Vergi Dairesi : Büyük Mükellefler V.D.
Vergi No : 0690039706

Sigorta Tahkim Komisyon üyesidir.

PLEASE READ YOUR POLICY
HEALTH-FRIENDLY INSURANCE POLICY

BRANCH	POLICY NO	RENEWAL NO	ENDORS NO	COMMENCEMENT-TERMINATION DATE	PERIOD	AGENCY NO	TABLE NO
765	22507833	0	0	14/07/2017 - 14/07/2018	365 Days	700389	T08519-SN2U
AGENCY NAME	LİMON SİGORTA ARACILIK HİZMETLERİ LTD.ŞTİ.						

INSURED / POLICY INFORMATION

INSURED NUMBER : 1[redacted]69
INSURED / INSURER NAME SURNAME / FIRM NAME : [redacted]
ADDRESS : [redacted]
TAX DEPARTMENT / NO :
CITIZENSHIP / ID NO :
PASSPORT NO : [redacted]

NET PREMIUM : 564.00 TL
AMOUNT PAYABLE : 564.00 TL

PREMIUM PAYMENT TABLE

TYPE OF PAYMENT	DUE DATE	AMOUNT
CASH	14/07/2017	564.00 TL

RISKS INFORMATION

SEX : FEMALE **AGE** : 58 **NATIONALTY** : A.B.D
HEIGHT : 1.57 **WEIGHT** : 75.00

INSURANCE COVERAGE	PREMIUM (TL)
HEALTH OUTPATIENT BENEFITS	0.00
HEALTH INPATIENT BENEFITS	564.00

SPECIAL CONDITIONS

Policies and vouchers that are not obtained from the system are invalid.

Explanations

1.Here in this policy has been issued on the basis of the health declaration of the Insured and provides the above mentioned coverage within the Health Insurance General and the attached Special Conditions. Other circumstances than these are excluded from this insurance policy coverage.
2. Even when the Policy has been submitted to the Insured, the responsibility of the Insurer does not begin, in case the first installment (advance payment) has not been paid. In case a bill of exchange has been received against the advance payment or installments, the policy premium shall not be regarded as paid unless the bill has been paid. Even when the advance payment has been made,the agreement will be cancelled in case the Policy Owner/Insured will not pay the premium installments which exact due dates are stated on the Policy or one of the premium installments on its due date which have been notified in written to him and despite of a notification within 10 days. The right of premium claim of the Insurer is reserved in accordance with the Provisions of the Code of Obligations.
3. The address of the Policy Owner/Insured which is written in the Agreement is accepted as the notification address and the Parties agree that all kinds of notification that the Insurer will make with respect to this Agreement will be made to this address.
4. Herein within the scope of this Policy, the request for individual insurance of the insured by leaving the group can only be accepted on condition that the Insurer will make a new risk analysis and a price determination.
5. The newborn baby or the adopted infant of the Insured can only be included to the insurance, in case the premium will be paid according to the current prices set by the Insurer.

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COVERAGE TABLE

PLAN CHOSEN : SAGLIK DOSTU						
	Contracted Healthcare Provider			Non-Contractual Healthcare Provide		
In-Patient Treatment	Application	Yearly Lim.Gr. *	Contribution %	Application	Yearly Lim.Gr. *	Contribution %
Surgery	Without Limit		0	20.000 TL		20
Hospital Treatment	Without Limit		0			20
Hospital Room - Hospital Attendant	Without Limit		0			20
Intensive Care	Without Limit		0			20
Special Treatment(Radiotherapy,Chemotherapy,Dialysis)	Without Limit		0			20
Angiography	Without Limit		0			20
	Contracted Healthcare Provider			Non-Contractual Healthcare Provide		
Out-Patient Coverage	Application	Yearly Lim.Gr. *	Contribution %	Application	Yearly Lim.Gr. *	Contribution %
	THE TOTAL OUT-PATIENT TREATMENT IS LIMITED WITH 2.000 TL.					
Doctor's Examination	2.000 TL		40	2.000 TL		40
Drug			40			40
Medical Examination			40			40
X-Ray			40			40
Modern Diagnosis			40			40
Small Intervention			40			40
Physical Therapy and Rehabilitation			40			40
	Contracted Healhtcare Provider			Non-Contractual Healthcare Provide		
Other Coverage	Application	Yearly Lim.Gr. *	Contribution %	Application	Yearly Lim.Gr. *	Contribution %
Tooth due to Traffic Accident	1.500 TL		40	1.500 TL		40
Emergency Help and Auxiliary Medical Equipment	2.000 TL		0	2.000 TL		0
Nurse Care at Home	Without Limit		0	NONE		NONE
Medical Consultancy and Ambulance	Without Limit		0	250 TL		0
Atifical Limb and Prosthesis	5.000 TL		0	TDU		0

***In this Plan valid for the Eko Groups.
The Nurse Care ot Home is limited with 7 days at the Contracted Healthcare Provider.
Intensive Care is limited with 45 days.
Hospital Room - Hospital Attendant is limited with 180 days.
Physical Therapy Coverage is limited with 15 sessions.
The non-contractual surgery fee at the Contracted-/Non-Contractual Healthcare Provider is paid at the rate of TDU Tariff.

* TDU=Turkish Doctors' Union

HEALTH FRIENDLY INSURANCE SPECIAL TERMS

1- SCOPE AND SUBJECT OF INSURANCE : Ankara Sigorta supplies treatment expenses including inpatient treatment in hospital and outpatient treatment to insured with stated name and date of birth in policy against any disease or accident in policy period according to type of received cover in accordance with warranty, limit and Health Insurance General Terms stated in policy and provisions of this Special Terms and Conditions. Medical examination, treatment and examinations of insurance should be made in effective period of policy in order to make payment in scope of this policy. All expenses of diseases with symptoms/findings or diagnosis and/or beginning of treatment based on before starting date

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of insurance and complications progressed depending on these are out of scope of insurance. Insurance covers are valid only for people stated in policy and rest can't benefit from covers. Age limit for insuring is 70 for foreign national people to be insured in the scope of 6458 numbered Law of Foreigners and International Protection.

2- DEFINITIONS :

a- INSURANT : Person or institution who applied for insurance cover and whose application was approved by insurance company and to whom insurance contract is issued.

b- INSURED : Person who filled disclosure form/health declaration under policy general and special terms and conditions and received insurance cover and dependent people who are included in this person's scope of insurance.

c- DEPENDANT: This definition includes insured's wife/husband and/or single children under the age of 18(including age of 18), single stepchildren under the age of 18(including 18), and adopted children under the age of 18(including age of 18).

d- PLAN : These are health insurance programs prepared as pack including various cover, limit and exemption combinations and offered by Private Health Insurance.

e- LIMIT OF COVER: Cover limit stated in policy for covers at which insured attendance is not applied is equivalent to payable maximum cover cost. Maximum indemnity price to be paid for covers at which insured attendance is applied is rest amount after removing related insurance share from cover limit.

f- IMPLEMENTATION OF PARTICIPATION: It means attendance of insured to each expense in cover extent at the rate stated in cover table.

g- WAITING-PERIOD: It means period required to be waited by insured as of starting date of insurance in order to benefit from cover.

h- EXISTENT DISEASE : It means diseases of which starting date of symptom, finding, diagnosis and treatment base on before starting date of insurance and depending diseases.

i- CONGENITAL DISEASES AND DISABILITIES: Diseases and disabilities emerging at the moment of birth or any period of life and progressing depending on structural imperfection existent as of moment of birth.

j- HEREDITARY DISEASES : Diseases and disabilities with genetic transition.

k- DIAGNOSIS : It means to determine disease of insured or situation caused by accident by symptoms and findings(such as physical examination, analysis, x-ray, tomography, endoscopy etc. results).

l- TREATMENT : Medical and surgical intervention made in order to heal disease of insurance or injury as a result of accident. Indemnity demands concerning treatment and diagnosis methods in phase of research or which was not accepted by FDA is not in the scope of treatment for which this insurance guaranteed to compensate.

m- HEATHCARE ORGANIZATION: Organizations authorized for outpatient (hospital polyclinics, diagnosis and treatment centers, doctor's offices) in country of settlement or impatient(hospital)medical and surgical treatment.

n- CONTRACTED HEATHCARE PROVIDER: Healthcare organizations authorized for outpatient and/or inpatient treatment and diagnosis of which names were notified to insured by insurer with this name.

o- NON CONTRACT HEATHCARE PROVIDER :
Healthcare organizations which were not included in 2nd article (n) sub clause.

p- OTHER HEATHCARE ORGANIZATION:
Healthcare organizations which are not included in described organizations in 2nd article (n) and (o) sub clauses.

q- TURKISH MEDICAL ASSOCIATION MINIMUM WAGE TARIFF:
It is a tariff by Turkish Medical Association to determine minimum wage required to be applied for health services. "unit value" was determined per each medical intervention in this tariff. Minimum wage for any medical intervention is found by multiplying this unit value and general coefficient found by Turkish Medical Association separately for each provinces and which is determined two times in a year in general.

r- EMERGENCY: Situations which occurred as a result of a sudden disease which is not out of the scope of the insurance, accident or injury and risking insured's life when it is not treated in 24 hours at hospital's emergency service.
"emergency" determined by ANKARA SİGORTA includes followings.

1. Acute abdomen,
2. Acute massive bleedings,
3. Sudden paralysis,
4. Asthma attack and acute respiratory problems,
5. Freezing, cold shock,
6. Electric shock,
7. Eye injuries,
8. Heat stroke,
9. Occupational accidents, loss of limb
10. Heart attack and arrhythmia, hypertension attacks (in case the disease has occurred after the commencement date of the Insurance in Ankara
12. Falling down from height or an object falls down on him / her,
13. Renal colic,
14. Drowning in water,
15. Conditions that cause blackout of consciousness except resulting from conditions that are out of coverage)
16. Rape,
17. Traffic accident,
18. Burns (Grade 2 and up),
19. Poisonings

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Sigorta),
11. Fractures of vertebra and lower-upper extremities
20. Sharp object injuries
21. Fever over 39,5 °C

s- SERVICE PROVIDER ; It means company providing impartial organization management services to insurer and insurer's insured in health insurance field. It provides provision and consultancy services for 7 days and 24 hours.

t- GEORAPHICAL BORDER OF INSURANCE : This insurance cover is valid all over the world including stated limits and exemptions in certain policies and is valid only in boundaries of Republic of Turkey in some policies(Geography of validity is stated separately in each policies).

u- TAXES, DUTIES AND CHARGES : Taxes, duties and charges to be accrued in future or taxes, duties and charges which are existent according to legislation in force over both insurance cover and tariff premiums belong to insured.

v- AMBULANCE(LAND/AIR) : Insured can get free consultancy service by calling our ambulance line in cases stated at emergency section in definitions and can benefit from land ambulance service. In case it is not possible to treat insured in-site and state of health is not appropriate to transport by land ambulance and insurer's approval was not received in domestic cases, transportation is provided by contracted air ambulance and/or air transportation.

3- START OF INSURER'S RESPONSIBILITY: Responsibility of insurer starts on condition of paying premium advance payment if it is decided to pay whole insurance premium or paying by installments.

4- INSURANCE PERIOD: This insurance is valid between start and end dates stated in policy. Inpatient treatments proceeding until ending date of insurance are valid until the end of inpatient treatment on condition of not to be more than 10 days.

5- RENEWING INSURANCE: This insurance is valid for 1 year most and there is no periodic or lifelong renewing guarantee in scope of the policy. However, a new policy may be issued upon request of insured/insurant in accordance with principles made by insurer in 30 days following insurance ending date. Insurer makes decision to renew insurance by examining state of health, and/or damage/premium rate of insured in insured period. Insurer may require declaration showing last state of health, presentation of registrations concerning social and/or private health insurance and additional examinations, can receive information from Insurance Information and Monitoring Center and from previous insurance companies if available or persons and institutions treating insured. Otherwise, by evaluating diseases arising in insurance period; an exemption can be made in renewal period; cover limit may be applied or can get related disease into scope of cover by applying disease premium.
Health declaration shall be received in case insured requires passing upper plan. Health declaration shall also be received in case of having requests to pass from plans excluding outpatient treatment cover to plans including outpatient treatment cover. Cover change can't be made on policies over % 200 H/P.
In case of quitting, retirement or end of agreement which group made with insurer however being in scope of group or corporate health insurance, insurer shall make medical risk assessment for persons who made policy application in 30 days. In case of excessing this period, vested rights can't be mentioned. Insurer has right to exemption application and/or bonus application.

ACCEPTANCE FOR INSURANCE: Insurer shall determine if insured applicant shall be included in insurance scope and terms. Age limit of insuring for foreign national people to be insured is 70 within 6458 numbered Law of Foreigners and International Protection.

a- Insurer has right to receive information and request document from person and institution which treated insured, Insurance Information Monitoring Center, SSI and Ministry of Health in accordance with related legislation by getting written approval of insured. Insured may require receiving doctor opinion in order to determined insured's state of health in case of need. Expenses of mentioned transaction are paid by insurer. Insurer may ask questions concerning health history and rest subjects. Insurant, insured and representative (if available) is obliged to give correct and complete answers to asked questions.

Such cases insured do not give health history information access authorization to insurer, if insurance contract is made by insurer, insured and representative, it has to be made based on representative's declaration and answers given for insurer's written questions if available. Insurer, insured and representative(if available) is obliged to notify cases requiring answering asked questions correctly and completely, avoiding to make agreement by company or to make under more difficult conditions. Insurer may require receiving doctor opinion in order to determine state of health of insured if required. Expenses of mentioned transactions shall be paid by insurant and insured.

It is an obligation that insurant and applicant insured must be resident in Republic of Turkey boundaries.
Insured's right to reject, accept with standard terms or accepting under special conditions by putting special exemption and/or waiting period for certain diseases and or/bonus first or next applications without showing a reason is reserved.

b- Following terms are valid for newborn children and children of whom birth was notified to insurer in written:
It is included in scope of health insurance by receiving day-based premium as of birth date in case of applying in 7 days with health insurance application form and birth certificate/report for baby and it is included in scope of health insurance by receiving day-based premium as of application date in case of accessing 7 days of period.

6- OBLIGATION OF DECLARATION AND DENOUNCEMENT: Insurant/insured is obliged to answer asked questions in proposal form and supplementary documentation correctly and to declared details that constitutes risk and effect appreciation of risk. If declaration of insurant/insured is deficient or contrary to facts, Turkish Commercial Code and 6th article of Health Insurance General Terms are applied. Insured has right to not make agreement or renounce if already made. In that case, if risk was realized, compensation is not paid to insured. Insurer entitles to get premium.

7- COVER AND LIMITS OF INSURANCE:

This insurance pays following cover of which was stated in policy based on limits and applications stated in policy within Health Insurance General Terms and this Special Terms.

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INPATIENT DIAGNOSIS / COVER OF TREATMENT EXPENSES: It supplies diagnosis and treatment expenses which requires insured to hospitalize and stay in hospital for at least 24 hours, surgical treatment, chemotherapy, radiotherapy and dialysis and cardiac and cerebral angiography expenses which is administered under general anesthesia and/or made without hospitalization under local anesthesia even though possibly to be administered under general anesthesia and which is 150 units and over in accordance with cover limit and application stated in policy. Expenses which do not match with diagnosis realized during inpatient treatment are not paid. Hospitalizations for the purpose of examination are out of inpatient treatment cover. Treatments proceeding as outpatient treatment after inpatient treatment made in hospital are paid from hospital examination cover and limit. There is no share.

a-OPERATION EXPENSES COVER : (Inpatient treatment cover)

In case treatment of insured requires a surgical intervention in inpatient treatments (surgical interventions administered under general anesthesia and/or made without hospitalization under local anesthesia even though possibly to be administered under general anesthesia without hospitalization and which is 150 units and over according to Turkish Medical Association Tariff) all expenses from entering into operating room to exiting from operating room(excluding room, accompaniment), (operation, anesthesia, assistant, consumables) are paid in accordance with limit application and exemptions written in policy. Angioplasty, coronary and cerebral angiography expenses and any prosthesis placed during operation is paid by cover.

Operation expenses are valid for each operation. Prices of Operator, Anesthetist, Assistant, Anesthesia for operations made in same or separate lacerations is applied at the rate of policy cover and limits in accordance with Turkish Medical Association general terms and conditions (It changes depending on policy cover.). Furthermore, operation room opening price is limited with 30% of operator price at non-contracted healthcare providers.

Such cases treatments require more than operations, payment is made within single operation limit. In case of making more than one operation under one anesthesia (with same laceration) and if all of them are not included in scope of insurance cover, operator price is paid in proportion to number of operations in scope.

In case of making more than one operation under one anesthesia (with same and different laceration), 3rd and 4th articles of general principles published by Turkish Medical Association is valid.

If a treatment is made again as a result of wrong diagnosis and treatment, causing institution or doctors shall be responsible.

Needs to be mentioned in operation expenses cover to emerge after being discharged from hospital shall be assumed as a separate operation even it is for same disease.

Insured presents documents concerning transactions to be carried out for healthcare expenses to be paid by also Social Security Institution to insurance company. All transactions are conducted by insurance company and required organization is provided.

b- HOSPITAL TREATMENT EXPENSES COVER: It is paid within;

- Doctor visits, consultations, medicines,
- All kinds of examinations such as analysis, x-ray,
- All required services and materials including blood, blood plasma, oxygen, serum, medical dressing, injection and similar applications, (Ankara Sigorta has right to buy required material from supplier company instead of hospital.)
- Expenses concerning urgent dentistry after traffic accident,
- Morgue expenses in case of death after hospitalization,
- Expenses consist of services including nursing services, medical services etc.
- Limit, applications and exemptions written in policy

which occurs in healthcare organization where insured's treatment do not require surgical intervention and/or insured receive inpatient treatment after and before operation.

Hospital treatment expenses cover is valid for each hospitalization.

Needs to be mentioned for Hospital Treatment Expenses to occur after being discharged from hospital shall be assumed as a different disease case even though being for same disease.

Treatment expenses of our insured of whom outpatient treatment after hospital is proceeds are paid from hospital treatment expenses cover as 100%.

c- COVER OF HOSPITAL ROOM - COMPANION EXPENSES : Standard room, food and companion expenses occurring in case of making insured's inpatient treatment at hospital is paid within daily cover limit and application stated in policy. Hospitalization period is 180 days most in one policy period.

d-COVER OF INTENSIVE CARE UNIT EXPENSES : It supplies intensive care unit expenses (bed-food price, usage prices of fixtures used in intensive care unit; monitorization etc., prices of other machines, required consumables for operations made in intensive care unit; air bearing and iv. pump prices) occurring in case insured's inpatient treatment is made in hospital within daily cover limit and application.

Examination and treatment expenses (laboratory and medicine expenses, expenses that are not exclusive to intensive care) to be carried out at intensive care are assessed in scope of inpatient treatment cover/hospital treatment cover. Companion expenses made in intensive care period are not in scope of cover.

Hospitalization period in healthcare organization is 45 days maximum in policy period both whether is same or different diseases.

e-SPECIFIC TREATMENT COVER(RADIOTHERAPY, CHEMOTHERAPY, DİALYSIS) : Any expenses(including examination, room-food-companion expenses) made for radiotherapy, chemotherapy and dialysis at insured's inpatient treatment or outpatient treatment are paid in accordance with limit, application and exemptions stated in policy. Limit of this cover is annual. Expenses pertaining to examinations and checks made in order to evaluate process of disease after chemotherapy and radiotherapy are paid from related covers, these are not paid from specific treatment cover.

f-COVER OF ANGIOGRAPHY EXPENSES: Angiography is a pack cover and all expenses are paid from this cover limit in accordance with limit, application and exemptions stated in policy (Insured has right to buy required material from supplier company instead of hospital).

OUTPATIENT DIAGNOSIS / TREATMENT EXPENSES COVER:

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Expenses of outpatient treatment by doctor, prescribed medicine required by doctor, consumables, laboratory tests for diagnosis, all endoscopic applications, angiographies(excluding cardiac and cerebral angiographies), MR, angio, radiographic examinations, nuclear medicine and algology applications; removing all kinds of moles and warts(nevus, verruca), any kinds of surgical treatment and other treatments(serum, cast, medical dressing, abscess drainage etc.) up to 150 units in Turkish Medical Association minimum wage tariff at private clinic or Healthcare Organizations are paid in accordance with cover limit and application stated in policy. Outpatient treatment expenses within unlimited plans out of HYPER plan are limited by 5.000 by 80% payments annually at non-contracted organizations.

Routine vaccines of 0-6 age children in Vaccine Calendar of Ministry of Health are paid.

a-MEDICAL EXAMINATION COVER: Examination prices paid for doctors with license to open private clinic and/or healthcare organizations in outpatient treatments are paid in accordance with limit, application and exemptions written in policy. Expenses concerning diagnosis methods applied by doctor during check in order to help diagnose shall be evaluated in medical examination cover. All expenses concerning examinations until 10th day about diagnosis at first examination are out of scope of cover.

b- COVER OF MEDICINE EXPENSES: Medicine expenses belonging to pharmaceutics (having characteristics of medicine) products received medicine license from only T.R. Ministry of Health and written in prescription issued after examination by doctor at outpatient examinations are paid in accordance with limit, application and exemptions written in policy. Expenses of medicine which have vital importance for examination and have no equivalent in Turkey and imported from overseas by Turkish Pharmacists' Association are paid on condition of receiving approval from insurer. Expenses of medicines of which continuous use is seen appropriate by doctors are paid only on condition of insured to certificate this situation by a medical report (report needs to be issued as being valid for 6 months most) and approval of Ankara Sigorta(use of medicines must be in policy period).

c-COVER OF ANALYSIS EXPENSES : Expenses made for laboratory analysis upon written request of doctor at outpatient treatments are paid in accordance with limit, application and exemptions written in policy.

d-COVER OF X-RAY EXPENSES: All examinations at 75 units and under according to Turkish Medical Association made upon written request of doctor at outpatient treatments are paid in accordance with limit, application and exemptions written in policy by labeling as x-ray.(Basic direct graphics(without medicine), respiration function test, audiometry, tympanogram, visual field, Doppler, USG, EKG, EKG with effort, EKO, EMG, EEG, USG etc.)

e-COVER OF MODERN DIAGNOSIS METHODS : Any kind of examination, tomography, scintigraphy, Fluoroscopy, Urography, MR, Doppler, Electron Angio, Mr Angio, Positron Emission Tomography, Gated Spect OGS Method and Vasodilator Perfusion Technic made out of methods stated in x-ray cover at outpatient treatments are paid in accordance with limit, application and exemptions written in policy.

f-COVER OF PHYSICAL THERAPY AND REHABILITATION: All expenses concerning functional education given insured in order to recover vital activities lost after any kind of surgical operation (walking with or without crutch, food & beverage, putting on and taking off clothes, sitting on toilet, climbing up and coming down stairs) and hand-arm-leg amputation, major trauma, neurological diseases on condition of receiving an outpatient/inpatient treatment in insurance year and expenses made for room, food and companion on condition of inpatient treatment execution and approval by company are paid in accordance with limit, application and exemptions written in policy. Rehabilitation services given except intensive care are assessed within the scope of physical therapy. It is limited with 15 sessions per year. Outpatient treatment or inpatient treatment is applied depending on type of disease. Physical therapy expenses excluding acute diseases are out of the scope of insurance for 12 months as of starting date of insurance.

g-COVER OF SMALL SURGICAL INTERVENTION EXPENSES: Medical dressing, injection, ear wash, cast implementation, oxygenation, abscess drainage, stomach irrigation, serum, endoscopic small surgical interventions, endoscopic biopsy, removing all kinds of moles and warts(nevus, verruca), lipoma removing, paracentesis, cauterization, criotherapy, algology implementations and prices of monitor and devices in hospital, medical hold, bed and similar intervention expenses in inpatient treatment of insured and expenses required by medical intervention up to 150 units in Turkish Medical Association minimum wage tariff are paid in accordance with cover limit and application stated in policy. Examination, check and medicine expenses of intervention are paid by this cover as well. Even though total units of more than one intervention made in same clinic are 150 and over, if these do not include an intervention with 150 and more units alone, it is evaluated within small surgical intervention cover.

OTHER COVERS

a- TOOTH COVER AS A RESULT OF TRAFFIC ACCIDENT: Dentistry expenses for correction of case occurred only as a result of traffic accident in such cases occurring as a result of traffic accident happened in validity period of policy are paid if certificated by traffic accident report and judicial report. Treatment should be made in 90 days following accident. This cover is limited 1.50 TL per year and there is 20% insured share.

b- COVER OF EMERGENCY AND AUXILIARY MEDICAL EQUIPMENT : It pays any out of scope healthcare expense of insured who went to healthcare organization by ambulance as a resut of emergency until removing urgent health risk. Furthermore, medical equipment including personal; brace(orthez, brace, active ankle, bon spur ped), orthopaedics arc support, walker, elastic band, sling, corset, nebulizator, hearing aid, neck collar, knee brace, wrist guards, crutch, pillow for sitting used for medical purposes only to support body from outside as a part of applied treatment to insured resulting form a disease or accident occurred after starting date of insurance are paid within annual limit and payment rate stated in policy within this cover. Auxiliary medical equipment except stated above is out of the scope.

c- COVER OF NURSING CARE AT HOME : It supplies payment for expenses occured in case insured is nursed through nursing care at its own home on condition of approval of doctors or a second doctor appointed bu insurer if required, if doctor treating insured finds necessary.

Insured has to have tracheostomy, frequent orotracheal aspiration need, enteral nutrition need, TPN/IV fluid support need and has to be dependent to ventilator and respiratory insufficiency, advanced onchology patients and pain protocol must be applied to insured for insured to profit from cover of nursing care at home.

Insured's insufficiency to fulfill daily life activities alone, being incontinence or immobilize, needing help to eat, orally taking pills, need for help for

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complete shower or need for help to have shower, occurring urinary catheter, living alone at home and having chronic disease requiring social support is not in scope of cover of nursing care at home.
Nurse who will undertake healthcare service of insured must be graduated from official state schools providing health education or equivalent health education organizations in foreign countries and must not have line of descent with insured. If "nursing care at home" cover is existent in chosen plan, it is paid by treatment cover of hospital limited by limits and number of days stated in table of cover from contracted health-care provider.

d- COVER OF MEDICAL CONSULTANT AND AMBULANCE (LAND/AIR) SERVICES:

Insured is informed about faced health problem concerning any urgent or non-urgent health problem. Doctor, specialist, hospital, diagnosis centers, pharmacy names, addresses and phone numbers are notified. Advice is given concerning measurements to be taken concerning faced health problems but diagnosis is not made, medicine is not advised.
Free consultancy service can be profitted by calling our ambulance line and land ambulance service can be profitted in such cases stated under emergency in definitions section. In case making treatment at insured's place is not possible and no possibility exist to carry with land ambulance due to state of health and on condition of receiving approval of insurer, transportation is made by contracted air ambulance and/or air transportation in domestic cases. Ankara Sigorta shall not be considered as responsible for any negative action to occur during this service provided by third persons. In case of not having contracted ambulance service, local land ambulance is used. This cost is limited with 250 TL per case.

e- ARTİFİCİAL LİMB AND PROSTHESİS COVERAGE: Expenditures made for artificial limb and reconstructive prostheses, which will result in any accidents or disease that may occur during the insurance period of the insured, are covered by the written limits, practices and exemptions in the policy.
However, the medical and surgical operations for artificial organs are not covered by this coverage. This cover does not include glasses-glasses frame, lens, dental prosthesis, wheelchair costs.
Prostheses used during the operation are covered by the limit application and exemptions written in the policy from the related coverage (coverage for inpatient-outpatient treatment) not from this coverage.
Artificial limbs to be used for existing disability at the beginning of the insurance period, renewal of existing artificial limbs and expenses related to dental prosthesis are not covered by this policy.

f-ALARM CENTER : In case of an emergency, you can call the telephone number stated in your health card for 24 hours a day, 365 days in a year to get service from Ankara Sigorta's alarm center. Please provide the followings to get help:

- ✓ Your name and surname, your Policy Number and validity date,
- ✓ Location and phone number,
- ✓ the problem you have and the type of help you need.

8- RIGHT TO CHANGE INSURANCE TERMS:

~~The coverage limits of this insurance can only be increa~~sed during the renewal of the insurance, with the approval of the insurer. In claims for a higher cover-up plan, the insurer has the right to request a new health declaration. The guarantee limits cannot be changed within the year of insurance.
If a new insured is included in the coverage during the exercise of the policy, the special terms shall be applicable at that time. The insurer has the right to impose changes in the premiums and in the policy of acceptance of the risk if the policy is renewed.

9- CANCELLATION:

If for any reason the premiums are not paid in due date, the provisions of the Turkish Code of Commerce shall apply. If the insurant and the insured claim the cancellation within the first thirty days from the date of the contract issuance and if no compensation is paid to the insured or his / her name during that period, the premiums paid shall be returned in full within five working days. In case the insured requests cancellation after 1 month from the date of issuance of the policy (possible in written request), if the premium amount paid by the insurer is more than the premium amount claimed by the Insurer on the day basis, the Insurer shall return the difference between them. If the amount of premium paid by the insured is less than the amount of premium that the insurer claims on the day basis, the insured shall return the difference to the insurer. If there is recourse charges payable even if the insured is liable to recourse, the recourse charge shall be deducted from the amount of premium return when the policy is cancelled.
However The policies issued pursuant to the Law on Foreigners and International Protection shall be cancelled according to the Circular no 6, dated 06.06.2014, on private health insurance required to be taken out for residence permit applications. In order to cancel the policy at the request of the insured, the following terms must be fulfilled.

- At the time of submission of a new private health insurance contract covering the residence permit period,
- In the event of a cancellation of the residence permit,
- At the time of submission of the certificate indicating that it is covered by General Health Insurance in accordance with the No. 5510 Social Insurance and General Health Insurance Law

Otherwise the policy cannot be cancelled.

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10- INSURANCE PREMIUM:

a-Tariff Premium : Insurance premiums are calculated using actuarial methods recognized in all sectors. The Company establishes the tariff premium based on the age, gender distribution and coverage usage frequency of the insured portfolio and the annual costs arising from their use and medical inflation rates. These premiums are not specific to the individual but are standard premiums applied to all insurance holders in the age and gender distribution for the related product and plan.

b-Policy Premium : Based on the tariff premiums, it refers to premiums specially designated as a result of the application of the additional premiums and / or discounts defined in the "Regulations Regarding Premium".

c-Regulations Regarding Premium:

- **Discount Due To Damage / Premium Rate /Additional Premium Application;** Discount and/or additional premium in the following conditions and ratios may be applied in new year premiums as a result of evaluation of damage/premium rate paid for the last year for each insured during the renewal period of the current policy.

No-claim discount: During the policy renewal period, the following discounts are applied according to the D / P rate of the policy.

D/P ORANI	DISCOUNT RATE
51 - 70 %	5%
31 - 50 %	10%
15 - 30 %	15%
1 - 14 %	20%
0 %	30%

Damage Surcharge: During the policy renewal period, the following surcharges are applied according to the D / P ratio of the policy.

D /P ORANI	SURCHARGE RATE
100 - 120 %	30%
121 - 160 %	60%
161 - 240 %	100%
241 % and above	It is applied with the approval of the General Directorate.

- **Payment Plan discount;** If the policy premium is paid in advance, a 5% discount is applied.
- **Risk Additional Premium:** It refers to an additional premium that will be applied between 10% and 300% as determined by the health status of the applicant.
- **Age-related Additional Premium:** An additional premium of 30% over the 61-62 age tariff premium will be applied for persons over 62 year old who are approved to continue their insurance.

11- ACQUIRED RIGHTS :

Acquired rights means the removal of special waiting periods and the rights of the previous company. The rights of the insured which are covered under the special terms/ coverage of the previous insurance company but not covered under special terms/coverage applying to the new insurance period shall not be considered as acquired rights. If the insured does not comply with the obligation to notify Ankara Sigorta about the health declaration which he/she provided to the previous insurance company (s), the insured shall not be entitled to the acquired rights. In order to be entitled to use acquired rights, the insured must have been covered by the insurance in the previous insurance company for at least 1 year and not more than 30 days from the insurance expiration date. Any discomfort found prior to the date of first insuring of the insured by the other insurer company(s) will not be included within the scope of the acquired right, even if the previous insurer was paid unknowingly. These discomforts are not covered by the coverage. Ankara Sigorta will decide whether or not to grant the acquired rights as a result of the risk assessment.

12- RIGHT OF RECOURSE:

The insurer collects the payments together with secondary payments which are not included in the coverage and contrary to the Special and General terms of the policy in accordance with its right of recourse.

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13- WAITING PERIOD : Aside from the first examination payment to doctor for diseases and complications written below, every expense of diagnosis and treatment carried out as outpatient diagnosis, outpatient treatment, small intervention, surgical and inpatient are out of insurance coverage for 12 months.

- All kinds of hernia (belly, groin, stomach, spine, loin, neck etc.),
- Anorectal diseases (hemorrhoid, fissure, fistula, sphincterotomy, pilonidal sinus, perianal abscess and bartholin abscess/cyst),
- Uterus, cervical, over and tuba diseases (ovary cysts, myoma, endometriosis etc.),
- Otitis media, eardrum surgery and tube insertion, hearing surgery (tympanoplasty, stapedectomy),
- Cataract, glaucoma and retina diseases etc.,
- Joint and link diseases (cartilage, synovial and link lesions, coxarthrosis, shoulder, elbow, ankle, knee, meniscus, hip joint etc.),
- Every rheumatologic and autoimmune sickness,
- Expenses for diagnosis and treatment of sarcoidosis,
- Breast diseases,
- Tonsil and adenoid diseases, sinusitis and head sinus diseases,
- Thyroid gland and parathyroid gland diseases and goiter,
- Vertebra and disk diseases (spine and intervertebral disk diseases),
- Gall bladder, gallstones and biliary track diseases,
- Pancreas and spleen diseases except as a result of an accident,
- Urinary system diseases (expenses with relation to kidney, ureter, bladder, urethra, urinary track diseases and ESWL dialysis),
- Liver diseases (all kinds of hepatitis sickness, cirrhosis, cyst hydatic etc.),
- Expenses with relation to stress incontinence, cystorectocele, prolapsus uteri and all kinds of diseases to be occurred as a result of deformation of reproductive organs of woman,
- Prostate gland diseases (including TUR),
- Trigger finger, entrapment neuropathy, carpal tunnel syndrome,
- All kinds of chronic diseases (hypertension, COPD, diabetes mellitus etc.),
- Hearth and vascular system diseases, (coroner by-pass, angiography, angioplasty, aneurysm, cardiac valve and cardiac pacemaker, varicosity),
- Stomach and gullet diseases (gastritis, ulcer, gastroesophageal reflux etc.), small intestine and large intestine diseases, GIS bleedings, disorders in relation to diverticulum,
- Expenses for diagnosis and treatment of all kinds of organ failures and organ transplantation,
- Every endoscopic and interventional-invasive diagnosis operations (ERCP, laparoscopy, arthroscopy etc. operations),
- All kinds of bulk, lesion (tumor, lipoma, wart, verru, nevus, polypus, nodule etc.), cyst (hygroma, ganglia, skin, under skin, kidney, vaginal etc.),
- All kinds of cancer treatment (chemotherapy, radiotherapy, immunotherapy and other expenses).

In case of diagnosing within these periods, these and/or similar diseases shall be left out of coverage indefinitely. In so far as:

- The Insurer, can prolong the waiting periods of the sicknesses determined above, also it can add waiting periods to the diseases other

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than these, provided that the Insurer writes the declaration/documents of Insured/Policy owner to the policy attachment after evaluation.

- Expenses for physiotherapy and rehabilitation except acute diseases are out of insurance coverage over the course of 12 months.

14- WARRANTY IMPLEMENTATIONS : Provided that the Insured has received outpatient/inpatient physiotherapy within the year of insurance, every expense related to functional education (rehabilitation) given to him/her for regain the life activities (walking with or without crutches, eating, drinking, getting dressed and undressed, sitting on toilet, ascending and descending from stairs) that he/she lost after neurological diseases, heavy trauma, hand-arm-leg amputation and all kinds of surgical operations, provided that the treatment has been carried out is inpatient and the İnsurance Company has accepted, expenses for room, food and companion shall be compensated from outpatient/inpatient treatment indemnity within the scope of limits, implementations and exemptions determined in the policy and related expenses of insurance people with physiotherapy expense warranty shall be compensated from this warranty.

Except from intensive care, rehabilitations carried out are evaluated within the scope of physiotherapy warranty. For annual treatment, payment is carried out up to 15 sessions in all plans (expenses for physiotherapies carried out as outpatient for inpatient-only treatment policies are out of coverage).
Price for diagnosis, treatment and follow-up of the doctor;

- In cases of the doctor is on permanent staff in Contracted Healthcare Provider, the agreed prices determined by the related institution for Ankara Sigorta and in cases of there is no doctor price determined by the institution for the operation, payment is carried out in a manner that does not exceed the current price system of institution and/or contracted price system determined for Ankara Sigorta. In cases of the doctor is not on permanent staff, payment is carried out in a manner that does not exceed the minimum price tariff of Turkish Medical Association.

- In Healthcare Providers without contract the price for diagnosis, treatment and follow-up of the doctor, the payment is carried out in a manner that does not exceed the minimum price tariff of Turkish Medical Association.

Expenses for diagnosis methods (ultrasonography, smear/culture sampling etc.) created by the doctors for assisting them in diagnosis during the examination is evaluated within the scope of doctor examination price.
The indemnity requests of Insured people that are not benefiting from the direct payment service in outpatient or inpatient examinations and treatments in contracted healthcare providers is compensated in accordance with warrant limits by basing upon agreed prices determined by the related institution for Ankara Sigorta.
If the insured receives an examination without the permission of Ankara Sigorta for re-evaluation of an indemnity that is not compensated within the term of insurance, either the indemnity has been decided to be paid or not, examination expenses made with the decision of insured shall not be compensated by Ankara Sigorta.
Insurer reserves its right for making changes in policy term in the 'Contracted Healthcare Providers List'.
For the expenses of insured for treating the disorder diagnosed in Turkey but treated in abroad and expenses made as a result of sudden diseases and/or injuries occurred while travelling abroad the liability of Insurer is calculated according to International Hospital prices located in Istanbul within the scope of related warrant limit written in policy. Insurance company shall be informed at least 10 days prior to going abroad for treatments of disorders planned to be carried out in abroad, but diagnosed in Turkey. In treatments carried out in abroad, it is mandatory for documenting that the insured was in abroad and in the country which the treatment has been carried out. Within the term of this Insurance Contract, aside from the situations of continuously receiving treatment as inpatient, Warranties of Insured people that continuously resides in abroad for more than three months is stopped starting from the third month of residency. Insurer shall not pay indemnity for treatment expenses to be occurred in abroad within the stopping term of warranties. Warranties of Insured persons restart after passing through the customs office of Turkey before the Expiration Date of Insurance Contract.

15- INDEMNITY PAYMENT: It is required that necessary and adequate document related to the sickness subjected to indemnity to be submitted to insurer by hospital/physician/insured. Following methods are implemented in Indemnity Payment period, depending upon if the health institution that provided the service is in agreement with our Company or not.

a - In accordance with the insured agreement in Contracted Healthcare provider, they can only benefit from services provided that they pay their own part in their own participation implementation, if there is any. Insured card must be submitted for benefiting from services. Otherwise, the insured cannot benefit from direct payment implementation.
In cases of the sickness that caused diagnosis/treatment has been determined to be outside the coverage after the direct payment transaction has been carried out by the insured, the amount paid to the healthcare institution shall be paid fully in cash to the Insurer by Insured. For actualizing provision transaction in inpatient treatments, aside from the emergency situations if the insured informs the Ankara Sigorta Provision Center at least 48 hours before, the waiting time in the hospital shall be removed.
Within the term of insurance, insured can change contracted healthcare provider or can add a new contracted healthcare provider.

b- In Healthcare providers without contract, Insured people pay every expense that they have made in these institutions and request from insurance company. Following the payment of treatment expenses to related institution the Insured, must submit the indemnity request form regulated and signed by the doctor and himself/herself and related invoice, sales slip, medicine clipping, receipt original and a copy of the examination (analysis, x-ray etc.) results to the Insurer and in cases of receiving treatment abroad, also a passport copy indicating that the insured was in the country which the treatment has been carried out must be submitted. If the policy has ended aforementioned period is limited to 15 days, payment is not carried out if renewal has been done and the received damage amount is affecting the premium of renewed policy.
Insurer pays the indemnity amount to a IBAN number notified with indemnity request by the insured.

16- EXCEPTIONS: As an addition to the 2nd article of the General Conditions of Health insurance, due to the situations occurring with circumstances and in connection with these circumstances; insured persons get sick and/or injured as a result of any accident within the period of insurance is left out of the cover.

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- Compensation for disorders arising in connection to, either known or not, current disorders and disabilities of insured before the starting date of insurance, diagnosis and treatments of inborn diseases and disabilities, diagnosis and treatments of genetic-hereditary sickness and disablements is not paid throughout the whole insurance period.
- Diagnosis and treatment of otosclerosis,
- Physical, mental, growth retardation and mental retardation.
- Chromosomal abnormality
- Multiple sclerosis (MS), amyotrophic lateral sclerosis, cerebral palsy, ankylosing spondylitis, sacroiliitis, lupus - SLE
- Amyloidosis, acromegaly, addison, cushing, hypophyseal dwarfism
- Ulcerative colitis, crohn sickness
- Myastenia gravis
- Hepatitis, hepatitis diagnosis, treatment costs
- Epilepsy,
- Vaccine left out of the routine vaccines in the vaccine calendar of Ministry of Health for 0-6 years old, (except rabies and tetanus vaccine)
- Hallux valgus diseases, pes planus diagnosis and treatment costs,
- inguinal hernia before the age of 7,
- Voice and speaking therapy expenses, diagnosis expenses done in the centers that sell hearing aids,
- All kinds of treatment costs about spinal curvatures (scoliosis, kyphosis, lordosis etc.),
- Diagnosis and treatments carried out with the purpose of esthetics (breast enlargement - breast reduction, including esthetic operations carried out after breast cancer, accessory breast surgery etc.), laser epilation, liposuction, belly esthetics, face lifting, esthetics for eyelid looseness and similar supraorbital esthetics, hair transplantation, sweating treatments, laser and phototherapy applications about all kinds of skin conditions, telangiectasias, skin haemangioma, xanthelesma etc.,
- Coronary artery calcium scoring test, coronary VCT angiography and all kinds of examinations under the title of EBT () in Turkish Medical Association minimum price tariff, virtual angiography and expenses of virtual colonoscopy and examinations carried out with similar purposes of scanning,
- Glasses-glass-frame, contact lens and solutions,
- Expenses belonging to the new methods and material that are not common and/or not yet proven to increase the success rate of treatment used in place of current treatment methods. Robot usage price and all kinds of material expenses specially used for this method. Expenses belonging to treatment and implementations based on new biomedical engineering - genetic and biotechnological,
- For whatever the reason might be, all kinds of Bariatric Surgery methods (gastric bypass, gastric balloon, gastric tube, adjustable gastric band, stomach reduction surgeries, biliopancreatic diversion, jejunoileostomy, bowel reduction etc.)
- Diagnosis-treatment of psychiatric and psychological disorders, treatment costs of psychosomatic disorders and psychology, pedagogue, social service specialist etc. (psychosis, bipolar, obsessive compulsive disorders, eating disorders, schizophrenia etc.),
- Child care fees, controls of healthy baby/child, expenses belonging to premature, baby formula, diaper, baby bottle, pacifier, hydrophilic cotton, alcohol, cologne, thermometer, ice bag, hot water bag, sweetening agents,
- Expenses in relation with doctor examinations and laboratory / x-ray etc. implementations carried out for precaution or protection without having any sickness, examinations carried out because of domestic risk factors and check-ups,
- All kinds of expenses with relation to menopause treatment (pre-peri-post Menopause, osteoporosis etc.).
- Diagnosis and treatment expenses of venereal diseases, all kinds of costs belonging to venereal - genital - sexually transmitted diseases,

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(syphilis, gonorrhea, chancroid, granuloma inguinale, herpes, papillomatous lesions, warts, condyloma acuminatum and molluscum contagiosum),

- Diagnosis and treatment expenses in relation to obesity,
- All kinds of circumcision expenses and phimosis diagnosis treatment expenses,
- kinds of expenses belonging to pregnancy, birth, g serean section, newborn and incubator costs, follow-up on infertility and ovulation, test-tube baby, microinjection, hysterosalpingography, adhesiolysis, spermiogram, miscarrioage follow-up, ectopic pregnancy, spurious pregnancy, AMH and all kinds of abortion processes, insertion of intra-uterine device, vasectomy, tube ligation etc., birth control methods, pregnancy and birth control medicines,
- Expenses of laser and surgical operations carried out for cross eye, squint eye, keraticonus, refractive flaw in eyes and expenses of all kinds of diagnosis, examination and treatment for amblyopia,
- Diagnosis and treatment costs for AIDS, HPV, ARCS and all kinds of diseases related to HIV virus,
- Occupational diseases occurring as a result of building demolition, explosive substance transportation, miner occupation, dock construction, blasting activities (asbestosis, pneumoconiosis, mercury poisoning, silicosis etc.),
- Accidents and disorders occurring while carrying out duties in police or military institutions,
- Accommodation expenses in domestics and abroad, food costs and telephone expenses outside of hospital etc., other expenses unnecessary for treatment,
- Transportation expenses outside of locally licensed ambulance,
- Expenses of donor in organ and tissue transplantations, organ and tissue prices, transportation expenses of organ and tissue,
- All kinds of expenses with relation to cordon blood and stem cell sampling, transportation and process,
- All kinds of expenses originating from physiotherapy implementations occurred more than 15 sessions within one insurance year, either in outpatient treatment or inpatient treatment,
- Diagnosis and treatment expenses originating from all kinds of sickness and accidents occurred because the insured being under the influence of alcohol and drugs, diagnosis and treatment costs belonging to all kinds of sickness and complications occurred in relation with usage of alcohol and drugs, expenses for treatment of quitting cigarette, alcohol etc. all kinds of addictive substances, all kinds of health expenses for insured person without a driver's license occurring as a result of a car crash, expenses with relation to treatments occurring as a result of getting involved in a fight, knowingly and willfully doing self-harm etc.,
- All kinds of expenses in relation with dangerous sport activities (mountain climbing, parachute jump, rodeo, paragliding, glider, rafting, street luge, sports that involve jumping from a high place (such as base jumping),sports with kite (such as kite boarding, kite surfing), underwater sports, cave diving, mountain biking, motorbike and automobile sports and all kinds of expenses in relation with diseases and/or injuries that can occur as a result of all kinds of competitions and/or practices as a professional athlete,
- All kinds of diseases and injuries that can occur in all kinds of competitions and/or participations in practices as professional or amateur licensed/unlicensed athlete,
- Expenses for all kinds of examination, diagnosis and treatment for pimples, acne and hair loss, sweating treatment, iontophoresis, botulin toxin implementations, isotretinoin and derivatives (roaccutane caps etc.), expenses for hair or dandruff shampoo, skin cream, skin soap, cosmetic products, thermophore, thermometer etc.,
- Expenses for diagnosis and treatment of geriatric and psychogeriatric diseases, Alzheimer sickness, Parkinson, dementia etc.,
- Expenses for diagnosis and treatment required for injuries occurred because of participating in strikes, labor movements in relation to lockout, public movements and fights,
- Expenses for diagnosis and treatment required for injuries occurred because of aircraft travel except being a ticketed passenger in a scheduled flight,
- All kinds of expenses originating as a result of implementations carried out without any diagnosis/treatment program stipulated by a physician,
- Diagnosis (polysomnography, sleep EEG etc.) and treatments of every disorder that causes snoring and sleep apnea syndrome, diagnosis

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and treatment for snoring and sleep apnea and all kinds of surgical operation to be done for this reason; uvula elongation, saggy palate and similar disorders,

- All kinds of vitamin, mineral and similar preparations, medical teas, herbal preparations prepared in form of medicine, water and sea water that do not contain active ingredients and prepared in form of medicine, hormones and medicines that supports sexual function, customs expenses of medicines imported from abroad,
- Expenses for diagnosis and treatment of asthma, Reactive Airway disease, bronchial hyperactivity and expenses for skin tests and allergic vaccine of all kinds of allergic diseases,
- Expenses for diagnosis and treatment of nasal Septum deviation, concha hypertrophy, nasal valve failure,
- Expenses for diagnosis and treatment of spermatocele, varicosele, hydrocele, cordon cysts,
- Diagnosis and treatment of all kinds of varicose vein, venous thrombosis and superficial varicose (sclerosant varicose treatment, endovenous laser treatments, varicose sock etc.),
- Expenses for all kinds of diagnosis and treatments in persons that are not medical doctors or centers working without license from Ministry of Health, rehabilitation centers, Sanitarium, eventide home, nursery, hot spring and thermal centers and similar institutions (including physiotherapy),
- Expenses that are not directly related to diagnosis and treatment such as private room, telephone, internet, television, cafeteria, minibar,
- Aside from the circumstances required from an accident to be had by the insured after the starting date of insurance, expenses for all kinds of diagnosis and treatment in relation to all kinds of plastic surgeries, gynecomastia, gender reassignment surgeries, impotency (erection disorders), sexual dysfunctions, peyronie's disease (penile, prosthesis etc.),
- Expenses for diagnosis and treatments of every teeth, gingiva and jaw surgery, teeth implants, wheelchair, aside from teeth treatments carried out for the purpose of orthodontia and esthetic, teeth treatment carried out as a result of a car accident occurred within the term of policy,
- All kinds of expenses made in all kinds of traditional, supplementary and alternative medical implementations (anti-aging, Ayurveda, hydrotherapy, healing cures, detox, mesotherapy, reflexology, chiropractic treatments, oxy therapy, carboxytherapy, ozone therapy, PRP acupuncture, hypnosis, aromatherapy, neural therapy etc.), treatments without proven scientific value, experimental treatments, examinations and treatments accepted to be currently in experimental phase and without an approval from the institution of American Food and Drug Administration (FDA), implementations carried out with purpose of obesity, gaining and losing weight, foot care centers, hot spring cures, massage, diet specialists, mud baths, weight loss resorts, gymnasium and similar places,
- Expenses belonging to the services of private nurse provided during outpatient or inpatient treatment in the hospital,
- Special cases out of coverage determined in attached conditions of policy and every expenses aside from warranty, limit and implementations determined in the policy,
- Health care service expenses received from doctors with incompatible area of expertise with the sickness of insured,
- Officially announced epidemics and quarantine,
- Expenses in relation with funeral in cases of death (expenses occurring in case of passing away after hospitalization such as morgue costs, funeral transportation etc.),

This manual is an inseparable part of health friendly insurance.

Special conditions of this policy shall come into force starting from the date of 01.07.2017 and shall be valid in policies carried out starting from the date of 01.07.2017.

ANKARA SİGORTA HEALTH FRIENDLY INSURANCE DISCLOSURE FORM

This form, issued as at least two separate copies, has been drawn up pursuant to The Regulation

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Regarding Information on Insurance Contracts, which was issued in the Official Gazette dated 28.10.2007, in order to provide an outline of certain matters regarding the insurance contract to the insurant, persons who would like to be a party to an insurance contract and other persons who will benefit from the insurance

A. DETAILS OF THE INSURER

Details of insurance intermediary;

Trade Name :

Address :

Tel & Fax no. :

Details of the insurer granting coverage;

Trade Name : Ankara Anonim Türk Sigorta Şirketi (www.ankarasigorta.com.tr)
Address : Kozyatağı Mh. Sarı kanarya Sk.K:2 plaza No:14 K:8 Kadıköy/Istanbul

Tel: 0216 665 85 00 / 8559 Faks: 0212 310 46 46

B. GENERAL INFORMATION AND WARNINGS

1. This insurance covers the expenses to be incurred by the Insured for the diagnosis and treatment required as a result of a disease and / or accident that may occur during the effective and expiration date of the insurance as stated in the policy/supplementary policy of the Insured depending on the agreement of the parties and within the cover, limit, participation rate and applications specified in the certificates attached to Assistance services and policy/supplementary policy, if any in accordance with Turkish Code of Commerce, General Provisions, General Requirements of Health Insurance and provisions of Special Terms. All costs related to the congenital diseases of the Insured and the disease symptoms and diagnosis occurred before the effective date of the cover and the diseases (complications) occurred linked with aforementioned diseases are excluded from the Insurance coverage.

2. The following coverage are provided to this Insured.

a. Inpatient Treatment

b. Outpatient Treatment

c. Immediate Aid and Aid Equipment Coverage

3. The Health-Friendly product does not cover the usual controls of labor and pregnancy. This product does not include birth coverage.

4. For further information on insurance, please read carefully the General Terms of Health Insurance and the Special Terms of Health-Friendly Insurance Policy issued by the insurer upon request.

5. Please refer to exclusion clause in the General Terms of Health Insurance and the Special Terms of Health-Friendly Insurance for the cases not covered.

6. Diagnosis and treatment expenditures of the diseases and complications included in the Waiting Period of the Special Terms for Health-Friendly Insurance are not covered by the insurance for 12 months.

7. In addition to the general terms of the insurance, the Parties have the right to decide on supplementary terms special for the insured in accordance with the characteristics of the risk, provided that it is not contrary to the law and is agreed mutually.

8. Health-Friendly Insurance applies only to EKO Group institutions. Claims for damages from non-EKO institutions will not be assessed. The Insurer reserves the right to amend the policy period at the 'List of Contracted Health Care Providers'. You can reach the Contracted Health Care Providers at <http://service.cgmturkiye.com/root/ekokurumsorgulamaiframe.aspx>.

9. It is an important obligation to answer all questions in the application form truly, accurately and completely and to exchange information regarding the period before the coverage starts which is known by the insured and insurant and should be known by the insurer. You also have the obligation to declare other matters, which are effective on risk assessment herein and are known by you, even if it is not asked in the application form. In case of breach of these obligations, the insurer has the right to withdraw from the contract or to keep the contract in force

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by taking additional premiums, applying the special exclusions to the person and / or bringing a coverage limit to the concerned disease. Therefore, any incomplete or incorrect information must not be given to the insurance company at any stage of the contract in accordance with Article 6 of the General Terms of Health Insurance. Any missing answers in the application form will be issued as NO.

10. Please refrain from providing incomplete or incorrect information to the insurer during the establishment of the contract and the insurance period and in case of the occurrence of the risk. When the policy is issued, check the coverage and limit if any, participation shares of the insured, exclusions, additional terms and waiting times. Otherwise, the compensation payment period may be prolonged and compensation may not be paid in full or may not be paid at all.

11. The period of the health insurance contract is 1 year and it starts at 12:00 p.m. and ends at 12:00 p.m. in the dates stated as the effective date and expiration date of the policy, unless otherwise agreed. The renewal of the policy is subject to the payment of the premium for the policy of new period provided that the approval of Ankara Sigorta is granted.

12. If the premium is agreed to be paid in full or in installments pursuant to Article 8 of the General Terms of Health Insurance, the first installment shall be paid at the latest at the delivery of the policy and the remaining installments shall be paid at the dates specified in the policy. If all or a part of the premium is agreed to be paid in installments, the insurer's liability will not start until the first installment is paid. In addition, provisions of the Code of Obligations shall be applied in case of default in the premium payment of health insurance with a term shorter than 1 year.

13. After the contract is executed, changes to the property that may affect the risk, without the consent of the insurance company, must be notified to the insurance company in accordance with Article 9 of the General Terms of Health Insurance within eight days.

14. To avoid certain future conflicts, be sure to get a payment voucher for your premiums (in advance or in installments).

15. If the contract is terminated due to legal reasons, the premium corresponding to the duration of the insurer's liability will be refunded to the insurant upon calculation of the number of days, or the insufficient amount not paid up to that date will be paid to the insurer upon calculation of the number of days.

16. The policies issued pursuant to the Law on Foreigners and International Protection shall be cancelled according to the Circular no 6, dated 06.06.2014, on private health insurance required to be taken out for residence permit applications. In order to cancel the policy at the request of the insured, the following terms must be fulfilled.

- At the time of submission of a new private health insurance contract covering the residence permit period,
- In the event of a cancellation of the residence permit,
- At the time of submission of the certificate indicating that it is covered by General Health Insurance in accordance with the No. 5510 Social Insurance and General Health Insurance Law,

Otherwise the policy cannot be cancelled.

17. Ankara Sigorta may change the Special Terms of Health-Friendly Policy. However, these changes will apply to the policy to be renewed the following year.

18. The coverage limits of the policy can only be increased during the renewal of the insurance, with the approval of the insurer. In claims for a higher cover-up plan, the insurer has the right to request a new health declaration. The coverage limits cannot be changed within the year of insurance. If a new insured is included in the coverage during the exercise of the policy, the special terms shall be applicable at that time. The insurer has the right to impose changes in the premiums and in the policy of acceptance of the risk if the policy is renewed.

19. Ankara Sigorta reserves the right to terminate the policy in case that any of the insured under the same policy makes an intentional attempt that seeks profit and is contrary to the general terms of the policy and the code of practice.

20. Those who will further be covered or are already covered by the insurance shall be deemed as consented to his/her health information, insurance registration and other information will be obtained from the Insurance Information and Monitoring Center (SBGM), the Social Security Institution, the Ministry of Health, health institutions and insurance companies in order to be able to make risk assessment by signing the relevant documents and his/her subjected information and records under the Company will be shared with SBGM, insurance companies and other authorities stated in the relevant legislation.

21. Ankara Sigorta may request the consultation of a physician to determine the health condition of the insured before he/she is covered by the insurance or when it is deemed necessary during the process of a claim. The expenses related to the subjected process are covered by the Ankara Sigorta. However, if the applicant gives inadequate and / or misrepresentation in the acceptance form and this disease occurs during the preliminary examination and therefore, the applicant gives up the insurance because the disease is excluded, the preliminary examination shall be paid by the applicant. For this reason, the pre-examination fee paid by the applicant or withdrawn amount from the credit card will be deducted and the remaining amount will be refunded to the applicant.

22. The Insurance Company will be able to apply discounts and / or additional premiums on conditions and rates specified in special terms in the new year premiums as a result of assessing the last year's loss / premium ratio for each insured in the policy during the renewal period of the existing policy.

23. Inpatient treatments that are continuing at the insurance expiration date shall be valid until the end of the inpatient treatment,

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HEALTH-FRIENDLY INSURANCE POLICY

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provided that it does not exceed 10 days.

24. The proposal and the supporting documents and the disclosure form are an integral part of the contract.

C.COMPENSATION PAYMENT

1. The scope of the coverage to be determined in mutual agreement and its limitations, if any, exemptions and / or the % or amount of the insured's participation in the damage (in the currencies to be set), additional conditions, exceptions, waiting periods and conditions of application shall be specified on the contract to be concluded on behalf of you.

2. Rights holders are obliged to provide the insurers with the relevant documents in order to claim their rights arising from the policy. The documents requested in compensation payments differ in the claims for compensation that will be made according to the coverage received in the policy. Please ask your insurer for a list of the information and documentation required for the application for compensation, following the preparation of the policy.

3. In case of the occurrence of the risk, the insurance company shall be obliged to pay the compensation, except Standard Exceptions, Waiting Periods and Personal Exceptions, which exist in General and Special Terms of Health Insurance.

4. Compensation procedures shall be concluded after completing required reviews within 15 days from the date of receipt of the required information and documents in full.

5. Insurer; ❑ Member of the arbitration system.

D. EXPLİCİT DECLARATİON OF CONSENT ON THE PROCESSİNG OF HEALTH DATA

In the scope of the policies and compensation payments issued by our Company, it is necessary to process personal data related to the health of the insured / rights holder in order to be able to make risk assessment and to evaluate compensation claims. Ankara Sigorta shall comply with legal obligations arising from the legislation and the insurance contract and shall obtain and evaluate personal data related to the health of the insured / right holder in order to enable him / her to exercise the rights of the insured person and to protect his / her legitimate interests and shall share the subjected data with business partners and third parties providing service to Ankara Sigorta and shall retain this data during the period of time allowed by the laws. Health information is processed to fulfill our insurance activities in accordance with the relevant provisions of the Law on the Protection of Personal Data and ANKARA Insurance's Data Protection Policy. In this regard, your party has been informed and enlightened in accordance with Article 10 of the Law on the Protection of Personal Data.

In order to fulfill the obligations undertaken by the insurance contract, your personal data may be transferred to our business partners, contracted lawyers or the service providers. Our business partners, contracted lawyers and service providers are obliged to keep this information confidential and not to use it for any other purpose in the context of its contractual obligations.

Personal health data is shared with the persons and organizations which provide expert advice on the health status of the applicant in the course of policy making. For the compensation applications, personal health data shall be provided to the provision service providers which examine and approve the healthcare services to be given in the country or abroad, to the institutions which evaluate or determine the reports including the disability and incapacity to work, to the institutions providing health assistance services and to the actuaries in order to make actuarial calculation in case of death and disability.

ANKARA Sigorta takes measures to ensure the appropriate level of security in accordance with the legislation in order to store your data in a secure manner or prevent from its illegal use in the process of processing your personal data.

I expressly accept and declare with my free will that I authorize ANKARA Sigorta to execute the following procedures since I am fully informed about how the personal data of me and my dependents will be processed by ANKARA Sigorta in the context of the abovementioned reasons: Therefore, all information and documents related to my current and past health data;

- will be obtained from public or private health service providers,
- will be stored in the ANKARA Sigorta data recording systems and will be classified and kept in these systems for the period prescribed by the legislation,

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HEALTH-FRIENDLY INSURANCE POLICY

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- will be used at each stage where the requirements of the insurance contract are to be fulfilled, for each transaction, including reinsurance and repayment,
- will be transferred to the service providers of ANKARA Sigorta in order to conduct risk acceptance and compensation evaluations,
- will be transferred to the Undersecretariat of Treasury, the Insurance Information and Monitoring Center, Financial Crimes Investigation Board (MASAK) and all other regulatory and supervisory public institutions İn accordance with the obligations arising from the legislation.

I hereby accept and declare that I acknowledge that I have the right to obtain information from ANKARA Sigorta, which is responsible from my data, regarding the processing of my personal data, to learn whether my personal data is issued appropriately for the purposes of processing, to request correction in case of incomplete / incorrect processing, to update the data, to request the data to be completely or partially deleted and to revoke the approval herein in whole or in part.

E. COMPLAİNTS AND İNFORMATİON REQUESTS:

1. The following addresses and telephone numbers can be used for any information requests and complaints regarding the insurance. The insurance company is obliged to answer the requests within 15 days of receiving the application.

2. If your policy or rejection letter is not delivered within 30 days from the date of your application, you can reach our Health Insurance Department at 0216 0216 665 85 00.

Address : Kozyatağı Mh. Sarı kanarya Sk.K:2 plaza No:14 K:8 Kadıköy/Istanbul
Tel: 0216 665 85 00 / 8559 Fax: 0212 310 46 46

I, the undersigned, declare that I have read, understood and accepted the insurance terms stated in this application and disclosure form consisting of 5 pages.

HEALTH DECLARATION

QUESTION	REPLY
1. IS THERE ANY CONGENITAL - INHERITED OR SUBSEQUENTLY ACQUIRED DISEASE OR DEFORMITY (DISFIGUREMENT, DISABILITY) IN YOUR BODY ?	NO
2. IS THERE A DRUG THAT YOU USE CONSTANTLY ? IF SO, WHAT IS THE NAME OF THE DIAGNOSIS AND WHAT ARE THE NAMES OF THE DRUGS ?	NO
3. IS THERE ANY CURRENTLY PLANNED, APPLIED TREATMENT OR SCHEDULED SURGERY ?	NO
4. HAVE YOU GONE THROUGH OR SUGGESTED ANY TREATMENT, SURGERY, TRANSPLANTATION, CHEMOTHERAPY, RADIOTHERAPY, PHYSIOTHERAPY, DIALYSIS, ESWL AND ETC FOR DISEASES SUCH AS CANCER, TUMOUR, CYST, NODULE ETC ?	NO
5. WAS THERE ANY ABNORMAL CONDITIONS DETECTED IN THE TESTS PERFOMED TO DAY IN IMAGING, ENDOSCOPY, LABORATORY, BIOPSY-PATHOLOGY ?	NO
6. AIDS, HIV	NO
7. DO YOU HAVE CARDIOVASCULAR DISEASES ? DID YOU HAVE ANY TREATMENT OR SUGGESTED SUCH AS STENT, BY-PASS OR PACE MAKER ?	NO
8. HYPERTENSION, HYPERLIPIDEMIA	NO
9. DIABETES MELLITUS (DIABETES TYPE1/TYPE2)	NO
10. HEPATITIS/JAUNDICE, CIRRHOSIS AND LIVER DISEASES	NO
11. PANCREAS DISEASES AND SPLENIC DISEASES	NO
12. KIDNEY, URINARY TRACT AND UROLOGIC DISEASES (RENAL FAILURE, SINGLE KIDNEY, KIDNEY STONE ETC.)	NO
13. NEUROLOGICAL / NERVOUS SYSTEM DISEASES (EPILEPSY, MULTIPLE SCLEROUS, PARKINSON'S DISEASE ETC.)	NO
14. PARALYSIS (STROKE), CEREBROVASCULAR DISEASES (CEREBRAL BLEEDING)	NO
15. PSYCHIATRIC DISORDERS	NO

İŞBU POLİÇE 17 / 19 'DEN İBARETTİR.

LİMON SİGORTA ARACILIK HİZMETLERİ LTD.ŞTİ.

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Vergi Dairesi : Büyük Mükellefler V.D.
Vergi No : 0690039706

Sigorta Tahkim Komisyon üyesidir.

PLEASE READ YOUR POLICY
HEALTH-FRIENDLY INSURANCE POLICY

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16. BLOOD AND BONE MARROW DISEASES, COAGULATION DISORDERS	NO
17. LUNG AND RESPIRATORY SYSTEM DISEASES	NO
18. BONES, MUSCLES, JOINTS, LYMPH NODE, CONNECTIVE TISSUE DISEASES	NO
19. RHEUMATIC DISEAES (ANKYLOSING SPONDYLITIS, SYSTEMIC LUPUS ERYTHEMATOSUS ETC.)	NO
20. NECK, BACK, SPINAL DISEASES, SPINAL CURVATURE (VERTEBRAL, INTERVERTEBRAL DISEASES)	NO
21. DIGESTIVE SYSTEM DISEASES (GASTRITIS, ULCERATIVE COLITIS, CHRON'S DISEASE ETC.)	NO
22. ANORECTAL DISEASES (HEMORRHOIDS, ANAL FISSURE, ETC.)	NO
23. GOITER / THYROID GLAND DISEASES	NO
24. PITUITARY GLAND, ADRENAL GLAND DISEASES (PROLACTINOMAS, CUSHING ETC.)	NO
25. GYNECOLOGICAL / UTERUS / OVARIAN DISEASES	NO
26. PROSTATE, VARICOCELE, HYDROCELE ETC. DISEASES	NO
27. VARICOSIS AND PERIPHERAL VENOUS VASCULAR DISEASES	NO
28. BRAIN DISORDERS / MENTAL RETARDATION	NO
29. BREAST DISEASES	NO
30. SKIN AND ALLERGIC SKIN DISEASES (PSORA/PSORIASIS, PODAGRA ETC.)	NO
31. TONSIL, SINUSES, CONCHA DISEASES AND SEPTAL DEVIATION	NO
32. EYE AND EAR DISEASES (VISION LOSS, HEARING DEFECTS, ETC.)	NO
33. GENETIC DISEASES (DOWN'S SYNDROME, KLINEFELTER'S SYNDROME, CHROMOSOMAL ABNORMALITIES ETC.)	NO
34. IS THERE A PROTHESIS / PLATINUM / SCREW IN ANY PART OF YOUR BODY ?	NO
35. ARE YOU CURRENTLY PREGNANT ? IF SO, FOR HOW MANY MONTHS ?	NO
36. DO YOU HAVE ANY DISABILITY / APOLOGY OR OBSTACLES TO PREVENT THE MILITARY SERVICE ?	NO
37. DO YOU SMOKE ? HOW MANY TIMES A DAY AND FOR HOW LONG ?	NO
38. DO YOU USE ALCOHOL ? HOW MANY GLASSES A WEEK AND FOR HOW LONG ?	NO
39. ARE YOU DEALING WITH A DANGEROUS AND PROFESSIONAL SPORT ? (DIVING, FLYING, MARTIAL ARTS, CAR AND MOTORCYCLE RACES ETC.)	NO
40. DO YOU HAVE A PREVIOUSLY APPROVED INSURANCE POLICY OR A REJECTED APPLICATION ? IF SO, WHICH INSURANCE COMPANY AND WHAT YEARS ? IS THERE ANY DISEASE WHICH REGARDED AS EXCEPTION / EXEMPTION AND APPLIED ADDITIONAL PREMIUM ? WHY ?	NO

QUESTION COMMENTS:

HEALTH DECLARATION AND UNDERTAKING

1) I have given complete and accurate answers to the questions above, I do not hide any matter within the framework of obligation to declare, I did not state any wrong or incomplete statements, I hereby accept, declare and undertake.

2) Depending on the basis of Ankara Incorporated Turkish Insurance Company's declaration to reassess any inconvenience that occur before and after the issued date of the policy, consequently to make changes in policy (exceptions/exemptions etc.), and the right of withdrawal from policy is hidden, I hereby accept, declare and undertake. Claims caused from the exempt illnesses will be excluded from the guarantee as the beginning of the application date, I hereby accept, declare and undertake.

3) Apart from the above replies and notifications, the answers given in other questions and forms issued policy will be the basis of the proposed contract, I accept the special terms of the insurance contract and Health Insurance General Terms that will be generated with this proposal, insurance and/or myself as insured and/or physicians who have information on other insured persons, health organizations, insurance company or other individuals and institutions to request, analyse any records regarding health status, I give authority to Ankara Incorporated Turkish Insurance Company, I hereby accept, declare and undertake.

4) In case of payment made to the bank account number that will be informed to me, Ankara Incorporated Turkish Insurance Company will be fully discharged.

5) I have read the special and general terms of the Health Friendly Policy of Ankara Incorporated Turkish Insurance Company, if any objections I have, I will report within 30 days from the start date of the policy otherwise I hereby agree, declare and undertake to all special and general terms of the policy.

Me the undersigned; declare that I have read, understood and accepted the insurance conditions that are specified in this application and information form of 19 pages.

İŞBU POLİÇE 18 / 19 'DEN İBARETTİR.

LİMON SİGORTA ARACILIK HİZMETLERİ LTD.ŞTİ.

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Vergi Dairesi : Büyük Mükellefler V.D.
Vergi No : 0690039706

Sigorta Tahkim Komisyon üyesidir.

PLEASE READ YOUR POLICY
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Date, Name-Surname Signature of the Insuree

Date, Company Seal and Authorized Signature
Of the Insurer or the Insurance Agent

ERDOĞAN AKYÜZ - 200924655

LİMON SİGORTA ARACILIK HİZMETLERİ
LTD.ŞTİ.