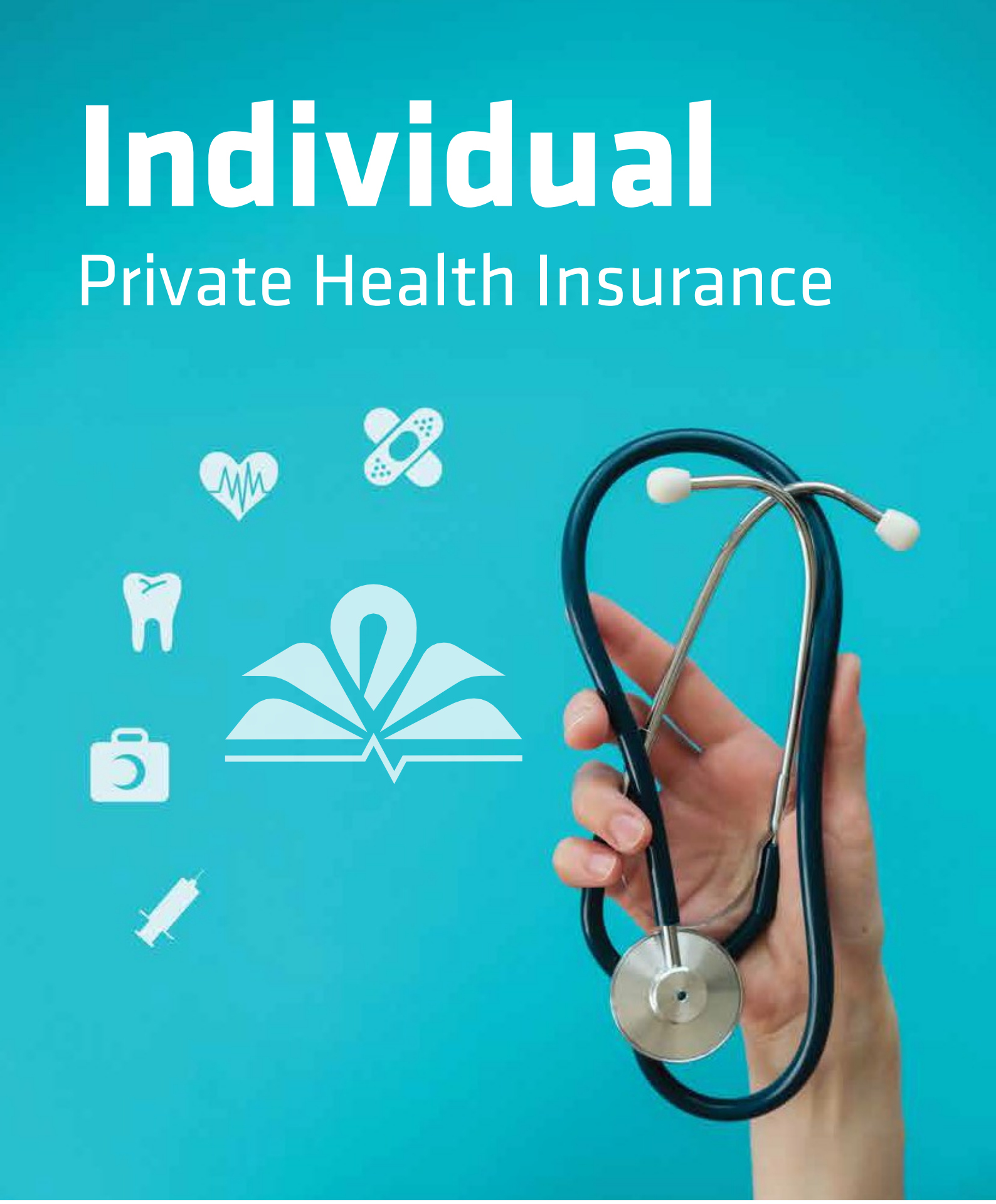
Individual

Private Health Insurance



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Contents

1. SUBJECT MATTER AND SCOPE OF COVERAGE

For purposes of this Insurance Contract, Katılım Emeklilik ve Hayat A.Ş. is hereinafter referred to as the "Insurer."

During the term of the Insurance Contract, the Insurer shall cover medical expenses incurred by each person named in the Policy as an Insured as a result of an Accident, Illness, and/or Medical Condition occurring after the Policy Effective Date. Such coverage is subject to the benefits, limits, Payment Percentages, deductibles, and Network specified in the Policy and shall be provided in accordance with these Special Terms and Conditions, the attached General Conditions of Health Insurance, the general provisions of the Turkish Code of Commerce, and, if included in the coverage table, the General Conditions of Personal Accident Insurance, the General Conditions of Life Insurance, the Life Insurance Special Terms and Conditions, and applicable laws and regulations.

The coverage provided under the Policy applies solely to the persons named as Insureds in the Policy. Persons not named as Insureds in the Policy are not entitled to coverage.

Any amendment to these Special Terms and Conditions shall take effect for each Insured on the effective date of the new Policy issued for that Insured and shall remain effective until the end of the applicable Policy Period.

The term of the Insurance Contract is one year. Unless otherwise agreed, the insurance shall commence at 12:00 noon Türkiye time and end at 12:00 noon Türkiye time on the dates specified in the policy as the commencement and ending dates.

This Insurance Contract is subject to the General Conditions of Health Insurance. Any legislative or regulatory amendments introduced by the Insurance and Personal Pension Regulation and Supervision Agency (IPRSA) or the Ministry of Treasury and Finance of the Republic of Türkiye shall be binding on this Insurance Contract from the dates on which they enter into force.

2. DEFINITIONS

2.1. Insurer

For the health insurance policies governed by these Special Terms and Conditions, the Insurer is Katılım Emeklilik ve Hayat A.Ş., a company incorporated in the Republic of Türkiye and duly licensed to conduct insurance business in the relevant lines of insurance.

2.2. Insured

An individual who has completed an application form for coverage under the Policy in accordance with the terms of the Policy and whose application has been accepted by the Insurer.

2.3. Policyholder

The natural person or legal entity that takes out the Policy for the person or persons named therein, undertakes to pay the insurance premium, and is responsible for fulfilling the obligations arising under the Insurance Contract.

2.4. Policy

The official document, issued in physical or electronic form, that constitutes legal evidence of the Insurance Contract entered into between the Insurer and the Policyholder and sets forth each Insured's identification and risk information, the Policy Effective Date and Policy Expiration Date, the benefits provided, applicable limits, coinsurance, deductibles, and premium payment terms.

2.5. Plan

The information set forth in the Policy specifying the coverage, coverage limits, and the Insurer's Payment Percentage or the Coinsurance applicable to each coverage.

2.6. Policy Effective Date

The date on which coverage under the Insurance Contract first becomes effective or, where applicable, becomes effective upon renewal. The Policy becomes effective at 12:00 noon, Türkiye time, on that date.

2.7. Policy Expiration Date

The date on which coverage under the Insurance Contract expires, whether at the end of the initial Policy term or any renewal term. The Policy expires at 12:00 noon, Türkiye time, on that date.

2.8. Policy Issuance Date

The calendar date on which the Insurer, after conducting a risk assessment based on the information provided by the Policyholder or the Insured in the application or renewal form, approves and formally issues the Policy.

2.9. Initial Insurance Date

The date accepted by the Insurer as the date on which the Insured first became covered under private health insurance.

2.10. Policyholder and Insured Contact Information

The home and business addresses, landline and mobile telephone numbers, and email addresses provided by the Policyholder and the Insureds in the application or renewal forms. The Policyholder and each Insured are responsible for ensuring that this information is accurate and up to date and for promptly notifying the Insurer of any changes.

2.11. Special Terms and Conditions

The document that forms an integral part of the Policy and sets out the rules and terms specific to the product.

2.12. General Conditions of Health Insurance (General Conditions)

The written rules prescribed by the Insurance and Personal Pension Regulation and Supervision Agency (IPRSA) and applied by all insurance companies to health insurance. The latest version of the General Conditions is available on the TSB website at www.tsb.org.tr.

2.13. Customer Services

The Katılım Emeklilik ve Hayat A.Ş. Health Contact Center telephone line, available at 0850 226 0 123, through which Insureds may obtain information and submit requests, suggestions, and complaints regarding their health insurance Policies, preauthorization processes, contracted healthcare institution network, and emergency services, including ambulance services.

2.14. Group Health Insurance

A type of health insurance under which persons connected to a Policyholder that is a legal entity through employment, student enrollment, membership, or a similar relationship are insured on a group basis, and members of the same immediate family may be insured together under the same Policy, including the employee, spouse, and children.

2.15. Individual Health Insurance

A type of health insurance under which individuals may be insured alone or together with members of their immediate family, including unmarried children, adopted children, and children whom they are legally required to support, as evidenced by official documentation.

2.16. Illness

An impairment of the Insured's bodily functions, organs, or systems that is identified by a Physician and requires medical testing, treatment, or intervention.

2.17. Medical Condition

An objectively and medically identifiable abnormal sign, symptom, or finding that requires examination by a Physician, medical testing, diagnosis, or treatment.

2.18. Pre-existing Illness/Condition

Any Illness or Medical Condition retroactive in nature, originating before the Initial Insurance Date that was diagnosed, produced symptoms, was subject to diagnostic testing or treatment, or was known or reasonably should have been known to the Insured, including any recurrence or complication thereof.

2.19. Application and Information Form

The form containing the prospective Insured's identification and contact information, health declaration, and bank account details, together with the selected product's risk parameters, including the Network, coverage, Limit, Payment Percentage, and Deductible, and the premium payment schedule. The form incorporates the statutory disclosures required under applicable law and the process for obtaining explicit consent under the PDPL. It must be approved in physical or electronic form by the Policyholder, the Insured, or both, as applicable, and constitutes a formal offer to enter into an Insurance Contract with the Insurer.

2.20. Duty of Disclosure

At the time of the initial application, at renewal, and at every stage of the Policy process, the Policyholder and the Insured must fully and accurately disclose to the Insurer the complete history of all past and current Illnesses, Medical Conditions, symptoms, and treatments that may affect the Insurer's Risk Assessment. This duty extends to every family member (dependent) to be covered under the Policy. Upon request, the Insured must provide the Insurer with any requested medical documentation, including diagnostic records, test results, physicians' reports, and discharge reports. If any disclosure is incomplete, misleading, or false, the relevant provisions of the Turkish Code of Commerce and the General Conditions of Health Insurance shall apply.

To enable the Insurer to properly administer its statutory disclosure and preauthorization processes, all contact information fields in the Application and Information Forms must be completed in full. Any change to this information must be reported to the Insurer in writing within 10 (ten) calendar days of the change. The Insurer shall not be liable for any loss of rights resulting from a failure to report such change.

2.21. Risk Assessment

The Insurer's evaluation of the declarations and/or health information provided by the Policyholder or the Insured to determine whether to enter into the Insurance Contract and, if so, on what terms and conditions.

2.22. Exclusion

The exclusion from coverage, following the Insurer's Risk Assessment, of any risk, including any Illness, Medical Condition, or medical complaint, that arose before the Policy Effective Date or arises during the term of the Policy.

2.23. Deductible

The portion of a medical expense eligible for payment under the Policy that must be borne by the Insured. Depending on its type, a Deductible may apply before the Insurer's liability begins, on a per-procedure basis, or within specified Limit ranges.

2.24. Medical Loading

An additional premium, calculated as a specified percentage of the Health Tariff Premium, that the Insurer may apply following a Risk Assessment in order to provide coverage for an Illness or Medical Condition that existed before the Policy Effective Date or arises during the term of the Policy.

2.25. Limit

The maximum annual gross claim amount for each coverage under the Policy. The gross Limit is the total of the amount payable by the Insurer and any Coinsurance and Deductible amounts payable by the Insured.

2.26. Premium

The amount payable for health insurance, as determined based on risk-profile factors such as the Coverage selected by the Insured, the applicable Payment Percentages, the Network structure, age, sex, and province of residence.

2.26.1. Health Tariff Premium

The portion of a medical expense eligible for payment under the Policy that must be borne by the Insured. Depending on its type, a Deductible may apply before the Insurer's liability begins, on a per-procedure basis, or within specified Limit ranges.

2.26.2. Health Premium

The amount calculated by adding any Medical Loading determined for the relevant Insured following a Risk Assessment to the Health Tariff Premium.

2.26.3. Net Health Premium

The Health Premium after applying any discounts to which the Insured is entitled under these Special Terms and Conditions, including no-claims and family discounts, together with any applicable promotional discounts then in effect.

2.26.4. Total Policy Premium

The total premium calculated by adding to the Health Premium any applicable premium for Illness Coverage (Illness Indemnity Coverage Premium), Personal Accident Coverage and/or Life Coverage, together with applicable taxes. This is the total amount payable by the Policyholder under the Policy.

2.27. Health Care Services Fee Schedule

For Contracted Healthcare Institutions, the prices and rules of application established under separate agreements with the Insurer and, for Non-Contracted Healthcare Institutions or reimbursement claims, the reference fee schedules that serve as the maximum amounts used in calculating claim payments. These reference fee schedules include the Turkish Medical Association Fee Schedule (TMA), the Medical Practice Database (MPD), the Health Implementation Communiqué (HIC), the Turkish Dental Association Fee Schedule (TDA), and similar statutory or institutional fee schedules.

2.28. Healthcare Institution

A hospital, clinic, outpatient clinic, diagnostic or treatment center, physician's office, or private maternity facility established for childbirth that is licensed to operate by the Ministry of Health of the Republic of Türkiye, is authorized to provide diagnostic, treatment, and surgical services, has one or more physicians available to provide care at all times, institutions incorporating private delivery rooms/maternity units, and provides medical care and treatment.

The term Healthcare Institution shall not be construed to include hotels, nursing homes, care facilities, convalescent homes, elderly care facilities, orphanages, sanatoriums, spas, thermal facilities, weight-loss centers, detoxification centers, cosmetic or beauty centers, drug or alcohol addiction isolation or treatment centers, or water-birth units, including pools. Any expenses incurred at such facilities are excluded from coverage.

2.28.1. Contracted Healthcare Institution:

A hospital, medical center, physician, pharmacy, laboratory, imaging center, or physical therapy center that has entered into a separate agreement with the Insurer, is approved by the Insurer, and agrees to collect payment for healthcare services provided to the Insured directly from the Insurer, subject to the applicable Policy Limits and after deduction of any applicable Deductibles and Coinsurance, provided that preauthorization has been granted by the Insurer.

The Insurer reserves the right to add Healthcare Institutions to or remove Healthcare Institutions from the List of Contracted Healthcare Institutions at any time during the Policy term.

2.28.2. Non-Contracted Healthcare Institution

A hospital, medical center, physician, pharmacy, laboratory, imaging center, or physical therapy center that is not included in the Insurer's active network of Contracted Healthcare Institutions and charges the Insured directly for the healthcare services provided, whether in cash, by credit card, or through another method of payment.

2.28.3. Overseas Healthcare Institution

A hospital, laboratory, diagnostic center, outpatient clinic, pharmacy, or similar institution that provides healthcare services outside the Republic of Türkiye and qualifies as a healthcare institution under the laws of the country in which it operates.

2.29. Contracted Healthcare Institution Network (Network)

The network of Contracted Healthcare Institutions applicable to the Policy selected by the Policyholder. Each Network is established by the Insurer from among its Contracted Healthcare Institutions, taking into account factors such as the services provided, geographic location, and contractual terms.

2.30. Claim Payment

The net amount approved by the Insurer for payment in respect of medical expenses determined to be covered under the General Conditions of Health Insurance and these Special Terms and Conditions, after applying the applicable Limits, Coinsurance, Deductibles, and, where applicable, the maximum amounts specified in the Health Care Services Fee Schedule.

2.31. Coverage

The legal and financial protection provided under the General Conditions of Health Insurance, these Special Terms and Conditions, and the Coverage Table attached to the Policy, under which medical expenses of the Insured that fall within the scope of coverage are subject to approval by the Insurer through preauthorization and/or payment by the Insurer.

2.32. Payment Percentage

The percentage of medical expenses incurred under each Coverage specified in the Policy that is payable by the Insurer. The Payment Percentage is applied to the net claim amount calculated after deducting from the medical expenses incurred any applicable Deductibles and any amounts exceeding the maximum amounts specified in the Health Care Services Fee Schedule (TMA/MPD/HIC, etc.). Together with the Coinsurance percentage payable by the Insured, the Payment Percentage equals 100%.

2.33. Coinsurance (Insured's Share)

The percentage of, or the amount corresponding to such percentage of, medical expenses incurred under the Coverage specified in the Policy that, after deducting any applicable Deductibles and any amounts exceeding the maximum amounts specified in the Health Care Services Fee Schedule, together with the Insurer's Payment Percentage equals 100% and must be borne directly by the Insured. For services received from a Contracted Healthcare Institution, the Coinsurance is paid directly by the Insured to the relevant Healthcare Institution.

2.34. New Business Policy

An individual health insurance Policy entered into by the Policyholder with the Insurer on behalf of the Insured upon selecting one of the Individual Health Insurance products offered by Katılım Emeklilik ve Hayat A.Ş., and which constitutes the Insured's first period of insurance in the system.

2.35. Transfer/Transition Policy

An individual health insurance Policy issued for an Insured who, following the Policyholder's selection of one of the Individual Health Insurance products offered by Katılım Emeklilik ve Hayat A.Ş., transfers without interruption from another insurance company or from a Group Health Insurance Policy held with the Insurer, with the Insured's previously acquired rights carried over in accordance with the applicable Risk Assessment principles.

2.36. Renewal Policy

The renewal, without interruption, for an additional one-year period of an Individual Health Insurance Policy held by the Insured with Katılım Emeklilik ve Hayat A.Ş. that has reached the end of its term, effective from the Policy Expiration Date, within the statutory period specified in these Special Terms and Conditions and subject to the Insurer's Risk Assessment.

2.37. Emergency

A condition arising from a sudden Illness or bodily injury that, except for applicable Waiting Periods and exclusions specified in the General Conditions of Health Insurance and these Special Terms and Conditions, cannot be delayed, requires medical or surgical treatment, and is determined by the Insurer to constitute an emergency. The following are emergencies as defined by the World Health Organization:

- Hypertensive crises,
- Poisoning,
- Traffic accidents,
- Acute strokes,
- Headaches associated with migraine and vomiting and resulting in loss of consciousness,
- Asthma attacks,
- Acute respiratory problems,
- Fever above 39°C,
- Severe allergic reactions,
- Anaphylaxis,
- Acute abdomen,
- Falls from a height,
- Serious occupational accidents,
- Traumatic amputation,
- Meningitis,
- Encephalitis,
- Cerebral abscess,
- Electric shock,
- Drowning,
- Frostbite,
- Hypothermia,
- Heat Stroke,
- Any condition causing loss of consciousness,
- Severe burns,
- Neonatal coma,
- Diabetic and uremic coma,
- Dialysis-related conditions accompanied by deterioration in general condition,
- Acute massive hemorrhage,
- Spinal and lower-extremity fractures,
- Rape,
- Myocardial infarction,
- Arrhythmia,
- Severe eye injuries,
- Gunshot and stab wounds.

2.38. Terrorism

Any loss or damage arising from biological and/or chemical contamination, infection, or poisoning caused by terrorist acts specified in Anti-Terror Law No. 3713, sabotage resulting from such acts, or actions taken by competent authorities to prevent such acts or mitigate their effects.

2.39. Alternative Treatment

Experimental or investigational procedures that have not been scientifically proven, wellness practices, alternative and traditional medicine treatments, including acupuncture and mesotherapy, and ozone therapy.

2.40. Principle of Maximum Goodwill

The Insurer enters into this Insurance Contract and determines its terms entirely in reliance on the declarations made by the Insured and/or the Policyholder. Accordingly, the Insured and/or the Policyholder must provide accurate, complete, and truthful answers to all questions contained in the Application Form, the Information Form, and any supplementary documents forming part of the Insurance Contract, and must disclose to the Insurer all matters that may affect the Risk Assessment.

The Principle of Maximum Goodwill requires all Insureds entitled to coverage under the Insurance Contract to fully, clearly, and accurately disclose to the Insurer, without omission or misrepresentation, all information concerning their past and current Illnesses, Medical Conditions, symptoms, and general health status. In the event of a breach of this principle, the provisions of the Turkish Code of Commerce and the General Conditions of Health Insurance governing breach of the Duty of Disclosure shall apply.

2.41. Congenital Condition

Any disease, hereditary anomaly, absence of an organ, or structural deformity that is present in utero or at birth, or that subsequently manifests clinically as a result of genetic or chromosomal factors.

2.42. Physician

A person duly qualified and licensed as a medical doctor under the laws applicable in the geographic area in which the healthcare service is provided.

2.43. Accident

A sudden, unexpected, unintended event that could not reasonably have been prevented or planned in advance, and any Illness or injury resulting from such event.

2.44. Acquired Rights

For purposes of this Insurance Contract, Acquired Rights means the rights associated with the Initial Insurance Date and the Lifetime Renewal Guarantee.

2.45. Medical Necessity

Diagnostic, testing, and treatment procedures are considered medically necessary when they are consistent with generally accepted medical standards, appropriate to the patient's current clinical condition and the symptoms of the relevant Illness or Medical Condition, and are necessary and effective. The fact that a diagnostic test, treatment, or surgical procedure has been prescribed or performed by a Physician does not, by itself, establish Medical Necessity.

In the event of a dispute regarding Medical Necessity, the final determination shall be made by the Insurer's Consulting Physician based on the patient's medical records, including discharge reports and test results, or, where deemed necessary, based on the opinion of an independent medical expert in the relevant specialty.

2.46. Consulting Physician

An independent specialist physician or panel of physicians appointed by the Insurer to review the Medical Necessity, including the clinical indication, of diagnostic, testing, and treatment procedures that are the subject of a claim under this Insurance Contract, in accordance with generally accepted medical standards and these Special Terms and Conditions, and to provide an expert medical opinion.

2.47. Remote Healthcare Service

A healthcare service provided remotely by a healthcare professional to a person seeking healthcare services through a remote healthcare information system at a Healthcare Institution authorized to provide such services in accordance with the Regulation on the Provision of Remote Healthcare Services (RHS) issued by the Ministry of Health.

2.48. Medical Expense Claim Form

The standard form that must be completed in full and signed by both the Insured and the treating Physician in order for the Insured to submit a claim for reimbursement of medical expenses incurred at a Non-Contracted Healthcare Institution or where preauthorization was not obtained. The form must be submitted to the Insurer through physical or digital channels together with the original invoice and all other required medical documentation.

2.49. Family

For purposes of this Insurance Contract, Family means the Insured's legal spouse who is covered under the Policy and all unmarried children over whom the Insured has legal custody, including adopted children.

2.50. Turkish Medical Association / MPD Current Fee Schedule and Rules of Application

The reference standards established by the Turkish Medical Association (TMA) and the Medical Practice Database (MPD), setting out the list of procedures for medical services provided to patients, including examinations by a Physician, surgery, diagnostic testing, and similar services, together with the applicable scoring and fee criteria and rules of application.

2.51. Health Implementation Communiqué (HIC)

The Social Security Institution Health Implementation Communiqué, which sets out the principles and procedures under which the SSI covers healthcare-related expenses incurred by persons covered by the SSI and their dependents, including healthcare services, transportation, per diem, and companion expenses, and determines the amounts payable for such services.

2.52. Katılım Emeklilik Coverage Start Date

The date on which the Insured first became covered under a Health Insurance Policy with the Insurer as part of an uninterrupted period of health insurance coverage with the Insurer.

2.53. Additional Fees

Additional amounts that foundation universities and private Healthcare Institutions contracted with the Social Security Institution may charge to individuals or Insureds, calculated based on the amounts billable to the SSI and provided that such additional charges do not exceed the rate determined by the SSI based on the total procedure fees for healthcare services set out in the HIC and its annexes.

2.54. Social Security Institution Copayment (SSI Copayment)

The amount payable at the time of a medical examination by a person covered by general health insurance or a dependent in order to receive healthcare services, as provided under Social Insurance and General Health Insurance Law No. 5510.

2.55. Preauthorization

The payment approval requested by the relevant Contracted Healthcare Institution from the Insurer's Preauthorization Center, indicating whether the planned treatment of the Insured at a Contracted Healthcare Institution within the selected Network will be covered. Such approval is valid only if the Policy is in force on the date the medical expense is incurred.

A Preauthorization granted by the Insurer constitutes a binding commitment under the General Conditions of Health Insurance and these Special Terms and Conditions, except where the use of forged documents, intentional misrepresentation, fraud, or bad-faith abuse of insurance coverage is subsequently identified. For Preauthorizations requested in advance for a future date, the medical claim adjudication date, on which the risk and applicable Coverage Limits are actually determined, shall govern.

2.56. Claim Adjudication

The formal stage at which the Insurer conducts a final financial and medical review of claims and invoices received in accordance with the General Conditions of Health Insurance and these Special Terms and Conditions, determines the final Claim amount, and records that amount in its accounting records. For claims for which Preauthorization has already been granted, this stage consists of verification of the invoice and issuance of the payment order. For claims for which no Preauthorization was obtained and reimbursement is sought, this stage constitutes the principal determination of entitlement to the Claim Payment.

2.57. Direct Payment

Where medical expenses are incurred at a Contracted Healthcare Institution within the Network selected under the Policy, the Insured may receive the relevant healthcare services after obtaining Preauthorization and, where the Policy provides for Coinsurance and/or a Deductible, by paying only the applicable Coinsurance and/or Deductible. The Insurer shall pay the portion for which it is responsible under the General Conditions of Health Insurance and these Special Terms and Conditions directly to the relevant Healthcare Institution on behalf of the Insured.

2.58. Reimbursement

Where no Preauthorization is obtained, the Insured first pays the medical expense to the Healthcare Institution and then submits to the Insurer the invoice relating to the medical expense, the Medical Expense Claim Form, and the required documents specified in the "Claim Payment" section of these Special Terms and Conditions. Following an evaluation in accordance with the General Conditions of Health Insurance and these Special Terms and Conditions, the amount determined to be payable is reimbursed to the Insured's account.

The expense incurred is evaluated in accordance with the General Conditions of Health Insurance and these Special Terms and Conditions, the applicable Coverage Limits and Coinsurance, and the maximum amounts specified in the relevant Health Care Services Fee Schedule (TMA/MPD/HIC, etc.). The approved amount is then transferred to the Insured's bank account by bank transfer or electronic funds transfer (EFT).

2.59. Endorsement

A supplementary insurance agreement issued as an integral part of the Policy to reflect any amendments made after the Policy takes effect and to set out the Policy as amended.

2.60. Triage Procedure

The process by which patients presenting to an emergency department are assigned a level of priority by a Physician or appropriately trained healthcare professional based on their medical complaints, the severity of their symptoms, and the urgency of their medical condition. Triage is performed at the time of presentation. Red, yellow, and green categories are used to establish the order of priority for examination, diagnostic testing, treatment, and medical and surgical intervention.

2.60.1. Green zone

Patients who present on an outpatient basis, are clinically stable, and have minor medical conditions that can be treated on an outpatient basis fall within the Green Zone. Green Zone presentations are not covered under Emergency Coverage and are instead covered under the standard Outpatient Treatment Coverage specified in the Policy, subject to the applicable Limits and Coinsurance.

2.60.2. Yellow Zone

Conditions that may be life-threatening, involve a risk of loss of limb or significant morbidity, or present with moderate or prolonged symptoms that have the potential to become serious fall within the Yellow Zone.

2.60.3. Red Zone

Critical conditions that directly threaten life and require immediate, concurrent assessment and treatment using rapid and aggressive medical management, with no delay in intervention, fall within the Red Zone. This category includes cases with a high likelihood of becoming life-threatening and requiring intervention within no more than 10 (ten) minutes.

2.61. Cancellation Date

The date on which this Insurance Contract is canceled at the written request of the Policyholder or as a result of rescission or termination by the Insurer for any of the reasons specified in the General Conditions of Health Insurance or these Special Terms and Conditions.

2.62. Pro Rata Cancellation

In connection with a premium refund or cancellation during the Policy term, the calculation of the premium based on the number of days the Policy remained in force and the refund to the Policyholder of the premium attributable to the remaining days, subject to the applicable claims-to-premium ratio criteria.

2.63. Medical Expense

An expense relating to diagnostic and/or treatment procedures that is determined to be covered under the Individual Health Insurance Contract, the General Conditions of Health Insurance, and these Special Terms and Conditions, is incurred during the Policy term, satisfies the Insurer's Medical Necessity requirements, and is planned in writing by the Insured's Physician.

2.64. Insurance Intermediary

A person authorized under applicable insurance legislation to act as an intermediary in connection with insurance contracts.

2.65. Healthcare Institutions and Physicians Ineligible for Reimbursement

Healthcare Institutions and/or physicians in respect of which the Insured is not eligible for reimbursement, even where the relevant Medical Expenses would otherwise fall within the scope of Coverage. Any procedures performed at Healthcare Institutions or by physicians found to have engaged in improper insurance practices, unnecessary diagnostic testing or treatment, or insurance abuse are excluded from Coverage under the Policy.

2.66. Case

Where claim requests relating to diagnostic and treatment services are stated to be made on a per-Case basis, Case has the following meaning:

a) All procedures performed following an initial examination prompted by a complaint for the purpose of identifying or confirming any pathology related to that complaint are considered part of the same Case. Such procedures include:
1. The initial examination by a Physician;
2. Laboratory tests and imaging procedures, including expenses related to X-rays, computed tomography (CT), magnetic resonance imaging (MRI), scintigraphy, endoscopy, audiometry, and similar advanced diagnostic procedures;
3. Consultations with specialist physicians relating to the diagnosis and all diagnostic tests requested by such consulting physicians; and
4. All outpatient and inpatient medical and surgical treatment required as a result of the procedures specified in items 1 through 3, together with related room, attendant, medical supply, medication, and physical therapy expenses.

b) Any pathology affecting an adjacent organ or a distant organ or system that is incidentally identified during the evaluation of the complaint referred to in paragraph a) shall be treated as a separate Case if it is unrelated to the initial treatment and to the underlying disease or syndrome.

c) For Outpatient Treatment, any additional procedure relating to a symptom, finding, diagnostic evaluation, or treatment classified as part of the same Case shall be treated as a separate Case if performed more than 10 (ten) calendar days after the initial Case. Any Complication arising within the first 10 (ten) calendar days of the same Case shall continue to be treated as part of that Case.

d) If an etiologically independent new Case arises during the course of the same Case as a result of an additional factor, including anesthesia, an adverse drug reaction, iatrogenesis, stress, or a Complication, diagnostic tests and treatment relating to the original Case shall remain within that Case, while those relating to the new condition shall be treated as a separate Case.

2.67. Discharge Report (Epicrisis)

An official medical report, signed and stamped by the treating Physician and the Healthcare Institution, that chronologically summarizes the diagnoses, diagnostic tests, surgical and medical treatments provided, and the patient's health status from the Insured's admission to the hospital through discharge. It serves as the primary reference document for the evaluation of Reimbursement and Preauthorization processes.

2.68. Complication

A health condition arising in connection with an Illness during the course of the Illness, during treatment, or following treatment.

3. COVERAGE

3.1. Inpatient Treatment Coverage

Treatment required as a result of an Illness or Accident occurring during the Policy term shall be considered Inpatient Treatment where the Insured is admitted to a fully equipped Healthcare Institution and continuous hospitalization for at least 24 (twenty-four) hours is medically required. Surgeries, same-day surgical procedures, and invasive procedures that meet the requirements of Medical Necessity are not subject to the 24 (twenty-four)-hour continuous hospitalization requirement and are also covered under Inpatient Treatment Coverage. Inpatient treatment expenses are covered by the Insurer subject to the Coverage Limits, Coinsurance percentages, Deductibles, and Waiting Periods specified in the Policy and in accordance with these Special Terms and Conditions and the General Conditions of Health Insurance. However, where the Policy is not renewed with the Insurer, coverage for such inpatient treatment may in no event continue for more than 10 (ten) calendar days after the Policy Expiration Date. If the Policy is canceled or transferred to another insurance company, any treatment provided after the effective time of cancellation or transfer is excluded from Coverage.

3.1.1. Surgery

Where treatment requires surgery, Coverage includes routine preoperative tests requested by the anesthesiologist, including HIV tests and hepatitis markers; operating room charges; fees of the operating surgeon, anesthesiologist, and assistant physician; and anesthesia medications and medical supplies. Coverage also includes specialized medical devices and materials that are medically necessary, including ICDs, implantable pumps, pacemakers, and heart valves, together with other surgery-related expenses and expenses associated with coronary angiography, ectopic pregnancy, hydatidiform mole, percutaneous transluminal coronary angioplasty (PTCA), and extracorporeal shock wave lithotripsy (ESWL) for kidney stones.

For all scheduled surgeries other than those required due to a medical emergency, the Medical Expense Claim Form, or the applicable medical information form, must be completed by the Physician who will perform the surgery and submitted to the Insurer at least 48 (forty-eight) hours before the scheduled surgery in order to obtain Preauthorization.

Where a surgery covered under the Policy and a procedure excluded from Coverage,
including an aesthetic or cosmetic procedure or a procedure subject to a Policy Exclusion, are performed during the same session, the amount of the invoice eligible for payment shall be calculated using a weighted average based on the applicable unit values under the Turkish Medical Association (TMA) Minimum Fee Schedule and the Medical Practice Database (MPD).

For any diagnostic test, treatment procedure, surgery, or delivery performed by a Physician who is not a staff member of the relevant Contracted Healthcare Institution, the amount payable to the Physician and the Physician's team shall be subject to the Limit and Payment Percentage applicable to Non-Contracted Healthcare Institutions under the relevant Policy. The Insurer shall not be liable for any physician fee differential exceeding the applicable Limit.

3.1.2. Inpatient Medical Treatment (Non-Surgical Treatment)

Where treatment does not require surgery but medically requires continuous hospitalization for at least 24 (twenty-four) hours in a standard room or intensive care unit at a fully equipped Healthcare Institution, all medical expenses associated with such inpatient treatment are covered under this Coverage. Even where continuous hospitalization for 24 (twenty-four) hours is not required, expenses incurred for emergency intervention, diagnostic testing, and treatment in connection with medical emergencies defined by the World Health Organization (WHO) are covered under this Coverage. The rules governing the Triage Procedure set forth in the Definitions section of these Special Terms and Conditions shall apply.

All inpatient medical expenses associated with the treatment of physiological jaundice in a newborn requiring hospitalization, including phototherapy, are covered under this Coverage, provided that the newborn is covered under the Policy.

Routine outpatient diagnostic tests and follow-up examinations that do not, by their nature, require hospitalization, as well as chemotherapy, radiotherapy, and dialysis administered on a session basis, unless otherwise specified in the Policy, are excluded from this provision and are subject to their respective specific Coverage provisions.

3.1.3. Artificial Limb

Where an Accident or Illness occurring during the period of insurance results in loss of bodily integrity, expenses for medically necessary artificial limbs and prostheses intended to restore lost function, including artificial hands, arms, legs, eyes, and penile prostheses, together with related reconstructive surgical expenses, are covered subject to the Artificial Limb Coverage Limit and applicable Coinsurance specified in the Policy.

Expenses for reconstructive breast prostheses used to restore bodily integrity following the medically necessary complete or partial removal of a breast (mastectomy) as part of cancer treatment or oncologic surgery are covered under this Coverage. Expenses for any breast prosthesis, implant, or silicone used for aesthetic or cosmetic purposes for reasons unrelated to cancer are excluded from Coverage.

Artificial limbs or prostheses required as a result of disabilities, limb loss, or congenital anomalies existing before the Initial Insurance Date, as well as expenses for the replacement, repair, maintenance, or adjustment of artificial limbs or prostheses fitted before the Policy Effective Date, are excluded from Coverage under the Policy.

3.1.4. Chemotherapy, Radiotherapy, and Dialysis Treatment

These treatments and the related treatment sessions are covered under Inpatient Treatment Coverage, subject to the applicable Limits and Coinsurance/Payment Percentage, even where they do not, by their nature, require continuous inpatient hospitalization for 24 (twenty-four) hours.

For antineoplastic drugs and targeted anticancer drugs, including immunotherapy, used during chemotherapy to be covered, they must be approved by the Ministry of Health of the Republic of Türkiye, licensed in Türkiye, and approved for the relevant cancer indication by both the U.S. Food and Drug Administration (FDA) and the European Medicines Agency (EMA). Experimental or unlicensed drugs are excluded from Coverage.

Expenses for supportive medications and intravenous fluids prescribed by a Physician to prevent acute complications and side effects caused by chemotherapy are also covered under this provision, even though such medications are not themselves anticancer drugs.

In addition to cancer treatment, expenses for medications formulated with the active ingredient interferon alpha (Roferon-A or Intron A) or peginterferon alpha (Pegasys or Pegintron) that are prescribed by a Physician and medically necessary for the treatment of Hepatitis C are also covered under this Coverage, subject to the terms applicable to this Coverage.

3.1.5. Chemotherapy, Radiotherapy, and Dialysis Tests

Regardless of whether treatment is provided on an outpatient or inpatient basis, all medically necessary laboratory tests, routine X-rays, and advanced diagnostic and imaging procedures, including PET-CT, computed tomography (CT), magnetic resonance imaging (MRI), and scintigraphy, performed in connection with chemotherapy, radiotherapy, or dialysis for the purpose of treatment planning, interim monitoring, or monitoring acute complications arising from treatment sessions are covered subject to the Chemotherapy, Radiotherapy and Dialysis Tests Coverage Limit and applicable Payment Percentage/Coinsurance specified in the Policy.

If this Coverage is not separately provided under the Policy, or if the applicable Chemotherapy, Radiotherapy and Dialysis Tests Coverage Limit is exhausted during the Policy term, such testing expenses shall continue to be covered under the standard Outpatient Treatment Coverage (Laboratory/Advanced Diagnostics), subject to the applicable Coverage Limit and Coinsurance specified in the Policy.

This Coverage applies solely to expenses for diagnostic tests, follow-up testing, and laboratory tests. Hospital services, Physician's fees, venous port placement, and medication expenses

incurred in connection with the administration of the relevant treatments are excluded from this provision and are covered directly under Chemotherapy, Radiotherapy and Dialysis Treatment (Inpatient) Coverage.

3.1.6. Minor Procedures

Surgical and orthopedic procedures assigned up to 149 (one hundred forty-nine) units under the Turkish Medical Association (TMA) and Medical Practice Database (MPD) unit schedules are covered under this Coverage regardless of whether they are performed on an outpatient or inpatient basis. Covered procedures include surgical procedures involving skin incisions; treatment of fractures and dislocations; application of casts or splints; removal of foreign bodies; and therapeutic excisional procedures involving the complete removal of a lesion, rather than procedures performed solely for diagnostic purposes.

For procedures performed under Minor Procedures Coverage, medical supplies and medications used during the procedure and the fee of the Physician who actually performs the procedure are covered under this Coverage. Examinations by a Physician performed before or after the procedure and diagnostic testing expenses, including laboratory tests and X-rays, are excluded from this provision and are covered under the applicable Outpatient Treatment Coverage, subject to the relevant Limits and Coinsurance.

Medical expenses associated with pain-management procedures for spinal and disc disorders, including facet nerve denervation, radiofrequency thermocoagulation, transforaminal epidural injections, and similar procedures, are covered under this Coverage based on the base unit assigned to the applicable procedure under the TMA and MPD schedules, regardless of whether the procedure is performed on an inpatient or outpatient basis.

Expenses for PUVA sessions, involving ultraviolet light therapy for dermatological conditions, are covered subject to the Limit applicable to this Coverage.

Where multiple procedures are performed during the same session and their combined TMA and MPD unit value is 149 or higher, all such procedures shall nevertheless be treated collectively under this Coverage, provided that none of the individual procedures has a listed unit value of 149 or higher.

3.1.7. Room, Meals, and Companion Coverage

For each full day during which the Insured receives inpatient treatment at a hospital, expenses for a standard private room with single occupancy, hospital meals, and a companion limited to 1 (one) person are covered in accordance with the General Conditions of Health Insurance and these Special Terms and Conditions. If the Insured is admitted to a luxury room, suite, deluxe room, royal suite, or similar accommodation, payment for room, meal, and companion expenses shall be based on the standard single-room rate charged by the relevant Healthcare Institution, and the Insured shall be solely responsible for any difference in cost.

Except for inpatient treatment resulting from acute Accidents, hospitalization for treatment of an Illness at Healthcare Institutions is limited to a maximum of 180 (one hundred eighty) days during any 1 (one)-year insurance period and an aggregate lifetime maximum of 720 (seven hundred twenty) days. Once these limits are exceeded, all expenses otherwise covered under Inpatient Treatment Coverage are excluded from Coverage.

For purposes of calculating the total hospitalization period, each 1 (one) day spent in a standard room counts as 1 (one) day against the applicable hospitalization limit. Each 1 (one) day spent in an intensive care unit counts as 2 (two) days against the total hospitalization limit.

Regardless of the Insured's age, expenses for a companion's bed and hospital meals are covered subject to the Limits and applicable rates of this Coverage, provided that Preauthorization is obtained from the Insurer and such attendance is supported by a medically justified report from the treating Physician or is required because the Insured is a child, elderly, or otherwise in need of care.

3.1.8. Intensive Care Coverage

Where the Insured requires hospitalization and treatment in an Intensive Care Unit, Coronary Intensive Care Unit, or Neonatal Intensive Care Unit of a fully equipped Healthcare Institution due to a life-threatening medical condition, all intensive care accommodation and treatment expenses are covered in accordance with the General Conditions of Health Insurance and these Special Terms and Conditions.

Except for treatment resulting from acute Accidents, intensive care hospitalization due to an Illness is limited to a maximum of 90 (ninety) days per year. The total period of inpatient treatment may not exceed 180 (one hundred eighty) days during any 1 (one)-year insurance period or an aggregate of 720 (seven hundred twenty) days over the Insured's lifetime. Intensive care and other hospitalization expenses incurred in excess of these limits are excluded from Coverage.

For purposes of calculating the total inpatient treatment period of 180/720 days, each 1 (one) day spent in a standard room counts as 1 (one) day against the applicable limit. Each 1 (one) day spent in an intensive care unit counts as 2 (two) days against the total hospitalization limit under the Policy.
Due to the medical operating procedures and isolation requirements applicable to intensive care units, expenses for a companion's room, meals, or similar expenses incurred during the Insured's stay in an intensive care unit are not covered under this Coverage and shall not be paid by the Insurer.

3.1.9. Rehabilitation

Rehabilitation expenses directly related to medical treatment received by the Insured under Inpatient Treatment Coverage during the Policy term are covered. To qualify for this Coverage, the Insured must apply for rehabilitation within 60 (sixty)

calendar days after discharge from the hospital and obtain Preauthorization from the Insurer. Approved expenses are covered subject to the applicable Coverage Limit and Payment Percentage/Coinsurance specified in the Policy.

This Coverage applies to the following specific medical conditions and complications: cerebral or spinal trauma; cerebrovascular events, including stroke and paralysis, and hemiplegia; neurogenic bladder disorders; spasticity resulting from neurological disorders; acquired, noncongenital neuromuscular disorders; spinal muscular atrophy (SMA); myopathies; and muscular dystrophies.

3.1.10. Postoperative Physical Therapy

Expenses for orthopedic rehabilitation deemed medically necessary following trauma or orthopedic surgery occurring during the period of insurance, including training in the use of implanted prostheses and physical therapy to release joint contractures, are covered. To qualify for this Coverage, the Insured must apply for such treatment within 60 (sixty) calendar days after discharge from the hospital and obtain Preauthorization from the Insurer. Approved expenses are covered subject to the applicable Coverage Limit specified in the Policy, any applicable annual session limit, and the applicable Payment Percentage/Coinsurance.

Where physical therapy is provided to more than one body region on the same day, treatment of each body region shall be treated as a separate session for claims administration purposes and deducted separately from the applicable limits.

Where the hospitalization of an Insured receiving inpatient treatment is extended solely for the purpose of physical therapy, any additional hospital expenses other than physical therapy session fees, including additional room charges, companion expenses, meals, or unrelated expenses, are not covered under this Coverage and shall not be paid by the Insurer.

3.1.11. Jaw Surgery and Dental Treatment Following a Traffic Accident

Provided that the claim is supported by a traffic accident report issued by the competent authorities and a Physician's report, expenses for all medical and surgical procedures performed by dentists on the teeth and jaw, together with expenses for dental prostheses, for the purpose of restoring teeth injured or damaged as a result of a traffic accident occurring during the period of insurance to their pre-accident condition are covered subject to the applicable Coverage Limit and Payment Percentage.

Crowns made of precious metals, including gold or platinum, and any related additional material and laboratory expenses are excluded from this Coverage.

The Insurer shall not pay any expenses for routine, chronic, or general dental treatment other than treatment required to repair damage to the teeth resulting from a traffic accident.

3.1.12. Home Care

Following the Insured's inpatient treatment, whether surgical or medical, at a fully equipped Healthcare Institution, expenses for medical care and treatment provided at the Insured's home as a continuation of such treatment and administered solely by qualified medical personnel, including nurses and health officers, are covered.

To qualify for this Coverage, all of the following conditions must be met:

• The specialist Physician who provided the treatment must issue an official report stating that, for medical reasons, the Insured's treatment must continue at home under the supervision of healthcare personnel following discharge from the hospital, and the report must be submitted to the Insurer.
• The scope of the medical services to be provided at home, the frequency of daily visits, and the anticipated total duration of treatment must be submitted to the Insurer for medical approval and Preauthorization must be obtained before home care services begin. Home care expenses incurred without prior approval are excluded from Coverage.
• Approved expenses are covered subject to the Home Care Coverage Limit and Coinsurance specified in the Policy and any applicable maximum duration or daily limits defined in the Plan.

This Coverage applies solely to active and acute medical care. Social, geriatric, palliative, or personal care and support needs are excluded from Coverage, including situations in which the Insured is unable to independently perform activities of daily living; is bedridden; requires assistance with eating; takes medication orally; requires full assistance with bathing or is able to bathe only with assistance; has a chronic indwelling urinary catheter; lives alone; or has a chronic Illness requiring social support. Expenses relating to any such circumstances shall not be paid by the Insurer.

3.2. Outpatient Treatment Coverage

Treatment required as a result of an Illness or Accident occurring during the Policy term shall be considered Outpatient Treatment where it does not medically require continuous hospitalization for 24 (twenty-four) hours at a fully equipped Healthcare Institution. Medical expenses incurred under this Coverage for examinations by a Physician, medications, diagnostic imaging procedures, including radiology, laboratory tests, and physical therapy and rehabilitation sessions are covered by the Insurer subject to the Coverage Limits, Coinsurance/Payment Percentage, Deductibles, and Waiting Periods specified in the Policy and in accordance with these Special Terms and Conditions and the General Conditions of Health Insurance.

3.2.1. Physician Examination

Expenses for examinations of the Insured by medical doctors who either practice at Healthcare Institutions licensed by the Ministry of Health of the Republic of Türkiye or are authorized to maintain a private medical practice, where such examinations are required as a result of an Accident, Illness, or Medical Condition, are covered in accordance with the General Conditions of Health Insurance and these Special Terms and Conditions, subject to the Coverage Limit and Coinsurance/Payment Percentage specified in the Policy.

Even in the absence of signs or symptoms of an Illness, expenses for routine gynecological examinations, routine eye examinations, and periodic routine growth and developmental examinations for children from 0 to 6 (zero to six) years of age are covered under this Coverage.

Provided that they relate to the diagnosis made at the initial examination, follow-up examinations performed within 10 (ten) calendar days after the date of the initial examination by the same Physician or by a Physician in the same specialty at the same Healthcare Institution are excluded from Coverage.

Unless the Policy expressly provides otherwise under a separate additional Coverage provision, examination invoices issued by dentists and examinations relating to dental procedures are excluded from Coverage.

3.2.2. Medication

Pharmaceutical products licensed by the Ministry of Health of the Republic of Türkiye and vaccines covered under the Policy that are prescribed by a Physician on a paper or electronic prescription (e-prescription) are covered under this Coverage, provided that they are documented by the Physician's prescription or e-prescription number/printout, the barcode printout from the Pharmaceutical Track and Trace System (İTS), and the original pharmacy invoice or receipt.

Unless a greater quantity is medically necessary, medication expenses under each prescription are covered for a maximum treatment supply of 1 (one) month.

For chronic Illnesses covered under the Policy, medications requiring continuous use shall continue to be covered for the portion of the validity period of the applicable official Physician's report (e-report) that falls within the Policy term, provided that the Insurer receives a copy of the report specifying the reason and medical justification for continuous use and the prescribed dosage, together with a prescription marked for continuous use.

Based on the system calculation using the dosage stated on the prescription, a request for an additional medication containing the same active ingredient shall not be accepted before the medically prescribed supply period of the previously dispensed medication has expired.

Medications must be purchased from a pharmacy within 5 (five) calendar days after the date on which the prescription is issued or entered into the system. If this statutory 5 (five)-day period is exceeded, the prescription shall be deemed invalid and no claim shall be processed.

Each prescription or e-prescription printout must include the Healthcare Institution's official protocol number, the Insured's definitive diagnosis, the prescribing Physician's medical license registration number, a stamp identifying the Physician's specialty, and the Physician's wet or electronic signature. Prescriptions that do not comply with these requirements or contain incomplete information shall not be processed. Prescriptions issued by occupational physicians for employees of an organization are also covered, provided that they satisfy these requirements.

Imported medications that are medically essential and for which no equivalent medication is available in Türkiye are covered subject to the Limit applicable to this Coverage, provided that they are approved by either the U.S. Food and Drug Administration (FDA) or the European Medicines Agency (EMA), have the required import authorization from the Ministry of Health, and are legally imported into Türkiye through the Turkish Pharmacists' Association (TPA).

Vitamins, normal saline preparations, antihistamines, and sprays used in the treatment of asthma and allergic rhinitis that are deemed necessary by the treating Physician are covered, provided that they are approved by the Ministry of Health of the Republic of Türkiye.

Oral contraceptives prescribed solely on the basis of Medical Necessity for the treatment of a gynecological Illness, including cysts or hormonal disorders, are covered under this Coverage. Use for family planning or contraceptive purposes is excluded from Coverage.

Expenses for the administration of covered prescription medications by injection, including intramuscular (IM), intravenous (IV), intra-articular, and trigger-point injections, together with the related service and medical supply expenses, are covered under this provision.

3.2.3. Laboratory

Expenses for biochemistry, microbiology, hematology, immunology, and pathology laboratory tests that are deemed medically necessary following an examination by a Physician prompted by the Insured's symptoms and are ordered by the Physician, either in writing or electronically through the system, for the purpose of establishing a definitive diagnosis or monitoring treatment are covered. Such expenses are covered subject to the Laboratory Coverage Limit and applicable Coinsurance/Payment Percentage specified in the Policy.

Expenses for hepatitis marker tests, including Hepatitis B and C screening tests, are covered under this Coverage only where laboratory results medically document liver enzyme levels, including AST and ALT, above the normal reference range or where there is a clinical suspicion of active liver disease. Routine screening performed in the absence of clinical signs or symptoms or elevated liver enzyme levels is excluded from Coverage.

For female Insureds, expenses for routine Pap smear testing for screening or follow-up purposes are covered under this Coverage, limited to a maximum of 1 (one) test per year.

For laboratory claims and Preauthorizations to be approved, the Insurer must be provided with the examination record containing the diagnosis
and the Physician's order, together with the official laboratory report showing the test results.

3.2.4. Imaging

Following an examination by a Physician prompted by the Insured's symptoms, expenses for routine diagnostic imaging and testing that are medically necessary for the diagnosis of an Illness and ordered by the Physician are covered. Such procedures include ultrasonography (USG), mammography, X-rays with or without contrast, electrocardiography (ECG), audiometry (hearing testing), electromyography (EMG), urography, and similar routine diagnostic procedures, together with expenses for contrast media, chemical agents, and medications used in connection with such procedures. These expenses are covered subject to the Imaging Coverage Limit and applicable Coinsurance/Payment Percentage specified in the Policy.

Expenses for radiological examinations and imaging procedures, including ultrasonography (USG), are covered under this Coverage.

For imaging claims and Preauthorizations to be approved, the Insurer must be provided with the examination record containing the diagnosis and the Physician's order, together with the official Radiology/Diagnostic Test Results Report signed by the specialist Physician who performed the procedure.

3.2.5. Advanced Diagnostics

Following an examination by a Physician prompted by complaints and symptoms arising during the Policy term, expenses for high-technology advanced diagnostic procedures that are medically necessary for the definitive diagnosis, staging, or monitoring of an Illness are covered. This Coverage includes expenses for advanced diagnostic imaging procedures such as computed tomography (CT), magnetic resonance imaging (MRI), angiography other than coronary angiography, scintigraphy, and similar procedures, together with expenses for contrast media, chemical agents, and medications used in connection with such procedures.

The following interventional diagnostic and endoscopic procedures performed without hospitalization for the purpose of establishing a definitive diagnosis are also covered subject to the Limit applicable to this Coverage: diagnostic arthroscopy and diagnostic laparoscopy; colonoscopy; gastroscopy; cystoscopy; bronchoscopy; mediastinoscopy; diagnostic incisional biopsies; needle biopsies; biopsy procedures performed under ultrasonography (USG) or MRI guidance; and angiographic procedures performed under MRI guidance, excluding coronary angiography.

For claims or Preauthorizations relating to procedures covered under Advanced Diagnostics to be approved, the Insurer must be provided with the clinically justified diagnostic test order issued by the examining Physician, including the indication for the test, together with the official Diagnostic Test Results Report, such as a CT/MRI report, pathology report, or endoscopy report, signed by the specialist Physician who performed the procedure.

3.2.6. Physical Therapy

Outpatient physical therapy expenses arising from the Insured's symptoms and deemed medically necessary are covered, provided that the official treatment plan and medical report prepared by a Physical Medicine and Rehabilitation Specialist are reviewed and Preauthorization is granted by the Insurer before the treatment sessions begin. Approved expenses are covered subject to the Limit, Deductible, and applicable Coinsurance/Payment Percentage specified in the Coverage Table.

If Postoperative Physical Therapy Coverage under Inpatient Treatment Coverage is not provided under the Policy, or if the Limit applicable to that Coverage is exhausted during the Policy term, physical therapy expenses relating to surgery shall also be considered for coverage under the Limits and terms of this Physical Therapy Coverage. If Postoperative Physical Therapy Coverage is included in the Coverage Table but the applicable budget or Limit is exhausted during the Policy term, such expenses may not under any circumstances be transferred to this Outpatient Treatment provision and shall not be covered under this Coverage.

Where physical therapy is provided to more than one body region on the same day, treatment of each body region shall be treated as 1 (one) separate session for claims administration purposes and deducted separately from any applicable annual session limits specified in the Policy.

This Coverage applies solely to outpatient physical therapy session fees. Room charges, meals, companion expenses, routine follow-up examinations by a Physician, dressings, injections, and similar general hospital expenses billed by Healthcare Institutions during or after physical therapy treatment are excluded from Coverage and shall not be paid by the Insurer.

3.3. Overseas Treatment Coverage

This insurance coverage is available only to persons who continuously reside in Türkiye. Coverage for treatment received outside the Republic of Türkiye and the Turkish Republic of Northern Cyprus (TRNC) applies only under plans for which Overseas Coverage is expressly included in the Coverage Table.

To qualify for Overseas Coverage, the Insured must not have spent more than a total of 90 (ninety) calendar days
in countries outside the Republic of Türkiye and the TRNC during the 1 (one)-year period immediately preceding the date of the event giving rise to the Medical Expense. This period shall be calculated based on the entry and exit stamp dates in the Insured's passport. Travel days on which the Insured enters or exits through a border crossing shall also be included in the total period spent abroad. Where deemed necessary, the Insurer reserves the right to require the Insured to submit an official Entry-Exit Records Inquiry obtained through the e-Government portal. If the 90 (ninety)-day limit is exceeded, all Medical Expenses incurred abroad are excluded from Coverage.

If the Insured pays medical treatment expenses incurred abroad by credit card, the Insured must submit the relevant credit card statement or bank-approved payment slip to the Insurer. If payment is made in cash, the original official payment receipt issued by the relevant Healthcare Institution must be submitted.

Invoices, medical reports, discharge reports, and diagnostic test results issued abroad in a language other than English must be submitted together with Turkish translations certified by a sworn translator in order for the expenses to be evaluated. All translation costs shall be borne by the Insured.

For Claim Payments relating to Medical Expenses incurred abroad, the Foreign Exchange Selling Rate announced by the Central Bank of the Republic of Türkiye (CBRT) on the invoice date shall apply. The calculated Claim Payment amount shall be paid in Turkish lira (TRY) to the Insured's bank account, subject to the applicable Limits and Coinsurance/Payment Percentage specified in the Coverage Table.

3.4. Supplementary Coverages

Supplementary Coverages are special coverages other than the principal coverage categories offered under the Policy, namely Inpatient Treatment Coverage, Outpatient Treatment Coverage, and, where applicable, Overseas Treatment Coverage, which may be added to the Policy at the request of the Policyholder and subject to the Insurer's approval.
Supplementary Coverages are not standard or automatically included under every health insurance Policy. To be valid, each such Coverage must have been purchased and its name, Limit, applicable Coinsurance/Payment Percentage, and/or Deductible must be expressly specified in the Coverage Table attached to the Policy as part of the applicable Plan.

Unless expressly provided otherwise by a specific provision of the Policy, all services, diagnostic tests, and treatments provided under Supplementary Coverages are subject to the restrictions, Waiting Periods, and general Exclusions set forth in these Special Terms and Conditions and the General Conditions of Health Insurance.

3.4.1. Emergency Transportation

Where the circumstances meet the Emergency criteria defined in these Special Terms and Conditions, this Coverage is available in geographic areas where ambulance services can be provided, provided that the Katılım Emeklilik ve Hayat A.Ş. Health Contact Center at 0850 226 0 123 is contacted and the service is arranged through the Company. The Coverage includes on-site medical intervention and/or transportation of the Insured to the nearest fully equipped Healthcare Institution.

Where it is medically impossible to transport the Insured by ground to the nearest Healthcare Institution with adequate medical facilities, the Insurer shall arrange air ambulance transportation by airplane or helicopter, or marine ambulance transportation, provided that this Coverage is expressly included in the Policy, the Insured's detailed medical records, including the discharge summary and emergency Physician's report, are submitted to the Insurer, and Preauthorization is granted by the Insurer. All of the following conditions must be satisfied:

- Emergency medical intervention and treatment must be medically impossible at the Insured's geographic location or at the Healthcare Institution where the Insured is located.
- The Insured's current acute medical condition must make transportation by ground ambulance to the nearest fully equipped Healthcare Institution medically unsuitable because such transportation would pose a life-threatening risk.

This Coverage is valid only within the Republic of Türkiye. International or cross-border ambulance transportation and transfer services are excluded from Coverage under the Policy.

Ambulance transportation that is not medically necessary, does not involve a life-threatening condition, and is requested solely for a discretionary transfer between hospitals or from one residence to another is not covered under this Coverage.

Expenses for ambulances independently called by the Insured or the Insured's relatives without the knowledge and approval of the Katılım Emeklilik ve Hayat A.Ş. Health Contact Center, including ambulances operated by municipalities, private companies, or other third parties, are not covered, and no Reimbursement shall be made for such expenses.

3.4.2. Medical Aids

Expenses for medical aids used externally to support the body solely for medical purposes are covered where such aids are required as part of treatment for an Accident or Illness occurring during the Policy term and are prescribed by the treating specialist Physician, with the medical justification documented in the applicable report.

Subject to the Medical Aids Coverage Limit and applicable Coinsurance/Payment Percentage specified in the Coverage Table, covered items include splints, elastic bandages, orthopedic insoles, orthopedic boots, cervical collars, compression stockings, crutches, knee braces, wrist braces, arm slings, ring cushions, medical nebulizers, hearing aids, medical dressings used in the treatment of burns or wounds, and similar external support devices used for medical purposes.

Expenses for periodic maintenance, repair, batteries, charging devices, and any consumable supplies associated with hearing aids, nebulizers, or similar devices covered under the Policy are excluded from Coverage.

For the avoidance of doubt, the phrase "and similar external support devices" shall not be construed to include sleep apnea devices such as CPAP/BPAP devices, oxygen concentrators, manual or powered wheelchairs, hospital beds, orthopedic mattresses or pillows, home blood pressure or blood glucose monitors, or any other high-cost durable medical devices or items intended to enhance comfort in the home. All such items are excluded from Coverage.

3.4.3. Maternity Coverage

Provided that Maternity Coverage is expressly included in the Policy and the applicable maternity Waiting Periods specified in these Special Terms and Conditions have been satisfied, hospital services and Physician's fees associated with vaginal or cesarean delivery are covered. This Coverage also includes medically necessary amniocentesis performed during pregnancy, miscarriage, medically necessary lawful termination of pregnancy, and inpatient hospitalization expenses arising from complications of pregnancy or delivery, subject to the applicable Limit and Coinsurance/Payment Percentage specified in the Policy.

This Coverage may be selected for female Insureds aged 18 (eighteen) or older who are included in the Policy as the Primary Insured or a dependent spouse. Hospital and Physician expenses associated with childbirth, whether by vaginal or cesarean delivery, are covered only once during each 1 (one)-year Policy term. Expenses relating to any subsequent delivery during the same Policy term are not covered.

For expenses relating to termination of pregnancy to be covered, the medical necessity for termination must be documented by an official medical board or Physician's report in accordance with applicable law and must result from one of the following circumstances: cessation of fetal cardiac activity, diagnosis of a severe fetal anomaly incompatible with life, or a pregnancy that directly threatens the life of the mother. Elective termination of pregnancy or termination without medical justification is excluded from Coverage.

Physician and hospital expenses associated with tubal ligation and the insertion or placement of an intrauterine device (IUD), where considered medically appropriate by a specialist Physician and performed surgically or by an interventional procedure, are covered. Approved expenses are covered subject to the applicable Limit and Coinsurance/Payment Percentage specified in the Coverage Table.

Surgical and interventional procedures covered under this Coverage, including tubal ligation, are subject to the 12 (twelve)-month maternity Waiting Period specified in these Special Terms and Conditions. Planned family-planning surgeries and IUD placement performed before the expiration of 12 (twelve) months from the Initial Insurance Date are not covered.

The terms applicable to the Katılım Sağlık Baby Program are as follows:

Provided that the Primary Insured's Policy includes Maternity Coverage and the Primary Insured has become eligible for such Coverage, the Policyholder and/or Insured must apply to add the newborn to the Policy within 30 (thirty) calendar days after the date of birth. At the time of application, the newborn's hospital discharge report, the results of all medical tests performed, and the newborn health declaration form must be submitted to the Insurer in full.

Newborns for whom an application is submitted within the first 30 (thirty) calendar days after birth and who are determined to be healthy following a Risk Assessment shall, upon acceptance for insurance, be granted the following special rights:

- The newborn's Policy Effective Date shall be recorded in the system as the actual date of birth.
- The Illness-related Waiting Periods specified in the Policy shall not apply to the newborn.
- The newborn shall be granted a Lifetime Renewal Guarantee, subject to uninterrupted insurance coverage.
- No Illness Exclusion shall be applied in respect of the newborn's existing condition. However, a Medical Loading may be applied in accordance with the applicable Risk Assessment principles.

Where an application is submitted within the first 30 (thirty) calendar days after birth for a newborn with a congenital Medical Condition or a premature newborn, but the newborn is unable to qualify for Katılım Sağlık Baby status due to the newborn's health condition, treatment expenses are covered subject to the specific Newborn/Premature Coverage Limits, coverage periods, and Payment Percentage separately specified for such circumstances in the Coverage Table.

A newborn who is not reported to the Insurer in writing and added to the Policy within the first 30 (thirty) calendar days after birth shall under no circumstances qualify for "Katılım Sağlık Baby" status. For applications submitted after the first 30 (thirty) calendar days, the standard new-enrollment Risk Assessment rules and standard Illness-related Waiting Periods shall apply in full in determining whether the newborn will be accepted for insurance.

3.4.4. Routine Prenatal Care Coverage

Provided that Maternity Coverage is included in the Policy and the Insured has become eligible for such Coverage, expenses for routine examinations by a Physician that are medically necessary during pregnancy, prenatal monitoring tests, including ultrasound examinations, blood and urine tests, screening tests, and similar tests, and medications prescribed in connection with the pregnancy are covered under Routine Prenatal Care Coverage.

Harmony, Prena, NIPT, and similar tests are excluded from Coverage.

3.4.5. Newborn Coverage

Provided that the Insured's current Policy includes Maternity Coverage and the Insured has become eligible for such Coverage, an application to add the newborn to the Policy must be submitted within 30 (thirty) calendar days after the date of birth. At the time of application, the newborn's hospital discharge report, the results of all medical tests performed, and the newborn health declaration form must be submitted to the Insurer in full.

This provision applies to newborns for whom an application to be added to the Policy is submitted within the first 30 (thirty) days after birth but who, due to their health condition, do not qualify for Katılım Sağlık Baby status. Expenses relating to prematurity and treatment expenses for congenital Medical Conditions incurred during the first 60 (sixty) calendar days after birth are covered subject to the applicable Limits and Coinsurance/Payment Percentage specified in the Coverage Table.

After the initial 60 (sixty)-day critical treatment period, the Insurer reserves the right, with respect to continuing treatment of chronic conditions arising from congenital Medical Conditions or prematurity, to apply a Medical Loading at renewal or by Endorsement, impose a permanent Illness Exclusion, or otherwise determine the applicable terms in accordance with Risk Assessment principles.

3.4.6. Screening Mammography and PSA Coverage for Insureds Age 40 and Over

For female Insureds age 40 (forty) and over, expenses for mammography performed once per year for routine screening purposes in the absence of any signs or symptoms of Illness are covered.

For male Insureds age 40 (forty) and over, expenses for a prostate-specific antigen (PSA) laboratory test performed once per year for routine screening purposes in the absence of any signs or symptoms of Illness are covered.

For screening tests under this provision to be covered, they must be performed at Contracted Healthcare Institutions specifically designated and announced by the Insurer for this service as part of its designated screening Network. Expenses for screening mammography or PSA testing performed at any Healthcare Institution other than those designated by the Insurer, including any Non-Contracted Healthcare Institution, are excluded from Coverage and are not eligible for Reimbursement. Approved expenses are covered no more than once per year, subject to the applicable Limit and Coinsurance/Payment Percentage specified in the Coverage Table.

3.4.7. Dental Treatment Coverage

Provided that this supplementary package has been expressly purchased and included in the Coverage Table, expenses for dental examinations and medications lawfully prescribed by the dentist following such examination are covered. This Coverage also includes expenses for panoramic X-rays requested for diagnostic or treatment purposes; dental fillings; root canal treatment; dental crowns required for treatment; standard or surgical tooth extractions; bridges; implants; orthodontic braces; night guards; dental scaling; periodontal treatment; and fissure sealants.

All examination, diagnostic, and treatment expenses covered under this Coverage are subject to the annual Dental Coverage Limit and applicable Coinsurance/Payment Percentage separately specified in the Coverage Table.

Expenses for teeth whitening, porcelain or composite veneers, cosmetic smile-design procedures, and fillings or crowns containing precious metals such as gold or platinum, where performed solely for aesthetic or cosmetic purposes and without Medical Necessity, are excluded from Dental Treatment Coverage and from Coverage under the Policy and shall not be paid by the Insurer.

3.4.8. Eyeglasses and Contact Lenses Coverage

Provided that this supplementary package has been expressly purchased and included in the Coverage Table, expenses for prescription eyeglass lenses, eyeglass frames, prescription contact lenses, and contact lens solution purchased in accordance with a prescription are covered where an Ophthalmologist determines, following an examination, that the Insured's vision impairment is to be corrected through the continuous use of prescription eyeglasses or contact lenses.

All sunglasses and sunglass frames are excluded from Coverage if they are non-prescription or, even if prescription, are manufactured for aesthetic or cosmetic purposes.

Non-prescription colored contact lenses used solely for aesthetic purposes and eye accessories that have no optical or medical function shall not be paid for by the Insurer.

Expenses for laser procedures, including Excimer Laser and LASIK, performed at eye hospitals for the permanent correction of vision impairment are excluded from this provision and, unless the Policy expressly provides otherwise, are excluded from Coverage under the Policy.

3.4.9. Check-Up Coverage

Provided that this supplementary package has been expressly purchased and included in the Coverage Table, expenses for examinations by a Physician and laboratory and imaging services performed as part of routine health screenings (check-ups), the content and medical panel of which are predetermined by the Insurer, are covered. Approved expenses are covered no more than 1 (one) time per year, subject to the applicable Limit and Payment Percentage/Coinsurance specified in the Coverage Table.
This Coverage is available only to Insureds within the age range expressly specified for Check-Up Coverage in the Coverage Table. To use this Coverage, the Insured must contact the Katılım Emeklilik ve Hayat A.Ş. Health Contact Center at 0850 226 0 123 before receiving the service, request an appointment, and have the service arranged at a Healthcare Institution approved by the Insurer.

This Coverage is provided exclusively through Direct Payment at Contracted Healthcare Institutions arranged by the Insurer. Expenses for check-ups independently obtained by the Insured at any Healthcare Institution without the knowledge and approval of the Katılım Emeklilik ve Hayat A.Ş. Health Contact Center are excluded from Coverage and are not eligible for Reimbursement.

Any additional diagnostic tests or examinations performed outside the predetermined check-up package at the request of the Insured or a Physician at the Healthcare Institution, as well as any medications prescribed following the check-up, are excluded from this provision. Such additional expenses shall be subject to the standard Outpatient Treatment Coverage terms and Limits specified in the Policy.

4. WAITING PERIODS

Regardless of causation or clinical course, all inpatient treatment, surgical procedures, and Physical Therapy expenses, whether Physical Therapy is provided on an outpatient or inpatient basis, relating to any of the conditions listed below are excluded from Coverage for 6 (six) months from the Insured's Initial Insurance Date, except where such treatment results from an acute traffic Accident documented by an official accident report.

4.1. Maternity Coverage Waiting Period

For the Insured or the Insured's dependent spouse, expenses relating to routine prenatal care, pregnancy, and childbirth shall become eligible for Coverage upon completion of a 12 (twelve)-month Waiting Period commencing on the Policy Effective Date of the Policy under which the relevant Maternity Coverage is first included.
Where an Insured transfers from another insurance company, the 12 (twelve)-month Waiting Period under the Katılım Emeklilik ve Hayat A.Ş. Policy shall commence on the date the Insured is first included in a Katılım Emeklilik ve Hayat A.Ş. Policy that includes Maternity Coverage, even if maternity coverage was provided under the Insured's previous policy.
If Maternity Coverage is discontinued at renewal and subsequently reinstated, the 12 (twelve)-month Waiting Period shall begin again.
If the Policyholder requests an expansion of the Contracted Healthcare Institution Network under the existing Policy, the Waiting Period shall restart with respect to the newly added Healthcare Institutions, and Medical Expenses relating to an existing pregnancy incurred at such institutions shall not be covered. If the Insured is pregnant, no increase in Maternity Coverage may be made, including any increase in Limits, Payment Percentage, or scope of Coverage.

Conditions Subject to the Waiting Period

- Surgical procedures involving the shoulder, hip and hip joint, elbow, or ankle joint;
- Knee conditions, including meniscal, tendon, ligament, and cartilage pathologies; carpal tunnel syndrome; and tarsal tunnel syndrome;
- Gallbladder diseases; urinary tract stones; prostate diseases; hydrocele; cystocele; rectocele; and bladder stones and diseases;
- All hernias; spinal surgery; and coxarthrosis;
- Surgical expenses relating to adenoids, nasal polyps, ventilation tubes, tonsils, sinusitis, and diseases of the eardrum and ossicles;
- Varicocele; all types of varicose veins (Superficial varicose is out of coverage); aneurysms;
- Hemorrhoids; anal fissures and fistulas; pilonidal sinus; and perianal abscess;
- Benign thyroid disorders and goiter;
- All benign cysts and masses;
- Benign conditions of the uterus and ovaries, including fibroids;
- Glaucoma, cataracts, and retinal deformities or pathologies;
- Heart valve diseases;
- Chronic kidney failure and chronic obstructive pulmonary disease (COPD);
- All expenses relating to menopause and osteoporosis;
- Ectopic pregnancy and hydatidiform mole;
- Breast diseases;
- Trigger finger; hammertoe; all types of entrapment neuropathy; ganglion cyst; cystic hygroma; and Morton's neuroma;
- Disorders of the liver, including Hepatitis B and C, spleen, pancreas, esophagus, stomach, and duodenum;
- Vascular diseases, excluding cardiovascular diseases;
- Inflammatory bowel diseases, including ulcerative colitis and Crohn's disease, and intestinal diverticula;
- Rheumatic diseases, including rheumatoid arthritis, systemic lupus erythematosus (SLE), and ankylosing spondylitis.

Waiting Periods do not apply to Insureds who qualify for Katılım Sağlık Baby status.

5. EXCLUSIONS

The following are excluded from Coverage:

- All Medical Expenses relating to any Illness or Medical Condition that is excluded from Coverage specifically for the individual Insured, whether or not expressly identified in these Special Terms and Conditions, and any circumstances not included in the Coverage Table or applicable Plan.
- Any pregnancy existing before the Insured first becomes insured, including a pregnancy that began before the Policy Effective Date; any undisclosed or concealed Illness or Medical Condition; and any ongoing, periodic follow-up or recurrence of such Illnesses or Medical Conditions.
- All expenses for the treatment, complications, and follow-up of congenital diseases and disabilities, genetic anomalies, absence of organs, and structural deformities, even if diagnosed after the Policy Effective Date.
- Subject to the provisions of Newborn Coverage under these Special Terms and Conditions concerning premature or congenital emergency care during the first 60 (sixty) days, expenses relating to congenital conditions in newborns and expenses for long-term incubator and premature infant care.
- All surgical and medical expenses relating to umbilical or inguinal hernias occurring in children under 7 (seven) years of age.
- All diagnostic, testing, and treatment expenses relating to Parkinson's disease, multiple sclerosis (MS), epilepsy, scoliosis, kyphosis, hallux valgus, hallux rigidus, and pes planus (flat feet).
- All Medical Expenses relating to human immunodeficiency virus (HIV) infection, AIDS, and any complications arising from either condition.
- All examination, diagnostic testing, and treatment expenses relating to sexual dysfunction of any kind, vasectomy, or sexually transmitted diseases.
- Diagnosis and treatment of genital herpes; genital or anal papillomatous lesions; condyloma acuminata; human papillomavirus

(HPV) infection; genital or anal molluscum contagiosum; syphilis; and gonorrhea.
• All COVID-19 vaccines and vaccination administration charges, including vaccines provided free of charge or mandated by the Ministry of Health of the Republic of Türkiye.
• Bodily injury and treatment expenses resulting from natural disasters, including floods, earthquakes, volcanic eruptions, landslides, and similar major natural events.
• Any loss or damage arising from biological and/or chemical contamination, infection, or poisoning caused by terrorist acts specified in Anti-Terror Law No. 3713, sabotage resulting from such acts, or actions taken by competent authorities to prevent such acts or mitigate their effects.
• All Medical Expenses arising from an attempted suicide or intentional self-inflicted injury by the Insured.
• All expenses relating to surgery, cross-linking, or other treatment for keratoconus or its progression.
• Investigation of the causes of miscarriage; diagnosis and treatment of infertility; and all assisted reproductive procedures performed for such purposes, including ovulation monitoring, hysterosalpingography (HSG), adhesiolysis, tuboplasty, in vitro fertilization (IVF), and intracytoplasmic sperm injection (ICSI).
• Diagnostic testing, treatment, and management of complications relating to dementia syndromes, including Alzheimer's disease and other forms of dementia; psychiatric and geriatric disorders; and conditions requiring psychotherapy; all expenses relating to psychologist and counseling services; psychotropic or psychiatric medications; intelligence testing; and voice or speech therapy, regardless of the reason for which such therapy is provided.
• Any treatment performed for cosmetic or aesthetic purposes; diagnostic testing relating to weight-control disorders, including obesity and excessive thinness; bariatric surgery; dietitian services; and all expenses relating to hyperhidrosis and alopecia, including hair or beard loss.
• In connection with organ, tissue, or blood transplantation, all surgical and medical expenses incurred by the donor, the cost of the organ or tissue itself, and all expenses incurred for the transportation or delivery of the organ.
• Strabismus surgery; laser procedures, including Excimer Laser and LASIK, performed to correct refractive errors; and all other refractive surgery expenses.
• The cost of a cochlear implant, including the device itself, the implantation surgery, and expenses relating to adjustment or consumable supplies for the device.
• Injuries and treatment expenses resulting from war or warlike operations, revolution, rebellion, uprising, looting, or civil disturbances arising from any such events.
• Unless documented by an official report as resulting from an acute Accident or burn injury, all cosmetic and reconstructive surgical procedures; diagnostic testing and treatment for gynecomastia; and breast reduction or augmentation surgery.
• All expenses relating to genetic diseases, genetic defects, chromosome analysis, DNA mapping, and any genetic testing performed for diagnostic purposes.
• All expenses relating to the diagnosis, follow-up, and psychological management of pseudocyesis (false pregnancy).
• Medical Expenses relating to bodily injury sustained by the Insured while committing or attempting to commit a criminal offense.
• Allergy vaccines, vaccine transportation charges, and allergy testing performed to identify allergic diseases, including skin-prick testing and blood allergy panels.
• All vaccines other than routine vaccines for children aged 0 to 6 (zero to six) included in the Ministry of Health Vaccination Schedule and rabies and tetanus vaccines; all travel vaccines; and antibody testing or other tests relating to such vaccines.
• Treatment for snoring and sleep apnea syndrome, including CPAP/BPAP devices; and all expenses relating to nasal septal deviation, turbinate disorders (hypertrophy of turbinates), and nasal valve disorders where treatment is not medically necessary.
• Expenses relating to screening procedures such as coronary artery calcium scoring, coronary CT/CT angiography, electron beam tomography (EBT), virtual angiography, virtual colonoscopy, and similar screening tests performed solely for general health screening or check-up purposes in the absence of any clinical signs or symptoms or suspicion of disease.
• All operational and laboratory expenses relating to the collection, storage, freezing, transplantation, or processing of umbilical cord blood or stem cells.
• Expenses relating to motor and mental developmental disorders, growth and developmental delays, pedagogical follow-up services, and delayed speech development.
• All expenses relating to any instrument or device that does not qualify as a medical supply or Medical Aid, together with any charges associated with the use of such instrument or device, regardless of how such charges are described, including technology surcharges and equipment or device rental charges, such as the additional rental charge for use of a robot in robotic surgery.
• Robotic surgery is excluded from Coverage. Physician professional fees associated with the use of robotic equipment, operating room charges, and similar services relating to robotic surgery are also excluded from Coverage.
• Expenses relating to spa treatments, mud baths, therapeutic cures, massage, gyms, Pilates, and weight-loss centers; childcare expenses and child-related consumable items, including baby formula, diapers, feeding bottles, and pacifiers; and alcohol, cologne, soap of any kind, shampoo other than medicated shampoo prescribed by a specialist Physician for treatment purposes, hair solutions, toothpaste, sweeteners, and cosmetic products.
• Private nursing expenses; personal-use charges incurred in a hospital room, including international telephone calls, television, and internet charges; cafeteria and food expenses other than standard meals provided to the patient and companion; similar additional luxury expenses; and additional charges for suite or deluxe rooms.
• All expenses relating to the Insured's alcoholism or substance addiction, together with treatment expenses required as a result of alcohol poisoning, alcohol consumption, or any Illness, intoxication, or Accident occurring while the Insured is under the influence of drugs.
• Invoices and claims relating to persons or institutions that do not meet the definitions of Physician and Healthcare Institution under the Policy, including persons or institutions that lack the required diploma, license, or authorization.
• Experimental or investigational procedures whose efficacy and scientific validity have not yet been established by medical science, even if approved or licensed by the Ministry of Health; wellness practices; alternative medicine treatments, including acupuncture, mesotherapy, leech therapy, and cupping therapy; and ozone therapy.
• Medical support substances that are not recognized as medications, dietary supplements, and any products that are not licensed as medications by the Ministry of Health of the Republic of Türkiye.
• Procedures performed in the absence of any clinical signs, symptoms, or complaints and having no direct medical relevance to the diagnostic or treatment process, together with routine screening expenses incurred for check-up purposes outside the standard check-up panel.

• Medical Expenses arising from mountaineering and climbing, canoeing, sky surfing, parachuting, gliding, hang gliding, ballooning, motorcycle and automobile sports, civil aviation, horseback riding, water sports, scuba diving, speed racing of any kind, and any dangerous sport undertaken through a club on a licensed, professional, or amateur basis.
• All Medical Expenses resulting from an Accident occurring while the Insured is operating a vehicle without a valid driver's license or operating a vehicle that the Insured's license does not authorize the Insured to drive.
• In the event of death, funeral-related expenses, including morgue charges, coffin expenses, and funeral transportation costs.
• Unless the Policy expressly includes separate Dental Treatment Coverage, expenses relating to examinations, diagnostic tests, treatment, and complications involving the teeth, gums, temporomandibular joint, or oral and maxillofacial surgery, together with expenses arising from prescriptions issued by a dentist.
• Purchase costs for sunglasses frames and lenses of any kind, even where the lenses are prescription lenses.
• Expenses relating to procedures performed at Healthcare Institutions or by Physicians included on the Insurer's Healthcare Institutions and Physicians Ineligible for Reimbursement list, whose agreements with the Insurer have been terminated, or who have been blacklisted.
• Any agreed daily disability benefit or compensation for commercial losses or lost earnings resulting from the Insured's inability to work due to an Illness or Accident.
• Daily care allowances, caregiver fees, and palliative care expenses arising where the Insured requires care.
• All Medical Expenses relating to epidemic diseases or pandemics declared by the World Health Organization (WHO) and/or the Ministry of Health of the Republic of Türkiye, and any syndromes arising from such diseases; and any procedures that have no corresponding item under the HIC and/or TMA-MPD fee schedules, have no proven therapeutic efficacy, and are not included in official treatment lists, including platelet-rich plasma (PRP) procedures.
• Expenses for circumcision performed for any reason.
• Screening and diagnostic testing performed before pregnancy solely to assess the general health status or genetic risks of the prospective parents.
• Gender reassignment surgery, hormone therapy associated with the gender reassignment process, and related psychological support services.
• Any postage or courier expenses incurred by the Insured or the Policyholder in connection with the preparation, notarization, or delivery of medical records and documents required for the review of a claim file.
• All expenses relating to treatment or care provided without a prescription or independently by persons who do not meet the Policy definition of Physician, including physical therapists, dietitians, nutritionists, and private nurses.
• Regardless of whether they relate to the treatment of a psychiatric disorder, all psychotropic medications; hospitalization in psychiatric clinics; and diagnostic testing, therapy, and treatment sessions provided by psychiatrists or psychologists.
• Examination and testing expenses incurred for medical board reports required by public authorities for purposes such as marriage, employment, obtaining a driver's license, or joining a sports club.
• Expenses for genetic or routine screening tests performed solely on the basis of familial risk factors where the Insured has no signs, symptoms, or complaints.
• Additional expenses arising from medical malpractice by Physicians or Healthcare Institutions, including complications resulting from improper treatment or surgery.
• All treatment expenses relating to occupational accidents and occupational diseases for which the Social Security Institution (SSI) and the employer are legally responsible under Law No. 5510.
• Expenses for comedone extraction, cosmetic acne care, and dermatological procedures performed for aesthetic purposes.
• Any direct or indirect bodily injury or Medical Expense resulting from the use of protein powders, amino acids, creatine, or similar dietary supplements or support products for bodybuilding, increasing muscle mass, or enhancing athletic performance.
• All laboratory testing and hospital treatment expenses ordered by the occupational physician at the Insured's workplace for the Insured, the Insured's spouse, or the Insured's children, except for the cost of lawfully prescribed medications prescribed by the occupational physician for the Insured personally.
• Statutory SSI Copayments and examination fees that the Insured is required to pay at public hospitals pursuant to Article 98/2 of Social Insurance and General Health Insurance Law No. 5510.
• All healthcare services provided by Physicians who are related to the Insured by blood and/or marriage, together with expenses for medications prescribed by Physicians for themselves and all diagnostic, testing, and treatment procedures that such Physicians perform or order for themselves.
• Cerebral arteriovenous malformations (AVMs).

6. GEOGRAPHICAL COVERAGE

Coverage is valid within the Republic of Türkiye and the Turkish Republic of Northern Cyprus (TRNC). Where Overseas Coverage is specified in the Coverage Table, coverage outside these territories shall apply in accordance with the applicable Overseas Treatment Coverage provisions.

7. COVERAGE APPLICATION PRINCIPLES

7.1. Application of Limits

For purposes of calculating Coverage under the Policy, Healthcare Institutions are divided into 3 (three) categories: Contracted Healthcare Institutions, Non-Contracted Healthcare Institutions, and, where expressly included and purchased or otherwise specified in the Coverage Table, Overseas Healthcare Institutions.
The main Coverage Limits applicable to each category of Healthcare Institution are expressly specified in the Coverage Table attached to the Policy on an annual, per-Insured basis.
Unless a separate independent Limit is specified in the Policy, all Sub-Coverages under the Policy, including Surgery, Inpatient Medical Treatment, Minor Procedures, and Medications, are applied against the individual Main Coverage Limit applicable to the category of Healthcare Institution to which they relate. If the applicable Main Coverage Limit is exhausted during the Policy term, all related Sub-Coverages shall automatically cease.

7.2. Application of Payment Percentage and Coinsurance

For each category of Healthcare Institution, namely Contracted Healthcare Institutions, Non-Contracted Healthcare Institutions, and, where purchased or otherwise specified in the Coverage Table, Overseas Healthcare Institutions, the Insurer shall make Claim Payments based on the applicable Payment Percentage specified in the Policy and the Coverage Table.

The percentage remaining after application of the Payment Percentage, which together with the Payment Percentage equals 100% (one hundred percent), constitutes the Coinsurance (Insured's Share) and must be borne directly by the Insured. For services provided at Contracted Healthcare Institutions, the applicable Coinsurance shall be paid directly by the Insured to the relevant Healthcare Institution.

The Payment Percentage and Coinsurance are not applied directly to the amount invoiced by the Healthcare Institution. They are applied to the net claim amount remaining after deducting any applicable Deductibles and any amounts exceeding the maximum amounts specified in the Health Care Services Fee Schedule (TMA/MPD/HIC, etc.) from the Medical Expense incurred.

7.3. Application of Deductibles

A Deductible is a fixed amount denominated in Turkish lira (TRY) or a foreign currency that must be borne directly by the Insured for purposes of calculating Claim Payments. Deductibles may be specified separately or on a combined basis in the Coverage Table for Contracted Healthcare Institutions, Non-Contracted Healthcare Institutions, and, where applicable, Overseas Healthcare Institutions.

When calculating the Claim Payment for a Medical Expense, any amount exceeding the applicable maximum under the Health Care Services Fee Schedule (TMA/MPD/HIC, etc.) shall first be excluded from the amount incurred. The fixed Deductible specified in the Policy shall then be deducted from the remaining eligible amount. The applicable Payment Percentage and Coinsurance specified in these Special Terms and Conditions shall then be applied to the resulting net balance to determine the final amounts payable by the Insurer and the Insured.

7.4. Calculation of Remaining Limit

The Remaining Limit is calculated by deducting from the gross Limit specified in the Policy the total of the Claim Payments made by the Insurer and the Deductible and Coinsurance amounts borne by the Insured.

7.5. Procedures at Healthcare Institutions

Where the Insured seeks treatment at a Contracted Healthcare Institution included in the Plan and Network selected under the Policy, electronic Preauthorization (e-Preauthorization) must be obtained from the Insurer's Preauthorization Center before the relevant procedure is performed. Based on the Preauthorization granted, amounts payable under the General Conditions of Health Insurance and these Special Terms and Conditions shall be paid by the Insurer directly to the relevant Healthcare Institution through the Direct Payment System. The Insured must provide the Contracted Healthcare Institution with proof of insurance, such as the Katılım Certificate or Turkish identity card, and must pay directly to the relevant Healthcare Institution any fixed Deductible and/or percentage-based Coinsurance specified in the Coverage Table.

The current lists of Contracted Healthcare Institutions and Networks are regularly updated and published for information purposes through the digital channels and mobile applications of Katılım Emeklilik ve Hayat A.Ş. and on its corporate website at www.katilimemeklilik.com.tr. The Insurer reserves the right to add or remove Healthcare Institutions from the Network lists at any time during the Policy term. If the agreement between the Insurer and any listed Healthcare Institution is terminated for any reason, the special contractual terms applicable to that Healthcare Institution and the Direct Payment arrangement shall automatically cease without further notice.
The inclusion of any Physician or Healthcare Institution in the Katılım Emeklilik ve Hayat A.Ş. Contracted Network does not constitute a recommendation, endorsement, or referral by the Insurer. The Insurer does not warrant or guarantee the quality, nature, or completeness of the medical services provided by such persons or institutions or any medical, legal, or criminal consequences arising from diagnosis or treatment, including medical errors or malpractice. The Physician or Healthcare Institution selected by the Insured shall be legally responsible for the services provided, the outcome of any procedure, and any defects or deficiencies in such services. Katılım Emeklilik ve Hayat A.Ş. shall have no legal liability for any loss, claim for damages, or dispute arising from such services.

The Policy specifies the Contracted Healthcare Institutions at which Coverage is valid and the terms and conditions applicable to such Coverage.

7.6. Payment of Medical Expenses by Healthcare Institution Type

Medical Expenses incurred at Contracted Healthcare Institutions within the Network selected under the Policy are covered through the Direct Payment System, provided that Preauthorization is obtained, and are subject to the Contracted Healthcare Institution Coverage Limit and applicable Coinsurance/Payment Percentage specified in the Policy.

In provinces where the Contracted Medical Office arrangement is available, expenses for examinations performed at the private offices of participating contracted Physicians are covered under Physician Examination Coverage, subject to the Contracted Healthcare Institution Coverage Limit and applicable Coinsurance specified in the Policy.

Unless otherwise specified, Medical Expenses incurred at Contracted Healthcare Institutions that are not included in the Network selected under the Policy are processed through Reimbursement, subject to the Non-Contracted Healthcare Institution Coverage Limit and applicable Coinsurance specified in the Policy.

Procedures performed at a Contracted Healthcare Institution within the selected Network by independent Physicians who are not members of that institution's staff are processed through Reimbursement, subject to the Non-Contracted Healthcare Institution Coverage Limits and applicable Coinsurance.

All Medical Expenses relating to services provided by Physicians who are not officially listed as members of the Contracted Healthcare Institution's staff in accordance with applicable Ministry of Health requirements, or who, despite being staff members, do not accept the contractual fee schedules or terms agreed with Katılım Emeklilik ve Hayat A.Ş., including Physicians who charge additional fees based on academic titles such as faculty member, professor, or associate professor, are processed through Reimbursement, subject to the Non-Contracted Healthcare Institution Coverage Limit and applicable Coinsurance specified in the Policy.
Medical Expenses incurred at State Hospitals affiliated with the Ministry of Health of the Republic of Türkiye and at official state-owned University Hospitals are processed through Reimbursement upon submission of the relevant invoice, subject to the Contracted Healthcare Institution Coverage Limit and applicable Coinsurance specified in the Policy.
Medical Expenses incurred at Healthcare Institutions that have no corporate agreement with Katılım Emeklilik ve Hayat A.Ş. are processed through Reimbursement, subject to the Non-Contracted Healthcare Institution Coverage Limit, applicable Coinsurance, and the maximum amounts specified in the Health Care Services Fee Schedule (TMA/MPD).
Medical Expenses incurred at Overseas Healthcare Institutions are processed through Reimbursement, provided that Overseas Coverage has been purchased and is included in the Coverage Table, subject to the applicable Overseas Coverage Limit, Coinsurance, and the foreign exchange rules set forth in these Special Terms and Conditions.
Expenses relating to Check-Up Coverage and Screening Mammography and PSA Coverage provided under Supplementary Coverages are not covered under any circumstances if the relevant services are obtained outside the designated screening Network selected under the Policy.
For Inpatient Treatment, if the estimated amount stated by the Physician on the medical form used during the Preauthorization process differs from the amount shown on the actual invoice issued by the Physician following treatment, the Insurer shall use the lower of the two amounts in calculating the Claim Payment. Any excessive difference between the two amounts shall not be paid.

8. CLAIM PAYMENTS

For outpatient and inpatient Medical Expenses incurred within the scope of Coverage at Contracted Healthcare Institutions of Katılım Emeklilik ve Hayat A.Ş., the Insurer shall, following Preauthorization granted to the relevant Healthcare Institution, pay the applicable invoice directly to that institution, subject to the Insured's Coverage Limits and payment by the Insured of any applicable Coinsurance. The documents and invoices relating to the Preauthorization shall be submitted to the Insurer by the relevant Healthcare Institution.
For Medical Expenses incurred at Non-Contracted Healthcare Institutions to be evaluated, the following documents must be submitted to the Insurer:
• The original Medical Expense Claim Form, with the relevant sections completed in full, stamped, and signed by the Insured and the specialist Physician who provided the treatment;
• Original invoices, self-employment receipts, IV fluid and medication itemizations relating to all Medical Expenses, together with detailed hospital service statements itemized by procedure;
• For Inpatient Treatment and surgical procedures, the operative report, anesthesia monitoring form, and/or official hospital discharge report;
• All laboratory test results and imaging reports, including radiology, MRI, and CT reports, on which the diagnosis of the relevant complaint or Medical Condition is based;
• The original prescription or e-prescription number, medication coupons or Pharmaceutical Track and Trace System (PTTS) barcode printouts, together with the original legally valid pharmacy receipt or invoice;
• For outpatient physical therapy expenses, medical imaging reports demonstrating the medical indication for treatment, together with an official treatment plan prepared by a Physical Medicine and Rehabilitation Specialist setting out the number and content of the treatment sessions in detail;
• For any judicial or forensic incident, including a traffic Accident, official documents issued by the competent authorities, including an incident report, alcohol test report, statement record, forensic medical report, and traffic accident report;
• For treatment received abroad, the relevant Physician's reports and diagnostic test results, together with Turkish translations prepared by a sworn translator where the documents are in a language other than English. Translation costs shall be borne by the Insured;
• For payment of expenses relating to dental and jaw injuries resulting from a traffic Accident, the traffic accident report, a Physician's report documenting the dental injuries and establishing the causal connection with the Accident, and panoramic dental radiographs taken at the time of the Accident; and
• For University Hospitals or State Hospitals, the relevant accounting office receipt or official receipt.

The Insurer may request additional information and documentation from the Insured where necessary to evaluate a Claim request.
The Insurer reserves the right to conduct further investigations into Medical Expenses, request from the Physician, Healthcare Institution, or any other person involved in the Insured's treatment any information, reports, or other documentation it considers necessary in connection with the diagnosis and/or treatment, and have the Insured examined by its Consulting Physician.
Claim requests shall be evaluated in accordance with these Special Terms and Conditions and the General Conditions of Health Insurance, the Coverage Table, and the information and documentation submitted. The mere fact that diagnostic tests or treatment relating to a Medical Expense have been ordered or performed by a Physician does not, by itself, establish Medical Necessity. In the event of a dispute, the opinion of the Insurer's Consulting Physician shall be determinative.

During the payment process relating to Contracted Healthcare Institutions and Non-Contracted Healthcare Institutions, the Insurer also reserves the right, where deemed necessary, to conduct further investigations; request from the Physician treating the Insured, the relevant Healthcare Institution, or any third party any information, reports, or other documentation it considers necessary in connection with the diagnosis and/or treatment;

and have the Insured examined by a Physician designated by the Insurer.
No payment shall be made to the Insured for any portion of a Medical Expense that is treated as an amount exceeding the applicable Limit, Coinsurance, and/or Deductible. However, after any expenses excluded from Coverage under these Special Terms and Conditions and the General Conditions of Health Insurance have been deducted from the total invoiced amount submitted as a Medical Expense, the total approved amount shall be treated as an eligible Medical Expense and, where applicable, deducted from the relevant Coverage Limit.
The applicable Claim Payment shall be made within 5 (five) business days after the relevant claim is received by the Insurer. If the bank account previously provided is no longer in use or the Insured requests that the Claim Payment be made to a different account, the new account number must be reported to the Insurer. For purposes of the Insurer's exercise of its rights under these Special Terms and Conditions and the General Conditions of Health Insurance, the date on which the Insurer determines, following its claim assessment, whether to make or deny payment shall govern.
Liability for any medical error occurring during treatment of the Insured at a Contracted Healthcare Institution shall rest with the relevant Healthcare Institution and Physician to the extent of fault determined by the competent authorities. Katılım Emeklilik ve Hayat A.Ş. shall have no liability for medical errors and shall have no obligation to compensate any resulting loss or damage.
In accordance with applicable laws and regulations, the Insurer is required to disclose any information obtained from Insureds in connection with the issuance of a health insurance contract, including Claim information, Coverage details, and personal information, to the Insurance Information Center, the Undersecretariat of Treasury, and, upon request, any other governmental authority. Each person who purchases health insurance agrees in advance to the disclosure of such information to the relevant public authorities.
Following the occurrence of a risk covered under the Policy and payment of a Claim Payment to the Insured or other beneficiary, Katılım Emeklilik ve Hayat A.Ş. shall, pursuant to the principle of subrogation and applicable law, be subrogated to the rights of the Insured and shall be entitled to seek recovery of the loss from the person or entity responsible for causing it. To enable the Insurer to exercise this right, the Insured must provide Katılım Emeklilik ve Hayat A.Ş. with all necessary information, documentation, and assistance. (Principle of Transfer of Rights)

9. POLICY RENEWAL AND LIFETIME RENEWAL GUARANTEE

9.1. Policy Renewal

Policy renewal means the issuance of a new Insurance Contract, following expiration of the existing Insurance Contract and subject to the Insurer's Risk Assessment, within a maximum of 1 (one) month after the Policy Expiration Date, with effect from the expiration date of the previous Policy. If the Policy is not renewed within this period, the Insurer reserves the right not to cover any risks arising before the new Policy is issued, to terminate the validity of any renewal rights, and to apply assessment criteria applicable to first-year enrollment.

Unless the Policyholder and/or the Insured requests otherwise in writing, the Insurer reserves the right to automatically renew or decline to renew the Insurance Contract upon its expiration.

Upon expiration of the existing Insurance Contract, the Insurer may, based on its assessment, decline to renew the Insurance Contract or renew it subject to additional terms applicable to the Insured's existing Medical Conditions and/or Illnesses, including Deductibles, Limits, Medical Loadings, Coinsurance, or similar terms.

Subject to the Insurer's assessment, the Policy shall be renewed without changing the Coverage, Contracted Healthcare Institutions, or other Coverage details previously selected by the Insured. However, if any selected feature of the Policy, including the scope of Coverage, Coverage Limit, Payment Percentage, Deductible, or Contracted Healthcare Institution, is no longer available at renewal, the Policy shall be renewed with the corresponding terms that are at least equivalent to those of the expiring Policy.

If the Social Security Institution (SSI) introduces statutory changes to the scope or implementation of General Health Insurance (GHI), the Insurer reserves the right to amend these Special Terms and Conditions and the applicable cost-sharing amounts accordingly.

At renewal, the Policyholder and/or the Insured may request a change to the insurance product, the Contracted Healthcare Institution Network, or the Coverage. The Insurer may accept or reject such request following a new Risk Assessment. If the request is accepted, the Insurance Contract may be renewed subject to the terms and conditions of the newly requested Coverage structure or insurance product, without the Insurer being bound by the Acquired Rights under the previous Insurance Contract.

The Insurer reserves the right to require the Insured to submit a health declaration reflecting the Insured's current health status or to undergo a medical examination and additional diagnostic testing. The expenses associated with such procedures shall be borne by the Insurer, provided that the Insured authorizes access to the Insured's prior health information and the relevant systems are accessible to the Insurer. Otherwise, such expenses shall be borne by the Insured.

Renewal offers shall be sent to the Policyholder and/or the Insured no later than 15 (fifteen) calendar days before the Policy Expiration Date. Unless the Policyholder provides written notice to the contrary before the expiration date, the payment method used for the previous Policy term shall continue to apply upon renewal. Where the premium is paid by credit card, the credit card information used for premium payments shall be carried over to the Renewal Policy.

If the Policyholder and/or the Insured submits a written cancellation request within the first 30 (thirty) calendar days after the Policy Effective Date of the renewed Policy, the renewed Policy shall be canceled with effect from its Policy Effective Date and the full premium shall be refunded to the Policyholder, provided that no Claim has been made or is payable under the renewed Policy. If a Claim Payment has been made or is payable, or if the cancellation request is submitted after the 30 (thirty)-day period, cancellation shall be processed in accordance with the Policy Cancellation Provisions.

9.2. Lifetime Renewal Guarantee

The Lifetime Renewal Guarantee is the Insurer's commitment to renew the Policy throughout the Insured's lifetime, subject to specified criteria such as the existing scope of Coverage, Coverage Limits, Payment Percentage, and Deductibles.
To be eligible for assessment for a Lifetime Renewal Guarantee, the Insured must meet all of the following requirements:

- The Insured must have been 60 (sixty) years of age or younger, including age 60, on the Initial Insurance Date;
- The Insured must have maintained continuous insurance coverage for 3 (three) full years;
- During that period, the Insured must have fully complied with the Principle of Maximum Goodwill and the applicable Duty of Disclosure; and
- The ratio of the total Claim Payments incurred during the most recent 3 (three) Policy years to the total Net Health Premium accrued for the Insured during the same period must be less than 80% (eighty percent).

Where these requirements are met, the Lifetime Renewal Guarantee may be granted based on the outcome of a medical and technical assessment.

Based on the results of its assessment, however, the Insurer reserves the right to grant the Lifetime Renewal Guarantee subject to additional terms, including Deductibles, Limits, Medical Loadings, Coinsurance, or similar conditions. For an Insured who has been assessed for a Lifetime Renewal Guarantee but has not been granted the guarantee, the Insurer reserves the right to conduct a Risk Assessment each year and to determine whether to renew the Policy.

The Insurer shall be responsible for renewing Policies of Insureds who hold a Lifetime Renewal Guarantee with equivalent Coverage. To retain the Lifetime Renewal Guarantee, the Insured's current and subsequent Insurance Contracts must be renewed without interruption with an equivalent Coverage structure, and all premiums must be paid when due.

After a Lifetime Renewal Guarantee has been granted, if the Insured requests a change in the insurance product or an expansion of Coverage, the Insurer shall reassess the Lifetime Renewal Guarantee. Based on the outcome of that reassessment, the Insurer reserves the right to reject the requested plan and/or product change or accept it subject to additional terms, including Deductibles, Limits, Medical Loadings, Coinsurance, Waiting Periods, or similar conditions.

Even where the Insured has a Lifetime Renewal Guarantee, the Insurer may terminate or rescind the Insurance Contract in any of the following circumstances, without prejudice to its right of recourse in respect of any improper payments made to the Policyholder and/or the Insured, as applicable:

- Cancellation of the Insurance Contract due to failure to pay the insurance premium by the due dates specified in the Policy;
- Failure by the Insured and/or the Policyholder to comply with the Principle of Maximum Goodwill; or
- A determination that the Insured made a false, incomplete, or inaccurate disclosure or used the insurance Coverage in bad faith.

The lifetime hospitalization limit of 720 (seven hundred twenty) days shall not apply to an Insured who has qualified for the Lifetime Renewal Guarantee. Based on the assessment described above, the Insurer may:
- Grant the Lifetime Renewal Guarantee without applying any Medical Loading or Exclusion, while reassessing any existing Exclusion and/or Medical Loading at the time the guarantee is granted;
- Grant the Lifetime Renewal Guarantee subject to additional terms, including Deductibles, Limits, Medical Loadings, Coinsurance, or similar conditions, with respect to risks arising before the date on which the Insured qualifies for the Lifetime Renewal Guarantee with Katılım Emeklilik ve Hayat A.Ş.; or
- Decline to grant the Lifetime Renewal Guarantee and continue to conduct a Risk Assessment at each renewal. Once the Insured has qualified for the Lifetime Renewal Guarantee:
- Unless requested by the Insured and/or the Policyholder, the scope of Coverage shall not be reduced, Coverage Limits shall not be decreased, and Coinsurance shall not be increased as a result of any Illness or Medical Condition arising thereafter. No amendment shall be made to the insurance technical principles or these Special Terms and Conditions to the detriment of the Insured for such reason.
- No Deductible, Limit, Medical Loading, Coinsurance, or similar condition shall be imposed as a result of any Illness or Medical Condition arising after the Insured has acquired this right.
- No claims-based premium loading shall be applied to a Renewal Policy that includes a Lifetime Renewal Guarantee.

If, between the date on which the Insurer conducts the Risk Assessment for the Lifetime Renewal Guarantee and the Policy Effective Date of the renewed Policy, a health risk is identified that was known to the Insured but unknown to the Insurer, the Insurer's rights of rescission, termination, recourse, and recovery of Claim Payments shall be reserved in accordance with applicable law and the terms of the Policy.

The Lifetime Renewal Guarantee is personal to the Insured and applies solely to the Insured who has acquired the right. Insureds who hold a Lifetime Renewal Guarantee shall be identified separately in the Policy. Further information regarding the Lifetime Renewal Guarantee is set forth under the Application and Information Form provision.
A spouse and/or child added to the Policy after the Policy Effective Date shall be assessed by the Insurer for a Lifetime Renewal Guarantee at the first renewal following completion of 3 (three) full years of coverage from the Policy term in which such person was added. The granting of a Lifetime Renewal Guarantee to one person insured under a health insurance Policy together with other family members does not mean that the guarantee is also granted to the other family members covered under the Policy. Each Insured shall be subject to the Special Terms and Conditions in effect on the date the Lifetime Renewal Guarantee is granted to that Insured.

A person who ceases to be covered under a Group Health Insurance Policy with Katılım Emeklilik ve Hayat A.Ş. must apply for Individual Health Insurance within no more than 30 (thirty) days after leaving the Group Policy. Where a person covered under a Group Health Insurance Policy with Katılım Emeklilik ve Hayat A.Ş.

does not have a Lifetime Renewal Guarantee and obtains Individual Health Insurance with Katılım Emeklilik ve Hayat A.Ş. equivalent to the Group Policy Plan within no more than 30 (thirty) days after leaving the Group Policy, the period of Group Health Insurance coverage with Katılım Emeklilik ve Hayat A.Ş. and the applicable claims-to-premium ratios under the Group Health Insurance Policy shall be taken into account in any subsequent assessment for an individual Lifetime Renewal Guarantee. The Lifetime Renewal Guarantee shall be granted based on the outcome of the assessment described above.

Where an Insured holds a Lifetime Renewal Guarantee with another insurance company, does not renew the Policy with that insurer, and applies for Individual Health Insurance with Katılım Emeklilik ve Hayat A.Ş. for the following period without an interruption of more than 1 (one) month, the Insured's health declaration, previous period of insurance coverage, and information from the previous insurer shall be reviewed. If the Insured is found eligible following a Risk Assessment, the Insured may be accepted for coverage with the Lifetime Renewal Guarantee rights acquired from the previous insurer transferred to Katılım Emeklilik ve Hayat A.Ş.

For an Insured who holds a Policy with another insurance company but has not yet acquired a Lifetime Renewal Guarantee, the period of coverage with the previous insurer shall be taken into account. Where such person obtains Individual Health Insurance with Katılım Emeklilik ve Hayat A.Ş. for the following period without an interruption of more than 1 (one) month, eligibility for the Lifetime Renewal Guarantee shall be assessed during the Policy period with Katılım Emeklilik ve Hayat A.Ş. in accordance with the Lifetime Renewal Guarantee criteria set forth above.

10. PREMIUM DETERMINATION

10.1. Criteria for Determining Premiums

Individual Health Insurance premiums are determined based on objective and actuarial criteria, including the Insured's age, sex, place of residence, the insurance product and scope of Coverage selected, trends in the overall claims-to-premium ratio of the applicable Policy Plan, amendments to the Health Implementation Communiqué (HIC), the Turkish Medical Association Fee Schedule (TMA), the Medical Practice Database (MPD), the Turkish Dental Association Fee Schedule (TDA), and similar statutory or institutional fee schedules, as well as increases in Healthcare Institution fee schedules and medical inflation.

10.2. Age Calculation

The Insured's age is calculated by subtracting the Insured's year of birth from the year in which the Policy becomes effective (Policy Effective Year – Year of Birth). The resulting number shall constitute the Insured's age for Policy purposes, based solely on the calendar year and without regard to the month or day of birth. Age is calculated as of the Policy Effective Date. No adjustment or premium revision resulting from a change in the Insured's age shall be made during the Policy term.

10.3. Premium Provisions

The Insurer periodically updates the Health Tariff Premium, taking into account the overall performance of the portfolio and each risk profile, medical inflation, and other general economic developments in the country. Any increase in the Health Tariff Premium shall not be lower than the rate of medical inflation and shall be limited to a maximum of 3 (three) times the tariff premium applicable to the same category in the preceding year. The Insurer reserves the right, as of each renewal, to make reasonable changes to the rates and criteria applicable to discounts and/or additional premiums.

The Total Policy Premium shall be collected in accordance with the payment method selected by the Policyholder, including credit card, debit card, bank transfer, or EFT, and on the due dates specified in the Policy. Where payment of the premium in installments has been agreed, this requirement applies to both the down payment and each installment.

10.4. Medical Loading

A Medical Loading is an additional premium, separate from the applicable tariff premium, that may be required in order to provide insurance coverage based on an assessment of the prospective Insured's individual health status. The Medical Loading applied to the Insured's Health Tariff Premium may not exceed 200% (two hundred percent) for each Illness.

10.5. Claims-Based Discount / Additional Premium

A claims-based discount and/or additional premium may be applied by the Insurer upon renewal or transfer of an Individual Health Insurance Policy issued by Katılım Emeklilik ve Hayat A.Ş., where this practice applies. Upon renewal of an Insurance Contract that has expired with the Insurer, provided that both the expiring Policy and the Renewal Policy provide either Inpatient Treatment Coverage only or both Inpatient Treatment Coverage and Outpatient Treatment Coverage, a discount and/or additional premium may be applied to the renewal premium of each Insured based on the ratio of Paid and Payable Claims to Net Health Policy Premium (C/P) for the most recent Policy year, in accordance with the conditions and rates specified below.

The claims-based discount and additional premium rates determined by reference to the Paid and Payable Claims / Net Health Policy Premium (C/P) Ratio are set forth in the table below.

No claims-based additional premium shall be applied upon renewal or transfer of a Katılım Emeklilik ve Hayat A.Ş. Individual Health Insurance Policy for an Insured who holds a Lifetime Renewal Guarantee.

Claim Premium Ratio	Discount/ Additional Premium Ratio
0% - 20%	30% Discount
21% - 40%	20% Discount
41% - 60%	10% Discount
61% - 100%	Tariff Premium (Standard Premium)
101% - 120%	10% Additional Premium
121% - 150%	20% Additional Premium
151% - 200%	30% Additional Premium
201% ≥	50% Additional Premium

NOTE: Discounts and additional premiums are calculated based on the tariff premium applicable to the Renewal Policy.

10.6. Family Discount

Where 2 (two) or more members of the same immediate family are insured under the same Insurance Contract, a 10% (ten percent) discount shall be applied to the applicable net health tariff premium. The discount is applied based on the number of persons insured.

10.7. Child Additional Premium

Children from age 0 through age 17, inclusive, may be insured individually under Individual Health Insurance without either parent being insured under the same Policy. In such cases, the Policy may be issued subject to an additional premium at the rates specified below.

Age Range	Additional Premium Ratio
Age 0 - 2	100% Additional Premium
Age 3 - 5	50% Additional Premium
Age 6 - 10	10% Additional Premium

For a child from age 0 through age 10 to be insured without application of the additional premiums specified above, the child must be insured under the same Plan as at least 1 (one) parent or under a lower-tier Plan.

10.8. Other Discounts and Promotional Campaigns

This term refers to any discount offered by the Insurer, other than the discounts specified in these Special Terms and Conditions, including discounts offered from time to time as part of promotional campaigns or in similar circumstances.

10.9. Premium Adjustment Endorsement

If, after a discount or additional premium has been applied to the Insured's Renewal Policy premium based on claims utilization, a Medical Expense relating to the year in which the assessment was made and/or a previous Policy term, for which no Claim Payment had previously been made by the Insurer for any reason, is subsequently reimbursed, the applicable discount and additional premium rates shall be recalculated based on the Insured's revised claims-to-premium ratio. Any resulting adjustment shall be reflected in the premium of the new Policy by Endorsement.

11. NEW ENROLLMENT PROCEDURES

11.1. Enrollment of New Insureds

Under this insurance, persons who reside within the Republic of Türkiye and are at least 15 days old and no more than 64 years of age, inclusive, may be insured. The Katılım Sağlık Baby Program is described above. Unless otherwise accepted by the Insurer in writing, only persons who reside or will reside within the Republic of Türkiye are eligible for insurance.

The Insured's age is determined by subtracting the Insured's year of birth from the year in which the Policy becomes effective. Only members of the same immediate family may be included under the same Policy. For this purpose, the immediate family consists of the mother, father, and/or unmarried children up to and including 24 (twenty-four) years of age. An individual and spouse may be included under the same Policy only if they are legally married.

For a person to be accepted for insurance, the Application and Declaration Form must contain the required information for each person to be included under the relevant Policy.

11.2. Evaluation of the Application and Information Form

Completion of the Application and Information Form does not, by itself, establish an Insurance Contract. The Insurer shall evaluate the disclosures made by the Policyholder and/or the Insured in fulfillment of the applicable Duty of Disclosure in accordance with its Risk Assessment criteria. Based on the results of this evaluation, the Insurer reserves the right to modify the proposed scope of the Policy, including the Network or Coverage; apply an Exclusion and/or Medical Loading; require the prospective Insured to undergo a medical examination and additional diagnostic testing where deemed necessary; or decline the application. If the application is accepted by the Insurer, the Policy shall become effective upon collection of the full premium or, where applicable, the down payment.

11.3. Adding New Insureds to an Existing Policy

A new Insured may be added to an Insurance Contract already in force during the Policy term only in the following circumstances and provided that a written application is submitted to the Insurer within 30 (thirty) calendar days after the date of the applicable event:

- Addition of a legal spouse following marriage;
- Addition of a newborn following birth; or
- Addition of a child following adoption.

Applications submitted within the applicable period shall be subject to a Risk Assessment in accordance with these Special Terms and Conditions and the General Conditions of Health Insurance. If the application is accepted, the application date shall be treated as the date on which the new Insured is added to the Policy. With respect to newborns of Insureds whose Policy includes Maternity Coverage and who have become eligible for such Coverage, the Maternity Coverage (Katılım Sağlık Baby) provisions of these Special Terms and Conditions shall continue to apply. A newborn whose mother and father are not insured with the Insurer and who is to be enrolled separately as a new Insured may be added to the Policy following a Risk Assessment conducted no later than the end of the 14th day after birth. Premiums for persons added to the Policy after its Policy Effective Date shall be calculated on a pro rata daily basis by reference to the annual premium and collected accordingly. If all installments under the Policy have already been paid, the additional premium shall be collected in a single payment. If installments remain outstanding, the additional premium shall be divided equally among the remaining installments.

11.4. Reinstatement of the Policy

If a Policy premium or installment is not paid within 30 (thirty) days after its due date, the Policy shall be canceled. If an application for reinstatement is submitted within 30 (thirty) days after cancellation, the Insurer shall conduct a reinstatement assessment. Based on the outcome of that assessment, the Insurer reserves the right to reinstate the Policy; apply an Exclusion and/or Medical Loading; require the Insured to undergo a medical examination and additional diagnostic testing where deemed necessary; or decline the application for reinstatement. A Policy canceled at the Insured's own request shall not be eligible for reinstatement.

11.5. Katılım Sağlık Baby Program

Provided that the Primary Insured's Policy includes Maternity Coverage and the Primary Insured has become eligible for such Coverage, the Policyholder and/or the Insured must apply to add the newborn to the Policy within 30 (thirty) calendar days after the date of birth. At the time of application, the newborn's hospital discharge report, the results of all medical tests performed, and the newborn health declaration form must be submitted to the Insurer in full.

Newborns for whom an application is submitted within the first 30 (thirty) calendar days after birth and who are determined to be healthy following a Risk Assessment shall, upon acceptance for insurance, be granted the following special rights:

- The newborn's Policy Effective Date shall be recorded in the system as the actual date of birth.
- The Illness-related Waiting Periods specified in the Policy shall not apply to the newborn.
- The newborn shall be granted a Lifetime Renewal Guarantee, subject to uninterrupted insurance coverage.
- No Illness Exclusion shall be applied in respect of the newborn's existing condition. However, a Medical Loading may be applied in accordance with the applicable Risk Assessment principles.

Where an application is submitted within the first 30 (thirty) calendar days after birth for a newborn with a congenital Medical Condition or a premature newborn, but the newborn is unable to qualify for Katılım Sağlık Baby status due to the newborn's health condition, treatment expenses are covered subject to the specific Newborn/Premature Coverage Limits, coverage periods, and Payment Percentage separately specified for such circumstances in the Coverage Table.

A newborn who is not reported to the Insurer in writing and added to the Policy within the first 30 (thirty) calendar days after birth shall under no circumstances qualify for "Katılım Sağlık Baby" status. For applications submitted after the first 30 (thirty) calendar days, the standard new-enrollment Risk Assessment rules and standard Illness-related Waiting Periods shall apply in full in determining whether the newborn will be accepted for insurance.

12. TRANSFER AND ACQUIRED RIGHTS

Individuals who were insured by another insurance company and who, after declining to renew or canceling their policy with that insurer, wish to obtain Individual Health Insurance from Katılım Emeklilik ve Hayat A.Ş. for the following period without an interruption of more than 30 (thirty) calendar days after the expiration or cancellation date of the previous policy may be eligible to retain Acquired Rights obtained under their previous insurance coverage.

Based on the individual's declarations and the information obtained from the previous insurer, the Insurance Information and Supervision Center (SBM), and other relevant authorities, the Insurer shall conduct a Risk Assessment to determine whether and on what terms the individual will be accepted for insurance. In particular, with respect to Illnesses arising before the Initial Insurance Date with Katılım Emeklilik ve Hayat A.Ş., the Insurer may include such Illnesses within Coverage, exclude them from Coverage, and/or apply a Medical Loading or Limit. Any continuation of Acquired Rights shall be determined based on the outcome of this Risk Assessment.

A 12 (twelve)-month Waiting Period shall apply in all circumstances to expenses relating to pregnancy and childbirth. This requirement applies regardless of whether a Lifetime Renewal Guarantee held with another insurance company is transferred to Katılım Emeklilik ve Hayat A.Ş.

For an Insured covered under Individual Health Insurance who holds a Lifetime Renewal Guarantee, no adverse change shall be made, without the Insured's consent, to the Coverage Limits or Coinsurance specified in the existing Policy. If it is determined that the Insured made a false, incomplete, or inaccurate disclosure or used the insurance Coverage in bad faith, Katılım Emeklilik ve Hayat A.Ş. may modify the terms of the Lifetime Renewal Guarantee by applying a Deductible or Medical Loading in respect of the relevant Illness, seek recovery from the Insured of Claim Payments made in connection with that Illness, revoke the Lifetime Renewal Guarantee, or cancel the Policy.

An Insured who has qualified for a Lifetime Renewal Guarantee and cancels the Policy due to military service may retain the Lifetime Renewal Guarantee, provided that the Insured applies within 30 (thirty) calendar days after completion of military service, submits documentation evidencing the military service, completes a health declaration form, and selects a Plan providing Coverage equivalent to or lower than the Plan held before military service. Any Medical Condition arising during the period in which the Insured was not insured with Katılım Emeklilik ve Hayat A.Ş. shall, however, be excluded from Coverage under the new Policy. In all other circumstances, the Insurer shall conduct a new Risk Assessment.

Requests to change the insurance product at renewal shall be evaluated during the 15 (fifteen)-day periods immediately before and after the Policy Expiration Date. If the Policyholder requests an expansion of the options under the Renewal Policy, including the scope of Coverage, Coverage Limits, Payment Percentage, Deductible, Network, or similar criteria, the Insurer shall obtain an updated health declaration and conduct a new Risk Assessment. Based on the outcome of that assessment, the Insurer reserves the right to modify the scope of the Policy, including the Network, Coverage, Limits, or Payment Percentage; apply an Exclusion and/or Medical Loading; impose a Waiting Period; require a medical examination or additional diagnostic testing where deemed necessary; or decline the application. If the Policyholder requests a reduction in the options under the Renewal Policy, no new Risk Assessment shall be conducted, and any existing Exclusion and/or Medical Loading shall remain in effect.

A person covered under a Katılım Emeklilik ve Hayat A.Ş. Group Health Insurance Policy who wishes to continue coverage under Individual Health Insurance must apply to Katılım Emeklilik ve Hayat A.Ş. within 30 (thirty) calendar days and submit a completed Application and Declaration Form. The Insurer shall determine whether the prospective Insured may retain Acquired Rights obtained under the Group Policy after reviewing the individual's declarations, prior insurance history, whether the individual has engaged in any conduct that could result in fraudulent or improper use of insurance, and the terms and conditions of the Group Health Insurance Contract. Based on its assessment under the Special Terms and Conditions applicable to the Individual Health Insurance product, the Insurer reserves the right to accept or decline the prospective Insured for Coverage or to accept the prospective Insured subject to an Exclusion and/or Medical Loading. Where a person who does not hold a Lifetime Renewal Guarantee obtains Individual Health Insurance within 30 (thirty) calendar days, the period of Group Health Insurance coverage with Katılım Emeklilik ve Hayat A.Ş. and the claims-to-premium ratios under the Group Health Insurance Policy shall be taken into account in the subsequent assessment for an individual Lifetime Renewal Guarantee.

Where an individual transfers to Katılım Emeklilik ve Hayat A.Ş. from another insurance company and holds a Lifetime Renewal Guarantee with the previous insurer, that right may be transferred to Katılım Emeklilik ve Hayat A.Ş. based on the outcome of a Risk Assessment conducted within the limits prescribed by IPRSA and applicable law.

For persons who have qualified for a Lifetime Renewal Guarantee under a Katılım Emeklilik ve Hayat A.Ş. Group Health Insurance Policy and subsequently transfer to an individual Insurance Contract, subject to preservation of their legally acquired rights:

- They shall be offered the equivalent Plan that most closely corresponds to the Coverage Limits and applicable Network structure under the Group Policy.
- Any request by the Insured to transfer to a more comprehensive individual Policy shall be determined based on a medical Risk Assessment conducted by the Insurer.
- Under the equivalent Plans offered at the time of transfer, Illness-specific maximum Limits and the premium structure shall be determined in accordance with risk acceptance principles to the extent permitted by the Insured's legally acquired rights.

For persons covered under Supplementary Health Insurance (TSS) with Katılım Emeklilik ve Hayat A.Ş. who apply for Individual Private Health Insurance (ÖSS) upon expiration of their Insurance Contract, no rights shall be transferred. A new Risk Assessment shall be conducted from the outset, and the Policy shall be issued as New Business, with first-year status.

13. TERMINATION AND CANCELLATION OF THE INSURANCE CONTRACT

13.1. Insurance Period

The Insurance Period is the period during which the Insurance Contract remains in effect. The Insurance Period is 1 (one) year and runs from the Policy Effective Date through the Policy Expiration Date specified in the Policy. Coverage begins at 12:00 noon on the Policy Effective Date and ends at 12:00 noon on the Policy Expiration Date.

13.2. Commencement of the Insurer's Liability and Default Provisions

Coverage becomes effective upon the Insurer's approval of the application and actual payment of the full Policy premium or, where payment in installments has been agreed, the first installment or down payment. The Policyholder shall be in default if any premium installment agreed with the Insurer is not paid on its applicable due date.

If the Policyholder fails to pay the outstanding premium within 15 (fifteen) calendar days after the date of default, Coverage shall be suspended and the Insurer shall send written notice to the Policyholder's last known mailing address or email address.

Provided that the insured risk has not occurred, if the outstanding premium is paid while Coverage is suspended, Coverage shall resume from the point at which it was suspended. If the outstanding premium is not paid within 15 (fifteen) calendar days after the date on which Coverage was suspended, the Insurance Contract shall be terminated.

13.3. Right to Cancel from the Policy Effective Date

If the Policyholder and/or the Insured submits a written cancellation request within the first 30 (thirty) calendar days after the Policy Effective Date, all premiums paid shall be refunded to the Policyholder in full, provided that no insured risk has occurred and no Claim request has been submitted as of the date of the cancellation request.

13.4. Right to Cancel During the Insurance Period

If the Policy is canceled at the request of the Policyholder and/or the Insured, the premium refund shall be calculated on a pro rata basis according to the number of days for which the Insurance Contract was in effect relative to the total Insurance Period. The amount, if any, to be refunded to the Policyholder shall be determined by taking into account the premium earned by the Insurer and any Claim Payments made, as follows:

• If the Claim Payments made to the Insured do not exceed the amount of premium earned by the Insurer for the applicable period, the earned premium shall be deducted from the premiums paid by the Policyholder and the remaining amount shall be refunded to the Policyholder.
• If the Claim Payments made to the Insured exceed the premium earned by the Insurer for the applicable period but do not exceed the premiums paid by the Policyholder for that period, the amount of the Claim Payments shall be deducted from the premiums paid and the remaining amount shall be refunded to the Policyholder.
• If the Claim Payments made to the Insured exceed both the premium earned by the Insurer for the applicable period and the premiums paid by the Policyholder for that period, no premium refund shall be made.
• Upon payment of a Claim Payment, any premium installments that have not yet become due shall become immediately due and payable to the extent that they do not exceed the amount of the Claim Payment payable by the Insurer.

Requests submitted after the Policy Effective Date to remove an individual Insured, including a spouse or child, from the Policy shall also be processed in accordance with the rules set forth above.

Where the Policyholder is also the Insured under a single-person Policy, the Policy shall cease to have effect upon the Policyholder's death. Upon written request by the Policyholder's legal heirs, the cancellation shall be processed in accordance with the criteria set forth above and any applicable premium refund shall be paid to the legal heirs.

Where more than one person is insured under the Policy and one of the Insureds dies, the deceased Insured shall be removed from the Policy with effect from the date of death. Any applicable premium refund shall be paid to the Policyholder in accordance with the cancellation criteria set forth above.
Where more than one person is insured under the Policy and the parents divorce, the parent whose removal from the Policy is requested shall be removed with effect from the date of divorce. Any applicable premium refund shall be paid to the Policyholder in accordance with the cancellation criteria set forth above. If a change of Policyholder is requested in such circumstances, the Policy shall continue in force with the new Policyholder.

Where more than one person is insured under the Policy and one of the children marries, that child shall be removed from the Policy with effect from the date of marriage. Any applicable premium refund shall be paid to the Policyholder in accordance with the cancellation criteria set forth above.

Any applicable premium refund shall be paid to the Policyholder in accordance with the cancellation criteria set forth above. If the Policyholder and/or the Insured is found to have acted in violation of the Principle of Maximum Goodwill, including by allowing a person who is not covered under the Insurance Contract to use the Coverage or arranging for Medical Expense documentation to be issued in the name of another person covered under the Insurance Contract, the Insurer shall, where it has made a Claim arising from such conduct, be entitled to recover the Medical Expenses paid and to declare the Insurance Contract void ab initio, in whole or in part, with respect to some or all Insureds. The Policyholder and the Insured shall be jointly liable for any loss incurred by the Insurer as a result of Claim requests by the Insured that are inconsistent with the Principle of Maximum Goodwill.

13.5. Death

Upon the death of the Policyholder, the Insurance Contract shall cease to have effect. If the policyholder is not named in the contract and the Insureds wish to continue the Insurance Contract by replacing the Policyholder, the written consent of the Policyholder's legal heirs must be submitted to the Insurer. Upon receipt of such consent, the Insurance Contract shall continue with the replacement Policyholder. If the consent of the legal heirs is not obtained, the Insurance Contract shall be processed in accordance with the cancellation criteria set forth above and any applicable premium refund shall be paid to the legal heirs. Where the Policyholder is also the Insured under a single-person Insurance Contract, the Insurance Contract shall cease to have effect upon the Policyholder's death. Upon written request by the Policyholder's legal heirs, the cancellation shall be processed in accordance with the criteria set forth above and any applicable premium refund shall be paid to the legal heirs.

Where more than one person is insured under the Insurance Contract and one of the Insureds dies, the deceased Insured shall be removed from the Insurance Contract with effect from the date of death, and any applicable premium refund shall be paid to the Policyholder in accordance with these Special Terms and Conditions.

14. ADDITIONAL PROVISIONS

14.1. Information Sharing and Collection

In accordance with the Insurance Law, applicable regulations, healthcare legislation, personal data protection legislation, and other applicable laws and regulations, the Insurer may obtain information and documentation from, and share information with, relevant institutions and organizations for purposes of conducting Risk Assessments, issuing Policies, processing Claim requests, preventing fraud and abuse, and fulfilling its statutory and regulatory obligations.

For these purposes, and to the extent permitted by applicable law, the Insurer is authorized to conduct inquiries with, obtain information and documentation from, and share information with:

- the Insurance and Personal Pension Regulation and Supervision Agency (IPRSA);
- the Insurance Information and Supervision Center (SBM);
- the Social Security Institution (SSI);
- the Ministry of Health of the Republic of Türkiye;
- the Insurance Association of Türkiye;
- healthcare institutions and organizations;
- other insurance companies; and
- authorized public institutions and authorities.

Persons who are to be or have been covered under the insurance acknowledge that they have received the required information regarding the processing of their personal data, including health data, the collection of such data from relevant institutions, and the sharing of such data in accordance with applicable law for purposes of conducting Risk Assessments, entering into and administering the Insurance Contract, processing Claim requests, and fulfilling statutory and regulatory obligations.

The processing and sharing of personal data shall be governed by the applicable personal data protection legislation then in force.

14.2. Failure to Comply with the Duty of Disclosure and Related Liability

Each prospective Insured to be covered under the insurance must complete the Application and Health Declaration Form accurately, completely, and truthfully.

Based on its evaluation of the information disclosed, the Insurer reserves the right to:

- request additional information and documentation;
- require additional diagnostic testing or a Physician's opinion;
- decline the application; or
- apply an additional premium, Limit, Deductible, Exclusion, or

Waiting Period.

If the prospective Insured is found to have breached the Duty of Disclosure intentionally or through gross negligence, the Insurer shall be entitled, in accordance with applicable law and the terms of the Policy, to reassess the scope of Coverage, deny a Claim request, or cancel the Policy. Insureds must provide accurate answers to all questions concerning themselves and their dependents and must fully disclose any Illnesses or Medical Conditions of which they are aware or reasonably should be aware.

The Policyholder acknowledges that the Insureds' contact information may be used in connection with communications relating to the Insurance Contract, notifications, delivery of the Policy, and operational processes.

If any false disclosure, concealment of information, use of forged documents, obtaining of an undue benefit, or other abuse of the insurance system is identified, the Insurer reserves the right to:

- remove the relevant Insured and, where applicable, the Insured's dependents from Coverage under the Policy;
- cancel the Policy;
- exercise its rights of recourse under applicable law in respect of Claim Payments already made; and initiate any necessary legal proceedings.

If, while the Policy is in force, the Insurer becomes aware that any disclosure concerning an Insured or the Insured's dependents was false, incomplete, or misleading, the Insurer may conduct a new Risk Assessment. In connection with such reassessment, the Insurer reserves the right to:

- require a new Application and Health Declaration Form;
- request additional information and documentation;
- require a Physician's opinion or diagnostic testing;

• impose additional terms; and
• modify the scope of Coverage.
If the Policyholder and the Insurer mutually agree, alternative Risk Assessment methods may be used without requiring the prospective Insured to submit an Application and Health Declaration Form. In such cases, the Insurer may, where deemed necessary, require a Physician's opinion and/or diagnostic testing regarding the applicant's health status, with the related expenses borne by the applicant.

Application and Health Declaration Forms may be submitted using physical forms prepared by the Insurer or through electronic platforms designated by the Insurer.

14.3. Notifications to the Insured and Policyholder

Before the expiration of the Insurance Contract, the Insurer may notify the Policyholder of the Policy Expiration Date and renewal procedures. The Insurer may also notify the Policyholder and/or the Insured, through written or electronic means of communication, as to whether the Policy has been renewed.

All notifications shall be made using the current contact information contained in the Insurer's records. If any contact information changes, the Policyholder and/or the Insured must notify the Insurer of the change in writing without delay.

The Insurer shall not be liable for the failure of any notification to reach its intended recipient due to incomplete, incorrect, or outdated contact information. Any notification sent by the Insurer using the most recent contact information contained in its records shall constitute valid notification.

For notification purposes, at least 1 (one) mobile telephone number or email address for the insured personnel and the Policyholder identified in the Policy must be provided to the Insurer.

If no contact information is available for the insured personnel or their dependents, any notification sent to the Policyholder shall also be deemed to have been given to the relevant Insureds.

14.4. Treatment Continuing at the End of the Insurance Period

If the Policy is renewed while treatment is continuing under Inpatient Treatment Coverage, Surgery Coverage, or Home Care and Treatment Coverage:

• Medical Expenses incurred up to 12:00 noon on the renewal date shall be evaluated under the terms and conditions of the expiring Policy; and
• Medical Expenses incurred after 12:00 noon on the renewal date shall be evaluated under the terms and conditions of the renewed Policy.

If the Policy is not renewed, or if an Exclusion applies under the renewed Policy to the relevant Illness or risk, Coverage for the continuing treatment shall be limited to a maximum of 10 (ten) days after the Policy Expiration Date.

14.5. Rights of Recourse and Recovery

Where a third party is liable for Medical Expenses paid by the Insurer under the General Conditions and these Special Terms and Conditions, the Insurer may, in accordance with applicable law, exercise the Insured's rights as subrogee and seek recovery from the liable party.

If any amount paid by the Insurer:

• to a Contracted Healthcare Institution;
• on behalf of the Insured; or
• to the Insured's account
is subsequently determined not to have been payable under the terms of the Policy, the Insurer shall be entitled to recover the relevant amount.

Any erroneous payment resulting from incomplete, inaccurate, or misleading information or documentation provided by the Insured, the Policyholder, a Healthcare Institution, or a Physician shall also be subject to recovery under this provision.

The granting of Preauthorization or other prior approval by the Insurer shall not prejudice or otherwise affect any rights available to the Insurer under applicable law or the terms of the Policy if it is subsequently determined that the relevant expense was excluded from Coverage or that the payment resulted from a false disclosure, incomplete information, fraud, or any similar circumstance.

14.6. Economic Sanctions

No insurer or reinsurer shall be deemed to provide Coverage under this Insurance Contract, nor shall any insurer or reinsurer be liable to make any Claim Payment or provide any benefit, to the extent that providing such Coverage, making such payment, or providing such benefit would expose the insurer or reinsurer to any trade or economic sanction, prohibition, or restriction under United Nations resolutions or under any law or regulation applicable to the reinsurer.

Individual Private Health Insurance

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