SPECIAL TERMS FOR THE EMERGENCY SITUATIONS INSURANCE

These special terms are applicable to Policy Holders who have Emergency Health Insurance issued as of 01.02.2013.

The Insurance Policy prepared as per the terms agreed upon by MAPFRE SİGORTA A.Ş. (hereinafter referred to as the Insurer) and the Policy Owner/Policy Holder consists of the Application Form filled in and signed by the Policy Owner/Policy Holder prior to its acceptance by the Insurer, except for sales made by telephone via telemarketing, and the integral parts of the policy i.e. Health Insurance General and Special Terms, Certificate, Contracted Institution Booklet and, if any, the Additional Protocol.

Any amendment and addition to be made to this Insurance Policy during its term shall not be applicable unless made in writing and mutually agreed by the parties.

ARTICLE 1 - SUBJECT MATTER OF THE INSURANCE

In addition to the Health Insurance General Terms, the Special and General Terms in accordance with the coverages, limits and participation rates stipulated in the certificate will be determinant in covering any treatment expenses required to bring the Policy Holder, who has contracted a disease and/or suffered an accident, to stable condition in an emergency treatment, as specified in Article 2.2, that takes place in any private or state healthcare institution licensed by the Ministry of Health.

Insurance coverage is only valid for the persons included in the Insurance Policy, and others cannot benefit from the coverage.

ARTICLE 2 - COVERAGE

1. SCOPE

The scope of coverage for the Policy Holder is indicated in the Insurance Contract and the coverage table.

The Insurance Contract includes the scope of coverage provided to the Policy Holder, the grounds, class and limits for indemnity at all service or coverage levels, the coverage percentage, Insurer's participation rate, special exceptions and all applicable special terms, as well as the type of healthcare services, the Contracted Institutions and the geographical coverage area.

Acceptable indemnities of the Policy Holder must accrue during the validity of this Insurance Contract. Hospital treatment expenses which accrue during the validity of this Insurance Contract and continue until the End Date of the Insurance Contract without any interruption will be paid within the coverage and limits of the Policy Holder. If a Policy Holder's insurance period ends, and a new contract is not executed, the expenses for their treatments which still continue as of the End Date of the Insurance Contract will be under coverage until the 10th day following the end date.

If the Insurance Contract is canceled, or if the Policy Holder exits from the Insurance Contract, hospital treatment expenses after the cancellation or exit will not be covered.

2. CASES INCLUDED IN THE COVERAGE

The following cases and diseases are identified as Emergency Situations.

Payments for cases under the scope of Emergency Situations which are approved by MAPFRE SİGORTA A.Ş. will be made using the participation rate indicated in the certificate as per the coverage limits specified by MAPFRE SİGORTA A.Ş.

1. Drowning in water: Cases of respiratory or heart failure, or lungs that are filled with water to the extent to cause drowning.

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2. Traffic accident: Acute cases where there are spine injuries and bleeding broken bones. Severe chest, abdomen or head traumas which may cause internal bleeding, even they may not have affected the patient at that moment. Sharp object injuries which are caused by vehicle parts, causing huge bleeding in the body.
3. Rape
4. Terror, sabotage, being shot, being stabbed, fight, etc. (Valid for the situations that the Policy Holder is not the planner or a party to and is exposed to them accidentally)
5. Falling from height: Acute cases where there are spine injuries and bleeding broken bones. Severe chest, abdomen or head traumas which may cause internal bleeding, even they may not have affected the patient at that moment. Sharp object injuries which are caused by vehicle parts, causing huge bleeding in the body.
6. Serious work accidents, severance of limbs: In addition to the cases in Article 2, emergency situations unique to the work that is being carried out. For example: Inhaling of poisonous gases, drinking of chemical-containing liquids, or spilling of chemical substances on the person, partial or complete severance of fingers, hands, feet, arms or legs.
7. Electric shock: Severe electric shocks to the extent causing burns or organ damages or disrupting the cardiac rhythm.
8. Getting frozen, frostbite: Getting exposed to cold to the extent affecting vital functions, creating shocks, or causing gangrene in limbs.
9. Heat stroke: Getting exposed to sun or heat to the extent affecting the cardiac rhythm, blood pressure or consciousness.
10. Serious burns: Burns from fire, chemical substances, electricity, etc. that may cause huge dehydration, organ loss, or skin damage. Inhaling smoke or hot air to the extent causing the narrowing of the respiratory tract.
11. Serious eye injuries: Severe sharp object injuries, blunt traumas, or contacts with chemical substances to the extent creating damage in the eye.
12. Intoxication: Oral intake of substances which have deteriorated vital functions at the time of the event or highly threaten to deteriorate them in the hours following the event, skin contact with chemical substances, or inhaling of toxic gases.
13. Anaphylactic Shock: Severe allergy or low blood pressure cases to the extent causing disturbance of the cardiac rhythm, or blocking of the respiratory tract.
14. Spine and lower-upper extremity breaks as a result of trauma: All types of broken bone, luxatio, sprain and plaster expenses, stitching.
15. Heart attacks, hypertension crises: Heart attack in action, cardiac rhythm disturbances requiring urgent treatment, increase in blood pressure to the extent causing serious conditions such as cerebral bleeding.
16. Acute respiratory problems: Drowning in water, swallowing of foreign objects, allergic reactions, respiratory tract burns, which can cause severe respiratory failure.
17. All kinds of organic defect resulting in blackout: Cases such as fainting or heart trauma which can cause deterioration in level of consciousness.
18. Immediate paralysis: The limbs or the whole body not being able to move or feel due to reasons such as cerebral bleeding, spine injury, etc.
19. Serious overall medical condition problems: Health condition severely deteriorating in general, for reasons such as lack of food, insufficient care, long lasting serious disease, etc.
20. High fever (over 39.5 degrees): Body temperature increasing to a high level so as to cause convulsion or cardiac rhythm disturbance because of intoxication, infection diseases, heat stroke, etc. 39.5°C or above in average.
21. Diabetic and uremic coma: Cases which may include blurred vision due to diabetes or renal impairment, up to total loss of consciousness (coma).
22. Dialysis disease accompanied by overall medical condition problems:
23. Acute abdomen: Diseases requiring urgent surgical operation related to abdominal organs such as puncture of hollow organs such as the stomach and intestines, intestinal obstruction or knot, obstruction of bile ducts because of stone or inflammation, serious organ inflammations such as appendicitis and pancreatitis, obstruction in intestines or peritoneal arteries, etc.
24. Acute massive bleeding: Internal or external bleeding so serious to threaten life, occurring usually as a result of a trauma.

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25. Meningitis, encephalitis, cerebral abscess: Inflammatory, infectious diseases related to the brain or cerebral cortex, which may affect neural system functions, and thus vital functions, which may change the state of consciousness.
26. Renal colic: Situation creating severe pain caused by renal stones, which may cause renal damage or urinary tract damage if they grow.

3. COVERAGE DEFINITIONS

a. Emergency Surgery Inpatient Coverage

For cases requiring surgical operation and/or inpatient status because of an emergency situation, expenses for operating room, operator, anesthetist, assistant, narcosis, medicine and consumables regarding surgical operation and/or inpatient status will be paid per case, within the participation rate and limit specified in the policy.
If the Policy Holder suffers from Acute Myocardial Infarction (AMI), all interventions in the hospital such as angiography, PTCA, by-pass, etc. will be considered a single case. Expenses for the course of treatment which will be followed and/or planned after the condition of the Policy Holder has stabilized are out of the scope of the policy coverage.

b. Emergency Internal Hospitalization Coverage

For emergency inpatient cases where no surgery is carried out and/or where surgical and orthopedic operations are carried out without the inpatient status, the following expenses will be paid per case, within the participation rate and limit specified in the policy: Consultation and doctor fee, blood and the related materials including blood plasma, oxygen, anesthesia, plaster and stitching, standard corset and orthopedic support advised by the doctor, bandage, gauze, dressing, injection, electrocardiography, x-ray, MRI, all diagnostic laboratory tests and patient care services.

c. Room - Meal Coverage

For every full day the Policy Holder spends in hospital because of an emergency, room and meal expenses (limited to a standard single bed room) and nursing expenses will be paid daily, within the participation rate and limit specified in the policy.

d. Intensive Care Coverage

For every full day the Policy Holder spends in the intensive care unit of the hospital because of an emergency, expenses for intensive care services will be paid daily, within the participation rate and limit specified in the policy.

e. Ambulance Coverage

When the Policy Holder, due to an illness or an accident included in the coverage, has to be transported from where they are to the closest general hospital by a locally licensed land ambulance within the borders of the Republic of Turkey, from the hospital to home, or from their province and hospital to the closest general hospital again by a land ambulance, provided that it is instructed by the doctor treating the Policy Holder and approved by MAPFRE SİGORTA A.Ş., the related expenses are paid according to general and special terms, within the coverage, limits and participation rates indicated in the certificate.

ARTICLE 3 - INSURANCE PERIOD AND ACCEPTANCE FOR INSURANCE

Insurance period is a maximum of 1 year and it remains in effect between the start and end dates stated in the policy. Insurance coverages enter into effect with the acceptance of the application and issuance of the policy by the Insurer, and the payment of the down payment.

This insurance covers babies older than 14 days, and persons younger than 66 years (up to 65 years). The Policy Owner must be older than 18 years of age.

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Children between 0-18 years of age can be included in the coverage as family and/or with at least one legally dependent person.

If requested, dependent, unmarried and student (must be documented) children of the Policy Holder can be included in the policy coverage until they are 24 years of age.

Those who live within the borders of the Republic of Turkey are accepted for insurance. This policy is valid only within the borders of the Republic of Turkey.

ARTICLE 4 - APPLICATIONS

Initial and all other subsequent applications of the Policy Owner/Policy Holder applicants must be made by application forms provided by the Insurer and declaration sections related to the Persons to be Insured should be filled in completely and accurately. All applications and/or change requests to be made for an Insurance Policy must be in writing and bear a wet signature by the Policy Holder.

At every policy renewal period, the Policy Holder must fill in a new application form to apply with and make a declaration to the Insurer.

The Insurer may demand medical examinations to assess the health risk of the Policy Holder. The Insurer reserves the right to decline, or to apply conditional acceptance (limit, additional premium, participation, waiting period, etc.) in line with the risk acceptance regulation in effect and/or state of health. When a down payment is collected by the Insurer during application to be offset against the first premium payment, and the policy cannot be finalized for any reason, this payment is returned to the Policy Owner.

For sales made by telephone via telemarketing, no application form is taken.

ARTICLE 5 - PREMIUMS

POLICY PREMIUM ACCOUNT
Premiums for the Policy Holder applicant is calculated annually based on valid premiums according to the Risk Acceptance Regulation of the Insurer, considering the health risks of the policy holder portfolio, selected plan, coverage, age, gender and health inflation.

If the spouse and children are included within the family scope after the start date of the insurance, the premium for the policy holder applicant to be included is calculated as per the number of days based on the policy premium, with the Insurer reserving the right not to accept such a request. Premiums for the Policy Holder covered by the policy and their payment due dates are indicated on the first page of the policy whereas the coverage, limit, participation rate, etc. are indicated on the certificate table.

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).

FAMILY DISCOUNT
In individual policies, if the number of the family members (mother, father and children) is 2 or more, family discount is applied. This discount is specified by the Insurer at every policy renewal, and applied to the net policy premium.

ARTICLE 6 - RESPONSIBILITY OF THE POLICY OWNER

If the policy is canceled, or if the Policy Holder is removed from the policy scope, documents that were issued in the name of these persons excluded must be returned to the Insurer. This responsibility is with the Policy Owner. Losses to be incurred because the documents were not returned completely will be claimed from the Policy Owner in recourse.

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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. For sales made by telephone via telemarketing, no application form is filled in.

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.).

ARTICLE 7 - PREMIUM PAYMENTS

The mode of payment, terms, and amounts for the insurance premium are stated on the application form and/or the premium payment form. The Policy Holder can make all of the premium payments as down payment and/or in installments in line with the payment plan approved by the Insurer.

The responsibility to make payments as stated on the policy and on the related due dates lies with the Policy Owner, or if any, the Policy Holder.

- Payment by Credit Card: Except for sales made by telephone via telemarketing, the Policy Holder is obliged to fill in the payment plan information specified in the application form completely. Premiums of the policy will be collected from the credit card on the related due dates. When the collection cannot be made, the provisions annexed to Article 8 of the General Terms are applied.

ARTICLE 8 - GENERAL LIMITS

Geographical Coverage Area: Any healthcare services provided in the areas specified on the Certificate annexed to the insurance policy, and their related expenses are under coverage within the specified limits.

Total Annual Limit: On the Certificate given as an annex to the insurance policy, limits are indicated as varying according to disease and/or the coverage with reference to the Geographical Coverage Area. These limits are applied by deducting the participation rate, if any, related to the coverage.

Deadline for Renewal Application: The Policy Owner/Policy Holder must apply to the Insurer for the renewal of the policy within 30 days as of the end date of such policy.

Inpatient Limit Going On After the Policy End Date: Expenses for hospital treatments which have started during the insurance policy period, and which have lasted until a date on which the insurance policy has expired, are under coverage until the 10th day after the end date, if the insurance period has ended and the policy has not been renewed.

ARTICLE 9 - POLICY RENEWALS

The Insurer can be applied to for a new contract (policy) up to 30 days before or 30 days after the end date of the current policy. The Insurer reserves the right not to provide coverage for risks that occur in the interim period until the drawing up of the new policy, to provide conditional coverage (limits, additional premiums, participation, waiting period, etc.) for such risks as per the Risk Acceptance Regulation and to revoke the validity of the renewal rights.

Following the delivery to the Policy Holder of the policy prepared based on the new contract terms as of the end date of the previous policy determined by the Insurer, the Insurer is entitled to ask for health declaration, additional tests, doctor's examination from the Policy Holder, and to decrease the coverage and/or to provide conditional acceptance (limit, additional premium, participation, waiting period, etc.) before issuing the new policy. If the Insurer offers a conditional acceptance, such conditional acceptance

will remain in effect for diseases from the previous policy and/or existing diseases added to the new policy, as long as the policy is renewed and not annulled by either of the parties.

The Policy Holder must comply with the declaration obligation set out in Article 6 of the General Terms of Disease Insurance and Article 1290 of the Turkish Commercial Code during the renewal.

ARTICLE 10 - 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 Holder/Policy Owner due to cancellation is calculated taking into account the paid indemnity.

If the indemnities that are paid to the Policy Holder do not exceed the premium amount that the Insurer is entitled to, the Insurer will deduct the premiums they are entitled to receive from the premiums they collected and return the remaining premiums to the Policy Holder.

If the indemnities that are paid to the Policy Holder exceed the premium amount that the Insurer is entitled to, but do not exceed the premium amount collected by the Insurer, then the Insurer will deduct such indemnity amount from the premiums they collected and return the remaining premium to the Policy Holder.

If the indemnity amount that is paid to the Policy Holder exceeds both the premium amount that the Insurer is entitled to, and the premiums paid by the Policy Holder, the policy will be canceled without a premium refund.

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. If the premium payable is not paid on time, the provisions of Article 8 of the General Terms of Disease Insurance and the annexed article are applied.

In cases where the Insurer detects malicious actions by the Policy Holder/Policy Owner (enabling non-insured persons to benefit from the insurance coverages; having health expenses issued in the name of other policy holders and the identification of current undeclared medical conditions which were not declared to the Insurer by the Policy Holder although they were known to the Policy Holder and/or the relevant symptoms began before the insurance start date, etc.) the Insurer has the right to claim the health expenses they paid for and/or to cancel the policy without a premium refund.

In the event of the death of the Policy Owner and/or the Policy Holder, the Insurer proceeds depending on the circumstances that follow.

In the event of the death of the Policy Owner, the policy will be null and void. The Insurer must be furnished with written approval of lawful heirs of the Policy Owner, if the Policy Owner and the 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 that case, the policy is continued after a change of the Policy Owner. In the cases where the approval of legal heirs is not received, the procedures are applied in line with the cancellation criteria stated above and the premium, if any, is refunded to legal heirs.

A one-party policy in which the Policy Owner and the Policy Holder are the same person will become null and void if the Policy Owner dies. The Policy Owner's policy is processed in accordance with the

cancellation criteria stated above upon the written request of their legal heirs and the premium, if any, is refunded to their legal heirs.
In cases where more than one person is insured, in the event of the death of one of the Policy Holders, it releases the person who has passed away from the policy as of the date of death. The premium, if any, is refunded to the Policy Owner on the policy in accordance with the above cancellation criteria.

ARTICLE 11 - STANDARD EXCEPTIONS

In addition to the excluded situations stated in Article 2 of the Health Insurance General Terms, the following situations are also excluded, for every type of coverage of the policy.

1. Any situations other than the emergencies stated under Cases Included in the Coverage in Article 2-Coverage section, and their results and continuance;
2. Emergency situations, private nursing expenses, and ambulance expenses which are not approved by the Insurer;
3. Expenses for treatments that continue after the Policy Holder's condition is stabilized, following the emergency situations approved by the Insurer;
4. All conditions contradicting the insurance legislation and the Health Insurance General Terms.
5. All kinds of health expenses, including conditions/diseases that exist and have not been declared before the start date of the policy, and recurrence and complications of these diseases (whether diagnosed and/or treated);
6.Expenses for treatment, examination, inspection that have been carried out or requested by persons who are not medical doctors, or by facilities which are not registered by the Ministry of Health, all medicine and materials prescribed by these;
7. Unnecessary inpatient cases which are stated in definitions section, expenses for diagnosis or treatment which are not linked to a specific complaint and/or disease (check-up, routine controls, etc.)
8. Expenses of the accompanying person;
9. Suicides or suicide attempts (in whatever mind or mental state);
10. Mental diseases and psychological disorders that require psychiatric treatment, all types of psychotherapies;
11. Driving without a license, alcoholism, addiction to alcohol, drugs, stimulants, hallucinogens and other substances, and expenses related to any conditions or accidents that may arise due to the use of such substances;
12. All extreme sports whether they are done in a professional or amateur way or as a hobby, and/or other activities not being limited to the following, not to exceed 3,000 TL and the total coverage limit: Mountaineering, scuba diving, flying plane or glider, parachuting, parapanting, flying with delta wings, horse riding, skiing, riding a motorcycle, even for transportation purposes, etc.);
13. Congenital disorders, anomalies and diseases, even when they are detected in later ages or after the start date of the policy, all types of genetic diseases, tests, treatment and complications related to genetics;
14. Dementia caused by old age, Alzheimer's, Parkinson, epilepsy diseases, and antipsychotic, anxiolytic, anticonvulsant and all psychotrophic medicine used in the treatment of these diseases;
15. Materials which are not considered medicine, all types of materials and chemicals licensed by the Ministry of Agriculture, all types of medicine which are not imported legally, vitamin and mineral combinations and/or preparations regulating food intake, which are used for the purposes of meeting the daily requirements of the body and/or protecting general health;
16. HIV virus - AIDS and all test, treatment and complication expenses related to it;
17. Organ transplants, even because of an emergency situation, and related expenses;
18. Epidemic diseases which are announced officially, and which are initiated with malicious motives;
19. Plastic and reconstructive surgery unless they are carried out as a result of a judicially filed accident that occurs within the policy period, hearing defect surgery, tooth, gingiva, refractive error, and tests and treatments related to these (implant and precious metal expenses, even when they are carried out following an accident);

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20. Expenses for all types of tests, controls, medicine, recurrence, complication and operations in the course of treatment, carried out after the discharge and related to the same disorder, which cannot be defined as emergency situation, and also inpatient expenses for these,
21. For situations that occur in the first 24 hours after the policy starts, indemnity cannot be requested, even when these are emergency situations within the coverage scope.
22. Eye glasses, contact lenses, lens solutions, refractive error surgeries;
23. All aesthetic and plastic surgery operations, excluding the ones that are applied to correct a defect during the first inpatient case following an accident that happened within the policy period, where the cause of that defect is the accident in question;
24. Miscellaneous expenses such as telephone, TV, cafeteria, administrative services, paramedical services and service fee, which are not required for treatment;
25. All types of treatment expenses which occur abroad;
26. Artificial limb, all types of external prosthesis, support prosthesis, wheelchair, hearing device, cochlear implant, stick, wristband, heel cup, arm hanger, ice bag, water bag, devices externally attached to the body;
27. Invoices issued by the 1st degree relatives of the Policy Holder;
28. Shampoo, skincare, soap and similar cosmetics, toothpaste, mouth and dental care preparations;
29. Expenses for pregnancy, miscarriage, normal and cesarean birth and/or complications arising out of these;
30. Treatments carried out in facilities which are not licensed by the Ministry of Health, treatments which are not proven to be scientific, experimental treatments, treatments which are accepted by FDA (USA Food and Drug Administration) to be at the experimental stage, operations/treatments which are not indicated in the Turkish Medical Association Price Tariff.

ARTICLE 12 - HEALTH INDEMNITY PAYMENTS

Except for the expenses made in the Contracted Institutions, the original invoice demonstrating the health expenses made by the Policy Holder in the non-contracted institutions are covered upon their delivery to the Insurer.

If premium of a policy is being paid in installments; when the risk is realized, the remaining installments become due and these are offset against the indemnity that will be paid to the Policy Holder.

When in-scope coverage expenses (Article 2) are made in non-contracted institutions, these must be approved by the Medical Operations Center, and the following documents must be delivered to the Insurer.

1. Detailed hospital invoices, report stating the reason for the inpatient situation;
2. When there are surgical operations, detailed operation report (including the pathology result report, if biopsy was carried out);
3. Observation file if required, traffic collision report, judicial report, judicial minutes, alcohol report, Policy Holder's declaration;
4. Epicrisis (flow summary) report;
5. If required, laparascopic/arthroscopic/endoscopic operation tapes.

ARTICLE 13 - DEFINITIONS

Explanations regarding definitions used within the scope of the insurance policy are attached.

EMERGENCY SITUATION: A health condition emerging as a result of a sudden disease or a body injury, therefore requiring immediate medical or surgical care, bringing about a justified medical opinion that there is a serious medical problem, and requiring the services of the emergency room of a hospital, whether the patient will later be hospitalized or not. Health conditions which will be considered as emergency situations within the scope of this policy are the situations which are approved by the Medical Operations Center, and which are included in Article 2, Coverage section.

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JUDICIAL ACCIDENT: An unexpected, sudden event which happens within the period of the policy, which results in the Policy Holder's having bodily injury, which has to be proceeded and investigated by legal authorities, and/or which has already been done so. It is documented by the authorities making the investigation.

CONTRACTED INSTITUTIONS: Hospitals, clinics, laboratories, diagnosis and treatment centers, pharmacies and doctors included in the Contracted Institutions List that is annexed to the policy, where the Insurer offers to the Policy Holder beneficial service without charges in line with the conditions of the policy.
Limits and coverage rates applicable to Contracted Institutions are indicated on the Certificate. Because this list is updated continuously, before applying for services, it should be asked to the Insurance Company whether the contract is still in place with the institution in question.

TYPE OF CONTRACTED INSTITUTIONS: In the list provided as an annex to the policy, Contracted Institutions are classified as two categories, A and B. The applicable category of the policy is indicated on the certificate. Contracted Institutions of a different category are considered to be Non-Contracted Institutions, even though they are MAPFRE contracted providers.

All entities included in the Contracted Institutions List stand for the general network of MAPFRE SİGORTA A.Ş.

LIST OF CONTRACTED INSTITUTIONS: 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 the final list updated is taken as a basis for all policies.

NON-CONTRACTED INSTITUTIONS: These are hospitals, clinics, laboratories, diagnosis and treatment centers, pharmacies and doctors which do not have a contract with the Insurance Company. If a doctor is working in a contracted hospital but issuing invoices on their own, these invoices are considered non-contracted institution invoice, unless the doctor has a separate contract with the Insurer.

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

HEALTH PROBLEM PREVIOUSLY EXISTING BUT HAS NOT BEEN DECLARED: Any existing and known complaint, symptom or disease not being declared to the Insurer in the application form, during or before the application for this Policy.

END DATE: Day (12.00 pm at local time in Turkey), month and year in which this policy expires. Any expenditures to be made after this date are excluded from coverage, regardless of their reason. However, if a Policy Holder is under treatment in a hospital when the policy expires, expenses are covered for an additional 10 days, provided that the patient has not left the hospital during this period.

REMOVAL DATE: Day (12.00 pm at local time in Turkey), month and year in 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. In the case that the Policy Holder is removed for rescission or termination, provisions and periods stated in Article 8, General Terms apply.

DOCTOR: A person who officially has the title and document for "medical doctor", in line with the legislation of the geographical area of the coverage, and who is given a working license by the Turkish Ministry of Health.

GENERAL TERMS: Written rules which are determined by the Turkish Prime Ministry Undersecretariat of Treasury and the application of which is obligatory in health insurances by all insurance companies.

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UNNECESSARY TREATMENT: It is the case that, where treatments, examinations and operations can be proceeded without being hospitalized (confirmed by an independent doctor), these are carried out as an inpatient.

TOTAL ANNUAL LIMIT PER DISEASE/COVERAGE: It is the annual maximum amount indicated on the Certificate which is specified by the Insurer per disease and/or coverage in line with the policy terms and which can be utilized by the Policy Holder, according to the special and general terms of the policy.

HOSPITAL: A private or public entity holding an official hospital license in its field of business, providing medical services to sick and wounded persons. The following are not classified as hospital: Clinics providing outpatient treatment, sanatoriums, physical treatment centers, health clubs, nursing homes, care entities for older persons, entities specialized in addiction (drugs, alcohol).

HOSPITALIZATION: The case where there is a situation which is not possible to treat outside the hospital, where the situation is within the policy coverage, and where the patient is required to stay at the hospital for at least 24 hours.

CANCELLATION DATE: Day (00.01 am at local time in Turkey), month and year in which the policy is canceled upon the written request of the Policy Owner or for the reason of rescission or termination due to the provisions stated in the General Terms by the Insurer.

ACCEPTABLE INDEMNITY: The part of the health expenses made by the Policy Holder which will be approved and reimbursed by the Insurer, considering coverage limits and rates, and according to the Health Insurance General Terms and Policy Special Terms (Article 2, Emergency Situations).

RECORD DATE: Day (12.00 pm at local time in Turkey), month and year in which the Policy Holder is covered by the Insurance Policy, whether initially or by renewal.

ACCIDENT: An unexpected, sudden event causing the Policy Holder to be bodily injured, which can be proved medically.

CONGENITAL DISEASE: Metabolic and/or body defects and/or disorders which have existed since birth.

CHRONIC DISEASE: A disease which does not begin suddenly, which develops and/or grows gradually, recurring from time to time, or is continuous.

SMALL SURGICAL INTERVENTION COVERAGE: This coverage covers small surgical operations and observations up to 149 units (including 149 units) as indicated in the Turkish Medical Association Price Tariff.

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.

ADDITIONAL RISK PREMIUM: It is the additional premium practice which is indicated in the policy that is annexed to the policy, to be applied only for the related Policy Holder. Applicable additional premiums are indicated on the certificate with their reasons and rates.

CERTIFICATE: It is a table as an integral part of the policy, which indicates domestic and overseas coverage agreed by the Policy Owner and the Insurer, as well as the Contracted Institution category, participation rates, coverage limits if any and exemption amounts if any.

POLICY OWNER: 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.

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POLICY OWNER/POLICY HOLDER PARTICIPATION RATE: The participation rate indicated on the certificate annexed to the insurance policy, which will be assumed by the Policy Owner/Policy Holder out of the Acceptable Expenses.

INSURER PARTICIPATION RATE: The participation rate indicated on the certificate annexed to the insurance policy, which will be assumed by the Insurer out of the Acceptable Expenses.

INSURANCE POLICY: It is issued within a special format by the Insurer and includes provisions about the policy such as maturity, special and general terms, limits, exceptions, practice information and payment terms; it is the entire set of documents including insurance certificates bearing company stamps and authorized signatures and guaranteeing payment of coverage within determined limits if terms are fulfilled.

INSURER: Insurance Company registered and holding an operating license in the country where the Insurance Policy is issued. The title "Insurer" is used for MAPFRE SİGORTA A.Ş in this policy.

PERSONS TO BE INSURED: The Policy Owner themselves or their personnel, spouse, unmarried children under 18 years of age, and unmarried children under 25 years of age, who continue university education full time, or who do not work full time or freelance.

POLICY HOLDER: Person and/or persons stated in the health insurance application of the Policy Owner and Persons to be Insured, or included afterwards, who are accepted by the Insurer and included in the policy coverage, or who are included afterwards with an addendum.

SPECIAL EXCEPTIONS FOR THE POLICY HOLDER: Exceptions which will be applied for the related Policy Holder such as conditional acceptances (additional premium, exception, participation rate, etc.), which are agreed in the insurance policy. These are indicated on the certificate which is given as an annex to the insurance policy.

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

INDEPENDENT DOCTOR: A medical doctor providing decisions or opinions according to objective principles of medicine.

COVERAGE: It is the scope of health expenses that the Insurer undertakes to pay within the framework of the special and general terms of the insurance policy, excluding the limits, exceptions, waiting periods and exemptions stated on the certificate.

ANNUAL TOTAL LIMIT: It is the scope of health expenses that the Insurer undertakes to pay within the terms of this Insurance Policy, excluding exceptions, waiting periods, limits and exemptions.
The maximum expense amount that the Policy Holder may use from their coverage specified annually during the period of the Insurance Policy.

RENEWAL: This is the case where the Policy Owner contacts the Insurer 30 days before or after the End 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 (12.00 pm at local time in Turkey), month and year of the new Insurance Policy, which is the same as the End Date of the previous Insurance Policy.

MAPFRE Sigorta

GENERAL TERMS FOR THE EMERGENCY SITUATIONS INSURANCE

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