

SPECIAL TERMS FOR THE 3S GROUP HEALTH

These special conditions shall be valid as of 01.01.2026 for Insured persons holding a MAPFRE Health Group Insurance Policy.

ARTICLE 1- SUBJECT OF INSURANCE

MAPFRE Sigorta A.Ş. ("Insurer") covers the health expenses of the Insured, which may arise as a result of accident and/or illness/disease during the period the insurance contract is in force, in accordance 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 SITUATION: 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. **3. Terrorism, sabotage, shooting, stabbing, fighting, etc.** (Applicable in cases of accidental exposure to which he or she was not the instigator or party.)
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 Article 2, 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 can cause burns, organ damage or disrupt heart rhythm.
7. **Frostbite, cold stroke:** Exposure to cold that may affect vital functions, lead to shock, or 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.
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 may 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. **Poisoning:** Ingestion of substances that have impaired vital functions at the time of the incident or are likely to impair them in the following hours, contact of chemical substances to the skin or inhalation of toxic gases.
12. **Anaphylactic Shock:** Severe allergies or low blood pressure that may lead to impaired heart rhythm, obstruction in the respiratory tract.
13. **Fractures of the spine and upper and lower extremities as a result of trauma:** Life- threatening or potentially life-threatening fractures of the spine, arms and legs in the absence of intervention.
14. **Heart attacks, hypertension crises:** A heart attack in progress, types of heart arrhythmia requiring urgent treatment, elevated blood pressure that could lead to serious conditions such as cerebral hemorrhage.
15. **Acute respiratory problems:** Drowning, foreign body ingestion, 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 lead to a deterioration in the person's state of consciousness.
17. **Sudden strokes:** Loss of mobility or sensation in one's limbs or entire body due to brain hemorrhage, 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 insufficiency, inadequate care, prolonged severe illness, etc.
19. **High fever above 39.5°C:** An increase in body temperature due to poisoning, infectious diseases, heat stroke, etc. that may lead to convulsions or heart rhythm disorders. High fever is considered to be 39.5°C and above.
20. **Diabetic and uremic coma:** Conditions caused by diabetes and renal insufficiency, starting from clouding of consciousness to complete loss of consciousness (coma).

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

23. Meningitis, encephalitis, brain abscess:

Inflammatory, infective diseases related to the brain and the membrane surrounding the brain that may cause 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.

FORENSIC ACCIDENT: An unexpected sudden event that results in bodily injury to the Insured during the policy validity period and that requires and/or has already been followed up and investigated by the judicial authorities. It is documented by the organizations conducting the investigation.

CONTRACTED HEALTH INSTITUTION: These are hospitals, clinics, laboratories, diagnostic and treatment centers, pharmacies and doctors who are licensed by the Ministry of Health of the Republic of Turkey and authorized by the Ministry of Health of the Republic of Cyprus, qualified for diagnosis, treatment and surgical intervention, and with whom the Insurer has an agreement for the Insured to benefit from health services in accordance with the Policy Terms. The limits and coverage percentages applicable at Contracted Institutions are specified in the Policy. You can access the list of Contracted Institutions at www.mapfre.com.tr and MapfreGo application.

Since this list is subject to continuous updating, it must be confirmed before receiving service. The insurer reserves the right to make changes to the "Contracted Healthcare Institutions List" during the policy period.

NON-CONTRACTED HEALTH INSTITUTION: Hospitals, clinics, laboratories, diagnostic and treatment centers, pharmacies and doctors who do not have a contract with the Insurance Company. Doctors who do not accept MAPFRE contract terms, even if they are employed by the Contracted Organization, are considered as "Non-Contracted Institution"

COMMENCEMENT DATE: The day (12.00 noon Turkish time), month and year on which the Policy comes into force for the first time or each subsequent iteration, if any.

END DATE: This Policy expires on the day (12.00 noon Turkish time), month and year. All expenses incurred after this date are excluded from coverage regardless of the reason. However, expenses of an Insured who is being treated in a hospital will be covered for up to 10 days after the Policy End Date, provided that he/she has never left the hospital.

WAITING PERIOD: The period starting from the date of registration of the Insured and the medical procedures/interventions specified as a waiting period in the Policy are not covered.

UNDECLARED PRE-EXISTING HEALTH CONDITION: Failure to disclose to the Insurer any complaint, symptom, disease/discomfort or complications arising out of or in connection with any existing and known complaint, symptom, disease/discomfort or complications arising out of or in connection with any such disease/discomfort, whether diagnosed or not, at or before the time of application for this Policy.

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DECLARATION OBLIGATION: The Policyholder/Insured is obliged to give correct answers to the questions asked to him/her at the application stage 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/which will affect the assessment of the risk.

DOCTOR: A person who has been granted a license to practice 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 the health service is provided.

GENERAL CONDITIONS: These are the written rules determined by the Republic of Turkey Ministry of Treasury and Finance and are mandatory for all insurance companies to apply in health insurance.

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

HOSPITAL: A public or private institution that has an official hospital license for its field of activity and provides medical services to sick and injured people. Outpatient clinics, sanatoriums, physiotherapy centers, health clubs, nursing homes, care homes, etc. and organizations specialized in substance (drug, alcohol) addiction are not included in the scope of hospitals.

HUV (Physician Practice Database): It is a tariff published by the Turkish Medical Association showing the fees and principles of practice for doctors practicing 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 Practice Database) by the general coefficient determined once a year for each province.

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

REGISTRATION DATE: The day (12.00 noon Turkish time), month and year on which the Insured is covered by the Insurance Policy or is 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 a medically verifiable bodily injury.

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

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

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

MEDICAL OPERATIONS CENTER: It is a unit consisting of experts who evaluate the payment of health expenses of the Insured applying to contracted health institutions within the scope of the Policy Conditions and provide 24/7 service within MAPFRE Sigorta.

REINSTATEMENT: In the event that the Insurance Policy is canceled, the Policy is reinstated after the evaluation to be made by the Insurer. Reinstatement can be evaluated for applications made within 1 month as of the date of cancellation. For this evaluation, the Insurer has the right to request an application form from the Insured, to apply a 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 request for reinstatement.

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NETWORK (TYPE OF CONTRACTED ORGANIZATION): Refers to the grouping of health institutions contracted by MAPFRE Sigorta A.Ş. The current Contracted Organization network type is indicated on each policy. Organizations outside the scope of the relevant network are considered as Non-Contracted Organizations for the relevant policy, even if they are MAPFRE Contracted Organizations. All organizations listed in the Contracted Organization list constitute the MAPFRE Sigorta A.Ş. network. MAPFRE Sigorta A.Ş. has the right to change the Contracted Organizations determined for the network within the policy period or to remove the relevant Contracted Organization completely from the scope of the contracted network.

SPECIAL CONDITIONS: The terms prepared by the Insurance Company in addition to the General Terms and Conditions of Health Insurance, stating mutual rights and obligations, coverage and validity conditions 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 hospitalization, surgical hospitalization, examination, diagnostic procedures, etc...) to be performed in contracted health institutions valid under the Insured's Policy will be covered.

PERSONNEL: A person who works continuously and on a full-time basis (at least 35 hours per week) in a workplace with legal personality and who meets the conditions to be insured.

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

RISK ADDITIONAL PREMIUM: This is the additional premium application related to the disease risks specified in the Policy annexed to this Policy and to be applied only for the relevant Insured. The reason and rate of the additional premiums applied are stated in the relevant Insured Policy.

POLICYHOLDER: 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 on behalf of himself/herself and the Insured Persons.

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 met, it guarantees the payment of the coverage within the specified limits; all documents bearing the authorized signatures of the company.

INSURER: An Insurance Company registered and licensed in the country where the Insurance Policy is issued. In this 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 in the Policy or in a subsequent addendum.

SPECIAL EXCEPTIONS FOR THE INSURED: The exclusions to be applied to the Insured agreed to be applied by the Insurer in the Insurance Policy shall be stated on the Insurance Policy.

STANDARD EXCEPTIONS: These are general exclusions that apply to all Coverages and Insureds and are specified in the special conditions.

HEALTH INSURANCE PATIENT INFORMATION FORM: The form filled out by the doctor to whom the Insured has applied 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 organizations, 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.

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CERTIFICATE: The table, which is an integral annex of the Policy, showing the domestic and international coverage group, Contracted Institution type, participation rates, coverage limits, if any, and exemption amounts, if any, selected by the Policyholder in the application form and agreed upon with the Insurer.

COVERAGE: The scope of medical 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 exceptions, waiting period and exemption specified in the policy.

RENEWAL: The Insured applies to the Insurer for a new contract 30 days before or 30 days after the Expiry Date of the existing Insurance Policy and the Insurer and the Policyholder agree on the terms of the new Insurance Policy and the new contract is continued uninterrupted.

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.

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

MAPFRE CUSTOMER SERVICE: 0850 755 0 755 telephone line where insured persons can communicate their suggestions, requests and complaints and receive various services such as ambulance and medical consultancy.

MAPFRE SIGORTA GO: MAPFRE Sigorta mobile application. Policy coverage conditions, claims management and all kinds of detailed information can be obtained by our Insureds through the mobile application.

MAPFRE SIGORTA WEBSITE: MAPFRE Sigorta corporate web site. Policy special conditions, contracted organizations 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 hospitalizations, emergency medical expenses that may cause a life-threatening situation, 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 hospitalization exceeding 24 hours are covered under this coverage.

In cases requiring a planned hospitalization and/or surgery, other than emergencies, the "Private Health Insurance Patient Information Form" completed by the doctor who will perform the surgery or internal hospitalization and the results of the examinations must be submitted to the Medical Operations Center by the relevant institution at least 48 hours before the hospitalization. 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 hospitalization period is limited to 720 days from the first date the Insured has health insurance. In the event 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. The lifetime hospitalization limit does not apply to Insureds with lifetime renewal guarantee.

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3.1.1 Internal Hospitalization Coverage

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

Medically mandatory inpatient physical therapy and rehabilitation expenses related to a condition covered by the coverage are evaluated with the Rehabilitation Coverage limit and contribution share specified in the Policy.

3.1.2 Surgical Hospitalization Coverage

All surgical interventions performed for the purpose of treatment, provided that the medical necessity of the Insured to be hospitalized 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, 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 excluded from the coverage, the total invoice (including all hospitalization and Doctor's fee) is proportioned according to the HUV TARIFF and the amount to be paid is found. In the proportioning to be made, proportioning 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/strong>

Services provided in the intensive care unit are covered under this coverage. Unless otherwise stated in the Policy, the duration of intensive care hospitalization is limited to 90 days and is considered within the total 180-day hospitalization period during the policy period. If these periods expire, the coverage for the procedures requiring hospitalization in the Policy will cease until the expiry of the Policy. The day limits specified for the said intensive care hospitalization period and daily hospitalization period are evaluated starting again in each renewed Policy period.

3.1.5 Operator and Doctor Costs

For all procedures covered under the Inpatient Treatment Coverage, if the treating physician (anesthesia and assistant physicians will also be considered within this scope) is a contracted physician with MAPFRE Sigorta A.Ş. or a permanent physician of the contracted institution, the physician's fee is evaluated with the contracted institution limit and contribution rates specified in the Policy. If the treatment is performed by a non-contracted doctor (permanent or non-permanent temporary doctor) in a contracted/non-contracted organization, the non-contracted limit and participation rates specified in the Policy shall apply for the doctor's fee. The Insured's invoice for a procedure performed by a non-contracted doctor 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 shall be 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 the Tax Procedure Law (Tax Procedure Law). Operator doctor, anesthesiologist and assistant fees must be invoiced separately. These fees cannot be included together in the same invoice, self-employment receipt / POS slip issued in accordance with VUK (Tax Procedure Law); documents issued 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.

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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, as well as dressing, all injection applications, insertion of serum, ear washing, all types of plaster cast application (including those over 199 units), oxygen administration, abscess drainage, gastric lavage, enema, catheter insertion, nail pulling, all types of cauterization, endometrial curettage, probe curettage, fractionated curettage and dilated curettage, even for therapeutic purposes, All minor interventions such as cryotherapy application, all kinds of pain treatment interventions and removal of all benign tumors of the skin, regardless of their size and number, 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 the treatment is documented by a doctor's report showing that the treatment is necessary and approved by MAPFRE Sigorta Medical Operations Center (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 treating physician and approved by MAPFRE Sigorta Medical Transaction Center (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 limits and participation rates 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 companion, 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. Apart from cancer treatments, drugs with the active ingredient "interferon alpha" (Roferon-A or Intron-A) and drugs with the active ingredient "peginterferon alpha" (Pegasys or Pegintron) used in the treatment of Hepatitis C are paid from the 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.

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 at a contracted health institution by an external physician who is not a staff physician of that health institution, the fee to be paid to the non-staff physician will be 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 dental/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 hospitalization 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.

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3.1.11 Artificial Limb/Prostheses

Support prostheses approved by the MAPFRE Sigorta Medical Operations Center, which are documented by a doctor to be necessary to be used as a result of an operation and/or a forensic accident after the insurance commencement date, prostheses applied externally to the body even if they are applied compulsorily 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 be tracheostomized, require frequent orotracheal aspiration, need enteral nutrition, need TPN/IV fluid support, be ventilator dependent, have respiratory failure, be an advanced oncology patient, and have a pain protocol in place.

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

3.1.13 Auxiliary Medical Equipment

Portable, personalized splint (orthosis, brace, active ankle, bon spur pad), rum walker, walker, nebulizer, elastic bandage, arm sling, corset, orthopedic boot, insoles, elbow brace, used for medical purposes only, 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.

3.1.14 Physical Therapy After Hospitalization

In the event that the doctor treating the Insured deems it compulsory and the MAPFRE Sigorta Medical Operations Center 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 hospitalization 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 covered under outpatient coverage.

3.1.15 Rehabilitation Coverage

This coverage is activated when the Insured needs inpatient physical therapy with an indication for hospitalization. Within the scope of the coverage, rehabilitation expenses that are medically obligatory to be performed inpatient for a condition are evaluated at the limit and co-payment rate specified in the Policy, if deemed compulsory by the treating physician and approved by MAPFRE Sigorta Medical Operations Center.

Apart from this limit, other coverage such as room-meal-companion, doctor follow-up, etc. do not come into effect.

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 under 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 departments of health institutions, are considered within the scope of Outpatient Treatment Coverage.

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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 MAPFRE Medical Operation Center (MIM) for 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 incurred during Robotic Surgery (room, companion fees, operator doctor fees, etc.) 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 related to medical examinations, diagnostic/advanced diagnostic examinations, prescription medication and outpatient treatment 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 Center (MIM).

Outpatient Treatment Coverage cannot be provided on its own, but can be taken together with Inpatient Treatment Coverage.

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 licensed to open private practices are evaluated within the limits, co-payment, exemption and coverage percentages specified in the Policy and special and general conditions.

Since 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 provisioning 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 physicians who are not employed by the Contracted Institutions on a permanent/non-permanent temporary basis 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.

MAPFRE Sigorta reserves the right to make partial payment or not to make payment for invoices belonging to certain doctors/organizations 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 Insurance 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 for children aged 0-6 years in addition to the Ministry of Health vaccination calendar) 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. For dose limitation in drug purchase, our application is organized as 1 monthly dose. However, the medication must be taken within 7 working days after the prescription is written. After 7 working days, the medication will not be paid by MAPFRE Sigorta A.Ş.

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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 medications requested during the treatment period will be paid within the participation rate and limit specified in the Policy upon presentation of a cash receipt/invoice.

3.2.3 Diagnostic Investigations

For conditions within the scope of the coverage, 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: expenses for tests, X-rays, hearing tests, USG, Doppler, EEG, EMG, ECG, EKG, ECHO, holter and similar diagnostic methods including but not limited to the aforementioned diagnostic methods, medication, anesthesia and physician 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.

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 indicated on this form.

3.2.4. Advanced Diagnostic Examinations

As deemed medically necessary by the medical doctor for diagnosis and treatment and specified in the Health Insurance Patient Information Form, CT, MR, PET-CT and scintigraphies (thallium etc.), endoscopic procedures (gastroscopy, colonoscopy (including biopsy), bronchoscopy etc.), angiographies (except coronary angiography), biopsies, Urodynamics expenses and similar diagnostic methods, including but not limited to these specified diagnostic methods, medication, anesthesia and physician 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.

For diagnostic procedures, the Health Insurance Patient Form must be filled out 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 Center 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 forensic accident, all Outpatient Treatment expenses related to the same case 30 days before and 30 days after the date of hospitalization are covered from 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 provided on its own, but can be taken together with Inpatient Treatment Coverage.

3.4 Maternity Coverage

Maternity Coverage is available in the preferred plan.

3.4.1 Standard Maternity Coverage

Hospital expenses incurred for the mother during labor and after delivery, medical abortion, curettage performed due to medical necessity, miscarriage, and/or all kinds of complications arising from pregnancy shall be assessed in accordance with the special and general conditions within the annual limit, participation, and coverage percentage of the coverage. In addition, if the Insured has outpatient treatment coverage; the determination of pregnancy and thereafter any illnesses that may occur in relation to pregnancy, routine check-ups and examinations (amniocentesis, non-invasive prenatal test, TORCH panel, etc.) shall be assessed within the scope of Maternity Coverage in accordance with the special and general conditions within the annual limit, participation, and coverage percentage of the coverage.

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Routine newborn baby expenses (the first examination and care expenses performed immediately after birth before the baby is discharged from the hospital) shall be covered within the Maternity Coverage limit, participation, and coverage percentage.

Within the scope of this coverage, all expenses to be incurred abroad shall be assessed within the limits and coinsurance of this coverage.

For this coverage to be valid, the waiting period for Maternity Coverage must have been completed and the Insured must not have become pregnant as of the date the coverage was first taken out. A 9-month waiting period applies for maternity coverage. This period shall commence as of the initial start date of the Insured's maternity coverage. In calculations to be made within the scope of maternity coverage, the Insured's last menstrual period shall be taken into consideration. The last menstrual period must be after the start date of the Maternity Coverage and must be compatible with the ultrasonography findings obtained during pregnancy follow-up. If the last menstrual period is prior to the start date of the maternity coverage, all expenses shall be excluded from the policy coverage. In the renewal period, if maternity coverage is interrupted and subsequently re-included in the policy, the waiting period shall restart.

3.4.2 Family Planning

Infrequently used family planning methods (tubal ligation, intrauterine device applications, etc.) may be paid up to 20% of the Maternity Coverage limit (within the Maternity Coverage limit), in accordance with the conditions and coverage specified in the Policy.

Frequently used family planning methods (oral contraceptives, condoms, etc.) are excluded from coverage.

In order to benefit from family planning methods, the waiting period for Maternity Coverage must have been completed.

3.5 Control Mammography / 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 at 100% for Insureds with inpatient and/or outpatient treatment plans, provided that they are performed at our company's checkup contracted institutions, unless otherwise stated in the Policy. You can find the details of the contracted organizations that are valid under the Policy for these examinations at www.mapfre.com.tr.

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 Dental Treatment Coverage

Dental examinations, panoramic x-rays, fillings, resin, plastic and temporary fillings, tooth extractions, gum diseases, gingivitis (gingivitis), compulsory bridge costs in case of tooth loss, total and partial dentures, detertraj (tooth cleaning) are covered.

Orthodontics, cosmetic dental expenses, night plaque, metal, gold or other precious veneers and routine dental check-ups, Orthodontic appliances (treatments applied to correct irregularities in the teeth or teeth in the wrong position or to prevent such formations) are not covered. For dental claims, it is mandatory to submit a dental diagram in the invoice attachment.

Dentist prescriptions are paid from dental coverage. Dental and maxillofacial surgeries will be paid from dental coverage.

If the relevant coverage is added to the policy, it is indicated in the policy coverage table.

3.7 Eye Treatment Coverage

The eye coverage covers prescription glasses lenses and frames, non-cosmetic contact lenses and lens solutions up to the annual maximum limit upon the written recommendation of an ophthalmologist. Prescription for glasses will be valid for 1 year.

Cosmetic lenses, sunglasses, voluntary lens replacement without doctor's advice and voluntary spectacle frame expenses are not covered.

For the assessment of compensation, it is mandatory to submit a spectacle diagram and accompanying spectacle warranty certificate with the invoice. For payment of lens invoices, the prescription will be sent with the invoice.

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The insured's microbial and viral infections and other eye-related conditions (whether optical or not) during the period will be paid from the doctor's visit in the outpatient coverage at the diagnosis stage and will not be included in the eye coverage. If the relevant coverage is added to the policy, it is indicated in the policy coverage table.

3.8 Overseas Treatment Coverage

The Insured's inpatient treatment expenses incurred abroad after the commencement date of the insurance, which require internal/surgical hospitalization and are covered under the coverage (as defined in the Domestic Inpatient Treatment Coverage) are 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.

Expenses for medical examinations, medication, diagnostic and advanced diagnostic examinations and physiotherapy expenses related to the Insured's illnesses that occur abroad after the policy start date are 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 terms and conditions.

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 will 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 will start 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 covered by inpatient and/or outpatient overseas treatment shall be calculated in Turkish Lira at the Effective Selling Rate of the Central Bank of the Republic of Turkey on the date of the invoice (or in TL at the US/USD cross rate if the currency of the relevant country does not have an equivalent at the Central Bank of the Republic of Turkey) 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 at the time of the expenses in question in order to be able to evaluate the expenses incurred abroad and to make the relevant invoice payments. In order for the relevant payment to be made under the coverage, a notarized translation of all relevant documents must be submitted to the Insurer.

ARTICLE 4. STANDARD WAITING PERIODS

The situations listed below shall be excluded from coverage for all treatments during the relevant waiting periods, unless they arise as a result of a judicial accident, as of the Insured's Enrollment Date. Provided that the Insurance Policy is continued by renewal in accordance with its renewal conditions and no specific exception is stipulated by the Insurer for any of the situations listed below, the standard Waiting Periods set out below shall not apply and such situations shall be included in coverage for Insureds who have completed an uninterrupted insurance period of 6 months and, if an additional Waiting Period has been imposed by the Insurer, who have also completed such Waiting Period.

Conditions Subject to a 6-Month Waiting Period Unless Arising from a Judicial Accident

1. All hernias,
2. Anorectal diseases (hemorrhoids, anal fistula and fissure, anal abscess, etc.), pilonidal sinus (sacral dermoid cyst),
3. Tonsillectomy, adenoid vegetation surgery, tympanic membrane surgery and tube insertion, sinus surgery,
4. All benign tumors, space-occupying lesions, nevi, polyps, and hyperplasia excisions, etc.,
5. Thyroid and parathyroid diseases,
6. Diseases and operations related to the cervix, uterus, ovaries, and fallopian tubes; endometriosis; cystocele,

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7. Hydrocele, spermatocele, spermatic cord cyst, and epididymal cyst,
8. Spinal and disc diseases; all joint disorders (knee, shoulder, etc.); trigger finger; ligament and tendon disorders; carpal tunnel and tarsal tunnel,
9. Varicose veins and venous thrombosis,
10. Stone diseases of the urinary system; prostate surgeries,
11. All endoscopic and laparoscopic procedures and angiographies (excluding procedures performed for diagnostic purposes),
12. Cataract, glaucoma, keratoplasty,
13. Diseases of the gallbladder and bile ducts,
14. All chronic disease treatments and home care services to be provided for chronic diseases (hypertension, ulcer, reflux, inflammatory bowel diseases [ulcerative colitis, Crohn's, etc.], COPD, asthma, diabetes mellitus, demyelinating diseases, myasthenia gravis, sarcoidosis, nephritis, and all rheumatic and connective tissue diseases).

Waiting Period for Maternity Coverage: A 9-month waiting period shall apply for all situations covered under Maternity Coverage (routine pregnancy check-ups, normal or cesarean delivery, miscarriage and/or any complications arising therefrom, etc.). This period shall commence as of the initial start date of the Insured's maternity coverage. In calculations to be made within the scope of maternity coverage, the Insured's last menstrual period shall be taken into consideration. The last menstrual period must be after the start date of the Maternity Coverage and must be compatible with the ultrasonography findings obtained during pregnancy follow-up.

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 excluded for all coverage of this Policy.

1. Congenital and genetic diseases determined after the Policy Commencement Date, even if they occur at an advanced age, premature infant and incubator expenses (even if the infant is insured from birth), unless otherwise specified in the contract.
2. Expenses related to examinations and treatments for pes planus, hallux valgus/rigitus.
3. Dementia caused by old age, Alzheimers, Parkinson's, epilepsy and antipsychotic, anxiolytic, anticonvulsant and all psychotropic drugs used in the treatment of these conditions.
4. Operations for nasal septum and concha.
5. Examination and treatment expenses related to strabismus, otosclerosis, keratoconus, ptosis.
6. All kinds of medical expenses (whether or not diagnosed and/or treated), including existing and undeclared ailments/diseases that existed before the policy commencement date, and recurrences and complications of these diseases.
7. All kinds of genetic disease/condition investigations, gene mapping, gene screening.
8. 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.).
9. Mental illnesses and psychological disorders requiring psychiatric treatment, neuropsychiatric tests, all kinds of psychotherapy and all related expenses.
10. Expenses related to any inconvenience and accidents that may occur due to driving without a license (the driver's license must be appropriate for the class of vehicle driven by the Insured).
11. Expenses related to alcoholism, alcohol (regardless of promile level), drug, stimulant, hallucinogen and other substance addiction and all kinds of diseases, poisoning, disorders and accidents that may occur after the use of these substances.

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12. Expenses arising from all hazardous sports activities, whether amateur or hobby, and/or hazardous activities including but not limited to (mountaineering, diving with breathing apparatus, airplane and glider piloting, parachuting, parapant, delta wing flying, horseback 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 not requiring a driver's license, skiing, using motorcycles even if for transportation purposes, etc.) and expenses arising from all kinds of professional and/or licensed sports activities are limited to TL 20.000. Among these activities, all expenses related to skiing, motorcycle and ATV use only for transportation purposes and with a driver's license will be covered within the scope of the policy limit and coinsurance rates with additional premium unless the risk occurs.
13. Alternative treatment methods (acupuncture, homeopathy, osteopathy, hypnosis, yoga, mesotherapy, aromatherapy, neural therapy, chiropractic treatments, ayurveda, ozone therapy, spa and drinking treatments, spa and thermal centers, sanatorium, nursing home, care home, precentorium and rehabilitation centers.
14. All expenses related to unscientifically proven treatments, experimental treatments and medicines and materials not approved by the US FDA (Food and Drug Administration).
15. Procedures/treatments that have no equivalent in the HUV (Physician Practices Database).
16. All kinds of procedures performed in aesthetic, cosmetic, laser and beauty centers, lens and optical centers, centers without a Ministry of Health work license, healthy living centers, traditional / complementary and alternative medicine centers, anti-aging centers, slimming centers, sports centers, life coaching centers and foot health centers and all expenses related to these procedures (examination, diagnosis, treatment, etc.).
17. All kinds of procedures performed by medical doctors and non-medical doctors who do not have a license from the Ministry of Health and all expenses related to these procedures.
18. Expenses related to nasal valve surgery.
19. Expenses incurred for obtaining a medical board or doctor's report for reasons such as before sports, before marriage, before starting work.
20. Invoices issued by 1st degree relatives of the insured.
21. Expenses related to screening tests such as coronary artery calcium scoring, coronary VCT angiography, EBT (Electron Beam Tomography), virtual angiography and virtual colonoscopy.
22. Analysis expenses from organizations without a laboratory license.
23. All expenses incurred for the removal of the Insured's special exception.
24. Expenses related to Inpatient Treatments that are not indicated by MAPFRE Sigorta Medical Operations Center 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 (Check-up, routine check-up, etc.)
25. Unless it occurs as a result of a forensic accident and disease (cancer, burns, etc.) occurring during the validity period of the Policy; All expenses related to plastic and reconstructive surgery, all kinds of aesthetic and cosmetic interventions and related complications, telangiectasia, treatments for skin hemangiomas, gynecomastia, antiperspirant and related examinations and treatment procedures, rhinoplasty, abdominal aesthetics, acne diagnosis and treatment, hair loss diagnosis and treatment (except alopecia areata), all kinds of breast reduction and augmentation surgery and accessory breast operation.
26. All expenses related to the diagnosis or treatment of obesity, weight, appetite disorders, surgery and complications, dietician, weight loss and weight gain program.
27. All examination and treatment expenses related to uvuloplasty, snoring, sleep apnea.
28. All examination and treatment expenses related to scoliosis and all spinal curvatures.
29. Examination, diagnosis, treatment and complication expenses of physicians who apply balanced nutrition, diet-exercise programs, alternative and/or complementary therapies.
30. Hearing defect surgery (except tube insertion, tympanoplasty, chronic otitis sequelae, etc.) and all related examinations and treatment procedures, voice and speech therapies.
31. For children under 7 years of age, expenses related to cord cyst, hydrocele, all kinds of hernia procedures (not applicable for MAPFRE Sigorta infants).
32. 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 aids, cochlear implants, etc.), injectors not taken with medication, patches, 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)
33. Vaccines for allergies, allergy tests, skin prick tests, food intolerance tests, all kinds of immunotherapies (except for the treatment of metabolic and autoimmune diseases)
34. 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.
35. Varicocele expenses, whether or not related to infertility (except for varicocele under the age of 18).
36. 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 3.4.2.
37. Syphilis, anogenital condylomas, HIV, AIDS and all related examination and treatment expenses regardless of the route of transmission.
38. All expenses related to circumcision and phimosis, even if medically necessary.
39. Expenses related to sclerotherapy, laser, warming, massage, stockings, etc. applied for the treatment of superficial varicose veins.
40. Donor-related costs in organ, tissue and blood transplantation.
41. Expenses related to cord blood and stem cell collection and storage.
42. All expenses related to officially declared epidemics and maliciously initiated epidemics.

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43. All vaccines except rabies, tetanus, influenza, pneumococcal for people over 65 years of age, rotavirus, meningococcal 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.
44. Pursuant to Article 98/2 of the Social Insurance and General Health Insurance Law No. 5510, the co-payments that insured persons are obliged to pay
45. Private nursing expenses not approved by the MAPFRE Sigorta Medical Operations Center (except for Home Care Coverage) and ambulance expenses other than emergencies (as described in Article 2 Definitions), all expenses of auxiliary health personnel (such as physiotherapists, respiratory therapists, caregivers).
46. Examinations performed by the practicing physician (except for basic laboratory tests approved by the Ministry of Health).
47. Medicines not licensed by the Ministry of Health, preparations that do not contain 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 that 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.
48. All expenses related to examination by dentists and maxillofacial surgeons, gum treatment and jaw treatments, toothpaste, oral and dental care preparations, etc.
49. Glasses-lenses, lens solution, toric and multifocal lenses and all kinds of diagnostic, examination and treatment costs for lazy eye, refractive errors in the eye (myopia, etc.) treatments, all kinds of diagnostic, examination and treatment costs for eye shifts, except for MAPFRE Babies.
50. All kinds of medical equipment and/or device usage/rent fees (excluding those covered under home care coverage)

ARTICLE 6. GEOGRAPHICAL SCOPE

This Policy is valid for persons residing within the borders of Türkiye and the T.R.N.C. Domestic coverage under the Policy shall be valid throughout Türkiye and the T.R.N.C., while overseas coverage shall be valid worldwide outside Türkiye and the T.R.N.C.

ARTICLE 7. COVERAGE IMPLEMENTATION PRINCIPLES

7.1 Limit Implementations

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

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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 hospitalization will be counted as one day. If the Inpatient Treatment Lifetime Total Day Limit is reached, all coverage of the Insured will automatically terminate on the day the limit is reached. If the lifetime day limit (720 days) is exceeded, the Insurer has the right not to renew the Policy.

For Insureds with Lifetime Renewal Guarantee, inpatient treatment lifetime total day limit does not apply.

Continued Hospitalization Limit After Policy End Date: The costs of hospital treatments that start while the Insurance Policy is in force and continue uninterrupted until a date after the End Date of the Insurance Policy are covered until the 10th day after the End Date of the Insurance Policy, unless the insurance period expires and a new contract is concluded. In the event that the Insurance Policy is canceled 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 Practices

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 Indemnity. The participation share remaining from the coverage percentage specified in the Policy shall be covered by the Insured/Policyholder.

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 with Inpatient Only or Inpatient and Outpatient Treatment, 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 INDEMNITY

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

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 and other necessary documents (doctor's report, test results, etc.) are submitted to the Insurer in full, the evaluation will be completed within 5 business days, and the claims eligible for payment will be paid within this period.

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

In a Policy with Inpatient Only or Inpatient and Outpatient Treatment, in order for payment for medical expenses to commence; regardless of the coverage (Inpatient, Outpatient and/or Maternity) from which the invoice comes, 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 treatments related to accepted health conditions notified to the Insurer during the insurance period are in progress, treatment expenses for 10 days after the expiration 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 Organization.

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

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

You are required to see your invoice after any medical treatment and to perform cost control on your behalf, especially to review and sign the hospital discharge invoices after all hospitalizations.

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 hospitalization,
- 2- Detailed operation report for surgical interventions (including pathology result report if a fragment was taken),
- 3- When deemed necessary, observation file, traffic accident report, forensic report, forensic minutes, alcohol report, statement of the insured,
- 4- Epicrisis (flow summary) report,
- 5- Endoscopic (laparoscopic, arthroscopic, robotic, thoracoscopic, etc.) surgery videos when deemed necessary. The following documents must be submitted to the Insurer in addition to the Health Insurance Patient Information Form in order to make payments under the coverage in the documentation of Outpatient Treatment expenses.

In 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 printout or report (medical record when necessary)

MAPFRE Sigorta reserves the right to make underpayment or non-payment for invoices belonging to certain organizations 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.

In Medicine Expenses

- 1- Original prescription of the relevant doctor (and doctor's report where necessary).
- 2- Cash register receipt or invoice.
- 3- If deemed necessary; drug coupons and barcodes with drug names and prices.
- 4- Doctor's certificate for medicines used continuously.

In 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 Physical Therapies

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

In Maternity Coverage

- 1- Relevant birth and medical report.
- 2- The hospital bill with the transcript.
- 3- Observation file when necessary.
- 4- Gynecological USG report, pathology result or Beta HCG result in mandatory curettage.

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ARTICLE 9. RENEWAL OF THE CONTRACT AND LIFETIME RENEWAL GUARANTEE

9.1 Renewal of 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/Policyholder in accordance with 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 examining the health status and/or loss/premium ratio of the Insured who does not have a Lifetime Renewal Guarantee during the period of insurance.

In the event that the Insurer makes conditional acceptances for the previous period and/or ongoing conditions to 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 and/or to add different products, networks, different coverage. The Insurer reserves the right to request a new application form, reject the application, or accept the application conditionally (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.

The Insured may apply to the Insurer for a new contract (Policy) 30 days before or up to 30 days after the expiry date of the existing Policy.

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 Lifetime Renewal Guarantee will not be valid, and a risk analysis will be made for his/her existing diseases.

Any discounts earned in previous Policies, such as those arising from the Insured's loss/premium ratio, etc. will not be valid.

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, Additional Risk 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 stipulated in Article 6 of the General Terms and Conditions of Health Insurance and Article 1435 of the Turkish Commercial Code during renewal.

9.2 Lifetime Renewal Guarantee

Provided that the Insured has continuously maintained insurance with MAPFRE Sigorta A.Ş. for 3 years with the same coverages without interruption, has been included in the insurance coverage before the age of 65, and the average Loss/Premium ratio for the last three years is below 80%, a "Lifetime Renewal Guarantee" shall be granted to insured persons holding a group health insurance policy, within the conditions to be determined, following a risk analysis assessment.

In order to conduct the "Lifetime Renewal Guarantee" assessment, the Insurer may request from the Insured an application form containing current health status information and, if deemed necessary, medical reports. In line with the applicable risk acceptance guidelines and depending on health conditions, the Insurer reserves the right to accept the Insured by applying conditional acceptances (limits, additional risk premium, exclusions, participation, waiting period, etc.) or to grant a "Lifetime Renewal Guarantee" without applying any conditions.

The Lifetime Renewal Guarantee is personal and applies solely to the Insured persons who have acquired this right. The phrase "Lifetime Renewal Guarantee" granted by the Insurer to the Insured shall be specified in each individual Insured's Policy.

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In policies to be transferred from another insurance company to MAPFRE Sigorta A.Ş., regardless of whether a renewal guarantee exists, a risk analysis shall be conducted for the insured, and applications such as limits, participation share, exclusions, additional risk premium, etc. may be applied. However, the additional risk premium to be charged shall not exceed 200%.

Any lifetime renewal guarantee right acquired with the previous insurance company shall be re-evaluated in accordance with MAPFRE Sigorta A.Ş. criteria, and as a result of the risk analysis to be carried out, the insured's renewal guarantee right may be continued under the Insurer's current special conditions.

For an Insured who has been granted a "Lifetime Renewal Guarantee," the Insurer shall not have the right, due to illnesses arising after the date on which the lifetime renewal guarantee was granted, to conduct a risk analysis assessment or to apply new additional conditions such as additional risk premium, exclusions, or limits, or to apply additional premiums based on the loss/premium ratio, except for the situations specified in Articles 6 and 7 of the General Conditions of Health Insurance.

In the event that the Insured requests an expansion of the scope of coverage, the Insurer reserves the right to re-evaluate the existing "Lifetime Renewal Guarantee" and, based on the risk analysis to be carried out, to apply limits, participation share, exclusions, additional risk premium, etc.

The health policy offered by the Insurer to its Insureds to whom it has committed a lifetime renewal guarantee shall be subject to the special conditions in force as of the date on which the policy acquired the lifetime renewal guarantee right. For insureds who do not have a Lifetime Renewal Guarantee, the special conditions of the policy in force in each policy period shall apply.

If the Insured exits the scope of the Group Health Insurance under which he/she holds a Lifetime Renewal Guarantee right and applies for an individual health insurance policy, the Insurer shall have the right to conduct a risk analysis and to apply exclusions, additional risk premium, limits, and participation share for illnesses up to the date on which the Lifetime Renewal Guarantee was granted/earned under the Group Health Insurance Policy.

ARTICLE 10. DETERMINATION OF PREMIUM

10.1 Criteria for Premium Determination

The insurer determines Group Health Insurance premiums by taking into account criteria such as the size of the group, past utilization, age/gender of the insured, insurance period, coverage structure, coverage limit and inflation rate. Instead of premium setting on an individual basis, premiums can be set according to the number of insureds in the group based on age and gender distribution. In addition, changes in the Health Service Tariff (Turkish Medical Association minimum wage tariff, SUT units and coefficients, HUV units and coefficients) are taken as a basis for health inflation in the evaluation. In case of any changes in the Health Service Tariff, a revaluation is made. 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).

10.2 Premium Payments

The terms, maturities 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 installments 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 due dates belongs to the Policyholder or the Insured, if any.

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a) 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.

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 Check

The Insured / Insurer can pay the premium amount specified on the Policy by check 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.

In the transfer transaction, the Insured's name and Policy number must be written in the description section. 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 INSURANCE ACCEPTANCE PROCEDURES

11.1 Insurance Period and Acceptance into Insurance

The insurance period is 1 year and shall remain in force between the start and end dates specified in the Policy. Insurance coverages shall enter into force upon acceptance of the application by the Insurer, issuance of the Policy, and payment of the advance premium.

Upon initial entry into our company, the Insurance Policy shall provide coverage for babies older than 14 days and persons under the age of 65. The Policyholder must be at least 18 years of age.

There shall be no age limit for renewals with our company for Insureds who have obtained a Lifetime Renewal Guarantee.

Children between the ages of 0–12 may be included in coverage under the same product together with at least one family member and/or at least one person who is legally obliged to provide care. Upon request, unmarried children of the Insured who are dependent and pursuing education (subject to documentation) may be covered under the Policy up to the age of 24. Unless otherwise stated by the Insurer, persons residing within the borders of the Republic of Türkiye and the Turkish Republic of Northern Cyprus shall be accepted into insurance. Any change in the country of continuous residence after the Policy inception must be notified to the Insurer in writing no later than one month. The Insurer reserves the right to request passports and/or overseas entry and exit records in order to determine such a situation and to refuse payment of expenses incurred abroad.

11.2 Applications

All initial and subsequent applications to be made by the Policyholder/Prospective Insureds must be submitted using the application forms provided by the Insurer, and the declaration sections relating to the Persons to be Insured must be completed fully and accurately. No corrections shall be accepted on the application form in written applications.

When establishing the initial contract, the Company may, if deemed necessary, request a physician's opinion in order to determine the Insured's health status. However, no physician's opinion shall be requested in renewals, plan changes, or transfer procedures from different insurance companies.

If a physician's opinion is still required, even though the Company has obtained information relating to the Insured from the persons and institutions providing treatment, the Insurance Information and Monitoring Center, and public institutions and organizations, the related expenses shall be covered by the Insurer. However, if the contract is established solely on the basis of the health declaration submitted by the Insured/Policyholder, any physician's opinion expenses that may be required shall be borne by the Insured/Policyholder.

The Insured must apply to the Insurer for renewal procedures in each Policy renewal period, even if a Lifetime Renewal Guarantee has been obtained.

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In line with the health status and/or the applicable risk acceptance guidelines, the Insurer reserves the right, for Insureds who have not obtained a renewal guarantee, to reject the application or to accept it by applying conditional acceptances (limits, additional risk premium, exclusions, participation share, waiting period, etc.).

11.3 MAPFRE Sigorta A.S. Baby

If mothers who hold the 3S Health Insurance product with MAPFRE Sigorta A.Ş. apply to our Company no later than 2 months after the newborn baby is discharged from the hospital, together with the newborn baby application form and the baby's hospital epicrisis report, a risk analysis shall be conducted and the baby may be included in the Policy as of the date of birth under the same product as the mother. Following the risk assessment to be carried out, such babies who are included in insurance coverage from birth shall be referred to as a "MAPFRE Sigorta Baby," and a Lifetime Renewal Guarantee may be granted to these babies. For babies who, as a result of the assessment, qualify for a Lifetime Renewal Guarantee, the "3-year waiting period condition applicable to congenital (inborn) diseases" shall not be applied. This condition shall apply provided that the baby is healthy and has no existing congenital (inborn) diseases.

If, at the claim stage, it is determined that an existing condition of a baby defined as a MAPFRE Sigorta Baby was not declared in the application form, exclusions may be applied for the relevant diseases, and such babies may lose their MAPFRE Sigorta Baby status and their Lifetime Renewal Guarantee right.

During the risk assessment conducted for the inclusion of the baby in insurance coverage, exclusions may be applied to babies who do not meet the definition of a MAPFRE Sigorta Baby, or the Insurer reserves the right not to include the baby in insurance coverage.

As an exceptional provision under this article; newborn babies born after the Insured has maternity coverage in the Policy and after completion of the waiting period for such coverage may be accepted as a "MAPFRE Sigorta Baby," provided that notification is made to the Insurer within 15 days from the date of birth, without applying any exclusions or limits, and by charging an additional premium for any existing illnesses.

In transfers from different insurance companies, for babies who are classified as a "company baby," insured as of the date of birth, have an existing renewal guarantee, and whose congenital conditions are covered under this status, and whose transfer to MAPFRE Sigorta under these conditions (with acquired rights) is accepted as a result of the risk analysis, the standard exclusion for congenital diseases that arise subsequently shall not be applied (for this provision to apply, it is a prerequisite that the baby is healthy and has no existing congenital disease at the time of transfer). Provided that the Policy of the Insured holding the MAPFRE Sigorta Baby right continues uninterrupted, this right shall be preserved. If the Insured switches to a product that does not include the MAPFRE Sigorta Baby right, such right shall become invalid. Newborn babies of mothers insured under a different product cannot be accepted as a MAPFRE Sigorta Baby. For a baby who does not meet the MAPFRE Sigorta Baby criteria, inclusion in insurance coverage shall be possible as of the application date, which may be at the earliest the 14th day following the date of birth.

11.4 Responsibility of the Policyholder

In the event that the Policy is canceled or the Insured is excluded from the scope of the Policy, the Policyholder is responsible for returning to the Insurer the documents issued on behalf of these persons who are excluded from the scope of the Policy.

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/Policyholder is untrue, incomplete or inaccurate, 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 has the right to evaluate the diseases not declared by the Insured/Insurer and to include them in the coverage with conditional acceptance (out of scope, Additional Premium for Risk, etc.).

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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 coverage.

ARTICLE 12. TRANSFER PROCEDURES AND ACQUIRED RIGHTS

12.1 Transfers from Other Insurance Companies and Acquired Rights

When the Insurer renews a Policy as a transfer from another insurance company, it reserves the right, provided that any existing Lifetime Renewal Guarantee conditions are preserved, to request a health declaration from the Insured and to apply conditional acceptances (such as limits, additional risk premium, participation share, waiting period, etc.). For an Insured who transfers from another insurance company with a Lifetime Renewal Guarantee right, the Lifetime Renewal Guarantee conditions applicable within our Company shall apply.

If diseases of the individual at other insurance company/companies and/or diseases determined to predate the initial insurance date were not declared on the application form, even if they were paid for by the previous insurance company, such diseases shall not fall within the scope of acquired rights. These diseases shall be excluded from coverage.

Acquired rights refer solely to the removal of waiting periods stipulated in the special conditions, the preservation of the initial enrollment date, and, if any, the transfer of the Lifetime Renewal Guarantee. Rights included in the special conditions/coverages of the Insured's previous Policy but not included in the special conditions/coverages applicable for the new insurance period shall not be considered as acquired rights. However, rights that exist in the special conditions applicable for the new period but were not included in the special conditions of the previous period shall also apply to the Insured. In order to preserve the Insured's acquired rights, an application must be submitted no later than 30 days following the policy expiration date.

12.2 Transfers from an Existing MAPFRE Sigorta A.Ş. Group Policy to an Individual Policy

An Insured who has not obtained a Lifetime Renewal Guarantee under a Group Policy must apply individually (for an Individual Policy) no later than 30 days from the date of exit from the group contract. The Insurer reserves the right to reject such application or, based on the risk analysis assessment carried out, to accept it under standard terms or by conditional acceptance (additional risk premium, limits, participation share, exclusions, etc.).

If an Insured who holds a Lifetime Renewal Guarantee under the group policy with our Company exits the scope of the Group Health Insurance Policy (due to retirement, dismissal, or resignation), he/she must apply for an Individual Policy within 30 days at the latest, together with the notice of termination of employment. Continuation of the Policy may be ensured with a product equivalent to the Group Health Insurance product previously held by the Insured, or, if not available, with one of the closest individual products. However, if the Lifetime Renewal Guarantee stated in the group policy certificate of the Insured is expressed as "granted for the Individual Policy, provided that medical evaluation is conducted for risks up to the renewal guarantee date specified in the certificate," then individual policy transfer conditions shall be determined by conducting an assessment of health risks prior to the relevant date.

If an Insured covered under a Group Policy applies for an Individual Policy without exiting the group, regardless of whether the Insured has a Lifetime Renewal Guarantee, a risk analysis shall be conducted for the transfer to the Individual Policy, and depending on the outcome of the assessment, conditions such as rejection of the application, application of exclusions, or application of an additional risk premium may be imposed.

If the Insured has an active group policy that includes Maternity Coverage and becomes insured under an Individual Policy that includes new Maternity Coverage, a 9-month waiting period shall apply as of the Individual Policy start date.

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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 canceled as of the Commencement 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 returned to the Insured/Policyholder due to cancellation is calculated on a daily basis, taking into account the compensation paid.

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 canceled without refund. When the risk occurs, the portion of the premiums up to the amount of the indemnity that the Insurer is obliged to pay, even if it is not yet due, 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/Policyholder (benefiting from the insurance coverage of persons who are not Insured and having medical 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 medical expenses paid and/or cancel the Policy without refund of the premium.

13.2 Death of the Policyholder 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 will be continued by changing the Policyholder. In cases where the approval of the legal heirs is not obtained, the policy will be canceled in accordance with the above-mentioned cancellation criteria and the premium refund, if any, will be made to the legal heirs.

In a single person Policy where the Policyholder is the same as the Insured, the Policy becomes null and void in the event of the death of the Policyholder. Upon the written request of the legal heirs of the Policyholder, the Policy shall be canceled 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 canceled from the Policy as of the date of death. In line with the above-mentioned cancellation criteria, the premium refund, if any, will be made to the Policyholder in the Policy.

ARTICLE 14. INFORMING SAGMER (INSURANCE SURVEILLANCE CENTER)

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

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Please click [here](#) to access the health insurance general terms published by the Insurance Association of Turkey.