specified in the Policy and in accordance with the special and general terms and conditions.
Except for the case of continuous Inpatient Treatment within the policy period, the coverage of the Insured who resides overseas for more than 3 months without interruption shall cease as of the third month of his/her stay abroad, unless there is a special agreement in the Policy. The Insurer shall not pay any compensation for the treatment expenses incurred overseas during the cessation of coverage. If the Insured enters the customs of Turkey before the End Date of the Insurance Policy, the coverage will start again. For this reason, the Insured must notify the Insurer if he/she needs to stay overseas for more than 3 months. The Insurer reserves the right to suspend or continue the coverage with special conditions depending on the destination country.
The same special and general conditions apply for overseas and domestic coverage.
Invoices for medical expenses covered under inpatient and/or outpatient treatment overseas are calculated in Turkish Lira at the Effective Selling Rate of the Central Bank of the Republic of Turkey on the invoice date (or in TL equivalent at the US/USD cross rate if the currency of the relevant country does not have an equivalent at the Central Bank of the Republic of Turkey) and paid to the Insured in accordance with the limit, participation and coverage percentage specified in the Policy and in accordance with the special and general terms and conditions. The Insurer reserves the right to ask the Insured to document that he/she was abroad in the relevant country at the time of the expenses in question in order to be able to evaluate such foreign expenses and make the relevant invoice payments. In order for the relevant payment to be made under the coverage, a notarized translation of all relevant documents must be submitted to the Insurer.

## ARTICLE 4. STANDARD WAITING PERIODS

The following conditions are excluded from the coverage of all treatments during the relevant waiting periods, unless they are the result of a forensic accident as of the Insured's Registration Date. In the event that the Insurance Policy is continued and renewed in accordance with the renewal conditions and the Insurer does not make a special exception for one of the situations listed below, the standard Waiting Periods listed below shall not apply and shall be included in the coverage for the Insureds who have completed the 12-month insurance period without interruption and who have completed this Waiting Period if an additional Waiting Period has been set by the Insurer.

**Cases with a 12-month Waiting Period, Unless Caused by a Judicial Accident**

**1.** All hernias.
**2.** Anorectal diseases (hemorrhoids, anal fistula and fissure, anal abscess, etc.) pilonidal sinus (cyst dermoid sacral).
**3.** Tonsillectomy, adenoid vegetation surgery, eardrum surgery and tube application, sinus surgery.
**4.** Excision of all benign tumors, space-occupying lesions, nevi, polyps and hyperplasia, etc.
**5.** Thyroid and parathyroid diseases.
**6.** Diseases and operations related to cervix, uterus, ovaries and tubes, endometriosis, cystorectocele.
**7.** Hydrocele, spermatocele, cord cyst and epididymal cyst.
**8.** Spine and disc diseases, all kinds of joint disorders (knee, shoulder, etc.) trigger finger, ligament and tendon disorders, carpal tunnel, tarsal tunnel.
**9.** Varicose veins and vein thrombosis.

**10.** Stony diseases of the urinary system, prostate surgeries.
**11.** All endoscopic, laparoscopic procedures and angiographies (except diagnostic procedures).
**12.** Cataract, glaucoma, keratoplasty.
**13.** Gallbladder and biliary tract diseases.
**14.** All chronic disease treatments and home care services for chronic diseases (hypertension, ulcers, reflux, inflammatory bowel diseases (ulcerative colitis, crohn's, etc.) COPD, asthma, diabetes, demyelinating diseases, myasthenia gravis, sarcoidosis, nephritis, all rheumatic and connective tissue diseases.
**15.** All conditions covered under the Maternity Coverage (Pregnancy routine checks, normal or cesarean delivery, miscarriage and/or any complications arising therefrom, etc.).

## ARTICLE 5. STANDARD EXCEPTIONS

In addition to the Out-of-Coverage conditions specified in Article 2 of the General Terms and Conditions of Health Insurance, the following conditions are excluded for all Coverages of this Policy.

**1.** Congenital and genetic diseases determined after the Policy Start Date, even if they occur at an advanced age, premature infant and incubator expenses (even if the infant is insured from birth), unless otherwise specified in the contract

**2.** Expenses related to examinations and treatments for pes planus, hallux valgus/rigitus.

**3.** Dementia caused by old age, Alzheimers, Parkinson's, epilepsy and antipsychotic, anxiolytic, anticonvulsant and all psychotropic drugs used in the treatment of these conditions,

**4.** Operations for nasal septum and concha.

**5.** Expenses for examinations and treatment of strabismus, otosclerosis, keratoconus, ptosis

**6.** All kinds of medical expenses (whether or not diagnosed and/or treated), including existing and undeclared ailments/diseases that existed before the policy start date, and recurrences and complications of these diseases (whether or not diagnosed and/or treated).

7. All kinds of genetic disease/condition investigations, gene mapping, gene screening.

**8.** All kinds of routine and specific examination and treatment expenses related to structural disorders, motor mental development and growth disorders (growth and development retardation/progress, early/late puberty, etc.).

**9.** Mental illnesses and psychological disorders requiring psychiatric treatment, neuropsychiatric tests, all kinds of psychotherapy and all related expenses.

**10.** All kinds of inconveniences and expenses related to accidents that may occur due to driving without a driver's license (the driver's license must be appropriate for the class of vehicle driven by the Insured).

**11.** Expenses related to alcoholism, alcohol (regardless of promile level), drug, stimulant, hallucinogen and other substance addiction and all kinds of diseases, poisoning, disorders and accidents that may occur after the use of these substances.

**12.** All hazardous sports activities, whether amateur or hobby, and/or hazardous activities including but not limited to (mountaineering, diving with a breathing apparatus, airplane and glider piloting, parachuting, parapant, delta wing flying, horseback riding, rafting, street sledding, expenses arising from high jumping sports (such as base jumping), kiteboarding, kitesurfing, underwater sports, mountain biking, motorcycle and automobile sports and electric scooters, electric bicycles and electric motorcycles that do not require a driver's license, skiing, riding motorcycles even for transportation purposes, etc.) and expenses arising from all kinds of professional and/or licensed sports activities are limited to 40000 TL. Among these activities, all expenses related to skiing, motorcycle and ATV use only 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.

**13.** Alternative treatment methods (acupuncture, homeopathy, osteopathy, hypnosis, yoga, mesotherapy, aromatherapy, neural therapy, chiropractic treatments, ayurveda, ozone therapy, spa and drinking treatments, spa and thermal centers, sanatorium, nursing home, nursing home, precentorium and rehabilitation centers.

**14.** All expenses related to unscientific treatments, experimental treatments and medicines and materials not approved by the US FDA (Food and Drug Administration).

**15.** Procedures/treatments that have no equivalent in the HUV (Physician Practices Database).

**16.** All kinds of procedures performed in aesthetic, cosmetic, laser and beauty centers, lens and optical centers, centers without a Ministry of Health work license, healthy living centers, traditional / complementary and alternative medicine centers, anti-aging centers, slimming centers, sports centers, life coaching centers and foot health centers and all expenses related to these procedures (examination, examination, diagnosis, treatment, etc.).

**17.** All kinds of procedures performed by medical doctors and non-medical doctors who do not have a license from the Ministry of Health and all expenses related to these procedures.

**18.** Expenses related to nasal valve surgery.

**19.** Expenses incurred for obtaining a medical board or doctor's report for reasons such as before sports, before marriage, before starting work.

**20.** Invoices issued by 1st degree relatives of the insured.

**21.** Expenses related to screening tests such as coronary artery calcium scoring, coronary VCT angiography, EBT (Electron Beam Tomography), virtual angiography and virtual colonoscopy.

**22.** Analysis expenses from organizations without a laboratory license.

**23.** All expenses incurred for the removal of the Insured's special exception.

**24.** Expenses related to Inpatient Treatments that are not indicated by the MAPFRE Insurance Medical Operations Center in accordance with the reports received from the hospital and expenses related to diagnoses and treatments that are not related to a specific complaint and/or disease (Check-up, routine check-up, etc.).

**25.** Unless it occurs as a result of a forensic accident and disease (cancer, burns, etc.) occurring during the validity period of the Policy; All expenses related to plastic and reconstructive surgery, all kinds of aesthetic and cosmetic interventions and related complications, telangiectasia, treatments for skin hemangiomas, gynecomastia, antiperspirant and related examinations and treatment procedures, rhinoplasty, abdominal aesthetics, acne diagnosis and treatment, hair loss diagnosis and treatment (except alopecia areata), all kinds of breast reduction and augmentation surgery and accessory breast operation.

**26.** All expenses related to the diagnosis or treatment of obesity, weight, appetite disorders, surgery and complications, dietician, weight loss and weight gain program.

**27.** All examination and treatment expenses related to uvuloplasty, snoring, sleep apnea

**28.** All examination and treatment expenses related to scoliosis and all spinal curvatures

**29.** Examination, diagnosis, treatment and complication expenses of physicians who apply balanced nutrition, diet-exercise programs, alternative and/or complementary therapies.

**30.** Hearing defect surgery (except for tube insertion, tympanoplasty, chronic otitis sequelae, etc.) and all related examinations and treatment procedures, voice and speech therapies.

**31.** For children under 7 years of age, expenses related to cord cyst, hydrocele, all kinds of hernia procedures (not applicable for MAPFRE Sigorta infants).

**32.** Medical supplies not covered under the auxiliary Medical Supplies Coverage defined in Article 3.1.13, CPAP device, its calibration and monitoring, humidifiers used at home, external devices (hearing aids, cochlear implants, etc.), injectors not taken with medication, patches, telephone, TV, cafeteria, administrative service, paramedical service and other expenses not required for treatment such as service fees, and all kinds of external prostheses and support prostheses (those that cannot be evaluated under the Inpatient Treatment Coverage).

**33.** Vaccines for allergies, allergy tests, skin prick tests, food intolerance tests, all kinds of immunotherapies (except for the treatment of metabolic and autoimmune diseases)

**34.** All examination, treatment and complication expenses related to optional curettage, infertility, sterility, miscarriage research and ensuring pregnancy (IVF, follicle follow-up, microinjection, tuboplasty, etc.) hystero salpingography (HSG), spermiogram, adhesiolysis expenses.

**35.** Varicocele expenses, whether or not related to infertility (except for varicocele under the age of 18).

**36.** Expenses for sex reassignment operations, impotence, peyronie, penile chordia, vaginismus, all examinations and treatments related to sexual dysfunctions (including penile prosthesis) and birth control methods (pills, condoms, etc.) not covered by Article 3.4.2.

**37.** Syphilis, anogenital condylomas, HIV, AIDS and all related examination and treatment expenses regardless of the route of transmission.

**38.** All expenses related to circumcision and phimosis, even if medically necessary.

**39.** Expenses related to sclerotherapy, laser, radiation, massage, stockings, etc. applied for superficial varicose vein treatment.

**40.** Donor-related costs in organ, tissue and blood transplantation.

**41.** Expenses related to cord blood and stem cell collection and storage.

**42.** All expenses related to officially declared epidemics and maliciously initiated epidemics.

**43.** All vaccines except rabies, tetanus, influenza, pneumococcus for people over 65 years of age, rotavirus, meningococcus in addition to the Ministry of Health vaccination calendar for children aged 0-6 years (including pre or post vaccination examinations and vaccine administration fees) and all kinds of protective procedures against the disease.

**44.** Pursuant to Article 98/2 of the Social Insurance and General Health Insurance Law No. 5510, the contribution fees that insured persons are obliged to pay.

**45.** Private nursing expenses not approved by the MAPFRE Sigorta Medical Operations Center (except for Home Care Coverage) and ambulance expenses other than emergencies (described in Article 2 Definitions), all expenses of auxiliary health personnel (such as physiotherapists, respiratory therapists, caregivers).

**46.** Examinations performed by the practicing physician (except for basic laboratory tests approved by the Ministry of Health).

**47.** Medicines not licensed by the Ministry of Health, preparations that do not contain active ingredients that do not fall under the definition of medicine, all kinds of substances and chemicals licensed by the Ministry of Agriculture, all medicines not officially imported (except for medicines imported with the permission of the Ministry of Health that are not available in Turkey and have no equivalent), vitamin-mineral combinations and/or nutritional preparations and medical foods used to meet the daily needs of the body and/or to protect general health.

**48.** All expenses related to examination by dentists and maxillofacial surgeons, gum treatment and jaw treatments, toothpaste, oral and dental care preparations, etc.

**49.** Eyeglasses-lenses, lens solution, toric and multifocal lenses, and all kinds of diagnostic, examination and treatment expenses for lazy eye, refractive errors (myopia, etc.), misalignment of the eye, except for MAPFRE Babies.

**50.** All kinds of medical equipment and/or device usage/rent fees (excluding those covered under home care coverage).

## ARTICLE 6. GEOGRAPHICAL SCOPE

It is valid for persons residing within the borders of Turkey. Domestic coverage is valid throughout Turkey, while overseas coverage is valid throughout the world outside Turkey.

## ARTICLE 7. PRINCIPLES OF COVERAGE APPLICATION

### 7.1. Limit Applications

Annual Total Limit: In the Policy attached to the Insurance Policy, limits that may vary per disease and/or coverage are specified, and transactions are made by deducting the contribution share, if any, for the relevant coverage from these limits.
The amount of indemnity to be paid is determined by first deducting the requested indemnity amount from the relevant limits and then deducting the participation share related to the collateral, if any. However, in any case, this amount cannot exceed the limit of the main collateral to which the relevant transaction will be valid.

Annual Inpatient Treatment Total Day Limit: The total number of days the Insured will be hospitalized in the Hospital in a Policy Period is 180, and maximum 90 days of this limit is used for intensive care. For this purpose, each day of hospitalization will be counted as one day. For each renewed Policy Period, the relevant limits will be re-evaluated.
Lifetime Inpatient Treatment Total Day Limit: The total number of Inpatient Treatment days that the Insured can benefit from during his/her lifetime is 720 and will be valid for the years in which the Insured renews the Policy without interruption. For this purpose, each day of hospitalization will be counted as one day. If the Inpatient Treatment Lifetime Total Day Limit is exhausted, all coverages of the Insured whose limit is exhausted will automatically terminate on the day the limit is exhausted. If the lifetime days limit (720 days) is exceeded, the Insurer has the right not to renew the Policy. Lifetime total days limit for inpatient treatment is not applicable for Insureds with lifetime renewal guarantee.
Continued Hospitalization Limit after the Policy End Date: Expenses of hospital treatments that started while the Insurance Policy was in force and continued uninterruptedly until a date after the End Date of the Insurance Policy are covered up to the 10th day after the End Date of the Insurance Policy, unless the insurance period expires and a new contract is concluded. In the event that the Insurance Policy is canceled or the Insured is excluded from the coverage of the Insurance Policy or changes the coverage plan, the costs of hospital treatments after the date of cancellation, exclusion or plan change are not covered without any conditions.

**7.2. Payment Percentage, Participation Fee Practices**
The portion to be paid by the Insurer for the medical expenses within the scope of the coverage specified in the General Terms and Conditions of Health Insurance and the Special Terms and Conditions of this Insurance Policy, taking into account the coverage percentage, limits and exemptions specified in the Policy, is determined as the Acceptable Compensation. The participation share remaining from the coverage percentage specified in the Policy shall be covered by the Insured/Policy Owner.

**7.3. Exemption Applications**
It is the total annual limit amount that the Insurer is not liable to pay, which may vary according to the coverage in the Policy attached to the Insurance Policy.
In a Policy with only Inpatient or Inpatient and Outpatient Treatment, in order for the payment of medical expenses to commence, the deductible amount is first deducted from the coverage (Inpatient, Outpatient and/or Maternity) for which the invoice will be evaluated, and the portion exceeding the deductible amount is paid in accordance with the limit, participation, special and general conditions specified in the Policy.

## ARTICLE 8. PAYMENT OF INDEMNITY
Provision approvals received for treatments to be performed at Contracted Healthcare Institutions are valid if they are realized within 7 days. Re-authorization is required for procedures not performed within this period. Within 7 days, MAPFRE Sigorta A.Ş. reserves the right of refusal for the procedures that are not performed and re-authorization approval is not obtained.
In addition to the expenses incurred at the Contracted Institutions, if the original invoices showing the medical expenses related to the payments made by the Insured at the Non-Contracted Institution other than the expenses incurred at the Contracted Institutions and other necessary documents (doctor's report, test results, etc.) are submitted to the Insurer in full, the evaluation will be completed within 5 business days, and the claims eligible for payment will be paid within this period.
For policies where the insurance premium is paid in installments, in the event of the occurrence of the risk, the remaining installments shall become due and payable and shall be deducted from the compensation to be paid to the Insured.
In a Policy with Inpatient Only or Inpatient and Outpatient Treatment, in order for payment for medical expenses to commence; regardless of the coverage (Inpatient, Outpatient and/or Maternity) from which the invoice comes, the deductible amount is deducted first and the portion exceeding the

deductible amount is paid in accordance with the limit, participation, special and general conditions specified in the Policy.
In the event that the Policy expires and is not renewed while hospital treatments are in progress for health conditions notified to and accepted by the Insurer during the insurance period, treatment expenses for 10 days after the expiration of the Policy shall be paid by the Insurer.
Within the scope of the Inpatient Treatment Coverage and within the scope of the Policy, invoices from state hospitals affiliated to the Ministry of Health and university hospitals affiliated to the state will be evaluated within the participation and limits of the Contracted Organization.
In the event of death of the Insured during treatment, morgue expenses will be covered within the limits and participation rates of this coverage.
A notarized translation of all necessary documents must be submitted to the Insurer for payments made in a foreign language for medical expenses incurred overseas.
You are required to see your invoice after any kind of medical treatment and to check the cost on your behalf; in particular, you are required to review and sign the hospital discharge invoices after all hospitalizations.
In order for payments to be made under the Inpatient Treatment coverage, the following documents must be submitted to the Insurer.
**1-** Documented hospital bills signed by the insured, medical report showing the reason for hospitalization.
**2-** Detailed operation report for surgical interventions (including pathology result report if a fragment was taken).
**3-** When deemed necessary, observation file, traffic accident report, forensic report, forensic report, alcohol report, statement of the insured.
**4-** Epicrisis (flow summary) report.
**5-** Endoscopic (laparoscopic, arthroscopic, arthroscopic, robotic, thoracoscopic, etc.) surgery videos when deemed necessary. The following documents must be submitted to the Insurer in addition to the Health Insurance Patient Information Form in order to make payments under the coverage in the documentation of Outpatient Treatment expenses.

**For Doctor Examinations**
**1-** Invoice or self-employment receipt showing the doctor's fee (Dr. stamp and branch must be specified) (Cash register receipts are invalid).

**2-** If an ultrasound was performed during the examination, the original or report (medical record when necessary).
MAPFRE Sigorta reserves the right to make underpayment or non-payment for invoices belonging to certain organizations as a result of the evaluation and legal investigations to be made by MAPFRE Sigorta. Please confirm the validity of the relevant doctor by contacting the Customer Services representative at MAPFRE Sigorta Go, MAPFRE Sigorta Website, 0850 755 0 755 number or musterihizmetleri@mapfre.com.tr in case you prefer a non-contracted doctor in our policies.

**For Medicine Expenses**
**1-** Original prescription of the relevant doctor (and doctor's report when necessary).
**2-** Cash register receipt or invoice.
**3-** If deemed necessary, the drug name and prices of the drug and the barcodes of the drug.
**4-** Doctor's report for medicines used continuously.
**For Diagnostic and Advanced Diagnostic Examinations**
**1-** Doctor's request letter/dispatch note or report.
**2-** Invoices showing related expenditures.
**3-** Examination results, reports, medical records when necessary.
**For Physical Therapies**
**1-** Imaging results that require treatment (MRI, Ultrasound, etc.).

**2-** Doctor's request letter, detailed report showing the treatment he/she has organized (the treatment required for each session and the total number of sessions must be specified).

**For Maternity Coverage**
**1-** Relevant birth and doctor report.
**2-** Documented hospital invoice.
**3-** Observation file when necessary.
**4-** Gynecological USG report, pathology result or Beta HCG result in mandatory curettage.

## ARTICLE 9. RENEWAL OF THE CONTRACT AND LIFETIME RENEWAL GUARANTEE

**9.1. Renewal of Contract**
This insurance is valid for a maximum period of 1 year. However, following the expiry date of the insurance, a new Policy may be issued upon the request of the Insured/Policy Owner in accordance with the principles to be determined by the Insurer. In case of a request for a plan upgrade change during the renewal period, a health declaration form may be requested.
The Insurer decides on the Policy Renewal Terms by examining the health status and/or loss/premium ratio of the Insured who does not have a Lifetime Renewal Guarantee during the insured period.
In the event that the Insurer makes conditional acceptances for the previous period and/or ongoing conditions to be valid in the new contract, provided that the Lifetime Renewal Guarantee provisions are reserved, these conditional acceptances will be valid as long as the Policy is renewed and the parties do not decide to invalidate it. Even if the Lifetime Renewal Guarantee is available at the time of renewal, the Policy Owner may apply to the Insurer to expand the Coverage Scope in the Insurance Policy and/or to add different products, networks, different coverage. The Insurer reserves the right to request a new application form, reject the application, or accept the application conditionally (Additional Premium, limit, participation, etc.) in relation to this change request. The waiting period starts again for the newly added coverage.
In addition, Policies are renewed with the current premium, tariff and special conditions.
The Insured may apply to the Insurer for a new contract (Policy) 30 days before or 30 days after the expiry date of the existing Policy.
If 30 days or more have passed since the renewal date, a new application form will be issued for the Insured as a new insured and he/she will join the insurance as a new insured. His/her vested rights and Lifetime Renewal Guarantee will not be valid, and a risk analysis will be made for his/her existing diseases.
The discounts earned in the previous Policy, such as those arising from the claim/premium ratio, etc. will not be valid.
The Insurer reserves the right not to cover the risks occurring during the period until the new Policy is issued, to cover them with conditional acceptances (limit, Risk Supplementary Premium, participation, waiting period, etc.) in accordance with the Risk Acceptance Regulation, and to revoke the validity of renewal rights. The Insured must comply with the declaration obligation stipulated in Article 6 of the General Terms and Conditions of Health Insurance and Article 1435 of the Turkish Commercial Code during renewal.

**9.2. Lifetime Renewal Guarantee**

"Lifetime Renewal Guarantee" can be given to the insured who has a group health insurance policy, provided that the insured continues the insurance with the same coverage for 3 years without interruption at Mapfre Sigorta A.Ş., is insured before the age of 55, and the average Damage/Premium ratio for the last three years is below 80%, as a result of the risk analysis assessment to be made, within the conditions to be determined.

The insurer may request medical examinations to evaluate the health risk of the insured who applies for "Lifetime Renewal Guarantee". Depending on the health condition of the insured and in line with the risk acceptance regulations in force, the Insurer reserves the right to reject the "Lifetime Renewal Guarantee" request, to accept it conditionally (limit, risk additional premium, participation share, waiting period, etc.) or to grant "Lifetime Renewal Guarantee" without applying any conditions.

The Lifetime Renewal Guarantee is personalized and belongs to the Insured who has earned this right. The "Lifetime Renewal Guarantee" granted by the Insurer to the Insured shall be indicated on the certificate of each Insured.

In the policies to be transferred from another insurance company to Mapfre Sigorta A.Ş., risk analysis will be made for the insured with or without renewal guarantee, and limit, contribution share, exception, additional risk premium, etc. applications may be in question. However, the additional risk premium that may be charged shall not exceed 200%.

The lifetime renewal guarantee right acquired in the previous company will be re-evaluated according to Mapfre Sigorta A.Ş. criteria, and as a result of the risk analysis, the insured's renewal guarantee right may be continued with the current special conditions of the Insurer.

For an Insured who has been granted "Lifetime Renewal Guarantee", the Insurer does not have the right to make a risk analysis assessment and to apply a new additional condition such as risk surcharge, exception, limit, or surcharge according to the indemnity/premium ratio, except for the cases specified in Articles 6 and 7 of the General Terms and Conditions of Health Insurance, due to disease conditions that arise after the date of the lifetime renewal guarantee.

In the event that the Insured wishes to extend the coverage, the Insurer reserves the right to re-evaluate the existing "Lifetime Renewal Guarantee" and to apply limits, co-payments, exclusions, risk surcharges, etc. according to the risk analysis.

The health policy offered by the Insurer to its Insureds to whom the Insurer has made a lifetime renewal guarantee commitment is subject to the Special Terms and Conditions in force at the date the policy gains the right to lifetime renewal guarantee. For Insureds without a Lifetime Renewal Guarantee, the Special Conditions of the policy in force at each policy term will apply.

In the event that the insured leaves the scope of the Group Health Insurance for which he/she is entitled to Lifetime Renewal Guarantee and requests an individual health policy, the Insurer has the right to apply an exception, risk surcharge, limit, co-payment by performing a risk analysis for the diseases included in the Group Health Policy until the date the Lifetime Renewal Guarantee is granted/earned.

## ARTICLE 10. PREMIUM DETERMINATION

### 10.1 Criteria for Premium Determination

The insurer determines Group Health Insurance premiums by taking into account criteria such as the size of the group, past utilization, age/gender of the insured, insurance period, coverage structure, coverage limit and inflation rate. Instead of premium setting on an individual basis, premiums can be set according to the number of policy owners in the group and age and gender distribution. In addition, changes in the Health Service Tariff (Turkish Medical Association minimum wage tariff, SUT units and

coefficients, HUV units and coefficients) are taken as a basis for health inflation in the evaluation. In case of any changes in the Health Service Tariff, a revaluation is made. The policy premium is calculated based on the age at the insurance start date (the difference between the start date and the date of birth calculated in days/months/years).

**10.2 Premium Payments**

The method, maturity and amounts of the premium payments are specified on the application and/or the premium payment form. The Insured may make all premium payments in advance and/or in installments in accordance with the payment plan approved by the Insurer, by choosing one of the following collection options.
The obligation to pay the premiums written on the Policy in the relevant terms belongs to the Policy Owner or the Insured, if any.

**a) Payment by Credit Card**

The insured is obliged to fill in the payment plan information specified in the application form completely and accurately on the Payment Notification Confirmation Form.
The premiums on the policy are collected from the credit card at the relevant maturities. In case the account is not available, the provisions of Article 8 and additional articles of the General Terms and Conditions shall apply.

**b) Payment by Check**

The Insured / Policy Owner can pay the premium amount specified on the Policy by check according to the payment schedule.

**c) Payment by Bank Transfer**

The Insured can transfer the premium amount specified in the Policy payment schedule (for down payment, the bank receipt must be sent with the application).
The name of the Insured and the Policy number must be written in the explanation section of the wire transfer. The Insurer shall not be responsible for the non-transfer of payments that do not include this information to the relevant Insured's account.

## ARTICLE 11. NEW ENTRY PROCEDURES

**11.1. Period of Insurance and Admission to Insurance**

The term of insurance is 1 year and remains in force between the start and end dates specified in the policy. Insurance coverage becomes effective upon acceptance of the application by the Insurer, issuance of the policy and payment of the down payment.

The insurance policy covers infants older than 14 days and persons under the age of 64 (inclusive) at the first entry into our company. The Policy Owner must be over 18 years of age.
There is no age limit for renewals in our company for policy owners who have received a lifetime renewal guarantee.
Children between the ages of 0-18 can be covered as part of a family and/or with at least one legally dependent person. Upon request, unmarried children of the insured who are dependent and studying (provided that they are documented) can be covered under the policy until the age of 24.

Unless otherwise stated by the insurer, residents residing within the borders of the Republic of Turkey are accepted for insurance. Changes in the country of permanent residence after the inception of the policy must be notified to the Insurer in writing within one month at the latest. The Insurer reserves the right to request a passport to determine such a situation and not to pay expenses incurred overseas.
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**11.2 Applications**

All initial and subsequent applications to be made by the Policy Owner / Insured candidates must be made with the application forms provided by the Insurer, and the declaration sections regarding the Persons to be Insured must be filled in completely and accurately. All applications and/or amendment requests for the Insurance Policy must be in writing and signed in writing.
The Insurer has the right to obtain information and request documents from persons and institutions treating the Insured with the written consent of the Insured.

In cases where the Insured authorizes the Insurer to access his/her health history information, the Insurer may request a physician's opinion, examinations, etc. if deemed necessary by the Insurer to determine the health status of the Insured. In this case, the costs related to such procedures shall be covered by the Insurer. However, in the event that the necessary documents cannot be obtained from the relevant institutions despite the authorization of access to the health information of the Insured, the costs of physician's opinion, examinations, etc. that may be required will be borne by the Insured and/or the Insurer.
In cases where the Insured has not authorized access to health history information, the Insured and/or the Policy Owner shall bear the costs of physician's opinions, examinations, etc. that may be required.
The Insured must apply to the Insurer at each policy renewal period, even if he/she has received a Renewal Commitment.
The Insurer reserves the right to reject the application and accept it with standard conditions or conditional acceptance (additional premium, limit, participation, etc.) according to the risk analysis evaluation, provided that the employee who is insured under the group policy and who has not received a renewal guarantee applies individually (individual policy) within 30 days at the latest from the date he/she leaves the scope of the contract, provided that he/she chooses a plan with the same or lower coverage in the last Insurance Policy.
In order for newborn babies to be covered by the policy, the application form must be completed within 2 months at the latest. Newborn babies are covered 14 days after birth (except Mapfre Sigorta A.Ş. Infant defined in Article 11.3).

If the policy premiums are paid by the policy owner, spouse and child entries are included in the policy as of the date specified by the policy owner (at the latest 1 month backward from the application form declaration date).

If the policy premiums are paid by the personnel themselves, spouse and child entries are included in the policy only if they are reported during the renewal period of the group policy (except for newborn infant and new marriage cases).

**11.3 MAPFRE Sigorta A.Ş. Infant**

Infants born to mothers who are insured at Mapfre Sigorta A.Ş. will be included in the policy coverage as of the date of birth by performing a risk analysis if they apply to our company with the newborn infant application form and the infant's hospital epicrisis report within 2 months after discharge from the hospital. After the risk assessment to be made, these infants who are included in the scope of insurance from birth will be named as "Mapfre Sigorta Infant" and a renewal guarantee assessment will be made for these infants.

As a result of the assessment, no exception will be applied for congenital diseases for these infants who are entitled to receive a Renewal Commitment.
This condition will apply if the infant is healthy and has no existing congenital diseases.

The newborn hospital expenses of the infant covered by the health insurance from birth will be covered from the maternity coverage.

In transfers from different companies, the current "standard exception for congenital diseases" will not be applied for babies who are "company infants", insured as of the date of birth, have a renewal guarantee, and whose congenital diseases are covered in this case, and who are transferred to Mapfre Sigorta under these conditions (transferred with vested rights). (For this situation, the prerequisite is that the infant is healthy and does not have any existing congenital diseases).

**11.4. Responsibility of the Policy Owner**

In the event that the Policy is canceled or the Insured is excluded from the scope of the Policy, the Policy Owner is responsible for returning to the Insurer the documents issued on behalf of these persons who are excluded from the scope of the Policy. Losses arising from the failure to return the documents in full shall be recourse to the Policy Owner.

The Policy Owner/Insured is obliged to answer the questions asked to him/her in the application form and supplementary documents correctly and to declare the information that constitutes the subject matter of the risk and/or will be effective in its evaluation.

If the declaration of the Insured/Policy Owner is untrue, incomplete or incorrect, the provisions of Article 6 of the General Terms and Conditions of Health Insurance shall apply. Without prejudice to the rights of the Insurer pursuant to Article 6, the Insurer shall have the right to evaluate the diseases not declared by the Insured/Policy Owner and include them within the scope of coverage with conditional acceptance (out of scope, Additional Premium for Risk, etc.).

The Insurer shall be entitled to collect from the Insured and/or the Policy Owner any expenses incurred in violation of the General and Special Terms and Conditions of the Health Insurance Policy and any payments made outside the scope of coverage.

## ARTICLE 12. TRANSITION PROCEDURES AND VESTED RIGHTS

**12.1 Transition from Other Insurance Companies**

While renewing the Policy as a transfer from another company, the Insurer has the right to request a health declaration from the Insured, request additional examinations, request a doctor's examination when deemed necessary, limit the coverage and/or make conditional acceptances (limit, Risk Additional Premium, participation share, waiting period, etc.), without prejudice to the provisions of the Lifetime Renewal Guarantee, if any. For the Insured who transfers from another company with the Lifetime Renewal Guarantee right, the Lifetime Renewal provisions of our company shall apply.

The ailments of the person in the other insurance company/companies and/or the ailments that are determined to date back to before the first insurance date are not included in the scope of vested rights, even if they were paid in the previous insurance company, if they were not declared in the application form. These conditions are excluded from the coverage.

Vested rights refer to the removal of the waiting periods in the special conditions and the rights he/she had in his/her previous Policy. Rights that are included in the special terms/content of the Insured's previous Policy but not in the special terms/content valid for the new insurance period will not be considered as vested rights.

However, the rights that are included in the special conditions applicable for the new term but not included in the special conditions of the previous term will also be valid for the Insured.

In order to grant vested rights, the Insured's first insurance enrolment date will be taken as a basis. The Insured must apply within 30 days at the latest as of the end date of the insurance in order to preserve the initial enrolment date.

**12.2 Transition Practices from Existing Group Policy to Individual Policy at MAPFRE Sigorta A.Ş.**

In the event that the personnel insured under the Group Policy who have not received a renewal guarantee applies individually (Individual Policy) within 30 days at the latest from the date of leaving

the scope of the contract, the Insurer reserves the right to reject the application and accept it with standard conditions or conditional acceptance (risk additional premium, limit, participation share, exception, etc.) according to the risk analysis evaluation.

In the event that the Insured personnel, who has a lifetime renewal guarantee with the condition of continuing to be insured for at least 6 months without interruption within the scope of the group policy in our company, leaves the Group Health Insurance Policy (due to retirement, dismissal or resignation), he/she must apply for a Personal Policy with a notice of dismissal within 30 days at the latest. If there is no equivalent product to the Group Health Insurance product previously owned by the Insured, the Policy can be continued with one of the individual tariffs with the closest plan. In the evaluation of the transition to the Individual Health Policy, the Insurer may apply exceptions, risk surcharge, limit, and co-payment by performing a risk analysis for the diseases included in the Group Health Policy until the Lifetime Renewal Guarantee date.

In the event that the Insured, who is covered under the Group Policy, applies for a Personal Policy without leaving the group, whether or not the Insured has a lifetime renewal guarantee, a risk analysis will be made in the transition to the Personal Policy, and conditions such as rejection of the application, application of an exception or application of a Risk Additional Premium may be applied according to the evaluation result.
If the Insured has an active Group Policy with Maternity Coverage and is insured in a new Personal Policy with Maternity Coverage, a 12-month waiting period will apply as of the Personal Policy start date.

## ARTICLE 13. PRINCIPLES OF TERMINATION OF THE INSURANCE CONTRACT

**13.1 Cancellations**
If the Policy Owner/Insured requests cancellation within 30 days after the issuance date of the Policy; in cases where the risk has not occurred, the Policy shall be cancelled as of the Inception Date and the premiums paid shall be returned to the Insured without interruption.
For claims approved by the Insurer and exceeding 30 days, the Insurer is entitled to premium depending on the time elapsed from the Policy Inception Date. The amount to be refunded to the Insured/Policy Owner due to cancellation is calculated on a daily basis taking into account the compensation paid.
If the indemnities paid to the Insured do not exceed the premium amount to which the Insurer is entitled, the Insurer shall deduct the premiums it is entitled to receive from the premiums collected and return the remaining premiums to the Insured. If the indemnities paid to the Insured exceed the premium amount to which the Insurer is entitled but do not exceed the premium amount collected by the Insurer, the Insurer shall deduct the relevant indemnity amount from the premium amount collected and return the remaining premium to the Insured.
If the amount of indemnity paid to the Insured exceeds both the premium amount to which the Insurer is entitled and the premiums paid by the Insured, the premium is cancelled without refund. When the risk is realised, even if the premiums are not yet due, the part of the premiums up to the amount of the compensation amount that the Insurer is obliged to pay becomes due and payable.
The Policy Owner shall be in default if he fails to pay any of the premiums, the exact due dates and amounts of which are specified on the Policy, by the due date. The provisions of Article 1434 of the Turkish Commercial Code shall apply in case of failure to pay the premium debt on time.
In cases where the Insurer detects malicious acts of the Insured/Policy Owner (benefiting from the insurance coverage of persons who are not Insured and having health expenses issued in the name of other Insureds, detection of existing undeclared diseases that the Insured knows and/or whose symptoms started before the insurance start date but did not declare to the Insurer, etc.), the Insurer has the right to collect the health expenses paid and/or cancel the Policy without premium refund.

**13.2 Death of the Policy Owner or the Insured**

In the event of the death of the Policy Owner and/or the Insured, the Insurer shall act according to the following conditions. In the event of the death of the Policy Owner; if the Policy Owner and the Insured(s) in the Policy are different and the Insured(s) wish to continue the Policy by changing the Policy Owner, the written consent of the legal heirs of the Policy Owner must be submitted to the Insurer. In this case, the Policy is continued by changing the Policy Owner. In cases where the approval of the legal heirs is not obtained, the policy is cancelled in accordance with the above-mentioned cancellation criteria and the premium refund, if any, is made to the legal heirs. In a single person Policy where the Policy Owner is the same as the Insured, the Policy becomes void in the event of the death of the Policy Owner. Upon the written request of the legal heirs of the Policy Owner, the Policy shall be cancelled in accordance with the above-mentioned cancellation criteria and the premium refund, if any, shall be made to the legal heirs.
In Policies where more than one person is an Insured, if one of the Insureds dies, the deceased Insured is cancelled from the Policy as of the date of death. In line with the above-mentioned cancellation criteria, the premium refund, if any, shall be made to the Policy Owner.

## ARTICLE 14. INFORMING SAGMER (INSURANCE SURVEILLANCE CENTRE)

Policy and health information of the Insured under this Insurance Policy will be transferred to SAGMER (Insurance Surveillance Centre) and Policy and health information of the Insured can be obtained from SAGMER and other public institutions.