-*- Demonstration Powered by OpenText Exstream 10/01/2025, Version 16.6.30 64-bit (DBCS) -*-

MAPFRE Sigorta

SPECIAL TERMS FOR THE HEPSİ BİRLİKTE HEALTH INSURANCE

These special terms and conditions shall be applicable as of 01.09.2025 to individual insureds holding the Hepsi Birlikte (All Together) Health Insurance policy.

ARTICLE 1 – SUBJECT OF THE INSURANCE

MAPFRE Sigorta A.Ş. ("Insurer") undertakes to cover the healthcare expenses of the Insured arising from accident and/or illness/disease during the term of the insurance contract, within the scope of the coverages, limits, co-payment rates, exclusions (general and special exclusions), and network specified in the Policy, and in accordance with these Special Terms and Conditions, the General Terms and Conditions of Health Insurance attached hereto, the Private Health Insurance Regulation, the Turkish Commercial Code, and the applicable Insurance and Healthcare Legislation.

This Policy is issued to provide coverage for inpatient treatments within the private health insurance (Özel Sağlık Sigortası – ÖSS) network held by the Insured, and for outpatient diagnosis/treatment procedures within the supplementary health insurance (Tamamlayıcı Sağlık Sigortası – TSS) network. Insurance coverage shall only apply to the persons listed in the Insurance Policy; no other persons shall benefit from the coverage.

ARTICLE 2 – DEFINITIONS

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

EMERGENCY: Situations such as sudden illness, accident, injury, or similar cases that require medical intervention within the first 24 hours following the occurrence of the event, where it is accepted that failure to provide immediate medical intervention or to transfer the patient to another healthcare institution would pose a risk of loss of life and/or impairment of health integrity. Treatments administered after the emergency has been stabilized are not considered within this scope. Below are the emergency health conditions as defined by the World Health Organization (WHO).

1. Drowning
2. Traffic accident
3. Terrorism, sabotage, gunshot wounds, stabbing, physical assault, etc.
4. Falls from height
5. Severe occupational accidents, amputations
6. Electric shock
7. Frostbite, hypothermia
8. Heat stroke
9. Severe burns
10. Severe eye injuries
11. Poisonings
12. Anaphylactic shock
13. Spinal and upper/lower extremity fractures due to trauma
14. Heart attack, hypertensive crises
15. Acute respiratory problems
16. Any organic disorder causing loss of consciousness
17. Sudden paralysis (stroke)
18. Severe impairment of general condition
19. High fever above 39.5°C
20. Diabetic and uremic coma
21. Acute abdomen
22. Acute massive hemorrhages
23. Meningitis, encephalitis, brain abscess
24. Renal colic

JUDICIAL ACCIDENT: An unexpected and sudden event occurring during the validity period of the Policy, resulting in bodily injury to the Insured, which requires and/or has been subject to investigation and prosecution by judicial authorities. The event must be documented by the investigating authorities.

CONTRACTED PHYSICIAN: Physicians employed in a Contracted Healthcare Institution who have accepted the contractual terms of MAPFRE Sigorta, or physicians who have a direct agreement with MAPFRE Sigorta.

NON-CONTRACTED PHYSICIAN: Physicians employed in a Non-Contracted Healthcare Institution, or those employed in a Contracted Healthcare Institution but who have not accepted the contractual terms of MAPFRE Sigorta.

Sistem Tarihi: 2025-10-01 13:06:31

Büyük Mükellefler V.D.: 879 001 8869 Sicil No: 38676

-*- Demonstration Powered by OpenText Exstream 10/01/2025, Version 16.6.30 64-bit (DBCS) -*-

SPECIAL TERMS FOR THE HEPSİ BİRLİKTE HEALTH INSURANCE

CONTRACTED HEALTHCARE INSTITUTION: Hospitals, clinics, laboratories, diagnostic and treatment centers, pharmacies, and physicians with which the Insurer has entered into an agreement, in accordance with the Policy Terms and Conditions, to provide healthcare services to the Insured. The applicable limits and coverage percentages for Contracted Institutions are specified in the Policy. The list of Contracted Institutions can be accessed at www.mapfre.com.tr
Since this list is subject to continuous updates, confirmation should be obtained before receiving services.

NON-CONTRACTED HEALTHCARE INSTITUTION: Hospitals, clinics, laboratories, diagnostic and treatment centers, pharmacies, and physicians that do not have an agreement with the Insurer. Physicians employed at a Contracted Institution but who have not accepted the contractual terms of MAPFRE Sigorta are also deemed “Non-Contracted Institutions.” It is the responsibility of the Insured to verify whether the physician of their choice, even if employed at a Contracted Institution, is contracted with MAPFRE.

OUTPATIENT TREATMENT COVERAGE: Coverage for services provided under this Policy that do not require hospitalization, inpatient treatment, or observation.

COMMENCEMENT DATE: The day, month, and year on which the Policy first takes effect, or, where applicable, on each subsequent renewal, at 12:00 noon (Turkey local time).

EXPIRY DATE: The day, month, and year on which the term of this Policy ends, at 12:00 noon (Turkey local time). All expenses incurred after this date, regardless of reason, are excluded from coverage. However, if an Insured is undergoing inpatient treatment and has not been discharged from the hospital as of the Policy Expiry Date, expenses may be covered for up to 10 days thereafter.

WAITING PERIOD: The period commencing on the Insured’s Enrollment Date, during which the medical procedures/interventions specified in the Policy as subject to a waiting period are not covered.

UNDECLARED PRE-EXISTING CONDITION: Any complaint, symptom, disease/illness, or related complications existing and known prior to or at the time of application for this Policy, regardless of whether diagnosed, that has not been declared to the Insurer.

PHYSICIAN: A person licensed by the Ministry of Health of the Republic of Turkey and officially authorized, under the laws applicable in the geographical area where healthcare is provided, to practice medicine and hold the title and credentials of a medical doctor.

GENERAL TERMS AND CONDITIONS: Written rules determined by the Republic of Turkey Ministry of Treasury and Finance, which are mandatory for all insurance companies to apply in health insurance policies.

UNNECESSARY TREATMENTS: Expenses related to inpatient treatments without medical indication, as determined by the MAPFRE Sigorta Medical Procedures Center based on hospital reports, and diagnostic and treatment procedures unrelated to any specific complaint and/or illness (e.g., check-ups, routine examinations, etc.).

CLAIM PREMIUM RATIO: The ratio of the Insured’s total paid and outstanding claims during the policy term to the premium. Also referred to as the Loss Ratio / Health Net Premium (T/P).

Sistem Tarihi: 2025-10-01 13:06:31

Büyük Mükellefler V.D.: 879 001 8869 Sicil No: 38676

-*- Demonstration Powered by OpenText Exstream 10/01/2025, Version 16.6.30 64-bit (DBCS) -*-

SPECIAL TERMS FOR THE HEPSİ BİRLİKTE HEALTH INSURANCE

HOSPITAL: A public or private institution officially licensed as a hospital, providing medical services to patients and injured persons within its field of activity. Clinics providing only outpatient treatment, sanatoriums, physiotherapy centers, health clubs, nursing homes, rest homes, and institutions specialized in substance (drug, alcohol) addiction are not considered within the definition of a hospital.

HUV (Physicians' Practice Database): A tariff published by the Turkish Medical Association, setting out the fees and practice principles for doctors practicing within the Republic of Turkey. The fee is calculated by multiplying the "unit value" determined for each medical procedure in the HUV with the general coefficient specified separately for each province.

ADDITIONAL CHARGES: In accordance with Article 73 of Law No. 5510 on Social Insurance and General Health Insurance, the difference fees charged to individuals by foundation universities and private healthcare institutions contracted with the Social Security Institution, based on the amounts invoiced to the Institution, provided that they do not exceed the percentage determined by the Institution over the total healthcare service fees specified in the Healthcare Implementation Communiqué (SUT) and its annexes.

CANCELLATION DATE: The day, month, and year on which the Policy is canceled either upon the written request of the Policyholder or by the Insurer due to withdrawal or termination under the circumstances set forth in the General Terms and Conditions.

CO-PAYMENT: The amount to be paid during examination by the general health insured or their dependents in order to benefit from healthcare services, as stipulated under Law No. 5510 on Social Insurance and General Health Insurance.

ENROLLMENT DATE: The day, month, and year (at 12:00 noon Turkey local time) on which the Insured is first covered under the Insurance Policy or under the first Contract issued pursuant to the conditions defined in the renewal clause.

ACCIDENT: An unexpected and sudden event causing bodily injury to the Insured, which can be medically substantiated.

RED ZONE: Situations classified as "red zone" according to the criteria of the Social Security Institution (SGK), which are life-threatening and require immediate, simultaneous evaluation and aggressive emergency treatment.

COMPLICATION: Undesired effects of a disease, illness, or medical treatment.

CONGENITAL DISEASE: Bodily and/or metabolic defects and/or disorders present from birth.

CHRONIC DISEASE: A disease that does not have a sudden onset, develops and/or progresses slowly, and causes recurring or continuous health problems.

MEDICAL PROCEDURES CENTER: A unit within MAPFRE Sigorta, staffed by specialists providing 24/7 service, which evaluates, within the scope of the Policy Terms and Conditions, the payment of healthcare expenses for Insureds applying to Contracted Healthcare Institutions.

Sistem Tarihi: 2025-10-01 13:06:31

Büyük Mükellefler V.D.: 879 001 8869 Sicil No: 38676

-*- Demonstration Powered by OpenText Exstream 10/01/2025, Version 16.6.30 64-bit (DBCS) -*-

SPECIAL TERMS FOR THE HEPSİ BİRLİKTE HEALTH INSURANCE

REINSTATEMENT: The reinstatement of the Insurance Policy following its cancellation, upon evaluation by the Insurer. Applications made within 1 month from the date of cancellation may be considered for reinstatement. For such evaluation, the Insurer reserves the right to request an application form from the Insured, to apply special exclusions and/or an additional risk premium specific to the Insured regardless of whether the Insured holds the Lifetime Renewal Guarantee (LRG), or to reject the reinstatement request.

NETWORK (TYPE OF CONTRACTED INSTITUTION): The grouping of Contracted Healthcare Institutions as determined by MAPFRE Sigorta. Each policy specifies the network type applicable for each coverage. Institutions outside the network relevant to the coverage shall be considered "Non-Contracted Healthcare Institutions" for that Policy and/or coverage, even if they are among MAPFRE's Contracted Healthcare Institutions. All institutions listed in the "Contracted Healthcare Institution" list constitute the MAPFRE Sigorta network. MAPFRE Sigorta reserves the right to modify its contracted institutions or to remove any institution entirely from the network during the policy period.

SPECIAL TERMS AND CONDITIONS: Provisions prepared by the Insurer in addition to the General Terms and Conditions of Health Insurance, defining mutual rights and obligations, coverages, and validity conditions, effective until the expiry date of the Policy.

PRE-AUTHORIZATION: The Insurer's assessment indicating whether, and under what conditions, the healthcare services (inpatient admission, surgical hospitalization, medical examinations, diagnostic procedures, etc.) to be provided at Contracted Healthcare Institutions under the Insured's policy will be covered.

RISK: The occurrence of any illness/disease that may create an indemnity obligation for the Insurer.

ADDITIONAL RISK PREMIUM (DISEASE LOADING): An additional premium applied for disease-related risks, as specified in the Policy annex, and applied only to the relevant Insured. The applied additional premiums are indicated in the Insured's policy, with their reasons and rates.

POLICYHOLDER: The person or legal entity who applies for the Insurance Policy, whose application is accepted by the Insurer, and who acts on behalf of themselves and the Insured Persons within the scope of this Insurance Policy, bearing responsibility accordingly.

INSURANCE POLICY: A document issued by the Insurer in a specific format, containing details regarding the term, special and general conditions, limits, exclusions, implementation guidelines, and payment terms of the policy, guaranteeing the payment of benefits within the specified limits if the insured event occurs, and bearing the authorized signatures of the company.

INSURER: The insurance company registered and licensed to operate in the country where the Insurance Policy is issued. In this Policy, the term “Insurer” refers to MAPFRE Sigorta A.Ş.

INSURED: The person(s) specified in the health insurance application of the Policyholder and/or Insured Persons, or subsequently added and accepted by the Insurer, who are covered under the Policy or through an endorsement attached thereto.

INSURED-SPECIFIC EXCLUSIONS: Exclusions decided and applied by the Insurer for the Insured, which are specified on the Insurance Policy.

Sistem Tarihi: 2025-10-01 13:06:31

Büyük Mükellefler V.D.: 879 001 8869 Sicil No: 38676

-*- Demonstration Powered by OpenText Exstream 10/01/2025, Version 16.6.30 64-bit (DBCS) -*-

SPECIAL TERMS FOR THE HEPSİ BİRLİKTE HEALTH INSURANCE

PERSONS TO BE INSURED: The Policyholder themself or their employees, spouse, unmarried children under the age of 18, or children under the age of 25 who are full-time university students and not engaged in freelance or paid employment.

STANDARD EXCLUSIONS: General exclusions that apply to all coverages and Insureds, as specified in the Special Terms and Conditions.

SAGMER (Insurance Supervision Center): The Insurance Supervision Center established to collect data in the health insurance sector in a centralized system, ensuring more comprehensive and effective insurance operations, sector-wide standardization of practices, accurate pricing, prevention of abuses, creation of reliable statistics, strengthening trust in the insurance system, and enhancing public oversight and supervision.

HEALTH INSURANCE PATIENT INFORMATION FORM: A form completed by the doctor consulted by the Insured, enabling the Insured to benefit from the coverages of the Policy during its validity period. For inpatient treatments at non-contracted institutions where this form is not available, the Insured must obtain the Patient Information Form from the Insurer and keep it on hand. This form is required for the assessment of healthcare expenses.

HEALTH IMPLEMENTATION COMMUNIQUÉ (SUT): A communiqué issued under Law No. 5510 and the Regulation on General Health Insurance Transactions, covering the principles and procedures for benefiting from healthcare services financed by the Social Security Institution (SSI) — including healthcare services, travel, daily allowances, and companion expenses — and setting forth the reimbursable amounts determined by the Healthcare Services Pricing Commission.

COVERAGE: The scope of healthcare expenses undertaken by the Insurer to be paid under the Insurance Policy, within the limits, exclusions, waiting periods, and deductibles specified in the special and general conditions of the Policy.

RENEWAL: The continuation of insurance whereby the Policyholder applies to the Insurer to renew the existing Insurance Policy within 30 days before or after its expiry date, and both the Insurer and the Policyholder mutually agree on the terms of the new Insurance Policy to ensure uninterrupted coverage.

RENEWAL DATE: The date (day, month, and year, at 12:00 noon Turkey time) on which the new Insurance Policy commences, coinciding with the expiry date of the previous Insurance Policy.

ANNUAL AGGREGATE LIMIT: The maximum annual gross amount that the Insurer is obligated to cover during the Insurance Policy period, as specified in the terms of this Policy. Co-payments and/or deductibles payable by the Insured are included in the gross amount.

MAPFRE CUSTOMER SERVICE: The call center available at **0850 755 0 755**, where Insureds may submit suggestions, requests, and complaints, as well as access various services such as ambulance assistance and medical consultation.

MAPFRE GO: The mobile application of MAPFRE Sigorta through which Insureds can obtain detailed information regarding coverage terms, claims management, coverage limits, and their policies.

MAPFRE SIGORTA WEBSITE: The corporate website of MAPFRE Sigorta where Insureds can access the Policy special terms, contracted institutions, and many other details (www.mapfre.com.tr).

Sistem Tarihi: 2025-10-01 13:06:31

Büyük Mükellefler V.D.: 879 001 8869 Sicil No: 38676

-*- Demonstration Powered by OpenText Exstream 10/01/2025, Version 16.6.30 64-bit (DBCS) -*-

SPECIAL TERMS FOR THE HEPSİ BİRLİKTE HEALTH INSURANCE

ARTICLE 3 – COVERAGES

3.1 Inpatient Treatment Coverage

Inpatient Treatment Coverage, provided that it is medically necessary and explicitly stated by the attending physician in his/her report, covers medical, surgical, and intensive care hospitalizations, emergency healthcare expenses that may pose a life-threatening risk to the Insured, minor surgical interventions, chemotherapy, radiotherapy, and dialysis expenses, in accordance with the general and special terms and conditions. Treatments requiring hospitalization exceeding 24 hours for the Insured are included under this coverage.

Except for emergencies, in cases requiring a planned hospitalization and/or surgery, the “Private Health Insurance Patient Information Form” completed by the physician who will perform the surgery or inpatient treatment, together with test results, must be submitted to the Medical Procedures Center at least 48 hours prior to hospitalization. The Insurance Company will then evaluate and decide whether the treatment expenses will be covered under the Policy.

In addition, starting from the Insured’s first date of enrollment under the health insurance policy, the lifetime limit for inpatient hospitalization is restricted to 720 days. If this limit is exceeded and the Policy does not include a Lifetime Renewal Guarantee, inpatient treatment coverage under the Policy ceases and renewal of the Policy for that term will not be allowed. For Insureds who hold a Lifetime Renewal Guarantee, no Lifetime Hospitalization Limit is applied

3.1.1 Internal Medicine Hospitalization Coverage

Provided that hospitalization exceeding 24 hours is medically necessary and explicitly stated in the physician’s report, all non-surgical hospitalizations and phototherapies, as well as expenses for emergency healthcare situations that may pose a life-threatening risk to the Insured, are covered under this benefit.

3.1.2 Surgical Hospitalization Coverage

All surgical interventions performed during hospitalizations exceeding 24 hours, provided that their medical necessity is explicitly stated in the physician’s report, as well as emergency healthcare expenses that may pose a life-threatening risk to the Insured, are covered under this benefit.

Among coronary angiographies and biopsies, only kidney, brain, bone marrow, and liver biopsies are evaluated within the limits and coinsurance rates of this coverage.

Pregnancy-related complications such as ectopic pregnancy and hydatidiform mole are evaluated within the limits and coinsurance rates of this coverage without the application of any waiting period.

In the event that multiple surgical procedures are performed in the same session through the same or different incisions, and one of the procedures is excluded from coverage, the total invoice (including all hospitalization and physician fees) is proportionally calculated based on the HUV Tariff. The proportional calculation is made over the total procedural points determined without applying the incision rule under the HUV Tariff for surgical interventions.

3.1.3 Room and Companion Coverage

For each case requiring inpatient treatment, the expenses for room and one companion (limited to one person) per full day are covered under this benefit, within the limits specified in the Policy and in accordance with the Special and General Conditions of the Policy. Luxury or suite room expenses are not covered; the benefit is strictly limited to the cost of a single standard room. Companion expenses for Insureds receiving treatment in intensive care units are excluded from coverage.

Sistem Tarihi: 2025-10-01 13:06:31

Büyük Mükellefler V.D.: 879 001 8869 Sicil No: 38676

-*- Demonstration Powered by OpenText Exstream 10/01/2025, Version 16.6.30 64-bit (DBCS) -*-

SPECIAL TERMS FOR THE HEPSİ BİRLİKTE HEALTH INSURANCE

3.1.4 Intensive Care Coverage

Services provided in the intensive care unit are covered under this benefit. Unless otherwise stated in the Policy, the intensive care hospitalization period is limited to 90 days and is evaluated within a total hospitalization period of 180 days during the Policy term. If these limits are exhausted, coverage for hospitalization-required treatments under the Policy will be suspended until the end of the Policy term. The day limits set for intensive care hospitalization and daily hospitalization are reset and reassessed at the beginning of each renewed Policy period.

3.1.5 Surgeon and Physician Fees

For all treatments covered under Inpatient Treatment Coverage: if the attending physician (including anesthesiologists and assistant physicians) is a Contracted Doctor, the physician's fees will be reimbursed in accordance with the limits and coinsurance rates of the Contracted Healthcare Institution specified under this benefit. If treatment is provided by a Non-Contracted Doctor, the limits and coinsurance rates for Non-Contracted Healthcare Institutions under this benefit will apply.

The fees paid by the Insured for non-contracted doctors must be submitted to the Insurer along with the Patient Information Form and its attachments for evaluation. The relevant invoices must be issued as e-invoices, professional service receipts, and/or POS slips prepared in compliance with the Tax Procedure Law (VUK).

Fees for the surgeon, anesthesiologist, and assistants must be invoiced separately. These fees cannot be included together on the same e-invoice, professional service receipt, or VUK- compliant POS slip; documents issued otherwise will not be processed by the Insurer.

3.1.6 Minor Intervention Coverage

Minor interventions defined in the HUV (Medical Practice Database) Tariff published by the Turkish Medical Association, up to and including 199 units, as well as procedures such as dressing, injections, IV infusions, ear irrigation, casting (including those exceeding 199 units), oxygen administration, abscess drainage, gastric lavage, enema, catheterization, nail extraction, all types of cauterization, endometrial curettage, probe curettage, fractional curettage, dilatation curettage (even when performed for therapeutic purposes), cryotherapy, all types of pain management interventions, and the removal of all benign skin tumors regardless of size or number, are covered under this benefit, provided that the medical necessity is documented in a physician's report and approved by the MAPFRE Sigorta Medical Procedures Center (MPC). Coverage is subject to the limits, coinsurance rates, and other special and general conditions specified in the Policy.

3.1.7 Ambulance

If, due to a covered illness or accident, the Insured requires transportation from the place of incident by a locally licensed ground ambulance to the nearest fully equipped hospital, or—if deemed medically necessary by the attending physician and approved by MAPFRE Sigorta Medical Procedures Center (MPC)—to another hospital in a different city, the ground ambulance expenses shall be covered under this benefit in accordance with the limits and coinsurance rates specified in the Policy, and subject to the Special and General Conditions. Expenses incurred from non-contracted ambulance services will be reimbursed according to the limits and coinsurance rates specified for Non-Contracted Healthcare Institutions under this benefit.

Air ambulance expenses are covered only within the borders of the Republic of Türkiye, if in an Emergency Situation it is not possible to transport the Insured by road to the nearest fully equipped healthcare institution, and provided that the transfer is approved by the MAPFRE Sigorta Medical Procedures Center (MPC).
All ambulance services are subject to the definition of Emergency Situations.

Sistem Tarihi: 2025-10-01 13:06:31

Büyük Mükellefler V.D.: 879 001 8869 Sicil No: 38676

-*- Demonstration Powered by OpenText Exstream 10/01/2025, Version 16.6.30 64-bit (DBCS) -*-

3.1.8 Chemotherapy, Radiotherapy, and Dialysis Coverage

Expenses related to chemotherapy and radiotherapy (including physician, room-attendant, medication, venous port insertion, etc.), required blood tests prior to such procedures, as well as the evaluation and treatment of complications occurring after such procedures, are covered under this benefit in accordance with the Policy's Special and General Conditions.

In addition to cancer treatments, medications containing the active ingredient interferon alpha (e.g., Roferon-A or Intron-A) and peginterferon alpha (e.g., Pegasys or Pegintron) used in the treatment of Hepatitis C are also covered under this benefit.

Examinations and diagnostic tests performed to evaluate the course of the illness before or after chemotherapy/radiotherapy are covered, where applicable, under the Outpatient Treatment Coverage and not under this benefit.

Expenses for chemotherapy drugs not licensed in Türkiye are reimbursed under this benefit only if such drugs are FDA (Food and Drug Administration) approved, invoiced by the Turkish Pharmacists' Association, and related to the Insured's current medical condition.

In Contracted/Non-Contracted Healthcare Institutions, the fees payable to a Non-Contracted Doctor for services within this benefit will be assessed in accordance with Article 3.1.5 of the Policy's Special Conditions.

3.1.9 Dental Treatment Coverage Resulting from Accidents

Dental treatment expenses related to dental or jaw surgery performed by dentists, and the replacement of teeth resulting from a traffic accident or judicial accident (provided that an official accident report issued by the relevant authority is submitted and treatment is completed within 90 days following the accident), are covered under the Surgical Hospitalization Coverage. Precious metals used in implants and crowns in such treatments will not be covered under the Policy.

3.1.10 Medication and Consumables Coverage

Expenses for medication and consumable supplies used during medical or surgical hospitalizations under the Inpatient Treatment Coverage are covered under this benefit, within the limits specified in the Policy and subject to the Special and General Conditions.

3.1.11 Artificial Limbs/Prostheses Coverage

Expenses related to supportive prostheses, externally attached prostheses (even if mandatorily applied during surgery), and artificial limbs (such as eye, hand, arm, or leg), which become medically necessary due to an operation and/or accident occurring after the Policy Commencement Date, and are documented by the attending physician and approved by the MAPFRE Sigorta Medical Procedures Center (MPC), shall be covered under this benefit, within the limits and coinsurance rates specified in the Policy and subject to the Special and General Conditions.

Expenses for breast/testicular prostheses required after cancer treatments that fall under the scope of coverage will be reimbursed under the artificial limb benefit, subject to the limits and conditions specified in the Policy.

Any type of prosthesis applied for cosmetic purposes shall be excluded from coverage.

3.1.12 Home Medical Care Coverage

For the Insured to benefit from the Home Medical Care Coverage, they must have a condition covered under the Policy and meet at least one of the following criteria: tracheostomy, frequent orotracheal aspiration requirement, need for enteral nutrition, requirement for TPN/IV fluid support, dependence on a ventilator, advanced-stage oncology patient status, or ongoing application of a pain management protocol.

Sistem Tarihi: 2025-10-01 13:06:31

Büyük Mükellefler V.D.: 879 001 8869 Sicil No: 38676

-*- Demonstration Powered by OpenText Exstream 10/01/2025, Version 16.6.30 64-bit (DBCS) -*-

SPECIAL TERMS FOR THE HEPSİ BİRLİKTE HEALTH INSURANCE

The purchase costs of materials/devices to be used under this coverage are excluded from coverage. If necessary, only rental costs shall be considered within the scope of this benefit, and the number of rental days for the rented device/material shall be deducted from the home care day limit.

If deemed medically necessary by the treating physician and approved by the MAPFRE Medical Procedures Center (MPC), the Insured's Home Medical Care expenses shall be covered in accordance with the limits and coinsurance rates specified in the Policy, for a maximum of 90 days, subject to the Special and General Conditions. This day limit shall not be deducted from the annual 180-day hospitalization limit defined under the Inpatient Treatment Coverage of the Policy.

3.1.13 Auxiliary Medical Equipment Coverage

As part of treatment applied to the Insured following an accident or illness occurring after the Policy Commencement Date, expenses for medically necessary, externally supportive, and exclusively medical-use equipment shall be covered under this benefit, within the annual limit and reimbursement percentage specified in the Policy. Coverage is limited to portable splints (orthoses, braces, active ankle, bone spur pads), ROM walkers, walkers, nebulizers, triflo devices, elastic bandages, arm slings, corsets, orthopedic boots, insoles, elbow supports, compression stockings, neck collars, knee supports, wrist supports, sitting rings, plaster shoes, colostomy bags, urostomy bags, wheelchairs (if permanent disability is documented by a physician's report), crutches, aerochambers, and dressing materials used for burn or wound treatments.

3.1.14 Post-Hospitalization Physiotherapy Coverage

In cases where medically necessary and following a surgical hospitalization or intensive care treatment for a covered condition, physiotherapy sessions performed within 3 months after discharge shall be reimbursed, provided they are prescribed by the treating physician and approved by the MAPFRE Medical Procedures Center (MPC). Related physiotherapy expenses shall be covered within the limit and coinsurance rate specified in the Policy. Physiotherapy sessions continuing beyond the 3rd month shall be reimbursed, if applicable, under the Outpatient Physiotherapy Coverage benefit.

3.1.15 Rehabilitation Coverage

This coverage applies when the Insured requires inpatient physiotherapy due to a medical indication for hospitalization. Rehabilitation expenses that must be medically performed on an inpatient basis for a covered condition shall be reimbursed, provided that such treatment is deemed medically necessary by the treating physician and approved by the MAPFRE Medical Procedures Center (MPC), within the limit and coinsurance rate specified in the Policy for this benefit.

3.1.16 Emergency Diagnosis Coverage

Expenses related to the examination and initial diagnosis of an emergency medical condition that necessitates the Insured's admission to a hospital shall be covered within the limit and coinsurance rate specified in the Policy for this benefit.

Even if performed in the emergency departments of healthcare facilities, diagnostic and examination procedures that do not require intervention shall be evaluated under the Outpatient Treatment Coverage, if applicable.

3.1.17 Robotic Surgery Coverage

If the treatment is deemed appropriate by the physician to be performed through a Robotic Surgery method (such as Da Vinci) and such robotic surgery is approved by the MAPFRE Medical Procedures Center (MPC) for the relevant condition, the expenses shall be covered under this benefit in accordance with the limits and coinsurance rates specified in the Policy and subject to the general and special conditions. All material costs specifically used for this method, as well as all other hospital expenses incurred during Robotic Surgery (room, companion fees, surgeon's fees, etc.), shall likewise be paid under this benefit within the stated limits and coinsurance rates.

Sistem Tarihi: 2025-10-01 13:06:31

Büyük Mükellefler V.D.: 879 001 8869 Sicil No: 38676

-*- Demonstration Powered by OpenText Exstream 10/01/2025, Version 16.6.30 64-bit (DBCS) -*-

SPECIAL TERMS FOR THE HEPSİ BİRLİKTE HEALTH INSURANCE

If the treatment is carried out by a Non-Contracted Physician, regardless of whether it takes place in a Contracted or Non-Contracted Healthcare Institution, the physician's fee shall be covered under the limits and coinsurance rates specified in the Policy under the heading "Surgeon and Physician Expenses," in accordance with the general and special conditions.

3.1.18 Supportive Outpatient Treatment Coverage

For inpatient treatments resulting in surgery (excluding childbirth) and/or arising from a judicial accident, all Outpatient Treatment expenses related to the same case incurred within 30 days before and 30 days after the date of hospitalization shall be covered under this benefit, subject to the Policy limits, coinsurance rates, and in accordance with the general and special conditions.

3.2 Outpatient Treatment Coverage

This coverage undertakes to pay, within the annual aggregate limit specified in the Policy and in accordance with the General and Special Terms of Health Insurance, the additional fees that may arise during the Insured's receipt of healthcare services from providers contracted with the Social Security Institution (SGK), as designated by MAPFRE Sigorta, for general health insured persons covered by SGK.

Medical consultations, laboratory tests, radiology, modern diagnostic procedures (endoscopic procedures for diagnostic purposes), as well as physical therapy and rehabilitation expenses related to conditions arising after the insurance inception date shall be evaluated under this benefit.

3.3 Maternity Coverage

Maternity Coverage shall be valid only if selected among the optional coverages.

3.3.1 Standard Maternity Coverage

Hospital expenses incurred for the mother due to childbirth and postpartum care, medical abortion, curettage performed due to medical necessity, miscarriage and/or any complications caused by pregnancy, as well as the detection of pregnancy and any pregnancy-related illnesses that may occur thereafter, routine check-ups and examinations (such as amniocentesis, non-invasive prenatal test, TORCH panel, etc.) shall be covered under the Maternity Coverage, subject to the annual limit, coinsurance, and coverage percentage specified in the Policy, and in accordance with the general and special conditions.

Routine newborn expenses (initial examination and care costs) are covered within the scope of the Maternity Coverage limit, coinsurance, and coverage percentage.

All expenses related to pregnancy and childbirth incurred abroad shall be evaluated within the maternity coverage limit and coinsurance specified in the Policy.

3.3.2. MAPFRE Sigorta Unlimited Maternity Coverage at Contracted Healthcare Providers

At healthcare providers contracted by MAPFRE Sigorta under the unlimited maternity agreement, only expenses related to the act of childbirth (normal or cesarean delivery) will be covered under this policy, without limit and at 100%.

The additional premium charged for this coverage is valid for one childbirth only. The unlimited maternity coverage will remain valid under the Insured's uninterrupted policy that includes Maternity Coverage until the childbirth occurs.

If the childbirth is performed by a Non-Contracted Doctor at a healthcare provider designated for unlimited maternity coverage, the doctor's fee (including operator, assistant, and anesthesiologist) will be paid up to the maximum amount specified in the HUV Tariff (HUV*1), and any excess amount beyond this limit will not be covered.

Sistem Tarihi: 2025-10-01 13:06:31

Büyük Mükellefler V.D.: 879 001 8869 Sicil No: 38676

-*- Demonstration Powered by OpenText Exstream 10/01/2025, Version 16.6.30 64-bit (DBCS) -*-

SPECIAL TERMS FOR THE HEPSİ BİRLİKTE HEALTH INSURANCE

Even if the delivery takes place at the designated healthcare providers, all pregnancy-related conditions that may occur before and after childbirth will be covered under the Standard Maternity Coverage limit.

Newborn baby expenses are included under the Unlimited Maternity Package. In cases of multiple births, the initial care expenses of only one baby will be covered under this coverage, while the care expenses of the other babies will be evaluated under the Standard Maternity Coverage.

Routine pregnancy check-up expenses will be evaluated under the Insured's Standard Maternity Coverage limit.

For policies that do not include Maternity Coverage, this coverage cannot be granted. For this coverage to be valid, the Maternity Coverage Waiting Period must be completed.

3.3.3 Family Planning

Infrequently repeated family planning methods (such as tubal ligation, intrauterine device (IUD) applications, etc.) will be covered up to 20% of the Maternity Coverage limit (within the Maternity Coverage limit) under the conditions specified in the Policy.

Frequently repeated family planning methods (such as birth control pills, condoms, etc.) are excluded from coverage.

To benefit from family planning methods, the Maternity Coverage Waiting Period must be completed.

3.3.4. Neonatal Incubator Coverage

In a plan that includes Maternity Coverage, if the mother has been insured with MAPFRE Sigorta for at least 1 year and has completed the waiting period, the medical expenses of the newborn baby's potential conditions (even if born prematurely)—such as respiratory distress syndrome, all bleeding disorders and apneas, hypoglycemia and hyperglycemia, convulsions, asphyxia, and sepsis treatments—will be covered under the Neonatal Incubator Coverage limit and participation rate specified in the Policy. This coverage is invalid for Insureds who have not completed the Maternity Coverage Waiting Period.

3.4 Control Mammography / Control PSA

For female Insureds aged 40 and above, the costs of mammography and breast ultrasonography performed for control purposes, and for male Insureds aged 40 and above, the costs of PSA (Prostate-Specific Antigen) tests performed for control purposes, will be covered once a year at 100%, provided that they are carried out at our company's check-up contracted healthcare providers, and unless otherwise stated in the Policy, for Insureds holding inpatient treatment and/or outpatient treatment plans.

Details of the contracted healthcare providers valid for these tests within the scope of the Policy can be accessed at www.mapfre.com.tr.

Control-purpose mammography/breast ultrasonography and PSA costs performed at other Contracted or Non-Contracted Healthcare Providers will not be covered under the Policy.

3.5 Check-Up Coverage

Regardless of the contracted healthcare provider type valid in the Insured's policy, the costs will be covered once a year at 100% provided that the check-up is carried out at the Contracted Healthcare Providers designated by our company for Check-Up Coverage. Details of the check-up package and the contracted healthcare providers valid under the Policy can be accessed at www.mapfre.com.tr

Check-up examination costs performed at other Contracted or Non-Contracted Healthcare Providers will not be covered under this coverage.

Sistem Tarihi: 2025-10-01 13:06:31

Büyük Mükellefler V.D.: 879 001 8869 Sicil No: 38676

-*- Demonstration Powered by OpenText Exstream 10/01/2025, Version 16.6.30 64-bit (DBCS) -*-

SPECIAL TERMS FOR THE HEPSİ BİRLİKTE HEALTH INSURANCE

3.6 Overseas Inpatient Treatment Coverage

If, after the Insurance Start Date, the Insured requires inpatient medical treatment abroad due to an internal disease/surgical condition covered under the Policy, the expenses will be covered under this benefit in accordance with the limits, coinsurance, and coverage percentages stated in the Policy (if overseas coverage is specified), subject to the Special and General Conditions.

Outpatient medical expenses abroad, including doctor's consultations, medications, diagnostic tests, advanced diagnostic examinations, and physical therapy related to illnesses occurring after the Insurance Start Date, are excluded from coverage.

Except for cases requiring continuous inpatient treatment during the policy period, coverage will be suspended for Insureds who reside abroad for more than 3 consecutive months without returning to Turkey, unless otherwise agreed in the Policy. During such suspension periods, the Insurer will not be liable for any medical expenses incurred abroad. The coverage will resume once the Insured re-enters Turkey prior to the Policy Expiry Date. Therefore, in cases where the Policyholder must stay abroad for more than 3 months, the Insurer must be notified.

The Insurer reserves the right to suspend coverage or continue coverage under special conditions depending on the country of stay.

The same Special and General Conditions apply to both domestic and overseas coverages. Healthcare expenses covered under Overseas Inpatient Treatment shall be calculated based on the Turkish Central Bank's (T.C.M.B.) effective selling exchange rate on the invoice date in Turkish Lira (or, if the relevant foreign currency does not have a direct T.C.M.B. equivalent, based on the cross-rate in USD to TL) and reimbursed to the Insured in accordance with the limits, coinsurance, and coverage percentages specified in the Policy and subject to the Special and General Conditions.

For the Insurer to evaluate overseas inpatient treatment expenses and make the relevant reimbursements, the Insurer reserves the right to request the Insured to provide proof of presence in the relevant country on the date the expenses occurred.

In order for the relevant payment under this coverage to be made, notarized translations of all related documents must be submitted to the Insurer.

ARTICLE 4 – STANDARD WAITING PERIODS

The treatments for the conditions listed below are excluded from coverage during the applicable waiting periods, unless they result from a judicial accident, starting from the Insured's Registration Date. Provided that the insurance policy is continuously renewed according to renewal conditions and no special exclusion has been applied by the Insurer for any of the conditions listed below, once the Insured has continuously completed the relevant waiting period (including any additional waiting period imposed by the Insurer), such conditions will no longer be subject to the waiting period and will be included under coverage.

Conditions with a 12-Month Waiting Period for Inpatient Treatment Coverage (unless caused by a Judicial Accident):

1. All hernias
2. Anorectal diseases (hemorrhoids, anal fistula and fissure, anal abscess, etc.), pilonidal sinus (sacral dermoid cyst)
3. Tonsillectomy, adenoid vegetation surgery, eardrum surgery and tube application, sinus surgery
4. Benign (non-malignant) tumors, space-occupying lesions, nevi, polyps, and excision of
5. Thyroid and parathyroid diseases
6. Diseases and surgeries related to the cervix, uterus, ovaries, and fallopian tubes; endometriosis;
7. Hydrocele, spermatocele, cord cyst, and epididymal cyst
8. Spinal and disc disorders, all types of joint disorders (knee, shoulder, etc.), trigger finger, ligament and
9. Varicose veins and venous thrombosis
10. Urinary system stone diseases, prostate surgeries
11. All endoscopic, laparoscopic procedures, and angiographies (except diagnostic procedures)
12. Cataract, glaucoma, keratoplasty
13. Gallbladder and biliary tract diseases
14. All chronic disease treatments and home care services related to chronic illnesses (hypertension, ulcer, reflux, inflammatory bowel diseases [ulcerative colitis, Crohn's disease, etc.], COPD, asthma, diabetes mellitus, demyelinating diseases, myasthenia gravis, sarcoidosis, nephritis, all rheumatic and connective tissue diseases)
15. All conditions covered under Maternity Coverage (routine pregnancy check-ups, normal or cesarean delivery, miscarriage, and/or all complications resulting therefrom, etc.)

Conditions with a 3-Month Waiting Period for Outpatient Treatment Coverage

All outpatient physical therapy and rehabilitation expenses under the Outpatient Treatment Coverage are subject to a 3-month waiting period starting from the date the coverage is obtained.

Sistem Tarihi: 2025-10-01 13:06:31

Büyük Mükellefler V.D.: 879 001 8869 Sicil No: 38676

-*- Demonstration Powered by OpenText Exstream 10/01/2025, Version 16.6.30 64-bit (DBCS) -*-

SPECIAL TERMS FOR THE HEPSİ BİRLİKTE HEALTH INSURANCE

ARTICLE 5 – STANDARD EXCLUSIONS

The circumstances listed under Article 2 of the General Conditions of Health Insurance as Excluded from Coverage, as well as the situations specified below, are excluded from the coverage of all benefits of this Policy. However, the situations listed under Articles 39 to 49 shall be considered within the scope of the Policy only for outpatient treatment expenses, provided that: the Insured has earned the right to the Lifetime Renewal Guarantee (Ömür Boyu Yenileme Garantisi) before 01.10.2023, the relevant expenses are covered by the Social Security Institution (SGK), and there is no specific exclusion related to this situation stated in the Policy.

1. The diseases mentioned in this article are excluded from coverage. However, if the Insured has completed at least 3 uninterrupted years within our Company's individual insurance period and has earned the right to Lifetime Renewal Guarantee, or if the Insured is insured as a MAPFRE Baby (MAPFRE Bebeği), the exclusions will not be applied.

   a. Congenital and genetic diseases diagnosed after the Policy Commencement Date, even if manifested at an advanced age, as well as expenses related to premature babies (unless otherwise agreed in the contract, and even if the baby has been insured since birth), are excluded from coverage except in cases where the Insured has purchased the Newborn Incubator Additional Coverage and the conditions of such coverage are met.

   b. Expenses related to examinations and treatments for pes planus and hallux valgus/rigidus.

   c. Treatments for dementia due to old age, as well as Alzheimer's, Parkinson's, and epilepsy (seizure disorders).

   d. Operations related to the nasal septum and concha shall only be valid in the Contracted Healthcare Institutions listed under the specially designated ENT Network (KBB Network) published on the MAPFRE Sigorta website, regardless of the type of Contracted Healthcare Institution stated in the Policy. If the Insured's treatment is performed by a Non-Contracted Doctor within an ENT Network healthcare institution, the doctor's fee will be paid up to the maximum amount specified in the HUV Tariff (HUV*1).

   However, if the Insured has completed at least 5 uninterrupted years of individual insurance with our company and has earned the right to the Lifetime Renewal Guarantee, these operations shall be valid in all Contracted Healthcare Institutions under the Policy. In such cases, if the treatment is performed by a Non-Contracted Doctor within a Contracted Healthcare Institution, the doctor's fee will be calculated according to the limits and co-payment rates applicable under the Surgeon and Doctor Fees benefit for Non-Contracted Institutions.

2. If the Insured has completed at least 5 uninterrupted years of individual insurance with our company and has earned the right to the Lifetime Renewal Guarantee, or is insured as a MAPFRE Baby, treatments for strabismus, otosclerosis, keratoconus, and ptosis (provided that they arise after the Policy's initial enrollment date) shall not be considered exclusions. Such treatments shall be valid only in Contracted Healthcare Institutions under the C Network, regardless of the network type included in the Insured's policy.For Insureds who have not yet completed 5 uninterrupted years of individual insurance and have not earned the right to the Lifetime Renewal Guarantee, these treatments remain excluded from coverage.

The list of Contracted Healthcare Institutions within the C Network is available on the MAPFRE Sigorta website.

3. Expenses related to the incubator care of a premature newborn baby of an Insured who has not yet completed the Maternity Waiting Period or who is covered under a plan without Maternity Coverage.

4. All medical expenses relating to pre-existing and undisclosed illnesses/conditions, and any recurrences and complications thereof (whether or not a diagnosis has been made and/or treatment has been received), prior to the Insured's first enrollment date with MAPFRE Sigorta.

5. Examinations related to any genetic diseases/conditions, genetic mapping, and genetic screening.

Sistem Tarihi: 2025-10-01 13:06:31

Büyük Mükellefler V.D.: 879 001 8869 Sicil No: 38676

-*- Demonstration Powered by OpenText Exstream 10/01/2025, Version 16.6.30 64-bit (DBCS) -*-

SPECIAL TERMS FOR THE HEPSİ BİRLİKTE HEALTH INSURANCE

6. All expenses arising from any accidents and the consequences thereof caused by the use of a vehicle without a valid driver's license.

7. Expenses related to alcoholism, alcohol (regardless of blood alcohol level), narcotics, stimulants, hallucinogens, and other substance addictions, as well as any illnesses, poisonings, disorders, and accidents resulting from the use of such substances.

8. Expenses arising from all hazardous sports activities whether performed as an amateur or hobby or other dangerous activities, including but not limited to: mountaineering, scuba diving with breathing apparatus, airplane and glider piloting, parachuting, paragliding, hang-gliding, horseback riding, rafting, street luge, high-altitude jumping sports (such as base jumping), kiteboarding, kitesurfing, underwater sports, mountain biking, motorcycle and automobile sports, and the use of electric scooters, electric bicycles, and electric motorcycles without a license, as well as skiing and motorcycle use as a driver or passenger even for transportation purposes. Expenses arising from professional and/or licensed sports activities are also subject to this limitation. Such expenses are covered up to a maximum of TRY 40,000. However, among these activities, expenses related to skiing, and to motorcycle and ATV use (as driver or passenger) are insurable under Policy limits and coinsurance rates, provided the driver is licensed and an additional premium is paid, and only as long as no risk has materialized.

9. Regardless of the institution where they are performed, expenses related to alternative treatment methods (such as acupuncture, homeopathy, osteopathy, hypnosis, yoga, mesotherapy, aromatherapy, neural therapy, chiropractic treatments, ayurveda, phytotherapy, functional medicine, holistic medicine, ozone therapy, spa and balneotherapy, drinking cure therapies, etc.) as well as treatments applied in spas, thermal centers, sanatoriums, nursing homes, care homes, preventoriums, and rehabilitation centers.

10. All expenses related to scientifically unproven/experimental treatments and to drugs and materials not approved by the U.S. FDA (Food and Drug Administration).

11. Procedures/treatments not listed in HUV (Medical Practice Database) for Inpatient Treatment Coverage.

12. All procedures and related expenses (examination, tests, diagnosis, treatment, etc.) performed at aesthetic, cosmetic, laser and beauty centers, optical and lens centers, centers without a Ministry of Health operating license, wellness centers, traditional/complementary and alternative medicine centers, anti-aging centers, slimming centers, gyms, life coaching centers, foot health centers, etc.

13. All procedures and related expenses performed by physicians without a Ministry of Health operating license and by non-physicians.

14. Expenses related to nasal valve surgery.

15. Expenses for obtaining medical board or doctor's reports for purposes such as pre-sports participation, pre-marriage, or pre-employment.

16. Invoices issued by the Insured's first-degree relatives.

17. Expenses incurred for the removal of the Insured's specific exclusion.

18. Expenses for inpatient treatments without medical indication and diagnostic/treatment procedures unrelated to a specific complaint and/or illness, based on hospital reports evaluated by MAPFRE Sigorta Medical Operations Center (MIM).

19. All diagnostic and treatment expenses related to uvuloplasty, snoring, and sleep apnea. (Uvuloplasty and sleep apnea-related expenses are covered for Insureds who earned the Lifetime Renewal Guarantee before 01.10.2023).

Sistem Tarihi: 2025-10-01 13:06:31

Büyük Mükellefler V.D.: 879 001 8869 Sicil No: 38676

-*- Demonstration Powered by OpenText Exstream 10/01/2025, Version 16.6.30 64-bit (DBCS) -*-

SPECIAL TERMS FOR THE HEPSİ BİRLİKTE HEALTH INSURANCE

20. All diagnostic and treatment expenses related to scoliosis and all spinal curvatures. (Scoliosis and all spinal curvatures are covered for Insureds who earned the Lifetime Renewal Guarantee before 01.10.2023).

21. Expenses related to cord cysts, hydrocele, and all types of hernia procedures in children under the age of 7. (This clause shall not apply exceptionally to MAPFRE Sigorta Babies.)

22. Medical supplies not covered under the definition of Auxiliary Medical Equipment Coverage (Article 3.1.13), CPAP device, calibration and monitoring, humidifiers used at home, externally attached devices (hearing aids, cochlear implants, etc.), syringes not used with medication, tapes, telephone, TV, cafeteria, administrative services, paramedical services and service fees, as well as all expenses related to external and supportive prostheses that cannot be evaluated under Inpatient Treatment Coverage.

23. Expenses for elective curettage, infertility, sterility, miscarriage investigation, and treatments/complications related to achieving pregnancy (such as in vitro fertilization, follicle tracking, microinjection, tuboplasty, etc.), hysterosalpingography (HSG), spermiogram, and adhesiolysis.

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

25. Expenses for superficial varicose vein treatment methods such as sclerotherapy, chemical blockage, laser, radiation, massage, stockings, etc.

26. Expenses related to the collection and storage of cord blood and stem cells.

27. All expenses related to officially declared epidemics and epidemics initiated with malicious intent.

28. Co-payments that the Insured is obliged to pay in accordance with Article 98/2 of the Social Insurance and General Health Insurance Law No. 5510.

29. Expenses for private nursing services not approved by MAPFRE Sigorta Medical Operations Center (except those covered under Home Care Coverage) and ambulance expenses other than Emergencies (as defined in Article 2 – Definitions), as well as all expenses for auxiliary healthcare personnel (such as physiotherapists, respiratory therapists, caregivers, etc.).

30. All expenses related to examinations, dental and gum treatments, and jaw treatments performed by dentists and oral surgeons, as well as expenses for toothpaste, oral and dental care products, etc.

31. Expenses related to eyeglasses, lenses, lens solutions, all corrective lenses for refractive errors (toric, multifocal, etc.), amblyopia, treatments for refractive errors of the eye (such as myopia, etc.), and—except for MAPFRE Babies—all diagnostic, examination, and treatment expenses for strabismus.

32. Except those evaluated under Home Care Coverage, all usage/rental fees of any medical equipment and/or devices.

33. For procedures evaluated under Outpatient Diagnosis/Treatment Coverage; health expenses incurred during the period when the General Health Insurance provided by the Social Security Institution is inactive due to reasons such as termination of employment, non-payment of insurance premiums, etc.

34. Health expenses incurred outside the Contracted Healthcare Institutions specified in the Policy and evaluated under Outpatient Treatment Coverage.

35. All expenses exceeding the usage quantity and/or coverage limits specified in the Policy.

Sistem Tarihi: 2025-10-01 13:06:31

Büyük Mükellefler V.D.: 879 001 8869 Sicil No: 38676

-*- Demonstration Powered by OpenText Exstream 10/01/2025, Version 16.6.30 64-bit (DBCS) -*-

SPECIAL TERMS FOR THE HEPSİ BİRLİKTE HEALTH INSURANCE

36. Within the scope of outpatient treatments, including the Green Zone practice, all medication expenses, materials and contrast agents used for tests, material costs, and vaccination expenses.

37. Travel, per diem, fees for a second companion, suite room differences, and personal expenses.

38. All expenses under the scope of Outpatient Treatment Coverage incurred abroad.

39. All examinations and treatment expenses related to structural disorders, motor-mental developmental and growth disorders (growth retardation/acceleration, early/late puberty, etc.).

40. Psychiatric treatments for mental illnesses and psychological disorders, neuropsychiatric tests, all kinds of psychotherapy, and all related expenses.

41. Expenses for tests performed for screening purposes such as coronary artery calcium scoring, coronary CT angiography, Electron Beam Tomography (EBT), virtual angiography, and virtual colonoscopy.

42. Unless occurring as a result of a judicial accident or illness (such as cancer, burns, etc.) during the validity of the Policy; plastic and reconstructive surgery, all aesthetic and cosmetic procedures (such as rhinoplasty, abdominoplasty, etc.) and related complications, treatments for telangiectasia and skin hemangiomas, gynecomastia, hyperhidrosis and all related examinations and treatments, acne and hair loss diagnosis and treatment (except alopecia areata), all breast reduction and augmentation surgeries, and accessory breast operations, together with all related expenses.

43. Diagnosis or treatment of obesity, weight and appetite disorders, surgeries and complications, dietician services, weight loss and weight gain programs, and all related expenses.

44. Examinations, diagnoses, treatments, and complications provided by physicians applying balanced nutrition, diet-exercise programs, alternative and/or complementary therapies.

45. Hearing loss surgery (excluding tube insertion, tympanoplasty, sequelae of chronic otitis, etc.) and all related diagnostic and treatment procedures, speech and voice therapies.

46. Varicocele-related expenses, whether related to infertility or not, except for Insured Persons under the age of 18.

47. Gender reassignment surgeries, erectile dysfunction, Peyronie's disease, penile curvature, vaginismus, sexual dysfunctions, all related examinations and treatments (including penile prosthesis), and contraception methods not covered under Article 3.4.3 (such as pills, condoms, etc.).

48. All examinations and treatments related to syphilis, anogenital condylomas, HIV, and AIDS, regardless of the transmission route.

49. Expenses related to the donor in cases of organ, tissue, and blood transplantation.

ARTICLE 6 – GEOGRAPHICAL SCOPE

The coverages of this Policy are valid for individuals residing within the borders of Turkey and the Turkish Republic of Northern Cyprus (TRNC). Domestic coverages under the Policy are valid throughout Turkey and the Turkish Republic of Northern Cyprus (TRNC), while, if included among the coverages, international coverages shall be valid worldwide outside of these countries.

Sistem Tarihi: 2025-10-01 13:06:31

Büyük Mükellefler V.D.: 879 001 8869 Sicil No: 38676

-*- Demonstration Powered by OpenText Exstream 10/01/2025, Version 16.6.30 64-bit (DBCS) -*-

SPECIAL TERMS FOR THE HEPSİ BİRLİKTE HEALTH INSURANCE

ARTICLE 7 – PRINCIPLES OF COVERAGE APPLICATION

7.1 Limit Applications

Annual Aggregate Limit: In the Policy attached to the Insurance Certificate, limits that may vary per illness and/or per coverage are specified, and claims are processed by deducting any applicable co- payment from these limits. First, the claimed compensation amount is considered, then any co-payment relating to the coverage is deducted, and the payable compensation amount is determined. However, this amount may in no case exceed the limit of the principal coverage under which the relevant procedure is valid.

Annual Inpatient Treatment Total Day Limit: The total number of days the Insured may be hospitalized within one Policy Period is 180, of which a maximum of 90 days may be used for intensive care. For this purpose, each day of hospitalization shall be counted as one (1) day. At the start of each renewed policy period, the relevant limits will reset and be reassessed.

Lifetime Inpatient Treatment Total Day Limit: The total number of inpatient treatment days the Insured may utilize throughout their lifetime is 720 days, applicable only for years in which the Policy is renewed without interruption. For this purpose, each day of hospitalization shall be counted as one (1) day. If the Lifetime Day Limit (720 days) is exceeded, the Insured's Inpatient Treatment Coverage shall automatically terminate on the day the limit is reached. In such case, the Insurer reserves the right not to renew the Policy.

For Insureds with a Lifetime Renewal Guarantee, the Lifetime Inpatient Treatment Total Day Limit does not apply.

Coverage for Hospitalization Continuing Beyond Policy Expiry Date: If hospitalization begins while the Policy is in force and continues uninterrupted beyond the expiry date of the Policy without renewal, hospitalization expenses shall remain covered for up to 10 days following the Policy Expiry Date. If the Policy is cancelled, or the Insured is removed from the Policy coverages, or the coverage plan is changed, hospitalization expenses occurring after the cancellation, removal, or plan change date shall in no case be covered.

7.2. Application of Coverage Percentage and Co-Payment

The Insurer shall cover healthcare expenses under the coverages specified in the Health Insurance General Terms and the Special Terms of this Policy, within the coverage percentage, limit, and deductibles stated in the Policy for the relevant coverage. Any amounts not covered or remaining shall be borne by the Insured/Policyholder as co-payment.

7.3 Application of Deductibles

If applicable under the policy coverages, the deductible refers to the annual aggregate amount that the Insurer is not liable to pay.

Sistem Tarihi: 2025-10-01 13:06:31

Büyük Mükellefler V.D.: 879 001 8869 Sicil No: 38676

-*- Demonstration Powered by OpenText Exstream 10/01/2025, Version 16.6.30 64-bit (DBCS) -*-

SPECIAL TERMS FOR THE HEPSİ BİRLİKTE HEALTH INSURANCE

ARTICLE 8 – CLAIM PAYMENT

For treatments to be performed at Contracted Healthcare Providers, prior authorization approvals obtained are valid for 7 days. If the treatment does not take place within this period, a new authorization must be obtained. MAPFRE Sigorta reserves the right to decline claims for procedures not carried out within 7 days and without renewed authorization.

Apart from healthcare expenses incurred at Contracted Healthcare Providers, invoices and other required documents (doctor's report, test results, etc.) evidencing expenses covered under the Inpatient Treatment Coverage and paid by the Insured at Non-Contracted Healthcare Providers must be submitted in original form and without deficiency to the Insurer. The Insurer shall complete the evaluation within 5 business days, and claims deemed eligible for payment shall be reimbursed within this period.

In policies where the insurance premium is paid in installments, in the event of a claim, the remaining installments shall become immediately due and payable, and the amount shall be deducted from the claim payment to the Insured.

For healthcare expenses covered under the Policy, payment shall commence only after any applicable deductible amount has first been subtracted from the invoice—regardless of whether the expense arises from Inpatient, Overseas, Maternity, or other coverage—and the amount exceeding the deductible shall be paid within the limits, co-payment, and subject to the Special and General Conditions of the Policy.

In cases where the Insurer has been notified of and accepted a health condition during the policy period, if inpatient treatment continues beyond the expiry of the Policy and the Policy is not renewed, the Insurer shall cover treatment expenses for up to 10 days following the expiry of the Policy.

Within the scope of Inpatient Treatment Coverage and as assessed under the Policy, invoices issued by public hospitals affiliated with the Ministry of Health and by state-affiliated university hospitals shall be evaluated in line with the participation rates and limits applicable to Contracted Healthcare Providers.

In the event that the Insured passes away during treatment, morgue expenses shall be assessed under the Inpatient Treatment Coverage and in accordance with the relevant participation rates.

For healthcare expenses incurred abroad and assessed under Inpatient Treatment Coverage, all documents issued in a foreign language relating to such payments must be submitted to the Insurer with a notarized translation.

For healthcare expenses under Outpatient Diagnosis/Treatment Coverage: expenses incurred by the Insured through Contracted Healthcare Providers (TSS Network) listed on the MAPFRE Sigorta website, with prior authorization obtained, shall be paid directly to the respective healthcare provider. Expenses incurred without prior authorization, or invoices for expenses incurred outside these Contracted Healthcare Providers, shall not be covered under the Policy.

For claim payments under Inpatient Treatment Coverage, the following documents must be submitted to the Insurer:

1- Itemized hospital invoices signed by the Insured, together with the medical report stating the reason for hospitalization.

2- Detailed surgical report for surgical interventions (including pathology report, if available).

3- Where necessary: observation file, traffic accident report, judicial report, judicial record, alcohol test report, insured's statement.

4- Epicrisis (summary of hospitalization).

5- In case requested by the Insurer: surgical videos of endoscopic (laparoscopic, arthroscopic, robotic, thoracoscopic, etc.) procedures.

For Maternity Coverage, the following documents must be submitted:

1- Birth report.

2- Hospital invoice.

3- Observation file, where necessary.

4- In case of compulsory curettage: Gynecological ultrasound report, pathology result and/or Beta HCG result.

Sistem Tarihi: 2025-10-01 13:06:31

Büyük Mükellefler V.D.: 879 001 8869 Sicil No: 38676

-*- Demonstration Powered by OpenText Exstream 10/01/2025, Version 16.6.30 64-bit (DBCS) -*-

SPECIAL TERMS FOR THE HEPSİ BİRLİKTE HEALTH INSURANCE

ARTICLE 9 – RENEWAL OF THE CONTRACT AND LIFETIME RENEWAL GUARANTEE

9.1 Renewal of the Contract

This Insurance shall be valid for a maximum period of 1 year. However, following the Policy Expiry Date, a renewal policy may be issued at the request of the Insured/Policyholder, subject to the principles determined by the Insurer. In the event that the Insured requests an upgrade of plan/network/product during the renewal period, a health declaration form may be required.

The Insurer shall review the health status and/or loss ratio of Insureds who do not hold a Lifetime Renewal Guarantee during the insured period and decide on the Policy Renewal Terms accordingly.

If the Insurer imposes conditional acceptances regarding pre-existing and/or ongoing medical conditions to be applied under the new contract (without prejudice to the provisions of the Lifetime Renewal Guarantee), such conditional acceptances shall remain valid as long as the Policy is renewed.

The Policyholder, even if already holding a Lifetime Renewal Guarantee, may apply to the Insurer during the renewal period to expand the scope of coverage under the Insurance Policy and/or to add different products, networks, or coverages. The Insurer reserves the right, regarding such a change request, to require a new application form, to reject the request, or to accept it conditionally (Additional Risk Premium, limit, coinsurance, etc.). In the event of a product change, the current individual Lifetime Renewal Guarantee conditions of the newly chosen product shall apply. The date of the Lifetime Renewal Guarantee will be deemed to be the commencement date of the newly chosen product.

For newly added coverages, the waiting period will restart. In addition, Policies are renewed under the current premium, tariff, and special conditions in effect. The Insured may apply to the Insurer for a new contract within 30 days before or after the Expiry Date of the existing Policy.

If more than 30 days have passed since the renewal date, the Insured shall be considered a new applicant, required to submit a new application form, and will join the insurance as a new Insured. In such cases, accrued rights and any previously earned Lifetime Renewal Guarantee rights shall no longer be valid, and a risk analysis shall be performed for pre-existing conditions. Any discounts earned under the previous Policy based on loss ratio or similar criteria shall not be applicable.

The Insurer reserves the right, until the new Policy is issued, not to cover risks occurring during the interim, to cover them only under conditional acceptance (limit, Additional Risk Premium, coinsurance, waiting period, etc.) in line with MAPFRE Sigorta's risk analysis criteria, and to suspend renewal rights.

The Insured is obliged to comply with the duty of disclosure stipulated in Article 6 of the General Conditions of Health Insurance and Article 1435 of the Turkish Commercial Code during renewal.

Sistem Tarihi: 2025-10-01 13:06:31

Büyük Mükellefler V.D.: 879 001 8869 Sicil No: 38676

-*- Demonstration Powered by OpenText Exstream 10/01/2025, Version 16.6.30 64-bit (DBCS) -*-

SPECIAL TERMS FOR THE HEPSİ BİRLİKTE HEALTH INSURANCE

9.2 Lifetime Renewal Guarantee

Provided that the Insured continues with the same product uninterruptedly for 3 years with MAPFRE Sigorta and that the average loss/premium ratio over the last 3 years remains below 80%, a "Lifetime Renewal Guarantee" may be granted to Health Policyholders deemed medically eligible following a risk analysis assessment under the conditions determined.

To evaluate the Lifetime Renewal Guarantee, the Insurer may request from the Insured a current application form reflecting the Insured's health status and, if necessary, supporting medical reports. Based on health conditions and in line with MAPFRE Sigorta's applicable risk analysis criteria, the Insurer reserves the right to reject the application, to accept it conditionally (limit, Additional Risk Premium, exclusion, coinsurance, waiting period, etc.), or to grant the Lifetime Renewal Guarantee without any conditions.

The renewal guarantee is personal and belongs solely to those Insureds who have acquired this right. The expression "Lifetime Renewal Guarantee" granted by the Insurer is indicated on the Policy of each Insured who has earned this right.

For Policies transferred to MAPFRE Sigorta from another insurance company, regardless of whether the renewal guarantee exists in the previous insurer, a risk analysis will be performed, and conditions such as limit, coinsurance, exclusion, Additional Risk Premium, etc. may be applied. However, the disease-related Additional Risk Premium applied shall not exceed 200% per disease.

Any renewal guarantee right previously earned with the former insurance company will be re-evaluated in line with MAPFRE Sigorta's criteria, and following the risk analysis, the Insured's renewal guarantee may continue under the Insurer's current special conditions. The Lifetime Renewal Guarantee issuance date from the previous company shall be updated as the first registration date with MAPFRE Sigorta.

For an Insured who has already been granted a Lifetime Renewal Guarantee, the Insurer has no right to conduct a new risk analysis or impose any additional conditions (Additional Risk Premium, exclusion, limit, coinsurance, etc.) or apply a premium surcharge based on loss/premium ratio for medical conditions that arise after the date the renewal guarantee was granted, except for the circumstances defined under Articles 6 and 7 of the General Conditions of Health Insurance.

If the Insured wishes to expand the scope of coverage and/or network, the Insurer may conduct a new risk analysis for the additional or amended coverage and impose conditions such as limits, coinsurance, exclusions, Additional Risk Premium, etc. Furthermore, the Insurer reserves the right to reject the relevant request.

The Health Policy provided by the Insurer to the Insureds who have been granted a renewal guarantee shall be subject to the Special Conditions effective on the date the Policy acquired the right to a Lifetime Renewal Guarantee. For Insureds without a Lifetime Renewal Guarantee, the Special Conditions of the Policy in force during each policy period shall apply.

Sistem Tarihi: 2025-10-01 13:06:31

Büyük Mükellefler V.D.: 879 001 8869 Sicil No: 38676

-*- Demonstration Powered by OpenText Exstream 10/01/2025, Version 16.6.30 64-bit (DBCS) -*-

SPECIAL TERMS FOR THE HEPSİ BİRLİKTE HEALTH INSURANCE

ARTICLE 10 – PREMIUM DETERMINATION

Criteria for Premium Determination

In accordance with MAPFRE Sigorta's risk analysis criteria, the premiums of the Insured candidate are calculated by taking into account the selected plan, coverage, the Insured's age and gender, medical inflation, and the claims-to-premium ratio. In the event that, after the Insurance Commencement Date, a spouse or child is added under family coverage, or if the Insured requests a plan change, such requests will be processed based on the premiums in force on the date of the request, provided that the Insurer reserves the right to reject the relevant request.

The premiums and maturities of the Insured under the Policy are indicated on the front page of the Policy; the coverages, limits, coinsurance, and other plan information are specified within the Policy. The policy premium is calculated based on the Insured's age at the Insurance Commencement Date (calculated as the difference in days/months/years between the commencement date and the date of birth).

As long as the weighted average of the variables affecting medical inflation for the relevant period remains below 50%, the increase rate to be applied to the tariff base premium for all ages and coverages shall not exceed an average of 300%. Otherwise, this rate may increase by taking into account the medical inflation variables for the relevant period. The variables of medical inflation include: Consumer Price Index (CPI), Producer Price Index (PPI), coefficient changes in the Turkish Medical Association Fee Schedule, exchange rate fluctuations, and the current price changes to be applied to our Company by healthcare institutions.

Within the scope of Inpatient Treatment, 25% of the healthcare expenses covered by the Social Security Institution (SGK) and not claimed from MAPFRE Sigorta will be deducted as a discount from the policy premium at the renewal period. This discount shall only apply provided that the total discount rate specified in the policy does not exceed 50%. If the Insured's existing total discounts are already 50% or higher, no additional discount will be applied.

Premium Adjustments

No-Claim Discount

The No-Claim Discount application consists of a total of 8 levels, including the entry level and 7 discount levels.

Insureds who obtain a policy as a New Business or through Transfer start at the entry level (Level 1). The renewal policy level for the following year is determined by taking into account the Insured's current Policy Term Level and the "Claim"/"Health Net Premium" (C/P) Ratio. For Insureds whose length of coverage in the previous year's Policy (calculated on a daily basis) is less than 6 months, the starting level will remain at Level 1. The renewal policy level is determined by considering the Insured's current Policy Term Level and the "Claim"/"Health Net Premium" (C/P) Ratio.

Renewal Policy

If the Claim/Premium ratio is less than 25%, the policy will be renewed at one level higher.
If the Claim/Premium ratio is between 25.01% (inclusive) and 70% (inclusive), the policy will be renewed at the same level.
If the Claim/Premium ratio is between 70.01% (inclusive) and 150% (inclusive), the policy will be renewed at one level lower.
If the Claim/Premium ratio is between 150.01% (inclusive) and 350% (inclusive), the policy will be renewed at two levels lower.
If the Claim/Premium ratio is 350.01% (inclusive) or higher, the policy will be renewed at three levels lower.

LEVEL	1	2	3	4	5	6	7	8
DISCOUNT RATES (%)	0	15	25	30	35	40	45	50

10.3 Premium Payments

The method, due dates, and amounts of the insurance premium payments are specified in the proposal and/or the policy.

The Insured may pay the full premium in lump sum and/or in installments in accordance with the payment plan approved by the Insurer.

The obligation to pay the premiums specified in the Policy on the relevant due dates rests with the Policyholder or, if applicable, the Insured.

Sistem Tarihi: 2025-10-01 13:06:31

Büyük Mükellefler V.D.: 879 001 8869 Sicil No: 38676

-*- Demonstration Powered by OpenText Exstream 10/01/2025, Version 16.6.30 64-bit (DBCS) -*-

SPECIAL TERMS FOR THE HEPSİ BİRLİKTE HEALTH INSURANCE

ARTICLE 11 – NEW ENROLLMENTS

Insurance Period and Admission to Insurance

The insurance period is 1 (one) year and remains in force between the commencement and expiry dates specified in the Policy. Insurance coverage enters into force upon acceptance of the application by the Insurer, issuance of the Policy, and payment of the initial premium.

At the first enrollment with our Company, the Insurance Policy provides coverage for babies older than 14 days and individuals under the age of 64 (inclusive). The Policyholder must be at least 18 years of age.

There is no age limit for renewals of Insureds who have obtained a Lifetime Renewal Guarantee.

Children between the ages of 0 and 12 may only be covered under the Policy as part of the family and/or together with at least one person legally responsible for their care, under the same product. Upon request, unmarried children under the care of the Insured who are in education (subject to proof of enrollment) may be covered under the Policy up to the age of 24. Children older than 14 days but under the age of 12 may only be insured under the product where their mother or father is insured. Children between the ages of 12 and 18 may be insured individually, provided that the Policyholder is over 18 years of age.

Unless otherwise stated by the Insurer, persons residing within the borders of the Republic of Türkiye (TR) and the Turkish Republic of Northern Cyprus (TRNC) are eligible for insurance. Any permanent change of residence after the commencement of the Policy must be notified to the Insurer in writing within one month at the latest. The Insurer reserves the right to request passports and/or entry-exit records abroad to verify such situations and to refuse payment of expenses incurred abroad.

Applications

All initial and subsequent applications of the Policyholder/Insured candidate must be submitted using the application forms provided by the Insurer, and the declaration sections regarding the Persons to be Insured must be completed fully and accurately.

The Insurer shall have the right, with the written consent of the Insured, to request information and documents from the persons and institutions providing treatment to the Insured. In cases where the Insured grants the Insurer authorization to access their medical history, the Insurer may, if deemed necessary, request physician opinions, examinations, and/or tests to determine the Insured's health condition. In such cases, the expenses related to these procedures shall be borne by the Insurer. However, if, despite the Insured having granted authorization to access medical records, the relevant documents cannot be obtained from the institutions, the expenses of the required physician opinions, examinations, and/or tests shall be borne by the Insured and/or the Policyholder. In cases where the Insured does not grant authorization to access their medical history, the expenses of any required physician opinions, examinations, and/or tests shall also be borne by the Insured and/or the Policyholder.

The Insured must apply to the Insurer at each Policy renewal period, even if a Renewal Commitment has been granted.

For renewal policies of Insureds who do not have the Lifetime Renewal Guarantee, the Insurer reserves the right to reject the application or to accept it with conditional terms (such as limit, Risk Surcharge Premium, exclusion, co-payment, waiting period, etc.) in accordance with the Insured's health status and/or MAPFRE Sigorta's risk analysis criteria.

11.3 MAPFRE Sigorta Baby

If the newborn babies of a mother who holds the Hepsi Birlikte Health Insurance product with MAPFRE Sigorta are applied for within a maximum of 2 months after discharge from the hospital, together with the newborn application form and the baby's hospital epicrisis report, they may be included under the Policy with the same product as the mother, effective from the date of birth, following a risk analysis. These babies, once accepted from birth after the risk assessment, will be designated as "MAPFRE Sigorta Baby" and may be granted the Lifetime Renewal Guarantee. For these babies who are entitled to the Lifetime Renewal Guarantee, the "3-year waiting period requirement for congenital diseases" shall not apply. This condition shall remain valid provided that the baby is healthy and has no existing congenital diseases.

Sistem Tarihi: 2025-10-01 13:06:31

Büyük Mükellefler V.D.: 879 001 8869 Sicil No: 38676

-*- Demonstration Powered by OpenText Exstream 10/01/2025, Version 16.6.30 64-bit (DBCS) -*-

SPECIAL TERMS FOR THE HEPSİ BİRLİKTE HEALTH INSURANCE

The definition of a MAPFRE Baby does not mean that an existing illness of the baby will be considered covered in case it was not declared in the application form during the claims stage, or if the illness was detected in the womb; in such cases, exclusions may be applied for the relevant conditions, and these babies may lose their MAPFRE Baby and Lifetime Renewal Guarantee rights.

During the risk assessment process for admitting the baby into the insurance coverage, if the baby does not meet the criteria of the MAPFRE Baby definition, the Insurer may apply exclusions or reject the application.

The newborn hospital expenses of a baby included in health insurance coverage from birth as a MAPFRE Baby will be covered under the Maternity Coverage.

In transfers from other insurance companies, "company babies" (babies insured as of birth, with renewal guarantee, whose congenital disorders are covered, and whose transfer to MAPFRE Sigorta has been accepted with these conditions based on risk analysis and acquired rights) will not be subject to standard exclusions for congenital diseases that appear later (provided that the baby is healthy and has no pre- existing congenital condition).

As long as the policy of the Insured with MAPFRE Baby rights continues uninterruptedly, this right will be preserved. If the Insured switches to a product that does not have the MAPFRE Baby application, this right will become invalid. Newborn babies of mothers insured under a different product cannot qualify as MAPFRE Babies. Admission of a baby that does not meet MAPFRE Baby criteria into the insurance coverage is possible starting from the application date, which may be no earlier than the 14th day after birth.

11.4 Responsibility of the Policyholder

The Policyholder/Insured is obliged to provide accurate answers to the questions asked in the application form and its supplementary documents, and to declare all information that constitutes the subject of the risk and/or that may affect its evaluation. If the declaration of the Insured/Policyholder is untrue, incomplete, or incorrect, the provisions of Article 6 of the General Conditions of Health Insurance shall apply. According to Article 6, the Insurer reserves the right to evaluate the undeclared illnesses of the Insured/Policyholder and to include them in the coverage subject to conditional acceptance (exclusion, Additional Risk Premium, etc.) or to withdraw from the policy.

Sistem Tarihi: 2025-10-01 13:06:31

Büyük Mükellefler V.D.: 879 001 8869 Sicil No: 38676

-*- Demonstration Powered by OpenText Exstream 10/01/2025, Version 16.6.30 64-bit (DBCS) -*-

SPECIAL TERMS FOR THE HEPSİ BİRLİKTE HEALTH INSURANCE

ARTICLE 12 – TRANSITION PROCEDURES AND ACQUIRED RIGHTS

Transfer Procedures and Acquired Rights from Other Insurance Companies

When renewing a Policy through transfer from another company, the Insurer reserves the right— while preserving any Lifetime Renewal Guarantee, if applicable—to request a health declaration, additional tests and/or a doctor's examination from the Insured, and to impose restrictions on coverage and/or conditional acceptances (such as limit, Risk Additional Premium, co-payment, waiting period, etc.). For an Insured transferring with a Lifetime Renewal Guarantee from another company, the current Lifetime Renewal Guarantee conditions of our company shall apply, and the Lifetime Renewal Guarantee date shall be deemed the start date of the MAPFRE Individual Health Insurance Policy.

If the Insured's illnesses that occurred during the policy period at the other insurance company/companies, or illnesses determined to have existed before the first date of insurance, are not declared in the application form, they shall not be considered within the scope of acquired rights—even if they were covered by the previous insurer. These illnesses shall be excluded from coverage.

Acquired rights only include the removal of waiting periods specified in the special conditions, preservation of the first registration date, and the transfer of the Lifetime Renewal Guarantee if applicable.

Rights included in the previous Policy's special conditions/coverages but not present in the new Policy's special conditions/coverages shall not be considered acquired rights. However, rights included in the new Policy's special conditions but not present in the previous Policy's special conditions shall also apply to the Insured.

For the preservation of the Insured's acquired rights, application must be made within 30 days from the end of the previous Policy, and the Insured must have been insured with the other insurance company for at least 1 full year.

Transition from an Existing MAPFRE Group Policy to an Individual Policy

If an Insured under a Group Policy applies for an Individual Policy without leaving the group, even if the Insured already has a Lifetime Renewal Guarantee, a risk analysis will be performed for the transition to the Individual Policy. Based on the outcome of this evaluation, the application may be rejected, exclusions may be applied, or a Risk Additional Premium may be imposed.

An Insured who has not been granted a Lifetime Renewal Guarantee under the Group Policy must apply individually (for an Individual Policy) within 30 days from the date of leaving the coverage of the contract. The Insurer reserves the right, based on its risk analysis evaluation, to accept this application under standard conditions, accept it conditionally (Risk Additional Premium, limit, co-payment, exclusion, etc.), or reject it.

If the Insured has been continuously covered under a Group Policy with our company for at least 6 months and holds a Lifetime Renewal Guarantee, and leaves the Group Health Insurance Policy (due to retirement, dismissal, or resignation), he/she must apply for an Individual Policy within 30 days together with the employment termination document. The Insurer may conduct a risk analysis within the framework of the Insured's Lifetime Renewal Guarantee under the group policy until the date specified in the group policy, or may preserve the rights without conducting a risk analysis. In either case, the Insured's policy may continue with an individual tariff equivalent to the previous Group Health Insurance product, or, if not available, with the closest comparable plan.

If the Insured has Maternity Coverage under the active Group Policy and becomes insured under an Individual Policy that also includes Maternity Coverage, a 12-month waiting period will apply from the Individual Policy Start Date.

For an Insured transferring from a Group Policy to an Individual Policy with a Lifetime Renewal Guarantee, the current individual Lifetime Renewal Guarantee conditions of our company shall apply, and the Lifetime Renewal Guarantee date shall be deemed the start date of the MAPFRE Individual Health Insurance Policy.

Sistem Tarihi: 2025-10-01 13:06:31

Büyük Mükellefler V.D.: 879 001 8869 Sicil No: 38676

-*- Demonstration Powered by OpenText Exstream 10/01/2025, Version 16.6.30 64-bit (DBCS) -*-

SPECIAL TERMS FOR THE HEPSİ BİRLİKTE HEALTH INSURANCE

ARTICLE 13 – TERMINATION OF THE INSURANCE CONTRACT

Cancellations

If the Policyholder/Insured requests cancellation within 30 days after the issuance date of the Policy, and provided that no risk has materialized, the Policy shall be canceled retroactively as of the Policy Start Date, and the premiums paid shall be refunded in full to the Insured. For cancellation requests approved by the Insurer exceeding 30 days, the Insurer shall be entitled to premiums corresponding to the elapsed period from the Policy Start Date. The amount to be refunded to the Policyholder/Insured in case of cancellation shall be calculated on a pro-rata basis, taking into account any claims already paid.

If the claims paid to the Insured do not exceed the amount of premium earned by the Insurer, the Insurer shall refund to the Insured the portion of the premiums collected exceeding the amount it is entitled to. If the claims paid exceed the amount of premium earned by the Insurer but are less than the total premiums collected, the Insurer shall deduct the relevant claim amount from the premiums collected and refund the remaining portion to the Insured.

If the claims paid exceed both the amount of premium earned by the Insurer and the total premiums paid by the Insured, the cancellation shall be effected without any refund of premiums. In the event of risk occurrence, even if the due date of the premium installments has not yet arrived, the portion corresponding to the indemnity amount payable by the Insurer shall immediately become due and payable.

The Policyholder shall be deemed in default if he/she fails to pay any of the premiums specified on the Policy with definitive maturities and amounts by the end of the respective due date. In case of late payment of premiums, the provisions of Article 1434 of the Turkish Commercial Code shall apply.

In the event the Insurer identifies bad faith actions of the Insured/Policyholder (such as allowing non- insured persons to benefit from the insurance coverage, arranging health expenses in the name of other Insured persons, or failure to disclose pre-existing conditions whose symptoms had commenced prior to the Policy Start Date despite the Insured's knowledge thereof), the Insurer shall be entitled to reclaim any health expenses already paid and/or to cancel the Policy without refund of premiums.

Death of the Policyholder or the Insured

In the event of the death of the Policyholder and/or the Insured, the Insurer shall act in accordance with the provisions below: In the event of the death of the Policyholder, if the Policyholder and the Insured(s) listed in the Policy are different persons, and the Insured(s) wish to continue the Policy by replacing the Policyholder, the Policy may be continued provided that the Insured(s) assume the remaining premiums or with the written consent of the legal heirs. In such case, the Policyholder shall be replaced, and the Policy shall remain in force. If the Insured(s) do not assume the premiums and the consent of the legal heirs is not obtained, the procedure shall be carried out in line with the cancellation criteria specified above, and any refundable premiums shall be paid to the legal heirs.

If the Policyholder and the Insured are the same person under a single-person Policy, the Policy shall become null and void upon the death of the Policyholder. Upon written request of the legal heirs of the Policyholder, the procedure shall be carried out in line with the cancellation criteria specified above, and any refundable premiums shall be paid to the legal heirs.

In the case of policies covering more than one Insured, if one of the Insured persons passes away, the deceased Insured shall be removed from the Policy as of the date of death. Any refundable premiums, in line with the cancellation criteria specified above, shall be paid to the Policyholder.

ARTICLE 14 – SAGMER (INSURANCE SUPERVISION CENTER) INFORMATION

The Policy and health information of the Insured persons under this Insurance Policy shall be transferred to SAGMER (Insurance Supervision Center), and such Policy and health information of the Insured may also be obtained from SAGMER and other public institutions.

The General Conditions of Health Insurance published by the Insurance Association of Türkiye can be accessed [here].

Sistem Tarihi: 2025-10-01 13:06:31

Büyük Mükellefler V.D.: 879 001 8869 Sicil No: 38676