SPECIAL CONDITIONS OF HEALTH INSURANCE

1. THE SCOPE OF HEALTH INSURANCE POLICIES

Anadolu Anonim Türk Sigorta Şirketi (Anadolu Sigorta) covers the costs of examination, diagnosis and treatment of the insured for the conditions occurred after the insurance commencement date within the framework of the General Terms and Conditions of Health Insurance and Special Terms and Conditions of Anadolu Sigorta Health Insurance within the scope, payment rates and limits of the coverage specified in the policy. The payments within the framework of this policy require that the examination, diagnosis and treatment of the insured must be effected in the policy period. No expenses regarding conditions of which symptoms/findings and/or diagnosis and/or the beginning of treatment predates the insurance commencement date, as well as complications to arise in relation thereof shall be covered by the policy.

The insurance coverage provided to the insured is limited to the matters specified as covered in the policy and the general and special terms and conditions of the insurance. No cases other than those explicitly stated as under coverage shall ever be construed as within the insurance coverage, even if such are not specified individually among the exceptions of coverage.

2. DEFINITIONS

Insurer: Anadolu Sigorta.

Insured: It refers to the person who filled out an approval form in order to become insured in accordance with articles of this policy and whose application is confirmed by Anadolu Sigorta and a policy has been drawn up.

Dependent: Refers to the spouse, children and step children and legally adopted children up to age 30 of the insured, who are included in the insurance coverage as per the articles of this contract.

Spouse: Refers to the person with whom the insured is legally married.

Health care provider: The institution to which operating license was given by the Ministry of Health of Turkey and which

- Provides patient care for 24 hours per day,
- Is qualified for diagnosis, treatment, and surgical operation,
- Where one or more physicians are available for operation at all times, hospital and / or clinics where medical care and treatment is performed,
- Hospitals and / or clinics where medical care and treatment is carried out where opened for especially childbirth.

The term "Health Provider" shall not be interpreted in a manner to include also hotels, nursing homes, convalescent hospitals, orphanages, poorhouses, places dedicated primarily for the isolation and treatment of substance and alcohol addicts, sanatoriums, spas, medical hydrosis, and weight loss resorts.

Contracted health provider: Refers to health providers with which Anadolu Sigorta has entered into direct payment contracts with, for the medical services to be provided to those who have medical insurance. The insurer is entitled to effect changes in the "Contractor Medical Institutions List" during the policy term.

Physician: Refers to qualified persons who have graduated from Medical School, who is licensed for all kinds of diagnosis and treatment, and to whom the patients apply for diagnosis and treatment of conditions.

Treatment: Refers to procedures carried out at health providers (hospital, clinic, polyclinic) which were granted operation license by the Ministry of Health of the Republic of Turkey or at private practices, by physicians qualified to work, with the purpose of treating diseases. Expenses regarding self-treatment and second degree relative by a doctor who is also an insured before Anadolu Sigorta shall not be paid.

Inpatient treatment at health provider: Refers to the treatment of the insured at a "Health Provider" as defined above, on an inpatient basis, through the accrual of room-board-bedside expenses.

Outpatient treatment: Refers to medical treatment provided at health providers, private practices, and polyclinics, without providing of room and bedside.

Coverage: Refers to the guarantees provided to the insured in accordance with the General Terms and Conditions of Medical Insurance and Special Terms and Conditions of Anadolu Sigorta Foreign Nationals Health Insurance.

Conditions predating insurance commencement date: Conditions (complications) of which symptoms/findings and/or diagnosis and/or the beginning of treatment predates the insurance commencement date.

Payment limit: Refers to the upper limit specified in the policy, regarding the payments to be made by Anadolu Sigorta in relation to the expenses incurred by the insured.

Insurance end date: Refers to the expiry date mentioned on the policy for the insurance coverage. The medical expenses incurred by the insured on that date are not covered under the policy.

Renewal: Refers to the continuation of the insurance at the policy expiry date, through the payment of the premium for the policy for the new term, provided that Anadolu Sigorta approves so.

Current price and application principles of Turkish Physicians Association: It includes the transaction list of the medical services (doctor's fee, examination fee etc), pricing and application principles determined by Turkish Physicians Association.

Insurance Premium: Premiums for individual health insurance products are determined on the basis of age, gender, coverage limit, coverage structure and payment rates of the preffered product, contractual health institutions (network), residence of the insured and the rate of increase in treatment costs.

3. DESCRIPTION OF COVERAGES

Descriptions of the coverage for health insurance products of our Firm is provided below. The insured shall not be able to benefit from the coverage if such is not included in their policies.

3.1. OUTPATIENT TREATMENT COVERAGE

Outpatient medical examination, medication, diagnosis and physical therapy expenses are evaluated within the scope of outpatient treatment cover.

3.2. PHYSICIAN EXAMINATION EXPENSES

Expenses relating to examinations to be performed by physicians employed at hospitals and clinics licensed by the Ministry of Health of the Republic of Turkey and/or physicians eligible to open private practices are payable within the limit and rate specified in the policy. However, expenses of lenses and eye examinations performed in optical centers and dentist examination bills are not covered. Expenses relating to the diagnostics performed by the physicians themselves during examination in aid of diagnosis will be covered as medical examination coverage.

Expenses relating to the examinations performed by the same doctor within 10 days relating to the diagnosis in the initial examination are outside coverage.

Routine physician examinations of children in 0-6 age group and routine gynecological examinations and smear tests of women for once a year are paid using the relevant coverage.

3.3. PRESCRIPTION EXPENSES (OUTPATIENT)

Drug expenses regarding pharmaceutical products (medicinal) written in the prescription made up by a physician in Turkey after an examination and for which relevant drug license was obtained from the Ministry of Health in Turkey and prescriptions written by doctors abroad will be covered by this coverage according to the rate and limit specified in the policy within the framework of the agreement. In the prescriptions prescribed subsequent to physician examination should include the protocol number in the "Patient Register Book" which is mandatory for the physicians or health providers to have and the diagnosis of the insured and also should bear the seal and signature of the physician indicating the physician's diploma number and medical specialty. Prescriptions not adhering to such format will not be accepted. Drugs should be purchased within ten days as of the prescription date. If ten days period is exceeded, the prescription shall be deemed invalid and no action shall be taken.

The route of administration by prescription is intramuscular, intravenous, intraarticular, intraosseous, intradermal, subcutaneous and intra-vitreous, etc. are covered by this cover.

Protective vaccines for children in 0-6 age group; tetanus, pneumococcus, meningitis, rotavirus and influenza vaccines for all insureds are covered within the scope of this coverage.

Drugs that vital to the treatment, non-equivalent in Turkey and institutions / organizations imported from abroad approved by and Turkish Pharmacits's Association, Social Security Institue (SSI), Ministry of Health.

Expenses for the drugs approved by a physician to be used continually shall only be paid if the insured documents this by a physician's report (the report should be issued to cover maximum 1 years), Anadolu Sigorta approves and the use of drugs are within the period of the policy.

Plants and plant products formulated as drugs and drugs containing fractions like plant extract and distillates and drugs prescribed by a dentist are excluded from coverage.

Prescriptions by Occupational Physician: In the prescriptions written by the occupational physicians of the company where the insured is working for, should include the protocol number and the diagnosis in the "Patient Register Book" and also should

bear the seal and signature of the physician and physician's diploma number, official title, and the adress of the workplace.

The prescription written for the spouse and children of the working insured under the policy,is out of the scope.

3.4. DIAGNOSIS UNITS EXPENSES (OUTPATIENT)

Expenses for all diagnosis units required by a physician to diagnose a disease (laboratory, radiology, cardiology, nuclear medicine etc) shall be covered within the limit and rate of the policy.

Procedural tests for the purpose of diagnosis (Colonoscopy, gastroscopy, cystoscopy, biopsy, biopsy with USG, angiography with MR etc) shall be covered under this coverage. Expenses in relation to radiological tests (USG etc) shall only be paid if the said tests are conducted by the relevant specialists. Expenses in relation to radiological tests (USG etc) done by the physician, who is not a radiology specialist, during the examination shall not be covered.

Expenses for hepatitis markers shall only be paid if the liver enzyme values are above the normal values.

Fees to be paid to the physician in relation to the procedural tests for the purpose of diagnostics done outside the contracted health providers shall be deducted from the non-contracted institutions limit according to the payment rates specified in the policy and be covered up to the amount of the fees specified in the current price and application principles of Turkish Physicians Association.

If the procedural tests for the purpose of diagnostics carried out by the non-staff physicians at the contracted health providers, the fees to be paid to such physicians shall deducted from the non-contracted institutions limit according to the payment rates specified in the policy and be up to the amount of the fees specified in the agreement signed between Anadolu Sigorta and the health provider.

Drugs and material expenses used during the radiological procedures shall be paid out of the diagnostics coverage (outpatients).

It is mandatory that the insured apply to the health providers they call for examination with the referral form to be completed by the examining physician and the claim form. Treatment expenses for the tests without a claim form and/or physicians report shall not be paid.

3.5. MINOR MEDICAL TREATMENT (MINOR OPERATION) EXPENSES

Any expenses in relation to procedures (plasters for broken limbs, stitching, removal of foreign substances from the eye, stomach irrigation, etc.) carried out for the treatment under general or local anesthesia or without anesthesia at the hospital or the doctor's practice, regardless of whether administered by the domestic outpatient or inpatient departments and the expenses regarding any kind of examinations like laboratory and radiology procedures to be made before and after procedures and drugs that will be prescribed, minor operations which is identified within the current price and application principles of Turkish Physicians Association, shall be paid within the limits and rates specified in the policy, excluding expenses for the physician examination and diagnostics.

Expenses of materials, drugs,(local and general anesthesia, prophylactic, antibiotics, activated carbon, ambustion, medical dressing salve and pomades etc.) pre-op blood analysis and physician fee of the relevant physician in the procedures to be carried out under this coverage.

However, all kinds of examinations, laboratory and radiology examinations before and after the procedureand the expenses of the prescribed drugs are not within the scope of the policy even if they are related to minor medical treatment. (As an exception of this sentence, medical examination and X-ray expenses before fracture, dislocation and sprains are covered by this coverage)The route of administration by prescription is intramuscular, intravenous, intraarticular, intraosseous, intradermal, subcutaneous and intra-vitreous, etc. are not covered by this guarantee but covered by drug expenses (outpatient) guarantee.

The pathologies taken during the intervention process are evaluated within the scope of this guarantee.

Medical expenses for non-surgical treatments that are suitable for the definition of emergency and not exceeding 24 hours of hospitalization period, (material, medicine, doctor's fees, related examination expenses, etc.) are evaluated within the scope of the minor medical treatment coverage specified in the policy.

However, in case of emergency situations that do not meet the definition, even if associated with these treatments; expenses of drugs that applied all kinds of examinations, analysis,

X-rays, laboratory, advanced diagnostic tests and / or prescribed intramuscular, intravenous, intra-articular, intradermal, intradermal, subcutaneous and intraocular vitreous etc. are not covered by this coverage but will be considered within the limits and payment rates of the related outpatient coverage.

The expenses for PUVA treatment (treatment of ultraviolet radiation) are paid from the minor medical coverage.

Several interventions within one session shall be considered within the TPA's current price and application principles. However, even the total of units exceed the minor operation unit which is identified within the application principles of TPA, If one of the

procedure does not exceed the small operation unit specified in the current price and application principles, will be evaluated under minor operation.

If the medical attention is carried out by the non-staff physicians at the contracted domestic health providers, the fees to be paid to such physicians shall be deducted from the non-contracted institution limit according to the payment rates specified in the policy and be up to the fees specified in the agreement signed between Anadolu Sigorta and the health provider.

The fee to be paid for the operations made outside the contracted domestic health providers and not specified in the the current price and application principles of Turkish Physicians Association shall be deducted from the non-contracted institution limit according to the payment rates specified in the policy and be limited to the amount stated in the agreement executed by our company and an equivalent hospital among the contracted health providers.

3.6. PHYSIOTHERAPY EXPENSES

Expenses of physiotherapy administered by physicians licensed to administer physiotherapy and any pain treatments will be paid within limits of physiotherapy coverages payment rate, session limits and rates specified in the policy regardless of whether treatment is given on outpatient or inpatient basis. Expenses such as room-board-bedside, doctors visit, etc. billed during the administration of physiotherapy shall not be included in the physiotherapy coverage.

The fees to be paid to the physicians for the examinations to be made during physiotherapy in non-contracted domestic health institutions shall be deducted from the limit of the non-contracted institutions according to the payment rates specified in the policy and shall be covered up to the amount of the current price and application principles of Turkish Physicians Association.

If the physiotherapy is carried out by the non-staff physicians at the contracted domestic health providers, the fees to be paid to such physicians shall be deducted from the limit of the non-contracted institutions according to the payment rates specified in the policy and be limited to the fees specified in the agreement signed between Anadolu Sigorta and the health provider.

For physiotherapy expenses to be payable, the results of imaging which makes treatment necessary (MR, tomography, ultrasound, etc.) and detailed doctor's report (how many sessions of physiotherapy are needed, detailed breakdown of therapy which must be administered in one session) must be furnished to Anadolu Sigorta.

3.7. CHECK UP

The expenses given below of the insured persons who have a check-up cover in their policies are paid once a year and 100%. This cover is valid for insured persons aged 14 (included) and above.

All Abdominal USG, Internal Examination, EKG, Lung PA, Urea, Total Cholesterol, HDL Cholesterol, LDL Cholesterol, Blood Count (18 Parameter), Glucose (Fasting Blood Sugar), Full Urine.

Check-up cover is only available in contracted health providers on our website.

If there is no health institution in the province where the insured is resident for check-up; If the insured have made examinations in a check-up panel at a different health institution, the amount to be paid shall be paid to the amount that is closest to that and the amount valid in the health institutions that we contracted for check-up.

3.8. INPATIENT TREATMENT COVERAGE

Expenses for the surgical and/or medical treatments which require staying in the hospital and the surgical and orthopedic operations which do not require the insured to stay in the hospital and the rate of the minor operation unit which is identified within the application principles of Turkish Physicians Association shall be considered under inpatient treatment coverage.

Pre-op tests required by the anesthesiologist are paid under the Inpatient Treatment Coverage.

Hospital stay approvals granted by the contracted health providers are not for an indefinite period of time. Hospital stay approval is valid on the condition that it is practiced within seven days and the policy is in force. If hospital stay is required for a longer period of time than the specified, the insured and the health provider should make an application again to receive provision.

A new report form should be sent and approval of the Insurer should be acquired in all hospital stays that exceed fifteen days so that expenses within the scope of the coverage incurred after fifteen days can be paid.

3.9. SURGERY EXPENSES

Surgical expenses such as operating room cost, equipment and drugs cost during the operation, fees of surgeon and the operating team (Assistants, anesthesiologists etc.) shall be paid within the limits specified in the list of covered procedures and the special and general terms and conditions of the policy, provided that the insured needs a surgical operation for the treatment is proven with a physician report and the operation is done at the health providers.

Pre-approval of operation: Except for emergencies, the Insured should notify the Insurance Company of their operation a few days prior to the operation, by faxing the "Patient Information Form" available at contracted hospitals which is to be filled out by the surgeon who will perform the surgery. It is important that the insured should take confirmation from our Company

officers whether the expenses shall be covered or not prior to the inpatient treatment so that they would not be kept waiting during their hospital admittance procedures.

Fee payable to surgeon and the team: If the insured is operated at a contracted health provider by an outside physician and their team (Assistant, anesthesiologist etc.), the fee payable to the non-staff surgeon and the team shall be deducted from the limit of the non-contracted institution according to the payment rates specified in the policy and be at most in the amount of the staff physician fees specified in the contract entered into between the health provider where the operation was performed and the insurer. If the fee asked by the non-staff physician is more than the amount to be paid to the health provider by the insurer for the staff physician and the team, the difference will be paid by the insurer. The fee to be paid to the operator doctors and his team (assistant, anesthesiologist, etc.) in the operations performed in non-contracted health institutions or clinics will be the amount specified in the current price and application principles of Turkish Physicians Association. If more than one operation is carried out in one clinic and if some of the operations are not covered under the insurance policy, the expenses regarding the operation or operations that are not covered herein shall not be paid;

Coronary Angiography with catheter procedure, ectopic pregnancy operation and ESWL (breaking kidney stones) expenses which are carried out in hospital conditions shall be paid under the operation coverage.

The fee to be paid for the operations made outside the contracted domestic health providers and not specified in the current price and application principles of Turkish Physicians Association shall be deducted form the non-contracted institution limit according to the payment rate specified in the policy and be limited to the amount stated in the agreement executed by our company and an equivalent hospital among the contracted health providers.

3.10. HOSPITAL ROOM - BOARD - BEDSIDE EXPENSES

Insureds expenses for room-board-bedside for each full day shall be paid within the limits specified in the policy and the special and general terms and conditions of the policy for each admission to inpatient treatment in health providers. In case of lodging in luxury rooms or suites, the payment for bed, meal and hospital attendant expenses shall be limited to the amount for the single private room in the hospital where the treatment is received. The difference in between shall be paid by the insured.

3.11. INTENSIVE CARE EXPENSES

Intensive care expenses to be incurred up to 90 days in the insurance year in the intensive care unit of the insured's health institutions are paid within the scope of the special and general terms and conditions of the policy and the limit specified in the policy.

3.12. DOCTOR'S VISIT

The expenses regarding the doctor's visit incurred by the insured during the inpatient treatment at the health provider shall be paid within the limit specified in the policy, and the special and general terms and conditions of the policy. Doctor's visit expenses should be specified as a separate item in the health provider's invoice.

If an outside physician is consulted for visit and medical consultation in the contracted health providers, the fee to be paid to that physician shall be deducted form the non-contracted institution limit according to the payment rate specified in the policy and be equal to the staff physician's fee specified in the contract entered by and between the hospital and the insurance company. If the outside physician asks for a higher fee, the difference in between shall be paid by the insured.

Doctor's visit expenses of the insured in the non-contracted health institutions will be covered up to an amount of the fees specified in the current price and application principles of Turkish Physicians Association. If the amount in the invoice is more than doctor's visit fees specified in the current price and application principles of Turkish Physicians Association, the difference in between shall be paid by the insured.

3.13. PRESCRIPTION EXPENSES (INPATIENT)

The expenses of drugs prescribed during the inpatient treatment of the insured at the health providers shall be paid within the limit specified in the policy, and the special and general terms and conditions of the policy.

3.14. DIAGNOSIS UNITS EXPENSES (INPATIENT)

the insured shall be paid within the limit specified in the policy, and the special and general terms and conditions of the policy.

Catheter angiographies (except catheter coronary angiography), mediastinoscopy videothoracoscopy are covered by this coverage.

Fees to be paid to the physician in relation to the procedural tests for the purpose of diagnostics done non- contracted health providers shall be covered up to the amount of the fees specified in the current price and application principles of Turkish Physicians Association.

If the procedural tests for the purpose of diagnostics carried out by the non-staff physicians at the contracted health providers, the fees to be paid to such physicians shall be up to the amount of the fees specified in the agreement signed between

Anadolu Sigorta and the health provider.

3.15. OTHER COVERAGE

3.15.1. MATERNITY EXPENSES

Maternity coverage is optional and will be included in the policy if it is received with additional premium. Insureds cannot benefit from covers not included in their policies.

Insureds who will purchase a health insurance policy for the first time are required to choose one of the products with maternity packages included in our current products and to add the maternity coverage to their policy by determining the maternity limit offered.

In order for the insured, who is the current health insurance policy, to renew her policy, to be entitled to use this cover; It is necessary to add the maternity benefit to the renewed policy, not to be pregnant when the policy is renewed, and if it is pregnant, the maternity cover should be in the previous policy.

Maternity coverage takes effect 1 year after the insured is covered by a policy with maternity coverage. Birth expenses incurred in the first policy year, routine controls, expenses related to pregnancy and complications caused by birth are excluded from the scope of the policy. Expenses related to maternity coverage begin to be paid in the second policy year of the insured.

Maternity expenses are paid 100% within the coverage limit. In addition, room-board-bedside expenses, diagnostic units, prescription, doctor's visit and other covers do not come into force. Expenses incurred during birth are paid only once during the 1 year policy period.

Insured under the status of child under the policy cannot benefit from the Maternity Expenses cover.

Maternity cover is not included in the products of Hesaplı Sağlık Sigortası, Hesaplı Plus Sağlık Sigortası, Hesaplı Maksi Sağlık Sigortası and Yardımcı paket. Therefore, expenses related to the pregnancy routine controls, birth, pregnancy and complications of birth are not covered.

Scope of Coverage: Expenses related to normal birth, cesarean expenses, pregnancy routine expenses and expenses related to pregnancy (compulsory abortion, miscarriage, threatened abortion, pregnancy vomiting, postpartum complications etc.) are paid within the limits of maternity coverge. In addition, room-board-bedside, diagnostic units, medicines, doctors and other covers do not enter into force. All expenses, except for the routine checks covered by the cover of maternity, are paid only once in the policy period of one year. (There is no limitation on the costs associated with compulsory abortion and miscarriage)

Non-invasive, noninvasive (NIFTY, Harmony, Prena, etc.) prenatal tests; provided to be deducted from the maternity cover for the contracted health providers are paid to be protocol of amniocentesis fee, for non-contracted health providers; it is paid up to amniocentesis fee specified in the current price and application principles of the Turkish Physicians Association.

3.15.2. Routine Pregnancy Controls

This cover is valid for the insured who have added the maternity cover to their policy by paying an additional premium.

For the insured that completed 1 year in a maternity cover policy, the expenses for pregnancy related (routine pregnancy checks) physician's examination, inspection and treatment during the pregnancy shall be covered within the limits and paymnet rate specified on the policy provided such expenses are deducted from the maternity expenses cover limit.

In the first years of Anadolu Sigorta, expenses related to birth controls are not paid even if the persons who switch to Anadolu Sigorta from other insurance companies have completed the waiting period.

Expenses for investigating the cause of a miscarriage in the previous pregnancy period are not covered by the policy.

During the pregnancy, any expenses that may arise as a result of discomfort of the baby are considered within the scope of the maternity cover in the policy.

In cases where the health status of the baby is a risk for the continuation of the pregnancy and the health of the mother, the compulsory abortion expenses are paid from the maternity cover. The current situation should be documented by a doctor's report and USG.

Maternity cover expenses are not covered in the first year of their first policy year who insured covered by our Company after the end of the insurance period in another company.

Newborn Expenses

Routine physician examination expenses following delivery and before discharging the healthy newborn and expenses for medicine and routine tests shall be covered within the limits of maternity cover.

Costs associated with congenital disorders of infants (congenital diseases, prematurity, low weight, blood incompatibility, etc.) and incubator expenses for such disorders are not covered by the policy. The exception to this is Anadolu Sigorta Babies.

3.15.3. Anadolu Sigorta Babies

In order to ensure that the new born babies of our insured, who have been entitled to use the maternity cover by completing their one-year term in a policy of maternity cover within the scope of individual health insurance can be "Anadolu Sigorta Baby";

- The mother is entitled to at least one year of waiting insurance coverage under her personal health insurance,
- Within 30 days of the date of birth, the application form must be filled and insured in the same individual plan as the mother,
- The mother and the baby must be insured under the same policy even if the plan is changed during the first renewal period.

As of the date of birth, the Lifetime Renewal Guarantee is provided and covered by insurance and the health expenses of the congenital diseases of these babies are paid under the policy.

These babies do not have 1-year operation waiting time for some operations.

Anadolu Sigorta Babies are entitled to newborn incubator cover.

Babies who are not admitted for insurance within 30 days from the date of birth or who have applied for insurance application at later dates are insured as of the date of medical underwriting. These babies are given Lifetime Renewal Guarantee as of the date of our insurance, but the expenses of their congenital diseases are excluded from the scope of the policy.

3.15.4. Newborn Incubator Expenses

Only Anadolu Sigorta Babies will benefit from this cover.

Incubator cover is given in order to cover the costs of Anadolu Sigorta's health expenses associated with prematurity (premature birth) and low birth weight within the first 60 days after birth.

If more than one baby is born and the above conditions are valid, each baby shall have the incubator cover specified in the policy. Incubator expenses of new-born babies will not be paid of the insureds who do not have a policy with maternity coverage, or haven't applied within 30 days as of the birth and insured in the same plan, even if they have a policy having maternity coverage.

3.15.5. Chemotherapy and radiotherapy expenses

Expenses of chemotherapy and radiotherapy (physician, room-board-bedside, drug, opening of venous port) and blood tests required for performance of these two procedures prior to chemotherapy and radiotherapy, blood test done for evaluation of complications which may occur post radiotherapy and chemotherapy and treatment of complications in this coverage in accordance with the special and general terms of the policy.

Drugs with "interferon alpha" active ingredient used in treatment of hepatitis C outside cancer treatments (Roferon-A or Intron-A) and drugs with "peginterferon alpha" active ingredient (Pegasys or Pegintron) used in treatment of hepatitis outside cancer treatments will be paid out of chemotherapy coverage.

Expenses for examinations and tests performed to evaluate the course of this disease after chemotherapy and radiotherapy will be paid out of the relevant coverage. It will not be paid out of the chemotherapy coverage.

For chemotherapy/radiotherapy performed at a contracted health provider by an outside doctor who is not a staff physician of that health provider, the fee payable to the non-staff physician will be deducted form the non-contracted institution limit according to the payment rates specified in the policy and be up to the amount of the staff physician fees specified in the agreement entered into between the health provider where the procedure was performed and the insurer. If the outside physician asks for a fee higher than that fee, the difference in between shall be paid by the insured.

Fees to be paid to the physician in chemotherapy and radiotherapy treatments performed at the non-contracted domestic health providers will be deducted from the non-contracted institution limit according to the payment rates specified in the policy and be up to the amount of the fee specified in the current price and application principles of Turkish Physicians Association.

3.15.6. Rehabilitation expenses

All expenses of the insured for functional training (rehabilitation) provided to him so that he can gain life function activities (walking with or without crutches, eating, drinking, dressing, undressing, sitting at toilet, going up or downstairs) he has lost after neurological diseases, severe trauma or extremity amputation, etc. will be paid within the coverage limits specified in the policy and the special and general terms of the policy provided that the treatment is on inpatient basis and the situation is approved by the Insurer. Moreover, other benefits like room-board-bedside, doctor's visit will not go into effect.

3.15.7. Home care expenses

Following the inpatient treatment of the insured at the health institution, the expenses made for medical care and treatment

performed by medical staff only at home shall be covered by this cover within the limits, general and special terms specified in the policy. In order to advantage this cover, the physician of the insured must notify the Insurer by a medical report documenting the requirement of continuing the treatment at home attended by a medical staff but stipulated treatment period must be confirmed by the Insurer before the home care takes place.

The insured person cannot perform daily life activities alone, incontinence or immobilization, need help in feeding the food, taking oral medication, having bath with full bath need or help, presence of urinary catheter, living alone at home and need for social support or presence of chronic disease are not covered by this cover.

3.15.8. Dialysis expenses

Dialysis related expenses – including physician, room-board-bedside, drug, diagnostics, shunt opening, etc. will be paid within the limits specified in the special and general terms of the policy.

If dialysis is performed on the insured at a contracted health provider by an outside doctor who is not a staff physician of that health provider, the fee payable to the non-staff physician will be deducted form the non-contracted institution limit according to the payment rates specified int he policy and be at most up to the fees received by the staff physician specified in the agreement entered into between the health provider where the procedure was performed and the insurer. If the outside physician asks for a fee higher than that fee, the difference in between shall be paid by the insured.

3.15.9. Artificial limb expenses

If an artificial limb is required for the treatment of an organ which lost its functions due to an accident or a disease during the term of the policy, artificial limb expenses (artificial hand, arm, leg and prosthesis outside the scope of aesthetical purposes) shall be paid within the limits of coverage and the special and general terms of the policy. Artificial limb coverage shall only cover the apparatus (Material) used. Artificial limbs to be used for the disability and renewal of the existing artificial limbs occurred prior to the commencement date of the insurance and dental prosthesis are not covered under the policy.

All expenses relating to the reconstruction surgery carried out after mastectomy for breast cancer covered by the policy will be paid only for once within the limits of this coverage. Other coverage such as further surgery, room-board-bedside, doctors visit, inpatient drug, inpatient diagnosis, etc. will not go into effect. The expenses for breast prostheses to be used by the insured for breast cancer covered by this policy will also be paid under this coverage.

3.15.10. Dental treatment due to a traffic accident

Expenses relating to dental treatment of the insured provided as a result of a traffic accident will be paid within the limit specified in the policy and the policy special and general terms, provided they are performed by hospitals, clinics licensed by the Ministry of Health and/or dentists licensed to open private practices. All expenses for the dental treatment required as a result of traffic accident (including dental and dental gum surgeries) are outside the scope of the other coverage. For treatment expenses of dental disorders occurring as a result of traffic accidents, the insured must get treatment within 90 days from the accident and the judicial report stating that the teeth were damaged is produced to the insurance company alongside with the invoice. Other expenses relating to dental treatments other than curing of damage sustained by teeth as a result of traffic accidents are not paid.

Invoice or self employment receipt for dentist fee relating to dental treatments as a result of traffic accidents and the graphic scheme of the mouth displaying which tooth is being treated should be submitted. The insurance company may also require a dental x-ray and the detailed report of the dentist treating.

3.15.11. Auxiliary medical material

As a part of the treatment applied to the insured as a result of a disease or accident that occurred after the starting date of the insurance, medical equipments such as personal splints (orthesis, braces, active ankle, bone spur pad) orthopedic sole plate, walker, elastic bandage, sling, corset, varsity sock, nebulizer, hearing aid, cervical collar, kneepad, wristguard, seating cushion, covers used in burn treatment, ileostomy bag, cystostomy bag, colostomy bag and adapters of ostomy bags, infusion pump, lymphedema sock, glucose test strips and crutch to be used as external support for the body only for medical purposes will be covered out of this coverage according to annual limit and payment rate specified in the policy. Auxiliary medical equipments other than the above-mentioned equipments are outside the insurance coverage.

3.15.12. Control mammography and breast ultrasonography

For the mammography, breast ultrasonography and the examination costs of these tests shall be paid once a year and 100% ratio for age of over 40 (include) women.

The relevant operations must be carried out by the selected health care facilities by Insurer, which are specified in the list of contracted health institutions in a separate table.

Mammography, breast ultrasonography and examination expenses shall be paid on condition that these procedures are performed in the same health institution.

Control mammography and breast ultrasound examinations in different health institutions with or without contracted institutions are not covered by the policy.

If there is no contracted health institution for mammography and breast ultrasonography for control purposes in the province where the insured is resident; In the event that the insured carries out the relevant procedures in a different health facility, it will be paid to the health institutions that contracted.

3.15.13. Control PSA (Prostate Specific Antigen)

For the PSA for control and the examination costs of these tests shall be paid once a year and 100% ratio for age of over 40 (include) men. The relevant operations must be carried out by the selected health care facilities by Insurer, which are specified in the list of contracted health institutions in a separate table. PSA and examination expenses shall be paid on condition that these procedures are performed in the same health institution.

Control mammography and breast ultrasound examinations in different health institutions with or without contracted institutions are not covered by the policy. If there is no contracted health institution for PSA for control purposes in the province where the insured is resident; In the event that the insured carries out the relevant procedures in a different health facility, it will be paid to the health institutions that contracted.

3.15.14. Control Colonoscopy

The costs of the colonoscopy shall be paid for once a year and 100% who are insured persons 50 years of age or older who have this cover in their policies. The relevant operations must be carried out by the selected health care facilities by Insurer, which are specified in the list of contracted health institutions in a separate table.

The cost of colonoscopy examination performed in other contracted health institutions or non-contracted health institutions is not within the scope of the policy. Expenses related to diseases that can be detected during the control colonoscopy will not be considered within the scope of this coverage.

If there is no contracted health institution for colonoscopy for control purposes in the province where the insured is resident; In the event that the insured carries out the relevant procedures in a different health facility, it will be paid to the health institutions that contracted.

3.15.15. Physical therapy after operation

Expenses after a treatment that requires surgery or intensive care, starting from two months following the date of removal of the cast applied to the hospital due to orthopedic surgery and physical therapy costs complementary to the treatment, wheter policy is inpatient or outpatient, shall be paid within the limits, special and general conditions of the policy.

The fee to be paid to the doctor in the physical treatments performed in non-contracted health institutions or in the clinics is limited to the amount specified in the current price and application principles of TPA.

In the case of contracted health institutions in Turkey, if the non-staff physicians perform physical therapy, the fee to be paid to these doctors is limited to the fees specified in the contract signed by Anadolu Sigorta with the health institution.

3.15.16. Ambulance

In cases of "Emergencies" specified herein below, the insured may, free of charge, make use of ground ambulance services in the company of a doctor, and receive consultancy services, by calling the number 0850 744 03 03 where doctors employed by the firm which provides such services for Anadolu Sigorta are available on the basis of 7 days a week and 24 hours a day. The firm which provides such services for the Insurance Firm shall also provide such services in provinces and districts other than Istanbul, where it has a local organization. As a response to calls from insured persons outside Istanbul, the Alert Centre shall direct the closest ambulance to the location of the insured, in the company of a doctor. The arriving team may either treat the insured at home or will take him to a suitable health provider. The insured will not pay any fee for this service provided by the contracted health provider of the Insurance Company in case of "Emergency Situations" specified herein below.

In case, in an emergency, the insured makes use of another ambulance other than those provided by the contractor of the Anadolu Sigorta, the ambulance fees for each case shall be reimbursed within the limit specified in the policy, and the Special and General Terms of the policy.

Cases to be considered as "Emergencies" within the policy are specified in the following list:

Drowning, traffic accident, falling down from height, loss of limb, electric shock, frostbite, cold and heat stroke, severe burns, severe eye injuries, poisoning, anaphylactic reactions, broken bones, myocardial infarction, acute severe arrhythmia, hypertensive crisis, stroke, acute paralysis, acute abdomen, diabetic and urea coma, acute massive hemorrhages, acute kidney failure, meningitis, encephalitis, brain abscess, asthma attack, renal colic, acute breathing problem, high fever (39 degrees and over), any condition that causes loss of consciousness, severe general condition disorder, migraine and / or vomiting, headaches associated with loss of consciousness, serious work accidents, acute gastroenteritis (fever, convulsion or dehydration), newborn coma.

The above-mentioned conditions apply only if the policy is in compliance with the special and general requirements.

3.15.17. Air ambulance in Turkey

This cover is available only for the insured with policies that include air ambulance in Turkey cover.

In domestic cases, if the treatment is impossible at the site of the insured and the health condition prevents transportation to an equipped health centre closest to the site by a land ambulance, the transportation of the insured shall be made via air ambulance and/or aerial transportation through the company contracted to Anadolu Sigorta with proper authorization by the insurer. Anadolu Sigorta shall not be held responsible for any negativity that may occur during the services provided by third persons. Anadolu Sigorta shall pay within the limits specified in the policy concerning the ambulance expenses.

3.15.18. Air ambulance abroad

This cover is available only for the insured with policies that include air ambulance abroad cover.

In abroad cases, if the treatment is impossible at the site of the insured and the health condition prevents transportation to an equipped health centre closest to the site by a land ambulance, the transportation of the insured shall be made via air ambulance and/or aerial transportation through the company contracted to Anadolu Sigorta with proper authorization by the insurer. Anadolu Sigorta shall not be held responsible for any negativity that may occur during services provided by third persons. Anadolu Sigorta shall pay within the limits specified on the policy concerning the ambulance expenses.

3.15.19. Modern Diagnostic Methods

Expenses related to all diagnostic procedures except direct radiological examinations and laboratory tests (direct radiological examinations and laboratory investigations mentioned in the current price and application principles of Turkish Physicians Association), EKG, expenses will be covered by this guarantee.

Some of the transactions to be paid from the modern diagnostic methods cover are as follows:

MRI, MR Angiography (Except cardiac MRI angiography), CT, CT Angiography (excluding coronary CT angiography), PET CT, ultrasonography, doppler, holter, treadmill exercise, scintigraphy, nuclear medicine (gallium, thallium, scintigraphy etc.), endoscopic procedures (gastroscopy, cystoscopy, bronchoscopy, mediastinoscopy, etc.), all biopsies (except for liver and kidney biopsy, paid for inpatient treatment), ph monitoring.

All expenses (anesthesia, drugs, material, pathology, etc.) generated during the procedures covered by the modern diagnostic methods cover.

The amount to be paid for the doctor's fees for the diagnostic interventional examinations in non-contracted health institutions shall be the amount specified in the current price and application principles of the Turkish Physicians Association.

In case of non-staff physicians conducting diagnostic procedures in contracted health institutions, the fees to be paid to these doctors shall be as much as the specified in the contract signed with Anadolu Sigorta and health provider.

3.15.20. Menopause expenses

Within the scope of Anadolu Sigorta Individual Health Insurance, the “premenopause/menopause/postmenopause expenses” are covered with regard the price limitations and payment rates stated in the plan that the insured has purchased.

3.15.21. Earthquake expenses

In the event that our policyholders who have earthquake coverage in their policy are injured as a result of a possible earthquake that will occur within the policy term, the examination and treatment expenses to be made in the health institutions that have been granted a working license by the Ministry of Health are within the scope of the policy under the special and general conditions . This benefit will be covered by the policy by paying additional premium, and if it is included in the policies of our existing insured in the interim period, it will be valid for the earthquake related physical damages that will occur after the coverage is added to the policy.

Coverage is valid only within the territory of the Republic of Turkey.

Hospital stay approvals granted by the contracted Health providers are not for an indefinite period of time. Hospital stay approval is valid on the condition that it is practiced within seven days and the policy is in force. If hospital stay is required for a longer period of time than the specified, the insured and the health provider should make an application again to receive provision.

A new report form should be sent and approval of the Insurer should be acquired in all hospital stays that exceed fifteen days so that expenses within the scope of the coverage incurred after fifteen days can be paid.

Intensive care expenses to be incurred up to 90 days in the insurance year in the intensive care unit of the insured's health institutions are paid within the scope of the special and general terms and conditions of the policy and the limit specified in the policy.

Home Health care, artificial limb and auxiliary medical material expenses related to bodily injuries of our policyholders who have earthquake coverage in their policy will be paid within the limits and special conditions of the related coverage in the policy.

All expenses related to dental, dental gum treatment and jaw treatments are excluded from the coverage.

The fee to be paid in all procedures performed in non-contracted health institutions or doctor's offices are limited to the amount specified in the current price and application principles of TPA.

3.15.22. Specific Medication Coverage

Carrying vital importance for the treatment of diseases that are included in the policy according to general and special terms and conditions, the expenses of medications that have no equivalent in Turkey and are imported by official public institutions that are approved by Turkish Pharmacists' Association, Social Security Institution, and Ministry of Health; the indications and combinations that are stated by the American Food and Drug Administration (FDA) whether those are inpatient or outpatient treatments, are covered by the Specific Medication Coverage as long as they have permit licence for appropriate dosage and duration of treatment. The exception of this article are the chemotherapeutic agents that fulfill the above-mentioned conditions but are used in chemotheraphy of cancers, which will not be covered by this coverage and will be evaluated in scope of chemoteraphy coverage. This benefit is paid for the customers who have Elit Sağlık Packages.

3.16. EXPENSES RELATED TO THE SEPTUM DEVIATION AND CONCHA TREATMENT

"If the insured has been insured under Anadolu Sigorta health insurance for at least 4 years without interruption and has obtained the "Lifetime Renewal Guarantee" and has been diagnosed with "septum deviation and turbinate diseases" during the insured period, expenses in relation to conditions of "Septum deviation and concha" shall be covered within the scope of special and general terms and conditions of the policy the policy offered."

The medical underwriting will be made for the expenses related to septum deviation and concha diseases in the transitions from other insurance companies and the transfer will not be considered as a right.

In order to be able to pay for treatment expenses related to septum deviation and concha diseases of the insured who have a Lifetime Renewal Guarantee in the corporate health insurance and which has been transferred to our Company's personal health insurance portfolio; Insured is insured for at least 4 years and diagnosis of septum deviation and concha diseases must be established within the scope of individual health insurance in Anadolu Sigorta.

In case of insured has outpatient coverage in his policy; The costs of examination for septum deviation and concha diseases shall be paid within the scope of the relevant outpatient treatment cover limits and payment rates under general conditions and general conditions.

3.17. NASAL FRACTURES CAUSED BY AN ACCIDENT

Treatment costs for nose fractures will be paid in the case of the documented by the doctor and if the relevant accident occurs after the policy start date.

3.18. OPERATION EXPENSES OF THE DISORDER EMERGING AFTER THE STARTING DATE OF THE INSURANCE AND, WILL BE OUTSIDE THE SCOPE OF THE POLICY FOR 1 YEAR AFTER THE STARTING DATE OF THE INSURANCE ARE SPECIFIED BELOW. MALIGN TUMORS ARE NOT APPLIED FOR 1 YEAR WAITING PERIOD

1. Wart, lipoma, cyst sebaceous (wen),
2. Varicosis, anorectal disorders (hemorrhoid, anal fissure, fistule, anal abscess, etc.), sinus pilonoidalis (pilonidal sinus), cyst hydatid, polypectomy in colonoscopy and gastroscopy, all kind of hernia (abdominal, visceral hernia, etc.), gallbladder, thyroid gland, and breast diseases,
3. Nose (except accidental nasal fractures, palatine tonsil, adenoid, sinusitis, hearing impairment, Eustachian Tube operations, thympanoplasty, etc.),
4. Cataract surgery, glaucoma, keratoconus, retina
5. Uterine, ovarian, endometriosis, cystorectocele
6. Trigger finger, hammer finger, all kinds of entrapment neuropathy, ganglion, cystic hygroma, morton neuroma
7. Breaking down the calculus in urinary system (ESWL) and surgery, hydrocele, prostate, bladder diseases
8. Operations regarding spinal and disc diseases, facet denervation, neural blocking,
9. All kinds of organ transplant (transplantation)
10. All kinds of joint diseases (knee, shoulder, hip, elbow, medium and large joints), meniscus lesion, tear and tendon injuries,

3.19. CONDITIONS NOT COVERED BY THE POLICY

Notwithstanding the occurrence reason, any expense (Physician, examination, tests, etc.) related to the below conditions shall

not be covered by the policy:

1. Conditions regulated in the General Terms of the Health Insurance that are not covered by the benefits,
2. Expenses related to the insured's excluded diseases that are specified on the policy and also the complications of such diseases,
3. Expenses resulting from the diseases that are known and/or inspected and received treatment by the insured before the insurance start date, all of the complications of the surgeries made prior to insurance period,
4. Expenses related to treatment for alcohol and substance addiction, expenses related to sicknesses and accidents resulting from alcohol and substance addiction, any health expense resulting from accidents occurred during the insured's driving without license, expenses related to treatments resulting from intentional and deliberate self-damaging, etc.
5. Officially announced epidemics,
6. Any aesthetical and plastic surgery operation other than the ones made due to accidental injury of the insured, cosmetic purpose treatments, gynecomasty, alopecia, hirsutism, sclerosant treatment of varicose veins, bariatrics (obesity), any drug and material used for dietary purposes, astheny; sweetener agents, moisturizing agents, cleansing preparations, healing cures, mud baths, quarantine, acupuncture, massage, mesotherapy, hydrotherapy, magnetotherapy, voice and speech therapies, orthopaedic treatments, etc.; invoices received from the institutions that do not comply with "Health Institution" definition on the policy such as nursing home, sanatorium, thermal spring, gym and beauty centres, foot care centres; expenses for any examination, test and treatment of health institutions and/or physicians that conduct alternative medicine treatment, gene therapy, prolotherapy, cupping, medicinal leech therapy, anti-aging program, balanced nutrition, personal diet-exercise programs, PERTH (Pulsating Energy Resonance Therapy)
7. At the time of application to the insured, any expense for which a controlled clinical study has not been published in a number and quality that will demonstrate the necessity, effectiveness and reliability of the diagnosis or treatment of a disease, or has not been accepted by one of the local/ foreign authorities (specialty associations, professional organizations, American food and drug administration (FDA), relevant chair scientific boards of medical schools, Ministry of Health), and/or written notifications from the medical society or authorities that they are at an experimental stage or that another person or institution is conducting experimental studies on the same process or equipment, is not covered.
8. Expenses related to treatments and cares performed by persons not qualified as "Physician" (Physiotherapist, dietician, private nurse, midwife etc.) definition made on the policy,
9. Expenses related to infertility examinations and treatments (Ovulation monitoring, HSG, adhesiolysis, tuboplasty, etc.) any medical and surgical artificial insemination, structural disorders related to genitals (unless related to sexual dysfunction or infertility except for hypospadias, hydrocele, cord cyst, epididymal cyst, undescended testicle in insured persons whose congenital diseases are paid), sexual dysfunctions, sex reassignment surgeries, any type of circumcision (even for phimosis), voluntary abortion, castration, birth control methods,
10. Expenses related to any varicocele examination and treatment whether related to infertility or not,
11. Expenses related to Pseudocyesis (mental pregnancy),
12. Expenses related to pre-insurance disabilities and required treatment, surgeries, organ transplants and inborn anomalies and diseases, genetic tests and genetic diseases, motor and mental developmental disorders, growth and developmental disorders,
13. Expenses related to physician's examination and inspections having general health check and check-up purpose other than the insurance company's check-up benefits, periodical checks,
14. Expenses related to psychiatry drugs whether related to psychiatric disease treatment or not, psychiatric diseases; examinations and inspections performed at psychiatry clinics and/or by psychiatrists and psychologists,
15. Expenses related to baby foods, baby diapers, feeding bottles and nipples; any type of soap, shampoo and solution, alcohol and colognes, hydrophilic cotton, thermometer, ice bag, hot water bag and similar sanitary goods; sleep apnea device, hearing device, wheelchair, orthopaedic sole, dentures and similar auxiliary medical goods and devices and TV / phone expenses, materials not required for the treatment and other expenses,
16. Expenses of vaccines and related tests, except for routine vaccines of children aged between 0-6 and tetanus, influenza, pneumococcal, menengitis and routavirus vaccines for all insureds,
17. Expenses related to skin tests for allergic diseases and allergy vaccines,
18. Hepatitis markers (not included age between 0 and 6 children),
19. Any expense related to physician's fee, drug, diagnosis, room-board-bedisde incurred for cases not covered due to nonpayment related to surgery and maternity benefits because of a case not covered,
20. AIDS and diseases related to HIV, sexually transmitted infections,

21. Expenses of the donor in organ transplants, fees and transportation expenses for organs and tissues,
22. Diseases and injuries that may result during dangerous sports (mountaineering, climbing, horse riding, driving ATV all-terrain vehicles, rafting, diving, parachuting, paragliding, sky skiing, bungee jumping, civil aviation activities, flying with deltaplan, gliding, balloon flight etc.) and while attending to any race and/or training in a professional or amateur way,
23. Fees for drugs without any prescription, invoice and coupon and other non-invoiced expenses,
24. Transportation and housing expenses of the insured incurred while filing an indemnity demand,
25. For whatever reason, any examination, test and treatment expenses related to dental, periodonthal therapy and maxillofacial surgery (Only the dental expenses due to traffic accidents are covered, within policy limitations, for the insureds who have dental expenses related to traffic accident coverage included in their policy),
26. Expenses related to frames, glasses and lenses; operations related to the correction of refractive errors of the eye (Myopia, etc.) and expenses related to strabismus,
27. Strabismus related expenses (except for the insureds whose congenital diseases will be paid),
28. Any expense related to examinations and treatments related to benefits not covered by the policy,
29. Expenses related to acnes, blackheads, genital warts and condyloma, nevus, epilepsy, snoring, sleep apnea syndrome, pre-menopause, menopause and complications (Osteoporosis, etc.),
30. Expenses related to epilepsy (except for the insured persons who have congenital diseases),
31. Geriatric diseases, sicknesses related to dementia resulting from ageing and Alzheimer disease,
32. inguinal hernia and expenses related to hydrocele of children below 24 months of age (except for the insureds whose congenital diseases will be paid)
33. Expenses related to septum deviation and concha surgery, (The conditions under which the expenses related to septum deviation and concha diseases can be paid are explained in the Special Conditions),
34. All expenses related to hallux valgus, hallux rigidus, fifth finger valgus (bunion, bunionette, etc.)
35. Expenses related to Coronary Artery Calcium Scoring Test, Coronary VCT Angiography, Cardiac MRI angiography, triple rule out, any examination performed under title EBT (Electron Beam Tomography) in Turkish Physicians Association tariff, costs for CT angiography and CT and MRI colonoscopy and similar scanning examinations,
36. Examination, test and treatment expenses given by individuals who have first or second degree blood relation to the insured.
37. *All kinds of expenses related to cord blood collection and storage
    *Expenses related to stem cell and embryo cloning, transplantation and treatments using these methods, storage and transfer (excluding bone marrow transplants performed for cancer diagnosis)
    *All expenses related to the PRP
38. Costs of any equipment, device which can not be considered as medical supplies and supporting medical supplies and regardless of name and title, cost of use of such instruments, rental of devices-equipment.
39. All expenses regarding to robotic surgery are out of coverage. (The exception of this article is the agreements that Anadolu Sigorta made with certain health care providers and in certain branches. Exclusive to this operation in health care provider that the agreement has settled with, expenses of the operation that the agreement has settled about, and the charge of the attending physician of the health care provider that the agreement has settled with will be covered for. For robotic surgery operations, in the case that an untenured physician operates in the health care provider with robotic surgery plan agreement, the maximum coverage will be same as the charge of the attending physician. The specialty equiment, usage-rent fee of the device, robotic arms etc. device expenses regarding to robotic surgery are out of coverage.)
40. Expenses incurred for health committee report obtained for causes like pre-marriage, pre-job start and pre-sporting activities, etc.
41. Suite and luxury room price difference in case of accommodation in rooms other than normal rooms,
42. Funeral expenses in case of death,
43. All kinds of spinal curvature (kyphosis, scoliosis, etc.), (except for those whose congenital expenses are covered)
44. Expenses regarding screening for family-related risk factors,
45. All expenses regarding diseases the formation of which were affected by congenital (natal), structural or genetic faults (e.g. AVM Accessory Pathway/WPW syndrome, ASD etc.) notwithstanding whether or not their existence is known and genetic tests.

46. Prematurity; medical expenses related to premature birth and low birth weight (except for Anadolu Sigorta babies)
47. Although whatever reason, egg collection and storage procedures in women with all expenses of semen collection and storage process in men.
48. All expenses related to nasal valve.
49. All kinds of examinations and treatment expenses related to the diagnosis of metabolic syndrome and expenses related to these complications,
50. All kinds of expenses for examinations and treatments written by the occupational physician for the working insured (except for the drug expenses that the occupational physician has written for our insured) , the spouse and the children.
51. Patient shares that the insured are liable to pay pursuant to Article 98/2 of the Social Security and General Medical Insurance Law No 5510 shall not be paid.
52. "Daily incapacity allowance determined for the earnings that can not be obtained by the insured due to inability to work as a result of illness" which should be paid pursuant to subparagraphs c and d of paragraph 1 of Article 1513 of the Turkish Commercial Code and "expenses arising as a result of care or daily care allowance determined if the insured becomes in need of care" are not covered herein.

4. GEOGRAPHIC SCOPE

Eco plans only valid in Turkey and Northern Cyprus; other individual health insurance plans are valid all over the world.

5. COVERAGE IMPLEMENTATION PRINCIPLES

5.1. PROCEDURES CARRIED OUT BY THE NON-STAFF PHYSICIANS IN THE CONTRACTED HEALTH PROVIDERS

Viable for all of the coverages within our private health insurance products; the medical fee for the nontenured physicians and their team (medical assistant, anaesthesiologist) who operate within the contracted domestic health care provider, the medical examinations and treatment-oriented procedures that are operated by them (small interventions, surgical operation, radiotherapy, chemotherapy, dialysis etc.), diagnostic interventional examinations (colonoscopy, gastroscopy, cystoscopy, biopsy, biopsy with USG, angiogrphy with MRI etc.) shall be paid according to the fee amount stated in the contract between Anadolu Sigorta and the respective health care provider.

If the fee that a nontenured physician demands is more than the fee which would be paid for an attending physician, the gap in between shall be paid by the insured. The bill for the mentioned gap shall not be claimed from Anadolu Sigorta.

Our insurance holders can obtain information about our contracted health care providers from www.anadolusigorta.com.tr or by calling our Company.

5.2. PROCEDURES CARRIED OUT BY THE PHYSICIANS OPERATING IN THE CONTRACTED HEALTH PROVIDERS

In case the insureds go to a staff doctor or a non-staff doctor operating within the mentioned health care provider in contracted health providers, but pay their health expenses themselves for any reason, they should show their insured cards and declare that they have a policy.

They should ensure that the invoice amount is discounted according to the contract signed between the insurance company and the health provider.

For the invoices sent to our company; our contracted prices will be taken into account for the repayment to the account of the insured. If the invoice amount of the health provider is higher than our contracted prices for that provider, the difference amount between them will be paid by the insured.

5.3. PROCEDURES CARRIED OUT BY THE PHYSICIANS IN THE NON-CONTRACTED HEALTH PROVIDERS

Fees to be paid to all branch physicians and their teams (assistant, anesthesiologist) in relation to the procedures for the purpose of treatment (minor medical attention, operation, radiotherapy, chemotherapy, dialysis etc) and procedural tests for the purpose of diagnostics (colonoscopy, gastroscopy, cystoscopy, biopsy, biopsy with USG, angiography with MR etc) done outside the contracted health providers or surgeries shall be deducted from the limit of the non-contracted institutions within the scope of payment rates specified in the project and be as much as the current price and application principles of Turkish Physicians Association.

The above-mentioned charges to be paid to the doctor and his team; will only be 2 times the amount specified in the current price and application principles of Turkish Physicians Association for our Elite Plus Health Insurance plan.

Therefore, if the insured is to be treated in a non-contracted health provider, it is important for them to call our Company and make queries about the physician fees prior to the treatment. If the physician fees for the procedures specified above and

carried out by the non-contracted health providers are more than the current price and application principles of Turkish Physicians Association, the difference in between shall be paid by the insured.

If the amount requested by the doctor for our Elite Plus Health Insurance product is more than 2 times the amount specified in the current price and application principles of the Turkish Physicians Association, the difference will be paid by the insured. This should be taken into account in the following collateral statements.

5.4. TREATMENT ABROAD

Treatment abroad only applies to those who are insured with policy cover for abroad treatment.

For persons have been insured for the first time in Anadolu Sigorta after 23.04.2014, the insured have to reside in the Republic of Turkey. However, Anadolu Sigorta reserves the right to request a passport and not pay any expenses abroad, if it is determined that a residence has been resident abroad for more than 120 days uninterrupted.

Amounts to be paid for treatment abroad are also stated in treatment abroad tables in the policy. Outpatient and inpatient treatment expenses are paid up to the limits specified in the policies. Therefore, before going abroad, the insured that shall undergo a planned abroad treatment must inform our company on the intended treatment and obtain information on the amount to be paid for such treatment.

There is not any abroad health institution that entered into a direct payment agreement with our company. However in order to allow our insured clients to benefit such treatments, our company have entered into an agreement with an assistant company which represents many contracted health institutions in various countries abroad. According to that agreement, the insured shall inform Anadolu Sigorta in advance about the name of the health institution where he/she shall undergo an inpatient treatment and in case such health institution had entered into an agreement with our company's contracted assistance company, the expenses on the subject matter treatment shall be directly paid by our company to the concerned health institution abroad within the limits of the insured's policy benefits limits.

However if the health institution where the insured shall undergo an inpatient treatment had no agreement with the assistance company, the insured shall pay his/her health expenses on his/her own account, deliver the related invoices and reports to our Company and then the payment shall be made to the bank account of the insured within the policy's general and special terms.

The insured should pay for their outpatient expenses of abroad. In order to receive a payment from our Company, they must complete the documents under the "Indemnity Procedures" heading and submit them to our Company.

The costs of the treatment of the insured patients in health institutions abroad are paid by T.C. The Central Bank on the basis of the foreign exchange buying rate, within the limits set forth in the policy specificed special and general terms by TL.

Within the scope of Inpatient benefits abroad there are sub collaterals; minor operation, medium operation, major operation, special operation, extra special operation, extra major operation, room-board-bedside expenses, intensive care, doctor's visit, prescription(Inpatient), diagnostic analysis (Inpatient), chemotheraphy, radiotheraphy, dialysis. Except the air ambulance abroad other sub-collaterals are used by deducting from the main abroad benefit limit. There is a separate limit for the air ambulance abroad.

Invoices for treatment expenses made abroad and reports and examination results of these treatments should be submitted together with the Turkish translation if they are in a language other than English. The translation fee will be covered by the insured.

If the insured has made a payment by credit card for his / her treatment abroad, he / she is obliged to send the credit card receipt or the statement showing that the credit card is paid to the insurance company.

5.5. ECONOMIC PLANS

The insured that purchases one of our economic plans agrees to undergo treatment only at company endorsed health institutions under previously determined prices. His/her abroad health expenses shall not be covered.

All health expenses such as examination, diagnosis, treatment, routine maternity checks and childbirth in the health institutions where the insured persons with economic plans are not contracted, for all covers; shall be paid within the limits and payment rates specified in the policy in the range of the current price and application principles of the Turkish Physicians Association.

As an exception to the above explanation; Expenses of outpatient drug in non-contracted pharmacies, expenses of auxiliary medical amterial provided by non-contracted health institutions shall be paid within the limit and payment rate of the cover specified in the policy.

The treatment costs incurred in the hospitals affiliated to the Ministry of Health and the State University Hospitals will be covered by the cover limit and payment rates applicable in the contracted institutions.

You can find the information on health care providers that are covered and those that are, including emergency situations, not covered by the Network* of your policy from Health Center step on www.anadolusigorta.com.tr address or from our Sağlığım Cepte application. Medical bills from health care providers that are completely uncovered by Eco Network, and new institutions

that might be owned by these institutions in the future, INCLUDING EMERGENCY SITUATIONS (stated in Special Conditions article 5.6), will not be paid under any circumstances. Anadolu Insurance always reserves the right to update the status of institutions in scope of networks.

*Network: States the contracted health care providers that the products cover.

Treatment costs for emergency situations as follows, In the case of non-contracted health institutions where economic plans are not valid, the limit and payment rates of the relevant cover in the policy is met by deducting it from the "Emergency Service Cover" limits.

5.6. VKV NETWORK

This network consists only of VKVSK Vehbi Koç Foundation and Health Care Providers Group Hospitals and Medical Centers (American Hospital, Koç University Hospital, American Medical Center and Bodrum American Hospital) and is not valid abroad (including Cyprus). It can only be preferred if Elite Health Insurance product is purchased. If this Network is preferred, no payment will be made in case of receiving services from a different institution other than the institutions within the VKVSK network, including in emergency situations,

5.7. EMERGENCY SITUATIONS

Drowning, traffic accident, falling down from height, loss of limb, electric shock, frostbite, cold and heat stroke, severe burns, severe eye injuries, poisoning, anaphylactic reactions, broken bones, myocardial infarction, severe acute arrhythmia, hypertensive, sudden strokes, acute abdominal, diabetic and urea coma, acute massive hemorrhages, acute kidney failure, meningitis, encephalitis, brain abscess, asthma attack, renal colic, acute respiratory problems, high fever (39.5 degrees and over), any situation lead to loss of consciousness, severe general condition disorder, migraine and vomiting, headaches with loss of consciousness, serious work accidents, acute gastroenteritis (fever, convulsions or dehydration), newborn coma. The above-mentioned conditions apply only if the policy is in compliance with the special and general requirements.

6. INDEMNITY PROCEDURES

In case the insured applies to a contracted provider for treatment, the contracted health provider receives a provision from our Company and the insured checks out the contracted health provider after paying the patient share within the coverage limits and signing a waiver.

If treatment is provided by a non-contracted provider, the insured is required to submit the invoice against the treatment expenses and other documents to our Company. Treatment expenses are assessed in accordance with the special and general terms and conditions of the policy and the indemnity amount to be paid is paid into the account of the insured.

For the payment of indemnity against the treatment expenses, the following documents should be submitted to the insurer:

a. Indemnity Claim Form (relevant fields of the Claim Form should be filled and signed by the insured, doctor, or the health provider where the treatment was received.),
b. Original invoices for all expenses and invoice statements,
c. Operations report and/or patient release epicrisis for inpatient treatments,
d. Results of analyses for the diagnosis of the condition,
e. Alcohol report, judicial report, photocopy of driver's license and traffic accident report, in case the treatment is necessitated by a traffic accident; alcohol report, judicial report and statement of the insured, in case of any other kinds of accident.
f. Original prescription, drug packing clipping cuts and receipt or invoice from the pharmacy, (attaching to the prescription and submitting of drug tags),
g. Original of paranasal sinus tomography before sinusitis surgeries,
h. For physiotherapy expenses to be payable, the results of imaging making treatment necessary (MR, tomography, ultrasound, etc.) and detailed physician's report (how many sessions of physiotherapy are needed, detailed breakdown of therapy which must be administered in one session),
i. Turkish translations of the reports and examinations conducted abroad, document indicating that the payment was made (credit card statement or credit card slip, transfer receipt)
j. Chemotherapy treatment schema.

Indemnity payments are made by the insurer on the bank account of the insured. Information on the payment will be transferred to the Insurance Information Center.

6.1. RIGHT OF RECOURSE OF THE INSURER

In case the Insurer becomes obliged to make payments in violation of the special and general terms and conditions of the policy due to provision of incorrect and/or incomplete information by the insured or the physician, it shall collect the figures paid as such through subrogation from the insured. Moreover, this practice shall also apply for the payments the insurer is obliged to make on behalf of the insured to "Contracted Health Provider" in accordance with the "Outpatient Direct Payment

Agreement" in relation to the expenses in breach of the special and general terms and conditions of the policy.

Any payment by the Insurance Company of any amounts which are not covered by the policy shall not vest a right to the insured.

6.2. PRE-APPROVAL BEFORE INPATIENT TREATMENT

The Insured should notify the Insurer a few days prior to any admittance to a health provider where the Insured should receive inpatient treatment in order to facilitate the procedures, except for the emergency cases where the Insured should be admitted immediately to a health provider. Moreover, submitting the claims to the Insurer within 10 days as of the invoice date shall speed up the procedure.

6.3. SUBJECTION OF THE INSURED TO PHYSICIAN'S EXAMINATION AND TESTS

Upon its discretion, the insurer may also require the insured to undergo an examination by a doctor to be appointed by the insurer, during the processing of the indemnity request. Prior to paying health expenses of the insured or when the insured is to receive inpatient treatment, the Insurer, if deems necessary, may require some examinations prior to its approval for inpatient treatment. Furthermore, with the insured's written approval, it shall also be entitled to request information and copies of records regarding the medical history of the insured, from all doctors, health providers, Social Security Institution, Insurance Information and Monitoring Center (SBM), public institutions, and third persons involved in the treatment of the insured before and after the insurance period. Anadolu Sigorta may transfer any and all details in relation to insured's health information to Insurance Information and Monitoring Center (SBM) and third persons involved in insurance services.

6.4. WRONG TREATMENTS APPLIED

All liability for wrong treatments of the insured by the health providers or physicians shall be of the health provider physicians that applied the treatment.

7. SPECIAL CONDITIONS OF IMPLEMENTATIONS

7.1. POLICY ISSUE

a. At the time of first application, people between the ages of 0-64 (excluding the age of 64) can be insured. Age is found by subtracting the person's date of birth as day/month/year from the date the policy is issued. Persons under the age of 18 years may be insured alone under the health insurance on condition that they pay additional premiums. New born babies can be covered by the policy 14 days after birth. (Except for Anadolu Sigorta Babies.) Single children up to 30 (inclusive) can be insured dependent on the family policy by making use of the family discount. Between 0-17 years (including 17), a 10% family discount will be applied to the policies of the siblings who will be insured without their parents. The additional premium will continue to be applied.
   A separate policy will be issued for each of the siblings. One person cannot be covered by Anadolu Sigorta more than one individual health insurance policy
b. In families with children, policy will be applied without children. In addition, all children under the age of 18 must be included in the policy if parents include one of them.
c. The insurance company may request the following before approving the coverage;
   - For the candidates at or over 55,
   - Height- weight index (height-Weight Index=Weight(kg)/Height2(m)), for the candidates at or over 35,
   - Although not included in the above two categories and send the current health status of the last six months showing the results of current reports and examinations to our company, candidates who are required by our Company physicians to have some tests, all could be requested to have the tests which are specified by the Company to be carried out before they are accepted under the insurance coverage.

   The health provider which will carry out the tests shall be determined by the insurer and the test expenses shall be paid by the insurer to the health provider. Whether the candidate shall be approved under an insurance coverage or not or the conditions of such coverage shall be determined by the insurer upon the review of the pre- test results.
   As a result of the tests, if some test results of the candidate are above the normal levels, the insurer may ask the candidate to have more tests done in order to understand the seriousness of the health problem. Expenses of such tests shall also be paid by the insurer.
   Except as stated above;
   Since the current reports of the last six months which will document the current health status by the insured candidate are not submitted to our Company, the inspection expenses to be requested by our Company's doctors will be covered by the insured candidate whether they are covered or not.
   In case the insured candidate subject to the out of coverage which was added to the policy as a result of the medical underwriting conducted by our Company doctors, some examinations regarding this disease can be requested. Inspection results are covered by the insured candidate if the results of the examination support the medical underwriting.
   If the resulted documentes shows that there is no problem in the current health status of the insured; all inspection

expenses shall be covered by the relevant coverage limits and payment rates for the policyholder.
In case of absence of relevant coverages in which the examination expenses will be paid in the policy, the examination expenses shall be covered by the insured.

d. If number of dependants increase after the commencement date of the policy; a new application form should be filled out for each dependant and if the dependant is a new born baby then a detailed physician report reflecting the health condition of the new born baby and if the dependant is a spouse then the official documents such as marriage certificate should be submitted to the insurer. Family members who are entitled as a dependant at a later date should be included in the insurance coverage within 30 days at the latest as of they are entitled to become a dependant. Premiums to be paid for the dependants who are taken under the policy after the commencement date of insurance are to be paid on the basis of the days acquired.
e. The insured's age is determined by subtracting the birth date of the person in question from the issuance date of the policy. This calculation is also taken into account for the validity of check-up, control mammography, PSA and colonoscopy covers.
If the insured did not qualify for the inclusion of the specified guarantees because it could not meet the age criterion at the time the policy was issued, the policy does not have the right to use these coverages until the next renewal period, even if it meets the age criterion within the policy period.
f. In our company, our insured, who have been insured for at least 4 years, within the scope of individual health insurance, from 5th year, the first diagnosis is made after the date of the individual insurance of our company, expenses of congenital diseases are paid under the special and general conditions of the policy. In order to be able to make the payment, the insured must provide a report from the doctor who diagnosed the first diagnosis of congenital disease by providing a report stating that he / she is the first to submit the diagnosis.
g. According to the provisions of Article 6 of Law No. 6698 on the Protection of Personal Data published in the Official Gazette dated 07.04.2016 and numbered 29677, the insured should read and sign the section "Information and Declarations Under the Protection of Personal Data" in the application form.

7.2. COMMENCEMENT OF THE POLICY

Medical Insurance policy coverage shall commence on the condition that, upon the approval of the acceptance form and conduct of the risk assessment done by the insurer, the policy is drawn up and the entire premium or the first installment is paid. Medical expenses to be incurred between the completion of the application form and the issuance of the policy shall not be in the scope of the policy.

7.3. INSURANCE CONTRACT PERIOD

The contract period is one year. The medical expenses incurred by the insured on the commencement date specified on the policy, regardless of the time of the day, shall be paid within the limit specified in the policy, and the special and general terms and conditions of the policy. However, the medical expenses incurred by the insured on the expiry date of the insurance, regardless of the time of the day, shall not be paid under the policy.

Benefits of the policy begin as of 00:01 on the commencement date specified in the policy and ends as 00:01 on the expiry date specified in the policy. (For example; Benefits of the policy starts as of 00:01 on 01.01.2021 and ends as of 00:01 on 01.01.2022.)

For a medical insurance policy to be accepted as renewal, new policy should become effective on the expiry date of the previous policy. Loss of rights may occur for the policies which have expired but the term has not been renewed. Policies must be renewed within 30 days at the latest following expiration.

Inpatient treatment cover accepted by the insurer prior to expiration of the insurance, in case contract term is expired and no new contract has been signed, shall continue for only an additional ten days on the condition that duration and cover limit specified in special terms are not exceeded. In case the private policy is renewed, medical expenses for the relevant treatment shall be paid within the limit and according to payment rates specified in the policy, and the special and general terms and conditions of the policy.

7.4. TRANSFER BETWEEN PLANS

During the policy renewal periods, the insured may transfer into another plan with different cover structure and limits provided that they are approved by the underwriter. In case of a request for transition to a higher profile plan, the insurer has the right to request a new health declaration.

In the case that an insured who has a maternity coverage chooses a different maternity coverage plan during the renewal period, there will be no need for an additional assessment.

Requests for change in interim periods after the start of the policy will not be accepted.

7.5. LIFTETIME RENEWAL GUARANTEE IMPLEMENTIONS

7.5.1. Qualifying for Lifetime Renewal Guarantee

Valid for insured persons before the date 3.1.2019: Anadolu Sigorta will provide a Lifetime Renewal Guarantee to individual

insurance holders with a rate of loss ratio less than 100% of the premiums paid in their policies for the last 4 years and for the last 4 years.

Valid for insured persons after the date 3.1.2019: Anadolu Sigorta will provide a Lifetime Renewal Guarantee to individual insurance holders with a rate of loss ratio less than 75% of the premiums paid in their policies for the last 4 years and for the last 4 years.

In the first evaluation made at the end of the 4th year, the insured, who are not entitled to receive Lifetime Renewal Guarantee, will be taken to the Lifetime Renewal Guarantee evaluation again by considering the loss ratios in the last 4 years during the policy renewal periods.

As a result of the evaluations made every year, the insured persons who are not eligible for Lifetime Renewal Guarantee from the age of 65, 30% additional premium will be applied in the renewal, until the age of 75 (excluding). It will be decided whether or not the policy will be renewed from the age of 75, as a result of the medical underwriting to be made by our Company, and the additional premium age to be taken from the policyholders approved for the continuation of the policy will be 50%.

Additional Premium charge for age, shall not be applied for insured persons who are eligible to receive Lifetime Renewal Guarantee before they reach 65. These persons will not have any upper age limit in their policies. The age of the insured shall be calculated by subtracting the date of birth of the person from the date on which the policy is issued as day / month / year.

Children up to 18 years old are entitled to a Lifetime Renewal Guarantee at the date of commencement of insurance, if they are covered by the insurance in Anadolu Sigorta unconditionally.

Lifetime Renewal Guarantee is given to the individual. Giving a Lifetime Renewal Guarantee to one of the persons covered by the health insurance with family members does not mean that Lifetime Renewal Guarantee is provided to other family members in the policy.

7.5.2. Advantages of Qualifying for Lifetime Renewal Guarantee

Diseases that emerged after the date of entitled the Lifetime Renewal Guarantee at Anadolu Sigorta will not be excluded during the renewal periods and no additional premium will be charged for these diseases.

In addition, considering loss / premium ratio, which is calculated by dividing the indemnity amount paid for the previous policy by the net premium amount received, no additional premiums will be charged, even it is over 100%. Non-indemnity discount will be applied.

The rates of non-indemnity discount are specific to individuals.

An insured person entitled Lifetime Renewal Guarantee within the scope of the individual health insurance, no change shall be made against the cover limits and participation shares in the current policy.

7.5.3. Change Of The Rights To Lifetime Renewal Guarantee

If it is determined that the insured is misrepresented or incomplete, or if the insurance coverage is used in bad faith, Anadolu Sigorta may change the terms of the Lifetime Renewal Guarantee by applying an exemption or additional premiums and recourse of the indemnity payments or cancel the policy.

After the lifetime renewal guarantee is granted, in the event of a refund of a health expense that has not been made by our company for any reason relating to the year of evaluation and/or previous policy period, if the loss ratio changes in such a way that it violates the criteria for obtaining a lifetime renewal guarantee, the right to a lifetime renewal guarantee will revoke.

7.5.4. Persons Recruited For The Military Services Who Qualify For Lifetime Renewal Guarantee

If the insured, who have earned the Lifetime Renewal Guarantee and canceled their policies due to the military service, apply within 1 month of completing their military service and fill the health declaration form provided that they document their military status, the renewal guarantee rights continue. However, the diseases occured not in the term of policy that issued by Anadolu Sigorta will be out of the scope of coverage for the new policy.

7.6. TRANSFER OPERATIONS

In our company, for those insured by a corporate health insurance and apply for an individual policy due to termination of employment, retirement or because of termination of the contract for the corparate health insurance with our company;

For those who have not been entitled to a lifetime renewal guarantee in their corporate policy;

- Medical underwriting shall be made,
- Exemption may be applied for diseases existing before the start of the individual policy or additional premiums may be taken for these diseases,
- Even if insured has completed a year in a corporate policy with a cover of maternity, insured should fill the waiting period of one year in order to cover the expenses related to birth and delivery when it switches to individual policy.

- The upper limits of the disease added in the group policy are re-evaluated, and the upper limits of the disease can be changed if necessary.

People who are insured within the scope of group health insurance in Anadolu Sigorta and leave the group, must apply for a personal health insurance within one month for switch to the individual health policy. In the event that individuals who do not have a Lifetime Renewal Guarantee receive individual health insurance within 1 month, the duration of corporate insurance and the loss ratio rates under the corporate insurance will be taken into account during the evaluation of the individual Lifetime Renewal Guarantee.

For those who have been entitled to a lifetime renewal guarantee in their corporate policy;

- Insured directed to the most similar plan regarding the coverage limits and network structure of the group policy.
- The request for the transition of the insured to a more comprehensive individual policy shall be decided upon by a medical underwriting by our Company.
- The upper limits of the disease added in the group policy are re-evaluated, and the upper limits of the disease can be changed if necessary.
- In the case of insured having completed one year in a corporate policy with a cover of maternity, the one-year waiting period for maternity coverage will not be implemented.

Waiting period of 1 year for some operations will not be implemented for those, who have completed 1 year in corporate health insurance policy, wheather or not they have entitled to a lifetime renewal guarantee.

If the individuals in the scope of Corporate Supplemental Health Insurance of our company make an application to Individual Health Insurance due to cease of employment, retirement or termination of contract between our company and theirs, the policy shall be issued after the risk assessment and without any conveyance of rights.

For Those Who Transfer to Individual Health Insurance in the Case of Termination of Their Anadolu Supplemental Health Insurance Contract;

- Within the scope of Supplemental Health Insurance, when the insurance holders who have Supplemental Health Insurance Renewal Guarantees are transferring to Individual Health Insurance, their Renewal Guarantee will be changed into Lifetime Renewal Guarantee. For insurance holders holders who do not have Renewal Guarantee, the policy period they had in Supplemental Health Insurance will be taken into consideration for Lifetime Renewal Guarantee assessment.
- For the insurance holders who have Supplemental Health Insurance policy in our company, whether or not they have Supplemental Renewal Guarantee, in the case of transferring to Individual Health Insurance policy, the risk assessment will be made, the Insurance Commencement Date of their Supplemental Health Policy will be transferred, and the waiting period of surgical operations will not be implemented.
- The conditions that are out of scope in Supplemental Health Insurance being likewise binding, the additional premium and upper limit implementations will be evaluated according to Individual Health Insurance provisions. Also, exemption or additional Premium may be applied for diseaes that emerged during the policy period of Supplemental Health Insurance.
- For the insureds who have maternity coverage in their Supplemental Health Insurance policy, the waiting period of maternity coverage in Individual Health Insurance will not be applied.

For Those Who Have Anadolu Supplemental Health Insurance in Our Company Who Also Want to Purchase Individual Health Insurance;

- Insureds who have Renewal Guarantee for their Supplemental Health Insurance policy, who want to purchase Individual Health Insurance in addition, can transfer their mentioned rights to Individual Health Insurance as Lifetime Renewal Guarantee. For the insurance holders who do not have Renewal Guarantee, their Individual Health Insurance First Insurance Commencement Date and special conditions will be predicated on.
- First Commencement Date of Supplemental Health Insurance will be transferred to Individual Health Insurance. For waiting periods of surgical operation and maternity coverage, Individual Health Insurance First Insurance Commencement Date and special conditions will be predicated on.
- Risk assessment shall be made whether or not the insured has Renewal Guarantee for their Supplemental Health Insurance, while existing out-of-scope conditions shall remain likewise, additional premium and upper limit implementations will be evaluated according to Individual Health Insurance provisions.

7.6.1. Transfer From Another Company

Persons who want to have individual health insurance in Anadolu Sigorta in the new period, instead of renewing their policies in their current insurance company, within a month of the end date of the policy;

- They can be insured by excluding diseases that emerged before the start date of insurance in Anadolu Sigorta and / or by taking an additional premium for these diseases.

- If deemed appropriate, it may be taken over in accordance with the practices of our Company in the event that it is documented and proved with the no claim discount, transition information and / or renewal proposal that has been obtained in the other insurance company.
- The discount rate on the document; The policy of the insured shall be initiated from that level if the corresponding discount / additional premium table corresponds to the usage. The maximum discount rate is 20%.
- Waiting periods of 1 year, which are valid for some operations, are not applied for the insured who completed one year in other insurance company and applied to our Company within 1 month from the expiry date of the policy.
- Waiting period of 1 year shall be applied for all expenses related to birth and pregnancy. This applies to anyone who is entitled or not a renewal guarantee, from the other insurance company.
- The start date of the first insurance will be based on the start date of Anadolu Sigorta.
- These rights of persons who have a renewal guarantee from the previous insurance company can be taken over as a result of the medical underwriting.

Valid for insured persons before the date 3.1.2019: Persons who have transferred from another insurance company without a renewal guarantee right; will be evaluated at the end of the 2nd year of Anadolu Sigorta. At the end of the 2nd year, if the rate of loss ratio for each year is below 100%, lifetime renewal guarantee will be provided to those who qualify.

At the end of the second year, for those who do not qualify for Lifetime Renewal Guarantee, will apply the same rules as for the persons that are insured for the first time in Anadolu Sigorta as a Policyholder. They will be evaluated for 4 years period; If their each year's loss ratio is below 100%, they will have a Lifetime Renewal Guarantee.

Valid for insured persons after the date 3.1.2019: Persons who have transferred from another insurance company without a renewal guarantee right; will be evaluated at the end of the 2nd year of Anadolu Sigorta. At the end of the 2nd year, if the rate of loss ratio for each year is below 75%, lifetime renewal guarantee will be provided to those who qualify.

At the end of the second year, for those who do not qualify for Lifetime Renewal Guarantee, will apply the same rules as for the persons that are insured for the first time in Anadolu Sigorta as a Policyholder. They will be evaluated for 4 years period; If their each year's loss ratio is below 75%, they will have a Lifetime Renewal Guarantee.

7.7. CHANGES IN THE POLICY TERMS AND CONDITIONS

The insurer is free to effect changes in the Special Terms of the Policy and the Scope of the Policy. However, such changes shall take effect on the renewal date of the insured's contract and in case the policy is renewed.

7.8. CRITERIA FOR PREMIUM DETECTION

Premiums of individual health insurance products; age, gender, collateral structure and payment rates in the selected product are determined within the framework of the rate of increase in contracted health institutions (network), insured's residence and treatment costs.

7.9. DISCOUNT AND ADDITIONAL PREMIUM IMPLEMENTATION

The non-indemnity discount rates and additional premium rates to be applied, by considering the indemnity / net premium rate, are shown in the following tables:

TABLE

	RENEWAL POLICY LEVEL – STANDART SAĞLIK SİGORTASI, STANDART PLUS SAĞLIK SİGORTASI, ELİT SAĞLIK SİGORTASI, ELİT PLUS SAĞLIK SİGORTASI, HESAPLI PLUS SAĞLIK SİGORTASI & HESAPLI MAKSİ SAĞLIK SİGORTASI, HESAPLI SAĞLIK SİGORTASI						
	CURRENT POLICY LOSS RATIO (%)0	**Between 0% - 20%**	**Between 21% - 50%**	**Between 51% - 75%**	**Between 76% - 100%**	**Between 101% - 150%**	**More than 150**
CURRENT POLICY LEVEL	7 (-%20)	7	6	6	5	5	4
	6 (-%10)	7	6	6	5	4	3
	5 (Base)	7	6	5	4	4	3
	4 (+%10)	6	5	4	3	3	2
	3 (+%20)	5	4	3	3	2	2
	2 (+%30)	4	3	3	2	2	2
	***1 (+%50)**	**3**	**3**	**2**	**2**	**2**	**1**

*50% additional premium will be applied for the insurers with loss / premium ratio exceeding 150% in the evaluation of each

year during the last two insurance periods.

When calculating the loss / premium ratio, the values of 0.5 and above are completed to a higher number, eg 0.5 and above 1; 20.5 and above 21; 40,5 and above 41; 60.5 and above is accepted as 61.

For the first time person to have a policy in Anadolu Sigorta starts from the 5th stage. The level of the renewal policy is determined by taking into account the Indemnity / Health Net Premium (Loss ratio) ratio with the policy period stage of the insured.

After the policy renewal, in case of reimbursement of a health expense which is incurred in the previous policy term; the loss premium rate may change for the renewal policy. If discount or additional premium rate changes; the premium difference will be reflected by an endorsement, to the new policy premium.

If the insured who provide savings to our Company by paid expenses of inpatient process over Social Security Institution, is higher than the additional premium to be renewed to the policy to be renewed, the additional premium shall not be applied to the policies to be renewed.

- Additional premium could be taken for these diseases in the following year's renewed policies of the policy holders who have a serious disease until they receive a Lifetime Renewal Guarantee. The additional premium rate, which will be valid every year when the policy is renewed, does not exceed 75% for each disease.
- Expenses of Signs/findings and/or diagnosis and/or treatment and complications related to that emerged before the policy period, if appropriate after the medical underwriting, those could be included with the diseases additional premium with the specified rates. Up to 200% of the base premium can be add with the disease additional premium per disease.

  The initiative belongs to the insurer.
- Children aged 0-17 (including 17) can be insured on their own without their parents under individual health insurance. In this case, the policy can be regulated by applying additional premiums in the following rates;

AGE	ADDITIONAL PREMIUM APPLIED TO THE STANDARD PREMIUMS
0	% 100
1-3	% 50
4-6	% 30
7-17	% 10

  Children 0-17 years of age are required to be insured with at least one of their parents in order to avoid the additional premiums mentioned above.
- Related institution / customer discount; It is a discount for persons working at T. İş Bankası and its subsidiaries, spouses, children, parents and siblings and members of the company or institutions that have a special agreement.
- Individual policies, whose premiums are covered by the same legal entity and where a minimum of 10 employees are covered, are discounted at the rates determined by our Company. This discount is defined separately for each policy.
- Insureds pay additional premium for optional covers added to their policies. No discount is applied to the cover premium.
- Valid for the insured persons whose starting date at Anadolu Sigorta is before the date 27.09.2023 for the policy that is the basis for the evaluation of the lifetime renewal guarantee: The actuarial tariff base premiums of the insureds who has lifetime guarantee will increase by a maximum of 75% in the renewal policy. The maximum increase rate of 75% is determined by the assumption that the inflation rate will not exceed 15%, and if inflation is above that rate, the difference may be added over 75%."

  Valid for the insured persons whose starting date at Anadolu Sigorta is after the date 27.09.2023 for the policy that is the basis for the evaluation of the lifetime renewal guarantee: The increase in the "Health Tariff Premium" of our insured members who have lifetime renewal guarantee is limited to a maximum of three times the previous year's tariff premium in the same plan, provided that it does not remain below the health inflation.
- The premium of the insured varies according to the city of residence.

7.10. TERMINATION PRINCIPLES OF THE INSURANCE AGREEMENT

7.10.1. Premium payments, premium payments irregularity, and cancellation for the request of insurance

The full insurance premium or the first instalment (advance payment) if payment in instalments is accepted, shall be paid immediately after the agreement is executed and at latest against the delivery of policy. Unless otherwise agreed, the liability of the insurer does not commence in the event that the insurance premium or advance payment is not paid even if the policy has already been delivered.

The insured may pay their premiums

- With a credit card order,
- via Türkiye İş Bankası branches,
- Through automated bill payment system provided by Türkiye İş Bankası as an interactive service,
- Direct to the Insurance Company.

Payments made at places other than those specified above, and with methods other than those specified above shall not release the insured of its obligation to pay premium. The insured, who fails to pay the premium required in compliance with article 1431 shall lapse

into default as per article 1434 of Turkish Commercial Code. If the premium, the first instalment or the entire amount of which should be paid at once, has not been paid in due time, the insurer may withdraw from the contract within three months during the period in which the payment is not made. This period shall start with the date of maturity. If the premium receivable is not claimed by suit or through execution proceedings within three months following the date of maturity, the contract shall be deemed to have been withdrawn from. If any one of the subsequent premiums is not paid in due time, the insurer shall warn the insured through the channel of a notary public or by registered mail by giving him/her a period of ten days to fulfil his/her obligations and states that otherwise, the contract shall be deemed to have been terminated at the end of this period. If the subject debt is not paid by the end of this period, the contract shall be deemed to have been terminated. The other rights of the insurer arising from the Turkish Code of Obligations due to the default of the insured shall be reserved. If two warnings were sent to the insured within one insurance term, the insurer may terminate the contract to be effective at the expiry of the insurance term. In case the insured requests in writing the cancellation of the policy;

a. In case the premium paid by the insured is more than the premium earned by the Insured on the basis of days, the Insurer shall return the difference to the insured.
b. In case the premium paid by the insured is less than the premium earned by the Insured on the basis of days, the insured shall pay the difference to the insurer.
c. In case there are outstanding back charges, unpaid despite recourse from the insured, the back charges figure shall be deducted from any returnable premium upon the cancellation of the policy, and the remainder shall be returned to the insured.

7.10.2. Termination of policy due to undeclared diseases or leaving diseases outside the scope of insurance

a. This policy has been issued considering that any information given in the approval form of the insured are complete and true. In case the declaration by the policy holder/insured is incorrect or incomplete, the insurer reserves the right to decline or cancel the contract.
b. The policies of all insured covered under the policy shall be terminated immediately, in case any one of the insured covered under the policy acts in violation of general terms and conditions of the policy or implementation principles, or attempts to willingly benefit from the insurance, and the premiums shall not be revoked or the policy shall continue on the condition that the illnesses known by the insured and not declared in the health report but identified by the insurer at a later date are left outside the policy coverage.

7.10.3. Automatic termination of the policy

The policy of a dependent covered under the medical insurance coverage shall be terminated automatically if any of the following occur;

a. If policy of an insured is terminated due to incomplete and wrong declaration or an illintentioned act, policies of other members of the family shall also be terminated as of the same date.
b. If the contract expires,
c. If dependant is no longer a dependant. (Policy of the spouse of an insured divorced shall be cancelled as of the date of divorce. Policies of married children shall be cancelled as of the date of marriage. In the year single children over age 30 shall be excluded in the family policy during the policy renewal period.)

The above-mentioned persons, if they wish to, may continue their insurance by purchasing any other policy without any interruption for more than 1 month.

7.10.4. Death of Insured

Upon the death of the insured while under treatment for a condition or injury, the expenses incurred for his/her treatment, provided that such are covered in the policy and coverage, shall be paid to legal heirs which submit the required paperwork for indemnity claim. The insurer shall be relieved of all its obligations as of the date on which the indemnity is paid. The policy shall then be terminated, and any unaccrued premium shall be returned on the basis of remaining days in the policy term. In the case of family policies, if the first person in the individual's status dies; the policy shall be canceled as of the date of death. Upon request, a new policy is issued for affiliates by moving all rights from the end date of the other policy.

8. GENERAL TERMS AND CONDITIONS OF HEALTH INSURANCE

SCOPE OF COVERAGE

Article 1

The present insurance pays the expenses required for treatment, and daily damages, if any, within the framework of the present general terms and conditions, and special terms and conditions, if any, up to the figures specified in the policy, in case the insured persons fall ill and/or incur any injuries throughout the term of the insurance.

EXCLUSIONS

Article 2

The illness and/or injury due to any accident, of the insured during the term of the insurance, in the cases described below, shall be excluded from coverage under the insurance.

a. War or any operation having the nature of war, revolution, rebellion, riot or any civil disturbances arising thereof;
b. Criminal acts or attempts at crime,
c. Except from the intention of saving persons and goods in danger, insured's taking actions that would put him/herself in great danger,
d. Use of substances such as heroin and drugs,
e. Any kind of assaults and sabotages that would lead to a nuclear risk or use of nuclear, biological and chemical weapons or release of nuclear, biological or chemical substances,
f. All the damages that would arise from terrorist actions stated in the Anti-Terror Law No.3713 and any consequential sabotages or biological and/or chemical contamination or intoxications occurred as a result of interventions made by authorized bodies in order to prevent such actions or mitigate the effects thereof.
g. Illness or injuries that may come to occur due to attempted suicide by the insured
h. Other exclusions to be provided in the special terms and conditions of the policy.

EXCLUSIONS UNLESS PROVIDED OTHERWISE IN CONTRACT

Article 3

The illness and/or injury due to any accident, of the insured during the term of the insurance, in the cases described below, shall be excluded from coverage under the insurance, unless provided otherwise in the contract.

a. Earthquake, flood, volcanic eruption and land slide.
b. Acts of terror and sabotage defined in Anti-Terror Law No.3713 or operations by authorities in order to prevent such actions or mitigate the effects thereof, excluding the damages specified in sub-paragraph (f) of article 2.

TERRITORIAL LIMITS OF INSURANCE

Article 4

The territorial limits of the insurance shall be specified in the policy.

COMMENCEMENT AND END DATE OF INSURANCE

Article 5

The insurance starts at 12:00 at noon according to Turkey time and ends at 12:00 at noon according to Turkey time unless decided otherwise on such days as prescribed to be the starting and ending dates in the policy.

DECLARATION OBLIGATION OF THE POLICY HOLDER AT THE TIME OF EXECUTION OF THE CONTRACT

Article 6

The insurer has agreed to this insurance relying on the representations of the insuring party written in the proposal and if there is no proposal in the policy and endorsements thereof. The policy holder/insured is under obligation to respond accurately to questions asked in the proposal and complementary documents, and to declare his/her knowledge regarding the issues which constitute the subject matter of the risk or which may affect the assessment of the risk. In case the declaration by the policy holder/insured is incorrect or incomplete, and in cases which require the insurer to refrain from executing the contract or which require harsher terms;

a. The insurer may withdraw from the contract within one month of coming to learn the facts, and may not pay indemnity to the insured in case the policy holder/insured has acted with malintent. The insurer shall still earn the premium in case of withdrawal.
b. In case the policy holder/insured had not acted with mal-intent, the insurer shall terminate the contract within 1 month following the date it became aware of the facts, or may maintain the contract in force by collecting additional premium. In case the policy holder/insured provides notification to refuse to pay the additional premium, within 8 days, the contract shall be deemed terminated.

The termination notice served by the insurer via return registered mail or notary public shall become valid at 12:00 on the fifth work day following the notification date of the policy holder/insured. The premium for the time until the effective date of the termination shall be calculated on a daily basis and the excess shall be returned.

a. The right to withdrawal, termination, or request additional premium shall lapse unless exercised within the period specified.
b. In case the policy holder/insured had not acted with mal-intent, upon the occurrence of the risk:
    1. Before the insurer becomes aware of facts, or
    2. Within the period in which the insurer may serve notification of termination, or
    3. Within the period required for the notification to be valid;

The insurer shall affect a discount on the indemnity to the rate of the difference between the actually accrued premium and the premium that should have been accrued.

OBLIGATION TO REPORT WITHIN THE INSURANCE PERIOD

Article 7

In case of any change after the execution of the contract, in the matters specified in the proposal, or in the policy and its annexes if no proposal is present, the policy holder shall be under obligation to report the case to the insurer, within a maximum period of 8 days. Upon learning about the change, the insurer, should the change require the insurer to refrain from executing a contract or to impose harsher terms, may, within 8 days;

Upon learning about the change, the insurer, should the change require the insurer to refrain from executing a contract or to impose harsher terms, may, within 8 days;

1. Terminate the contract, or
2. Keep the contract in force by demanding additional premium.

In case the policy holder provides notification to refuse to pay the additional premium, within 8 days, the contract shall be deemed terminated.

The termination notice served by the insurer via return registered mail or notary public shall become valid at 12:00 on the fifth work day following the notification date of the policy holder.

The premium for the time until the effective date of the termination shall be calculated on a daily basis and the excess shall be returned. The right to terminate or ask for a Premium difference, which is not exercised within the specified period, shall lapse.

In case the insurer, upon learning about the change, does not terminate the contract within eight days, or acts in a manner to confirm its consent to maintain the insurance contract as is, such as collecting insurance premium, its right to termination or demand additional premium shall lapse

PAYMENT OF INSURANCE PREMIUM, COMMENCEMENT OF THE LIABILITY OF THE INSURER, AND DEFAULT BY THE INSURED

Article 8

The full insurance premium or the first instalment (advance payment) if payment of the Premium in instalments is accepted, shall be paid immediately after the agreement is executed and at latest against the delivery of policy. Unless otherwise agreed, the liability of the insurer shall not commence in the event that the insurance premium or advance payment is not paid even if the policy has already been delivered, and this matter shall be specified on the cover of the policy. In case the policy holder does not pay the insurance premium or the advance payment on the premium if payment in instalments is accepted, before the end of the day on which the insurance policy was delivered, it shall be considered in default. In case the premium obligation is not paid even in the 30 days period following the date of default, the insurance contract shall be terminated without any further notice. In cases where it is accepted that the liability of the insurer shall commence with the delivery of the policy, even if the premium is not paid, the liability of the insurer shall remain in effect in the first fifteen days of the abovementioned one month period.

The final payment dates for instalments in case instalment payments are accepted, as well as the consequences of nonpayment on the specified dates shall be noted on the policy, and the policy holder shall be informed of such in writing, along with the policy. The policy holder shall be in default in the event that it fails to pay any premium instalments before the end of the due date which had been specified on the policy or notified to itself in writing. The insurance coverage shall be suspended in case the policy holder does not pay the premium obligation within fifteen days following the default. The coverage shall commence from the date of suspension, in case the premium obligation is paid during the suspension of the coverage, provided that the risk has not occurred yet.

In case the premium obligation is not paid within 15 days following the suspension of insurance coverage, the insurance contract shall be terminated without further notification. If provided for on the cover of the policy, the premium instalments yet to become due, shall become due upon the occurrence of the risk, to the amount not exceeding the indemnity to be paid by the insurer. In case the insurance contract

OBLIGATIONS OF THE INSURED UPON OCCURRENCE OF THE RISK
Article 9

A. Risk occurrence notification:
   I. The policy holder / insured shall be under obligation to report in writing to the insurer, within eight days after becoming aware of the risk occurrence, or in any case after becoming able to report.
   II. The policy holder / insured shall be under obligation to state in the said report, the place, date, and causes of the accident or illness, and also obtain and submit to the insurer a report by the physicians that apply the treatment, attesting the state of the accident or illness, and potential results thereof.

B. Commencement of treatment and taking necessary measures:
   It is obligatory to commence treatment immediately after the accident or illness, and to take measures required for the recovery of the injured or patient.
   The insurer shall be entitled to have the injured or patient examined or checked for his/her health at all times, and it is mandatory to allow the execution of such examinations or controls.
   It is also mandatory to comply with the recommendations, which may directly affect the results of the accident or illness, by the physician of the insurer on the recovery of the injured or patient.
   Upon failure to abide by the obligations specified in paragraphs (A) and (B) above;
   a. Wilfully, the rights to arise out of the policy shall disappear.
   b. Due to negligence, and in case the results of the accident get more severe because of said negligence, the insurer shall not be held liable for the excess.
   c. Delivery of required documents

The policy holder or the insured are under obligation to deliver with the firm notification and treatment forms to be filled out by the physician or hospital that carries out the treatment, the originals or copies beyond doubt of the documents which attest the examination, treatment, medicine and hospital expenses required to be paid due to the accident or illness.

DETERMINATION OF EXPENSES
Article 10

The present insurance shall provide coverage up to the limits specified in the policy for expenses incurred by the policy holder due to the occurrence of the covered risks, along with the Daily damages, if any.

In the following cases, the insurer shall not fulfil the demands regarding the expenses:

a. Expenses which were not called for as part of the work, and claims exceeding reasonable figures on the basis of a special agreement,
b. Expense claims in breach of special terms and conditions of insurance,

In case the parties do not concur on the expense figures, the figure shall be established by persons to be appointed by the professional organizations of physicians, if any, or elected among experts, and which will be called arbitrator-expert, on the basis of the following provisions.

a. İln case both parties fail to agree on the appointment of a single arbitrator-expert, both shall appoint its own arbitratorexpert, and shall notify the other about the event via the notary public. Within seven days following the appointment of arbitrator-experts, and before commencing review, the parties shall elect a third and neutral arbitrator-expert, and establish the event in a minute. The third arbitrator-expert is authorized to decide only on matters where the arbitrator-experts appointed by parties cannot agree on, and within the limits and scope of the said disagreement. The third arbitrator-expert may submit his/her decision in a separate report, or may incorporate it in a report with other arbitrator-experts.
   The reports by arbitrator-experts shall be simultaneously notified to the parties.
b. In case a party does not appoint its arbitrator-expert within 15 days following the notification by the other party, or in case the arbitrator-experts of parties fail to agree on the election of the third arbitrator-expert within a period of seven days, the arbitrator-expert of the party or the third arbitrator-expert shall be elected by the chief justice of the court with jurisdiction over commercial cases at the place of treatment, among impartial experts.
c. Both parties are entitled to request the election of the third arbitrator-expert from a place other than the residence of the insurer or the insured, or the place where the treatment took place, regardless of whether the said person is elected by the arbitrator experts of parties or by the chief justice of the court with jurisdiction. Requests in this respect should be fulfilled.
d. Upon the death, resignation, or refusal of an arbitrator-expert, the replacement for the previous arbitrator-expert shall be elected in accordance with the same principles, and the determination shall resume from its existing stage. The death of the insured shall not relieve the appointed arbitrator-expert from his/her duty. The right to raise objections against arbitratorexperts on the grounds of non-qualification shall lapse unless exercised within seven days after learning about the relevant person.
e. The arbitrator-experts may request evidence, records, and documents they shall deem necessary for determining the

expenses, and may carry out investigations on the site of the treatment.

f. The decisions by the arbitrator-expert(s) or the third arbitrator-expert on the matter of expense shall be final and binding for the parties. Claims shall not be demanded from the insurer, and the insurer cannot be sued without an arbitrator-expert decision. Objections against arbitrator-experts and their decisions may be raised only in case it is clear that the decisions are substantially incompatible with the facts at hand, and the annulment of decisions may be requested from the court with jurisdiction over commercial cases at the place of treatment, within one week following the notification about the report.
g. Unless the parties agree on the indemnity figure, the damages shall become due only through a decision of arbitratorexperts, and the statutory limitations shall not apply before the delivery of the final report to parties. provided that two years has not passed between the appointment of arbitrator-experts and the notification period as stipulated in article 1446 of Turkish Commercial Code.
h. The parties shall pay for the remunerations and expenses of the arbitrator-expert they appoint. The remunerations and expenses of the third arbitrator-expert shall be shared equally among the parties.
ı. The determination of the expense shall not affect the provisions and terms and conditions specified in the present policy and regulations, on the risks covered, sum insured, insurance amount, commencement of liability, causes to lapse or reduce rights, as well as the claiming thereof.

RESULTS OF INDEMNIFICATION AND THE SUBROGATION BY THE INSURER
Article 11

The insurer shall subrogate the insured before any liable third parties, to the amount it has paid for treatment costs.

CO-INSURANCE
Article 12

In case treatment costs are guaranteed by more than one insurer, such expenses shall be shared among the insurers, to the rate of the coverage each provides.

CONFIDENTIALITY
Article 13

The insurer shall be liable for the damages to arise due to not keeping confidential the secrets it may come to learn about the policy holder/insured.

NOTIFICATION AND NOTICES
Article 14

The notifications and notices by the policy holder shall be sent in writing or through notary public, to the headquarters of the Insurance Company or to the agent which serves as the broker for the insurance contract.

The notices and notifications of insurer firm shall be made to the address of policy holder stated in the policy; in the event that this address changes, then to the headquarters of the insurance company or the address last notified to the agency acting as the broker to the insurance agreement.

JURISDICTION
Article 15

The competent court for the lawsuits to be initiated against the insurer firm for disputes arising out of the present policy shall be the court with jurisdiction over commercial cases at the place where the registered office of the insurance firm is or the domicile address of the agency acting as an intermediary for the insurance agreement, or at the place of damage, and for the lawsuits to be initiated by the insurer firm, shall be the court with jurisdiction over commercial cases at the domicile address of the defendant.

STATUTE OF LIMITATIONS
Article 16

All claims to arise out of the insurance contract shall be subject to a statute of limitations of two years.

SPECIAL TERMS
Article 17

The policies may also incorporate special terms and conditions which do not conflict with the present general terms and conditions and clauses regarding thereof.

NOTIFICATION FORM AND PARTICIPATION CERTIFICATE FOR GROUP AND FAMILY INSURANCES
Article 18

It's a requirement that people insured under the scope of group contract are provided with notification form and participation certificate. Notification form and participation certificate are provided against signature and a signed copy is kept at the

company.

Notification form is provided before insured is included into group contract; participation certificate is provided within fifteen days from inclusion of insured to group contract.

However; where it's beside the point that insurer and insured meet physically or required by the content of work, notification form and participation certificate can be provided within the periods specified above via the electronic media or similar tools enabling access for insured. If written approval of insured regarding information share of the insured can't be procured via notification form and participation certificate provided against signature, then it's procured by a proposal or a deed of consent or such other method. The burden of proof that notification form and participation certificate were provided and approval regarding share of information were received belongs to Insurer. One copy of each of notification form and participation certificate are uploaded to his/her personal page which insured can access via company webpage. Policy holder provides any type of convenience in order for insurer to duly meet its obligation to provide notification form and participation certificate.