SPECIAL TERMS FOR THE COMPLEMENTARY HEALTH INSURANCE

No Difference Health Insurance
The following statement shall be added regarding applicability at the beginning, immediately under the heading: These special terms and conditions shall be applicable to insured persons holding a No Difference Health Insurance policy as of 01.01.2026.

ARTICLE 1 - SUBJECT MATTER OF INSURANCE

The Policy Holder's treatment expenses arising from a disease and/or accident in addition to the Health Insurance General Terms are covered within the coverage, limit, special and general terms specified in the policy. Insurance coverage is valid only for the persons included in the insurance policy, and others cannot benefit from the coverage. Pursuant to the Social Security and General Health Insurance Law, only those who benefit from health services can benefit from this insurance coverage.

ARTICLE 2 - DEFINITIONS

Explanations for the definitions used within the insurance policy are provided below.

IN-NETWORK PROVIDER:Healthcare providers where the insurance company offers policy holder beneficial service with and/or without charge within the frame of special agreements, and that serve within the special and general terms of the policy.

LIST OF IN-NETWORK PROVIDERS: The list of healthcare providers that serve within the special and general terms of the policy and the list where the insurance company introduces policy holder beneficial service with and/or without charge within the framework of special agreements. This list is updated by the insurance company and its final updated version is taken into consideration for all policies.

OUT-OF-NETWORK PROVIDER: These are the healthcare providers that do not have a contract with the insurance company

OUTPATIENT TREATMENT COVERAGE: It is the coverage including services within the scope of this policy and in the cases where hospitalization or treatment at the hospital, and being kept under observation is not required.

START DATE: Day, month and year in which the policy enters into force for the first time or upon each renewal. (12.00 at local time in Turkey)

WAITING PERIOD: It is the period that is applied by the insurer depending on the health status of the candidate policy holder during which certain medical situations are not covered.

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END DATE: Day (12.00 at local time in Turkey), month and year in which this policy expires. Any expenses to be made after this date are excluded from coverage, regardless of their reason.

REMOVAL DATE: Day, month and year on which the policy holder is removed by the insurer from a policy under which more than one person is covered as policy holder and that continues for other policy holders, upon the request of the policy owner and/or in the case that the policy holder does not meet the conditions stated in the definition of Persons to be Insured. (12.00 at local time in Turkey) In the case that the policy holder is removed for rescission or termination, provisions and periods stated in Article 8, General Terms apply.

GENERAL TERMS: Written rules which are determined by the Insurance and Private Pension Regulation and Supervision Agency, the application of which is obligatory in health insurances by all insurance companies.

LOSS RATIO: It is the ratio of total paid and pending indemnities of the policy holder within the policy period to the premium

ADDITIONAL FEES: Foundation universities and private health institutions and organizations contracted with the Social Security Institution; extra fees requested from people based on amounts that may be invoiced to the Institution on condition that they do not exceed the rate determined by the Institution over all costs of healthcare services included in SUT and its appendices.

CANCELLATION DATE: Day, month and year on which the policy is canceled upon a written request by the policy owner or a rescission or termination due to the matters specified in the General Terms by the insurer. (00.01 at local time in Turkey)

CONTRIBUTION SHARE: It is the amount to be paid for examination by the general health policy holder or the persons whom they are obliged to look after, to benefit from healthcare services in the Social Insurances and General Health Insurance Law No. 5510

RED ZONE: Life-threatening cases requiring urgent evaluation and treatment along with a fast and aggressive approach. In such cases, the patient is taken to the red zone without waiting. In addition, they are cases with a high probability of being life-threatening, which should be evaluated and treated within 10 minutes.

OCCUPATIONAL DISEASE: Temporary or permanent physical or mental disease that results from a recurring cause due to the nature of the policy holder's occupation or occurs at the time of performing such work. (e.g. asbestosis, silicosis, silicotuberculosis).

NETWORK (IN-NETWORK PROVIDER TYPE): Refers to the grouping of In-Network Providers by MAPFRE Sigorta A.Ş. The network type of the valid in-network provider is specified on each policy. Even if the providers outside the scope of the relevant network are MAPFRE In-Network Providers, they are considered as out-of-network providers for the relevant policy. All entities included in the In-Network Providers list constitute the general network of MAPFRE Sigorta A.Ş.

SPECIAL TERMS: Terms prepared by the insurance company in addition to the Health Insurance General Terms and which state mutual rights and liabilities, coverages and validity terms and which are effective until the end date of this policy

PERSONNEL: A person actually working in an entity having a legal personality permanently and full time (at least 35 hours a week), who is complying with insurance conditions

SCOMMUNIQUE ON HEALTHCARE PRACTICES (SUT): The communique containing the principles and procedures of benefiting from healthcare services, travel, daily allowance and attendant expenses financed by the Social Security Institution for the persons with general health insurance, and their dependents, whose healthcare benefits are covered by the Social Security Institution, and the fees to be paid for the said services, set by the Healthcare Services Pricing Commission.

SAGMER: The insurance oversight center aiming at making public oversight-audit more effective, increasing the trust on insurance system, creating reliable statistics, preventing misuse, making sound pricing, ensuring practice uniformity in the sector, performing insurance business in a more comprehensive and effective way by gathering data in the health insurance branch in one center.

POLICY OWNER: A person or legal person applying for the insurance policy, whose application is accepted by the insurer, and being the responsible party within the scope of this insurance policy, acting in favor of themselves and the persons to be insured.

INSURANCE POLICY: Any document including an insurance certificate, which bears a company stamp and authorized signatures, issued by the insurer in a special format and includes matters such as term, special and general terms, limits, exclusions, as well as application information and payment conditions for the policy and which guarantees the payment of claims within the specified limits of the coverage, if the required conditions are fulfilled.

INSURER: Insurance company registered and holding an operating license in the country where the insurance policy is issued. The term "insurer" stands for MAPFRE Sigorta A.Ş. in this policy.

POLICY HOLDER: The person stated in the health insurance application of policy owner and the persons to be insured, accepted by the insurer and included in the policy coverage.

STANDARD EXCEPTIONS: General exceptions which are specified in special terms and apply to all coverages and policy holders.

COVERAGE:It is the scope of health expenses that the insurer undertakes to pay within the limit stated in the policy within the framework of special and general terms of insurance policy.

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ANNUAL TOTAL LIMIT: The maximum amount that the policy holder may use from their coverage specified annually during the period of insurance policy.

RENEWAL: The case where the policy owner contacts the insurer 15 days before or after the expiration date of the existing insurance policy to execute a contract again and the insurer and the policy owner agree on the conditions of the new insurance policy upon which the new contract remains in force without interruption.

RENEWAL DATE: The start day, month and year of the new insurance policy, which is the same as the expiration date of the previous insurance policy. (12.00 at local time in Turkey)

MAPFRE CUSTOMER SERVICES: It is the hotline through which the policy holders can convey their suggestions, requests and complaints and receive various services such as ambulance and medical advice by dialing 0 850 755 0 755.

ARTICLE 3 - SUBJECT AND SCOPE OF COVERAGE

This insurance guarantees to pay additional fees that may arise while the persons with general health insurance and the ones they are obliged to look after, who are included in the coverage by the Social Security Institution are receiving healthcare services from the healthcare providers contracted/having a protocol with the Social Security Institution as determined by MAPFRE Sigorta A.Ş. within the annual total limit in accordance with Health Insurance General Terms and these special terms

This policy coverage is applicable for occasions covered by the Social Security Institution except the cases stated in Special Terms Article 5.

According to the provisions of the Social Insurances and General Health Insurance Law, the contributions that beneficiaries of healthcare services are obliged to pay shall not be covered by this policy. Coverage stated in the policy is only applicable for the persons whose names are included in the policy and shall not be applicable for any other person.

The coverage that may be given under this policy is specified below:

3.1. Inpatient Treatment Coverage

In relation to disorders that occur after the commencement date of the policy holder, on condition that it is required medically and the doctor specifies this reason in his/her report in detail; the expenses for the policy holder's internal and/or surgical hospitalizations, emergency medical condition that may cause a life-threatening danger, and minor interventions are covered in accordance with special and general terms

In the case that the policy expires and it is not renewed while the hospitalization continues for medical conditions informed to and accepted by the insurer during the insurance period, the treatment expenses after the expiry of policy are not paid by the insurer.

3.2. Outpatient Treatment Coverage

Doctor examinations, analyses, radiology, modern diagnosis methods (diagnostic endoscopic procedures) and physical therapy and rehabilitation expenses for disorders occurring after the commencement date of the policy holder are considered within the scope of outpatient treatment.

In the cases where Outpatient Treatment Coverage is purchased, treatment expenses are met by this coverage in line with the limit stated in the policy and in accordance with special and general terms. Treatment expenses that exceed the upper limit of outpatient treatment are not covered by policies. Outpatient treatment coverage cannot be provided alone, but can be purchased together with the Inpatient Treatment Coverage.

3.3. Medical Equipment Coverage

As part of the treatment applied due to an accident or illness occurring during the policy term, the following items used externally for support to the body and solely for medical purposes are covered within the policy under the "Medical Supplies" coverage limit and payment percentage specified: portable, personalized orthoses (such as braces, active ankle bone spur pads), elastic bandages, orthopedic shoes, insoles, corsets, neck braces, knee braces, wrist supports, elbow braces, arm slings, seat cushions, rollators, walkers, crutches, plaster slippers, nebulizers, ventilators, compression stockings, aerochambers, wheelchairs (if permanent disability is documented by a doctor's report), crutches, urostomy bags used during hospital stays or home care, colostomy bags, and covering materials used for burn or wound treatment. Medical supplies not covered under General Health Insurance (GHI) and used during inpatient treatment or surgery in hospital are covered under this coverage provided that the necessity is documented by a doctor's report and approved by the Insurer. If medical supplies are prescribed after the examination performed using the General Health Insurance (GHI), payment is made within the coverage limit and payment percentage for the medical supplies within the scope (only limited to those mentioned above).

3.4. Check-Up Coverage

Regardless from insured policy's contracted health institutions type, check up service expenses covered 100% at Mapfre Sigorta's contracted health institutions once a year. You can reach the details of check up service and contracted health institutions from www.mapfre.com.tr

Other services provided by contracted/non-contracted health institutions will not be evaluated by this coverage.

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3.5. Dental Package

It is valid in the institutions contracted for this service within the scope determined for the Dental Package, and it is required to make an appointment to benefit from this service. In the event that the policy holder performs the transactions on their own, this service will be out of the scope. The package includes dental examination, scaling (lower and upper jaw), and dental x-ray.

The relevant coverage applies to individual policies and is provided in return for an additional premium upon the request of the policy owner for group policies. It is indicated in the policy coverage table if the relevant coverage is included in the policy. The contact information for appointment is provided in your policy

3.6. Birth Coverage

Birth Coverage shall be valid for female insureds aged 18 and over, whether insured in their own right or as a spouse, provided that outpatient treatment coverage is included in the policy and that this coverage has been added as an additional coverage. Expenses related to normal birth, cesarean section, birth and pregnancy complications (medical abortion, curettage performed due to medical necessity and/or miscarriage, preeclampsia, threatened miscarriage, hospitalizations due to hyperemesis, etc.), routine newborn expenses (the initial examination and care expenses incurred immediately after birth before the baby is discharged from the hospital), and all treatments related thereto shall be covered within the birth coverage limit and payment percentage specified in the policy. Periodic physical physician examinations related to pregnancy and pre-pregnancy TORCH tests, as well as follow-up and diagnostic procedures performed during pregnancy (TORCH, amniocentesis, NST, Down syndrome triple screening, etc.), and routine pregnancy check-ups shall be covered within the outpatient treatment coverage limit and payment percentage.

The Birth Coverage taken as an additional coverage, as well as routine pregnancy check-ups covered under the outpatient treatment coverage, shall be valid provided that the waiting period has been fully completed and that the pregnancy had not commenced as of the initial policy start date on which the coverage was first taken out. This period shall commence as of the initial start date of the Insured’s Birth Coverage. In the calculation to be made for the Birth Coverage to be valid, the Insured’s Last Menstrual Period shall be taken into consideration. The last menstrual period must be after the start date of the Birth Coverage and must be consistent with the ultrasonography findings obtained during pregnancy follow-up. If the last menstrual period is prior to the start date of the Birth Coverage, all expenses shall be excluded from the scope of policy coverage. If, during the renewal period, the Birth Coverage is not added to the policy or if the coverage is interrupted, the waiting period shall recommence for the re-added coverage. Birth and routine pregnancy check-ups shall be valid only within the contracted healthcare provider network defined in the policy. The relevant coverage shall be invalid at non-contracted healthcare providers.

3.7. Home Care and Treatment

Provided that the medical treatment plan requested to be applied at home by the treating physician after the inpatient treatment of the insured is approved by the Insurer when the insured is discharged from the hospital, the medical home care service expenses applied by the healthcare personnel from the date of discharge and the medical device rental expenses indicated as necessary by the doctor's report are covered with this coverage limit and payment percentage. The insured's inability to perform daily living activities independently, incontinence or immobility, needing assistance with feeding, taking medication orally, requiring full bathing assistance or being able to bathe with help, having a urinary catheter, living alone at home, and having a chronic illness requiring social support are not covered under the Home Care Services coverage. This coverage is only valid at institutions that have an agreement with Mapfre Sigorta for home care coverage.

3.8. Artificial Limb

The prostheses and the maintenance of these prostheses installed to replace the lost limb of the insured as a result of an accident or illness occurring during the insurance period are covered within the scope of this coverage limit and payment percentage. Artificial limb coverage is only for the material used. The replacement or maintenance of the artificial limb must take place within the relevant policy period. Artificial limbs used or to be renewed for disabilities existing before the insurance start date are not covered by the policy. Artificial limb expenses (additional fees) above the SUT price covered by the SSI and artificial limb expenses not covered by the SSI are considered within the scope of this coverage.

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ARTICLE 4 - WAITING PERIOD

Under this Policy, within the scope of Inpatient Treatments (excluding Red Zone cases), a waiting period of the first 3 months shall apply as of the date on which the coverage is taken out for all procedures, and for all expenses related to physical therapy and rehabilitation, regardless of whether they are provided on an outpatient or inpatient basis. If the Birth Coverage is taken out as an additional coverage, a waiting period of the first 9 months shall apply.In group policies, if maternity benefit is included as an optional / additional coverage, a 12-month waiting period will apply.

ARTICLE 5 - CASES THAT ARE NOT COVERED

The exceptional cases stated below are excluded from the coverage for all coverage types of this policy: However, policy holders who have a renewal guarantee for individual policies before 01.11.2022 will be exempt from the exceptions between Articles 18 and 53. As of 01.11.2022, all exclusions stated below will be valid for policy holders switching from group to individual policy or switching from another insurance company. All the following exclusions will apply to policy holders in group policies.

1. Any kind of health expense arising from a diagnosis given, treatment received and/or treatment recommended due to a complaint and/or disease existing before the commencement date of the policy and related recurrences and complications are not included in the policy coverage, even if declared in the application form,

2. Health expenses arising in the period when the General Health Insurance provided by Social Security Institution is inactive for the reasons such as leave of employment, non-payment of insurance premium are not included in the policy coverage,

3. Procedures whose method, type, quantity, usage period are determined by Social Security Institution, materials that are permitted to be supplied from medical institution and paid by Social Security Institution within the rules in inpatient treatments and medical services not provided by Social Security Institution except materials used in the scope of protocol made with in-network providers in the cases where Social Security Institution makes payment on equivalent material prices are not included in the policy coverage,

4. Health expenses regarding treatments to be provided out of In-Network Service Provider and/or Providers written in the Policy including emergency are out of policy coverage,

5. Outpatient treatment expenses exceeding the number of use and/or coverage limit written in the policy are out of policy coverage,

6. Within the scope of outpatient treatments including Green Zone application, all kinds of medication expenses, materials and contrast materials used for examinations, material costs and vaccination expenses are excluded from the policy coverage,

7. Tests and/or treatments that may be performed after examinations out of the In-Network Provider(s) written in the policy They are out of policy coverage, even if they are performed in the In-Network Provider(s) written in the policy,

8. All expenses related to examinations, teeth and dental-gum treatments and jaw treatments performed by dentists and maxillofacial surgeons, expenses for toothpaste, oral and dental care preparations, etc.,

9. Eyeglasses, glass, frame and lens expenses and all the costs regarding them,

10. All treatments to be made and medicine to be used abroad, and all medicine to be imported are out of policy coverage,

11. Expenses for out-of-network local or interprovincial ambulance services

12. Travel expenses, daily allowance, second attendant expenses, suite room differences and special expenses,

13. Abortion which is not medically required, infertility, low sterility research and all examination, treatment and complication expenses to maintain the pregnancy (in vitro fertilization, follicle follow-up, microinjection, tuboplasty, etc.), hysterosalpingography (HSG), spermiogram, adhesiolysis expenses,

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14. Specialist physician reports, medical board reports, reports requested before starting a sport, prior to marriage, or before employment, and the related expenses,

15. All pregnancy-related expenses and maternity expenses, if not covered as additional coverage,

16. Any kind of health expenses regarding epidemics officially announced by the Ministry of Health or epidemics announced as phase 5 and above anywhere in the world by the World Health Organization,

17. All expenses related to circumcision and phimosis even if it is a medical requirement,

18. Treatment expenses incurred by dentists related to dental/genioplasty surgery resulting from traffic accidents/judicial accidents and replacement of teeth (provided that the accident report issued by official institutions is submitted) are paid from the Inpatient Treatment Coverage),

19. Expenses related to refractive defects (myopia, etc.) treatments, amblyopia, all kinds of diagnosis, examination and treatment expenses for toric and multifocal lenses, the problem of strabismus,

20. Congenital and genetic diseases, which are diagnosed after the start date of the policy even if they occur at an advanced age, and expenses for premature babies unless a contract is made otherwise,

21. Spinal curvature disorders such as scoliosis, kyphosis, etc.,

22.Expenses related to tests and treatments for pes planus, hallux valgus/rigidus, etc.,

23. Diagnosis or treatment of dementia caused by old age, Alzheimer's, Parkinson's, and epilepsy, and antipsychotic, anxiolytic, anticonvulsant and all psychotropic medicines used in the treatment of these diseases,

24. Mental diseases and psychological disorders that require psychiatric treatment, neuropsychiatric tests, examinations and treatment, all types of psychotherapies,

25. Nasal septum and concha operations,

26. Expenses related to nasal valve surgery unless it occurs as a result of a judicial accident,

27. Treatments of strabismus, otosclerosis, keratoconus, and ptosis,

28. Tests related to research and screening of all kinds of genetic diseases/conditions, genetic disease treatments,

29. Any kind of routine and specific examination and treatment expenses related to structural disorders, motor mental development and growth disorders (growth and development retardation, acromegaly, early/late puberty, etc.),

30. All types of illnesses and expenses related to accidents that may occur due to unlicensed vehicle use (the driver's license must be suitable for the class of the vehicle used by the policy holder),

31. Alcoholism, alcohol addiction (regardless of the BAC level), drugs, stimulants, hallucinogens and other substances, any illness and expenses that are related to accidents occurring after the use of these substances,

32. Expenses arising from all hazardous sports activities 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, electric motorcycles, electric scooters, skiing, motorcycle riding even if it is for transportation purposes, etc.) whether for amateur or hobby purposes, and all expenses arising from professional and/or licensed sports activities are excluded. Expenses arising from all kinds of professional and/or licensed sports activities are excluded from the coverage, and only expenses related to skiing, motorcycle and ATV use 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,

33 Regardless of the institution where they are performed, alternative treatment methods (acupuncture, homeopathy, osteopathy hypnosis, yoga, mesotherapy, aromatherapy, neural therapy, chiropractic treatments, ayurveda, spa and mineral water treatments, etc.), anti-aging applications, and treatments performed by centers operating without the license of the Ministry of Health, and spa and thermal centers, sanatorium, nursing home, nursing home preventorium and rehabilitation centers,

34. All examination, testing and treatment expenses at aesthetics and beauty centers,

35.Expenses related to examinations such as coronary artery calcium scoring, coronary VCT angio, EBT (Electron Beam Tomography) for screening purposes, virtual angio and virtual colonoscopy,

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36. All expenses made for the removal of the special exception of the policy holder,

37. Unless it occurs as a result of a judicial accident or illness (cancer, burn, etc.) that occur during the validity period of the policy, expenses related to plastic and reconstructive surgery, all kinds of aesthetic and cosmetic procedures, treatments for telangiectasia, skin hemangiomas, gynecomastia, antiperspirant treatments and related examinations and procedures, rhinoplasty, hair loss (diagnosis and treatment, excluding alopecia areata), all types of reduction and augmentation mammaplasty,

38. Expenses related to weight loss and weight gain programs related to weight and appetite disorders, diagnosis or treatments of obesity and surgery,

39. Snoring treatment, sleep disorders, examinations and treatments for sleep apnea (polysomnography, sleep EEG), and any appliances used for sleep apnea,

40.All kinds of examination, analysis and treatment expenses, regardless of the area of expertise of the health center and/or doctors applying a balanced diet, diet-exercise programs,

41. Voice and speech therapies;

42. Expenses related to cord cyst, hydrocele and any kind of hernia for children below 7,

43. Medical supplies which are not considered within the scope of auxiliary medical supplies coverage, CPAP device, its calibration and monitoring, home humidifiers, externally worn devices (hearing aid, cochlear implant, etc.), sanitary items such as oral and dental care apparatus, thermometers and temperature probes, ice packs, hot water bags or gels, heated blankets, diapers, baby bottles, milking pumps and apparatus, pacifiers, injectors not received with medicine, other expenses not required for treatment such as tapes, telephone, TV, cafeteria, administrative service, paramedical service and service fee, and all kinds of (external) prostheses and support prostheses (those that cannot be considered within the Inpatient Treatment Coverage),

44. Varicocele expenses, whether related to infertility or not (except for people under 18 years of age),

45. Expenses of all examinations and treatments related to gender reassignment operations, impotence, peyronie's, penile chordee, vaginismus, sexual function disorders (including penile prosthesis) and birth control costs,

46. Regardless of how they spread, anogenital condylomas, HIV, AIDS, and all examination and treatment costs related to these,

47. Expenses related to sclerotherapy, laser, radiation, massage, socks, etc. applied for superficial varicose treatment,

48. Expenses related to donor in organ, tissue and blood transfusion,

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

50. Healthcare expenses for occupational diseases and occupational accidents,

51. The contribution shares that the policy holders are obliged to pay in accordance with Article 98/2 of the Social Insurance and General Health Insurance Law No. 5510,

52. Coverages not preferred in the policy and all kinds of medical expenses not included in the coverage descriptions specified in the policy,

53. Research, check-ups and non-diagnostic tests ordered without any symptoms and/or complaints or due to a general complaint,

ARTICLE 6 - GEOGRAPHICAL SCOPE

Coverages written in this policy are valid in the in-network providers written in the policy, within the boundaries of the Republic of Turkey. Overseas treatment expenses are not included in this policy coverage.

ARTICLE 7 - INDEMNITY PAYMENT

Expenses that may occur while the policy holder is receiving healthcare services from in-network provider(s) written in the policy shall be paid to the in-network provider directly after provision to be given to the provider when the policy is considered within coverage. Invoices and papers regarding the provision shall be sent to the insurer by the in-network provider. Invoices regarding the expenses that the policy holder makes on their own for the procedures for which provision is not received shall not be considered within the coverage

All expenses out of the policy coverage shall be paid by the policy holder.

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ARTICLE 8 - RENEWAL OF THE CONTRACT AND GIVING RENEWAL GUARANTEE

8.1. Renewal of the Contract

The policy holder may apply to the insurer for a new contract (policy) 30 days after the expiry date of the existing individual policy at the latest. If 30 days or more have passed since the renewal date, a new application form shall be prepared for the policy holder as if they were a new policy holder, and they shall be included in the insurance like a new policy holder.

The insurer reserves the right to apply additional premium or discount as per the loss ratio, not renew the policy as per the loss ratio and/or risk acceptance criteria and to apply conditional acceptance such as exemption, contribution share, limit, additional premium for policy holders who have no Lifetime Renewal Guarantee in the individual policy renewal period.

8.2. Lifetime Renewal Guarantee

Provided that the Insured has been continuously insured with MAPFRE Sigorta A.Ş. under the No Difference Health Insurance product for three consecutive years and that the average Claim/Premium (H/P) ratio for the last three years is below 80%, a Lifetime Renewal Guarantee shall be granted to Insureds holding a health insurance policy, subject to the conditions to be determined as a result of the risk analysis assessment to be conducted.

For policies to be transferred from another insurance company to MAPFRE Sigorta A.Ş., a risk analysis shall be conducted for the Insureds regardless of whether they have a Lifetime Renewal Guarantee, and applications such as limits, participation share, exclusions, additional risk premium, etc. may be applied. However, the additional risk premium that may be applied per disease shall not exceed 200%.

The renewal guarantee right acquired at the previous insurance company shall be evaluated in accordance with the criteria of MAPFRE Sigorta A.Ş., and within the framework of the conditions to be determined, the Insured's renewal guarantee right shall be maintained subject to the Insurer's current special terms and conditions. In the event of a transfer from other products of our Company to the No Difference Health Insurance product, the Insured's existing Lifetime Renewal Guarantee right shall be preserved. However, if a request is made to transfer from the No Difference Health Insurance product to a different product, a new risk analysis shall be conducted by the Insurer.

For an Insured who has become entitled to a Lifetime Renewal Guarantee, if the product last used by the Insured is discontinued at the time of renewal due to a change in legislation, force majeure, and/or by the Company, the renewal shall be effected with another product that is parallel to or closest to the coverages and the contracted healthcare provider network of the previous policy. In such a case, the Insured's existing Lifetime Renewal Guarantee right shall be preserved. The renewal commitment is personal and applies solely to the Insureds who have acquired this right. The statement "Lifetime Renewal Guarantee Granted" provided by the Insurer shall be specified in each Insured's policy.

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 renewal commitment was granted, to conduct a risk analysis assessment or to impose new additional conditions such as additional premium for the disease, exclusions, or limits, nor to apply an additional premium based on the claim/premium ratio, except for the cases specified in Articles 6 and 7 of the General Terms and Conditions of Health Insurance.

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During this period, if the Insured requests an extension of the scope of coverage, the Insurer reserves the right to re-evaluate the existing Lifetime Renewal Guarantee. The health insurance policy offered by the Insurer to Insureds for whom it has undertaken a renewal commitment shall be subject to the special terms and conditions in force as of the date on which the policy acquired the renewal guarantee right. However, the Insurer reserves the right to make changes to the contracted healthcare provider network.

ARTICLE 9 - DETERMINING THE PREMIUM

9.1. Premium Calculation for Individual Policies

In accordance with the insurer's Risk Acceptance Regulation, the premiums of the applicant are calculated by taking into account the health risk plan, coverage, age and gender of the policy holder, health inflation, indemnity premium rate. If spouse or children are requested to be included after the policy start date, this request of the policy holder is processed using the premium tariff in force at the time of request, provided that the insurer reserved the right not to accept the relevant request. Premiums and payment due dates, and plan details such as coverages, limits, contributions, etc. for the policy holders under the policy are indicated on the front page of the policy.

Policy premium is calculated based on the age on the start date of the insurance (calculation of difference between start date and date of birth as day/month/year). Actuarially calculated tariff base premiums can be updated periodically by taking into account the overall portfolio performance, health inflation and medical inflation variables. Variables of medical inflation include the changes in the Consumer Price Index, Producer Price Index, and coefficients of the Price Tariff of Turkish Medical Association, changes in exchange rates, and the current prices to be applied to our company by healthcare institutions. The increase in tariff base premiums is limited to a maximum 300% increase of the previous tariff premium, provided that it is not below the health inflation rate.

The policy premium is determined within the place of residence, age, gender and coverage criteria of the policy holder. Premiums vary in Istanbul and other provinces. The policy premium is determined within the place of residence, age, gender and coverage criteria of the policy holder. Premiums vary in Istanbul and other provinces.

The policy premium is calculated on the basis of the age on the insurance start date (calculation of the difference between the start date and the date of birth as day/month/year).

The mode of payment, terms, and amounts for the insurance premium are stated on the application form and the policy. The policy holder shall make all the premium payments via a credit card in line with the payment plan included in the policy.

9.2. Premium Calculation for Group Policies

The insurer determines the Group Health Insurance premiums taking into consideration the criteria such as the size of the group, previous usage, age/gender of the policy holders, insurance period, coverage type, coverage limit, and inflation rate. Instead of determining the premiums on an individual basis, premiums can be determined based on the number of the policy holders in the group, as well as the age and gender distribution. In addition, the changes in the Health Service Tariff (Turkish Medical Association minimum fee tariff, SUT units and coefficients, HUV units and coefficients) are considered as health inflation in the evaluation. If the implementations in the Health Service Tariff change, a reevaluation is made.

Policy premium is calculated based on the age on the start date of the insurance (calculation of difference between start date and date of birth as day/month/year).

9.3. Arrangements Relating to Premiums;

No-Claim Discount for Individual Insureds
**Only the heading of this clause has been amended.

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ARTICLE 10 - NEW ENTRY PROCEDURES

10.1. Insurance Period and Acceptance into Insurance

The insurance period is 1 year and shall remain in force between the commencement and expiry 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. Turkish citizens shall be accepted within the scope of this insurance contract. In order for the contract between the Insured and the Insurer to be concluded, the Insured must be under the age of 64 (inclusive) as of the policy commencement year.

Age shall be calculated by determining the difference between the insurance commencement date and the date of birth in days/months/years. Children between the ages of 0 and 6 may be included in coverage under the same product within the family scope and/or together with at least one person whom they are legally dependent on. Upon request, unmarried children of the Insured who are in education (subject to documentation) and for whom the Insured is legally responsible may be covered under the policy up to the age of 24. Children older than 14 days and under 6 years of age may only be insured under the product in which the mother or father is insured. Children between the ages of 7 and 18 may be insured individually, provided that the Policyholder is at least 18 years of age. Persons residing within the borders of the Republic of Türkiye shall be accepted into insurance under the policy.

10.2. Applications

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

At the time of entering into the initial contract, the Company may, if deemed necessary, request a physician's opinion in order to determine the Insured's health condition. However, no physician's opinion shall be requested in renewals, plan changes, or transfer procedures from other 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 costs shall be borne by the Insurer. However, if the contract is concluded solely based on the health declaration submitted by the Insured/Policyholder, any physician's opinion costs 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 the Insured has been granted a Lifetime Renewal Guarantee.

In line with the health condition and/or the risk acceptance regulation in force, the Insurer reserves the right, for Insureds who do not have a renewal guarantee, to reject the application or to accept it by applying conditional acceptances (such as limits, additional risk premium, exclusions, participation share, waiting period, etc.).

10.3. Liability of the Policy Owner

If the policy is canceled, or if the policy holder is excluded from the policy coverage, documents that were issued in the name of these persons excluded must be returned to the insurer. This responsibility rests with the policy owner. Losses that shall be incurred because the documents were not returned in full shall be claimed from the policy owner in recourse. The Policy Owner/Policy Holder is obliged to correctly answer the questions asked in the application form and complementary documents and to declare the information that constitutes the subject of the risk and/or that will be effective in its assessment.

If the declaration of the Policy Holder/Policy Owner is false, incomplete or incorrect, the provisions of Article 6 of the General Terms of Health Insurance will be applied. According to Article 6, reserving the rights of the insurer, the insurer is entitled to evaluate the diseases that were not declared by the policy holder/policy owner, and to include them in the coverage conditionally (out of scope, additional premium, etc.).

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The insurer has the right to collect from the policy holder and/or the policy owner the expenses that are against the Health Insurance General and Special Terms of the policy and the payments made outside the scope of the coverage.

ARTICLE 11 - TRANSFER PROCEDURES AND VESTED RIGHTS

11.1. Transfer Procedures from Other Insurance Companies

When the Insurer renews a Policy as a transfer from another insurance company, it reserves the right without prejudice to any existing Lifetime Renewal Guarantee conditions 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 Insureds transferring with a Lifetime Renewal Guarantee right from another insurance company, the Lifetime Renewal Guarantee conditions applicable at our Company shall apply.

Diseases of the Insured that existed with other insurance company/companies and/or diseases determined to have originated prior to the initial insurance date shall not be deemed vested rights if they were not declared in the application form, even if they were paid by the previous insurance company.

Such diseases shall be excluded from coverage. Vested rights refer solely to the removal of waiting periods stipulated in the special terms and conditions, the preservation of the initial enrollment date, and, if applicable, the transfer of the Lifetime Renewal Guarantee. Rights included in the special terms/coverages of the Insured's previous Policy but not included in the special terms/coverages applicable for the new insurance period shall not be considered as vested rights.

However, rights included in the special terms applicable for the new period but not included in the special terms of the previous period shall also apply to the Insured. In order to preserve the Insured's vested rights, the application must be submitted no later than 30 days as of the insurance expiry date.

11.2. Transition Procedures from an Existing Group Policy at MAPFRE Sigorta A.Ş. to an Individual Policy

An Insured who has not been granted a Lifetime Renewal Guarantee under a Group Policy must submit an individual application (Individual Policy) within a maximum of 30 days as of the date of exit from the scope of the group contract. The Insurer reserves the right to reject such application or, based on the risk analysis assessment conducted, to accept it under standard terms or to grant a conditional acceptance (such as additional risk premium, limits, participation share, exclusions, etc.).

If an Insured who has a Lifetime Renewal Guarantee under the group policy held with our Company exits the scope of the Group Health Insurance Policy (due to retirement, dismissal, or resignation), the Insured must apply for an Individual Policy within a maximum of 30 days together with the employment termination notice. Continuation of the Policy may be ensured with a product equivalent to the Group Health Insurance product previously held by the Insured, or, if no such product exists, with one of the closest available individual products. However, if the Lifetime Renewal Guarantee stated in the group policy certificate of the Insured is worded as "granted for the Individual Policy, subject to medical assessment for risks up to the renewal guarantee date specified in the certificate," then the individual policy transition terms shall be determined by conducting an assessment of health risks arising 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 transition to the Individual Policy, and based on the outcome of such 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 Birth Coverage and is insured under an Individual Policy that includes new Birth Coverage, a 9-month waiting period shall apply as of the commencement date of the Individual Policy.

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ARTICLE 12 - PRINCIPLES OF INSURANCE CONTRACT EXPIRY

12.1. Cancellations

If the policy owner/policy holder makes a cancellation request within 30 days following the drawing up of the policy, the policy is canceled as of its start date, if no risks have materialized, and the paid-in premiums are fully refunded to the policy holder.

For requests delivered after 30 days but approved by the insurer, the insurer is entitled to collect premium based on the number of days, from the start date of the policy to the cancellation date. The amount to be returned to the policy owner/policy holder due to cancellation is calculated based on days by taking paid indemnity into consideration.

If the indemnity payments made to the policy holder do not exceed the premium amount earned by the insurer, the insurer deducts the paid-in premiums due to them and refunds the remaining sum to the policy holder. If indemnities paid to the policy holder exceed the premium amount the insurer is entitled to, but do not exceed the premium amount that the insurer collects, the insurer deducts the indemnity amount from collected premium amount and returns the remaining premium to the policy holder

If the indemnity amount paid to the policy holder exceeds both premium amount that the insurer is entitled to have and the premiums paid by the policy holder, cancellation is done without refunding the premiums. Even if the premiums are not due yet when the risk occurs, the portion corresponding to the indemnity amount that the insurer is obliged to pay becomes due and payable.

The policy owner will go into default if they fail to pay any of the premiums, whose exact due dates and amounts are indicated in the policy, before the maturity date. The provisions of Article 1434 of the Turkish Commercial Code shall apply if the premium is not paid on time.

If the insurer detects that the policy owner/policy holder is acting in bad faith (making persons not covered by the policy benefit from the policy coverages, misrepresentation of health expenditures as costs incurred by other policy holders, discovery of medical conditions known to the applicant before the insurance start date but deliberately not reported to the insurer, etc.), the insurer is entitled to claim back the health expenses paid, and/or to cancel the policy without returning premium.

12.2. Death of the Policy Owner or the Policy Holder

In the event of the death of the policy owner and/or the policy holder, the insurer proceeds depending on the following circumstances. In the event of the death of the policy owner, the insurer must be furnished with written approval of lawful heirs of the policy owner if the policy owner/policy holder(s) on the policy are different and if the policy holders wish to continue on the same policy by revising the policy owner. In this case, the policy continues by changing the policy owner. In the cases where the approval of lawful heirs is not received, the procedures are applied in line with the cancellation criteria stated above and the premium, if any, is refunded to lawful heirs.

A one-party policy in which the policy owner and the policy holder are the same person shall become null if the policy owner dies. The policy owner's policy is processed in accordance with the cancellation criteria set out above upon the written request of his lawful heir and the premium, if any, is refunded to the lawful heir.

In cases where more than one person is insured, in the event of the death of one of the policy holders, the person who has passed away is excluded from the policy as of the date of death. The premium, if appropriate, is reimbursed to the policy owner in the policy in accordance with the above cancellation criteria.

ARTICLE 13 - SAGMER (INSURANCE OVERSIGHT CENTER) NOTIFICATION

The policy and health information of the policy holders in this insurance policy will be transferred to SAGMER (Insurance Oversight Center), and the policy and health information of the policy holders will also be able to be obtained from SAGMER and other public institutions.

The General Terms of Health Insurance published by the Insurance Association of Turkey is available on www.tsb.org.tr.

GENERAL TERMS FOR THE COMPLEMENTARY HEALTH INSURANCE

Please click here to access the health insurance general terms published by the Insurance Association of Turkey.