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A. 'SAĞLIĞIM MİSAFİR' HEALTH INSURANCE SPECIAL CONDITIONS

The following text explains the legal scope of SAĞLIĞIM MİSAFİR Health Insurance Product, in addition to the covers to be provided to you in line with your plan, the conditions and requirements under which you shall be qualified to use the insurance services as well as the conditions excluded from your Policy Coverage. Please carefully read these conditions and explanations and keep this document in a safe location for future reference.

Please also read your Policy carefully.

This Policy specifies the Insurance Covers your Insurer shall provide you during the Policy Term in return for the premium amount paid and also conditions and requirements applicable to the aforementioned covers and conditions excluded from the Policy scope.

1. SUBJECT AND SCOPE OF INSURANCE

AXA SİGORTA A.Ş. guarantees to cover the expenses to be incurred by the Insured person(s) specified in the Policy/Endorsement, for diagnosis and treatment of diseases, sickness and/or accidents specified in the Policy/Endorsement, which may occur between the Insurance Inception and Expiration dates, within the insurance coverage amount, limits, participation rates as specified in the Policy/Endorsement and certificates attached thereto, and in accordance with the Special Conditions contained therein, pursuant to the General Provisions of Turkish Commercial Code and General and Special Conditions of Health Insurance.

Health Insurance Policies are arranged for a period of 1 year. The Insurance shall be valid during the period between the inception and expiration dates as specified on the Policy/Endorsement. The Insurance Coverage starts at 12:00 PM on Inception date and ends at 12:00 PM on Expiration date, both times being in Turkish local time and the dates indicated on the Insurance Policy. This Insurance covers persons who reside within the boundaries of Turkish Republic.

Insurer's liability shall commence after Policy issuance, provided that the entire premium amount for prepaid Policies and the downpayment amount (first installment) for installment Policies is made. Insurer's liability shall commence upon payment of the advance payment of insurance premium. Premium amount shall be collected in cash or by credit card.

AXA Sigorta A.Ş shall be entitled for on-site monitoring and obtaining information, requesting documents and records from the treating physician, healthcare facility SAGMER and other relevant third parties as they may deem necessary within the Policy's validity period. By purchasing a Policy, the Policyholder shall be considered as having granted to AXA Sigorta A.Ş the right to obtain information regarding the Policyholder's health history

and current health status. AXA Sigorta A.Ş shall be entitled to assign independent representatives in their name for the aforementioned inquiry.

2. DEFINITIONS

Emergency: Urgent conditions occurring as a result of an acute disease, accident or injury, which are included within Insurance Coverage and in compliance with General Conditions of Health Insurance and AXA Sigorta Special Conditions, and which may endanger the Policyholder's life if not intervened within 24 hours by a hospital emergency service.

1. Traffic Accidents,
2. Drowning,
3. Battery and similar general bodily traumas (falling from heights, torn off limbs, all types of fractures and dislocations, torn off or cut nerves due to trauma, acute massive bleeding, etc.),
4. Gunshot wounds, stabbing (felony and attempted felony are excluded),
5. Burns from irritating substances,
6. Respiratory track poisoning (suicide attempts are excluded),
7. Angioedema which may occur due to animal or insect bites and all types of anaphylactic shock cases,
8. Third degree burns,
9. Drug, food and chemical substance poisoning (suicide attempts are excluded),
10. All medical treatments regarding Acute Myocardial Infarction,
11. Foreign objects in respiratory tract,
12. Acute Appendicitis ,
13. Sudden strokes not connected with a disease diagnosed before Policy Inception date (facial paralysis excluded),
14. Gastric perforation (perforations caused by alcohol are excluded),
15. Gastric bleeding (perforations caused by alcohol are excluded),
16. Meningitis, encephalitis and cerebral abscess,
17. Electric Shock,
18. Freezing,
19. Eye Injuries,
20. Ileus,
21. Acute Pneumothorax (due to trauma or otherwise),
22. Pulmonary Embolism,
23. Cerebral Embolism,
24. Aortic Dissection,
25. Sudden Hearing Loss,
26. Sudden Vision Loss,
27. Acute pancreatitis (those caused by alcohol are excluded).

Contractual (Healthcare) Institution: All hospitals, polyclinics, diagnosis centers, physiotherapy centers, pharmacies and private physician offices which, subject to a special service contract executed with AXA Sigorta A.Ş., provide healthcare services to persons insured with a health insurance policy purchased from AXA. A list of Contractual Healthcare

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Institutions can be found at Insurer AXA SİGORTA A.Ş's website at www.axasigorta.com.tr. Insurer reserves the right to modify the said list.

Non-Contractual (Healthcare) Institution: Any healthcare institution/facility and private physician offices which do not have a special service contract executed with AXA Sigorta A.Ş., and not listed in the list of contractual institutions as published on AXA website at www.axasigorta.com.tr.

Ambulance Services: Includes emergency aid and ambulance services coverage within Turkey 24hr/365 days in accordance with Insurance General & Special Conditions.

Waiting Period: The period which should elapse as of the Insurance inception date for the in-patient treatment expenses of the Policyholder to be accepted and evaluated under the Insurance coverage scope.

Congenital Disease: Chromosome anomalies, genetic disorders, structural defects, all kinds of disabilities, motor and mental development disorders, all metabolic and genetic diseases, anatomic and functional anomalies, biological faults and defects, which may occur and/or emerge during prenatal and/or perinatal stages and/or childbirth due to physical, metabolic, genetic and chemical reasons, even if their symptoms show up and diagnosed during older ages.

Participation Share: Contribution by the Policyholder to each expenditure included in Insurance Coverage with the percentage as specified in the Policy.

Permanent Physician:: Physician included in full-time or part-time contractual staff of the relevant healthcare institution who have accepted the conditions of the contractual relationship established between the said healthcare institution and the Insurer.

Participation Protocol: Participation share of the Policyholder, applicable only to a specific disease of the Policyholder and only to situations included in inpatient treatment scope as accepted by the Insurer.

Accident: Situations not arising from natural occurrences or any kind of diseases/sicknesses, in which the Policyholder encounters with sudden external events beyond the Policyholder's will.

Occupational Diseases: Temporary or permanent diseases and psychological disorders suffered by the Policyholder due to a repetitive cause and/or conditions intrinsic to the performance of the tasks & duties of the Policyholder in their workplace are considered as occupational diseases.
These include: diseases such as asbestosis, silicosis, silicotuberculosis, bird influenza etc.; diseases reported to have emerged due to presence of and exposure to asbestos, aluminum, mercury, cadmium, lead, chromium, manganese, arsenic, phosphorus, beryllium, vanadium, thallium, heavy metals, nickel, wood chips, chemical agents, viruses and similar biological organisms, radiation and mechanical agents available at the workplace.

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Exclusions (Out of Coverage Circumstances): Conditions applied by the Insurer for a specific disease of the Policyholder, not to be covered by the Insurer but to be paid by the Policyholder.

Pre-existing Disease: Any disease, initial symptoms/indications or diagnosis/treatment and onset and progress of which goes back in the past to a time period which took place before the Insurance inception date and all relevant disorders (complications) developed in connection therewith.

Policy: Health Insurance Contract arranged and provided by AXA Sigorta A.Ş.

Healthcare Institution: Institutions established in accordance with the regulations of and authorized and licensed by Turkish Ministry of Health to perform diagnosis, treatments and/or surgical interventions as required of/for patients and casualties.

Policy Owner: Real or legal person entering into and executing the Contract with the Insurer, assuming the payment liability of the premiums under the said Contract.

Insurance Firm / Insurer: The entity undertaking payment of Compensation to the Policyholder or the specified beneficiary in case of realization of the covered risk(s) in return for the premium amounts paid by the Policyholder by means of being commercially registered and obtaining/holding a business license in accordance with the laws of the country/jurisdiction where the Insurance Contract is established. AXA Sigorta A.Ş. is the Insurer for this Insurance Policy you have purchased.

Policyholder: Real person(s) residing within Turkey, health expenses of whom are covered by the Insurance Contract and who has/have the right to claim for damages in case of risk realization.

Hospitalization for Medical Examination: Hospitalization for advanced examination, inspection and treatment by physicians of the same or different discipline for a disease or a symptom without any indications requiring hospitalization and which could be diagnosed/treated through outpatient treatment methods.

TMA - MPD Fee List: List prepared by Turkish Medical Association (TMA) in accordance with TMA Foundation Act No.6023, specifying the definitions of medical services offered by physicians, means of application thereof and units and rules to be used for calculation of the fees to be paid for such medical services. This list was initially named and has been known as Minimum Wage Tariff of Turkish Medical Association (TMA-MWT). Name of the list was first changed as TMA Reference Fee List in Article 28 of Act No.6023 as amended by Act No.54766 enacted in 2006. The List was transferred to electronic environment to meet the changing conditions of the country and by taking the rules set forth by Act No.5846 the name of the List was modified finally as Medical Practices Database Fee List of Turkish Medical Association ("TMA - MPD Fee List") as of January 1, 2015. Remuneration is determined by multiplying the relevant item listed in TMA - MPD Fee List with the coefficient determined

and updated once in every six months by the respective provincial Chamber of Physicians and by adding VAT to this calculated amount.

3. INSURANCE COVERAGE

Scope of the product you have purchased is valid for the limits, participation share and coverage indicated in the Policy. The product purchased during Policy Inception cannot be altered during the Policy Year. Any requests for product alteration shall be assessed in line with the opinions of the Insurer.

3.1. In-patient Treatment

Inpatient treatment coverage covers Policyholder's hospitalization requiring medical treatment and/or surgery. Policyholder should apply to our authorization center minimum 3 days before the planned treatment date for expenditures to be charged to inpatient treatment coverage, except for emergency cases.

Surgical operations performed under general/local anesthesia where the Policyholder's treatment requires a surgical intervention with a cost of 200 units or more as indicated in TMA - MPD Fee List are considered as surgeries. Surgical expenses to be incurred during circumstances requiring hospitalization of the Policyholder for a surgery or treatment of a disease (expenses incurred in the surgery room; surgery room fees, fees of surgeon(s), assistants, surgical nurse(s), anesthetist technician and specialist (physician), all kinds of medical materials used during or in connection with the surgery such as disposable medical materials, drugs and medications, blood, IV drip etc.) and expenses such as materials used for non-surgical purposes like drugs and medications, dressings, bandages, plaster casts, plasters, all kinds of intravenously administered medications and serums, blood and blood products; expenses for physician's follow-up and consultation; expenses incurred for disease follow-up of the hospitalized Policyholder and physician examinations guiding the stated treatment, expenses for medical analysis, x-rays, standard single hospital room, meal and hospital attendant shall be paid out of this coverage.

Physician's medical examinations and procedures performed by healthcare facilities not holding a surgical license shall not be eligible for Inpatient Treatment Coverage.

In cases where multiple surgeries are performed under single anesthesia and one or more of the foregoing is/are not included in Insurance Coverage, no expenses related with such out-of-Coverage surgery/surgeries shall be paid. The amount not to be paid shall be calculated via weighing method based on TMA - MPD Fee List points and the compensation shall be paid after deduction of such amounts from the total invoice amount.

Coronary angiography expenses, pre-surgical examinations, ectopic pregnancy surgeries, reconstructive surgical operations following cancer treatment (breast reconstruction, etc.), rabies and tetanus vaccines are also considered within this Coverage. Hospitalization expenses for examination purposes shall be excluded.

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The period for which Inpatient Treatment Coverage shall be valid is 180 days during one Insurance Year. Maximum 90 days out of these 180 days may be an intensive-care cover. For services included in Inpatient Treatment Coverage rendered during treatments exceeding the aforementioned period: physician fees and expenses of all medical examinations shall be covered up to TMA - MPD Fee List amounts; hospital room & attendant expenses shall be covered up to the limit amount of 50$ per day; and daily surgery room usage fee shall be paid up to 30% of the surgeon fee indicated in TMA - MPD Fee List.

Expenses (inpatient treatment, ICU, chemotherapy, radiotherapy and dialysis, small operations) charged for inpatient treatment conducted by the permanent physicians of domestic contractual healthcare institutions shall be included in the Coverage.

In cases where surgeries , interventions, examinations, treatment, follow-up and consultation for the foregoing operations, which are included in Inpatient Treatment coverage, are performed by a non-permanent physician of the said facility, physician fee shall be paid up to the amount indicated in TMA - MPD Fee List.

Inpatient treatment expenses (inpatient treatment, intensive care, chemotherapy, radiotherapy and dialysis, minor surgeries) incurred by physicians of public health institutions are included in the scope of coverage.annual upper limit is 250,000 TRY and with 20% Policyholder participation share.

For inpatient treatment expenses (Inpatient Treatment, Intensive Care Unit (ICU), Chemotherapy, Radiotherapy and Dialysis, Minor Interventions) incurred at non-contractual healthcare institutions, annual upper limit is 150,000 TRY. Expenses incurred at non-contractual healthcare facilities for Guest Health Insurance, physician, anesthesia and assistant physician fees and expenses shall be paid over TMA - MPD Fee List prices with 40% Policyholder participation share. Hospital room and meal & attendant expenses incurred at non-contractual healthcare facilities are limited to 50$ per day; daily surgery room usage fee is limited to 30% of the surgeon fee listed for the relevant surgery in TMA - MPD Fee List and shall be paid with 40% Policyholder participation share.

3.2. Intensive Care

Intensive Care Coverage includes ICU expenses in cases where Policyholder's treatment requires ICU stay & care. All surgeries, surgical interventions, actions taken for diagnosis or medical examination performed and relevant physician fees and expenses incurred during the time stayed in ICU for an inpatient Policyholder at a hospital or clinic which has an ICU shall be paid from this coverage. Intensive Care Coverage shall be limited to 90 days. (The total period in which inpatient treatment cover is valid throughout an insurance year is 180 days. Maximum 90 days out of these 180 days may be an intensive-care cover.)

3.3. Chemotherapy, Radiotherapy & Dialysis

This coverage includes chemotherapy, radiotherapy expenses and expenses of medications required by these treatment methods, as well as expenses of dialysis treatments for renal

failure. Oncological examinations and blood analysis made for preparation to chemo shall be assessed under this coverage.

3.4. Minor Intervention (Small Operations)

Expenses incurred for all surgical interventions specified as less than 200 units in TMA - MPD Fee List (200 excluded), as well as interventions such as suturing, wound treatment, application of plaster case and repositioning due to fractures, acute rash treatment, dressing, application of IV drip, oxygen administration, stomach irrigation, ear wash, injection, administration of vaccines & IV drips, hyperbaric oxygen treatment, enema, catheter application, abscess drainage, all types of cauterization, cryotherapy, surgical nail removal (single or multiple), mole removal (single or multiple) and costs of disposable materials used for the foregoing shall be paid from this coverage. For cases covered by the definition of "Emergency" as defined in Policy Special Conditions where the medical treatment/procedure to be implemented within the first 24 hours is included in the Policy, medical equipment, medication, operation room, medical analysis, imaging, advance diagnostics and physician fees and expenses to be used and applied during such emergency medical interventions shall be evaluated within Minor Intervention coverage. However, any medical examination, medical analysis, x-ray, laboratory analysis, advanced diagnostics etc. and/or medications to be prescribed which do not fall into "Emergency" definition or which are performed for follow-up purposes after the initial intervention shall be evaluated under Outpatient Treatment coverage.

3.7. Auxiliary Medical Materials

Auxiliary medical materials required by medical report in order to support the treatment of the Insured, as well as crutch, wristband, elastic bandage, orthopedic neck protector, wheel chair (covered in cases where permanent disability is proved with a medical report) , orthopedic binders, orthopedic sole plate, rom walker, “plaster slippers”; ice bag , İleostomy-cystostomy-colostomy bags and adaptors, burn cover and pressure cloth, resting ring, water closet heightener (following hip operation), varsity socks are covered under this coverage up to the annual limits specified in the policy and within the payment percentage. Auxiliary medical materials apart from the foregoing materials are not covered.

Ambulance Services

Every Policyholder holding a health insurance policy from AXA Sigorta A.Ş. shall be entitled to benefit from medical consultancy and emergency ambulance services provided by AXA Sigorta Emergency Service Line.

This coverage includes on-site intervention and/or transfer to the nearest appropriate healthcare center in case of an emergency; transfer to a more superior & appropriate hospital with an ambulance under required medical surveillance, if proper medical equipment for the relevant bodily injury or disease is not available in the first healthcare center.

3.14. Out-patient Treatment

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Outpatient treatment includes coverage for medical examination, laboratory services, imaging and diagnosis methods, advances diagnostics methods and physiotherapy items. Medical examinations and diagnostic procedures performed during hospitalization for medical inspection purposes shall be covered herefrom. However, relevant hospital room, meal & attendant expenses shall be excluded.

Expenses for outpatient treatment conducted by permanent physicians of a domestic contractual healthcare facility shall be paid from outpatient Treatment Coverage in line with the annual upper limit amount 15,000 TRY and 20% Policyholder participation share as specified in the Policy.

Outpatient treatment expenses incurred by staff physicians of public health institutions are covered by the Outpatient Treatment Guarantee at the annual upper limit of 15,000 TL and 20% co-payment rate specified in the policy.

Outpatient treatment expenses incurred at non-contractual healthcare institutions shall be applied with 40% Policyholder participation and over TMA - MPD Fee List figures and limited to the annual upper limit of 15,000 TRY as specified in the Policy.

Health expenses incurred in non-contractual healthcare centers should be paid by the Insured and relevant medical documents and original invoices should be sent to Insurer for assessment.

3.14.1. Physician's Examination

Expenses made for medical examinations performed at hospitals, clinics and private physician's offices by medical doctors holding a Medicine School diploma shall be covered hereunder.

3.14.2. Medication

Expenses of medications prescribed by physicians shall be included in this coverage. Medication expenses shall be paid as limited to max. 30-day dose for each medication. Medications for chronic diseases to be used continuously by the Policyholder shall be paid from the relevant coverage as limited to max. 3-month dose, upon submission of such prescription and with the constraint that these shall be explicitly indicated on the prescription. Claims made for medications without any prescription, invoice or cashier bill, lacking a drug label (or data matrix) or the name of illegible on the label shall not be paid.

3.15.4. Laboratory Services

All kinds of lab services ordered by a physician as necessary for disease diagnosis and treatment follow-up shall be covered hereunder.

3.14.5. Imaging and Diagnosis Methods

Expenses of x-rays (direct and contrasted), mammography, arthrography, ECG, effort ECG (treadmill), Holter, EEG, EMG, visual field, audiological examinations, respiratory functions tests, urodynamic examinations, sleep test (except CPAP calibration), hearing tests deemed as necessary by the relevant physician for disease diagnosis and treatment follow-up, as well as expenses of medications, anesthesia used for conduction of the foregoing and any relevant bed prices etc. shall be covered hereunder. Procedures for calibration of medical devices (CPAP, etc.) are excluded.

3.14.6. Advanced Diagnosis Methods

Expenses of angiography implementations except coronary angiography (eye, brain, kidney etc.), biopsy and pathologic analysis, Magnetic Resonance (MR), Scintigraphy, Tomography, Endoscopy, Echocardiography, Doppler and Ultrasonography deemed as necessary by the relevant physician for disease diagnosis and treatment follow-up, as well as expenses of medications, contrast agents and anesthesia etc. used for conduction of the foregoing shall be covered hereunder.

3.14.7. Physiotherapy

Expenses for therapies deemed as necessary by the relevant physician for, falling within the scope of physiotherapy and incurred at hospitals and physiotherapy centers shall be covered hereunder. Payment of physiotherapy expenses shall be limited to the annual limit, participation rate and annual session numbers specified by the purchased physiotherapy Coverage, even if performed as hospitalized at an inpatient healthcare center. other expenses (room, attendant, meals, physician follow-up etc.) incurred during such inpatient stays shall not be paid. Physiotherapy expenses shall be limited to 30 sessions per year.

4. WAITING PERIODS

Medical intervention and in-patient treatment expenses for the following diseases and complications shall be excluded from Insurance Coverage for a period of 9 months as of the Inception Date, regardless of whether the sickness/injury has occurred acutely or as a result of an accident:

- Polyps, lipomas, cysts, nodules and similar formations emerged during the initial Policy year and all kinds of masses (removal of lipomas, nevuses, warts, etc.),
- All types of carcinoma and cardiac diseases emerged during the initial Policy year,
- Tonsillar interventions, removal of adenoids, ear intubation, sinusitis, eardrum surgeries,
- All kinds of hernia (inguinal, stomach, etc.), hemorrhoid, pilonidal sinus, fistula, fissure and perianal abscess surgeries,
- Chronic renal disorders and dialysis, prostate diseases,
- Organ failures,
- Rheumatic diseases (Rheumatoid arthritis, Ankylosing spondylitis, etc.),

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- Gall bladder diseases, stone diseases of biliary tract and urinary system,
- Varicosis (including Esophageal varices), hydrocele, spermatocele,
- Myoma, ovarian, breast and uterine diseases, endometriosis, cystocele, rectocele and uterine prolapse, varicosis (including esophageal), hydrocele, spermatocele
- All types of disc hernia (spinal, cervical, etc.), knee surgery (meniscus, chondromalacia, connective tissue ruptures, etc.), shoulder surgery (habitual shoulder dislocation, rotator cuff rupture, impingement syndrome, etc.), spinal surgery and arthroscopic surgery procedures,
- Cataract, glaucoma and thyroid diseases, retinal diseases,
- All surgical interventions for sleep apnea, uvula elongation, lowered palate and similar disorders,
- Multiple Sclerosis (MS) and Lupus (SLE),
- Cyst Hydatid,
- Entrapment neuropathy, hallux valgus, trigger finger,
- Invasive diagnosis methods (ERCP, Diagnostic Laparoscopy, Diagnostic arthroscopy, etc.),
- Inpatient treatment expenses related with complications of aforementioned diseases,

Waiting Period shall not be applicable to new Policies issued on the Expiration Date to ensure Policy Inception without any interruption.

5. EXCLUSIONS

Any sickness and/or injury in any kind of accident suffered by Policyholders during Insurance Period shall be excluded from Insurance Coverage for the following reasons:

1- War or military operations having the nature of war, insurrections, riots, commotions and domestic disorders arising from the foregoing,
2- Commit or attempt to commit a crime,
3- Cases where Policyholder acts in a way deliberately exposing themselves to grave danger, except for attempts to save endangered persons and/or property,
4- Use of narcotic substances such as marijuana, heroin,
5- Nuclear risks and/or use of nuclear, biologic and/or chemical weapons and/or all kinds of attacks and/or sabotage causing any nuclear, biologic and/or chemical substances to be released/exposed,
6- All damages due to terrorist acts as stipulated in Anti-Terror Act No.3713, sabotages originated from such activities and due to biologic and/or chemical pollution, contamination or poisonings arising from interventions of competent bodies to prevent and mitigate the foregoing,
7- Injuries or sicknesses which may occur due to a suicide attempt by Policyholder, and
8- Other conditions not included in Insurance Coverage as specified in Policy Special Conditions.
9- All health expenses related to diseases of the Policyholder existing prior to the Policy Inception Date, recurrence of surgeries and treatments implemented during Insurance Period

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and relevant complications, even if declared to the Insurer during Insurance arrangement phase. (Expenses for incisional hernia, adhesiolysis, recurrences, explantation, etc.),
10- All diseases classified between Q-00 and Q-99 in ICD-10 (International Statistical Classification of Diseases and Related Health Problems, Rev.10) under congenital malformations, deformations and chromosome anomalies categories are considered as congenital diseases. All expenses included in the foregoing classification shall be excluded.
11- Expenses related to all kinds of congenital diseases and disabilities (natal anomalies, genetic disorders) even if diagnosis is made afterwards, inguinal hernia diagnosed until age 7, lacrimal duct obstruction occurring until age 3 (incubator care, etc.), expenses for regular or specific examinations and treatments (e.g., genetic tests, all kinds of karyotype research, hemoglobin electrophoresis, phenylketonuria test, thyroid tests until age 7, newborn metabolic screening tests, newborn hearing tests, hand-wrist radiographies, hip dislocation USG, undescended and retractile testicles, polycystic kidney, Vesicoureteral reflux (VUR) etc.) for motor and mental development disorders (growth and developmental delay/advancement, early/delayed puberty, etc.),
12- Expenses related to spinal deformations for persons under age 25,
13- Expenses related to umbilical cord blood bank and bloodletting & storage of umbilical cord blood,
14- Expenses related to storage of materials belonging to donor and receiver for bone marrow transplantation,
15- Stem cell transplantation and stem cell procedures for therapeutic purposes, embryo cloning, all kinds of treatment and transplantation procedures made with the cells obtain through such treatment,
16- Vaccination for allergic diseases (immunotherapy),
17- All vaccines except rabies and tetanus,
18- Expenses related to Menopause, Osteoporosis , Alzheimer, Parkinson , geriatric diseases, MS,
19- Health expenses due to occupational diseases and work accidents,
20- Expenses made for tests, analysis and required treatments for AIDS and AIDS connected diseases and all diseases and syndromes caused by HIV virus,
21- All kinds of aesthetic and plastic surgeries (nose reshaping, rhinoplasty, liposuction, breast reduction, etc.), all examinations, interventions, vaccinations, injections and treatments for aesthetic purposes, perspiration treatment, gynecomastia, aesthetic and plastic surgeries which may be required due to falling, traumas, impacts, burns or diseases which have occurred before Policy Inception,
22- Expenses related to skin care, skin spots, skin chaps; shampoos and hair lotions; cosmetic soaps and creams; medications and interventions, solutions and shampoos for hair loss and dandruff; perfumery, cotton, alcohol and colognes; hot water bags, skin soaps, toothpaste; sugar stripes and blood sugar meter device, sweeteners, dietary products and drugs, etc.,
23- Expenses related to acne and blackheads,
24- Expenses related to infertility diagnosis and treatment, examinations and treatments for assisted reproduction (follicle follow-up, hysterosalpingography, spermiogram, adhesiolysis, artificial insemination, in-vitro fertilization, miscarriage investigations, embryo reduction, etc.), abortion interventions without any medical indication, birth control methods and related medication and devices (birth control pills, intrauterine devices, tubal ligation, injections, subcutaneous implants, condoms, spermicide chemicals etc.); all types of circumcisions, even

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if for treatment purposes (phimosis, etc.), examinations & treatments related to sexual disorders, impotence (penile doppler, penile prosthesis, etc.), expenses for gender reassignment surgeries and all kinds of post- & pre-surgery hormonal therapies; diagnosis, treatment, control examination and complications of genital herpes, genital & anal papillomatous lesions (warts, condyloma acuminatum, etc.), genital molluscum contagiosum,
25- Varicosele treatment,
26- Notwithstanding the reason for the surgery, surgical interventions for nasal septum and all types of structural nasal deformations (septum deviation, SMR, all concha surgeries, nasal valve operations) and all surgeries and interventions for snoring,
27- All interventions and treatments for superficial varicose veins (sclerotherapy, laser, radio frequency, chemical blockade, foam sclerotherapy and laser surgery etc.),
20- Medical devices, leasing and calibration expenses of medical devices (robotic surgery leasing amounts, sleep apnea device and its calibration, holter device, nebulizer, hearing aid devices etc.),
28- Delivery expenses and all pregnancy related expenses,
29- Expenses for spectacles glasses & frame, all types of contact lenses, lens solutions,
30- Expenses related to speech and voice therapy, ophthalmic refractive error (myopia, etc.) surgery, treatment of strabismus and amblyopia, lenses correcting ophthalmic refractive errors such as multifocal lenses,
31- Examination, diagnosis, treatment expenses and expenses for relevant complications in every branch of dental, gum, jaw bone, temporomandibular joint and maxillofacial surgery,
32- Organ transplants,
33- Blood transfusion; expenses incurred for the organ, blood products and the donor,
34- Expenses related to home care and special nurse care services,
35- Expenses for child care, baby food, diapers, nursing/feeding bottles & dummies, etc.,
36- Expenses not required for the treatment such as phone calls, TV, cafeteria administrative services and paramedical service fees,
37- Expenses related to any kind of alternative therapies (acupuncture, mesotherapy, magnetotherapy, oxytherapy, CO2, neural therapy, chiropracty, PRP (Platelet Rich Plasma) reiki, ayurveda etc.), weight control disorders, massage, hydrotherapy, mud bath, obesity, obesity treatment (xenical, reductil etc. drugs), all drugs and materials used for dietary purposes, asthenia treatment, PERTH (Pulsating Energy Resonance Therapy), botox and ozone applications (even if for treatment purposes) and any kind of treatments implemented by persons who are not medical doctors/physicians,
38- Expenses related to examinations, analysis, treatment and interventions at gymnasiums, alternative medicine centers, weight loss centers, foot health centers, anti-aging and well-being centers, spa and beauty centers, dermatology, aesthetics and laser centers (including examinations made dermatologists, fees paid for homocystein, DHEA, GH, fat and muscle measurement, etc.),
39- Expenses related to supplementary products with a non-medication nature and used for meeting daily requirements of and/or preserving and supporting overall well-being of the body, vitamins in the form of packages containing more than 30 pills, herbal drugs, dietary supplements and import medications without a permit issued by Turkish Ministry of Health, drugs sold with the license of Ministry of Agriculture, all pharmacological substances not approved by FDA (Food and Drug Administration) (Pharmaton, umca, immunex, esbertitox, sinus rinse, lid care, seven seans, minadex, vitagil, osteo bi flex, etc),

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40- Medical interventions, implementations and treatments with an experimental & research nature without any evidence for efficacy (all kinds of food intolerance tests, imo pro 300,vega test, york, etc.),
41- Deliberate or indeliberate self-injuries and hazards occurring in sane or insane condition, drunk driving, alcohol intoxication, diseases and injuries arising from alcoholism and alcohol abuse; all types of health expenses incurred as a result of use of narcotics and addictive substances such as heroine, morphine etc.,
42- Expenses related to treatments, medications and devices for quitting and/or clearing the effects & toxins of nicotine, alcohol and similar addictive substances (nicotine plasters, nicotine chewing drops, antabus, zyban etc.),
43- Injuries during driving without a driver's license as referred to in provisions of Highway Traffic Act and all relevant travel, transportation and treatment expenses,
44- Expenses related to psychiatric examinations and treatments, psychosomatic disorders, psychologist and psychological consultancy fees, mental & neurological disorders treated at psychiatric hospitals and/or similar clinics;
45- Any and all health expenses likely to be incurred during the performance of dangerous sports (any amateur aviation, hang-glider, glider, parachuting, parasailing, paragliding, bungee jumping, mountaineering, scuba diving, riding etc.) are not covered. However, the activities that are performed professionally; health expenses likely to be incurred during the performance of the foregoing activities as a hobby are covered up to the policy limits and covers provided that health costs likely to be incurred during the competitions whether professional or not, are not covered once again. Health costs that belong to the sportspersons during any sports competition including automobile and motorcycle races are not covered under the policy. Any diseases and injuries likely to take place during participation to any professional or amateur competitions and/or trainings as a licensed athlete are not covered under the policy.
46- Diseases and disabilities which may occur during participation in a sports game and/or training session, whether as a licensed professional or an amateur athlete,
47- Ambulance expenses for services received from centers other than AXA Sigorta Emergency Center,
48- All health expenses for out-of-coverage & diseases and disorders specific to the relevant person as indicated in the certificate attached to the Policy and those related to coverage scopes not specified in the Policy and/or the attached certificate,
49- Expenses incurred due to complications arising from wrong treatments and interventions/surgeries caused by physicians and/or healthcare institutions,
50- Expenses for healthcare services received from physicians with a specialty not matching/appropriate for the Policyholder's disease and for treatments performed by family members, even if such member is a medical doctor; expenses for examinations, analysis and treatments by doctors dealing with weight control disorders other than their medical specialty area, even if these are related with their own medical discipline,
51- Procedure prices not corresponding to those listed in AXA Sigorta A.Ş. Contractual Price List on invoices issued by Contractual Healthcare Institutions,
52- Regular analysis & check-up expenses,
53- Examinations and treatments made for check-up purposes without any doubt for a disorder or disease (scanning tests, vaccination control tests, viral markers, Ca markers, etc.), dietitian fees, analysis requested by a dietitian and preventive medical services,

54- Any procedure, intervention and treatment method not listed in TMA - MPD Fee List,
55- Material expenses related to robotic surgery,
56- Expenses for all kinds of Bariatric Surgery methods (gastric by-pass, gastric balloon, gastric tube, adjustable gastric band, weight loss surgery -stomach reduction-, biliopancreatic diversion, jejunoileostomy, colon shortening surgery, etc.), regardless of the reason,
57- Coronary Artery Calcium Scoring Test and procedures listed under Electron Beam Tomography (EBT) in TMA - MPD Fee List, virtual colonoscopy, virtual angiography and similar examinations for scanning purposes,
58- Ptosis (Droopy Eyelids) treatments for whatever reason,
59- Daily incapacity wage amounts which the Policyholder is not able to earn due to sickness,
60- Care costs & expenses in case the Insured becomes in need of care or daily care costs or the agreed daily care fee,
61- All health expenses incurred in foreign countries,
62- All expenses incurred at healthcare facilities included in the "List of Excluded Healtcare Facilities", which can be found under "Online Procedures" tab on AXA Sigorta A.Ş's website at www.axasigorta.com.tr, and related physician's expenses thereof,

6. CONDITIONS EXCLUDED UNLESS A COUNTER AGREEMENT EXISTS

Unless a contract exists otherwise, any sickness and/or injury in any kind of accident suffered by Policyholders during Insurance Period shall be excluded from Insurance Coverage for the following reasons:

a) Earthquake, flood, volcanic eruption and landslide,
h) Save for the damages indicated in paragraph 6 of "Exclusions" section above, damages due to terrorist acts as stipulated in Anti-Terror Act No.3713, sabotages originated from such activities and interventions of competent bodies to prevent and mitigate the foregoing.

7. GEOGRAPHICAL TERRITORY

Health expenses incurred in foreign countries shall be excluded.

8. INSURANCE COVERAGE IMPLEMENTATION PRINCIPLES

All procedures within inpatient & outpatient treatment scope conducted by permanent physicians of domestic Contractual Healthcare Institutions of AXA Sigorta A.Ş. shall be paid from relevant coverage subject to the annual upper limit specified in the Policy.

Policyholder can receive healthcare services to the extent specified by Health Insurance General Conditions and AXA Sigorta Special Conditions, coverage limits and participation shares as specified in the Policy, by applying to a center listed in the Contractual Healthcare Institutions List and upon presenting their health insurance cards & official ID cards. Policyholders shall be liable to cover expenses not included in Policy Coverage & limit and those included but exceeding the coverage limit. AXA Sigorta A.Ş. reserves the right to alter & modify the aforementioned list. Policyholders can find the updated current list at www.axasigorta.com.tr.

Contractual Healthcare Institution Network includes authorized healthcare institutions

providing healthcare services pursuant to a special contract executed with the Insurer to the Insured persons holding a Health Policy. These are healthcare centers listed in the list of contractual institutions as enclosed to the Policy; the updated list can be found at www.axasigorta.com.tr. Insurer reserves the right to modify the said list.

For cases requiring inpatient treatment, an Inpatient Treatment Authorization Form should be filled in and sent to AXA Sigorta A.Ş. within max. 24 hours. Otherwise and if the permitted time is exceeded, AXA Sigorta A.Ş. reserves the right not to make a direct payment.

In cases where inpatient treatment of the Policyholder is still ongoing at Policy Expiry Date, such treatments shall be included in Inpatient Treatment Coverage, but only for 10 days following Policy expiration.

AXA Sigorta A.Ş. does not make any direct payments to healthcare institutions, contracts of which have already expired.

In such cases, Policyholder shall make a compensation claim to AXA Sigorta A.Ş. by submitting the documents indicated in Article 18.
All state hospitals and research hospitals of medical schools are considered as contractual healthcare institutions. Cash receipts and credit card receipts given by these institutions shall as well be considered as invoices.

9. COMPENSATION PAYMENTS

Compensation payments shall be made via ire transfer/EFT to the bank account specified by the Policyholder. No compensation payments shall be made to credit card accounts. Payment to the Policyholder shall be made within max. 15 days following receipt of all documents required by the Insurer.

Right of Subrogation: Pursuant to the "Right of Subrogation" and in accordance with the applicable relevant legislation, AXA Sigorta A.Ş shall be entitled to subrogate the Policyholder following realization of an insured risk and payment of compensation to the Policyholder (beneficiary), and claim payment for damages from the person(s) or entity(ies) causing such damage. Policyholder shall be liable to provide all kinds of information, documents and assistance to AXA Sigorta A.Ş. to enable the Insurer use such right.

Competent Authorities to Report Compensation Payments : Pursuant to the legal legislations, Insurance Firm shall be liable to disclose and submit, upon request, all information (e.g. damage, compensation details, personal details, etc.) they have obtained from the Policyholders during the arrangement stage of the Health Insurance Contract to SSI Information Center, Undersecretariat of Treasury, SAGMER and all similar governmental authorities. Everyone purchasing health insurance shall be deemed to have accepted in advance that such information shall be disclosed to the relevant competent authorities.

Documents Required by Insurer for Indemnity Claims: Health expenses incurred at non-contractual healthcare institutions and/or paid by the Insured can be claimed from the Insurer by submitting the below mentioned documents. Insurance Company is entitled to request

additional information as to the expenses so incurred and to make inquiries on information contained in the indemnity file where required.
Policyholder shall be liable to submit the documents (Incident Scene Investigation Report, Breath Analysis Report, Forensic Report, Traffic Accident Report, Public Prosecutor's Order, etc.) arranged and issued by relevant/competent public authorities for traffic accidents and all kinds of legal incidents in attachment to the compensation claim request.

Inpatient Treatment Expenses

- Original invoices indicating details, arranged in the name of the Policyholder, documenting the health expense,
- Medical Report evidencing Policyholder's treatment/surgery, Epicrisis/Discharge Report, Technical Surgery Report in case of a surgery,
- Results of analysis made during treatment (including pathology reports),
- For Chemotherapy and Radiotherapy, Report arranged by the Policyholder's physician, summarizing the onset and course of the disease and showing the number of cures realized during treatment.

Outpatient Treatment Expenses

- In addition to the Compensation Claim Form arranged by the treating physician, following documents should be sent;
- Original invoices indicating details, arranged in the name of the Policyholder, documenting the health expense,
- Request Letter indicating the request reason by the physician for the analysis & examinations and results of the foregoing,
- For medical examinations, invoice issued by the hospital/clinic in the name of Policyholder or official self-employed invoice indicating the attending physician's name & surname, are of specialty, associated tax office and tax no.,
- Credit card slip bill for payments made via credit card,
- For medication expenses, Physician's prescription arranged in the name of Policyholder and drug labels indicating the drug names,
- For physiotherapy expenses, Physician's Report indicating the essence of treatment and number of sessions,

10. RENEWAL

Insurer can assign upper limits, additional premium and/or participation protocol to the renewed policy due to excess usage or disease risk or can leave certain risks out of coverage.

Exclusions specific to the Policyholder shall be continued as unchanged upon Policy renewal, unless these are declared invalid by the Insurer.

In case Insured requests a product change during renewal period, an application form shall be obtained from the Insured to be assessed medically and according to the risk conditions, additional premium can be required, existing risks can be excluded from coverage, disease

upper limit or participation share can be applied or product change can be rejected.

Insurer shall have the right to request health information of the Policyholder (even if this belongs to the period before Policy inception) from public or private healthcare institutions, private insurance providers or Insurance Information Center at initial Policy arrangement stage or during policy period.

Insurer can change, alter, modify and/or amend Policy Special Conditions, waiting periods, out-of-coverage cases, coverage contents/amounts, coverage limits and policy premium amounts. Such changes shall be applicable as of the Policy renewal date for each Policyholder. Continued (renewed) Policies shall maintain the same conditions as at policy issuance date. Product changes cannot be made within a Policy period.

Expired Health Insurance Policies must be renewed within 60 days. Otherwise, vested rights for renewal shall be forfeited and the new Policy can only be issued in accordance with the principle of initial insurance.

11. RENEWAL WARRANTY

This Policy does not provide any renewal warranty. All policies are issued as new business even if the Insured used to have a renewal warranty in their previous policy and this right cannot be continued.

12. PREMIUM ASSESSMENT

Criteria regarding Premium Assessment: Premium amounts shall be determined according to the tariff premium designated by Insurer based on certain criteria such as portfolio experience, Policyholder's age, gender and purchased coverage types. Insurer may update this tariff premium periodically and also in consideration of the portfolio performance. AXA Sigorta '**Guest**' Health Insurance Product does not contain any discount/ additional premium options. Compensation payments shall be made in line with the coverage limit amount and participation share amounts specified in the Policy.

Payment terms for Guest Health Insurance Product: Prepayment

13. NEW ENTRY PROCEDURES

Infants who have completed 90 days after birth and persons who have not turned 55 can be included in the Policy Coverage.
Policies of Insured persons covered by this product before turning 55 can also be continued after 56 years of age.

Insurance Coverage is applicable to persons who reside within the boundaries of Turkish Republic. Insurance premium is calculated individually, based on age & gender.
No transfer policies (from other insurance providers) shall be accepted and all policies shall

be issued as new business.

14. PRINCIPLES FOR TERMINATION OF INSURANCE CONTRACT

Pursuant to the Circular Letter No.2024/34 dated 25/12/2024 on Private Health Insurance Policies Required for Visa and Residency Permit Applications, minimum one condition among the following must be met for health insurance policies purchased for residency permit applications to be terminated upon Policyholder's request.

a. Submission of a new health insurance policy covering the residence permit period to the Insurer,
b. Cancellation of residence permit or residence permit not qualified for further extension,
c. Submission of a document confirming General Health Insurance coverage in accordance with the Social Security and General Health Insurance Act No.5510,
ç. Rejection of residence permit application or or withdrawal of the application before any final decision is announced.

In case insurance contract is terminated in accordance with paragraph (ç), premium amounts paid shall be reimbursed without any deductions within five business days following the date when the cancellation request is received, provided that no compensation payment has been made previously. In case the contract is terminated pursuant to other paragraphs, premium reimbursement shall be made on used days basis in line with insurance principles, within five business days after submission of required documents.

15. DECEASE OF POLICY OWNER / POLICYHOLDER

Decease of Policy Owner: In case Policy Owner is deceased, Insurance Contract shall become null and void. However, the Contract can be continued through replacement of Policy Owner with someone else with a letter of content to be submitted by legal successors. In cases where legal successors do not accept continuation of Insurance Contract, provisions of contract termination shall be applied and if the premium amount paid exceeds the premium amount earned, then the difference shall be reimbursed to legal successors in accordance with the provisions of Contract Special Conditions.

Decease of Policyholder(s): In case Policyholder is deceased, if the premium amount paid exceeds the premium amount earned, then the difference shall be reimbursed to Policy Owner; if the deceased Policyholder has the capacity of Policy Owner at the same time, then the difference shall be reimbursed to legal successors in accordance with the provisions of Contract Special Conditions.
Policy shall remain valid for other relevant Policyholders unless notified as otherwise by the Policy Owner. If no other Policyholder is included in the Policy, then Insurance Contract shall become null and void. In such case, provisions of contract termination shall be applied.

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16. RIGHT TO RECOURSE

In case Insurer makes a payment violating General and/or Special Conditions of the Insurance Policy due to misrepresentations and/or incomplete representations of the Policyholder or an attending physician, then Insurer shall recollect such payments through recourse to the Policyholder. Payment made for whatever reason by the Insurer which is not included in Policy Coverage cannot be construed as a vested right for the Policyholder.

17. INFORMATION

Pursuant to Article 14 of Health Insurance General Conditions, Insurant/Policyholder shall be responsible for checking & ensuring up-to-date status of contact information (mobile phones, e-mails, etc.) of Policyholders included in policy Coverage and make any required corrections.

18. TREATMENTS AFTER EXPIRATION OF POLICY PERIOD

In cases where the Policy is expired and not renewed or a new Insurance Contract is not made, Inpatient Treatment Coverage included in the expired Policy shall continue for hospitalized Policyholders until the end of such treatment, subject to the limits specified in the expired Policy plan for health conditions already notified to and approved by Insurer before the Policy expiration date However, this extended period for treatment cannot exceed 10 days after the Policy expiration date.

19. ARBITRATION:

AXA Sigorta A.Ş. is a member of Insurance Arbitration System. You can access the Insurance Arbitration Board by visiting www.sigortatahkim.org, or by sending an e-mail to bilgi@sigortatahkim.org or by calling 0216 651 65 65 (pbx).

20. APPLICABLE LAW

This Contract shall be construed according to Turkish Law. Istanbul Central (Çağlayan) Courts, Execution Offices and Insurance Arbitration Board shall be the competent jurisdiction for disputes related to or arising from the performance hereof.

21. SIBER ATTACK EXCLUSION CLAUSE

Losses and damages, liabilities and expenditures directly or indirectly caused by or contributed by computers, computer systems, software programs, malware, viruses, computer processes or other similar electronic systems or arising from the misuse or use with deliberate bad intentions of the foregoing shall be excluded from insurance coverage.

22. PERSONAL DATA PROTECTION

Your Personal Data shall be processed during provision of the services to ensure establishment and execution of your insurance contract and shall be transferred to respective competent authorities and/or other entitled receivers in accordance with the insurance legislation and other relevant applicable laws and regulations.

Please call Axa Call Center at (0850) 250 99 99 or send an e-mail to kisiselverikoruma@axasigorta.com.tr or visit https://www.axasigorta.com.tr /aydinlatma-bildirimi in case you need additional information about the objectives of personal data processing, methods of and legal grounds for collection of personal data and about Data Owner Rights.

23. OTHER WARNINGS

This Policy is arranged in accordance with the General Conditions specified or with the explanations and Special Conditions included in the Policy and delivered to the Insured with the enclosed General Conditions. The entire General Conditions can be found at AXA website: www.AXAsigorta.com.tr .

Important: Policyholder's address and contact information is included in the Policy in line with the Policyholder's representations. Insurer shall use the aforementioned address and contact information for all kinds of correspondence and communications regarding your insurance. Insurer's liability shall commence upon payment of the entire premium amount for prepaid Policies or the down payment amount (first installment) for installment Policies. Payment due dates specified in your premium payment plan are definite and failure in payment of any premium installment shall give rise to default.
Please visit www.axasigorta.com.tr to access information regarding your policies and other details on your portfolio.

Trade Registry No. of AXA Sigorta A.Ş. is 98645.

This Policy is drawn up in accordance with the General Conditions or otherwise explanations and the Special Conditions specified in the Policy.

B. HEALTH INSURANCE GENERAL CONDITIONS

Effective Date: October 10, 1990

Article 1- This Insurance provides coverage for treatment costs required in cases where invoice issued in the name of Policyholders get sick and/or injured in any kind of accident during Insurance Period, as well as daily indemnities, if any, in accordance with these General Conditions and associated Special Conditions, if any, and to the amount(s) specified in the relevant Insurance Policy.
Conditions Excluded from Insurance Coverage
Article 2- Any sickness and/or injury in any kind of accident suffered by invoice issued in the name of Policyholders during Insurance Period shall be excluded from Insurance Coverage for the following reasons:
a) War or military operations having the nature of war, insurrections, riots, commotions and domestic disorders arising from the foregoing,

b) Commit or attempt to commit a crime,
c) Cases where Policyholder acts in a way deliberately exposing themselves to grave danger, except for attempts to save endangered persons and/or property,
d) Use of narcotic substances such as marijuana, heroin,
e) Nuclear risks and/or use of nuclear, biologic and/or chemical weapons and/or all kinds of attacks and/or sabotage causing any nuclear, biologic and/or chemical substances to be released/exposed,
f) All damages due to terrorist acts as stipulated in Anti-Terror Act No.3713, sabotages originated from such activities and due to biologic and/or chemical pollution, contamination or poisonings arising from interventions of competent bodies to prevent and mitigate the foregoing,
g) Injuries or sicknesses which may occur due to a suicide attempt by Policyholder, and
h) Other conditions not included in Insurance Coverage as specified in Policy Special Conditions.

Conditions Excluded from Insurance Unless a Counter Agreement Exists

Article 3- ‘ Unless a contract exists otherwise, any sickness and/or injury in any kind of accident suffered by Policyholders during Insurance Period shall be excluded from Insurance Coverage for the following reasons:
a) Earthquake, flood, volcanic eruption and landslide,
b) Save for the damages indicated in Article 2(f), damages due to terrorist acts as stipulated in Anti-Terror Act No.3713, sabotages originated from such activities and interventions of competent bodies to prevent and mitigate the foregoing.

Territory

Article 4- Territory (geographical boundaries) for this Insurance Contract shall be specified on the Policy.

Inception and Expiration Dates

Article 5- Unless agreed as otherwise, this Insurance Contract starts at 12:00 PM on the Inception Date and ends at 12:00 PM on the Expiration Date, both times being in Turkish local time and the dates being indicated on the Insurance Policy.

Representation Liability of Policyholder at Contract Execution

Article 6- Insurer has accepted to provide this Insurance by relying upon the representations made by Policy Owner on the Proposal, or otherwise, on the Policy and its enclosed attachments. Policy Owner/Policyholder is liable to give correct and true answers to questions asked on the Proposal and its supplementary documents and accurately declare, to the extent known by the Policy Owner/Policyholder, all issues which constitute the subject matter of and which may affect assessment of the relevant risk. In cases where the representation of Policy Owner/Policyholder is inaccurate and/or insufficient, which may require the Insurer not to provide any insurance coverage or to impose heavier conditions;
a) If such inaccuracy and/or insufficiency arises from deliberate acts of the Policy Owner/Policyholder, Insurer shall be entitled to use their right of withdrawal from the Insurance Contract within one month after the Insurer becomes aware of the said situation and not to pay any compensation if the risk has been realized.
In case of withdrawal, Insurer shall be entitled to collect the premium.
b) Otherwise, if such inaccuracy and/or insufficiency is not caused by deliberate acts of Policy Owner/Policyholder, Insurer may terminate the Contract within one month after the Insurer becomes aware of the said situation or may continue by collecting the relevant premium

surplus. The Insurance Contract shall be terminated in case Policy Owner/Policyholder notifies within 8 days their rejection to pay the required premium surplus. Termination notice to be sent by the Insurer via registered mail with return receipt request or served through a notary public shall go into effect at 12:00 hours on the fifth business day following the receipt of such notice by the Policy Owner/Policyholder. Premium for the period up to when termination comes into effect shall be calculated on days basis and the surplus shall be reimbursed.

c) Rights of withdrawal, termination or request for premium surplus shall be forfeited if they are not used in due time.

d) In case the Policy Owner/Policyholder has no such deliberate acts or intentions and if the risk is realized:

1- Before the Insurer finds out the situation, or

2- Within the time period allowed to the Insurer for serving a termination notice, or

3- Within the period allowed for this notice to go into effect, then the Insurer shall make a discount on the compensation amount based on the difference between the premium amount charged and the premium amount which should have been charged.

Liability of Notification within Insurance Period

Article 7- Policy Owner shall be liable to notify the Insurer within maximum 8 days about any changes in/to the issues declared in the Proposal or otherwise in the Policy and its attachments which occur after Contract execution. In cases where such change requires the Insurer not to provide any insurance coverage or to impose heavier conditions, the Insurer may, within 8 days after being notified of such change:

1- either terminate the Contract, or

2- maintains the Contract by demanding the premium surplus amount.

The Insurance Contract shall be terminated in case Policy Owner/Policyholder notifies within 8 days their rejection to pay the required premium surplus.

Termination notice to be sent by the Insurer via registered mail with return receipt request or served through a notary public shall go into effect at 12:00 hours on the fifth business day following the receipt of such notice by the Policy Owner/Policyholder.

Premium for the period up to when termination comes into effect shall be calculated on days basis and the surplus shall be reimbursed.

Rights of termination or request for premium surplus shall be forfeited if not used in due time.

In case the Insurer, having been notified of such change, does not terminate the Contract within the following 8 days or acts in a way implying acceptance for keeping the Contract with the same conditions, such as collecting the initially agreed insurance premium, Insurer shall lose their right of termination or request for premium surplus.

Payment of Insurance Premium and Commencing of Insurer's Liability

Article 8*- Insurance premium amount would either be collected in entirety at policy delivery, or depending on the relevant provision, the first installment is to be paid at policy delivery and the outstanding installments on the dates specified on the policy.

Insurer's liability shall not commence before the first installment payment is made, whether the premium is defined to be paid in total or in installments.

For Policy premiums not paid on their due dates (either the first installment or the entire premium in case installment payment is not provided for), Insurer shall be entitled to use the right of withdrawal from the Agreement if the payment is still not made within three months. This period shall begin as of the due date. In case the premium payable is not requested

through litigation or legal proceedings within three months after its due date, Insurer is deemed to have withdrawn from the Contract.
In case any of the subsequent installment amounts is not paid on the relevant due date, Insurer shall send a notification to the Policy Owner, a formal notification sent either via notary public or via registered mail with return receipt, stating that ten days' time is allowed for the obligation to be paid or otherwise the Contract shall be terminated. In case the payment is still not made at the end of this time, Insurance Contract shall be terminated. Insurer's other rights provided by Turkish Code of Obligations due to Policy Owner's default shall be reserved.
Insurer shall be entitled to terminate the Insurance Contract to be enforceable at the end of the Insurance Period if Policy Owner has been served two warnings within the same period. Provisions regarding discounts in life insurances are reserved.
Premium payment dates, premium amounts and consequences of failure in payment are written on the front page of the Policy.
Linkage of Insurance price to bills of exchange shall not change the nature of obligation, nor shall it injure the rights and privileges provided in Turkish Commercial Code. (*: As amended with the Industrial Announcement No. 2016/12 on 15.06.2016.)
Liability of Policyholder in Case of Risk Realization
Article 9 –
A) Notification of Risk Realization:
- Policy Owner/Policyholder shall be liable to notify the Insurer in writing within 8 days after the date when they find out that the risk has been realized or in all cases on the date when they are able to make such notification.
- Policy Owner/Policyholder shall be liable to report the location, date, reason(s) of accident or sickness and additionally obtain a written report prepared by the treating physician indicating the status of sickness or accident and its possible consequences and send this report to the Insurer.
B) Initiation of Treatment and Taking Required Measures:
Initiation of treatment immediately after the accident or sickness and taking precautions required for healing of the injured or patient is compulsory.
Insurer shall always be entitled to have the injured or patient examined and check their medical status and Policy Owner/Policyholder must allow such examinations and checks.
Advices to be given by the Insurer's physician on recovery of the injured or patient which would directly affect the results of the accident or sickness must be observed as well.
In case the liabilities indicated in paragraphs A) and B) above
a) are deliberately not fulfilled, rights provided by the Policy shall be forfeited;
b) are not fulfilled due to negligence and if the consequences of accident or sickness are worsened for this reason, the Insurer shall not be liable for the portion such worsened.
C) Submission of Required Documents
Policy Owner/Policyholder shall be liable to deliver the original documents or true copies thereof, showing the medical examination, treatment, medicine and hospital(ization) costs & expenses payable due to the accident or sickness, together with the company notification and treatment forms to be filled in by the treating physician or the relevant hospital.
Cost/Expense Assessment
Article 10- This Insurance Contract shall cover, to the limits as specified in the Policy the costs & expenses incurred by the Policy Owner on per diem compensation basis, if any, pursuant to realization of the risks covered herein.

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Insurer shall not pay the claims regarding costs & expenses incurred on following conditions:
a) Cost & expenses which are not required by the nature of the respective accident or sickness and claims based on a specific agreement and exceeding reasonable amounts;
b) Expense claims contradictory to Insurance Special Conditions.
In case a mutual agreement cannot be reached between parties as to the cost & expense amounts, cost assessment shall be made by professional medical associations (if any), or otherwise, by persons called as "arbiter/expert" to be selected among specialists, in accordance with the following provisions: a) In case Parties cannot mutually agree on selection of a common and single arbiter/expert as defined in paragraph (b) above, each Party shall assign their own arbiter/expert and notify the situation to the other Party through a public notary. Parties shall select an impartial arbiter/expert within seven days after assigning their own arbiter/expert and before examination and review process starts and this shall be documented on a written protocol. This third arbiter/expert shall be authorized for making decisions on issues where the other two arbiters/experts fail to reach a mutual agreement, provided that these decisions shall remain within this specific scope and the relevant defined limits. The third arbiter/expert may submit their decision either in a separate report or on the same report jointly with the other two arbiters/experts. Arbiter/expert report(s) shall be served to Parties simultaneously.
c) In case Parties fail to assign an arbiter/expert within 15 days or Parties' arbiters/experts cannot agree on a third arbiter/expert within seven days following the notification of the other Party, then such Party's arbiter/expert or the third arbiter/expert shall be selected among impartial and specialized professionals by the chief judge of the competent commercial court within the treatment territory.
d) Both Parties shall be entitled to request the third arbiter/expert, whether this person is selected by Parties' arbiters/experts or by the chief judge of the competent court, to be selected from a place outside the residence of the Insurer or the Policyholder or the treatment location, and it is compulsory to fulfill this request.
e) In case an arbiter/expert dies, withdraws or is rejected, the new substitute arbiter/expert shall be selected with the same procedure and assessment process shall be released from the point suspended due to such decease, withdrawal or rejection. Decease of the Policyholder shall not end the commission of the assigned arbiter/expert. Right of rejection to arbiters/experts due to lack of expertise shall be forfeited unless such rejection is made within seven days after such deficiency is found out.
f) Arbiters/experts shall be entitled to request any evidence, records or documents and make inspections at treatment site as they may deem as necessary for assessment of cost & expense amounts.
g) Decisions of Party arbiters/experts and/or the third arbiter/expert regarding cost & expense amount shall be final and binding on Parties. Compensation claims cannot be raised against the Insurer or the Insurer cannot be sued without being based on an arbiter/expert decision.
Objection to the decisions of arbiters/experts can only be made when such decisions explicitly prove out to be significantly deviated from the actual situation and request for cancellation of such decisions can be made within one week after the delivery date of the arbiter/expert report by the competent commercial court within the treatment territory.
h) Unless Parties settle on the compensation amount and unless a period of two years have elapsed between the assignment date of arbiters/experts and the notification period as stipulated in Article 1292 of Turkish Commercial Code, the receivable shall become due and

payable only with an arbiter/expert decision and the prescription period shall not commence until the date when the final report is delivered to Parties. .

ı) Parties shall pay the remunerations of their own arbiters/experts. Remuneration and expenses of the third arbiter/expert shall be shared 50%-50% by both Parties.

i) Assessment of cost & expense amount shall affect neither the existing terms and conditions regarding risks covered, insurance price, inception of liability for the insured value, reasons for forfeiture provided both in this Policy and by the applicable legislation, nor the right to claim the foregoing.

Consequences of Indemnification and Insurer's Subrogation Right

Article 11- Insurer shall become the successor of Policyholder's all rights, including those provided by Social Security Act, to the extent of the compensation amount paid. Insurer can use the right to recourse against obligors for the amount paid.

Policy Owner and Policyholder are liable provide the information and documents which are obtainable and useful for the litigation or the legal case which might be filed by Insurer. (Amended by Industrial Announcement No.2015/22 on Amendments in Health Insurance General Conditions.)

Co-Insurance

Article 12- In case treatment expenses have been insured by multiple insurers, such expenses shall be shared between the insurers pro rata to the coverage amounts assured.

Confidentiality

Article 13- By signing the relevant documents, persons insured or to be insured are considered to have given their consent that their health information, coverage records and other data can be shared with the purpose of performing risk assessments and finalizing Compensation claims in accordance with Articles 31/A and 31/B of Insurance Act No.5684. This circumstance is specified on the information form, Policy or participation certificate.

Information and documents required in the first item of this Article to be able to make risk assessments and conclude the compensation claims should be suitable for and directly linked to this requirement.

The Company cannot give health information, coverage records and other data of Policyholders to third parties without obtaining their prior consent.

All third parties, whether real persons or legal entities, are responsible to keep such Policyholder data and information confidential. (Amended with the Industrial Announcement No. 2015/22.)

Notices and Notifications

Article 14- Notifications of the Policy Owner shall be made, in writing or via notary public, to the Insurer's headquarters or to the insurance agency intermediating this Insurance Contract.

Notifications of the Insurer shall be made, in writing or via notary public, to the address of the Policy Owner specified in the Policy, or, in case such address is changed, to the address last notified to the Insurer's headquarters or to the insurance agency intermediating this Insurance Contract.

Competent Jurisdiction

Article 15- Competent commercial courts within the place where the registered/residence address of the Insurer or the intermediary insurance agency is located or where the damage has occurred shall be in charge for legal cases to be filed against the Insurer and competent commercial courts within the place where the registered/residence address of the defendant is

located shall be in charge for legal cases to be filed by the Insurer due to disagreements and conflicts arising from this Insurance Policy.

Prescription

Article 16- All claims arising from this Insurance Contract shall be subject to a prescription period of two years.

Special Conditions

Article 17- Special conditions not conflicting with these General Conditions and/or related Clauses (if any) can be included in Insurance Policies.

Liability of Providing Information Form, Policy and Participation Certificate

Article 18* ‘ A. General Considerations

Policyholders must be delivered an Information Form and Insurance Policy or a Participation Certificate.

Information Form and Insurance Policy or Participation Certificate shall be delivered in return for signature, a signed copy of which shall be retained by the Company.

However, Information Form and Insurance Policy or Participation Certificate can be given in electronic environment or via similar tools enabling Policyholder's access in cases where Insurer and Policyholders cannot come together physically or where the nature of the business requires as such.

Written approval of Policyholders for information sharing can be obtained on a proposal, or a statement of consent proving such approval or other similar means in case such approval cannot be obtained on the Information Form and Insurance Policy or Participation Certificate delivered in return for signature.

Burden of proof for delivery of Information Form and Insurance Policy or Participation Certificate and obtaining Policyholder's consent for personal data sharing lies with the Insurer.

A copy of Information Form and Insurance Policy or Participation Certificate shall be posted on the Policyholder's personal page on the Insurer's website.

B. Group Insurance

A single insurance contract can be executed to cover a group of people comprising of minimum ten persons, who can be identified by the Policy Owner according to certain criteria. Every member of such group can use such insurance during the contract validity period until the expiration date. Insurance Contract shall not be affected if the number of members in the group drops below ten persons after Contract execution.

Information Form shall be delivered to group members before they are included in the group Insurance Contract and Participation certificate shall be delivered within fifteen days following such inclusion.

Insurer requires the contact information of Policyholders from the Policy Owner to be able to deliver the Information Forms and Participation Certificates. Policy Owner shall make the best efforts to facilitate and support Insurer in fulfilling their liability of providing Information Forms and Participation Certificates.

However, Insurer cannot be held responsible in case Insurer fails to duly fulfill their liability set out in this Article due to the failure of Policy Owner in providing the contact information of Policyholders as required.

In case Policyholder contact information is not shared with the Insurer, Insurer shall deliver the Information Forms and Participation Certificates to Policy Owner in accordance with the procedure stipulated in this Article to be handed over to Policyholders. A copy of Information Form and Participation Certificate shall be posted on the Policyholder's personal page on the Insurer's website. Insurer shall inform Policyholders about the means of access to their personal pages on Insurer's website.

C. Family Insurance

For Insurance Contracts including family members, delivery of separate Information Forms and Participation Certificates to dependents (spouse, children younger than 18 and other dependents) is not required. (*: Amended with the Industrial Announcement No. 2016/12 on 15.06.2016.)