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## FOREIGN HEALTH PARTICIPATION INSURANCE SPECIAL TERMS AND CONDITIONS

### 1. SUBJECT AND SCOPE OF THE INSURANCE

This insurance is a private health insurance policy required for short-term residence permit applications pursuant to the Law on Foreigners and International Protection No. 6458. In addition to the General Terms and Conditions of Health Insurance, it covers the healthcare expenses incurred for inpatient and/or outpatient treatment of the insured due to any disease and/or accident occurring during the policy period, in any public or private healthcare institution licensed by the Ministry of Health, in accordance with the coverage, limits, and payment rates specified in the policy, and subject to the general and special terms and conditions.

The insurance coverage is valid only for the individuals named in the insurance policy; no other person shall benefit from the coverage. In the case of family coverage, insured individuals may not have documents related to their treatment issued on behalf of other insured persons covered under the same policy.

The policy does not provide a daily allowance for loss of income due to the insured's inability to work resulting from disease, nor does it cover any expenses related to caregiving or daily care in the event the insured requires assistance.

This policy applies exclusively to foreign nationals (non-Turkish citizens) who hold a Katılım Emeklilik Misafirim Güvende Health Participation Insurance Policy. The insurance agreement comprises the application forms of the policyholder and the insured, definitions, the General Terms and Conditions of Health Insurance, Special Terms and Conditions, limits, exclusions and special exclusions, the policy itself, the coverage table, and all appendices thereto (hereinafter collectively referred to as the "Insurance Agreement"), and constitutes the agreement between the insurer and the policyholder. Under this agreement, a health insurance policy may be issued, and coverage may be granted, solely to foreign nationals (non-Turkish citizens) (hereinafter referred to as the "Policyholder/Insured").

The insurer undertakes to cover the medical expenses of the policyholder within the scope of the coverage, subject to the payment of the premium determined based on the information provided in the application form and in accordance with the terms and conditions set forth in the annexes forming an integral part of this Insurance Agreement.

The participation insurance policy prepared in line with the conditions mutually agreed upon by Katılım Emeklilik ve Hayat A.Ş. (hereinafter referred to as the "Insurer" under these Special Terms and Conditions) and the policyholder/insured; the application form completed and signed by the policyholder/insured and accepted by the Insurer; the insured information form; and the General and Special Terms and Conditions of Health Insurance, which are integral parts of the policy, along with the list of contracted institutions, together constitute the insurance policy.

From the moment the insured completes the application form to request coverage and throughout the policy term, the insured shall be deemed to have authorized the insurer to obtain information regarding their medical history and current condition and to request any relevant information, records, or on-site inspections concerning their treatment from institutions, physicians, and third parties, as deemed necessary by the insurer.

### 2. DEFINITIONS

**Insurer:** It refers to the institution that undertakes to pay indemnity to the policyholder/insured upon the occurrence of a covered risk, in return for the premium paid by the policyholder.

**Insured/Participant:** It refers to individual(s) whose name(s) appear on the policy and whose health expenses are covered under the Health Participation Insurance contract.

**Policyholder:** It refers to the natural or legal person who enters into an insurance agreement with the insurer and assumes all obligations arising from the insurance, including the payment of premiums.

**Policy:** It refers to the written document of the insurance agreement entered into between the insurer and the policyholder, which includes the identifying information of the insured individual(s), the start and end dates of the coverage, and the applicable premium and coverage amounts.

**Plan/Product:** It refers to the information specified in the policy that sets forth the scope of coverage, the coverage limits, and the insurer's payment rate or the insured's patient share under the coverage.

**Policyholder/Insured Contact Information:** It refers to the residential and/or business addresses, landline, mobile and/or business telephone numbers, and email addresses of the policyholder and the insured individuals named in the policy.

**Special Conditions:** It refers to the manual prepared by the insurer and forming an integral part of the policy, which outlines product-specific rules and provisions that do not include any clauses contrary to the interests of the policyholder/insured, as stated in the General Terms and Conditions of Health Insurance and the Private Health Insurance Regulation.

**General Terms and Conditions of Health Insurance ("General Terms and Conditions"):** It refers to the written rules set forth by the Insurance and Personal Pension Regulation and Supervision Agency and applied by all insurance companies in their health insurance policies. The most current version of these terms is available at [www.tsb.org.tr](http://www.tsb.org.tr).

**Customer Services:** It refers to the phone line (0850 226 01 23) through which insured persons may communicate any inquiries, requests, suggestions, or complaints, and access various services such as ambulance assistance.

**Disease:** It refers to a medically recognized condition where a physician determines that there is a deterioration in the psychological or physical functions, organs, or systems of the insured that requires medical examination, treatment, or intervention.

**Disorder:** It refers to an abnormal psychological or physical symptom that prompts an individual to seek medical attention.

**Pre-existing Disease/Disorder:** It refers to a disease/disorder that existed prior to the commencement of the insurance. The onset and progression of symptoms, diagnosis, or treatment-along with any recurrence or complications-are considered to have occurred prior to the policy start date.

**Exemption:** It refers to any risks (diseases/disorders) that existed before the policy start date or that arise during the insurance period and are excluded from coverage as a result of the insurer's assessment.

**Healthcare Institution:** It refers to private healthcare entities licensed by the Ministry of Health of the Republic of Türkiye, or public hospitals, laboratories, diagnostic centers, polyclinics, medical clinics, and other institutions providing inpatient and/or outpatient diagnostic and treatment services.

**a) Contracted Healthcare Institution:** It refers to the institutions that have entered into a special agreement with the Company and provide healthcare services to the insured individuals covered by the insurance company within the scope of such agreement.

The current list of contracted institutions is specified in the policy issued to the insured and published on the website of KATILIM EMEKLİLİK VE HAYAT A.Ş. ([www.katilimemeklilik.com](http://www.katilimemeklilik.com)). The insurance company reserves the right to amend the list of contracted institutions.

**b) Network of Contracted Healthcare Institutions (the "Network"):** The Network refers to the set of contracted healthcare institutions specified in the policy, based on the policyholder's selection.

**c) Non-Contracted Healthcare Institution:** It refers to the health institutions that have not entered into a special agreement with the Company and are not included in the list of contracted institutions. Physicians who are not officially appointed by the Ministry of Health, or who, despite being on staff, do not accept the terms of the Katılım Emeklilik Agreement, are also considered Non-Contracted Healthcare Institutions-even if they are employed at a healthcare institution listed in the selected Network.

**Indemnity:** It refers to the amount approved and/or paid by the insurer for healthcare expenses, in accordance with the applicable health policy and subject to the policy's General and Special Terms and Conditions.

**Provision:** It is the result of an assessment by the insurer indicating whether planned medical examinations, diagnoses, or treatments at healthcare institutions within the selected Network will be covered. This assessment is valid only if the relevant health policy is in force on the date the medical service is or will be rendered.

A provision granted at the time of claim does not constitute final approval. During claims processing, the insurer may reassess the situation and make a different determination regarding the scope of coverage or payment. For provisions obtained in advance, the settlement date is used as the basis for exercising the rights stated in the General and Special Terms and Conditions of the Policy.

**Accrual:** It refers to the stage at which the insurer evaluates the submitted claim for indemnity-regardless of whether prior authorization (provision) was obtained-and determines, in line with the policy coverage and limits as well as the Special and General Terms and Conditions, whether a payment will be made to the healthcare provider and/or the insured. If a payment is approved, this stage also determines the amount to be paid.

**Direct Payment:** In the case of healthcare expenses incurred at institutions within the preferred network specified in the policy, the insured, upon obtaining provision, pays only their applicable patient share, if any, and receives the services. The portion of the cost falling under the insurer's responsibility is paid directly to the relevant institution on behalf of the insured, subject to the policy's Special and General Terms and Conditions.

**Subsequent Payment:** When healthcare expenses are paid upfront by the insured without obtaining prior authorization, the insured may later submit the invoice, the "Treatment Expenses Claim Form," and all required supporting documents outlined in the "Indemnity Payment" clause of the Special Conditions. Upon evaluation in accordance with the Policy's Special and General Terms and Conditions, the approved amount is reimbursed to the insured's account.

**Treatment Expenses Claim Form:** It refers to the form that must be completed by the insured and submitted to the insurer in order to have healthcare expenses paid without prior provision considered for reimbursement. The form must include invoice details related to the incurred treatment expenses.

**Coverage:** It refers to the assurance provided by the insurer to compensate the insured in the event of the occurrence of a covered risk.

**Limit:** It refers to the scope of healthcare expenses covered by the insurer within the framework of the Insurance Policy, excluding items such as exclusions, waiting periods, disease-specific sub-limits, and deductibles. It represents the maximum amount of eligible expenses that the insured may utilize from the specified coverage during the policy period.

**Payment Percent:** It refers to the rate specified in the policy for each type of coverage, representing the share of expenses that the insurer is obligated to pay.

**Patient Share:** It refers to the portion of the total expense that corresponds to the remaining percentage not covered by the insurer, which is to be borne by the insured, as defined in the policy for each type of coverage.

## Premium

**a) Health Tariff Premium:** It refers to the base premium amount calculated based on the insured's coverage selection, payment percentage, chosen provider network, province of residence, age, gender, and other risk profile criteria.

## Katılım Emeklilik ve Hayat A.Ş.

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Mersis No: 0528064104700018, Ticaret Sicil Müd. İstanbul Ticaret Odası (İTO), Ticaret Sicil No: 895027

Katılım Sağlık, bir Katılım Emeklilik ve Hayat A.Ş. markasıdır.

**b) Health Premium:** It refers to the total premium amount obtained by adding any applicable disease-related surcharge to the Health Tariff Premium for each insured person.

**c) Health Net Premium:** It refers to the resulting premium amount after applying any discounts entitled under the policy's special conditions and/or any campaign discounts valid during the period, to the Health Premium.

**d) Total Policy Premium:** It refers to the total payable premium amount under the insurance policy, calculated by adding any applicable Personal Accident and/or Life Insurance premiums and tax amounts (SMV) to the Net Health Premium.

**e) Additional Premium for Illness:** It refers to the premium applied as a percentage increase to the Health Tariff Premium to include in the policy coverage any pre-existing diseases or conditions identified prior to the policy start date or arising during the policy period, based on the insurer's evaluation.

**Endorsement:** It refers to the official insurance document that records amendments made after the policy has entered into force and constitutes an integral part of the policy, reflecting its updated status.

**Insurance Commencement Date:** It refers to the date on which the insurance coverage defined in the policy becomes effective for the first time or upon renewal, as applicable. The policy enters into force at 12:00 p.m. (noon), Türkiye time, on the date stated in the policy. The policy term is one (1) year.

**Insurance Ending Date:** It refers to the date on which the insurance coverage stated in the policy terminates. The policy expires at 12:00 p.m. (noon), Türkiye time, on the date specified in the policy.

**Policy Issuance Date:** It refers to the date on which the policy is issued based on the application or renewal form completed by the insured.

**Emergency:** It refers to a sudden disease, accident, or injury-within policy coverage-that poses an immediate life threat to the insured and requires emergency intervention at a hospital within 24 hours. Situations not listed by the World Health Organization or the "Healthcare Services Tariff" are not considered emergencies. (Any treatment provided after the patient's condition has stabilized is not deemed an emergency.)

**Emergencies Defined by the World Health Organization:**

- Any condition resulting in loss of consciousness
- Myocardial infarction
- Arrhythmia
- Hypertensive crisis
- Poisoning
- Traffic accident
- Sudden stroke
- Severe headache with vomiting and loss of consciousness (e.g., migraine)
- Asthma attack
- Acute respiratory distress
- Fever above 39°C
- Severe allergic reaction
- Anaphylaxis
- Acute abdominal pain
- Falls from height
- Severe occupational injuries
- Extremity loss
- Meningitis
- Encephalitis
- Cerebral abscess
- Electric shock
- Serious eye injuries
- Gunshot wounds
- Stabbing injuries
- Drowning
- Frostbite
- Hypothermia
- Heatstroke
- Severe burns
- Neonatal coma
- Diabetic or uremic coma
- Dialysis-related condition accompanied by general deterioration
- Acute massive hemorrhage
- Spinal and lower limb fractures
- Rape

**Katılım Emeklilik ve Hayat A.Ş.**

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**Terror:** As defined in Anti-Terror Law No. 3713, any act constituting a criminal offense carried out by persons affiliated with an organization, using force and violence or methods of coercion, intimidation, suppression, or threat, with the intent to alter the constitutional characteristics of the Republic, or to change the political, legal, social, secular, or economic order; to disrupt the indivisible integrity of the state with its territory and nation; to endanger the existence of the Turkish State and the Republic; to undermine, abolish, or seize state authority; to eliminate fundamental rights and freedoms; or to threaten national security, public order, or public health.

**Waiting Period:** It refers to the minimum duration that must elapse from the insurance commencement date before the insured's medical expenses can be assessed under the relevant coverage.

**Complication:** It refers to the medical condition that arises during the course of a disease, throughout its treatment, or following treatment, in connection with that disease.

**Congenital Disease:** It refers to any disease, anomaly, or physical (organ) defect that is present at birth.

**Chronic Disease:** It refers to a medical condition that cannot be completely cured and requires continuous or long-term monitoring and treatment.

**In Default:** It refers to the point at which a premium and/or indemnity becomes payable or claimable.

**Remote Health System:** It refers to the delivery of healthcare services by a licensed healthcare professional through a remote health information system, in institutions authorized under the provisions of the Regulation on the Provision of Remote Health Services issued by the Ministry of Health.

**Remote Health Information System:** It refers to the secure software either developed or approved by the Ministry of Health, enabling written, audio, or visual communication for the purpose of delivering remote healthcare services.

**Deductible:** It refers to the portion of healthcare expenses that the insured is personally responsible for and that is not covered by the insurer. A deductible may be defined as a monetary amount, a waiting period, and/or a percentage or value relating to the coverage.

**Risk:** In the context of health participation insurance, risk refers to diseases and accidents, as well as physical conditions, habits, or similar factors that increase the likelihood of their occurrence.

**Recourse:** It refers to the insurer's legal right, under the principle of recourse, to seek reimbursement from third parties responsible for the treatment expenses it has paid.

**Information and Application Form:** It refers to a document that includes the personal information of the insurance applicant, selected coverage limits, health declaration, and premium payment plan. It is used to eliminate any lack of information that may arise during agreement negotiation or formation regarding the subject matter, coverages, and features of the agreement, and to ensure that the insured/policyholder is informed about any changes or developments during the term of the agreement that may affect the policy's execution. This form, which must be signed by the policyholder and/or the insured, constitutes an offer on the part of the insurer. Completion of the form does not establish the contractual relationship; the policy is issued only upon the insurer's acceptance following evaluation and full collection of the premium.

**Company:** It refers to the legal entity that enters into agreements with contracted healthcare institutions and, under such agreements, enables insured individuals of the insurance companies with which it has contracts to receive healthcare services from these institutions in accordance with the content of the products they have purchased.

**SAGMER (Insurance Information and Monitoring Center):** Initially established as "TRAMER" under the Regulation on the Traffic Insurance Information Center, published in the Official Gazette numbered 25318 and dated December 16, 2003, and later renamed "Insurance Information Center" by the Regulation published in the Official Gazette numbered 26962 dated August 9, 2008. Its current title, "Insurance Information and Monitoring Center," was adopted through the amendment published in the Official Gazette numbered 28131 and dated November 3, 2011. Operating as a legal entity within the Insurance Association of Türkiye, SBM (Insurance Information and Monitoring Center) provides centralized services related to Life Insurance, Health Insurance, Compulsory Motor Third Party Liability Insurance, Green Card Insurance, Compulsory Motor Vehicle Liability Insurance for Road Transport, Compulsory Bus Seat Accident Insurance, Motor Vehicle Casco Insurance, Compulsory Medical Malpractice Insurance, Compulsory Liability Insurance for Hazardous Substances and LPG, and Professional Liability Insurance. SAGMER aims to enhance the comprehensiveness and efficiency of insurance operations, ensure consistency across the sector, enable sound pricing, prevent fraud, produce reliable statistics, strengthen confidence in the insurance system, and support effective public oversight and supervision.

**Accident:** It refers to a sudden, external event that causes the insured to be subjected to physical impact beyond their control.

**Turkish Medical Association (TMA) Minimum Fee Tariff:** It refers to the fee tariff issued and updated by the Central Council of the Turkish Medical Association, setting the minimum physician service fees for healthcare services. Fees are calculated by multiplying the unit values listed for medical procedures by the applicable provincial service coefficient and adding VAT.

**Declaration Obligation:** The policyholder/insured is required to fully and accurately disclose in writing any pre-existing medical conditions of the proposed insured individuals, or any circumstances that may influence the risk assessment, at the time of applying for the insurance agreement.

**Tax Deduction:** Pursuant to Articles 63 and 89 of the Income Tax Law No. 193, as amended by Law No. 3239 effective as of January 1, 1986, premiums paid for Health and Personal Accident Participation Insurance for the taxpayer, their spouse, and minor children are eligible for tax deductions. These provisions were further amended by Law No. 6327, published in the Official Gazette dated June 29, 2012, and became effective as of January 1, 2013. For salaried employees: The Health and Personal Accident Participation Insurance premium paid may be deducted from the income tax base, provided it does not exceed 15% of the gross monthly earnings for the month in which the premium is paid and does not exceed the monthly minimum wage. For self-employed individuals: The premium paid may be deducted from the income tax base, provided it was paid in the year the income was earned and was not previously deducted in the calculation of net earnings. This deduction is capped at 15% of the declared annual income and the annual minimum wage amount. To benefit from this tax regulation:

- If you are a salaried employee, submit the Health and Personal Accident Insurance receipt to your workplace's Accounting Department.
- If you are self-employed, declare the premium amount shown on the Health and Personal Accident Insurance receipt in your income tax return. (Bank transfer receipts, ATM slips, or credit card statements may be accepted in place of a receipt, provided they include the name and surname of the premium payer, the period covered by the payment, the amount paid, the name of the insurance company, and the total payment amount.)

The insured must be between the ages of 15 days and 69 years (inclusive) to be eligible for this insurance.

### 3. SCOPE OF COVERAGE

This policy includes the minimum coverage structure set forth in the General Circular on Health Insurance to be Taken Out for Visa and Residence Permit Applications, dated May 10, 2016, and numbered 16.

The Health Participation Insurance Agreement covers the payment of medical expenses incurred by policyholders while receiving healthcare services from institutions and organizations contracted by the Company, in accordance with the coverage, limits, payment ratios, and the special and general terms and conditions of the agreement between the insurer and the Company.

If the policy expires and is not renewed while inpatient treatment is ongoing, the associated medical expenses will continue to be covered under the policy for a period of 10 days from the expiration date, provided that the expenses remain within the coverage limits and subject to the policy's special and general terms and conditions.

The Company reserves the right to make changes to the list of contracted institutions applicable under this policy, including the addition of new institutions or termination of existing agreements. The current list is available at [www.katilimemeklilik.com.tr](http://www.katilimemeklilik.com.tr).

#### 3.1. Inpatient Treatment Coverage

Inpatient treatment coverage includes medically necessary inpatient admissions for medical and/or surgical treatment, emergency medical expenses that may pose a life-threatening risk to the insured, and minor procedures-provided that the necessity of hospitalization is clearly stated in the physician's report and subject to the General and Special Terms and Conditions.

If the insured receives inpatient treatment at a hospital, the following expenses are covered: daily room charges (limited to the standard single room rate), meals, companion, physician, medications, operating room, surgeon, anesthesiologist, nurse (limited to the standard nursing fee), intensive care, and all consumables. Chemotherapy (including medications with "interferon and peginterferon alpha" used in Hepatitis C treatment), radiation therapy, dialysis (within the annual limit specified in the policy), coronary angiography, kidney stone fragmentation (ESWL), and prostheses required during surgery (e.g., heart valves, pacemakers, hip prostheses, etc.) are covered under this policy and reimbursed according to the coverage limits and payment rates outlined in the coverage table, subject to the Special and General Conditions.

Under this insurance, the maximum hospitalization period is 720 days over the insured's lifetime and 180 days within any one-year policy period. Standard room stays are counted as one (1) day per day of hospitalization, while intensive care stays are counted as two (2) days. These are deducted from the total allowable hospitalization period. Any hospitalization expenses beyond the 180-day annual limit or the 720-day lifetime limit are excluded from coverage.

Provision approvals granted for treatments at contracted healthcare facilities are valid for 7 days. If the treatment is not completed within this period, a new provision must be obtained. The insurer reserves the right to reject claims for treatments not completed within 7 days and for which a new provision was not obtained.

In all inpatient admissions where initial pre-authorization has been obtained, a second approval from the insurer must be secured on the 11th day for expenses incurred after the 10th day. Expenses for diagnostics, consultations, and initial examinations that do not require medical intervention-even if carried out in an emergency department-are covered under the outpatient treatment benefit.

#### 3.1.1. Surgeon's Fee

Inpatient treatment expenses incurred at healthcare institutions contracted with the insurer under a valid policy are covered in line with the coverage, limits, and payment ratios set forth in the policy, subject to the General and Special Terms and Conditions.

Regardless of whether the treatment is received at a contracted or non-contracted facility, any procedures performed by a non-contracted (non-staff) physician are reimbursed up to a maximum of one (1) unit as specified in the Turkish Medical Association (TMA) Minimum Fee Tariff.

If the physician performing the treatment-including anesthesiologists and assistant physicians-is not a full-time or contracted temporary staff member of the contracted institution, the treatment fee must be paid by the insured and submitted to the insurer for evaluation. The relevant invoices must be issued either as a freelance receipt or a POS slip prepared in compliance with the Tax Procedure Law (TPL).

Anesthesiologist and assistant physician fees may not be included on the same freelance receipt or POS slip. Any documents issued contrary to this rule will not be processed by the insurer.

Fees for contracted physicians will be covered according to the limits and payment ratios specified in the policy, subject to the General and Special Terms and Conditions. In cases where the procedure is not listed in the TMA Minimum Fee Tariff or where there is a dispute, the insurer may refer to the TMA for expert opinion.

### 3.1.2. Minor Procedure Coverage

Minor procedures listed in the Turkish Medical Association (TMA) Minimum Fee Tariff up to and including 149 units-such as dressing changes, injections, intravenous fluid administration, ear irrigation, all types of plaster applications (including those exceeding 149 units), oxygen administration, abscess drainage, gastric lavage, enema, catheter insertion, nail extraction, cauterization, probe curettage, fractional curettage (including therapeutic dilation and curettage), intra-articular injections, and removal of all benign skin tumors regardless of size or number-are covered by the insurance, provided they are performed under local or general anesthesia, are supported by a physician's report indicating medical necessity, and are approved by the insurer. Reimbursement will be made in accordance with the coverage table, limits, and payment ratios, and subject to the General and Special Conditions.

### 3.1.3. Home Care

If deemed medically necessary by the treating physician and approved by the insurer, home care treatment and its associated costs will be covered under this benefit for a maximum of 45 days, unless otherwise stated in the policy. Coverage is provided in accordance with the terms, limits, and payment ratios specified in the policy and subject to the General and Special Conditions. To qualify for home care coverage, the insured must meet at least one of the following criteria: presence of a tracheostomy, frequent orotracheal aspiration needs, requirement for enteral nutrition, need for TPN/IV fluid support, dependence on mechanical ventilation and respiratory failure, advanced-stage oncology, or implementation of a pain management protocol.

### 3.1.4. Artificial Limbs

Surgical expenses resulting from an accident or disease occurring during the policy period are covered under the hospitalization benefit. Costs related to prosthetic devices (e.g., artificial hands, arms, legs, breasts, eyes, etc.) are evaluated under the artificial limb coverage limit. Prosthetics required for disabilities that existed prior to the policy start date and costs related to the replacement of existing prosthetics are excluded from coverage.

### 3.1.5. Ambulance

If the insured experiences a covered disease or accident within the borders of the Republic of Türkiye, transportation by a contracted ambulance, or-if unavailable-a locally licensed land ambulance, from the site of the incident to the nearest fully equipped hospital, from the hospital to the insured's residence, or from the insured's residence to the hospital will be covered. Additionally, if deemed medically necessary by the treating physician and approved by the insurer, land ambulance transfers from the city and hospital of origin to a different city and hospital will be covered in accordance with the applicable limits and payment ratios specified in the coverage table and subject to the General and Special Terms and Conditions. If a non-contracted local ambulance is used, the reimbursement amount will be limited to the fee applicable to a contracted land ambulance for the same distance.

Only emergency conditions as defined in the Special Conditions qualify for ambulance coverage. To access ambulance services, you may contact the Katılım Emeklilik Health Communication Center at (0850) 226 0 123.

### 3.2. Outpatient Treatment

Outpatient treatment coverage includes physician consultations, laboratory tests/X-rays, prescription medications, advanced diagnostic procedures, and session-based outpatient treatments for diseases that occur after the insured's policy effective date.

Where outpatient treatment coverage applies, treatment expenses are reimbursed under this coverage in accordance with the limits and payment percentages stated in the policy, and subject to the General and Special Terms and Conditions. Expenses that exceed the upper limit for outpatient treatment coverage are not reimbursed. This coverage cannot be issued independently and must be taken together with inpatient treatment coverage.

#### 3.2.1. Physician Examination

Expenses for medical examinations conducted as part of outpatient treatment by physicians working in hospitals and clinics licensed by the Turkish Ministry of Health or authorized to operate private practices are covered, provided they are documented using the Participation Health Insurance Patient Information Form. Reimbursement is made in line with the coverage limits, payment percentages, deductibles, and the General and Special Terms and Conditions set forth in the policy. Examination costs incurred for services provided by non-staff or temporarily employed physicians at contracted institutions must be paid by the insured and submitted to the insurer for evaluation. The relevant invoices must be issued as a freelance receipt and/or a POS slip prepared in accordance with the Tax Procedure Law (TPL).

### 3.2.2. Prescription Medication

Expenses related to medications approved by the Turkish Ministry of Health will not be reimbursed unless the original prescription, medication label (cut-out), and invoice and/or receipt are submitted.

Our medication coverage is subject to a one-month dosage limit. However, the medication must be purchased within 15 days of the prescription date. For long-term treatments, each one-month dosage indicated on the same prescription is reimbursed in line with the applicable policy limits, payment percentages, and General and Special Terms and Conditions.

### 3.2.3. Laboratory Tests and X-Rays

Laboratory tests and X-rays performed during the policy period, as deemed medically necessary by a physician for diagnostic or treatment purposes, as well as the cost of medications, anesthesia, and physician fees required to perform these tests, are covered in accordance with the policy's limits, payment percentages, and the General and Special Terms and Conditions.

### 3.2.4. Advanced Diagnostic Methods

The cost of advanced diagnostic methods prescribed by a physician as medically necessary for diagnosis or treatment-such as tomography, scintigraphy, MRI, magnetic resonance imaging, nuclear medicine and scintigraphy (e.g., thallium), endoscopic procedures (gastroscopy, colonoscopy, cystoscopy, bronchoscopy, mediastinoscopy, etc.), EMG, angiography (excluding coronary angiography), biopsies (including those performed during endoscopic procedures, excluding liver biopsies), hearing tests, and associated medication, anesthesia, and physician fees-are reimbursed in accordance with the limits and payment percentages specified in the policy, and subject to the General and Special Terms and Conditions.

### 3.2.5. Physical Therapy and Rehabilitation

Expenses for physical therapy and rehabilitation prescribed by a physician for the treatment of a condition covered by the policy and approved by the insurer on a session/day basis are reimbursed in accordance with the coverage limits, payment percentages, and the General and Special Terms and Conditions of the policy.

### 3.2.6. Auxiliary Medical Supplies

Medical supplies used in the treatment of the insured following an accident or disease occurring after the policy commencement date are covered under this policy, provided they are portable, patient-specific, and used exclusively for medical purposes to provide external support to the body. These include splints, walkers, elastic bandages, arm slings, corsets, compression stockings, neck braces, knee and wrist braces, seating cushions, crutches, and dressing materials used in the treatment of burns or wounds. Reimbursement is made in accordance with the annual limits and payment percentages specified in the policy.

## 4. CASES WITH WAITING PERIOD

For newly issued policies, the following diseases and their complications are excluded from coverage for outpatient consultations, diagnostic and treatment procedures, minor interventions, surgeries, and all inpatient diagnostic and treatment services for a period of 6 months for outpatient treatment and 9 months for inpatient treatment from the effective date of the policy:

- Surgical procedures involving the shoulder, hip, hip joint, elbow, and ankle joints,
- Knee-related conditions (meniscus, tendon, ligament pathologies, and cartilage disorders), carpal and tarsal tunnel syndromes,
- Gallbladder disorders, urinary system stones, prostate disorders, hydrocele, cystocele, rectocele,
- All types of hernias, spinal surgeries,
- Adenoidectomy, nasal polyps, insertion of ventilation tubes, surgeries related to tonsils and sinusitis,
- Varicocele, all types of varicose veins (excluding superficial varicose veins), aneurysms,
- Hemorrhoids, anal fissures/fistulas, pilonidal sinus,
- Benign thyroid gland disorders,
- All benign cysts and masses,
- Benign uterine and ovarian disorders,
- Glaucoma, cataracts, retinal deformities/pathologies,
- Heart valve diseases,
- Chronic renal failure, Chronic Obstructive Pulmonary Disease (COPD),
- All expenses related to menopause and osteoporosis,
- Ectopic pregnancy.

## 5. STANDARD EXEMPTIONS

In addition to the exclusions set forth in Articles 2 and 3 of the General Terms and Conditions of Health Insurance, the following conditions, as well as all complications arising therefrom, are excluded from coverage under all benefits of this policy:

- Congenital anomalies and diseases identified after the policy effective date, regardless of the age of onset; genetic diseases; expenses related to premature infants and incubator costs (even if the newborn is insured from birth); expenses for cord cysts, hydrocele, and any hernia-related procedures for children under the age of 7, unless otherwise specified in the agreement.
- Conditions not listed in the coverage table.
- Expenses related to examinations and treatments for scoliosis, kyphosis, lordosis, pes planus, hallux valgus/rigidus.
- Treatments for nasal septum deviation and turbinate hypertrophy; diagnosis, treatment, and device costs related to sleep apnea, sleep disorders, and all other disorders causing snoring.
- Dementia due to aging, Alzheimer's disease, Parkinson's disease, epilepsy, and all psychotropic drugs including antipsychotics, anxiolytics, and anticonvulsants used in the treatment of these disorders.
- All medical expenses (regardless of diagnosis and/or treatment) related to pre-existing and undeclared conditions prior to the policy inception date, including relapses and complications.
- All genetic conditions/diseases, examinations for screening purposes, structural abnormalities, motor or mental development, and growth disorders.
- Mental illnesses and psychological disorders requiring psychiatric treatment; expenses related to pedagogues, social workers, and similar professionals.
- Alcoholism, substance use (alcohol, drugs, stimulants, hallucinogens, etc.), all types of substance dependency, and treatment for substance cessation; any conditions or accidents resulting from the use of such substances; treatment expenses related to driving without a valid license.
- Medical treatment expenses arising from participation in dangerous/non-dangerous sports activities and/or all types of races-whether professional (licensed), amateur, or recreational-including but not limited to mountaineering, scuba diving, piloting airplanes or gliders, parachuting, paragliding, delta-wing flying, horseback riding, skiing, water sports, diving, riding ATVs or motorcycles (even for transportation purposes).
- Alternative treatment methods such as acupuncture, homeopathy, hypnosis, yoga, mesotherapy, Ayurveda, spa and thermal treatments; treatments provided by facilities operating without a license from the Ministry of Health or by sanatoriums, preventoriums, or rehabilitation centers; any expenses related to unscientific or experimental treatments, including those considered experimental by the U.S. FDA (Food and Drug Administration); treatments not covered under the Turkish Medical Association Minimum Fee Tariff (TMAMFT); and expenses for weight loss or gain programs or treatments related to appetite or weight disorders.
- For surgeries performed using Robotic Surgery (Da Vinci method): robot usage fees and all materials specifically used for such procedures; expenses related to new biomedical engineering, genetic, and biotechnology-based treatments and applications.
- Invoices issued by individuals who are not medical doctors or by institutions without a valid operating license from the Ministry of Health; invoices issued by first-degree relatives of the insured; expenses for diagnostic tests, examinations, and treatments prescribed by these individuals; all medications and materials prescribed; and health services received from physicians whose specialty does not match the insured's diagnosed condition.
- Expenses for unnecessary inpatient procedures defined in the policy and diagnostic and treatment services not related to a specific complaint or disease (e.g., check-ups, routine controls).
- Plastic and reconstructive surgery, all aesthetic and cosmetic procedures, telangiectasia treatments, treatments for skin hemangiomas, gynecomastia, treatments and tests related to sweating disorders, hair loss treatments (including shampoos, creams, soaps, and similar cosmetic products), iontophoresis, and botox applications-unless arising from a judicially recognized accident during the policy period.
- Surgical procedures for hearing loss (excluding tube insertion, tympanoplasty, stapedectomy, and chronic otitis sequelae) and all related diagnostic and treatment services.
- Laser and surgical treatments for refractive errors, keratoconus, cross-eye, strabismus, and amblyopia, multifocal lenses; all diagnostic and treatment expenses for multifocal lenses.
- In the absence of dental coverage under the policy: all interventions, diagnostic and treatment expenses performed by dentists on teeth, gums, and jaw; dental prosthetics (excluding those required due to jaw or tooth damage from traffic accidents occurring after the policy inception date); and all orthodontic and cosmetic dental treatments even if dental coverage exists.
- Expenses for materials not classified as medication, all substances and chemicals licensed by the Ministry of Agriculture, all non-officially imported medications, external prostheses, and support devices (in cases where they are not covered under Inpatient Treatment Coverage), vitamin and mineral supplements and/or nutritional support products used to meet daily nutritional needs or to protect general health, home-use moisturizers, external devices attached to the body, syringes not provided with medication, patches, eyeglasses, lenses, frames, lens solutions, wheelchairs, hearing aids, orthopedic boots, insoles, slippers, shoes, toothpaste, oral and dental care products, and other non-treatment-related expenses such as telephone, television, cafeteria services, administrative or paramedical services and service fees, baby diapers, formula, feeding bottles, pacifiers, and baby care creams are not covered under this policy.
- Expenses related to allergy vaccines, allergy tests, and all types of immunotherapy (except for those administered to treat metabolic and autoimmune diseases), including diagnostic tests and treatment procedures, are excluded from coverage.
- Routine prenatal check-ups and related expenses, miscarriage, abortion (even if medically necessary), delivery (normal or cesarean), birth control methods, family planning procedures, abortion-related investigations, in vitro fertilization, penile prosthesis, infertility (including follicle monitoring, hysterosalpingography, spermogram, adhesiolysis, tuboplasty, etc.), sexual dysfunctions, varicocele related to infertility, gender reassignment surgeries, and sexually transmitted diseases (regardless of transmission method) such as syphilis, gonorrhea, chancroid,

lymphogranuloma venereum, granuloma inguinale, genital warts, and AIDS-including all related diagnostic and treatment expenses-are excluded. Expenses for circumcision are also excluded, even if medically required, as well as voice and speech therapy.

- Treatment expenses related to varicose veins and venous thrombosis, including sclerotherapy, laser, radiation, massage, compression stockings, etc.
- Expenses related to providing organ or blood donors and all donor-related costs in organ and blood transplantation procedures.
- Medical expenses related to officially declared epidemics or those initiated with malicious intent.
- All medical expenses resulting from errors in diagnosis, treatment, or surgical procedures carried out by healthcare institutions or physicians.
- Private nursing expenses that are not approved by the insurer, ambulance services other than those specified as Emergency in the policy, and all air or sea ambulance expenses.
- Vaccinations for rabies, tetanus, and influenza, and all vaccines for children aged 0-6 years that are not included in the Ministry of Health's routine vaccination schedule (including pre-and post-vaccination examinations and administration fees).
- Regardless of whether they are inpatient, outpatient, or emergency services, all medical treatment expenses incurred abroad by the insured.
- Daily indemnity benefits for income lost due to the insured's inability to work as a result of disease, as well as coverage for expenses arising from the need for care or daily care allowance if the insured becomes dependent on care, are not included within the scope of the policy.
- Regardless of the reason, all types of bariatric surgery procedures are excluded from coverage. These include gastric bypass, gastric balloon, sleeve gastrectomy, gastric banding, stomach reduction surgeries, biliopancreatic diversion, jejunioileostomy, intestinal shortening, and similar procedures.
- Ectopic pregnancy and hydatidiform mole are excluded from coverage. However, if maternity coverage has been purchased and the applicable waiting period has been completed, such expenses shall be covered.
- In the event of the insured's death during treatment, mortuary expenses are not covered under the policy.

## 6. GEOGRAPHICAL SCOPE

Coverage under insurance agreements issued pursuant to these Special Terms and Conditions is valid solely within the borders of the Republic of Türkiye. Under no circumstances shall medical expenses related to diagnosis or treatment abroad be covered.

## 7. APPLICATIONS AND ACCEPTANCE TO INSURANCE

All initial and subsequent applications by the policyholder or prospective insured must be submitted using the application forms provided by the insurer, and the declaration sections concerning the individuals to be insured must be completed fully and accurately. All applications and/or requests for changes to the Participation Insurance Policy must be submitted in writing and with wet signatures.

The permanent place of residence of both the policyholder and the prospective insured must be within the borders of Türkiye. The insurance entry age is calculated based on the policy start date and the insured's year of birth.

Coverage applies to individuals between 15 days and 69 years of age at the time of first enrollment. Children aged between 15 days and 17 years may be insured independently, provided that the policyholder is at least 18 years old. Newborns must be added to the policy by applying within 30 days of birth. Requests submitted after this period will be reviewed during the next renewal period.

Minors (under the age of 18) may only be insured upon submission of a written parental consent verified by the insurer.

Children may remain under their parents' policy coverage until the age of 25, provided they are single and enrolled as students. However, except for newborns and newly adopted children, no mid-term additions are allowed after the policy start date; such additions may only be requested during the renewal period.

The insurer reserves the right to reject any initial or subsequent application without providing any justification, to accept under standard terms, or to accept under special terms by applying additional premiums and/or waiting periods, specific exclusions, sub-limits, or patient share. The insurer may also require a medical examination and request additional tests if deemed necessary.

This product does not allow policy transitions from other insurance providers.

Any acquired rights under a previous health insurance policy held with another company shall not apply under this policy.

If the insured wishes to add a spouse to the policy during the policy term, they must submit an application to the insurer by completing the relevant form within 30 days following the date of marriage. Following a risk assessment by the insurer, the spouse may be added to the policy subject to the payment of an additional premium, provided the application is approved. Applications submitted after this 30-day period will only be considered at the next renewal date.

Prospective insureds who miss the applicable deadlines after the policy start date may be eligible for coverage under a separate, individual policy.

### Katılım Emeklilik ve Hayat A.Ş.

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Katılım Sağlık, bir Katılım Emeklilik ve Hayat A.Ş. markasıdır.

#### 7.1. SAGMER (Insurance Information and Monitoring Center) Notification

Policy and health-related data of insured individuals under this Insurance Policy will be transferred to SAGMER (Insurance Information and Monitoring Center), and this information may be accessed from SAGMER and other public institutions. In accordance with the Regulation on the Insurance Information Center, submission of such data is mandatory, and the insurer bears no liability for the information provided to the Information Center.

### 8. RESPONSIBILITY OF THE POLICYHOLDER

In addition to the obligations set forth in the General Terms and Conditions of Health Insurance, the policyholder is required to notify the insurer within no more than 30 days if any individuals previously eligible under the policy cease to meet the definition of insurable persons and must request their removal from the policy.

If the policy is canceled or an insured person exits the scope of the policy, it is the policyholder's responsibility to return all documents and the insured identification card issued for that individual to the insurer. The insurer reserves the right to recover any losses arising from incomplete or missing documentation from the policyholder. If the declarations made by the insured or the policyholder are false, incomplete, or incorrect, Article 6 of the General Terms and Conditions of Health Insurance shall apply. Under this article, and without prejudice to the insurer's rights, the insurer may assess any undeclared medical conditions and decide to include them in the coverage with conditional acceptance, such as exclusion from coverage, additional premium, or other limitations.

The insurer has the right to collect from the insured and/or the policyholder any costs or payments made in violation of the General and Special Terms and Conditions of this policy or outside the scope of coverage.

### 9. INDEMNITY EVALUATION AND PAYMENT

The Policyholder/Insured is obligated to fully inform the insurer about the disease and treatment and must refrain from providing misleading or inaccurate information. If it is determined-whether during or after the course of treatment-that the disease or treatment in question is not covered under the policy, the insurer reserves the right to request reimbursement of any indemnity paid, even if a payment guarantee was issued to the contracted provider or indemnity was paid based on incomplete or incorrect information.

Expenses incurred at non-contracted healthcare providers are reimbursed within the policy's coverage limits and patient shares, provided that the original invoices showing the medical expenses are submitted to the insurer.

All diseases and the related examinations and treatment procedures must be documented with a medical report. During the indemnity assessment process, the insurer may request any documents it deems necessary from the policyholder or insured for review. The insurer will notify the insured in writing of any expenses not covered under the policy, along with the reasons for rejection.

Inpatient and outpatient treatment expenses incurred at contracted healthcare providers will be paid directly to the provider by the insurer in accordance with the limits, reimbursement rates, and special and general terms outlined in the policy.

If inpatient treatment is provided at a contracted institution by a non-contracted physician, the insurer does not guarantee direct payment of the physician's fee. In such cases, the maximum amount reimbursable to the policyholder/insured for the physician's services is limited to the applicable amount as per the Turkish Medical Association Minimum Fee Tariff (1 TMA). If the attending physician is contracted, their fee will be paid within the applicable limits, reimbursement rates, and the general and special terms set forth in the policy.

After any kind of medical treatment, the insured must review and verify their invoice to ensure accurate billing. In particular, invoices issued upon discharge following hospitalization must be reviewed and signed by the insured.

For planned hospitalizations and/or surgeries (excluding emergencies), the medical institution must submit a provision approval form, completed by the attending surgeon, to the insurer at least 48 hours prior to the scheduled admission. Following the necessary evaluation, the insurer will inform the policyholder whether the related hospitalization and/or surgical expenses will be covered under the policy.

**To receive indemnity under inpatient treatment coverage, the following documents must be submitted to the insurer and/or the insurance company:**

- Itemized hospital invoices signed by the insured, and a report indicating the reason for hospitalization,
- A detailed surgical report for all surgical procedures (including pathology results if tissue samples were taken),
- Where applicable, the observation file, traffic accident report, forensic report, legal statement, alcohol report, and insured's statement,
- Discharge report (epicrisis),
- Laparoscopic, arthroscopic, or endoscopic procedure videos if requested,
- When necessary, identity verification documents as required under the Regulation on Measures Regarding Anti-Money Laundering and

Combating the Financing of Terrorism issued by MASAK ([www.masak.gov.tr](http://www.masak.gov.tr)). For reimbursement of outpatient treatment expenses, in addition to the Participation Health Insurance Patient Information Form, the following documents must be submitted to the insurer:

**For Physician Examinations:**

- Invoice or self-employment receipt indicating the physician's fee (must include physician's stamp and specialty),
- If an ultrasound was performed during the visit, the original printout or report (and medical records if required).

**For medication expenses:**

- The original prescription issued by the attending physician (and medical report where necessary),
- Cash register receipt or invoice,
- Medication package slips and barcodes showing the name and price of each drug,
- Medical report for regularly prescribed medications.

**For laboratory tests, X-rays, and advanced diagnostic procedures:**

- Doctor's referral note, request form, or report,
- Invoices showing the related expenses,
- Test results, medical reports, and, where applicable, supporting medical records.

**For physical therapy:**

- Imaging results supporting the medical necessity of the treatment (MRI, ultrasound, etc.),
- Physician's referral letter and a detailed treatment report indicating the specific therapy prescribed for each session and the total number of sessions,
- Signed session breakdown.

**For expenses related to auxiliary medical equipment:**

- Physician's prescription,
- Medical report and test results, if applicable.

## 10. RENEWAL OF INSURANCE AND LIFETIME RENEWAL GUARANTEE

The insured must renew their expired health insurance policy within 30 days. If the renewal is made after this period, the insured will lose all existing rights and will be considered a first-time applicant. Based on the outcome of the risk assessment, a patient share, deductible, upper limit, or medical loading may be applied.

During the renewal period, the insurer reserves the right to apply an additional premium based on the claims-to-premium ratio or to decline renewal based on the claims ratio and/or underwriting criteria.

This product does not include a Lifetime Renewal Guarantee (LTRG) or a Renewal Guarantee/Assurance (RG).

## 11. VESTED RIGHTS AND TRANSITION PROCEDURES

The protection of vested rights refers to the continuation of the original insurance commencement date (first registration date) for uninterrupted policies that have not exceeded the 30-day renewal period from the policy's expiry. For such policies issued by Katılım Emeklilik ve Hayat A.Ş., the waiting periods specified in the special general conditions will not apply, and any conditional acceptances in the previous policy will continue to apply under the new policy issued by Katılım Emeklilik ve Hayat A.Ş.

This product does not allow policy transitions from other insurance providers. Any acquired rights under a previous health insurance policy held with another company shall not apply under this policy.

**However, insured individuals under this product who wish to continue their coverage under a Participation Private Health Insurance or Participation Complementary Health Insurance policy may be evaluated for eligibility if all the following conditions are met:**

- Application must be submitted to the Company no later than 30 days from the expiry of the previous policy,
- The insured must have held a previous health insurance policy for at least one full year,
- The insured must be no older than 64 years of age (inclusive).

The insurer will determine the eligibility for the transition by reviewing the applicant's declarations, previous insurance history, and data obtained from the Insurance Information and Monitoring Center (SBGM), and other relevant authorities. Based on the underwriting assessment carried out in accordance with the product-specific policy terms, the insurer may decide to include or exclude the applicant from the policy or include them with a medical exclusion and/or a condition-specific additional premium.

## 12. AMENDMENTS TO THE AGREEMENT

If the policy coverage is expanded as a result of a change requested by the Policyholder and approved by the insurer, the newly selected coverage will apply only to conditions arising after the new coverage takes effect. In such cases, standard waiting periods will restart. Risk assessment is conducted prior to the extension of coverage.

**Katılım Emeklilik ve Hayat A.Ş.**

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Katılım Sağlık, bir Katılım Emeklilik ve Hayat A.Ş. markasıdır.

### 13. PREMIUM DETERMINATION CRITERIA

The insurer determines the premium rates for Private Health Participation Insurance on an individual basis, considering factors such as age, gender, duration of coverage, previous utilization (medical expenses-to-premium ratio), coverage structure, coverage limits, the province where the medical services will be utilized, commission rate, and inflation. Premiums may be recalculated and adjusted by the insurer when deemed necessary in line with these criteria.

The maturity dates and payment amounts for policy premiums are specified on the policy, and premium payments must be made by the insured in accordance with the specified payment schedule.

The policy premium is calculated based on the insured's age at the start of the policy, which is determined as the difference in years between the policy start date and the insured's date of birth.

#### 13.1. NO-CLAIMS DISCOUNT AND ADDITIONAL PREMIUM FOR DISEASES

##### Discounts and additional premiums based on the claims-to-premium ratio:

Following the evaluation of each insured's Paid Claims-to-Payable Premium (T/P) ratio for the previous year, the insurer may apply disease-specific exclusions, surcharges, or additional premiums based on utilization. The network of contracted providers, minimum coverage limits, minimum reimbursement rates, and annual usage conditions may also be revised.

The rate of disease-related additional premiums to be applied to the insured's "Health Tariff Premium" may not exceed 200% per condition.

This product does not include a no-claims discount.

The insurer reserves the right to apply or withdraw discounts or modify discount rates, offered under specific rules or promotional campaigns.

### 14. CANCELLATION UPON REQUEST OF THE POLICYHOLDER/INSURED

The policy premium amount and payment method are specified on the front page of the policy. The insurer's liability commences upon full payment of the premium. If the premium is not paid in full, the policy shall be terminated following notification. In case of default in premium payment, the provisions of the Turkish Code of Commerce shall apply.

For health insurance policies issued within the scope of residence permit applications, cancellation upon the request of the policyholder/insured is subject to the submission of at least one of the following:

- Submission of a new health insurance policy covering the entire duration of the residence permit,
- Cancellation or non-renewal of the residence permit,
- Submission of a document demonstrating that the insured has been included under the General Health Insurance scheme pursuant to Law on Social Insurance and General Health Insurance No. 5510,
- Rejection of the residence permit application or withdrawal of the application prior to the decision.

If the cancellation is requested by the policyholder/insured on the grounds of residence permit application rejection or withdrawal prior to the decision, and provided that no indemnity has been paid, the premiums paid shall be refunded in full without any deductions within five (5) business days following the receipt of the cancellation request by the insurer.

In the event that cancellation is requested under subparagraphs a, b, or c above, or if an indemnity payment has been made on behalf of the insured, the premium for the period during which the insurer's liability remained in force shall be calculated on a daily basis, and any excess premium shall be refunded to the policyholder in accordance with the following procedures.

The amount to be refunded due to cancellation is calculated by considering the amount the insurer is entitled to and the total indemnity paid. If the total amount of indemnity paid during the insurance period is equal to or less than 60% of the premium payable on a pro-rata daily basis, the amount corresponding to the used period shall be deducted from the total premium paid, and the remaining balance shall be refunded to the policyholder.

However, if the total indemnity amount (paid or payable) exceeds 60% of the daily prorated premium payable, no premium refund shall be made in the event of cancellation under this article.

The same cancellation rules apply to individual exits (spouse or child) requested after the start date of the policy. In the event of the death of the policyholder, the policy shall become null and void. If the policyholder and the insured(s) under the policy are different persons, and the insured(s) wish to continue the policy by changing the policyholder, the written consent of the policyholder's legal heirs must be submitted to the insurer. In such cases, the policy may be continued under the new policyholder. If the consent of the legal heirs cannot be obtained, the policy shall be canceled in accordance with the criteria set forth above, and any applicable refund shall be made to the legal heirs.

In single-insured policies where the policyholder is the same as the insured, the policy shall become null and void upon the death of the policyholder. Upon the written request of the legal heirs, the policy shall be processed in accordance with the cancellation rules specified above, and any applicable refund shall be made to the legal heirs.

In policies covering more than one insured person, if one of the insured persons passes away, that individual shall be removed from the policy effective as of the date of death. In line with the cancellation criteria set forth above, any applicable premium refund shall be made to the policyholder.

In multi-insured policies, if the parents divorce, the parent whose removal from the policy is requested shall be removed as of the date of the divorce. In line with the cancellation criteria set forth above, any applicable premium refund shall be made to the policyholder. If a change in policyholder is also requested, the policy may be continued under the new policyholder.

In multi-insured policies, if one of the children gets married, that individual shall be removed from the policy effective as of the date of marriage. In line with the cancellation criteria set forth above, any applicable premium refund shall be made to the policyholder.

## 15. ADDITIONAL INFORMATION

### 15.1. Share and Supply of Information

Katılım Emeklilik ve Hayat A.Ş. is authorized to obtain and share information and/or documents by conducting inquiries before the Republic of Türkiye Prime Ministry Undersecretariat of Treasury, the Health Insurance Information and Monitoring Center (SBGM), the Association of the Insurance, Reinsurance and Pension Companies of Türkiye Insurance Association of Türkiye, all healthcare institutions and organizations, other insurance companies, and public institutions and organizations, within the scope of applicable legal regulations, including insurance legislation, regulations concerning insurance, and healthcare legislation.

By signing the relevant documentation, individuals who are or will be covered under the insurance shall be deemed to have given their consent, pursuant to Articles 31/A and 31/B of Insurance Law No. 5684, to the sharing of their health data, insurance records, and other personal information for the purposes of risk assessment and claims processing.

### 15.2. Failure to Fulfill Obligations

The policyholder and the insured are obligated to notify the insurer in writing of all known or reasonably knowable facts and any changes related to their health condition both during the initial application process and throughout the insurance period.

If it is determined that the declarations made by the policyholder and/or insured during the application process are false, incomplete, or misleading-or if the policyholder and/or insured has any pre-existing diseases or conditions that they were aware of or should have been aware of but failed to disclose-the insurer reserves the right to cancel the policy. Alternatively, the insurer may choose to continue the policy by excluding such diseases and/or conditions from the coverage or by applying a condition-specific additional premium. The insurer shall not later reconsider including any diseases or conditions excluded from coverage on these grounds.

If any malicious activity is detected-such as attempting to allow individuals not covered under the insurance to benefit from the policy, having medical expense documents issued in the name of a covered family member for the benefit of another, submitting claims for expenses not covered under the policy, failure to comply with the criteria outlined under the "New Registration Procedures" section, or any similar bad-faith acts not limited to the foregoing-the insurer reserves the right to recover any medical expense payments made and to cancel the policy, even if it includes a Lifetime Renewal Guarantee.

Should you, in your capacity as Insured/Policyholder/Beneficiary/Right Holder, engage in any action that results in an unfair benefit to yourself or to third parties within the insurance relationship, the indemnity may be reduced or denied. Furthermore, action shall be taken in accordance with the provisions of the Turkish Penal Code and the "Regulation on the Procedures and Principles of Detection, Notification, Registration of False Insurance Practices and Combating These Practices" published in the Official Gazette dated April 30, 2011, and numbered 27920.

### 15.3. Notification to the Insured/Policyholder

Before the expiration of the agreement term, the insurer shall notify the policyholder regarding the policy expiry date and the renewal process. Additionally, the insurer shall inform the policyholder/insured in writing or electronically about whether the agreement has been renewed. If the product includes a renewal guarantee, the insurer shall also notify the insured about this. The insurer will use the current contact information recorded in the company's systems as the basis for such communications.

However, if any of the contact details are changed, incomplete, or incorrect, the insurer shall be deemed to have fulfilled its duty of notification unless the insured/policyholder immediately informs the insurer in writing of such changes.

In order for notifications to be successfully delivered, in addition to address information, the insurer must also be provided with at least one

mobile phone number or email address belonging to the policyholder and one insured family member included in the policy. If contact information is missing for other family members, the notification shall be sent to the individual whose information is complete and shall be deemed to have been delivered to all insured family members included in the policy.

#### **15.4. Treatments Continuing After the Expiry of the Insurance Period**

If the policy is renewed by Katılım Emeklilik or another insurance company while treatments covered under Inpatient Treatments or Home Care and Treatment are ongoing, medical expenses for procedures performed up to 12:00 p.m. on the renewal date shall be covered under the old policy, whereas expenses for procedures performed from 12:00 p.m. onwards shall be covered under the new policy. However, in policies that are not renewed or in which an exclusion is applied for the relevant disease, coverage for these treatments may not extend beyond 10 days following the policy end date.

#### **15.5. Right of Recourse and Recovery**

If third parties are responsible for the medical expenses paid by the Insurer pursuant to the Special and General Conditions of the Policy, the Insurer is entitled to step into the shoes of the insured and seek reimbursement from the liable third parties for the amount paid.

The Insurer may directly claim from the insured any payments- including indemnity-made either to contracted healthcare institutions on behalf of the insured or directly to the insured if such payments are subsequently determined to be unjustified under the Special and General Conditions of the Policy. This also applies in cases where the unjustified nature of the payment arises from the failure of the insured and/or the treating healthcare institution or physician to provide the necessary information, or if they provide it inaccurately or incompletely. The fact that the Insurer has granted e-approval or issued a prior authorization for such payment does not preclude the Insurer from exercising its rights under this clause if the unjustified nature of the payment is discovered afterward.

#### **15.6. Terrorism Clause**

Without prejudice to the provisions of the General Terms and Conditions of Health Insurance, medical expenses for inpatient treatments resulting from the insured falling ill or being injured during the insurance period due to terrorist acts defined in Anti-Terrorism Law No. 3713, or sabotage resulting from such acts, or interventions made by competent authorities to prevent or mitigate such events, within the territory of the Republic of Türkiye, shall be covered under the Inpatient Treatment Coverage, subject to the applicable limits, deductibles, and payment percentages set forth in the policy.

Medical expenses for outpatient treatments shall be covered under the policy in accordance with the scope and limits of the Outpatient Treatment Coverage as stated in the policy.

However, all damages arising from biological and/or chemical contamination, exposure, or poisoning that result in disease or injury to the insured-even if caused by direct or indirect acts covered under this clause-are excluded from coverage.

#### **15.7. Notification of Official Authorities**

Katılım Emeklilik is authorized to obtain and share information and/or documents by conducting inquiries before the Ministry of Treasury and Finance of the Republic of Türkiye, the Insurance Information and Monitoring Center (SBGM), the Association of the Insurance, Reinsurance and Pension Companies of Türkiye, all healthcare institutions and organizations, other insurance companies, and public institutions and organizations, within the scope of relevant legal regulations, including insurance legislation, insurance-related regulations, and healthcare legislation.

By signing the relevant documents, individuals who are or will be covered by the insurance are deemed to have consented to the acquisition of their health data, insurance records, and other personal information from SBGM, the Social Security Institution, the Ministry of Health, healthcare institutions and organizations, and insurance companies, for the purposes of risk assessment and claims processing, and to the sharing of such data and records held by the Company with SBGM, other insurance companies, and other authorities authorized under the applicable legislation.

#### **15.8. Changes in Legislation**

This Insurance Agreement is subject to the applicable legislation of the Republic of Türkiye.

#### **15.9. Taxes**

All official stamp duties, charges, and taxes specified in the Insurance Agreement shall be borne by the policyholder.

#### **15.10. Currency**

All payments made to the insurer or to the policyholder shall be made in Turkish Lira.