Allianz

Allianz Foreign Health Insurance

Special Terms and General Conditions

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"In case any conflict occurs between the Turkish and the English version of this contract/ policy/guarantee table, Turkish version will be deemed valid legally."

Allianz Foreign Health Insurance Special Terms

1. SUBJECT AND SCOPE OF INSURANCE

This private health insurance is required for short-term residency permit applications pursuant to the Law on Foreigners and International Protection.Allianz Sigorta A.Ş. (Allianz) shall guarantee all health expenses the Insured may incur due to accident, disease, or illness during the term of the insurance contract within the scope of plan(s), benefit, limits, co-insurance percentages, deductibles and contracted institution network (Network) listed in the policy pursuant to the legal legislation, including the Special Terms (Special Terms) and its attachment, Health Insurance General Terms (General Terms), Private Health Insurance Regulation (Regulation), Turkish Commercial Code (TCC), and insurance and health regulations.

Modules and benefits included in the policy are separately provided to individuals described as an Insured in the policy, and individuals not included in the policy as Insured shall not be entitled to any insurance benefits.

The insurance period of this product may be from one (1) to two (2) years, depending on residency permit requirements. The insurance contract shall cover the time between the start and end dates stated in the policy. Unless agreed otherwise, the policy shall go into effect at noon and end at noon Turkish time, on the policy start and end dates, respectively.

2. DEFINITIONS

Insurer
An insurance company established in Turkey, licensed to operate in the related business segments. The Insurer shown on the health insurance policy to be drawn up under these Special Terms is Allianz.

Insured
The person(s) whose name(s) is/are indicated in the policy, and whose health expenses are covered by the health insurance contract.

Policy Owner
A natural or legal person, who has agreed to and entered into an insurance contract, and who is responsible for the obligations arising from the insurance contract, including the payment of insurance premiums.

Policy
Refers to the agreement which documents the private health insurance contract. The policy can be viewed on the My Allianz mobile application and on the insured's personal page at www.allianz.com.tr Online Customer Portal.

Policy Owner / Insured Contact Information
The home and/or business addresses; and home, work and/or mobile telephone numbers; and email addresses of the Policy Owner and Insured(s) stated in the policy.

Special Terms
A document that contains special rules and terms

related to the product, drawn up by the Insurer as an integral part of the policy.

Health Insurance General Terms (General Terms)
The written rules established by Turkish Insurance and Private Pension Regulation and Supervision Authority (SEDDK), which apply to all health insurance products offered by all insurance companies.

The most up-to-date version of the General Terms is available at: www.tsb.org.tr.
http://www.tsb.org.tr/

Allianz Customer Services
The Insured can direct all their questions, requests, suggestions, and complaints, as well as access various services such as an ambulance, by calling the Help Line on 0850 399 99 99.

Individual Health Insurance
A health insurance product under which the immediate family including the individual and his/her mother, father and unmarried children (including adopted) are covered together.

Disease
A disorder/condition determined by a physician in relation to the Insured's organs or systems, and psychological or physical functions, which requires medical examination, therapy, or intervention. (For example: migraine, gastritis)

Illness
An abnormal psychological or physical symptom(s) that require the adult person to visit a physician. (For example: headache, nausea)

Existing Disease / Illness
All kinds of illnesses and/or diseases that existed before the policy start date.

Application and Information Form
The form, which must be signed by the Policy Owner/prospective Insured(s) and includes the insurer-provided data on the Policy Owner/ prospective Insured(s) (for example, identification and contact data, health declarations, account numbers), selected policy benefits (for example, the Network and Plan), and the premium payment plans. The form serves to remedy any omissions which could arise at the time of both negotiating and executing the contract in regards to the subject matter of the contract, benefits, and other features, and to inform the relevant parties about any changes and developments which could affect the Policy Owner and the Insured(s) in regards to the application of the contract. This form comprises a proposal made to the Insurer.

Disclosure Obligations
This requires the Policy Owner / Insured to provide information about all existing diseases, illnesses, and risks of the Insured(s) at the time of application and during the tenure of the insurance contract, and about any issues that may affect the risk assessment. The Policy Owner / Insured(s) is required to provide the Insurer with complete contact information in writing to allow the Insurer to notify them about the necessary information.

Exceptions
The risks (illnesses and diseases) excluded from coverage by the policy after an assessment by the Insurer which preexisted the policy start date or that arose during the policy term.

Health Services Tariff
The base tariff that covers the unit and implementation rules used as a benchmark in determining the fees related to the medical services Allianz includes in the contracts drawn up with the institutions that provide health services. (for example, the Turkish Medical Association [TMA] Tariff, Medical Practices Database [HUV], Healthcare Implementation Communique [SUT], Turkish Dental Association [TDA] Tariff, and so forth.)

Health Institution
A public institution or private business licensed by the T.R. Ministry of Health, such as a hospital, medical center, clinic, polyclinic, laboratory, diagnostic center, private practice, or pharmacy, that provides inpatient and/or outpatient diagnostics and therapy.

a) Contracted Health Institution (CHI)
A health institution with which Allianz Sigorta has signed a contract, and the physicians who are on the payroll of such institutions and have agreed to the Allianz contract terms.

b) Contracted Health Institutions Network (Network)
The contracted health institutions included in the policy selected by the Policy Owner.

Each Network is composed of Contracted Health Institutions contracted with Allianz after consideration of features such as services provided, location, and contract terms.

c) Non-contracted Health Institution (NHI)
A health institution that is not included in the Network selected by the Policy Owner in their policy and/or does not have contract with the Insurer.

Physicians on the payroll of a health institution included in the Network selected in the policy, but who are not officially appointed by the Ministry of Health nor bounded by the Allianz contract terms, shall be treated as a non-contracted health institution.

d) Overseas Health Institution (OHI)
The institutions which operate outside the borders of the Turkish republic and are considered in accordance with the regulations of the related countries, including health institutions such as hospitals, laboratories, diagnostic centers, polyclinics, and pharmacies.

Claims
The health expenses approved and/or reimbursed by the Insurer under the related health policy and Policy General and Special Terms.

a) Authorization / E-authorization
The result of the assessment the Insurer makes as to whether a planned medical examination, diagnosis, or therapy is covered by the health institutions included in the Network selected by the Policy Owner. This assessment shall be effective if the policy is still in force on the date the health expense is incurred.

The authorization/e-authorization granted at the time of making a claim may not be the final approval, as the Insurer reserves the right to make a different decision at the accrual stage after making an assessment regarding both the benefits and reimbursement. In any advance authorizations/e-authorizations sought, the date of realization shall provide the basis for exercising the rights under the Policy General and Special Terms.

b) Accrual
The assessment stage in which the Insurer reviews the claim submitted within the framework of the policy coverage and limits and the Policy General and Special Terms and decides whether to reimburse the health institutions and/or Insured and, if a reimbursement is to be made, the amount, regardless of whether any prior authorization/e-authorization has been obtained.

c) Direct Reimbursement
Health services obtained by the Insured by paying the co-insurance, in the event that the policy terms stipulate co-insurance/deductibles for health expenses incurred within the Network selected in the policy and after obtaining authorization/ e-authorization. The Insurer will pay the partial amount under its responsibility to the relevant institution on behalf of the Insured within the Policy General and Special Terms.

d) Subsequent Reimbursement
The reimbursement made by the Insurer to the account of the Insured in the amount determined by an assessment made under the Policy General and Special Terms, in association with health expenses related to the payments made by the Insured to the health institution without obtaining a prior authorization/e-authorization from the Insurer. The Insured has to submit to the Insurer the invoice for all related health expenses, the Medical Expenses Claim Form (MEC Form), and all required documents listed in the private terms of Claims Payment.

Medical Expenses Claim Form (MEC Form)
The form which the Insured has to complete and submit to the Insurer to allow the payments made by the Insured related to any health expenses incurred without obtaining a prior authorization/ e-authorization to be evaluated for subsequent reimbursement.

Plan
Information provided in the policy that shows the benefits, benefit limits, Insurer's deductibles and

the Insured's co-insurance percentage under the policy terms.

Benefit
The coverage that the Insurer warrants to provide to the Insured in the event that a risk occurs.

Term
In those policies drawn up for a period longer than one (1) year, each year shall be considered a term within the policy start and end dates.

Limit
The maximum annual gross claim amount to be paid for each benefit included in the policy. The gross limit is the sum of the claims to be paid by the Insurer and the co-insurance and exemption covered by the Insured.

Co-insurance Percentage
The proportion shown in the policy that the Insurer is responsible for paying for each benefit.

Co-insurance
The ratio shown in the policy for each benefit in relation to the remainder of balance left after the co-insurance percentage and committed to by the Insured.

Premium

a) Health Tariff Premium
The base health premium, calculated by taking into account the Insured's risk profile criteria, including benefits, the co-insurance percentage, Network, domiciled province, age, sex, and so on.

b) Health Premium
The premium amount calculated by adding to the Health Tariff premium, additional disease and claim related premiums, if any, for each Insured.

c) Health Net Premium
The premium amount calculated by adding to the Health Premium, campaign-related discounts applicable in the period, if any, plus the discounts earned based on Policy Special Terms.

d) Total Policy Premium
The premium amount calculated by adding to the Health Net Premium, the premiums related to personal accidents and/or life benefits, if any, and the tax amount. The total policy amount which the Policy Owner is required to pay.

Additional Disease Premium
A coverage decision by the Insurer made after an assessment to include in the policy any disease or illness existing before the policy start date or that has arisen during the policy tenure, by applying a certain additional premium over the Health Tariff Premium.

New Contract Policy
The first individual health insurance policy which the Policy Owner has entered into with the Insurer on behalf of the Insured by selecting an Allianz Individual Health Insurance product and in which the Insured stays without interruption.

Transfer Policy
The individual health insurance policy which the Policy Owner has entered into with the Insurer on behalf of the Insured, transferred from another insurance company or from an Allianz Group Health policy, by selecting an Allianz Individual Health Insurance product and which covers the Insured.

Renewal Policy
The policy renewal granted to the Insured for the period between the start and end date stated in the policy upon the expiration of the Allianz Individual Health Insurance product.

Endorsement
The supplementary insurance contract. This is an integral part of the policy and shows its latest status, including those amendments made since the policy start date.

Policy Start Date
The Insured's first enrollment date in a new contract or a transfer policy issued by Allianz to provide uninterrupted individual health insurance coverage.

Remote Health Service
According to the provisions of the Regulation on the Delivery of Distance Health Services published by the Ministry of Health; It is the health service provided by the healthcare professional to the person requesting the health service via the remote health information system in the health facilities that have received an operating license.

Remote Health Information System
It refers to the secure software that enables written, audio or video communication produced by the Ministry of Health or approved by the Ministry to be used in remote health service delivery by being registered by the Ministry.

3. COVERAGES

The coverage within the scope of this product accords with the minimum benefit structure defined in the Circular on Health Insurances Required for Visa and Residency Permit Request No. 2021/8 dated June 16, 2021.

3.1. INPATIENT TREATMENT
Surgery, nonsurgical treatment, intensive care, chemotherapy, radiotherapy, dialysis treatment and examinations, dental treatment after a traffic accident, minor surgery, post-operative physiotherapy, and home care and treatment expenses are all be covered under the terms of the "Inpatient Treatment" limits and co-insurance percentages as stated under "Coverage"

Expenses related to physicians' fees (for example, those of surgeons, anesthesiologists, and assistants); the use of an operating room, standard room, and intensive care unit; companion charges and meals; health expenses related to the use of medication; and all types of medical supplies and examinations used in surgeries or during the Insured's hospital stay between admission and discharge dates for surgical and nonsurgical inpatient treatments (details of which are shown below) shall be covered within the limits and co-insurance percentages and deductions applicable in the "Inpatient Treatment" benefits.

Inpatient treatment shall be limited to a maximum of 180 days within each policy term. Each 24-hour stay in a normal room is calculated as one day, and in the intensive care unit as two (2) days. The sum is deducted from the total 180-day inpatient limit.

3.1.1. Surgery
Expenses related to in-vivo pumps, intra-cardiac devices (ICDs), cardiac pacemakers, breast cancer and post-accident plastic surgeries, artificial limbs used after breast cancer treatments, extracorporeal shockwave therapy (ESWT) and extracorporeal shock wave lithotripsy (ESWL), surgeries associated with hydatidiform mole and ectopic pregnancies, and treatments medically classified as surgeries where physicians have documented that treatment is only possible by surgical operation, shall all be covered under the "Surgery".

In cases that involve one or more surgical procedures in the same session, the procedure with the highest unit price in the Health Services Tariff shall be taken as a benchmark to determine the benefit amount of the surgery/minor surgery.

In situations where more than one surgical procedure is performed during the same session, irrespective of whether it is through the same incision or a different one, and if an excluded treatment is involved, the total bill to be paid (including physician's fees) shall be calculated by prorating the costs based on the Health Services Tariff. The excluded amount calculated by prorating the costs, based on the Health Services Tariff, shall be established as the patient's portion.

3.1.2. Nonsurgical Treatment
In situations where the treatment is nonsurgical but needs to be performed in a hospital and/or an intensive care unit on an inpatient basis, and this is confirmed by medical and/or hospital reports, those health expenses incurred during hospital stays in excess of 24 hours shall be covered under "Nonsurgical Treatment and Surgery."

Medical treatments performed in less than 24 hours (observation, medical hold) shall be covered within the scope and under the conditions of "Advanced Diagnostic Methods and Outpatient Treatment."

3.1.3. Home Care and Treatment
If a treatment plan drawn up by the Insured's physician stipulates home care after inpatient treatment, and is approved by the Insurer at the time of the Insured's discharge from the hospital, then provided that the home care does not last for more than eight weeks in the policy

year, all medical expenses related to home care and medical equipment (as listed in the medical report) incurred after the date of release from hospital shall be covered within the limits and co-insurance percentages applicable in "Home Care Treatment" benefit.

3.1.4. Post-Operative Physiotherapy

The Insured's expenses incurred during physiotherapy are considered a supplementary treatment and are included under the Surgical and Nonsurgical Treatment coverages for a period of up to 60 days starting with the end of the post-operative or post-ICU stay resulting from an accident or ailment. This is included under the "Post-Operative Physiotherapy" coverage and co-insurance percentage shown in the policy, regardless of whether the treatment is inpatient or outpatient. If the surgery that requires physical therapy takes place within the waiting period, regardless of the fact that any physical therapy session coincides after the waiting period all sessions related to the operation are considered out of coverage.

The physiotherapy and rehabilitation expenses to be covered in the policy year shall be limited to 10 sessions annually (each term), and each procedure at non-contracted institutions shall be limited by the Health Services Tariff. Where treatment is applied to more than one body part, each instance shall be treated as one session.

In the case of hospital stays that are prolonged only on account of physiotherapy sessions, expenses not related to the physical therapy shall not be covered.

3.1.5. Chemotherapy, Radiotherapy, and Dialysis

Expenses related to dialysis treatments (such as hospital, medication, and physician fees), and chemotherapy and/or radiotherapy performed to treat malignant formations shall be covered within the limits and co-insurance percentages applicable in the "Chemotherapy, Radiotherapy, and Dialysis" benefit shown in the policy.

3.1.6. Dental Treatment After a Traffic Accident

In the cases where an accident report is submitted to official authorities (either judicial or administrative), all types of treatment expenses resulting from traffic accidents and related to dental and gingival treatments performed by dentists and maxillofacial surgeons to the Insured's dental and oral injuries shall be covered within the benefit limits and co-insurance percentages applicable under the "Inpatient Treatment."

3.1.7. Minor Surgery

Expenses related to surgical operations performed through a dermal incision classified as minor surgeries in the Health Services Tariff, as well as the health expenses related to surgical procedures in the case of lacerations, fracture reductions, plaster cast applications, foreign object removals, nasal packing, cryo and electrocautery procedures, and biopsies performed through full lesion excisions shall be covered within the limit and co-insurance percentages applicable in "Minor Surgery," regardless of the anesthetics used and whether the treatment is categorized inpatient or outpatient. Of these procedures, any application that costs over 150 units based on the Health Services Tariff shall be covered under "Inpatient Treatment and Surgery."

For procedures performed within the scope of "Minor Surgery," the materials and medications used, as well as operating room and physician's fees shall be covered under "Minor Surgery."

Health expenses related to the treatment of pain administered for spinal diseases and disorders of spinals discs (such as facet nerve denervation, radiofrequency thermo-coagulation, and transforaminal epidural injection) shall be covered within the limits and payment percentages applicable in the "Minor Surgery" benefits shown in the policy, regardless of the units specified in the Health Services Tariff, and whether administered as inpatient or outpatient treatment.

Even if related to the above-mentioned procedures, all types of fees related to examinations and laboratory tests associated with radiology and the related prescribed medication and fees for injections; injections of medication that may be performed individually or for other reasons, such as intra-articular, before, during, or after the

procedure (except those administered within the operating room); and all types of pain treatments except those targeting spinal and disc diseases, shall be covered within the scope and under the conditions of the relevant "Inpatient Treatment" or "Advanced Diagnostic Methods and Outpatient Treatment" benefits.

In cases that involve one or more surgical procedures in the same session, the procedure with the highest unit price in the Health Services Tariff shall be taken as a benchmark to determine the benefit amount of the surgery/minor surgery.

In situations where more than one surgical procedure is performed during the same session, irrespective of whether it is through the same incision or a different one, and if an excluded treatment is involved, the total bill to be paid (including physician's fees) shall be calculated by prorating the costs, based on the Health Services Tariff. The excluded amount calculated by prorating the costs, based on the Health Services Tariff, shall be established as the patient's portion.

3.2. Prostheses

Expenses related to artificial limbs that replace parts lost due to accident or disease within the Insured's insurance term, as well as their maintenance, and that of in vivo devices such as PCA, cochlear implants, and insulin pumps, shall be covered within the annual term limits and co-payment percentages shown in the "Artificial Limb" benefits shown in the policy, if justified by a medical report and approval is obtained from the Insurer.

3.3. OUTPATIENT TREATMENT

In cases where diagnosis and treatment do not require hospitalization, the physician's examination, medicine, all types of laboratory analyses, x-rays, physiotherapy and rehabilitation, medication, advanced diagnosis, medical observation, and medical supply expenses, as detailed below, shall be covered under "Outpatient Treatment" benefits with the co-payment percentage determined by deducting from the annual term limit.

3.3.1. Doctor Visit

Expenses for the diagnosis and treatment of the insured person due to an accident, illness or illness in the hospital, medical center, clinic, polyclinic, private practice and physical examinations to be performed by the doctor at home in emergencies are covered within the limit and co-insurance percentage applicable in the "Outpatient Treatments" benefit.

A physician's examination of the Insured and related expenses arising from the diagnosis and treatment for an accident, illness, or disease shall be covered under "Outpatient Treatment," with the co-payment percentage determined by deducting from the benefit limit.

In regions where the Insurer has initiated the "Specialist Network" system, in-office examinations by contracted physicians shall be 100 percent covered under the physician's examination benefits.

3.3.2. Medication

Expenses related to the medication prescribed after the physical examination by the doctor for the Insured and required for treatment shall be covered up to 30-day daily doses for each medication and within the co-insurance percentage applicable in "Outpatient Treatment," if the usage under the Policy Special Terms does not exceed the term of the policy. However, if the attending physician treating the Insured has confirmed the regular use of a certain medication by a medical report, then this specific medication may be prescribed for up to 90 days within the Policy Special Terms, if the usage period does not exceed the term of the policy and authorization is obtained from the Insurer. Expenses related to a medication authorized by the Insurer shall be reimbursed depending on their usage rate and extent.

If there is a difference of more than 10 days between the prescription and the purchase dates of the medication (as indicated by the invoice or bill) then the related medication expense will not be reimbursed.

Expenses related to the medication that are vital to treatment and have no generic or equivalent in Turkey shall be covered under related benefits, if the usage period does not exceed the term of

the policy and authorization is obtained from the Insurer.

3.3.2.1. Vaccinations

Routine pediatric vaccinations:
0-1 For age: 3 doses of rotavirus vaccine,
0-2 For age: 2 doses, for age 3-11: 1 dose of meningococcus/ Menectra/ Menveo, vaccine,
0-3 For age: 2 doses hepatitis A vaccine,
For ages 0-6: 4 doses of each: Polio, diphtheria, pertussis, tetanus, and haemophilus influenza B vaccines; 3 doses: Hepatitis B vaccine, 2 doses of each: Measles, rubella, and mumps vaccines; 1 dose of each: Varicella, BCG (tuberculosis) vaccines,
For ages 0-9: 4 doses of pneumococcus vaccine, 2 doses of influenza vaccine.

Adult vaccinations:
1 dose of hepatitis A vaccine,
3 doses of hepatitis B vaccine,
Women of ages 9-26: 3 doses of HPV (cervical cancer) vaccine
1 dose of pneumococcus vaccine,
1 dose of influenza vaccine.

In addition to these, rabies and tetanus vaccines are covered for all age groups.
The vaccines shown above shall be covered within the co-insurance limits of "Outpatient Treatments" shown under "Medication" in the policy.

3.3.3. Laboratory Examinations and X-rays

Expenses related to laboratory analyses, such as the blood and urine tests required after the physical examination by the doctor for the diagnosis of a disease, and diagnostic methods such as X-rays (including mammography and medicated radiography), ultrasonography, ECG, EEG, and EMG, hearing test and respiratory function test are covered within the limits and reimbursement percentages applicable in "Inpatient Treatment."

The expenses related to medications and anesthesia, and the physicians' fees required for these diagnostic methods shall be included under this benefit, regardless of whether the treatment is inpatient or outpatient.

3.3.4. Physiotherapy and Rehabilitation

Expenses related to the physiotherapy and rehabilitation treatments drawn up after the physical examination by a physical therapy specialist and authorized by the Insurer shall be covered within the limits and reimbursement percentages applicable in "Outpatient Treatment," regardless of whether the treatment is classified as inpatient or outpatient.

Each procedure that takes place at a non-contracted institution shall be limited by the Health Services Tariff. Where treatment is applied to more than one body part, each instance shall be treated as one session.

3.3.5. Advanced Diagnostic Methods and Medical Observation Treatment

Any computerized tomography; stress ECG; holter; Doppler ultrasound; MRI; use of nuclear medicine; extracorporeal shockwave therapy (ESWT) and extracorporeal shock wave lithotripsy (ESWL), and all types of biopsies and diagnostic curettage performed using methods such as smears, punch, and needle biopsies deemed medically necessary for diagnosis and treatment and that are included in the examination after the physical examination by the doctor are included under "Advanced Diagnostic Methods."

Liver, renal, cerebral, and mediastinoscopic pulmonary biopsies, and excisional biopsies performed for the complete excision of lesions, shall be included under the "Surgery" or "Minor Surgery" benefits with consideration of Health Services Tariff units.

Angiography (covered under "Coronary Angiography Surgery") and endoscopic examinations such as gastroscopy, colonoscopy, cystoscopy, and bronchoscopy, including biopsies, medication, medical supplies, and related expenses are included under "Advanced Diagnostic Methods." The expenses related to medications and anesthesia, and the physicians' fees required for these diagnostic methods shall be included under this benefit, regardless of whether the treatment is inpatient or outpatient.

Whether classified as inpatient or outpatient, and regardless of the units specified in the Health Services Tariff, for all health expenses related to instances of nonsurgical treatments with an inpatient treatment duration of less than 24 hours (observation, medical hold), pain treatments (irrespective of the units specified in the Health Services Tariff) and related expenses shall be covered under "Advanced Diagnostic Methods and Medical Observation Treatment." (Pain treatments performed in relation to spinal and disc diseases are covered under "Minor Surgery.")

Other expenses related to the diagnostic methods not included above shall be covered under "Laboratory Examinations and X-rays."

3.3.6. Medical Supplies

As part of the Insured's treatment applied as a result of an accident or disease that occurred during the term of insurance, medical equipment that supports the body externally and is used only for medical purposes such as a personal brace or splint, elastic bandage, orthopedic boots, an orthopedic arch support, corset, compression socks, neck collar, knee breech, wrist support, elbow protector, sling, sitting ring, aerochamber, nebulizer, rom walker, walker, crutches, plaster slippers, urostomy bag, colostomy bag, wheelchair (if permanent disability is documented by a medical report), hearing aids (device maintenance and consumption expenses excluded), and covering materials used in the treatment of burns or wounds shall be covered under "Medical Supplies" as shown in the policy.0

Any urostomy bag, colostomy bag or covering material used in the treatment of burns or wounds used during inpatient treatment or home care shall be covered under "Surgery," "Nonsurgical Treatment," "Home Care and Treatment," or "Minor Surgery."

3.4. EMERGENCY AND AMBULANCE SERVICES

The Insured may benefit from emergency services provided within the borders of the Republic of Turkey in cases of life-threatening situations, provided that he/she calls Allianz Customer Service for the purposes of on-site intervention and/or transfer to the nearest health institution.

If it is not possible to transfer the Insured by land to the nearest health institution with adequate medical equipment, then the Insurer shall provide air or marine ambulatory services within the borders of the Republic of Turkey, as long as detailed medical information is submitted and prior approval is obtained from the Insurer.

3.5. REGULAR MAMMOGRAPHY SCREENING

Fees related to the mammography screening of female Insureds who are 40 years of age or older at the policy start date, and that are performed at one of the "Private Contracted Mammography Screening Centers" shown on our website, shall be covered within the co-insurance percentages shown in the policy on a once per year basis, provided an appointment and authorization are both obtained in advance. For policies longer than one (1) year, female Insureds who are younger than 40 years old at the policy start date shall not be covered under this benefit, even if they turn 40 within the policy term. Age calculations shall be based on the policy start date.

3.6. PSA SCREENING SERVICES

Fees related to the PSA screening of male Insureds who are 40 years of age or older at the policy start date, and that are performed at one of the "Private Contracted PSA Screening Centers" shown on our website, shall be covered within the co-insurance percentages shown in the policy, on a once per year basis, provided both an appointment and an authorization are obtained in advance. For policies longer than one (1) year, male Insureds who are younger than 40 years at the policy start date shall not be covered under this benefit, even if they turn 40 within the policy term. Age calculations shall be based on the policy start date.

4. WAITING PERIODS AND BENEFIT ENTITLEMENTS

All treatments and complications related to the following diseases/illnesses within the scope of inpatient treatment, after 9 months of being covered by insurance, all physical therapy and rehabilitation-related expenses are within the scope of outpatient treatment, covered after 6 months of being covered by insurance.

- Gall bladder and biliary tract diseases,
- All kinds of hernias,
- Vertebral column and disk diseases,

- Dermoid cyst, sacral abscess,
- Anorectal disorders (including hemorrhoids, fistulas, and fissures),
- Uterine and ovarian diseases,
- Tonsil and adenoid diseases,
- Nasal polyps,
- Cranial sinus diseases,
- Knee, shoulder, hip, and elbow joint diseases and lesions (including meniscus and ligament injuries, and chondral fractures),
- Cataracts,
- Prostate diseases,
- All kinds of varicose veins,
- Hydrocele,
- Kidney and urinary system stones,
- Thyroid gland diseases,

Health Expenses due to global, regional or country-wide epidemic diseases declared by the World Health Organization and / or Ministry of Health are covered within the policy guarantees, limits and copayments provided that the symptoms and complaints about the disease occurred 1 month after they are included in the policy.

However valid for all the above mentioned diseases / conditions,

Diseases that had existed before the policy start date and diseases included under the exceptions indicated in the policy shall fall outside benefits.

5. EXCLUSIONS AND EXCEPTIONS

The following shall be excluded from the policy benefit and shall be paid for solely by the Insured. In addition, the Insurer reserves the right to revise the policy and decide on whether to include or exclude newly introduced treatment methods and technological advances by grouping them under "Exclusions" after evaluating their effectiveness and the existence of alternative treatment methods. Any amendments made shall become effective for every Insured identified in the policy following the new policy start date, including those Insureds who have a Lifetime Renewal Guarantee.

1. Exclusions from the Health Insurance General Terms:
2. All kinds of health expenses related to illnesses and diseases that existed before the policy start date (whether or not diagnosed and/or treated),
3. Even if they have been diagnosed/identified after the policy start date;
   - Birth (congenital) defects/anomalies and diseases,
   - Examinations and screenings related to all kinds of genetic diseases and conditions, excluding accepted prenatal follow-ups,
   - Growth and developmental disorders,
   - Under-18 groin hernias, cord cysts, and hydrocele,
   - Existing defects, impairments, and complications,
   - All types of spinal deformations, including kyphosis and scoliosis,
   - Keratoconus,
   - Pes Planus, Halluks Valgus,
   - Nasal septum deviation, concha diseases and disorders, and nasal valve collapse,
   - Gynecomastia and
   - obesity diagnoses, treatments, complications, and monitoring expenses.

Exception: For an Insured who was engaged in a contract without interruption prior to May 1, 2017, within the scope of this Allianz Foreign Health product, and had completed three (3) full uninterrupted insurance years at Allianz, and had earned the right for a Lifetime Renewal Guarantee as per the Special Terms of the previous policy:

- Congenital defects, anomalies, and diseases, and genetic diseases (provided that the diagnosis post-dates the Allianz policy start date and no exception is) Genetic defects, anomalies, and diseases, and genetic diseases (provided that the diagnosis or exception post-dates the Allianz policy start date)
- Under-18 groin hernias, cord cysts, and hydrocele,
- Keratoconus,
- Pes Planus, Halluks Valgus,
- Nasal septum deviation, concha disorders and diseases.

However, those expenses relating to all types of examinations and screening tests performed for

birth (congenital) defects and genetic anomalies, diseases and conditions that occur without any clinical complaints and/or diagnosis, as well as all kinds of gene mapping expenses, shall be excluded from benefits and will not be reimbursed, even for those Insureds who have earned Lifetime Renewal Guarantees,

4. Health expenses related to premature birth (prematurity), low birth weight, or being small for gestational age (SGA),
5. All types of health expenses related to intoxicants and those diseases and accidents caused by addiction or alcohol abuse, drugs, stimulants, hallucinogens, or similar substances,
6. Examinations, tests, treatments, and preparations related to quitting smoking (such as nicotine strips, gums, and electronic cigarettes),
7. All kinds of health expenses related to accidents that occur while the Insured drives without the required driving license,
8. All types of health expenses related to psychiatric and psychological disorder examinations, neuropsychiatric tests, examinations, and treatment procedures such as psychotherapy, and associated complications,
9. All types of expenses related to illnesses caused by old age, dementia, and other diseases similar to dementia,
10. All types of expenses incurred at places shown below or not in compliance with the definition of a health institution,
    a. All types of expenses incurred at sanatoriums, nursing homes, nurseries, thermal springs, thermal centers, and similar institutions (including physiotherapy centers),
    b. All types of expenses incurred at traditional, supplementary, and alternative medical centers; anti-aging centers; fitness centers; coaching centers; weight loss centers; sports centers; foot health centers; and aesthetics, cosmetics, beauty, and laser centers,
    c. Examinations, tests, and treatments performed at lens and optometry centers,
    d. Examinations, tests, and procedures performed at hearing aid sales centers,
11. Regardless of the institution and the expertise of the person doing it; , acupuncture, ayurveda, hydrotherapy, hypnosis, aromatherapy, healing cures, massage, detox, mesotherapy, reflexology, neural therapy, chiropractic treatment, oxygen therapy, carboxytherapy, ozone therapy, platelet rich plasma treatment (RPR), and all other types of traditional, supplementary, and alternative medicine treatments,
12. Regardless of the institution and the expertise of the person doing it; all kinds of expenses related to aesthetic and cosmetic treatments, surgery procedures, check-ups, and complications, including telangiectasia; dermalhemangioma;xanthelasma;superficial varicose treatments (for example, chemical blockage, bubble and sclerosant-laser treatments); aesthetic injections; nasal valve procedures; rhinoplasty; breast enlargements, reductions, and plastic surgeries (excluding plastic surgery performed after breast cancer treatment); accessory breast surgery; liposuction; abdominoplasty; face-lifts; eyelid and eye contour aesthetic treatments; hair loss treatments and hair transplants; and anti-perspiration, anti-dermal dehydration, and anti-aging treatments;
13. All types of expenses related to procedures for which there is an insufficient amount and quality of controlled, published, and reviewed clinical studies that would prove the necessity, effectiveness, and reliability of diagnostic or therapeutic procedures developed in relation to a disease at the time of applying it to the Insured, or which are not endorsed by domestic or foreign authorities (such as specialist associations, professional organizations, the US Food and Drug Administration [FDA], medical schools, relevant departmental scientific councils, the Ministry of Health), and/or that written publications exist that indicate medical associations or authorities argue that the procedures involved are at an experimental stage, or that other organizations or individuals are working on experimental trials related to the same procedure or tool,
14. Expenses associated with the use of surgical robots in robot-assisted surgical procedures (e.g. da Vinci® Surgery), and all materials used during these procedures,
15. Expenses related to the examinations listed below and other examinations performed for

monitoring and screening purposes without an observed symptom of disease or illness,

a. All expenses for investigations and general check-ups for monitoring purposes requested by the physician without any symptoms, complaints, and/or family risks,
b. Expenses for screening tests and treatments that are not included in current national international diagnosis-treatment guidelines and/or requested without indication,
c. All expenses related to screenings performed for factors, coronary CAT angiography, the Coronary Arterial Calcium Score Test, Cardiac Electron Beam Tomography (EBT),
d. Expenses related to hepatitis examinations performed without any medical symptom or findings (such as jaundice or high liver enzyme levels),
e. Expenses related to medical or health board reports obtained for reasons related to marriage, employment, and sports activities,

16. All types of apparatus used for sleep disorders, sleep apnea, and snoring examinations and treatment procedures such as polysomnography and sleep EEG,
17. Expenses related to the following preparations which do not have any medical purpose:
    a. Medications not licensed by the T.R. Ministry of Health; nutritional supplements, immune system boosters, medical infant formulas, and preparations not defined as medication or that contain no active ingredients,
    b. All kinds of medicinal teas, Ministry of Health Traditional Herbal Medicinal Product (GBTU) licensed herbal medicines, plants, and herbal compositions prepared as a form of medication, and those that contain fractions of medication such as herbal extract distillates (except herbal medicines licensed by the Ministry of Health for human medicinal products),
    c. Ministry of Health licensed intermediate products (except antiseptic solutions and nasal sprays containing saline)
    d. Ministry of Health CE certified drugs (except insulin needle tips and intra-articular intra-articular injectors containing sodium hyaluronate)
    e. Water and seawater formulations that do not contain active ingredients but are prepared as a form of medication,
18. Vaccination expenses for all types of allergic diseases,
19. Expenses related to examinations, tests, and treatments for obesity and emaciation, including diet and dietitian expenses, body and mass measurement tests, body fat percentage tests, food intolerance tests, herbal weight loss supplements, brans and fibers, and artificial sweeteners,
20. General and personal hygiene supplies and apparatus, non-medication cosmetic products, all kinds of soaps, shampoos, hair solutions, anti-dandruff and anti hair loss preparations, oral and dental care apparatus, thermometers and body temperature probes, ice bags, hot water bags or gels, electric blankets, diapers, nursing bottles, breast pumps and apparatus, pacifiers and similar medical supplies,
21. In relation to the eye diseases indicated below,
    a. Operations correcting refractive error in the eye (such as myopia, hyperopia, astigmatism) and all kinds of related drugs, materials (such as lenses with a corrective effect on refractive errors such as multifocal lenses), examination, treatment and complication expenses,
    b. Expenses related to the examination and treatment of cross-eye, diplopia, and amblyopia (such as diplopia surgery and orthoptics treatment procedures),
    c. Expenses related to eyeglasses, contact lenes, contact lense care preparations and bioptric telescopic apparatus, and including but not limited to all other types of orthoses,
22. Voice and speech therapies,
23. Expenses related to the diagnosis, examination, treatment, and complications of and relating to HIV virus-related diseases (including AIDS),
24. All types of circumcision expenses and phimosis treatment procedures,
25. Health expenses related to pregnancy, delivery, Cesarean section and/or all types of tests, treatments, and complications with respect to these, and expenses relating to all kinds of birth control methods, as well as procedures related to infertility,
    a. Expenses related to infertility diagnoses, examinations, treatments, and complications (such as ovulation follow-ups, tube babies, micro-injections, hysterosalpingography, hysterosonography, spermiogram, and AMH), and related surgical procedures and infertility treatments, including those for varicocele, endometriosis, and adhesion (tube adhesion) diagnoses,
    b. Miscarriage investigations and pre-pregnancy examinations performed for monitoring purposes,
    c. Expenses related to birth control methods such as birth control medication (excluding birth control medication used for medical reasons aside from birth control purposes), voluntary curettages, installation of intrauterine devices (such as spirals), vasectomies, and tubal ligations,
26. Examinations, surgery, and treatment procedures relating to gender reassignment, sexual or libido dysfunction, and Peyronie's disease (such as penile artificial limb applications, as well as hormones and medication that supplement sexual functioning),
27. Expenses related to genital and anal herpes, papillomatous lesions (such as warts and condyloma accuminata), and molluscum contagiosum examinations, treatment, and complications,
28. Fees owed to a physician who is related to the Insured by blood or marriage, whom the Insured has gone to for diagnosis and treatment,
29. All kinds of expenses related to injuries, disabilities, and/or diseases caused by dangerous sports activities such as mountain climbing, parachute jumping, participation in rodeos, para-gliding, gliding, rafting, street luge, base jumping, kite sports such as kite-boarding and kite-surfing, underwater sports, cave diving, mountain biking, motorcycling, and automobile sports, as well as those expenses related to injuries, disabilities, and/or diseases caused by all types of professional sports competitions, training and/or exercises,
30. All kinds of expenses not directly related to health services, details of which are indicated below:
    a. Expenses related to all transportation and accommodation of the Insured, even if incurred during the diagnosis and treatment period, and customs-related expenses for medication imported or supplied from abroad,
    b. Expenses not directly related to diagnosis and treatment, such as telephone, internet, television, cafeteria, and mini-bar expenses,
    c. All types of expenses incurred in preparing and dispatching the documents requested by the Insurer,
    d. Room fees with the exclusion of standard rooms,
31. Expenses relating to organ and tissue transplants and blood transfusion procedures, including organ and tissue costs, protection and transfer expenses, examination of donors and prospective donors, as well as all associated medication, procedures, surgery, and costs resulting from complications,
32. All types of medical supplies and artificial organ expenses not identified in "Medical Supplies and Prosthetic Device" definitions,
33. All types of expenses related to drawing and storing umbilical cord blood,
34. Expenses related to stem cell and embryo cloning and transplants, including storage and transfer expenses, as well as procedures performed using these methods, excluding bone marrow transplants performed after cancer diagnoses,
35. All kinds of expenses related to inpatient treatments performed during hospital stays that exceed 180 days in one (1) policy year (a 24-hour period in a normal room is counted as one day, and in an intensive care unit as two [2] days),
36. All types of expenses related to benefits not stated in the policy,
37. All kinds of expenses related to the examination, observation, treatment, and complications of dental, gum, mandible, temporomandibular joint, and maxillofacial surgeries,
38. All expenses of the institutions and doctors in "the Excluded Institutions List" under the "Customer Portal" step on the Allianz website
39. Daily allowances for incapacity identified for earnings that the Insured could not earn as he or she was not able to work, as well as the

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expenses associated with care services or the identified daily care allowance in the event that the Insured becomes in need of care, are not covered by the policy.

40. All kinds of expenses which are incurred within the scope of remote health services

6. GEOGRAPHICAL COVERAGE

The benefits regarding the insurance contracts drawn up within the scope of these Special Terms shall apply within the borders of the Republic of Turkey. Health expenses related to any diagnosis or treatment received abroad shall not be covered under any circumstances.

7. CODE OF PRACTICE FOR COVERAGE

7.1. Application of Limits

There are two types of contracted health care providers: contracted health institutions and non-contracted health institutions. The main benefit limits that apply for each type of institution are indicated in the policy. Sub-benefits shall be applied by deducting from the basic benefit limits relevant for the associated institution type.

If main or sub-benefits are limited for a domestic contracted health institution (CHI), then this shall be used as a common limit for any non-contracted health institutions (NHI), and total claim payments made shall be deducted from the gross CHI limit of the associated coverage.

For those policies drawn up for a period more than one (1) year, limits shall apply separately for each year as stated in the policy.

7.2. Co-insurance Percentages and Co-payments

Reimbursements made by the Insurer shall be calculated in accordance with the co-insurance percentage indicated in the policy associated with each type of institution, either contracted or non-contracted. Any co-payment amount remaining after the co-insurance percentage shall be payable by the Insured.

7.3. Calculation of Remaining Limits

The remaining limits shall be calculated by deducting from the gross limit (the Limit) indicated on the policy, all the claims amounts paid by the Insurer as well as the co-payment totals paid for by the Insured.

7.4. Contracted Health Institutions and Networks

The list of contracted health institutions and networks are regularly updated and published for informative purposes at www.allianz.com.tr, the corporate website of Allianz.

The Insurer reserves the right to change those contracted health institutions included in networks. In the event of the expiration of the contract between a contracted health institutions in the Network and the Insurer, all procedures adopted specifically to the health institution in the associated Network shall terminate automatically.

It is absolutely essential to seek proper authorization before accepting any service from a contracted health institution. After securing proper authorization, health expenses incurred within the selected Network shall be directly paid within the benefit limits and co-insurance percentages of the associated coverage.

The inclusion of any institution or individual in the list of contracted health institutions does not constitute a recommendation by Allianz, and the company provides no guarantees whatsoever for the quality of services to be provided by such institutions and individuals, or for the ensuing medical consequences. Individuals and institutions selected by the Insured shall be directly responsible for the services they provide as well as for the results of these services. Allianz cannot be held responsible for any such services under any circumstances.

7.5. Claims Payments for Health Expenses on the Basis of Health Institution

- Health expenses incurred at a contracted health institution included in a Network selected in the policy shall be compensated through the direct reimbursement process within the benefit limits and co-insurance percentage that apply to the contracted institution, as shown in the policy.
- In regions where the Insurer has initiated the "Specialist Network" system, the "examination by a physician" benefit shown in the policy shall cover 100 percent of expenses relating to the examinations performed by physicians enrolled in the system, within the contracted institution benefit limit.
- Health expenses incurred at any contracted health institution not included in the Network selected in the policy shall be compensated through "subsequent reimbursement," within the benefit limits and co-insurance percentages relevant to non-contracted institutions shown in the policy. Physicians' fees at these institutions shall be limited to the minimum fees stated by the Health Services Tariff and that was valid on the date of the procedure, and shall be compensated through "subsequent reimbursement," within the benefit limits and co-insurance percentages relevant to non-contracted institutions shown in the policy.
- If performed by a non-contracted physicians at a contracted health institution included in the Network selected in the policy, then the associated health expenses incurred shall be limited to the minimum fee that is stated by the Health Services Tariff and that was valid on the date of the procedure, and shall be compensated through "subsequent reimbursement," within the benefit limits and co-insurance percentages relevant to non-contracted institutions, as shown in the policy.
- If performed by a physician who is on the payroll of a contracted health institution included in the Network selected in the policy, but who has not been officially appointed by the Ministry of Health and is not bounded by the Allianz contract terms, then the associated health expenses incurred shall be limited to the minimum fee that is stated by the Health Services Tariff and that was valid on the date of the procedure, and shall be compensated through "subsequent reimbursement," within the benefit limits and co-insurance percentages relevant to non-contracted institutions shown in the policy.
- Health expenses incurred at overseas health institutions shall be excluded from benefits.
- Health expenses incurred at the State University Hospitals and State Hospitals of the Ministry of Health shall be covered through "subsequent reimbursement," within the benefit limits and co-insurance percentages relevant to contracted institutions shown in the policy.
- Health expenses incurred at a health institution not contracted by Allianz shall be compensated through "subsequent reimbursement," within the benefit limits and co-insurance percentages relevant to non-contracted institutions shown in the policy. Physicians' fees at these institutions shall be limited to the minimum fees stated by the Health Services Tariff and that was valid on the date of the procedure, and shall be compensated through "subsequent reimbursement," within the benefit limits and co-insurance percentages relevant to non-contracted institutions shown in the policy.

For inpatient treatment, if there is a discrepancy between the amount stated by the physician on the Insurer's form used during the preliminary authorization stage and the amount stated on the physician's invoice issued later, then the Insurer shall use the lower of the two in compensation calculations.

8. CLAIMS PAYMENTS

8.1. Rules Related to Claims

Health expenses incurred with prior authorization of the Insurer at a contracted health institution included in the Network approved as part of a policy, plan, or benefit offered by the Insurer shall be paid to the contracted health institution by the Insurer on behalf of the Insured and in accordance with the benefit limits and co-insurance percentages shown in the policy. Any such payment shall be carried out according to the "direct reimbursement" process.

The Insured is required to inform the contracted heath institution that he/she is covered through an insurance policy under which co-payments are required and as indicated in the policy.

If the Insured first pays to a health institution and/or physician the charges related to the health services received, and then files a claim with the Insurer requesting the reimbursement of the related health expenses by completing

the associated Medical Expenses Claim Form (MEC Form) and then submitting it to the Insurer all the required documents explained in the "Documentation of Health Expenses" section, then these expenses shall be treated under "subsequent reimbursement" and covered by the Insurer.

No direct reimbursement shall be carried out unless the contracted health institution notifies the Insurer 48 hours in advance of any surgical and/or medical treatment to be performed, with the exception of emergency care treatment.

8.2. Documentation of Health Expenses

The Insurer shall complete the compensation process within the time frames stipulated by the Special Terms and the Turkish Commercial Code, upon receiving and reviewing complete documentation and information (explained in detail below) and assessing health expenses as necessary.

1. 1. In the applications submitted for direct reimbursements:

- The Private Health Insurance Patient Information Form, which includes diagnostic and treatment information, must be completed by the attendant physician treating the Insured,
- And any related documents such as examination results, medical reports, prescriptions, and judicial and due process reports must be attached.

2. In the applications submitted for subsequent reimbursements:

- If health expenses are first paid to the health institution by the Insured, then the Insured shall claim these expenses using the Medical Expenses Claim Form (MEC Form). Health expenses covered under the policy shall be compensated by the Insurer in accordance with the benefit limits and co-insurance percentages applicable to non-contracted health institutions. Payments shall be made to the bank account indicated on the policy or to the bank account whose information is submitted by the Insured.
- The Medical Expenses Claim Form (MEC Form) must include only health expenses incurred by the relevant Insured. The following must be attached:
- The original copy of the invoice (from an institution or self-employed entity) must be attached to the form;
- If an invoice could not be produced, a sales (POS) slip should be attached to the form, and the diagnostic/therapeutic report and examination results of the individual receiving the services must also be submitted to determine the beneficiary;
- If a sales (POS) slip is submitted, it must either be accompanied by a medical report or bear on the slip the first name and surname of the individual receiving the services. The physician's seal or stamp and signature must also appear on the slip;
- If more than one item is included in the invoice (for example, an inpatient admission/stay, examination, analysis, and radiography), then the following are required: Invoice details;
- The original copy of the prescription, and original covers and barcodes of the medication;
- Examination request forms and results (this can be a photocopy);
- Admission and surgery epicrisis, anamnesis, pathology reports, and so forth;
- Detailed medical reports related to diagnostic and therapeutic interventions;
- For physiotherapy and rehabilitation invoices, a detailed report including the treatment plan prepared by a physical therapy specialist (with start and end dates clearly indicated);
- The Insured must present all relevant documents issued by legal authorities regarding judicial incidents (including all types of traffic accidents), including the driver's license (if the driver is the Insured); incident scene investigation, alcohol, traffic accident, medical examiner, and workplace accident reports; prosecutor's verdicts; and so on, (including for direct reimbursements);
- The Insurer reserves the right to make further inquiries if necessary; request all kinds of information, reports, and other documents related to diagnoses and/or treatment from the physician treating the Insured, or from the health institution or another third party; and have the Insured examined by an authorized physician to whom the Insurer refers the Insured.

9. POLICY RENEWAL AND THE LIFETIME RENEWAL GUARANTEE

9.1. Policy Renewal

The Insured's insurance policy shall be renewed under the following conditions:

- The Insured's Foreigner Identification Number (FIN) or Taxpayer Identification Number (TIN) must be presented by those Policy Owners who are Turkish citizens and therefore posses a TRIN, or by those who have been residing in Turkey for more than six months and therefore have a FIN. The policy cannot be renewed with only a passport number; the above information must also be submitted.
- Prior to the end of the policy period, the Policy Owner and the Insurer can agree to draw up a new policy valid from the end date of the previous policy.
- The renewal must take place on the expiry date of the previous policy at the latest. Otherwise, the Insurer reserves the right not to cover the risks that occur until the new policy is drawn up, and to terminate the validity of the renewal rights. However, the foreigner whose residence permit period, visa period or visa exemption period expires, is required to renew the health insurance or apply for a new permit from the same insurance company before the expiry of the ten-day period defined in the second article of Article 21 of the Regulation on the Implementation of the Law on Foreigners and International Protection. policy will be considered as an uninterrupted renewal. In this case, the waiting period will not be applied for the new or renewed policy within the scope of Article 4/A of the Circular on Health Insurance to be Made in Visa and Residence Permit Requests.
- The Insurer shall perform renewal risk assessment at each policy end date. As a result of the assessment, it may choose to renew the policy under the same conditions, renew it after applying exceptions and/or additional premiums, or choose not to renew it. During all assessments, the Insurer reserves the right to ask the Insured to provide his or her latest health disclosure, or take additional medical examinations.
- If an existing Allianz Foreign Health Insurance policy is discontinued by the Insurer, then the coverage of the Insured through this policy shall be continued until its expiry date.

9.2. Lifetime Renewal Guarantee

This product/policy does not include a Lifetime Renewal Guarantee.

However, within the scope of this Allianz Foreign Health product, any Lifetime Renewal Guarantee shall continue in accordance with the Policy Special Terms for any Insured covered without interruption beginning prior to May 1, 2017.

10. DETERMINING THE PREMIUM

10.1. Criteria for Determining the Premium

Premiums shall be determined according to several criteria, including the Insured's age, sex, residential address, product scope, performance, amendments made to the Health Services Tariff, and price changes implemented by health institutions.

10.2. Premium Related Regulations

The Insurer periodically updates the Health Tariff Premium on the basis of risk profiles, taking into account the general performance of the portfolio, health inflation and changes in other general economic parameters in the country Any increase in the Health Tariff Premium shall be capped by twice the tariff premium applied to the same category from the previous year, provided that it does not fall below health inflation.

The Insurer reserves the right to make changes to discounts and/or additional premium rates at the time of renewal.

10.3. Additional Disease Premium

Additional disease premiums applied to the Health Tariff Premium of the Insured shall not exceed 200 percent per disease

10.4. Limitations Applied to Tariff Changes

The Insurer is entitled to introduce upper and lower limits to the Health Tariff Premium increase and decrease rates to avoid excessive impact on renewed policies caused by Health Tariff Premium changes introduced, thereby keeping the difference between the Health Tariff Premium during the renewal period and the Insured's Health Tariff Premium for the previous year within a certain range.

10.5. Other Discounts

This product does not include a no claim discount or additional compensation premiums.

The Insurer reserves the right to implement the changes introduced under certain rules or campaigns, change the discount ratio, or revoke the discount altogether.

11. ENROLLMENT PROCEDURES

11.1. Enrollment of the Insured

Unless otherwise stated by the Insurer, foreign nationals residing within the borders of the Republic of Turkey during the policy term can be included in the policy. Those who make a residency application shall be regarded as having settled in Turkey. Turkish citizens shall not be insured within the scope of this policy.

The Insured's age is calculated by subtracting the Insured's birth year from the policy start year. Only immediate family members may be covered under a given policy. The immediate family comprises the mother, father and unmarried children.

Only individuals who are 0 to 64 years of age at the time of the first application shall be insured. Unmarried children aged 25 and younger can continue to be insured under family policy.

11.2. Assessment Application and Information Form

Completing the Application Form does not constitute the formation of a contractual relationship. The Insurer shall review the application based on assessment criteria and the disclosures made by the Policy Owner/Insured under the disclosure obligations. As a result of this assessment, the Insurer reserves the right to amend the proposed policy coverage (such as Network, plan, and so forth); apply exceptions and/or additional disease premiums; request medical and additional examinations; or reject the application altogether. The policy shall enter into force upon the collection of the premium in full, and upon the approval of the Insurer. In the event the Insurer decides to apply additional disease premium, the Insured may request related health risk benefit be left out of policy provisions.
Health expenses incurred before the policy start date shall not be included in the policy benefit.In the event of setting the policy start time later than the date the Application and Information Form was signed, the Insurer reserves the right to apply additional disease premiums and exceptions for those diseases and illnesses that arise before the policy start date.

11.3. Insured's Enrollment in an Applicable Policy

There is no insured entry into the current policy in the interim period.

In the renewal period of a current policy the insured can be entered into the policy. The special terms, coverages and premiums of the applicable policy shall apply to the enrollment of other family members (spouse, children, including newborn babies and adopted children) in the applicable policy, who shall be considered under the "Insured's Enrollment" clause.

12. TRANSFER PROCEDURES AND VESTED RIGHTS

Any health policy or benefit (for example, modular health insurance, supplemental health, or disease insurance) of our company shall not be connected to Allianz Foreign Health Health insurance rights. It can not be regarded as the beginning, continuation and/or complement of the individual and/or group health policy.

12.1. Benefit Amendment Procedures

Any requests made by the Insured to amend the product or benefit at the time of renewal shall be assessed within a 15-day period that encompasses the policy expiry date.

If the Policy Owner wishes to expand the selections (such as criteria like the Network) in the policy to be renewed, the Insurer shall perform a risk assessment based on the Insured's previous insurance information by obtaining the Insured's health declaration as necessary. Upon receipt of this assessment, the Insurer reserves the right to amend policy coverage, and even if there is a Lifetime Renewal Guarantee in place, apply exceptions and/or additional disease premiums, request medical or other additional examinations, or reject the application altogether.

If the Policy Owner wishes to restrict the options on the policy to be renewed, no new risk assessment shall be made, and any existing exception and/or additional disease premiums shall continue to apply.

12.2. Transfer Procedures

There is no transition to this product from our other products or from other insurance companies.

If the insure in this product wants to continue as Allianz Private Health or Complementary Health insurance, they are taken into consideration if the following conditions are met:

• Applying to our Company within 30 days at the latest as of the expiry date of the previous health policy.
• Being insured for at least one full year in the previous health insurance
• Being at most 64 (inclusive) years old.

The insurer decides on the eligibility for transition by examining the statements of the insured candidates, past insurance information, information obtained from the Insurance Information and Monitoring Center (SBGM) and other relevant authorities. The insurer reserves the right to accept the insured candidates with in the scope of the policy special conditions of the product to be switched, or to include them in the policy by applying an additional exclusion/additional disease premium.

13. TERMS RELATING TO TERMINATIION OF THE INSURANCE CONTRACT

In the event that the policy is cancelled or the Insured terminates the insurance contract the Insurer's commitments to the Insured shall end.

13.1. Cancellation of the Policy Upon the Request of the Insured or Policy Owner

Upon the request of the Policy Owner or Insured, the health insurance policy issued for residence permit application can be cancelled provided that the following conditions are met:

i. The presentation of a new health insurance policy that covers the period of the residence permit, or
ii. Cancellation or non-extension of a residence permit,
iii. The presentation of a document evidencing that the individual is covered by general health insurance as per the Social Security and General Health Insurance Law No. 5510,
iv. Rejection of a residence permit application or withdrawal of a residence permit application before the decision

If the above conditions are satisfied;

The Policy Owner shall be in default if the premium is not paid by the end of the policy delivery day. Likewise, if the premium is to be paid in installments, a nonpayment of the down payment or of any of the installments by their respective due dates, as indicated on the policy, shall be considered a default.

In the event of the Policy Owner or Insured requesting a cancellation based on the reason for rejection of a residence permit application or withdrawal of a residence permit application before the decision, the premiums paid shall be refunded to the Policy Owner, as long as no compensation has been paid to the Insured or on his or her behalf in the meantime.

In the event that the Policy Owner or Insured request the cancellation of the policy for other reasons, if any compensation payment is made to or on behalf of the insured during this period, then the remaining balances of the paid premiums shall be refunded to the Policy Owner only after deducting the premiums calculated on pro rata basis by considering the period that the Insurer's responsibilities have applied.

The amount to be refunded to the Policy Owner upon cancellation shall be calculated as follows, with consideration of the premiums earned and compensation paid by the Insurer:

- If the claims compensations paid to the Insured do not exceed the premiums earned by the Insurer, then the premiums earned shall be deducted from the premiums collected from the Policy Owner to calculate the premium amount to be refunded to the Policy Owner.
- If the compensations paid to the Insured exceeds the premiums earned by the Insurer,

but does not exceed the premiums collected from the Policy Owner, then the compensation amount shall be deducted from the premiums collected to calculate the premium amount to be refunded to the Policy Owner.

- If the compensations paid to the Insured exceed both the premiums earned by the Insurer and the premiums paid by the Policy Owner, then no refund shall be applicable..
- Upon payment of compensation, all undue premium installments that do not exceed the compensation amount payable by the Insurer shall be due. The above rules shall also apply to any request of the Insured for termination of the insurance contract after the policy commencement date.

13.2. Death of the Policy Owner or Insured within the Insurance Period

In case of death of the Policy Owner, the contract can be continued by changing the Policy Owner if a deed of consent is submitted by the lawful heirs. If a written consent cannot be obtained or the heirs of the Policy Owner do not approve the continuation of the policy, then the rules stipulated in the "Cancellation of the Policy Upon the Request of the Insured/Policy Owner" clause shall apply. The Policy Owner's lawful heirs shall be considered as the Policy Owner during the implementation of these rules.

In case of death of one of the Insured persons, the rules stipulated by the "Cancellation Due to Request by the Policy Owner or Insured" clause shall apply. If unpaid health expenses of the deceased Insured exist, then to have the expenses paid, inheritance and tax documents must be submitted to the Insurer by the Insured's heirs.

14. APPENDIX

14.1. Obtaining and Sharing Information

The Insurer is entitled to obtain and share information and/or documents by making inquiries with the T.R. Prime Ministry Undersecretariat of Treasury, the Insurance Information & Monitoring Center (SBGM), the Insurance Association of Turkey (TSB) , all health institutions and organizations, other insurance companies, and State Institutions and Organizations, pursuant to relevant regulations including insurance legislation, regulations regarding the insurance business, and health legislation.

By signing the relevant documents, persons who are/will be covered by an insurance policy shall be assumed to have allowed the Insurer to obtain their health information, within the framework of the provisions of Articles 31/A and 31/B of the Insurance Law No. 5684 legislation, to perform a risk assessment and finalize any claims filed.

14.2. Fulfilling Disclosure Obligations and Responsibilities

The Policy Owner and Insured shall be required to notify the Insurer in writing about any matters they are and should be aware of and about any changes in his or her health condition, both during the application stage and the insurance period.

If disclosures made by the Policy Owner and/or Insured on the Application Form are found to be incorrect, incomplete, or false, or if the Insured/ Policy Owner fails to duly disclose any diseases and/or illnesses that are known or should be known to exist, the Insurer may opt to cancel the subject policy, omit such diseases and/or illnesses from the coverage, or apply additional disease premiums. The Insurer shall not reassess for coverage of any disease and/or illness omitted from the coverage for these reasons.

The Insurer reserves the right to recover the paid health expenses and cancel the policy, even if there is a Lifetime Renewal Guarantee in place, under the following cases: uncovered individuals benefiting or allowed to benefit from the policy; individuals covered under a family policy having their health expense documents issued in the name of other Insureds; fraudulent attempts for having uncovered expenses covered; failure to comply with the criteria stated in the enrollment procedures clause; and other malicious acts similar but not limited to the ones mentioned above.

By signing the related documents, persons who will be/are covered under an insurance policy shall be assumed to have consented to share their health information, insurance records, and other information obtained from the Insurance

Information and Monitoring Center (SBGM), Social Security Institution, Ministry of Health, as well as any health institution, organization, or insurance company, with the SBGM, insurance companies and/or authorities authorized as per the related legislation, to do a risk assessment and finalize the claims filed.

14.3. Notification of Policy Owner/Insured

The Insurer shall send written or electronic notification to the Policy Owner regarding the expiration and renewal dates of the contract prior to its end; to the Policy Owner/Insured on whether the contract has been renewed or not; and to the Insured about the renewal guarantee if the product has one. Such notifications are sent to up-to-date contact information available in the Insurer's records.

However, if any contact information provided is incomplete or incorrect, and/or changes have been made, unless the Policy Owner/Insured notifies the Insurer in writing immediately, the Insurer shall be considered to have performed its notification duty.

In order to perform notification duties, in addition to address information, at least one mobile phone or email address belonging to a family member covered under the related policy as an Insured and mobile phone or email address of the Policy Owner must be given to the Insurer. If information related to family members is incomplete, then the individual with complete contact information shall be notified, and this shall be considered as having notified all family members included in the policy.

14.4. Treatments Continuing at the End of the Insurance Term

In the event that the policy is renewed by Allianz or another insurance company during inpatient treatments and treatments within the scope of Home Care and Treatment coverage, the portion of the medical procedures subject to health expenses up to 12:00 on the renewal day will be covered by the old policy coverage, and the health expenses of the transactions to be carried out at this hour and after. Expenses will be covered by the new policy coverage. However, the inpatient treatment coverage accepted by the insurer before the expiry date of the insurance continues, provided that the contract period expires and a new contract is not concluded, provided that it does not exceed the period specified in the special conditions and the coverage limit, at least ten days. The duration of the coverage related to these treatments cannot exceed 10 days from the policy expiry date. In this context, the inpatient treatment coverage accepted by the insurer before the expiration date of the insurance for the foreigner whose health insurance contract period has expired with the residence permit period, provided that the inpatient treatment has started before the policy expires, preliminary approval has been received and the inpatient treatment continues on the date the policy expires, It will continue, not exceeding the coverage limit, until a new health insurance is made within the scope of the new permit application, not to exceed 10 days.

14.5. Recourse and Recovery Rights

In the event of holding third parties responsible for the health expenses paid by the Insurer under the Policy General and Special Terms, the Insurer shall be entitled to act on behalf of the Insured and recourse to the third parties responsible for the compensation it has paid.

The Insurer shall have the right to claim from the Insured directly all types of payments, including compensation payments made to the contracted health institution on behalf of the Insured(s), and reimbursements made directly into the account of the Insured(s), which have been discovered to have been wrongfully paid under the Policy General and Special Terms at a later time.

Wrongful payments made on account as a result of improper, inadequate, and/or incorrect information provided by the health institution, the attending physician responsible for administering the treatment, and/or the Insured(s), or the lack of such information, will be subject to the same proceedings. An e-authorization or a preliminary authorization provided by the Insured shall create no impediment for the Insurer to exercise its rights under this clause due to a late discovery of such facts involved.

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14.6. Economic Sanctions

No insurance / reinsurance company may be subject to commercial or economic sanctions, prohibitions or restrictions, subject to United Nations resolutions or reinsurers under this Agreement, or to the reinsurer, and shall not be deemed to have provided any kind of assurances, will not be liable.

Health Insurance
General Conditions

"In case any conflict occurs between the Turkish and the English version of this contract/ policy/guarantee table, Turkish version will be deemed valid legally."

Article 1 SCOPE OF COVERAGE
This insurance policy covers all medical expenses arising out of illnesses and/or injuries due to any accident within the insurance period, and daily indemnity if any, within the framework of these general conditions and special conditions where applicable, up to the limits stated in the policy.

Article 2 EXCLUSIONS
The treatments, conditions and expenses arising out of illnesses and/or injuries due to the following causes are excluded from the insurance cover.

a) War and warlike acts, revolution, riot or civil commotion resulting thereof.
b) Crime or attempt to commit crime.
c) Putting oneself consciously in jeopardy, except in the course of rescuing people or goods in danger.
d) Consumption of narcotic agents like hashish, heroin,
e) Nuclear risks, or any kind of attacks or sabotages which result in leakage / exposure of biological and chemical substances
f) All the damages to occur as a result of terrorist acts set out in the Prevention of Terrorism Act No. 3713 and biological and/or chemical pollution, infection and intoxication arising as a result of sabotages caused by these acts or interventions performed by authorized bodies to prevent or minimize these acts,
g) Suicide or attempt at suicide,
h) Exclusions listed in the Special conditions of the policy.

Article 3 EXCLUSIONS IF THERE IS NO AGREEMENT TO THE CONTRARY
If there is no agreement to the contrary, illnesses and/or injuries of the insureds as a result of any accident within the insurance period due to the following conditions are excluded from the coverage:

a) Earthquake, flood, volcanic eruption and landslide,
b) Except for damages set out in paragraph (f) of Clause 2, terrorist acts set out in the Prevention of Terrorism Act No. 3713, sabotages and interventions performed by authorized bodies to prevent or minimize these acts.

Article 4 TERRITORIAL SCOPES
Territorial scope of the insurance shall be stated in the policy.

Article 5 COMMENCEMENTS AND EXPIRY OF THE POLICY
The policy begins at 12:00 pm and ends at 12:00 pm by Turkish local time on the dates stated as the commencement and expiry dates in the policy unless otherwise agreed.

Article 6 DECLARATIONSOBLIGATIONS OF THE POLICYHOLDER
The insurer accepts to insure the policyholder based on the written information provided by him/ her on the application form or on the policy and its attachments.

The insured is obliged to answer all the questions given in the application form or in other documents.

He/she should also declare all information regarding his/her health, to the extent of his/her knowledge and information which shall have a material effect on the acceptance of the proposal. If the information provided by the insured does not correspond to actual facts or the questions are partially answered or are not answered at all and if the consequences are such that they would warrant the imposition of more stringent conditions under the insurance, then the following regulations shall apply;

a) If a deliberate act by the policyholder is established, the insurer has the right to cancel the policy within one month of the date on which the action is discovered and to refuse to pay claims. In this case, no refund of premiums received is payable to the policyholder.
b) If a deliberate act by the policyholder is not proven, the company has the option either to collect an additional premium proportionate to the risk involved in order to keep the policy in force or to cancel it. The policy will become void if the policyholder notifies within 8 days that he is unwilling to pay the extra premium. Notification of cancellation by the insurer sent by registered letter or delivered to a notary public will be valid by 12:00 pm on the 5th day following receipt of the notification by the policyholder. The unearned premium for the remaining period of the insurance shall be refunded.
c) The right to renounce or cancel the policy or to ask for an additional premium will be forfeited if not exercised within the time limits prescribed.
d) If it is established that no deliberate act by the policyholder has been committed and, if the risk occurs before
   1) The insurer is aware of the facts or
   2) The deadline for the notification of cancellation by the insurer or
   3) The end of the prescribed time after the notification the indemnity paid to the

Policyholder shall be proportionally reduced by applying the ratio of the premiums already charged and the premiums that would have been charged had the true facts been known to the insurer.

Article 7 OBLIGATION OF NOTIFICATION DURING INSURANCE PERIOD
During the validity of the policy, the policyholder is obliged to notify the insurer of any change that has taken place in the information declared in the proposal form or the policy and its attachments within 8 days.

If the changes result in an increased risk, within 8 days the insurer may
a) Cancel the policy or
b) Agree to maintain the policy in force subject to the payment of an additional premium.

If the policyholder notifies within 8 days that he is unwilling to pay the additional premium, the policy will become void by 12:00 pm on the 5th day following receipt by the policyholder of the insurer's letter of notification of cancellation sent by registered mail or delivered to a notary public. The unearned premium calculated according to a pro-rata basis as of the above mentioned date shall be returned to the policyholder. The right of cancellation or of changing the premium shall be forfeited if not exercised within the time limits prescribed. If the insurer, despite being informed of the changes, fails to cancel the policy or continues to collect premiums as if agreeing to the original terms of the policy, he shall lose the rights to cancel the policy and to ask for extra premiums.

Article 8 PAYMENT OF THE PREMIUM AND THE BEGINING OF THE RESPONSIBILTY OF THE INSURER
If the premium is decided to be paid in full or in installments, the first installment is paid at the latest on the delivery of the policy and the remaining installments are paid on the dates specified in the policy.

If the premium is decided to be paid in full or in installments, the responsbility of the insurer does not begin before the first installment is paid.

If the first installment or the premium, which must be paid in full, is not paid on time, the insurer may withdraw from the contract within three months, as long as the payment is not made. This period starts with term. In the event that the premium receivable is not requested through lawsuit or

follow-up within three months from the date of term, the contract shall be withdrawn.

If any of the following premiums are not paid on time, the insurer warns the policyholder to fulfill its debt by giving a period of ten days via a notary public or registered letter with return receipt, otherwise the contract will be deemed terminated at the end of the period. If the debt is not paid at the end of this period, the insurance contract is terminated. Other rights of the insurer arising from the Turkish Code of Obligations due to the default of the insured are reserved.

If two warnings are sent to the policyholder within an insurance period, the insurer may terminate the contract with effect at the end of the insurance period. Provisions regarding discount in life insurances are reserved.

The premium payment time, amount and the consequences of not paying the premium are written on the front of the policy.

Linking the insurance fee to bills of exchange does not change the nature of the debt, nor does it prejudice the rights and privileges granted by the Commercial Code. (*: Amended by the Sector Announcement dated 15.06.2016 and numbered 2016/12.)

Article 9 OBLIGATIONS OF THE POLICYHOLDER IN THE EVENT OF CLAIM

A) Notification of claim;

The insured shall report any claim or potential claim to the insurer in writing within 8 days starting from the date of the occurrence of the incident or from the date on which he is able to report the claim.

The policyholder shall report to the insurer the location, the date and the cause of the accident or illness and shall also obtain a medical report from the doctor treating the insured, giving details of the effects of the accident or illness and their possible consequences.

B) Starting the treatment and taking the necessary precautions

It is agreed that immediately after the accident or the appearance of the illness, a doctor shall be summoned to undertake the necessary treatment and to carry out whatever actions are necessary for the recovery of the insured.

The insurer has the right to have the insured examined and have his health condition checked at any time and the insured is obliged to allow such examinations.

It is also obligatory to comply with the recommendations of the doctor of the insurer pertaining to the treatment and the recovery of the insured.

If the obligations set forth in paragraphs A and B above

a) Shall deliberately not be complied with, then the insurer has the right to be released from all his liabilities.

b) Shall accidentally not be complied with and if the results of the accident or illness are aggravated because of this, then the insurer shall not be liable for the consequences of the aggravation.

c) Providing the necessary documents;

The policyholder is responsible for submitting all documentation and receipts from the medical examinations, treatments, prescribed drugs and hospital services resulting from any occurrence covered by the terms and conditions of the policy, or copies considered to be acceptable by the insurer, together with a claim form fully completed by the attending doctor or the hospital.

Article 10 DETERMINATIONS OF EXPENSES

This insurance provides coverage for the daily indemnities and all expenses incurred by the policyholder arising out of the injuries or illnesses agreed to be covered in the policy.

The insurer shall not be liable for expenses arising out of the following situations:

a) Claims due to unnecessary treatments or, depending on specific agreements or, those go beyond customary and reasonable level. Claims not in accordance with the special conditions of the policy. In cases where the parties fail to agree on the claim amount due to be paid, the amount is established as per the conditions stated below, by experts called arbitrators, to be elected by the Physicians' Association, if such exists, or from among appropriate specialists.

b) If the parties fail to agree on the selection of a single arbitrator-expert in accordance with paragraph (b), each party assigns its own arbitrator-expert and informs the other party via notary public. The parties select a third impartial arbitrator-expert within seven days as from the appointment of their own arbitrator-experts and before the investigation starts and establish it with a protocol. The third arbitrator/expert is authorized to take decisions on issues that the party arbitrator-experts fail to reach an agreement provided that he remains within the limits and within this scope. The third arbitrator-expert may take his decision in a separate report as well as in the form of a single report with other arbitrator-experts. The arbitrator-expert reports are notified to the partied at the same time.

c) If one of the parties does not appoint his own arbitrator within 15 days following the notification of the other party or if the arbitrators cannot agree within 7 days on the appointment of an umpire, then the arbitrator of the other party or the umpire shall, upon the request of one party, be appointed from among impartial and specialized persons, by the court authorized to handle commercial law suits at the locality where the treatment is received.

d) Both parties reserve their rights to request the third arbitrator-expert be selected outside the place where the Insurer or the insured resides or where the treatment has taken place whether such arbitrator- expert is to be appointed by the party arbitrator-experts or the authorized court chairman and this request is required to be fulfilled.

e) Should the arbitrator die, resign or be refused, the new arbitrator shall be elected in the same way and the assessment proceedings will be continued from the point where they were suspended. Should the policyholder die, the arbitrator shall continue to fulfill his duties. The right of objection against the non-specialization of the arbitrators shall be forfeited in the event that no objection is made within 7 days from the date these persons have been appointed.

f) The arbitrators may demand whatever proofs they deem necessary in order to determine the amounts of claims as well as the records and documents, and may conduct investigations at the place of treatment.

g) The award of the arbitrator, the arbitrators or the umpire as to the amounts of claims is final and binding upon both parties. No payment can be required from the insurer, nor any law suits brought against him without the decision of an arbitrator. Objections against the arbitrators can only be made in the event that it is clearly understood that the award is considerably different from the reality. The cancellation of these awards can be requested within one week from the date of publication of the report, from the court authorized to handle commercial law suits at the locality where the treatment is received.

h) If the parties fail to agree upon the amount of indemnity, the debt becomes due only by the award of the arbitrator and the prescribed period of time does not start until the award has been notified to the parties, provided that the period between the appointment of the arbitrators and the claim notification in Article 1292 of the Turkish Commercial Code has not exceeded two years.

i) The parties shall pay the fees and expenses of their own arbitrator and share the fees and expenses of the umpire equally.

j) The determination of the amounts of claims has no influence on the terms and conditions existing in this policy and in the regulations, or on the interpretation of these terms and conditions as regards to the risks covered, the sum insured, the value of insurance, commencement of liability and the forfeiture and reduction of rights.

Article 11 RESULTS OF COMPENSATION AND INSURER'S SUBROGATION OF RIGHTS

Insurer shall succeed all of the Policyholder's rights, including those within the scope of the social security law, equaling to the compensation amount it has paid. Insurer may use its recourse right to the those liable for the amount it has paid.

Policy Owner and Policyholder shall be obligated to provide the Insurer the attainable documents and information that may be useful in any possible lawsuits it brings. (Amended with the Industry Disclosure regarding the amendment on the Health Insurance General Terms No. 2015/22.)

Article 12 CO INSURANCE
In cases where there is more than one policy in force, the losses shall be divided among the insurers on a proportionate basis with respect to the indemnity sub limits of the policies.

Article 13 CONFIDENTIALITY
By signing the related documents, the people who will be/are in the insurance coverage shall be regarded to have consented to sharing their health insurance, insurance records and other information pursuant to the provisions of articles 31/A and 31/B of the Insurance Law No. 5684 so that risk assessment can be performed and compensation claims can be finalized. Conditions shall be stated in the information form and the policy or participation certificate.

In order to perform the risk assessment and finalize compensation claims as per clause one of this article, requested information and documents must be in line with the need and present a direct link.

The company shall not provide the health information, insurance records and other information to any natural and legal persons, with the exception of the authorities empowered by the related legislation, without the consent of the Policyholder.

All natural and legal persons that possess private information about the Policyholder shall be responsible to keep them confidential. (Amended with the Industry Disclosure No. 2015/22.)

Article 14 COMMUNICATIONS AND NOTIFICATIONS
Communications and notices from the policyholder shall be made via a notary or by registered letter either to the Insurance Company's Head Office or the agent through whom the policy has been written.

Communications and notices from the Insurance Company shall be made via similar ways as above to the address of the policyholder shown in the policy or, in the event that the address has been changed, to the last address notified either to the Company's Head Office or to the agent through whom the policy has been written.

Article 15 AUTHORIZED COURT
For suits that shall be brought against the insurance company due to disputes arising from this policy, the authorized court is the court charged with hearing the commercial case of the place where the center of the insurance company or the agency that mediates for the insurance agreement resides or where the damage occurs; for suits that shall be brought against by the insurance company, the authorized court charged with hearing commercial cases of the lace where the defendant resides.

Article 16 LAPSE OF TIME
The prescribed period of time for claims to be brought against the company is two years from the date of the insurance agreement.

Article 17 SPECIAL CONDITIONS
Special conditions which do not contradict the above general conditions or attached clauses can be added to the policy.

Article 18 OBLIGATION TO PROVIDE INFORMATION FORM, POLICY AND CERTIFICATE OF PARTICIPATION

A. General Matters
Information Form and Policy or Participation Certificate must be provided to the insureds.

Information Form and Participation Certificate shall be given against signature, and a copy shall be kept in the company.

Information Form and Participation Certificate may be provided within the stated periods in electronic environment or through other means that allow access by the Policyholder, when the Insurer and Policyholder could not come together physically or when necessitated by the business.

If the Policyholder's written approval regarding share of information cannot be obtained through the Information Form and Participation Certificate, which is given against signature, it shall be obtained by a proposal and consent showing permission, or by another similar method.

The Insurer shall have the responsibility to prove that Information Form and Participation Certificate have been given, and consent has been received for share of information.

A copy of the Information Form and Participation Certificate shall be provided on the personal page that the Policyholder can access through the corporate website.

B. Group Insurances
Insurance can be made with a single contract in favor of individuals who belong to a group of at least ten people, who have the opportunity to determine who they are according to certain criteria, by the policyholder. During the continuation of the contract, everyone in the group benefits from the insurance until the end of the group insurance contract. If the group falls below ten people after the conclusion of the contract, it does not affect the validity of the contract.

Information Form, shall be given before the Policyholder is enrolled in the group contract, whereas Participation Certificate shall be given within 15 days after enrollment.

In order to issue the information form and participation certificate, the insurer requests the contact information of the insureds from the policyholder. The policyholder makes every effort to ensure that the insurer fulfills its obligation to inform and issue participation certificates.

However; The insurer cannot be held responsible if the insured's contact information is not notified to the insurer by the policyholder, and the obligation mentioned in this article is not duly fulfilled.

In case the contact information of the insured is not shared with the insurer; The insurer delivers the information form and participation certificates of the insured to the policyholder in accordance with the procedure set forth in this article in order to ensure that they are given to the insured. The information form and a copy of the participation certificate are placed on the insured's personal page, which the insured can access via the insurer's corporate website. The insurer informs the policyholder about the method of accessing the personal page of the insured.

C. Family Insurances
In contracts involving family members, dependents (spouse, children under the age of 18 and other dependents) are not required to provide a separate information form, policy or certificate of participation, unless otherwise requested. (*: Amended by the Sector Announcement dated 15.06.2016 and numbered 2016/12.)

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