3S HEALTH INSURANCE SPECIAL CONDITIONS

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These special conditions are valid for policyholders who have a MAPFRE Health Personal Insurance Policy as of 01.10.2023.

ARTICLE 1- SUBJECT OF INSURANCE

MAPFRE Sigorta A.Ş. ("Insurer") guarantees the health expenses of the Insured that may arise as a result of accident and/or illness/discomfort during the period the insurance contract is in force, in line with the coverage, limits, participation rates, exclusions (general and special exclusions) and network coverage specified in the Policy, within the framework of these Special Terms and Conditions and the General Terms and Conditions of Health Insurance attached hereto and the Regulation on Private Health Insurance, Turkish Commercial Code, legal regulations including insurance health legislation.

The insurance coverage is valid only for the persons listed in the Insurance Policy and other persons cannot benefit from the coverage.

ARTICLE 2- DEFINITIONS

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

EMERGENCY: Situations requiring medical intervention within the first 24 hours following the occurrence of the event in cases of sudden illness, accident, injury and similar situations, and situations where it is accepted that there is a risk of loss of life and / or health integrity in the absence of immediate medical intervention or transfer to another health institution.

1. Drowning in water:
In cases of respiratory or cardiac arrest or where the patient's general condition is such that water is entering the lungs to the extent that drowning may occur.

2. Traffic accident:
Acute conditions with spinal injuries and haemorrhagic fractures. Severe chest, abdominal or head trauma that may cause internal bleeding, even if it does not affect the patient's condition at the time. Cutting and penetrating injuries caused by vehicle parts that cause major haemorrhage in the body.

3. Terrorism, sabotage, shootings, stabbings, fights, etc. (Applicable in cases where he/she was not the instigator or party to the incident and was accidentally exposed).

4. Falling from a height:
Acute conditions with spinal injuries and haemorrhagic fractures. Severe chest, abdominal or head trauma that may cause internal bleeding, even if it does not affect the patient's condition at the time. Cutting and penetrating injuries caused by vehicle parts that cause major haemorrhage in the body.

5. Serious occupational accidents, amputations:
In addition to the situations in the second article, emergencies specific to the work performed. For example: Inhalation of poisonous gases, drinking or spilling of chemicals, partial or complete amputation of fingers, hands, feet, arms or legs.

6. Electric shock:
Severe electric shocks that may cause burns, organ damage or disrupt heart rhythm.

7. Frostbite, cold stroke:
Exposure to cold that may lead to shock that may affect vital functions and cause gangrene in the limbs.

8. Heat stroke:
Exposure to the sun or a hot environment that affects the heart rhythm, blood pressure or state of consciousness.

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9. Serious burns:
Burns from fire, chemicals, electricity, etc. that are extensive enough to cause massive fluid loss, organ loss or skin damage. Inhalation of smoke or hot air that can cause narrowing of the respiratory tract.

10. Serious eye injuries:
Severe sharp or piercing injury, blunt trauma or chemical substance contact that may cause eye damage.

11. Poisonings:
Ingestion of substances that have impaired vital functions at the time of the incident or are likely to do so in the following hours, skin contact with chemical substances or inhalation of toxic gases.

12. Anaphylactic shock:
Severe allergies or low blood pressure that may lead to heart rhythm disturbance, obstruction of the respiratory tract.

13. Traumatic fractures of the spine and upper and lower extremities:
Life-threatening or potentially life-threatening fractures of the spine, arms and legs in the absence of intervention.

14. Heart attacks, hypertensive crises:
Heart attack in progress, types of heart rhythm disorder requiring urgent treatment, elevated blood pressure that can lead to serious conditions such as cerebral haemorrhage..

15. Acute breathing problems:
Drowning, ingestion of foreign bodies, allergic reaction, respiratory burns, which may lead to severe respiratory failure.

16. Any organic defect that causes loss of consciousness:
Conditions such as fainting, cardiac trauma that may cause deterioration in the person's state of consciousness.

17. Sudden paralyses:
Loss of mobility or sensation in the limbs or the whole body due to brain haemorrhage, spinal injury, etc.

18. Severe general condition disorder:
Deterioration of a person's health to a degree that may be dangerous in general terms due to nutritional deficiency, inadequate care, prolonged severe illness, etc.

19. High fever over 39.5:
A rise in body temperature due to poisoning, infectious diseases, heatstroke, etc. that may lead to convulsions (convulsions) or heart rhythm disorders. 39.5 °C and above.

20. Diabetic and uremic coma:
Conditions caused by diabetes (diabetes) and renal insufficiency, starting from clouding of consciousness to complete loss of consciousness (coma).

21. Acute abdomen:
The occurrence of diseases related to intra-abdominal organs that require urgent surgical intervention, such as perforation of hollow organs such as the stomach and intestines, intestinal obstruction or knotting, obstruction of the bile ducts due to stones or inflammation, serious organ inflammation such as appendicitis, pancreatitis, blockage of intestinal or peritoneal arteries, etc.

22. Acute massive haemorrhages:
Life-threatening internal or external bleeding, usually as a result of trauma.

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23. Meningitis, encephalitis, brain abscess:
Inflammatory, infective diseases related to the brain and the membrane surrounding the brain, which may lead to changes in the state of consciousness that may affect the functions of the nervous system and thus vital functions.

24. Renal colic:
Severe pain caused by kidney stones, which can lead to urinary tract or kidney damage if it progresses.

JUDICIAL ACCIDENT: It is an unexpected sudden event that results in bodily injury of the Insured during the policy validity period and that requires and/or has already been followed up and investigated by the judicial authorities. Documented by the organisations conducting the investigation.

CONTRACTED HEALTH INSTITUTION: These are hospitals, clinics, laboratories, diagnostic and treatment centres, pharmacies and doctors with whom the Insurer has made an agreement for the Insured to benefit from health services in accordance with the Policy Terms. The Policy specifies the limits and coverage percentages applicable at Contracted Institutions. You can access the list of contracted organisations at www.mapfre.com.tr.

Since this list can be updated continuously, it should be confirmed before receiving service.

NON-CONTRACTED HEALTH INSTITUTION: Hospitals, clinics, laboratories, diagnostic and treatment centres, pharmacies and doctors who do not have a contract with the Insurance Company. Doctors who do not accept MAPFRE contract terms even if they work as a permanent staff in the contracted institution are considered as "Non-Contracted Institution".

START DATE: The day (12:00 noon Turkish time), month and year on which the Policy becomes effective for the first time or each subsequent renewal, if any.

END DATE: This Policy expires on the day (12:00 noon Turkey time), month and year. All expenses incurred after this date are excluded from coverage regardless of the reason. However, the expenses of an Insured who is being treated in a hospital are covered up to 10 days after the Policy End Date, provided that he/she has never left the hospital.

WAITING TIME: The period starting with the Insured's Registration Date and specified as a waiting period in the Policy, during which medical procedures/interventions are not covered.

UNDECLARED PRE-EXISTING HEALTH PROBLEM: Failure to declare to the Insurer any complaint, symptom, disease/discomfort or complications arising from these, regardless of whether they are diagnosed or not, existing and known at the time of or before the application for this Policy.

OBLIGATION TO DECLARE: The Insured / Insured is obliged to answer the questions asked to him/her correctly during the application for the insurance contract or during the continuation of the insurance contract and to inform the Insurer about the matters that constitute the subject matter of the risk / that will be effective on the assessment of the risk, which are known to him/her.

DOCTOR: A person who has been granted a work licence by the Ministry of Health of the Republic of Turkey and who has been officially granted the title and certificate of medical doctor within the framework of the laws applicable in the geographical region where health services are provided.

GENERAL CONDITIONS: These are the written rules determined by the Republic of Turkey Prime Ministry Undersecretariat of Treasury and compulsory to be applied by all insurance companies in health insurance..

UNNECESSARY TREATMENT PROCEDURES: Although the Insured does not require hospitalisation, the examinations and treatments planned by the doctor are performed by hospitalisation.

HOSPITAL: A public or private institution providing medical services to sick and injured persons, which has an official hospital licence for its field of activity. Outpatient clinics, sanatoriums, physiotherapy centres, health clubs, nursing homes, nursing homes, etc. and institutions specialised in substance (drug, alcohol) addiction are not included in the scope of hospitals.

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HUV (Physician Practice Database): The tariff published by the Turkish Medical Association, showing the fees and principles of practice of doctors practising their profession within the borders of the Republic of Turkey.

The fee in the tariff is calculated by multiplying the "unit value" determined for each medical procedure in the HUV (Physician Practices Database) by the general coefficient determined once a year, separately for each province.

CANCELLATION DATE: The day, month and year on which the Policy is cancelled upon written request by the Policyholder or by the Insurer due to withdrawal or termination due to the issues specified in the General Terms and Conditions.

REGISTRATION DATE: The day (12:00 noon Turkey time), month and year on which the Insured is covered by the Insurance Policy or covered by the first Contract repeated under the conditions specified in the renewal definition.

ACCIDENT: An unexpected, sudden event that causes the Insured to suffer bodily injury that can be medically proven.

COMPLICATION: Unwanted effects of a disease, disorder or medical treatment.

CONGENITAL DISEASE: Physical and/or metabolic defects and/or disorders that are present from birth.

CHRONIC ILLNESS: A disease that does not have a sudden onset, develops and/or progresses slowly, recurs from time to time or causes a permanent health problem.

MEDICAL PROCEDURES CENTRE: It is the unit consisting of specialists who evaluate the payment of health expenses of the Insured who apply to contracted health institutions within the scope of the Policy Conditions and provide 7/24 service within MAPFRE Sigorta.

OPERATION: In case of cancellation of the Insurance Policy, the Policy is reinstated after the evaluation to be made by the Insurer. Reinstatement process can be evaluated for applications to be made within 1 month as of the cancellation date. For this evaluation, the Insurer has the right to request an application form from the Insured, to apply special exception and/or additional risk premium to the Insured whether or not the Insured is entitled to Lifetime Renewal Guarantee (LLRG), and to reject the reinstatement request.

NETWORK (TYPE OF CONTRACTED ORGANISATION): It refers to the grouping of health institutions contracted by MAPFRE Sigorta A.Ş. The valid contracted organisation network type is indicated on each Policy. Institutions outside the scope of the relevant network are considered as Non-Contracted Institutions for the relevant Policy even if they are MAPFRE Contracted Institutions. All entities listed in the Contracted Entity list constitute the MAPFRE Sigorta A.Ş. network. MAPFRE Sigorta A.Ş. has the right to change the Contracted Organisations determined for the network within the policy period or to exclude the relevant Contracted Organisation from the contracted network completely.

SPECIAL CONDITIONS: These are the terms prepared by the Insurance Company in addition to the General Terms and Conditions of Health Insurance, stating mutual rights and obligations, guarantees and conditions of validity and valid until the End Date of this Policy.

PROVISION: It is the insurer's assessment that informs whether or not or under what conditions the expenses of health services (internal hospitalisation, surgical hospitalisation, examination, diagnostic procedures, etc...) to be performed in contracted health institutions valid in the Policy of the Insured will be covered.

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

HAZARD SUPPLEMENTARY PREMIUM: This is the additional premium application related to the disease risks specified in the Policy attached to this Policy and to be applied only for the relevant Insured. The additional premiums applied are stated in the relevant Insured Policy together with the reason and rate.

INSURANCE PROVIDER: The person or legal entity who applies for the Insurance Policy, whose application is accepted by the Insurer and who is the responsible party within the scope of this Insurance Policy and acts in favour of himself/herself and the Persons to be Insured.

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INSURANCE POLICY: It is a document issued by the insurer within the framework of a special format and contains issues such as maturity, special and general conditions, limits, exclusions, application information and payment conditions related to the Policy; if the conditions are fulfilled, it guarantees the payment of the guarantees within the specified limits; all documents bearing the authorised signatures of the company.

INSURER: An Insurance Company which is registered and licensed to operate in the country in which the Insurance Policy is issued. This In the Policy, the title of Insurer is used for MAPFRE Sigorta A.Ş.

INSURED: The person and/or persons specified in the health insurance application of the Policyholder and the Persons to be Insured or added subsequently and accepted by the Insurer and included within the scope of the Policy either in the Policy or with a subsequent addendum.

SPECIAL EXCEPTIONS FOR THE INSURED: It has been decided to be applied by the Insurer in the Insurance Policy The exclusions applicable to the Insured are stated on the Insurance Policy.

STANDARD EXCEPTIONS: These are the general exclusions valid for all Coverages and Insureds and specified in the special conditions.

HEALTH INSURANCE PATIENT INFORMATION FORM: The form filled out by the physician to whom the Insured applies in order for the Insured to benefit from the Policy coverage during the validity period of the Policy. Since this form is not available in Non-Contracted Institutions, the Insured must obtain the Patient Information Form from the Insurer and keep it with him/her. This form is required for the evaluation of medical expenses.

COVERAGE: It is the scope of health expenses that the Insurer will undertake to pay within the framework of the special and general terms and conditions of the Insurance Policy, except for the limit exception, waiting period and exemption specified in the policy.

RENEWAL: It is the application of the Policyholder to the Insurer for a new contract 30 days before or 30 days after the Expiry Date of the existing Insurance Policy and the continuation of the new contract uninterruptedly after the Insurer and the Policyholder agree on the terms of the new Insurance Policy.

RENEWAL DATE: The Start Date (12:00 noon Turkish time), month and year of the new Insurance Policy, which is the same as the End Date of the pre-existing Insurance Policy.

ANNUAL TOTAL LIMIT: This is the annual gross maximum amount that the Insurer may use during the Insurance Policy period specified annually in the terms and conditions of this Insurance Policy. Participation shares and/or exemption amounts to be paid by the Insured are also included in the gross amount.

MAPFRE CUSTOMER SERVICES: The telephone line 0850 755 0 755, where policyholders can communicate their suggestions, requests and complaints, and receive various services such as ambulance and medical counselling.

MAPFRE SİGORTA GO: It is MAPFRE Sigorta's mobile application. Policy coverage conditions, claims management and all kinds of detailed information can be obtained by our policyholders through the mobile application.

MAPFRE SİGORTA WEBSITE: It is MAPFRE Sigorta's corporate web site. Policy special conditions, contracted organisations and detailed information can be accessed via www.mapfre.com.tr.

ARTICLE 3. COVERAGES

3.1. Inpatient Treatment Coverage

Inpatient Treatment Coverage covers internal, surgical and intensive care hospitalisations, emergency medical expenses that may cause a life-threatening condition of the Insured, minor interventions, chemotherapy, radiotherapy and dialysis treatment expenses in accordance with the special and general conditions, provided that it is medically necessary and the doctor states this reason in detail in his/her report. Treatments of the Insured requiring hospitalisation exceeding 24 hours are covered by this coverage.

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In cases requiring a planned hospitalisation and/or surgery, other than emergencies, the "Private Health Insurance Patient Information Form" completed by the doctor who will perform the surgery or internal hospitalisation and the results of the examinations must be submitted to the Medical Operations Centre by the relevant institution at least 48 hours before the hospitalisation. The insurance company decides whether the treatment expenses will be paid within the scope of the Policy after making the necessary examination.

In addition, the lifetime hospitalisation period is limited to 720 days from the first date the Insured has health insurance. In case of exceeding this period, if there is no lifetime renewal guarantee in the Policy, all coverage in the Policy will cease and the Policy will not be renewed. Lifetime hospitalisation limit is not applied for Insureds with lifetime renewal guarantee.

3.1.1 Internal Hospitalisation Coverage

All non-surgical hospitalisations and phototherapies, emergency health expenses that may cause a life-threatening situation of the Insured, provided that the treatment expenses to be incurred by hospitalisation of the Insured exceeding 24 hours are medically necessary and the doctor states this reason in detail in his/her report are covered by this coverage.

Medically compulsory inpatient physiotherapy and rehabilitation expenses related to a condition covered by the coverage are assessed with the Rehabilitation Coverage limit and contribution share specified in the Policy.

3.1.2 Surgical Hospitalisation Coverage

All surgical interventions performed for the purpose of treatment, provided that the medical necessity of the Insured to be hospitalised for more than 24 hours is stated in detail in the doctor's report, and emergency health expenses that may cause a life-threatening situation of the Insured are covered by this coverage.

Coronary angiography, kidney stone crushing (ESWL), kidney, brain, bone marrow and liver biopsies are evaluated within these coverage limits and participation rates.

Ectopic pregnancy and mole hydatiform conditions, which are pregnancy complications, are evaluated within the limits and participation rates of this coverage without any waiting period.

In the event that more than one surgical procedure is performed in the same session with the same or separate incisions and there is a treatment that is not covered, the total invoice (including all hospitalisation and doctor's fee) is proportioned according to the HUV Tariff and the amount to be paid is found. In the ratio to be made, the ratio is made over the total procedure score calculated without applying the incision rule in the HUV Tariff for surgical procedures.

3.1.3 Room-Companion Coverage

In all cases requiring inpatient treatment, room and board (limited to 1 person) expenses for each full day are covered under this coverage within the limits specified in the Policy and the special and general terms and conditions of the Policy. Luxury room or suite room expenses are not covered, the coverage is limited to the cost of a standard single-bed room.

3.1.4 Intensive Care Coverage

Services performed in the intensive care unit are covered by this coverage. The duration of intensive care hospitalisation is limited to 90 days unless otherwise stated in the Policy and is considered within the total 180-day hospitalisation period during the Policy period. In case of expiry of these periods, the coverage for the procedures requiring hospitalisation in the Policy will cease until the expiry of the Policy. The day limits specified for the said intensive care hospitalisation period and daily hospitalisation period are evaluated starting again in each renewed Policy period.

3.1.5 Operator and Doctor Expenses

For all procedures within the scope of Inpatient Treatment Coverage, if the treating doctor (anaesthesia and assistant doctors will also be considered within this scope) is a contracted doctor with MAPFRE Sigorta A.Ş. or a permanent doctor of the contracted institution, the doctor's fee is evaluated with the contracted institution limit and contribution rates specified in the Policy.

In the event that the treatment is performed by a non-contracted doctor (permanent or non-permanent temporary doctor) in a contracted/non-contracted organisation, the non-contracted limit and participation rates specified in the Policy are applied for the doctor's fee.

The invoice of the Insured for a procedure performed by a non-contracted physician within the scope of inpatient treatment is evaluated with this coverage limit and participation rates.

The non-contracted doctor's fee paid by the insured is sent to the Insurer for evaluation together with the Patient Information Form and its annexes. The relevant invoices must be in the form of e-invoice, self-employment receipt and/or POS slip issued in accordance with VUK (Tax Procedure Law).

Operator doctor, anaesthetist and assistant fees must be invoiced separately. These fees cannot be included together in the same e-invoice, self-employment receipt / POS slip issued in accordance with the TPL; documents arranged otherwise will not be processed by the Insurer.

The opinion of the Turkish Medical Association shall be taken for the physician fees of the procedures that are not specified in the HUV's tariff or for which there is a dispute.

3.1.6 Minor Intervention Coverage

Minor interventions up to 199 units (including 199 units) specified in the HUV (Physician Practices Database) tariff published by the Turkish Medical Association; dressing, all injection applications, insertion of serum, ear washing, all kinds of plaster application (including those above 199 units), oxygen administration, abscess drainage, gastric lavage, enema, catheter insertion, nail pulling, all kinds of cauterisation, endometrial curettage, probe curettage, fractionated curettage and dilatation curettage even if it is for therapeutic purposes, cryotherapy application, all kinds of pain treatment interventions and removal of all benign tumours of the skin, regardless of size and number; All minor interventions are covered under this coverage in accordance with the special and general conditions in line with the coverage, limits and participation rates specified in the Policy, provided that they are documented by a doctor's report showing that the treatment is necessary and approved by MAPFRE Sigorta Medical Transaction Centre (MIM).

3.1.7 Ambulance

Expenses incurred for the transportation of the Insured from the province and hospital where he/she is located to the nearest full-fledged hospital by a locally licensed land ambulance due to an illness or accident within the scope of the coverage, or from the province and hospital where he/she is located to another province and hospital by land and/or air ambulance, if deemed necessary by the doctor treating the Insured and approved by MAPFRE Sigorta Medical Transaction Centre (MIM), are covered in accordance with the special and general conditions in line with the relevant coverage, limits and participation rates specified in the Policy. Non-contracted ambulance expenses are evaluated in accordance with the limit and participation rate specified in the Policy.

Air ambulance is valid within the borders of the Republic of Turkey provided that it is approved by the Insurer. Emergency situations are taken as basis for ambulance services.

3.1.8 Chemotherapy, Radiotherapy, Dialysis Coverage

Expenses related to chemotherapy and radiotherapy (doctor, room and board, medication, venous port opening), blood tests required for these two procedures before chemotherapy and radiotherapy, blood tests for the evaluation of complications that may occur after chemotherapy and radiotherapy, and treatment of complications are covered under this coverage in accordance with the special and general terms and conditions of the Policy.

Drugs with the active substance "interferon alpha" (Roferon-A or Intron-A) and drugs with the active substance "peginterferon alpha" (Pegasys or Pegintron) used in the treatment of Hepatitis C, except for cancer treatments, are paid from chemotherapy coverage.

Expenses related to examinations and tests performed to evaluate the course of the disease before and after chemotherapy and radiotherapy are paid from outpatient coverage, but not from chemotherapy coverage.

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If the chemotherapy drugs that are not licensed in Turkey are FDA approved for the current health condition of the Insured and invoiced by the Turkish Pharmacists Association, the related expenses are evaluated within the contracted institution participation share and limit specified in the Policy.

For chemotherapy/radiotherapy performed in a contracted health institution by an external physician who is not a permanent physician of that health institution, the fee to be paid to the non-permanent physician is paid up to the Non-Contracted Physician Expense as stated in Article 3.1.5 of the special conditions of the Policy.

3.1.9 Accidental Dental Coverage

Treatment expenses incurred by dentists related to disc/jaw surgery resulting from traffic accidents/forensic accidents and replacement of teeth (provided that the accident report issued by official institutions is submitted and the treatment is performed within 90 days following the accident) are paid from the surgical hospitalisation coverage. Precious metals that can be used in interventions to be performed within this scope and materials such as implants and coatings will be considered outside the scope of the Policy.

3.1.10 Medicine and Consumables Coverage

Expenses for medicines and consumables used during inpatient treatment are covered by this coverage within the limits specified in the Policy and the special and general terms and conditions of the Policy.

3.1.11. Artificial Limb/Prostheses

Support prostheses approved by the MAPFRE Sigorta Medical Operations Centre, which are documented by a doctor to be necessary for use as a result of an operation and/or a forensic accident after the insurance start date, prostheses applied externally to the body even if they are compulsorily applied during surgery, artificial limb (eye, hand, arm, leg) expenses are covered under this coverage in accordance with the special and general conditions in line with this coverage, limits and participation rates specified in the Policy.

Breast/testicular prosthesis expenses that may arise after cancer treatments are paid from the artificial limb coverage in accordance with the limits, special and general conditions specified in the Policy.

Any prosthesis applied for aesthetic purposes other than those mentioned above are not covered.

3.1.12 Home Medical Care

In order for the insured to benefit from Home Medical Care coverage, he/she must have a tracheostomy, frequent orotracheal aspiration requirement, enteral nutrition requirement, TPN/IV fluid support requirement, ventilator dependency and respiratory failure, advanced oncology patient and pain protocol must be applied.

If deemed necessary by the physician treating the Insured and provided that the Insurer approves, the Insured's Home Medical Care Treatment organisation and the expenses incurred shall be covered from this coverage in accordance with the special and general terms and conditions, limited to 90 days during the term of the Policy, unless otherwise stated in line with the coverage, limits and participation rates specified in the Policy. The relevant day limit is not deducted from the annual 180-day hospitalisation limit defined for Inpatient Treatment Coverage in the Policy.

3.1.13 Auxiliary Medical Equipment

Portable, personalised splint (orthosis, brace, active ankle, bon spur pad), rom walker, walker, nebuliser, elastic bandage, arm sling, corset, orthopaedic boot, insoles, elbow pads, used only for medical purposes and to support the body externally as part of the treatment applied to the Insured as a result of an accident or illness occurring after the insurance start date, Compression stockings, cervical collar, knee brace, wrist brace, sitting wheel, plaster slippers, colostomy bag, urostomy bag, wheelchair (in case of permanent disability documented by a doctor's report), crutches, aerochamber and covering materials used in burn or wound treatment are covered under this coverage within the annual limit and payment percentage specified in the Policy.

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3.1.14 Physiotherapy After Hospitalisation

In the event that the doctor treating the Insured deems it compulsory and the MAPFRE Sigorta Medical Operations Centre approves it, the related physical therapy expenses are paid at the limit and participation share rate specified in the Policy, provided that they support the treatments performed after surgical hospitalisation or intensive care for a condition covered by the coverage and provided that they are performed within 3 months. After the 3rd month, physiotherapy sessions, if any, will be considered under outpatient treatment coverage.

3.1.15 Rehabilitation Coverage

This coverage is activated when the Insured needs inpatient physiotherapy with an indication for hospitalisation. Within the scope of the coverage, rehabilitation expenses that are medically compulsory to be performed inpatient for a condition are considered as compulsory by the physician treating the Insured and approved by MAPFRE Sigorta Medical Operations Centre; at the limit and contribution rate specified in the Policy.

Apart from this limit, other guarantees such as room and board, doctor follow-up, etc. do not come into force.

3.1.16 Emergency Diagnosis Coverage

Expenses for the examination and initial diagnosis of the emergency health condition that caused the Insured to apply to the hospital are covered by this coverage within the limit and participation rate specified in the Policy.

Diagnosis and examination procedures that do not require intervention, even if performed in the emergency services of health institutions, are considered within the scope of Outpatient Treatment Coverage.

3.1.17 Robotic Surgery Coverage

In the event that the treatment is performed with the Robotic Surgery method (such as Da Vinci) deemed appropriate by the doctor and the robotic surgery is approved by the MAPFRE Medical Transaction Centre (MIM) in the relevant diagnosis, Robotic Surgery coverage specified in the Policy is covered in accordance with the special and general conditions in line with the limits and participation rates.

All kinds of material expenses specially used in this method and all hospital expenses (room, accompanying fees, operator doctor fees, etc.) incurred during Robotic Surgery are paid with this coverage limit and co-payment rates.

Regardless of whether the treatment is at a Contracted or Non-Contracted Institution, the doctor's fee for procedures to be performed by a non-contracted doctor (permanent or non-permanent temporary non-employee) is covered in accordance with the special and general conditions in line with the limits and participation rates specified in the Policy. The opinion of HUV shall be taken for the doctor's fees for the procedures that are not specified in HUV's tariff or for which there is a dispute.

3.2. Outpatient Treatment Coverage

Outpatient Treatment Coverage is valid if it is included in the Policy.

Expenses for medical examination, diagnostic/advanced diagnostic examinations, prescription medication and outpatient treatment with sessions for conditions occurring after the insured's start date are considered within the scope of outpatient treatment.
In cases where Outpatient Treatment Coverage is taken, treatment expenses are covered from this coverage in accordance with the limits and participation rates specified in the Policy and in accordance with the special and general conditions. Treatment expenses exceeding the Outpatient Treatment upper limit in the policies are not paid.
Examination, diagnosis and treatment procedures of the insured in any health institution shall be covered in accordance with the special and general conditions in line with the outpatient treatment coverage, limits and participation rates specified in the Policy only if approved by MAPFRE Sigorta Medical Transaction Centre (MIM).
Outpatient Treatment Coverages cannot be given alone, but can be taken together with Inpatient Treatment Coverage.

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3.2.1. Doctor Examination

Physical examination expenses within the scope of Outpatient Treatment documented with the Health Insurance Patient Information Form and performed by physicians working in hospitals and clinics licensed by the Ministry of Health of the Republic of Turkey or by physicians licensed to open a private practice are evaluated within the limits, co-payment, exemption and coverage percentages and special and general conditions specified in the Policy.

Since the examinations performed by the same physician up to the 10th day in relation to the diagnosis in the first examination are control examinations, treatment expenses invoiced in this way are not paid.

In the event that the doctors in the MAPFRE Sigorta A.Ş. Contracted Doctor List perform the authorisation process through online systems, the relevant examination amount will be evaluated 100% within the coverage limits specified in the Policy, taking into account the special conditions.

Expenses related to examinations performed by doctors who do not work as permanent/non-permanent temporary staff in contracted organisations shall be paid by the Insured in any case and sent to the Insurer for evaluation. The relevant invoices must be in the form of self-employment receipts and/or POS slips issued in accordance with the Tax Procedure Law (Tax Procedure Law).

MAPFRE Sigorta reserves the right to make partial payment or not to make payment for invoices belonging to some doctors/organisations as a result of the evaluation and legal investigations to be made by MAPFRE Sigorta.

If you prefer a non-contracted doctor in our outpatient policies, you should contact MAPFRE Sigorta Customer Services, MAPFRE Go and our Corporate Website to confirm the validity of the relevant doctor.

3.2.2. Prescription Medicine

Within the scope of outpatient treatment, medications documented with a doctor's prescription, preventive vaccination expenses (rabies, tetanus, influenza, pneumococcus for people over 65 years of age, rotavirus, meningococcus in addition to the Ministry of Health vaccination calendar for children aged 0-6 years) are considered within the scope of this coverage and are covered within the limits, coverage percentage and special and general conditions specified in the Policy.
Expenses for medicines approved by the Republic of Turkey Ministry of Health are not paid without the original prescription and invoice and/or cash receipt.
Our application for dose limitation in drug intake is arranged as 1 monthly dose. However, the medication must be taken within 7 working days after the prescription is written. Drugs taken after 7 working days will not be paid by MAPFRE Sigorta A.Ş.

When medication is required for chronic diseases, the Insured must apply to the Insurer with a doctor's report including the condition, the history of the condition and the planned treatment. If the use of chronic medication is approved, it will be sufficient for the Insured to apply to the contracted pharmacy with the "first doctor's report and/or a copy of the prescription" for the necessary medication during the treatment period within the Policy period. Approved medicines requested during the treatment period will be paid within the participation rate and limit specified in the Policy upon presentation of the cash receipt/invoice.

3.2.3. Diagnostic Investigations

Expenses for tests, X-rays, hearing tests, USG Doppler EEG-EMG-EKG-EKG-EKO holter expenses and similar diagnostic methods, including but not limited to these diagnostic methods, medication, anaesthesia and doctor's fees required for the application of these diagnostic methods and other expenses related to the diagnostic procedure are covered within the limits, coverage percentage and special and general conditions specified in the Policy, which the medical doctor deems medically necessary for diagnosis and treatment and specified in the Health Insurance Patient Information Form, and which occur within the validity period of the Policy.

For diagnostic procedures, the Health Insurance Patient Information Form must be filled out completely by the Doctor and each diagnostic procedure deemed necessary by the Doctor must be specified in this form.

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3.2.4. Advanced Diagnostic Examinations

Expenses for CT, MRI, PET-CT and scintigraphies (thallium etc.), endoscopic procedures [gastroscopy, colonoscopy (including biopsy) bronchoscopy etc.] angiographies (except coronary angiography) biopsies, urodynamics and similar diagnostic methods, including but not limited to the aforementioned diagnostic methods, medication, anaesthesia and physician fees required for the application of these diagnostic methods, and other expenses related to the diagnostic procedure, as deemed medically necessary by the medical doctor for diagnosis and treatment and specified in the Health Insurance Patient Information Form; Covered within the limits, coverage percentage and special and general conditions specified in the Policy.

For diagnostic procedures, the Health Insurance Patient Form must be filled in completely by the Doctor and Any diagnostic procedure deemed necessary by the doctor must be indicated on this form.

3.2.5. Sessional Outpatient Treatment Procedures

Physical Therapy and Rehabilitation, PUVA (UVA), Hyperbaric O2, ESWT, etc. expenses deemed necessary by a physician for the treatment of a condition covered by the coverage and approved by MAPFRE Sigorta Medical Operations Centre in sessions/day are covered in accordance with the limit, coverage percentage and special and general conditions specified in the Policy. If the treatments to be applied are applied to more than one body region, each region will be treated as one session

3.3. Support Outpatient Treatment Coverage

Support Outpatient Treatment Coverage is valid if it is included in the Policy.

For inpatient treatments resulting in surgery and/or inpatient treatments resulting in a judicial accident, all Outpatient Treatment expenses related to the same case 30 days before and 30 days after the date of hospitalisation are covered under this coverage in accordance with the special and general conditions in line with the coverage, limits and participation rates specified in the Policy.

Support Outpatient Treatment Coverage cannot be given alone, but can be taken together with Inpatient Treatment Coverage.

3.4. Maternity Coverage

Maternity Coverage is valid if it is available in the preferred plan.

3.4.1. Standard Maternity Coverage

Hospital expenses incurred for the mother during and after labour and delivery, medical abortion, curettage or abortion due to medical necessity and/or any complications caused by pregnancy, as well as all kinds of diseases, routine controls and examinations (amniocentesis, non-invasive prenatal test, TORCH panel, etc.) that may occur during and after the detection of pregnancy, if the Insured has outpatient treatment coverage within the plans determined by the company.) are covered under the Maternity Coverage in accordance with the special and general conditions within the annual limit, participation and coverage percentage of the coverage.
Newborn routine baby expenses (first examination and care expenses) are covered within the Maternity Coverage limit, participation and coverage percentage.
Maternity Coverage cannot be given alone, but can be taken together with Inpatient Treatment Coverage.
All expenses related to pregnancy and childbirth that will be incurred abroad will be evaluated within the limits and coinsurances of this coverage.

3.4.2. MAPFRE Sigorta A.Ş. Birth Unlimited Birth Coverage Valid in Contracted Institutions

Within the framework of the inpatient treatment coverage determined by the Company, only the expenses related to the delivery (normal-sesarean delivery), which will be valid only in the institutions where MAPFRE Sigorta A.Ş. has an unlimited delivery agreement, and the standard additional premium to be received will be paid 100% and without limit in individual policies.

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The relevant additional premium will be charged only for one birth and will be paid for the uninterrupted period of the Insured Person until the birth takes place. Unlimited maternity benefit will continue in the policy. This additional premium will be charged only once for each labour.

In the event that the doctor who performs the delivery in these designated institutions is not a permanent physician of the relevant institution (even if there is a doctor / institution contracted with MAPFRE), the doctor's fee (operator, assistant, anaesthesia) to be paid will be paid up to the fee specified in the maximum HUV tariff (HUV*1). The part exceeding this amount will not be paid.
Even if the birth takes place in these institutions, any condition related to pregnancy that may occur before and after the birth will be covered within the limit of the Standard Maternity Coverage if it is within the Policy Coverages.
Newborn baby expenses are covered under the unlimited maternity package, and the first care expenses of the other baby in twin pregnancies are evaluated within the Standard Maternity Coverage.

Pregnancy-related check-up expenses will be evaluated within the standard maternity coverage limit if the Insured has Outpatient Treatment Coverage. (Supportive outpatient treatment is not considered within this scope.).
The relevant coverage cannot be provided for Policies that do not have Maternity Coverage. Maternity coverage waiting period is also valid for this coverage.

3.4.3. Family Planning

Family planning methods that are not frequently repeated (sterilisation, tubal ligation, spiral applications, etc.) can be paid up to 20% of the Maternity Coverage limit (within the Maternity Coverage limit) under the conditions and coverage specified in the Policy.
Family planning methods that are repeated frequently (contraceptive pills, condoms, etc.) are not covered.
In order to benefit from family planning methods, the waiting period for Maternity Coverage must be exceeded.

3.4.4. Baby Incubator Coverage

The treatment costs of the newborn baby (even if born before the due date) of a mother who has been insured at MAPFRE Sigorta for at least 1 year in a plan including Maternity Coverage and who has completed the waiting period (respiratory distress syndrome, all bleeding disorders and apnoeas, hypoglycaemia and hyperglycaemia, convulsions, retinopathy of prematurity, asphyxia and sepsis treatments, etc.) and incubator costs that may arise due to the specified diseases are paid within the Baby Incubator Coverage limit specified in the Policy, within the percentage of participation. The treatment costs (incubator costs due to the diseases specified in the Policy) are paid within the limit and participation percentage of the Infant Incubator Coverage specified in the Policy. This coverage is invalid for Insureds who have not completed the maternity waiting period

3.5. Control Mammography and Control PSA Coverage

Mammography expenses of female Insureds aged 40 years and over for control purposes and PSA examination expenses of male Insureds aged 40 years and over for control purposes are paid once a year and 100% for Insureds with inpatient treatment and/or outpatient treatment plans, provided that they are performed at our company's check-up contracted institutions, unless otherwise stated in the Policy.
For these examinations, you can access the details of the contracted organisations that are valid under the Policy at www.mapfre.com.tr.
Costs of mammography / PSA and, if necessary, breast ultrasonography for control purposes performed at other contracted / non-contracted health institutions will not be paid under the Policy.

3.6. Check-Up Coverage

Regardless of the type of contracted organisation valid in the Insured's Policy, it is paid once a year and 100%, provided that it is performed in the Contracted Organisations established by our company for the Check-Up Coverage. You can access the details of the check-up package and check-up Contracted Institutions valid under the Policy at www.mapfre.com.tr.
The same or other examination costs incurred at other contracted/non-contracted health institutions will not be covered under this coverage.

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3.7. Overseas Treatment Coverage

Inpatient treatment expenses incurred by the Insured abroad after the policy start date, which require internal/surgical hospitalisation and are covered under the coverage (as defined in the Domestic Inpatient Treatment Coverage) are covered by this coverage in accordance with the limit, participation and coverage percentage specified in the Policy and in accordance with the special and general conditions.

Expenses for medical examinations, medication, diagnostic and advanced diagnostic examinations and physiotherapy expenses related to the illnesses of the Insured occurring abroad after the inception date of the insurance shall be covered under this coverage in accordance with the limit, participation and coverage percentage specified in the Policy and in accordance with the special and general conditions within the scope of outpatient treatment (the conditions defined in the Domestic Outpatient Treatment Coverage shall apply).

Except for the case of continuous Inpatient Treatment within the policy period, the coverage of the Insured who resides abroad for more than 3 months without interruption shall cease as of the third month of stay abroad, unless there is a special agreement in the Policy. The Insurer shall not pay any compensation for the treatment expenses incurred abroad during the period of cessation of coverage.

If the Insured enters the customs of Turkey before the End Date of the Insurance Policy, the coverage starts again. For this reason, the Insured must notify the Insurer if he/she needs to stay abroad for more than 3 months. The Insurer reserves the right to suspend or continue the coverage with special conditions depending on the destination country.

The same special and general conditions apply for international and domestic coverage.

Invoices for medical expenses within the scope of inpatient and/or outpatient treatment abroad shall be calculated in Turkish Lira at the Effective Selling Rate of the Central Bank of the Republic of Turkey on the date of invoice (in case the currency of the relevant country does not have the equivalent of the Central Bank of the Republic of Turkey, the equivalent of TL at the US / USD cross rate) and shall be paid to the Insured in accordance with the limit, participation and coverage percentage specified in the Policy and in accordance with the special and general conditions.

The Insurer reserves the right to ask the Insured to certify that he/she was abroad in the relevant country on the date the expenses were incurred in order to be able to evaluate such foreign expenses and to make the relevant invoice payments..

Notarised translation of all relevant documents in order to make the relevant payment under the guarantee, it must be forwarded to the Insurer.

ARTICLE 4. STANDARD WAITING PERIODS

The following conditions are excluded from the coverage of all treatments during the relevant waiting periods, unless they are the result of a judicial accident as of the date of registration of the Insured. In the event that the Insurance Policy is continued in accordance with the renewal conditions and no special exception is made by the Insurer for one of the situations listed below, the standard Waiting Periods listed below shall not apply and shall be included in the coverage for the Insured who have completed the 12-month insurance period without interruption and who have completed this Waiting Period if an additional Waiting Period has been set by the Insurer.

3S HEALTH INSURANCE SPECIAL CONDITIONS

Cases with a Waiting Period of 12 Months Unless a Judicial Accident Occurs

1. All hernias.
2. Anorectal diseases (haemorrhoids, anal fistula and fissure, anal abscess etc.) pilonidal sinus (cyst dermoid sacral).
3. Tonsillectomy, adenoid vegetation surgery, eardrum surgery and tube application, sinus surgery.
4. Excision of all benign tumours, space-occupying lesions, nevi, polyps and hyperplasia, etc.
5. Thyroid and parathyroid diseases.
6. Diseases and operations on the cervix, uterus, ovaries and tubes, endometriosis, cystorectocele.
7. Hydrocele, spermatocele, cord cyst and epididymal cyst.
8. Spine and disc diseases, all kinds of joint disorders (knee, shoulder, etc.) trigger finger, ligament and tendon disorders, carpal tunnel, tarsal tunnel.
9. Varicose Veins and Venous Thrombosis.
10. Calculous diseases of the urinary system, prostate surgery.
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 for chronic diseases (hypertension, ulcers, reflux, inflammatory bowel diseases (ulcerative colitis, crohn's, etc.) COPD, asthma, diabetes, demyelinating diseases, myasthenia gravis, sarcoidosis, nephritis, all rheumatic and connective tissue diseases.
15. All conditions covered by the Maternity Coverage (Pregnancy routine checks, normal or caesarean delivery, miscarriage and/or any complications arising from these, etc.).

ARTICLE 5. STANDARD EXCEPTIONS

In addition to the Out-of-Coverage conditions specified in Article 2 of the General Terms and Conditions of Health Insurance, the following conditions are also covered Excluded for all Coverages of the Policy.

1. The diseases specified in this article are not covered, and the exclusions will not apply if the Insured has completed at least 3 years of uninterrupted individual insurance with our company and is entitled to the Lifetime Renewal Guarantee or is insured as a MAPFRE Baby:

a. Congenital and genetic diseases determined after the Policy Start Date, even if they occur at an advanced age, unless otherwise agreed (even if the baby is insured from birth), premature infant expenses (Exception if the Baby Incubator Additional Coverage is not taken).

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

c. Dementia due to old age, Alzheimers, Parkinson's, epilepsy and antipsychotic, anxiolytic, anticonvulsant and all psychotropic drugs used in the treatment of these disorders,

d. Operations for nasal septum and turbinate.

- Septum and turbinate operations are valid only in contracted institutions specially designated by the Insurer under the name of ENT Network, regardless of the type of contracted institution in the Policy.
- In the event that the treatment of the Insured is performed by a non-contracted doctor (even if it is a doctor / organisation contracted with MAPFRE Sigorta who does not work full-time or non-permanent temporary full-time) in the contracted institution, the doctor's fee will be paid up to the maximum fee specified in the HUV Tariff (HUV*1).
- However, in the event that the Insured has completed at least 5 years of uninterrupted individual insurance period in our company and the Insured is entitled to Lifetime Renewal Guarantee, the relevant operations are valid in all contracted institutions valid in the Policy. In the event that the treatment of the Insured is performed by a non-contracted doctor (even if it is a doctor/institution contracted with MAPFRE Sigorta who does not work full-time as a permanent or non-permanent temporary full-time employee) at the Contracted Institution, the doctor's fee will be paid up to the fee specified in the non-contracted doctor coverage.

3S HEALTH INSURANCE SPECIAL CONDITIONS

2. If the Insured has completed at least 5 years of uninterrupted individual insurance period in our company and is entitled to Lifetime Renewal Guarantee or is insured as a MAPFRE Baby, treatments related to strabismus, otosclerosis, keratoconus, ptosis that did not exist before the Policy Start Date will not be considered as an exception and will be valid only in institutions within the scope of C network, regardless of the network that the Insured has in the Policy. There is an indication requirement for the related diseases and the evaluation will be made by the Medical Operations Centre. These conditions are not covered for Insureds who have not completed 5 years in the individual policy of our Company and are not entitled to Lifetime Renewal Guarantee.

3. Premature incubator baby expenses of the newborn baby of the Insured who has not completed the maternity waiting period and has a plan without Maternity Coverage.

4. All kinds of medical expenses (whether or not diagnosed and/or treated), including existing and undeclared ailments/diseases that existed before the policy start date, and recurrences and complications of these diseases (whether or not diagnosed and/or treated).

5. All kinds of genetic disease / condition research, gene mapping, gene screening examinations.

6. All kinds of routine and specific examination and treatment expenses related to structural disorders, motor mental development and growth disorders (growth and development retardation/progress, early/late puberty, etc.).

7. Mental illnesses and psychological disorders requiring psychiatric treatment, neuropsychiatric tests, all kinds of psychotherapy and all related expenses.

8. All kinds of inconvenience that may occur due to driving without a licence and expenses related to accidents (the driving licence must correspond to the class of vehicle driven by the Insured).

9. Expenses related to alcoholism, alcohol (regardless of promil level), drug, stimulant, hallucinogen and other substance addiction and all kinds of diseases, poisoning, discomfort and accidents that may occur after the use of these substances.

10. Expenses arising from all hazardous sports activities and/or hazardous activities including but not limited to (mountaineering, diving with breathing apparatus, aircraft and glider piloting, parachuting, parapant, delta wing flying, horse riding, rafting, street sledding, high jumping sports (such as base jumping), kiteboarding, kitesurfing, underwater sports, mountain biking, motorcycle and automobile sports and electric scooters, electric bicycles and electric motorcycles that do not require a driving licence, skiing, using motorcycles even if it is for transportation purposes, etc.) whether for amateur or hobby purposes. Expenses arising from professional and/or licensed sports activities of any kind are limited to 20,000 TL. Among these activities, all expenses related to skiing, motorbike and ATV use for transportation purposes and with a driving licence will be covered within the scope of the policy limit and coinsurance rates with additional premium unless the risk occurs.

11. Alternative treatment methods regardless of the institution (acupuncture, homeopathy, osteopathy, hypnosis, yoga, mesotherapy, aromatherapy, neural therapy, chiropractic treatments, ayurveda, ozone therapy, spa and drinking treatments, spa and thermal centres, sanatorium, nursing home, nursing home, precentorium and rehabilitation centres.

12. Unscientific treatments, experimental treatments and American FDA (Food and Drug Administration) All expenses related to medicines and materials not approved by the institution.

13. Procedures / treatments that have no equivalent in HUV (Physician Practices Database).

14. All kinds of procedures performed in aesthetic, cosmetic, laser and beauty centres, lens and optical centres, centres not licensed by the Ministry of Health, healthy living centres, traditional / complementary and alternative medicine centres, anti-aging centres, slimming centres, sports centres, life coaching centres and foot health centres and all expenses related to these procedures (examination, examination, diagnosis, treatment, etc.)

3S HEALTH INSURANCE SPECIAL CONDITIONS

15. All kinds of procedures performed by medical doctors and non-medical doctors who do not have a Ministry of Health work licence and all expenses related to these procedures.

16. Expenses related to nasal valve surgery.

17. Expenses incurred for obtaining a medical board or doctor's report for reasons such as before sports, before marriage, before starting work.

18. Invoices issued by 1st degree relatives of the insured.

19. Coronary artery calcium scoring, coronary VCT angiography, EBT (Electron Beam Tomography), virtual angiography and virtual colonoscopy.

20. Expenses for analyses from institutions without a laboratory licence.

21. All expenses incurred for the removal of the insured's special exception.

22. Expenses related to Inpatient Treatments that are not indicated by MAPFRE Sigorta Medical Operations Centre in accordance with the reports received from the hospital and expenses related to diagnoses and treatments that are not related to a specific complaint and / or disease and unrelated to the complaint (Check-up, routine check-up, etc.).

23. Plastic and reconstructive surgery, all kinds of aesthetic and cosmetic interventions and related complications, telangiectasia, treatments for skin haemangiomas, gynaecomastia. All expenses related to plastic and reconstructive surgery, all kinds of aesthetic and cosmetic interventions and related complications, telangiectasia, treatments for skin haemangiomas, gynaecomastia, antiperspirant and related examinations and treatment procedures, rhinoplasty, abdominal aesthetics, diagnosis and treatment of acne (acne), diagnosis and treatment of hair loss (except alopecia areata), all kinds of breast reduction and augmentation surgery and accessory breast operation

24. All expenses related to the diagnosis or treatment of obesity, weight, appetite disorders, surgery and complications, dietician, weight loss and weight gain programme.

25. All examination and treatment expenses related to uvuloplasty, snoring, sleep apnoea (All expenses related to uvuloplasty and sleep apnoea are covered for Insureds entitled to Lifetime Renewal Guarantee before 01.10.2023).

26. All examination and treatment expenses related to scoliosis and all spinal curvatures (Scoliosis and all spinal curvatures are covered for Insureds entitled to Lifetime Renewal Guarantee before 01.10.2023).

27. Examination, diagnosis, treatment and complication expenses of physicians who apply balanced nutrition, diet-exercise programmes, alternative and/or complementary therapies.

28. Hearing defect surgery (except tube insertion, tympanoplasty, chronic otitis sequelae, etc.) and all related examinations and treatment procedures, voice and speech therapies.

29. Expenses of children under 7 years of age related to cord cyst, hydrocele, all kinds of hernia procedures (not applicable for MAPFRE Insurance infants).

30. Medical supplies not covered under the auxiliary Medical Supplies Coverage defined in Article 3.1.13, CPAP device, its calibration and monitoring, humidifiers used at home, external devices (hearing aid, cochlear implant, etc.), injectors not taken with medication, tapes, telephone, TV, cafeteria, administrative service, paramedical service and other expenses not required for treatment such as service fees, and all kinds of external prostheses and support prostheses (which cannot be evaluated under the Inpatient Treatment Coverage)

3S HEALTH INSURANCE SPECIAL CONDITIONS

31. Vaccinations for allergies, allergy tests, skin prick tests, food intolerance tests, all kinds of immunotherapies (except for the treatment of metabolic and autoimmune diseases).

32. All examination, treatment and complication expenses related to optional curettage, infertility, sterility, miscarriage research and ensuring pregnancy (IVF, follicle follow-up, microinjection, tuboplasty, etc.) hystero salpingography (HSG), spermiogram, adhesiolysis expenses.

33. Varicocele expenses, whether or not related to infertility (except varicocele under the age of 18).

34. Expenses for sex reassignment operations, impotence, peyronie, penile chordia, vaginismus, all examinations and treatments related to sexual dysfunctions (including penile prosthesis) and birth control methods (pills, condoms, etc.) not covered by Article 3.4.3.

35. Syphilis, anogenital condylomas, HIV, AIDS and all related examination and treatment expenses regardless of the route of transmission.

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

37. Expenses related to sclerotherapy, laser, radiation, massage, stockings, etc. applied for the treatment of superficial varicose veins.

38. Donor-related costs in organ, tissue and blood transplantation.

39. Expenses related to cord blood and stem cell collection and storage.

40. All expenses related to officially declared epidemics and epidemics started in bad faith.

41. All vaccines except rabies, tetanus, influenza, pneumococcus for people over 65 years of age, rotavirus, meningococcus in addition to the Ministry of Health vaccination calendar for children aged 0-6 years (including pre or post vaccination examinations and vaccine administration fees) and all kinds of protective procedures against the disease.

42. Pursuant to Article 98/2 of the Social Insurance and General Health Insurance Law No. 5510, the participation fees that the insured are obliged to pay.

43. Private nursing expenses not approved by the MAPFRE Insurance Medical Operations Centre (except for Home Care Coverage) and ambulance expenses other than emergencies (explained in Article 2 Definitions), all expenses of auxiliary health personnel (such as physiotherapist, respiratory therapist, patient carer).

44. Examinations performed by the doctor in the practice (except for basic laboratory tests approved by the Ministry of Health).

45. Medicines not licensed by the Ministry of Health, preparations without active ingredients that do not fall under the definition of medicine, all kinds of substances and chemicals licensed by the Ministry of Agriculture, all medicines not officially imported (except for medicines imported with the permission of the Ministry of Health, which are not available in Turkey and have no equivalent), vitamin-mineral combinations and/or nutritional preparations and medical foods used to meet the daily needs of the body and / or to protect general health

46. All expenses related to examination by dentists and maxillofacial surgeons, tooth-gum treatment and jaw treatments, toothpaste, oral and dental care preparations, etc.

47. Glasses-lens, lens solution, toric and multifocal lenses, and all kinds of diagnosis, examination and treatment expenses for lazy eye, refractive errors in the eye (myopia, etc.), eye misalignments, except for MAPFRE Babies.

48. All kinds of medical equipment and / or device usage / rental fees (except for those evaluated within the scope of home care coverage).

3S HEALTH INSURANCE SPECIAL CONDITIONS

ARTICLE 6. GEOGRAPHICAL SCOPE

It is valid for persons residing within the borders of Turkey. Domestic coverage is valid throughout Turkey, while international coverage is valid throughout the world outside Turkey.

ARTICLE 7. PRINCIPLES OF GUARANTEE APPLICATION

7.1. Limit Applications

Annual Total Limit: In the Policy attached to the Insurance Policy, limits that may vary per disease and/or by coverage are specified, and transactions are made by deducting the contribution share, if any, for the relevant coverage from these limits. The amount of indemnity to be paid is determined by first deducting the amount of indemnity claimed from the relevant limits and then deducting the contribution share, if any, related to the coverage. However, in any case, this amount cannot exceed the limit of the main collateral to which the relevant transaction will be valid.

Annual Inpatient Treatment Total Day Limit: The total number of days the Insured will be hospitalised in the Hospital in a Policy Period 180 and maximum 90 days of this limit is used for intensive care. For this purpose, each day of hospitalisation will be counted as one day. For each renewed Policy Period, the relevant limits will be re-evaluated.

Inpatient Treatment Lifetime Total Day Limit: The total number of Inpatient Treatment days that the Insured can benefit from during his/her lifetime is 720 and will be valid for the years in which the Insured renews the Policy without interruption. For this purpose, each day of hospitalisation will be counted as one day. If the Inpatient Treatment Lifetime Total Day Limit is exhausted, all coverages of the Insured whose limit is exhausted will automatically terminate on the day the limit is exhausted. In case the lifetime day limit (720 days) is exceeded, the Insurer has the right not to renew the Policy.

Inpatient treatment lifetime total day limit is not applied for Insureds with lifetime renewal guarantee. Continued Hospitalisation Limit after the Policy End Date: Expenses of hospital treatments that started while the Insurance Policy was in force and continued uninterruptedly until a date after the Policy End Date are covered up to the 10th day after the Policy End Date, unless the insurance period expires and a new contract is concluded. In the event that the Insurance Policy is cancelled or the Insured is excluded from the coverage of the Insurance Policy or changes the coverage plan, the costs of hospital treatments after the date of cancellation, exclusion or plan change are not covered without any conditions.

7.2. Payment Percentage, Participation Fee Applications

The portion to be paid by the Insurer for the medical expenses within the scope of the coverage specified in the General Terms and Conditions of Health Insurance and the Special Terms and Conditions of this Insurance Policy, taking into account the coverage percentage, limits and exemptions specified in the Policy, is determined as the Acceptable Compensation. The participation share remaining from the coverage percentage specified in the Policy shall be covered by the Insured / Insurer.

7.3. Exemption Applications

The total annual limit amount that the Insurer is not liable to pay, which may vary according to the coverage in the Policy attached to the Insurance Policy.

In a Policy where only Inpatient or Inpatient and Outpatient Treatment has been taken, in order for the payment of medical expenses to commence, the deductible amount is first deducted from the coverage (Inpatient, Outpatient and/or Maternity) for which the invoice will be evaluated, and the portion exceeding the deductible amount is paid in accordance with the limit, participation, special and general conditions specified in the Policy.

ARTICLE 8. PAYMENT OF COMPENSATION

Provision approvals received for treatments to be performed in Contracted Health Institutions are valid if they are performed within 7 days. Re-authorisation is required for procedures that are not performed within this period. Within 7 days, MAPFRE Sigorta A.Ş. reserves the right to refuse for procedures that are not performed and re-authorisation approval is not obtained.

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Except for the expenses incurred at the Contracted Institutions, in case the original invoices showing the medical expenses related to the payments made by the Insured at the Non-Contracted Institution other than the expenses incurred at the Contracted Institutions and other necessary documents (doctor's report, examination results, etc.) are delivered to the Insurer in full, the evaluation is completed within 5 business days, and the claims eligible for payment are paid within this period.

For policies where the insurance premium is paid in instalments, in the event of the occurrence of the risk, the remaining instalments shall become due and payable and shall be deducted from the compensation to be paid to the Insured.

In a Policy with only Inpatient or Inpatient and Outpatient Treatment, in order for the payment of medical expenses to commence; regardless of which coverage (Inpatient, Outpatient and/or Maternity) the invoice comes from, the deductible amount is deducted first and the portion exceeding the deductible amount is paid in accordance with the limit, participation, special and general conditions specified in the Policy.

In the event that the Policy expires and is not renewed while hospital treatment is in progress in relation to health conditions notified to and accepted by the Insurer during the insurance period, treatment expenses for 10 days following the expiry of the Policy shall be paid by the Insurer.

Within the scope of the Inpatient Treatment Coverage and within the scope of the Policy, invoices received from state hospitals affiliated to the Ministry of Health and university hospitals affiliated to the state will be evaluated within the participation and limits of the Contracted Institution.

In the event of death of the insured during the treatment, morgue expenses are evaluated within the limits and participation rates of this coverage.

A notarised translation of all documents required for payments made in a foreign language for medical expenses incurred abroad must be submitted to the Insurer.

It is necessary to see your invoice after any kind of health treatment applied and to control the cost on your behalf, especially the hospital discharge invoices after all hospitalisations should be examined and signed.

In order to make payments under the Inpatient Treatment coverage, the following documents must be submitted to the Insurer.

1- Documented hospital bills signed by the insured, medical report showing the reason for hospitalisation.
2- Detailed operation report for surgical interventions (including pathology result report if a fragment is taken).
3- When deemed necessary, observation file, traffic accident report, forensic report, forensic report, alcohol report, statement of the insured..
4- Epicrisis (flow summary) report.
5- Endoscopic (laparoscopic, arthroscopic, arthroscopic, robotic, thoracoscopic... etc.) surgery videos when deemed necessary.
In the documentation of Outpatient Treatment expenses, in order to make payments within the scope of the coverage, Health The following documents must be submitted to the Insurer in addition to the Patient Information Form.

Doctor Examinations

1- Invoice or self-employment receipt showing the doctor's fee (Dr. stamp and branch must be specified) (Cash register receipts are invalid).
2- If ultrasound was performed during the examination, the original or report (medical record when necessary).

MAPFRE Sigorta reserves the right to make underpayment or non-payment for invoices belonging to certain organisations as a result of the evaluation and legal investigations to be made by MAPFRE Sigorta. Please confirm the validity of the relevant doctor by contacting the Customer Services representative at MAPFRE Sigorta Go, MAPFRE Sigorta Website, 0850 755 0 755 number or musterihizmetleri@mapfre.com.tr in case you prefer a non-contracted doctor in our policies.

3S HEALTH INSURANCE SPECIAL CONDITION

Medicine Expenses

1- Original prescription of the relevant doctor (and doctor's report if necessary).
2- Cash register receipt or invoice.
3- If deemed necessary, the drug name and prices of the drug and barcodes.
4- Doctor's report for medicines used continuously.

Diagnostic and Advanced Diagnostic Examinations

1- Doctor's request letter / dispatch note or report.
2- Invoices showing related expenditures.
3- Examination results, reports, medical records where necessary.

In Physiotherapy

1- Imaging results requiring treatment (MRI, Ultrasound, etc.).
2- Doctor's request letter, detailed report showing the treatment he/she has organised (the treatment required for each session and the total number of sessions must be specified).

Maternity Coverage

1- Relevant birth and doctor's report.
2- Draped hospital bill.
3- Observation file when necessary.
4- Gynaecological USG report, pathology result or Beta HCG result in case of compulsory curettage.

ARTICLE 9. RENEWAL OF THE CONTRACT AND LIFETIME RENEWAL GUARANTEE

9.1. Renewal of the Contract

This insurance is valid for a maximum period of 1 year. However, following the expiry date of the insurance, a new Policy may be issued upon the request of the Insured/Insurer within the principles to be determined by the Insurer. In case of a request for a plan upgrade change during the renewal period, a health declaration form may be requested.

The Insurer decides on the Policy Renewal Terms by analysing the health status and/or loss/premium ratio of the Insureds whose Lifetime Renewal Guarantee is not available during the insured period.

In the event that the Insurer makes conditional acceptances for the previous period and/or ongoing conditions that will be valid in the new contract, provided that the Lifetime Renewal Guarantee provisions are reserved, these conditional acceptances will be valid as long as the Policy is renewed and the parties do not decide to invalidate it.

Even if the Lifetime Renewal Guarantee is available at the time of renewal, the Policyholder may apply to the Insurer to expand the Coverage Scope in the Insurance Policy and/or to add a different product, network, different coverage. The Insurer reserves the right to request a new application form, reject or conditionally accept the application (Additional Premium, limit, participation, etc.) in relation to this change request. The waiting period starts again for the newly added coverage. In addition, Policies are renewed with the current premium, tariff and special conditions.
For a new contract (Policy) up to 30 days before or 30 days after the expiry date of the existing Policy
It may apply to the Insurer.

If 30 days or more have elapsed since the renewal date; a new application form will be issued for the insured as a new insured and he/she will join the insurance as a new insured. His/her vested rights and the Lifetime Renewal Guarantee right he/she has earned will not be valid, and a risk analysis will be made for his/her existing diseases. The discounts earned by the Insured in the previous Policy, such as those arising from the loss/premium ratio, etc. will not be valid.

3S HEALTH INSURANCE SPECIAL CONDITION

The Insurer reserves the right not to cover the risks occurring during the period until the new Policy is issued, to cover them with conditional acceptances (limit, Risk Supplementary Premium, participation, waiting period, etc.) in accordance with the Risk Acceptance Regulation and to revoke the validity of renewal rights..

The Insured must comply with the declaration obligation regulated in Article 6 of the General Terms and Conditions of Health Insurance and Article 1435 of the Turkish Commercial Code at the time of renewal.

9.2. Lifetime Renewal Guarantee

"Lifetime Renewal Guarantee" can be given to the Insured who have a Health Policy, provided that the Insured continues to be insured in the same product for 3 years at MAPFRE Sigorta A.Ş. without interruption and the average of the Damage/Premium ratio for the last three years is below 80%, within the conditions to be determined for those who are medically suitable as a result of the risk analysis assessment to be made.

In order to evaluate the "Lifetime Renewal Guarantee", the Insurer may request the application form containing the current health status of the Insured and medical reports if necessary. The Insurer reserves the right to reject the application, accept the application by applying conditional acceptances (limit, Risk Supplementary Premium, exception, participation, waiting period, etc.) or grant "Lifetime Renewal Guarantee" without applying any conditions in line with the risk acceptance regulation in force according to the health conditions.

The renewal guarantee is personalised and belongs to the Insured who has earned this right. Given to the Insured by the Insurer The phrase "Lifetime Renewal Guarantee" is stated in the Policy of each Insured.

In the policies to be transferred from another insurance company to MAPFRE Sigorta A.Ş., risk analysis will be made for the insured, whether or not there is a renewal guarantee, and applications such as limit, contribution share, exemption, Risk Additional Premium, etc. may be in question. However, the sickness additional premium will not exceed 200%.

The right of Renewal Guarantee earned in the previous company will be re-evaluated according to the criteria of MAPFRE Sigorta A.Ş. and within the framework of the risk analysis to be made, the Insured's right of renewal guarantee can be continued with the current special conditions of the Insurer.

The Insurer shall not have the right to make a risk analysis assessment and apply a new additional condition such as Risk Supplementary Premium, exception, limit, co-payment, or apply a supplementary premium according to the indemnity/premium ratio, except for the cases specified in Articles 6 and 7 of the General Terms and Conditions of Health Insurance, due to disease conditions that arise after the date of the renewal guarantee for an Insured who has been granted a "Lifetime Renewal Guarantee".

During this period, if the Insured wishes to extend the coverage, the Insurer may apply conditions such as limit, contribution share, exemption, Risk Additional Premium, etc. by re-analysing the risk for the coverage to be added or changed. In addition, the Insurer reserves the right to reject the relevant request.

The Health Policy offered by the Insurer to its Insureds to whom the Insurer has made a renewal guarantee commitment is subject to the Special Terms and Conditions in force at the date the Policy is entitled to Lifetime Renewal Guarantee. For Insureds for whom Lifetime Renewal Guarantee is not available, the Special Conditions of the Policy in force in each Policy Period shall apply.

ARTICLE 10. PREMIUM DETERMINATION

10.1 Criteria for Premium Determination

In accordance with the Insurer's Risk Acceptance Regulation, the premiums of the Insured candidate are calculated by taking into account the plan, coverage, age and gender of the Insured, health inflation and indemnity premium rate. In the event that a spouse or child is added to the family or the Insured requests a change of plan after the insurance commencement date, the Insurer reserves the right not to accept the relevant request, provided that it is processed on the premiums in force on the date of the request.

3S HEALTH INSURANCE SPECIAL CONDITION

The premiums and maturities of the Insured within the scope of the Policy are stated on the front side of the Policy; the coverage, limit, participation, etc. plan information is stated in the Policy. The policy premium is calculated based on the age at the insurance start date (the difference between the start date and the date of birth calculated in days/months/years).

As long as the actuarially calculated tariff base premiums remain below 50% of the weighted ratio of the variables that will affect the medical inflation for the relevant period, the rate of increase to the tariff base premium to be applied for all ages and coverages will not exceed 300% on average. Otherwise, this rate may increase by taking into account the medical inflation variables for the relevant period. Medical inflation variables include CPI, PPI, Turkish Medical Association Fee Schedule coefficient changes, foreign exchange rate changes, current price changes to be applied to our company by health institutions.

Provided that it is within the scope of the coverage, 25% of the amount not claimed from MAPFRE Sigorta A.Ş. or paid by SSI with referral will be deducted from the Policy premium in the renewal period. (Not valid for outpatient treatment.)

However, the sum of all discounts applied to the Insured's tariff premium must not exceed 50% of the Insured's premium.

10.2. Regulations Related to Prime

No Claim Discount

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

Insureds who purchase a Policy as a new business and as a Transfer begin this application from the entry tier (tier 1). Taking into account the Insured's current Policy Period Tier and the "Compensation"/"Health Net Premium" (T/P) Ratio, the tier of the renewal Policy for the following year is determined. The starting step will be 1 for Insureds whose insurance period is shorter than 6 months and who entered the Policy on a day basis in the previous year. The tier of the Renewal Policy is determined by taking into consideration the Policy Period Tier of the Insured in force and the "Compensation"/"Health Net Premium" (T/P) Ratio.

Renewal Policy

- If the Compensation/Premium ratio is less than 25%, the next higher grade,
- If the Compensation/Premium ratio is between 25,01% (inclusive) and 70% (inclusive), the same grade,
- If the Compensation / Premium ratio is between 70,01% (inclusive) and 150% (inclusive), 1 lower grade,
- If the Compensation / Premium ratio is between 150,01% (inclusive) and 350% (inclusive), 2 lower grades,
- If the Compensation / Premium ratio is 350.01% (inclusive) and above, it is renewed with 3 lower grades..

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

10.3 Premium Payments

The method, maturity and amounts of the premium payments are specified on the application and/or the premium payment form. The Insured may make the entire premium payment in advance and/or in instalments in accordance with the payment plan approved by the Insurer, by choosing one of the following collection options..

The obligation to pay the premiums written on the policy at the relevant maturities belongs to the Policyholder or the Insured, if any.

Payment by Credit Card

The insured is obliged to fill in the payment plan information specified in the application form completely and accurately on the Payment Notification Confirmation Form.

3S HEALTH INSURANCE SPECIAL CONDITION

The premiums on the policy are collected from the credit card at the relevant maturities. In case the account is not available the provisions of Article 8 of the General Terms and Conditions and additional articles shall apply.

b) Payment by Cheque

The Insured / Insurer can pay the premium amount specified on the Policy by cheque according to the payment schedule.

c) Payment by Bank Transfer

The insured can pay the premium amount specified in the Policy payment schedule (for down payment, the bank receipt must be sent with the application) by wire transfer.

The Insured's name and Policy number must be written in the description section of the remittance. The Insurer shall not be responsible for the non-transfer of payments that do not include this information to the relevant Insured's account.

ARTICLE 11. NEW ENTRY PROCEDURES

11.1. Insurance Period and Admission to Insurance

The term of insurance is 1 year and remains in force between the start and end dates specified in the Policy. The insurance coverage becomes effective upon acceptance of the application by the Insurer, issuance of the Policy and payment of the down payment.

The Insurance Policy covers infants older than 14 days and persons under 60 years of age at the first entry to our company. The policyholder must be over 18 years of age.

There is no age limit for the renewals of Insureds who have received Lifetime Renewal Guarantee.

Children between the ages of 0-12 can be covered under the same product with at least one family member and/or at least one legally dependent person. If requested, unmarried children of the Insured who are dependent and studying (provided that they are documented) can be covered under the Policy until the age of 24.
Children older than 14 days and younger than 12 years of age can only be insured under the product where the mother or father is insured.

Children between the ages of 12-18 can be insured alone, provided that the Policyholder is over 18 years of age. Unless otherwise stated by the insurer, residents within the borders of the Republic of Turkey are accepted for insurance. Policy Policy changes in the country of permanent residence after the commencement of the policy must be notified to the Insurer in writing within one month at the latest must be notified. The Insurer reserves the right to request a passport for the determination of such a situation and not to pay the expenses incurred abroad.

11.2 References

All initial and subsequent applications to be made by the Insurer/Insured candidates must be made with the application forms provided by the Insurer, and the declaration sections regarding the Persons to be Insured must be filled in completely and accurately. All applications and/or amendment requests for the Insurance Policy must be in writing and signed in writing. Any correction or scribbling on the application form is not accepted.

In cases where the Insured has access to the Insurer's health history information, the Insurer may request a physician's opinion, examinations, etc. if deemed necessary by the Insurer to determine the Insured's health condition. In this case, the expenses related to such procedures shall be covered by the Insurer. However, in the event that the necessary documents cannot be obtained from the relevant institutions although the Insured has authorised access to the health information of the Insured, the costs of physician's opinion, examinations, etc. that may be required shall be borne by the Insured and/or the Insurer. In cases where the Insured has not authorised access to health history information, the costs of physician's opinion, examinations, etc. that may be needed will be covered by the Insured and/or the Policyholder.

3S HEALTH INSURANCE SPECIAL CONDITION

The Insured must apply to the Insurer at each Policy renewal period, even if he/she has obtained a Renewal Commitment..

The Insurer reserves the right to reject the application for Insureds who have not received a renewal guarantee, or to accept the application by applying conditional acceptances (limit, Risk Supplementary Premium, exception, participation share, waiting period, etc.) in line with the health status and/or the risk acceptance regulation in force.

11.3 MAPFRE Sigorta A.Ş. Baby

If the babies born to mothers who have 3S Health Insurance product at MAPFRE Sigorta A.Ş. apply to our company with the newborn baby application form and the baby's hospital epicrisis report within 2 months at the latest after being discharged from the hospital, they will be included in the Policy coverage from the same product as the mother as of the date of birth by performing a risk analysis. After the risk assessment to be made, these babies who are included in the scope of insurance from birth will be named as "MAPFRE Sigorta Baby" and lifetime renewal guarantee will be given to these babies. As a result of the assessment, the "3-year waiting period requirement for congenital diseases" will not be applied to these babies who are entitled to receive a lifetime renewal guarantee. This condition will be valid if the baby is healthy and has no existing congenital diseases.

In the event that it is determined that the existing disease of an infant with the definition of MAPFRE Sigorta Baby is not declared in the application form at the compensation stage, an exception may be applied for the relevant diseases, and these infants may lose the right to MAPFRE Insurance Baby and lifetime renewal guarantee.

During the risk assessment carried out for the coverage of the baby, exceptions may be applied to babies that do not meet the definition of MAPFRE Sigorta Baby or it may not be possible to be covered by the insurance.
The newborn hospital expenses of the baby, who is covered by health insurance from birth, will be covered from the maternity coverage.

In transfers from different companies, for babies who are "company babies", insured as of the date of birth, have a renewal guarantee and whose congenital disorders are covered and whose transition to MAPFRE Sigorta with these conditions is accepted as a result of the risk analysis (transition with vested rights), the standard exception will not be applied for congenital diseases that occur later (For this situation, there is a prerequisite that the baby is healthy and does not have an existing congenital disease).

If the Policy of the Insured who is entitled to MAPFRE Baby continues uninterruptedly, this right will remain reserved. In case the Insured switches to a product without MAPFRE Baby application, this right will be invalid. Newborn babies of mothers insured from another product cannot be MAPFRE Sigorta A.Ş. Baby. The baby that does not meet the criteria of MAPFRE Sigorta A.Ş. Baby can be included in the insurance coverage as of the application date, and this date can be the 14th day after the date of birth at the earliest.

11.4. Responsibility of the Insurer

In the event that the Policy is cancelled or the Insured is excluded from the scope of the Policy, it is the responsibility of the Policyholder to return the documents issued on behalf of these persons who are excluded from the scope of the Policy to the Insurer. Losses arising from the failure to return the documents in full shall be recourse to the Policyholder.
The policyholder/insured is obliged to answer the questions asked to him/her in the application form and supplementary documents correctly and to declare the information that constitutes the subject matter of the risk and/or will be effective in its evaluation.

If the declaration of the Insured/Insured Person is untrue, incomplete or incorrect, the provisions of Article 6 of the General Terms and Conditions of Health Insurance shall apply. Without prejudice to the rights of the Insurer pursuant to Article 6, the Insurer shall have the right to evaluate the diseases not declared by the Insured/Insured Person and include them within the scope of coverage with conditional acceptance (out of scope, Additional Premium for Risk, etc.).

The Insurer shall have the right to collect from the Insured and/or the Policyholder any expenses incurred in violation of the General and Special Terms and Conditions of the Health Insurance Policy and any payments made outside the scope of the coverage.

3S HEALTH INSURANCE SPECIAL CONDITION

ARTICLE 12. TRANSITION PROCEDURES AND VESTED RIGHTS

12.1 Transition from Other Insurance Companies

While renewing the Policy as a transfer from another company, the Insurer has the right to request a health declaration from the Insured, request additional examinations, request a doctor's examination when deemed necessary, limit the coverage and/or make conditional acceptances (limit, Risk Additional Premium, participation share, waiting period, etc.), without prejudice to the provisions of the Lifetime Renewal Guarantee, if any. For the Insured who transfers from another company with the Lifetime Renewal Guarantee right, the Lifetime Renewal provisions of our company will apply.

The ailments of the person in other insurance company/companies and/or the ailments that are determined to date back to before the first insurance date are not covered by the vested right if they are not declared in the application form, even if they were paid in the previous insurance company. These conditions are excluded from the coverage.

Vested rights refer to the removal of the waiting periods in the special terms and conditions and the rights he/she had in his/her previous Policy. The rights that are included in the special terms and conditions of the Insured's previous Policy but not included in the special terms and conditions applicable for the new insurance period will not be considered as vested rights. However, the rights that are included in the special terms and conditions of the new term but not included in the special terms and conditions of the previous term will also be valid for the Insured.

In order to grant vested rights, the Insured's first insurance registration date will be taken as basis. The Insured must apply within 30 days at the latest as of the end date of the insurance in order to preserve the first registration date.

12.2 Transition Practices from Existing Group Policy to Individual Policy at MAPFRE Sigorta A.Ş.

In the event that the personnel insured under the Group Policy who have not received a renewal guarantee applies individually (Individual Policy) within 30 days at the latest from the date of leaving the scope of the contract, the Insurer reserves the right to reject the application and accept it with standard conditions or conditional acceptance (risk additional premium, limit, participation share, exception, etc.) according to the risk analysis evaluation.

In the event that the Insured personnel, who has a lifetime renewal guarantee with the condition of continuing to be insured for at least 6 months without interruption within the scope of the group policy in our company, leaves the Group Health Insurance Policy (due to retirement, dismissal or resignation), he/she must apply for a Personal Policy with the notice of dismissal within 30 days at the latest. If there is no equivalent product to the Group Health Insurance product previously owned by the Insured, the Policy can be continued with one of the individual tariffs with the closest plan.

In the event that the Insured, who is covered by the Group Policy, applies for a Personal Policy without leaving the group, whether or not the lifetime renewal guarantee of the Insured is available, a risk analysis will be made in the transition to the Personal Policy, and conditions such as rejection of the application, application of an exception or application of a Risk Additional Premium may be applied according to the evaluation result.

If the Insured has an active Group Policy with Maternity Coverage and is insured in a new Personal Policy with Maternity Coverage, a 12-month waiting period will apply as of the Personal Policy start date.

ARTICLE 13. PRINCIPLES OF TERMINATION OF THE INSURANCE CONTRACT

13.1 Cancellations

If the Policyholder/Insured requests cancellation within 30 days after the issuance date of the Policy; in cases where the risk has not occurred, the Policy shall be cancelled as of the Inception Date and the premiums paid shall be returned to the Insured without interruption.
For claims approved by the Insurer and exceeding 30 days, the Insurer is entitled to premium depending on the time elapsed from the Policy Inception Date. The amount to be refunded to the Insured/Insurer due to cancellation is calculated on a daily basis taking into account the compensation paid.

3S HEALTH INSURANCE SPECIAL CONDITION

If the indemnities paid to the Insured do not exceed the premium amount to which the Insurer is entitled, the Insurer shall deduct the premiums it is entitled to receive from the premiums collected and return the remaining premiums to the Insured. If the indemnities paid to the Insured exceed the premium amount to which the Insurer is entitled but do not exceed the premium amount collected by the Insurer, the Insurer shall deduct the relevant indemnity amount from the premium amount collected and return the remaining premium to the Insured.

If the amount of compensation paid to the Insured exceeds both the premium amount to which the Insurer is entitled and the premiums paid by the Insured, the premium is cancelled without refund. When the risk is realised, even if the premiums are not yet due, the part of the premiums up to the amount of the indemnity amount that the Insurer is obliged to pay becomes due and payable.

The Policyholder shall be in default if it fails to pay any of the premiums, the exact due dates and amounts of which are specified on the Policy, by the due date. The provisions of Article 1434 of the Turkish Commercial Code shall apply in case of failure to pay the premium debt on time.

In cases where the Insurer detects malicious acts of the Insured/Insurer (benefiting from the insurance coverage of persons who are not Insured and having health expenses issued in the name of other Insureds, detection of existing undeclared diseases that the Insured knows and/or whose symptoms started before the insurance start date but did not declare to the Insurer, etc.), the Insurer has the right to collect the health expenses paid and/or cancel the Policy without premium refund.

13.2 Death of the Insurance Holder or Insured

In the event of the death of the Policyholder and/or the Insured, the Insurer shall act according to the following conditions. In the event of the death of the Policyholder, if the Policyholder and the Insured(s) in the Policy are different and the Insured(s) wish to continue the Policy by changing the Policyholder, the written consent of the legal heirs of the Policyholder must be submitted to the Insurer. In this case, the Policy is continued by changing the Policyholder. In cases where the approval of the legal heirs is not obtained, the policy is cancelled in accordance with the above-mentioned cancellation criteria and the premium refund, if any, is made to the legal heirs.

In a single person Policy where the Policyholder is the same as the Insured, the Policy shall be cancelled in the event of the death of the Policyholder. Upon the written request of the legal heirs of the Policyholder, the Policy shall be cancelled in accordance with the above-mentioned cancellation criteria and the premium refund, if any, shall be made to the legal heirs.

For Policies with more than one Insured, if one of the Insureds dies, the deceased Insured is cancelled from the Policy as of the date of death. In line with the above-mentioned cancellation criteria, the premium refund, if any, is made to the Policyholder in the Policy.

ARTICLE 14. SAGMER (INSURANCE SURVEILLANCE CENTRE) INFORMATION

Policy and health information of the Insured under this Insurance Policy will be transferred to SAGMER (Insurance Surveillance Centre) and Policy and health information of the Insured can be obtained from SAGMER and other public institutions.