TÜRK NİPPON SİGORTA

TÜRK NİPPON SİGORTA SAĞLIĞIM SİZDE HEALTH INSURANCE POLICY

Product Code	: 908	**Inception Date**	: 30/08/2022
Policy / Renewal No	:	**Expiration Date**	: 30/08/2023
Endorsement No	:	**Time**	: 365 Days
Agency Code / Business Title	:		

POLICYHOLDER DETAILS

Insured Customer No	:	**Passport No**	: ****
Name & Surname/ Business Title	:	**Mobile**	: *** **
Phone No	:	**Policyholder's Gender**	:
Date of Birth	:		
Place Of Birth	:		
Address	:		

NAME OF COVERAGE	COVERAGE LIMIT (TRY)	PAYMENT SHARE (Percentage):
INPATIENT TREATMENT	UNLIMITED	%100
OUTPATIENT TREATMENT	5,000	%80
INPATIENT TREATMENT AT NON-CONTRACTUAL HEALTHCARE FACILITY	50,000	%80
OUTPATIENT TREATMENT AT NON-CONTRACTUAL HEALTHCARE FACILITY	5,000	%60

NET PREMIUM	:	1,794.00
EXCISE TAX	:	0.00
TOTAL POLICY PREMIUM	:	**1,794.00**

PREMIUM PAYMENT INFO

	Payment Date	Amount (TRY)
Down Payment	30/08/2022	1,794.00

(*) Contractual and Non-Contractual Healthcare Facility limits are common annual limits.
Chemotherapy/Radiotherapy/Dialysis coverage is limited with 10,000 TRY on annual basis. This is the common annual limit for expenses incurred in both Contractual and Non-Contractual Healthcare Facilities. It shall be covered under Inpatient Treatment Coverage.
Prosthesis coverage is limited with 5,000 TRY on annual basis. This is the common annual limit for expenses incurred in both Contractual and Non-Contractual Healthcare Facilities. It shall be covered under Inpatient Treatment Coverage.
Dental Treatment due to Traffic Accident coverage is limited with 1,500 TRY on annual basis. This is the common annual limit for expenses incurred in both Contractual and Non-Contractual Healthcare Facilities. It shall be covered under Outpatient Treatment Coverage.
Ambulance coverage shall be limited to 500 TRY for single use within a year. This is the common annual limit for expenses incurred in both Contractual and Non-Contractual Healthcare Facilities. It shall be covered under Inpatient Treatment Coverage.
Auxiliary Medical Materials coverage is limited with 2,000 TRY on annual basis. This is the common annual limit for expenses incurred in both Contractual and Non-Contractual Healthcare Facilities. It shall be covered under Outpatient Treatment Coverage.
These coverages shall not be valid in foreign countries. TRNC (Turkish Republic of Northern Cyprus) is considered as a foreign country.

It is extremely important for us to receive full and correct contact information from you to be able to meet your requests and needs and to provide timely and fast service throughout compensation payment process and all other relevant insurance processes. Please check your details included in your Policy and contact your customer representative or agency in case of any inconsistency.

This Policy covers the minimum coverage structure set forth in the Circular Letter No.2021/8 dated 16/06/2021 on Private Health Insurance Policies Required for Visa and Residency Permit Applications.

This Policy is arranged in accordance with the printed and attached General Conditions, Special Conditions and proposal and

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declarations of the Policyholder. The entire premium amount must be paid upon Policy issuance and in any case not later than the Policy delivery date. In case premium amount is not paid in full, liabilities of Insurer shall not commence, even if the Policy is already delivered, and if the foregoing are still not paid until the end of the business date on which the Policy is delivered, Policyholder shall go into default.

Diseases already existing before Policy Inception (all health expenses incurred for sicknesses and complaints even if already declared or undeclared even if undiagnosed yet) and all diseases included in the exclusions list in the Policy shall be excluded, even if the relevant waiting periods have already been expired. Insurer may impose exclusions or request for additional premium or cancel the Policy in case Insurer determines the existence of an undeclared disease within Policy Period.

Lung/Respiratory Tract Diseases, Intestinal Diseases, Nose, Head, Sinus, Concha Diseases, Skin and/or Lymph Node Diseases, Joint Diseases (e.g. Knee, Hip, Shoulder etc.), Ophthalmic Diseases, Benign Cysts, Bulks/Tumors, Blood Diseases, Endocrine System Diseases (e.g. Hormonal Disorders, etc.), Muscle and Bone Diseases,

Prostate and Testicular Diseases, Uterine and Ovarian Diseases, Nervous System, Brain/Cerebrovascular Diseases, High Blood Pressure, Varicosis, Anorectal Diseases (e.g. Hemorrhoid, Fistula, etc.), Kidney and Urinary Tract Diseases, Growth and Developmental Delay, Congenital and Genetic Diseases, Hernias (e.g. Inguinal, Umbilical, etc.), all types of Cancer, Malignant Cysts, Bulks/Tumors, Cardiovascular Diseases, Otorhinolaryngologic Diseases and Vestibular Balance System Disorders, Liver, Gall Bladder, Pancreas and Spleen Diseases, Diabetes, Insulin Resistance, Glucose Metabolism Disorder, Spinal Diseases (e.g. Neck, Back, Waist, etc.), Psychiatric Diseases, Rheumatic Diseases, Esophagus, Stomach and Duodenum Diseases, Thyroid and Parathyroid Gland Diseases.

Have you ever received any treatment, had surgery, hospitalized for the foregoing diseases and/or any other disease or accidental event not mentioned above and do you currently have any ongoing treatment or any pending analysis results?

The answer provided by Policyholder/Policy Owner to the above question is NO.

NB:

1- Health expenses incurred at American Group Hospitals and Outpatient Clinics, Acıbadem/International Medical Group, Florence Nightingale Medical Group, LIV Hospital, Memorial Health Group and Anadolu Medical Center shall be excluded and shall not be reimbursed by any means under this Policy.

2- Hospitalization period shall be limited with 180 days for each period during Policy Term. ICU stay shall be limited with 90 days and shall be deducted from the period hospitalization total of 180 days.

3- Expenses related with the medical services received from healthcare facilities not included in the Network preferred in the Policy (including emergencies) shall be covered up to the limit and with the participation share specified in the Policy for Non-Contractual Healthcare Facilities.

4- Health expenses from treatments given by physicians who have not accepted the agreement terms are determined by Medical Services Price List and limited to the minimum fee amount applicable on the event date and shall be covered up to the Non-Contractual Healthcare Facility coverage limit and the payment share percentage.

5- The entire list of Contractual Healthcare Facilities for this product can be found at Türk Nippon Sigorta A.Ş.'s website www.turknippon.com.tr in detail. This list is regularly updated and announced for information purposes. Please contact your Customer Services Representative or Agency for more detailed information.

6- Waiting period shall be calculated according to Türk Nippon Sigorta's initial Policy Inception Date for Policies continuing uninterruptedly before 30 days after Policy Expiration Date has expired.

7- This product does not provide Lifetime Renewal Warranty.

8- All treatments and complications related with the diseases subject to the waiting period specified in the relevant Special Condition shall be included in the coverage upon completion of the respective waiting period, after the health expenses regarding outpatient treatment (except the first medical examination) and inpatient treatment are included in the insurance coverage (excluding the red zone in Triage and Emergency cases).

9- This Policy copy is merely a web copy and Company records shall be valid in case of a discrepancy between this web copy and Company copy.

10- This Policy may be terminated when a new health policy covering the residence period is submitted to the Company, or if the

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residence permit is terminated, or a document proving coverage by General Health Insurance in accordance with Social Security and General Health Insurance Act No.5510.

11- Product Information Form, PDPA Clarification Text and Product Special Conditions are also delivered as enclosed to this Policy. Please do not forget to fill in the Health Insurance Application Form.

This Policy is arranged on 30/08/2022 at 17:17:12 in city.

SAĞLIĞIM SİZDE (FOREIGNER HEALTH INSURANCE) HEALTH INFORMATION FORM

This Text, drawn up in minimum two copies, is prepared with the purpose of providing general information to other person(s) desiring to become a party to the Insurance Policy who shall benefit from the insurance about the insurance agreement to be executed, pursuant to the Directive on Information Providing for Insurance Agreements promulgated in Turkish Official Journal on 14.02.2020.

Although signed by all parties, this Text by itself is not and shall not be a proposal or agreement by any means unless it is used as a basis for a separate proposal and/or is concluded with an Insurance Agreement executed by and between the parties.

A. INSURER INFORMATION

Insurance Agency intermediating for the agreement:

Agency Code / Business Title	
Address	:
	:
Phone No	
Tax Office	:
Tax No	:
Chart No	:

Co-Insurer providing insurance coverage
Business Title : TÜRK NİPPON SİGORTA A.Ş.
Address: Mahir İz Cad. No: 24 Altunizade -Üsküdar 34662 İstanbul
Phone No.: 0 216 554 11 00
Fax No: 0 212 310 69 19
E-mail: info@turknippon.com
Türk Nippon Customer Services: 444 8 867
Scope of Activity: Insurance Operations

B. WARNINGS

1. Insurance Contract is a private health insurance required to be purchased for short term residence permit applications pursuant to Foreigners and International Protection Act. This Insurance Contract covers the risks arising after Policy Inception Date and within the Contract validity period, in line with the coverages specified in the Policy, provisions of Turkish Commercial Code ("TCC"), Insurance General Conditions and Policy Special Conditions. Please carefully read Health Insurance General Conditions, Health Insurance Special Conditions and your Insurance Contract/Policy to be delivered to you by your Insurer in the attachment of your Policy to obtain more detailed information on your insurance.

2. Unless agreed by Insurer otherwise in writing, citizens of foreign countries residing within the boundaries of Turkish Republic shall be accepted to be covered by this insurance during Policy validity period. Individuals who have applied for a residence permit are considered to be a Turkish resident. Turkish citizens cannot be insured with this insurance product.

3. Health Insurance Application Forms shall be evaluated according to Policy Special Conditions, Health Insurance General Conditions and risk assessment rules of our Company.
The Company reserves the right to alter the premium amounts specified in the initial proposal, exclude and/or request additional premium amounts for certain diseases or reject the application. In case a payment is made at the application stage, it shall be

considered as a prepayment for the Policy premium amount if the Company accepts the application and issues the Policy; otherwise it shall be reimbursed to the applicant.

4. Cell phone number or e-mail address of both Policy Owner and at least one Policyholder specified in the Policy should be provided to the Company in addition to the postal address information to enable the Company to fulfill its liability to provide the required Information to Policy Owner/policyholder(s).

5. The entire premium amount, or the first installment amount for installment payments, must be paid immediately upon delivery of the insurance policy.
In case the entire premium amount or downpayment amount is not paid in full, liabilities of Insurer shall not commence, even if the Policy is already delivered. For Policy premiums not paid on their due dates (either the first installment or the entire premium in case installment payment is not provided for), Insurer shall be entitled to use the right of withdrawal from the Agreement if the payment is still not made within three months.
This period shall begin as of the due date (Policy Inception). In case any of the subsequent installment amounts is not paid on the relevant due date, Insurer shall send a notification to the Insurant stating that 10 (ten) days' time is allowed for the obligation to be paid or otherwise the Agreement shall be terminated. In case the payment is still not made at the end of this time, Insurance Contract shall be terminated. Insurer's other rights provided by Turkish Code of Obligations due to Policy Owner's default shall be reserved. Insurer shall be entitled to terminate the Insurance Contract to be enforceable at the end of the Insurance Period if Policy Owner has been served two warnings within the same period. For premium payments to be made in installments, all premium amounts regarding the compensation or insurance amount shall become due and payable in case of risk realization.

6. Please do not forget to get a payment receipt in return for your premium payments (for advance payments or installments) to prevent any potential future disputes which may arise.

7. In addition to the requirements stated below, Policy Owner should also arrange and send to Insurer a termination request letter, bearing Policyholder's signature and current date to initiate the cancellation procedure. Upon such cancellation request, the unearned portion of the premiums paid shall be returned in accordance with Article 13 "Principles for Termination of Insurance Contract" of Policy Special Conditions.
   - Submission of a new private health insurance policy covering the residence permit period to the Insurer,
   - Cancellation of residence permit,
   - Submission of a document confirming General Health Insurance coverage in accordance with the Social Security and General Health Insurance Act No.5510,
   - Provision of required documents showing the date of departure in case Policyholder leaves the country,
   - Provision of required documents in case of death.

8. In case existence of malicious acts are determined, such as allowing persons not included in Insurance Coverage benefit from the said Coverage or Policyholders included in family coverage having health expense documents arranged in the name of third parties, Insurer shall have the right to claim and receive back the health expense payments made under the said Coverage and cancel the respective Policy without making any premium reimbursements.

9. Policy can be renewed in case Policy Owner and Insurer come to a mutual agreement in this regard before the Policy Expiry Date, subject to the provisions set forth in "Policy Renewal" section. In case Insurer prefers automatic renewal, Policies shall be issued on the due date at the latest and unless Policy Owner notifies as otherwise before the due date, payment terms of previous Policy period shall also be applicable to such renewal.

10. During the phase before contract establishment, Policy Owner/Policyholder should provide correct answers to all questions asked by Insurer, represent all issues known or expected to be known, refrain from providing incomplete or incorrect information; during Contract period, Insurer should be promptly informed about any relevant changes, particularly in case of risk realization. Otherwise, Insurer shall reserve the right to reject the application or withdraw from the agreement in case contract is already established, or to terminate the contract, or to continue the contract by imposing additional premium for the respective disease or

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to increase the premium amount or to exclude the respective disease from the coverage. Compensation payment period may be prolonged and/or Policyholder may encounter with short- or non- payment in case liability of providing information is not fulfilled. Please see "Failure in Fulfillment of Liability to Provide Information" section in Special Conditions for more detail.

11. Türk Nippon Sigorta is authorized to obtain and share information and/or documents from/with Turkish Undersecretariat of Treasury, Insurance Information & Monitoring Center (SBGM), Insurance Association of Turkey, all healthcare facilities and institutions, physicians, other insurance companies and Public Entities and Institutions in accordance with the legislation regarding Personal Data Protection Act, including but not limited to insurance legislation, regulations on insurance and underwriting and health legislation.

    By signing the relevant documents, policyholders or candidate policyholders are considered to have given their consent that their medical information, coverage records and other data can be obtained from Insurance Information and Monitoring Center (SBGM), State Social Security Institution (SGK), Ministry of Health, healthcare institutions and other insurers with the purpose of performing risk assessments and finalizing damage claims; and information in Company's possession can also be shared with SBGM, other insurers and other institutions and authorities as specified in the relevant legislation.

12. In case of Policy renewal, Insurer may apply additional premium for the renewed Policy by considering the Compensation Paid/Net Premiums Received ratio of the expired Policy.

13. Türk Nippon Sigorta reserves the right to change its Contractual Healthcare Facilities. Current list of Contractual Healthcare Facilities for our insurance products can be found at www.turknippon.com for your information.

14. Approval must be obtained from the Authorization Center minimum 48 hours in advance for Inpatient Treatment to be performed at a Contractual Healthcare Facility.

C. GENERAL INFORMATION

1. Sağlığım Sizde Health Insurance Policy is a private health insurance to be purchased for short term residence applications by citizens of foreign countries in accordance with the Foreigners and International Protection Act, under which the Policyholder's expenses shall be covered subject to Policy Special Conditions. This Policy shall be valid at healthcare facilities included in the Company's Contractual Facilities List, in addition to other non-contractual facilities as well. Contractual and Non-Contractual Facility limits are specified in the Policy.

2. Unless agreed by Insurer otherwise in writing, citizens of foreign countries residing within the boundaries of Turkish Republic shall be accepted to be covered by this insurance during Policy validity period. Individuals who have applied for a residence permit are considered to be a Turkish resident. Turkish citizens cannot be insured with this insurance product.

3. This insurance provides the coverages included in the Health Insurance Package content requested and approved by Policy Owner/Policyholder. Infants who have completed 15 days after birth and persons who have not turned 65 can be included in the Policy Coverage.

4. Policyholder's age is calculated by subtracting the birth date of Policyholder from Policy Inception Date. Unless stated as otherwise, only the elementary family members can be included within the scope of a single Policy. Elementary family consists of the mother, father and their unmarried children (under 25 years of age), including adopted ones.

5. Premium amounts are determined according to criteria such as age, gender, residence address of Policyholders, product scope and changes in Medical Services Price List, etc. Insurer shall update the "Medical Services Price List Premium" periodically, also by taking the performances of each risk profile and the overall performance of the portfolio, inflation rate

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in medical services, and other general economic changes in the country in consideration. Increase in "Medical Services Price List Premium" shall be limited to maximum three times the previous period's medical services price list premium within the same category, provided that this increase shall not be less than the inflation rate realized in the relevant medical services. Insurer shall reserve the right to make reasonable changes in discount rates and/or additional premium rates and relevant criteria during policy renewal periods.

6. For Uninterrupted Personal Renewal policies, additional premium is introduced in accordance with the following requirements. It is calculated by taking the "Compensation/Health Net Premium" ("C/P") ratio into account within the current Policy Period of the respective Policyholder.
   After Policy renewal, in case the outstanding compensation payments belonging to the previous Policy period increases the renewed Policy's premium amount by changing the Policyholder's C/P ratio, then Insurer shall request the premium difference with an endorsement or shall be entitled to deduct the premium difference amount from the payable compensation amount.

7. For exclusions please refer to the conditions specified in Health Insurance General and Special Conditions. Conditions included in the exclusion list shall be definitely excluded from Policy scope, even if they have already been declared. Insurer may modify the list of Exclusions as required.

8. All treatments and complications related with the diseases listed below shall be included in the coverage upon completion of the respective waiting periods, after the health expenses regarding outpatient treatment (except the first medical examination) and inpatient treatment are included in the insurance coverage (excluding the red zone in Triage and Emergency cases).

   Waiting periods for this product: 9 months for Inpatient Treatment, 6 months for Outpatient Treatment coverages. Waiting period shall be calculated according to Türk Nippon Sigorta's initial Policy Inception Date for Policies continuing uninterruptedly before 30 days after Policy Expiration Date has expired.

   Diseases already existing before Policy Inception (all health expenses incurred for sicknesses and complaints even if already declared or undeclared even if undiagnosed yet) and all diseases included in the exclusions list in the Policy shall be excluded, even if the relevant waiting periods have already been expired.

   - All types of hernia (umbilical, inguinal, gastrocele, spinal, lumbar, cervical, etc.),
   - Anorectal diseases (hemorrhoid, fissure, fistula, sphincterotomy, pilonidal sinus, perianal abcess and bartholin abcess/cyst),
   - Uterus, cervix, ovary and tuba diseases (ovarian cysts, myoma, endometriosis, etc.),
   - Otitis media, tympanic membrane surgery and tympanic tube placement, auditory surgery (tympanoplasty, stapedectomy),
   - Cataract, glaucoma and retinal diseases,
   - Joint and connective tissue diseases (carthilage, synovia, connective tissue lesions, coxarthrosis, shoulder, elbow, ankle, knee, meniscus, hip, etc.),
   - All kinds of rheumatic and autoimmune diseases (multiple sclerosis, SLE-Lupus, etc.),
   - Sarcoidosis, diagnosis and treatment expenses,
   - Breast diseases,
   - Tonsillar and adenoid diseases, nasal polyps, sinusitis, paranasal sinus diseases,
   - Thyroid gland, parathyroid gland diseases and goitre,
   - Spine and spinal disc diseases (spinal and intervertebral disc diseases),
   - Gall bladder and biliary tract diseases, gallstones,
   - Pancreatic and splenic diseases, except those emerging as a consequence of an accident,
   - Urinary system diseases (kidney, ureter, urinary bladder, urethra, urinary tract diseases; medical expenses regarding dialysis and ESWL treatment),
   - Liver diseases (cirrhosis, cyst hydatid, etc.),
   - Stress incontinence, cystorectocele, prolapsus uteri and all medical expenses incurred for deformation of female reproductive organs,

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- Prostate gland diseases (including TUR),
- Trigger finger, entrapment neuropathy, carpal tunnel syndrome,
- All kinds of chronic diseases, (high blood pressure, chronic obstructive pulmonary disease-COPD, diabetes mellitus, etc.),
- Cardiovascular system diseases (coronary by-pass, angiography, angioplasty, aneurysm, cardiac valve and cardiac pace maker,
- All kinds of varicosis, venous stasis,
- Stomach and esophagus diseases (gastritis, peptic ulcers and esophageal reflux, etc.), small & large intestine diseases, gastrointestinal bleedings, disorders connected with diverticulitis,
- Organ failures, organ transplant diagnosis and treatment expenses,
- All endoscopic and interventional-invasive diagnostic processes (ERCP, laparoscopic, arthroscopic etc. processes),
- All kinds of bulks, lesions /tumor, lipoma, wart, verrucous, nevus, polyp, nodule, etc.), cysts (hygroma, ganglia, cutaneous, subcutaneous, kidney, vaginal, etc.),
- Treatment of all kinds of cancer (chemotherapy, radiotherapy, immunotherapy etc.) and other related expenses,
- Neurological diseases,
- Uvula elongation.

Red Zone: Life threatening conditions requiring rapid and aggressive approach and urgent simultaneous assessment and treatment. In such conditions, patient shall be immediately transferred to Red Zone. Additionally, conditions with a high potential of life threatening nature and requiring assessment and treatment within maximum 10 minutes.

Emergency:

Conditions defined as "Emergency" by World Health Organization (WHO) are provided below:

- Drowning,
- Rape,
- Falling from height,
- Serious occupational accidents, torn limbs,
- Electric Shock,
- Freezing, cold stroke,
- Heat stroke,
- Serious burns,
- Serious eye injuries,
- Poisoning,
- Anaphylactic shock,
- Spinal and lower-upper extremity fractures,
- Heart attack, hypertension attack (emerging after Policy Inception date),
- Acute respiratory problems,
- All kinds of organic defects causing blackout,
- Sudden strokes,
- Serious general medical condition disorders,
- High fever (39.5°C and above),
- Diabetic and uremic coma,
- Kidney failure accompanied by general medical condition disorder,
- Acute abdomen,
- Acute massive bleedings,
- Meningitis,
- Renal colic.

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9. No right can be transferred in case Policyholder switches from this product to another health insurance product or vice versa.

10. Commitments made to Policyholder by Insurer shall terminate in case Policy is canceled or Policyholder is removed from Policy. In addition to the requirements stated below, Policy Owner should also arrange and send to Insurer a termination request letter, bearing Policyholder's signature and current date to initiate the cancellation procedure.

    - Submission of a new private health insurance policy covering the residence permit period to the Insurer,
    - Cancellation of residence permit,
    - Submission of a document confirming General Health Insurance coverage in accordance with the Social Security and General Health Insurance Act No.5510,
    - Provision of required documents showing the date of departure in case Policyholder leaves the country,
    - Death.

    Cancellation requests shall be processed in case the above listed requirements are met.

11. Policy period shall be 1 year unless agreed as otherwise by contractual parties. This product does not provide Lifetime Renewal Warranty. Insurance Contract starts at 12:00 PM on the beginning date and ends at 12:00 PM on the end date, both times being with Turkish local time and the dates being indicated on the Insurance Policy. Unless agreed as otherwise between parties, the Policy can be renewed for another year in case parties come to a mutual agreement and the requirements stipulated in Special Conditions are met, provided that Insurer shall reserve the right to make a risk assessment for such renewal and decide whether to renew the Policy at their own discretion. Renewal must be made on the Policy Expiry date of the previous Policy at the latest. Otherwise, Insurer shall reserve the right to not cover any risk emerging within the period until the new Policy is issued.

12. Daily incapacity wage amounts which the Policyholder is not able to earn due to sickness, care costs & expenses in case the Policyholder becomes in need of care or daily care costs are not covered by this Policy.

13. In addition to the Insurance General Provisions, Parties shall have the right to stipulate special provisions, provided that these shall not be immoral or illegal or against Policyholder.

D. COVERAGE

1. This Policy covers the risks specified herein in accordance with the network list, coverage specifications, limits, payment percentages and exclusions (if any) indicated in the Policy and with Health Insurance General and Special Conditions and relevant Regulations. This Policy covers the minimum coverage structure set forth in the Circular Letter No.2021/8 dated 16/06/2021 on Private Health Insurance Policies Required for Visa and Residency Permit Applications. Coverage types included in the Policy are separately applicable to the persons indicated as Policyholders on the Policy only; persons not included as Policyholders cannot benefit from the insurance coverage.

2. Health insurance coverage is for compensation of diseases and disorders of Policyholder emerging after Policy Inception date (i.e. already existing diseases and disorders shall be excluded, regardless of whether declared or not).

3. This Policy provides coverage for Inpatient and Outpatient Treatment. Details regarding the coverages can be found in the Proposal/Policy and Policy Special Conditions. Please beware that the Network and coverage types you prefer during contract execution phase should be capable of covering your potential risks.

4. All Contractual Healthcare Facilities included in Networks are listed in detail on our corporate website located at **http://www.turknippon.com**; this list is regularly updated and provided for information purposes. Apart from this list, you can also contact your Customer Representative, Agency or Türk Nippon Customer Services to obtain detailed information.

   We strongly recommend that before going to the hospital, you check whether the healthcare facility you have chosen from the Contractual Healthcare Facility Network List announced at http://www.turknippon.com/ is valid for your Policy or not.

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Insurer reserved the right to change the healthcare facilities included in Healthcare Facility Networks. Applications specific to a Contractual Healthcare Facility included in Insurer's Networks shall automatically cease in case the contract between such Healthcare Facility and the Insurer is terminated.

E. RISK REALIZATION

1. Please pay attention to limits, participation share percentages, specific exclusions and special conditions (if any) of coverages during contract establishment (i.e. execution) stage. Insurance coverage limit is the maximum coverage limit amount indicated in the Policy which Insurer warrants to pay in case of risk realization.

2. In cases where a compensation amount is payable, Insurer shall pay (or reimburse) the expenses incurred by Policyholder up to the limits and subject to the participation share percentages, specific exclusions and special conditions indicated in the Policy where an insured risk is realized. Original copies of expense documents must be submitted to Insurer for compensation assessment.

3. The Company has two healthcare facility categories: Contractual and Non-Contractual. Coverage limits according to the type of healthcare facility are specified in the Policy. Limits specified for Inpatient and Outpatient Treatment expenses shall be deducted from Inpatient and Outpatient Treatment Coverage limits specified in the Policy. Contractual and Non-Contractual Healthcare Facility limits indicated in the Policy are single common limit. Remaining limit amount shall be calculated by deduction of the sum of compensation amounts paid by Insurer and participation share amounts paid by Policyholder from the gross limit amount specified in the Policy.

4. Policyholder must obtain authorization at the relevant facility before obtaining any service from a Contractual Healthcare Facility. Insurer shall make direct payment to the Contractual Healthcare Facility for medical services provided in line with the relevant Network specifications, specified limits and payment percentages.

5. Health expenses for treatments provided by Non-Contractual Physicians and/or Physicians included in permanent/contractual staff list of the respective Contractual Healthcare Facility who have not accepted Türk Nippon Agreement is determined according to the Medical Services Price List and shall be limited to the minimum fee amount applicable on the event date and shall be covered according to the Non-Contractual Healthcare Facility limit and payment percentage indicated in the Policy.

6. Expenses related with the medical services received from healthcare facilities not included in the Network which is preferred in the Policy (including emergencies) shall be covered up to the limit and with the participation share specified in the Policy for Non-Contractual Healthcare Facilities.
   Health expenses from treatments given by physicians of this healthcare facility are determined by Medical Services Price List and limited to the minimum fee amount applicable on the event date and shall be covered up to the Non-Contractual Healthcare Facility coverage limit and the payment share percentage.

7. Health expenses incurred in foreign countries shall be excluded. TRNC (Turkish Republic of Northern Cyprus) is considered as a foreign country.

8. In cases where parties cannot agree on the treatment expense amount, each party shall appoint their arbitrator/expert assessor in accordance with the provisions stipulated in the Policy. This fact is notified to the other party via notary public. Parties shall appoint a third arbitrator before examination process is initiated.

F. COMPENSATION PAYMENT

The amount committed to be paid by the Insurer in case of risk realization shall be limited with the Contractual Healthcare Facilities, coverage types and amounts, limits and payment percentages specified in the Policy and the relevant claim shall be evaluated in line with the Turkish Commercial Code, Policy Special Conditions and Health Insurance General Conditions. Policyholder shall be responsible for covering the participation share amounts and expenses exceeding the coverage limit.

Medical expenses incurred at the hospitals/healthcare facilities included in the Network preferred in the Policy shall be directly paid to the respective Contractual Healthcare Facility in line with the relevant contract.

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Anadolu Kurumlar V.D. 8760048993 Ticaret Sicil No: 275255 Mersis No: 0876004899300015

TÜRK NİPPON SİGORTA

TÜRK NİPPON SİGORTA SAĞLIĞIM SİZDE HEALTH INSURANCE POLICY

Product Code	: 908	**Inception Date**	: 30/08/2022
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In case it is specified that the Policy is also valid at non-contractual healthcare facilities, all documents related with the treatment such as medical reports, analysis reports etc. must be submitted to Insurer in the attachment of the respective invoices for medical expenses incurred at hospitals and healthcare facilities not included in the preferred Network to be assessed. Information and documents required for compensation payment applications are specified under "Documentation of Medical Expenses" article of Policy Special Conditions.

Insurer shall make the necessary reviews and complete compensation procedures within the maximum time period allowed in insurance legislation, Turkish Commercial Code and the relevant Policy Special Conditions and General Conditions after the required information and documents are submitted to the Insurer in complete form.

G. COMPLAINTS AND INFORMATION REQUESTS

1. Türk Nippon Sigorta A.Ş. is a member of Arbitration System.
2. The address and phone numbers of Insurer stated above may be used for all information requests and complaints regarding the insurance. Insurer has to reply all requests within 15 days upon receipt of application.

Address : Mahir İz Cad. No: 24 Altunizade -Üsküdar 34662 İstanbul
Fax No: 0 212 310 69 19
E-mail: info@turknippon.com
Türk Nippon Customer Services: 444 8 867

H. NOTIFICATION

Contact information of Policy Owner/Policyholder (i.e. postal address, e-mail address, cell phone no.) provided in the Policy shall be considered as full and correct. In case the contact information of Policy Owner/Policyholder specified in the Policy is not fully complete or correct, or Policy Owner/Policyholder has not requested completion or correction of the missing or incorrect contact information, or has not sent a written notification to correct the aforementioned information, then the notifications to be sent to the contact address and/or cell phone number last notified to Insurer shall be considered as legally valid, which notification shall have legally valid and binding consequences.

Policy Owner's Title:

Date : 30/08/2022
Name & Surname
E-Mail
Phone
Stamp & Authorized Signature:

Intermediary:
Date
Name & Surname
E-Mail

Stamp & Authorized Signature:

Information contained herein is applicable as of the date when this Form is signed by both parties. This Information Form may need to be updated due to potential changes in respective conditions in case an Insurance Contract is not executed within 15 days after the aforementioned date.

CLARIFICATION ON PROCESSING OF PERSONAL DATA

Türk Nippon Sigorta A.Ş.
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Türk Nippon Sigorta A.Ş. ("Türk Nippon") cares about ensuring security of all your personal data (your personal data and specific data). All your personal data is processed, preserved and protected in accordance with the main principles and data processing rules and requirements set forth in the Personal Data Protection Act No.6698 ("PDPA"). In this regard, Türk Nippon family takes all required measures and shows utmost care to protect such data and we would like to explain how your personal data shall be processed.

a) Data Controller: Türk Nippon processes your personal data with the capacity of "Data Controller" as defined in Article 3 of Personal Data Protection Act No.6698.

b) The purpose for which Such Personal Data is Processed: Your personal data and your personal health data may be processed by Türk Nippon, acting with the capacity of "Data Controller" in accordance with the PDPA and within the framework of your insurance proposals and insurance contracts, as described below and with the purposes of fulfillment of policy and contract requirements, risk assessment, determination of insurance premium amounts, collection, finalize compensation applications, offering insurance product and services, advantages and campaigns, communication including information, promotion, marketing and sales and sending of commercial e-mails with such purposes, fulfillment of liabilities prescribed in the legislation, identification of the person(s) performing or ordering performance of transactions, entry of records and arrangement of documents in printed or electronic format, fulfillment of record/document keeping, reporting and information liabilities as instructed in the legislation, as well as for statistical purposes. Additionally, our Company is also entitled to process your personal data with other purposes stipulated in Articles 5 & 6 of PDPA, limited only with the specified data processing conditions and requirements.

c) How Specific Data Shall Be Processed: Türk Nippon, acting with the capacity of "Data Controller", shall be entitled to process your specific data (your health information, genetic data etc.) in relation with respective proposals and/or insurance contracts in connection with all types of health insurance agreements, with the purposes of Policy and Contract execution and performance, for being the share requesting party and the sharing party for transfer phases of health insurances, for making risk assessments, determination of insurance premium amounts, making respective collections, finalization of compensation claims, fulfillment of relevant legal liabilities, identification of the person(s) performing or ordering performance of transactions, entry of records and arrangement of documents in printed or electronic format, fulfillment of record/document keeping, reporting and information liabilities as instructed in the legislation and for statistical purposes.

d) Parties where Such Processed Personal Data Can Be Transferred and for what Reason: Your personal data, and your personal health data in case you provide your explicit consent, can be transferred to supervisory and regulatory authorities and relevant public institutions, occupational organizations and similar institutes; to legally permitted natural and legal persons, to the receiving insurers for health insurance policy transfer processes, affiliates or subsidiaries located within the country or in foreign countries, reinsurers, insurance and private pension companies and intermediaries, parties of insurance policies and contracts, service providers used for obtaining support and for performance of activities to fulfill the objectives specified in the legislation, to the extent permitted by law.

e) Method(s) of and Legal Grounds for Collecting Personal Data: Your personal data and your personal health data included in your health insurance contract details in addition to other information and documents related thereto can be collected from Insurance Information & Monitoring Center (SBGM), Social Security Institution (SSI), Ministry of Health, public or private healthcare institutions and facilities, your current Insurers and/or other Insurers, physicians and/or all public and private organizations and third parties as specified in the relevant legislation, national and international affiliates, program partner institutes and organizations and public entities, domestic and foreign banks, either verbally or in writing or in electronic format; by partially or entirely automatic means or by non-automatic means as part of a data recording system; and can be processed, updated and periodically checked.

f) Data Owner's Rights: We hereby would like to inform you that, upon application to our Company you shall have the following rights on your own personal data as the Data Owner:

· Learn whether your personal data is processed or not,

· If yes, request information regarding such processing,

· Request information as to the purpose of processing and whether such processed data is being used for its intended purposes,

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- Learn the third parties located within the country or in foreign countries where such personal data is transferred,
- Request correction in case your personal data has been incorrectly or incompletely processed,
- Request deletion or destruction of your personal data in line with the provisions set forth in Article 7 of PDPA,
- Request notification of such correction or deletion or destruction of your personal data to the third parties located within the country or in foreign countries where such personal data has been transferred,
- Object to a consequence emerging in your disadvantage due to analysis of such processed personal data exclusively through automates systems,
- Request compensation for damages in cases where you incur loss and damage due to illegal processing of your personal data.

You may notify Türk Nippon on your requests regarding your above mentioned rights and also about other issues related with PDPA applications, either in writing or by other means to be determined by Personal Data Protection Board. Türk Nippon shall finalize your requests made in this regard, free of charge and as soon as possible but within maximum 30 days, depending on the nature of your request. However, in case your request is accompanied by a cost to be fulfilled, some fee amount to be determined by the Board to cover such cost may be requested.

Please visit our corporate website at the following address to access our Personal Data Policy and the application form to be filled to use your personal rights: **www.turknippon.com.tr**

SAĞLIĞIM SİZDE (FOREIGNER HEALTH INSURANCE) SPECIAL CONDITIONS

1- SUBJECT AND SCOPE OF INSURANCE

This Insurance Contract is for private health insurance required to be purchased for short term residence permit applications pursuant to Foreigners and International Protection Act, where Türk Nippon Sigorta A.Ş. as the Insurer shall insure the Policyholders' health expenses incurred due to accidents and/or sicknesses which may occur during the validity period of this Insurance Contract and the relevant Policy, subject to the "Network" and the plan(s), coverage types, limits, payment portions, exceptions indicated on the Policy and in accordance with the provisions of Policy Special Conditions and the enclosed General Conditions.

This Insurance Contract shall be valid between Inception and Expiration Dates specified on the Policy. The Insurance Coverage starts at 12:00 PM on Inception date and ends at 12:00 PM on Expiration date, both times being in Turkish local time, unless otherwise is specified herein.

2- DEFINITIONS

Policy:

Health Insurance Contract arranged and provided by Türk Nippon Sigorta A.Ş. It is the official document for Sağlığım Sizde Private Health Insurance.

Policy Owner:

Natural or legal person entering into and executing the Contract with the Insurer, assuming the liabilities arising out of the existing

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Insurance Contract, including payment liability of the Policy premiums.

Insurance Firm / Insurer:

The entity undertaking payment of Compensation to the Policyholder or the specified beneficiary in case of realization of the covered risk(s) in return for the premium amounts paid by the Policyholder by means of being commercially registered and obtaining/holding a business license in accordance with the laws of the country/jurisdiction where the Insurance Contract is established. Türk Nippon A.Ş. is the Insurer for this Insurance Policy you have purchased.

Policyholder:

Natural person(s) health expenses of whom are covered by the Insurance Contract and who has/have the right to claim for damages in case of risk realization.

Healthcare Facility:
Private healthcare facilities or public institutions licensed by the Ministry of Health to render inpatient and/or outpatient medical and diagnostic services, such as hospitals, laboratories, diagnostic centers, outpatient clinics and private medical practices.

1) **Contractual Healthcare Facility:**
Healthcare facilities with which the Insurer has an executed contract for Sağlığım Sizde Private Health Insurance and the physicians working on payroll at such facilities by accepting the Türk Nippon Sigorta A.Ş. contractual terms and conditions.

2) **Contractual Healthcare Facility Network ("Network"):**
Network is the group of Contractual Healthcare Facilities specified in the Policy based on the preference of Policyholder. The Network specific to the insurance product in question can be found in the Company's official website at http://www.turknippon.com.

3) **Non-Contractual Healthcare Facility:**
Healthcare Facilities not having a service agreement with Türk Nippon Sigorta A.Ş. and therefore not included in the Network preferred by the Policyholder as specified in the Policy, but having a service agreement with State Social Security Institute (SSI).

Physicians officially working for a healthcare facility included in the preferred Network specified in the Proposal/Policy but not agreeing with the terms and conditions of Türk Nippon Sigorta A.Ş.'s service agreement.

Waiting Period:

Period which should elapse as of the Insurance inception date for Policyholder to be accepted and evaluated under the Insurance coverage scope.

Existing Disease/Disorder:

Disease or disorder existing before Policy Inception Date. Any disease or disorder, initial symptoms/indications or diagnosis/treatment and onset and progress of which goes back in the past to a time period which took place before the Policy Inception Date and all relevant complications developed in connection therewith.

Disease

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Any deterioration in Policyholder's psychological or physical/bodily functions, organs or systems as detected by a physician, requiring medical analysis, treatment or intervention.

Disorder
Any emerging psychological or physical symptom requiring the individual to consult to a physician to be checked.

Plan/Coverage Table
Information contained in the Policy, showing the coverage types, coverage limits, Insurer's payment percentages for such coverages and Policyholder's participation share percentages in the compensation amount payable.

Policy Owner/Policyholder Contact Information:
Home and/or business postal addresses, home, office and/or mobile phones and e-mail addresses of individuals shown as Policyholders in the Policy.

Special Conditions:
Document containing product specific conditions and rules, drawn up as an integral part of the Policy.

Health Insurance General Conditions ("General Conditions"):
Written rules defined by Turkish Ministry of Treasury and Finance and used in health insurance contracts by all insurance companies.

Türk Nippon Sigorta A.Ş. Customer Services:
Phone number 444 8 867 through which the Policyholders can process their authorization procedures, appointments for ambulance and assistance services specified in their Policy and ask questions and express their requests, suggestions and complaints.

Personal Policy:
Type of health insurance where a single individual or members of an elementary family (comprising of the mother, father and their unmarried children) can be covered.

Group Policy:
Type of health insurance where the Policy Owner is a legal person and employees of such Policy Owner and elementary family members of such employees (i.e. employee, their spouse, unmarried children including adopted ones) can be included.

Occupational Disease:
Temporary or permanent physical or psychological sickness or disorder arising from a recurring reason due to the nature of Policyholder's job and/or emerging during performance of such job.

Occupational Accident:
Traumatic diseases occurring at the Policyholder's workplace due to a task performed therein or occurring during transportation of Policyholder to/from workplace in a vehicle provided by their employer

Hazard Class:
In Occupational Health & Safety context, the hazard class assigned to the workplace based on the nature of activities and tasks performed, materials used or emerged during any stage of such activities or tasks, work equipment, production methods and means and other aspects regarding work environment and working conditions.

Exclusion:
Exclusion of risks (i.e. diseases, sicknesses, disorders) existing before Policy Inception Date or emerging within Insurance Period from Policy scope, based on Insurer's assessments.

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Medical Service Price List:
Tariff including the units and the implementation principles used for determination of medical service prices for agreements to be executed between Insurer and facilities and institutions providing healthcare services (e.g. Minimum Wage Tariff of Turkish Medical Association (MWT), Medical Practices Database Fee List (MPD), Healthcare Practices Communiqué (HPC), etc.).

Compensation:
Portion of health expenses approved and/or paid by Insurer in line with the relevant health insurance Policy, Policy Special Conditions and General Conditions.

1) Authorization:

Result of the evaluation made by Insurer, indicating whether the physical examination, diagnosis and treatment expenses planned to be performed at healthcare facilities specified as applicable in the Proposal/Policy shall be covered or not. A valid Policy must exist at the date of authorization request to be able to obtain authorization.

Authorization is a preliminary approval. Insurer can make an assessment at the final accrual stage and may decide as otherwise in case Insurer determines a new fact/condition (including without being limited to reject payment of compensation or request additional information or change the approved amount, etc.).

2) Accrual:

Last stage of the evaluation to be made by Insurer for an incoming compensation claim to decide whether it shall be paid and if so, the what the payment amount shall be, in line with the Policy coverage types and limits and Policy Special Conditions and General Conditions, regardless of whether an authorization was already obtained previously for such expenses.

3) Direct Payment to Contractual Healthcare Facility:

Policyholder obtaining medical services from a healthcare facility included in the Network specified in the Policy by only obtaining authorization/e-authorization from Insurer or by paying only the participation share amount (if any) for health expenses incurred at such facility. The portion of the total expense amount for which the Insurer is liable shall be paid by Insurer directly to the respective healthcare facility in accordance with Policy Special Conditions and General Conditions.

4) Direct Payment to Policyholder:

Policyholder obtaining medical services without obtaining any authorization/e-authorization from Insurer and by directly paying the expense amount to the respective a healthcare facility and reimbursement of such medical expense amount by Insurer to Policyholder's bank account after an assessment made in accordance with the relevant Policy Special Conditions and General Conditions upon receipt of the relevant invoices sent by the Policyholder, as well as any other required documents specified in "Compensation Payment" article of Policy Special Conditions.

Coverage:
Protection committed to be provided by Insurer to Policyholder in case of risk realization.

Limit:
Maximum gross annual compensation amount which may be paid for each coverage included in the Policy. Gross limit is the sum of compensation amount payable by Insurer and the participation amounts to be paid by Policyholder.

Payment Share (Percentage):
Amount of compensation specified per coverage in percentage in the Policy which the Insurer is liable to pay.

Participation Share (Percentage):
Amount in excess of the Insurer's payment share specified in the Policy and to be assumed and paid by Policyholder.

Premium:

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Total Policy premium is the total amount to be paid for the Insurance Policy for which the Policy Owner is liable to pay.

1) **Health Tariff Premium:**

Base health premium determined in consideration of the Policyholder's coverages, participation share, preferred Network, and risk profile criteria such as city of residence, age and gender.

2) **Health Premium:**

Premium amount calculated by adding any additional sickness premium amount (if any) to Health Tariff Premium amount for each Policyholder.

3) **Health Net Premium/Policy Total Premium:**

Total Policy premium amount determined by application of any discount amounts deserved in accordance with the Policy Special Conditions, periodical campaign discounts and applicable tax amounts (if any).

Additional Sickness Premium:
Inclusion of diseases, sicknesses, disorders existing before Policy Inception Date or emerging within Insurance Period within Policy scope, after application of an additional premium amount at a certain rate to be determined according to the assessments of Insurer.

Endorsement:
Insurance contract issued as an integral part of the master Policy and containing the changes made after Policy Effective Date.

Insurance Inception Date
Date when the Policyholder is first included in uninterruptedly continuing Sağlığım Sizde personal health policies provided by the Insurer.

Initial Insurance Start Date:
Date when Policyholder has first entered in uninterruptedly continuing health insurance policies provided by other insurers. Therefore the Inception Date specified on the Policy of a Policyholder who is accepted as a transfer can be a date before the actual Insurance Inception Date of that Policy.

Triage:
The priority assessment process to be made by physicians or healthcare professionals specifically trained on this area for patients applying to emergency units of healthcare facilities, by taking their complaints, severity of shown symptoms and emergency of their health condition into consideration. Triage is made at the application stage. Red, yellow and green colors are used (in the given order) to indicate severity/priority of the medical condition for physical examination, treatment, medical and surgical interventions and operations.

Green Zone: Used for simple health conditions for patients applying to the healthcare facility as an outpatient in a generally stable health condition.

Yellow Zone: Health conditions with a life threatening potential, risk of limb/organ loss with significant morbidity rates and those with symptoms ongoing for mid-term to prolonged periods with a certain potential for being a severe case are categorized in this area.

Red Zone: Life threatening conditions requiring rapid and aggressive approach and urgent simultaneous assessment and treatment. In such conditions, patient shall be immediately transferred to Red Zone. Additionally, conditions with a high potential of life threatening nature and requiring assessment and treatment within maximum 10 minutes.

Emergency:
Conditions defined as "Emergency" by World Health Organization (WHO) are provided below:

- Drowning,
- Rape,
- Falling from height,
- Serious occupational accidents, torn limbs,

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- Electric Shock,
- Freezing, cold stroke,
- Heat stroke,
- Serious burns,
- Serious eye injuries,
- Poisoning,
- Anaphylactic shock,
- Spinal and lower-upper extremity fractures,
- Heart attack, hypertension attack (emerging after Policy Inception date),
- Acute respiratory problems,
- All kinds of organic defects causing blackout,
- Sudden strokes,
- Serious general medical condition disorders,
- High fever (39.5°C and above),
- Diabetic and uremic coma,
- Kidney failure accompanied by general medical condition disorder,
- Acute abdomen,
- Acute massive bleedings,
- Meningitis,
- Renal colic.

3- COVERAGES

This insurance shall provide coverage for the following as specified in the Policy in accordance with Policy Special Conditions and Health Insurance General Conditions, by taking the limits and payment conditions of the Policy as basis.

This Policy covers the minimum coverage structure set forth in the Circular Letter No.2021/18 dated 16/06/2021 on Private Health Insurance Policies Required for Visa and Residency Permit Applications.

3.1 Inpatient Treatment Coverage:

Following costs and expenses shall be covered hereunder in line with the respective coverage limit and payment percentage: costs of surgical or internal hospitalization from first admission date to discharge date, Intensive Care Unit expenses, costs of standard private room for single person, meal expenses and room & meal expenses for one hospital attendant, chemotherapy, radiotherapy, dialysis treatment expenses regardless of whether the patient is hospitalized or not, expenses regarding planning and control of treatment and complications faced during the treatment period, coronary angiography and medical operations performed within 24 without hospitalization or discharge.

Hospitalization period shall be limited with 180 days for each period during Policy Term. ICU stay shall be limited with 90 days and shall be deducted from the period hospitalization total of 180 days. All expenses included in Inpatient Treatment Coverage regarding hospitalizations exceeding the 360 days limit for all insured years shall be excluded.

Approval must be obtained from the Authorization Center minimum 48 hours in advance for Inpatient Treatment to be performed at a Contractual Healthcare Facility.

Surgery; Expenses for treatments which are proven to be performed through surgical intervention by a physician's report and included in medical surgery definition; operating room, surgeon, anaesthesiologist, resident costs, anesthesia medication and medical consumable material costs, special materials used during the surgery for medical requirements (ICD, cochlear implants and in-vivo

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pumps, pacemakers, cardiac valves and surgery specific consignment materials, etc.), Hydatidiform Mole and Ectopic Pregnancy operation costs shall be covered hereunder.

In cases where multiple surgical procedures are applied during the same session, coverage shall be determined by taking the procedure unit (Surgery or Minor Intervention) with the highest value in the Medical Service Price List into account. In cases where multiple surgical procedures are performed with the same or a separate incision and an excluded treatment is included in the foregoing, total invoice amount is calculated in proportion with the Medical Service Price List to determine the payable amount. The unpaid portion calculated in proportion with the Medical Service Price List for the excluded procedure shall be determined as the Policyholder's share.

Additional analysis other than the pre-op laboratory analysis to be performed as preparation to the surgery shall be processed under Outpatient Treatment Coverage (if existing in the Policy), even if the patient is hospitalized before the surgery took place.

Hospitalization; In cases where a treatment not requiring surgery is proven to require minimum 24-hour hospital stay (in standard room or in ICU) by a physician's or hospital report, all health expenses regarding hospitalization diagnosis shall be covered hereunder. Medical treatments requiring less than 24 hours shall be covered under Outpatient Treatment Coverage (if any), or another relevant coverage.

Chemotherapy/Radiotherapy/Dialysis; Chemotherapy and/or Radiotherapy expenses incurred for malignant diseases and Dialysis expenses (hospital and physician costs, medication expenses, analysis costs, expenses for complications and advanced diagnostics methods) shall be covered hereunder subject to the limit and payment percentage specified in the Policy.

Ambulance: In cases where situations covered by the "Emergency" Red Zone definition hereinabove are included in Policy Coverage in accordance with the Special and General Conditions, expenses incurred for on-site interventions and/or transportation of Policyholder to the nearest healthcare facility shall be covered hereunder. In cases where an ambulance service is requested from Insurer due to the limited treatment capacity of the healthcare facility where the Policyholder is transported and/or if Policyholder's treatment must be performed by another Contractual Healthcare Facility for whatever reason, medical information such as the "health report", "certification of eligibility for transfer in patient transfer form" should be provided to Insurer in writing. Transfer can be made after the approval of accepting Healthcare Facility is received. The aforementioned processes are required for determining whether the Policyholder's health condition is acceptable for such transfer and Insurer cannot be held responsible for the time required for completion of the said processes.

Prosthesis; Expenses incurred for prosthesis applied to replace the limbs and/or organs (hand, arm, leg, eye) lost in an accident (or breast(s) due to a disease) which has occurred within Policy Period shall be covered hereunder subject to the respective coverage limits, provided that such expenses shall not exceed the one thirds of the total invoice amount of the surgery to be performed for implanting such prosthesis upon approval of the Insurer.

Expenses made for the breast prosthesis to be placed following the mastectomy surgery for breast cancer treatment covered by the Insurance Contract shall be processed within this coverage. However, other reconstructive surgery expenses except the prosthesis application shall be excluded. Prosthesis to be used for disabilities existing before Insurance Inception Date, including replacements thereof, and expenses made for dental prosthesis shall be excluded.

3.2 OUTPATIENT TREATMENT COVERAGE

Expenses for medical examination, medications, dental treatments required as a result of an accident, auxiliary medical materials, minor interventions, imaging, modern diagnostics methods and laboratory procedures and physiotherapy costs for cases where diagnosis and treatment do not require hospitalization shall be covered hereunder, subject to the coverage limit and payment percentage specified in the Policy. All medical expenses incurred for conditions for which the hospitalization time does not exceed 24 hours and which are not included in the Medical Emergency Case definition of World Health Organization (WHO) and expenses for hospitalizations for diagnostic purposes shall also be covered hereunder.

Physician's (Medical) Examination: Expenses related with the medical examination to be performed by a physician for diagnosis and treatment of Policyholder due to an accident, disease or disorder shall be covered in line with the specified payment percentage and

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shall be deducted from Outpatient Coverage limit.

Expenses related with the initial diagnosis made during the first examination or incurred for medical examinations performed by the same physician after a surgical procedure shall be excluded. For follow-up checks, the periods indicated in the Medical Service Price List applicable to the Policyholder's Policy.

Medication: Pharmaceutical products licensed by the Ministry of health and included in the Physician's prescription (including vaccines contained within the coverage) shall be covered hereunder subject to the coverage limit and payment percentage specified in the Policy, provided that requirement/use of such medications is documented by a prescription, medication price tag or a printout of Medication Monitoring System (MMS) or a cashier's bill or an invoice.

Medication expenses corresponding to maximum one month dosage per prescription shall be covered. However, medications for accepted chronic diseases shall be covered in the form of 3-month treatment dosages compliant with the insurance period in case the physician report indicating the reason for continuous usage and the photocopy of the relevant prescription is submitted to the Insurer. Prescriptions arranged after medical examination must include the protocol number assigned in the "patient Record Book" which must be kept by the relevant physician or the healthcare facility, diagnosis given for the Policyholder in writing and also include the respective physician's signature and stamp indicating their diploma no. and specialty area. Prescriptions not meeting the above requirements shall not be accepted. Medications must be purchased within maximum 10 (ten) days after the prescription date. In case this 10 days' period is exceeded, the prescriptions shall be deemed as invalid and no process shall be performed. Claims made for other medications with the same active substance before the usage period allowed for the medication specified on the prescription is expired (according to the calculation made by taking the medication dosage specified on the prescription) shall not be accepted.

Rabies and Tetanus vaccines shall also be included in the coverage for all age groups, however other vaccines shall be excluded.

Laboratory: This coverage includes the medical analysis required for diagnosis and treatment of the relevant disease and the chemical materials and medications required for such analysis. Expenses for hepatitis markers shall be covered only in cases where the liver enzyme values exceed the acceptable normal values.

Imaging:
Radiologic analysis, ultrasonography, mammogram, graphies requiring and not requiring medication, ECG, effort ECG, audiometry, EMG, urography and similar imaging expenses and chemical materials and medications used for the aforementioned imaging procedures shall be covered hereunder.

Expenses regarding radiologic analysis (analysis referred as direct radiologic examinations in MWT Reference Tariff Price List) shall be paid only if such analysis are performed by a specialist (i.e. radiology specialist). Expenses for radiologic analysis performed by a non-specialist physician shall not be paid.

Modern Diagnostics: Expenses regarding modern diagnostics methods medically required for diagnosis of the disease shall be covered hereunder. Some procedures which shall be paid under modern diagnostics coverage are provided below for information purposes: Tomography, MR, angiography, endoscopic analysis, incisional biopsies, scintigraphy and chemical materials and medications used during the aforementioned procedures. Interventional examinations for diagnostic purposes and endoscopic analysis (diagnostic arthroscopy, diagnostic laparascopy, colonoscopy, gastroscopy, cystoscopy, bronchoscopy, mediastinoscopy, biopsy, USG accompanied biopsy, angiography - excluding coronary angiography), MR accompanied angiography.

Physiotherapy and Rehabilitation: For expenses related with medically required physiotherapy, it is not important whether treatment is given as inpatient or outpatient treatment. Physiotherapy expenses shall be covered upon review of the treatment plan and the report prepared by the specialist physician in line with the limit and payment percentages specified in the Policy, provided that Insurer's approval shall be obtained before such treatment.

In case the treatment is applied to multiple areas in the body, each area shall be considered as one session. In case physiotherapy treatment is given through hospitalization, additional expenses such as costs of hospital room, meals, hospital attendant expenses (limited to one person), physician's follow-up etc. shall not be covered.

Each procedure performed at Non-Contractual Facilities shall be limited with the Medical Service Price List. In case the treatment is

applied to multiple areas in the body, each area shall be considered as one session.

Auxiliary Medical Materials: Auxiliary medical materials required as part of the treatment such as air splints, support bandages, orthopedic arch supports, boats, neck collars, compression stockings, crutches, medical nebulizer etc. shall be covered hereunder subject to the limits and payment percentages specified in the Policy.

Minor Intervention: Surgical and/or orthopedic procedures with treatment nature up to item 149 (149 included) in Medical Services Price List (all interventions for dermal incisions, interventions for fractures and dislocations, cast and air splint applications, extraction of foreign objects, excisional biopsies and other similar procedures with treatment nature) shall be covered hereunder, regardless of whether treatment is given as inpatient or outpatient treatment. Procedures indicated under Item no.150 and higher shall be covered under Surgery coverage.

Expenses for medical materials, medications required for minor interventions and relevant physician's fee shall also be covered hereunder.

Facet nerve denervation for spine and disc diseases, radiofrequency thermocoagulation, transforaminal epidural injection etc. expenses for pain treatment shall be covered hereunder subject to the limit and payment percentages specified in the Policy, regardless of the unit in Medical Services Price list or whether the treatment is given as inpatient or outpatient treatment.

In cases where multiple surgical procedures are applied during the same session, coverage shall be determined by taking the procedure unit (Surgery or Minor Intervention) with the highest value in the Medical Service Price List into account. In cases where multiple surgical procedures are performed with the same or a separate incision and an excluded treatment is included in the foregoing, total invoice amount is calculated in proportion with the Medical Service Price List to determine the payable amount. The unpaid portion calculated in proportion with the Medical Service Price List for the excluded procedure shall be determined as the Policyholder's share.

Expenses incurred for PUVA treatment (Psoralen Ultra-Violet A, treatment of skin diseases via ultraviolet rays) shall be covered hereunder.

Dental Treatment due to Traffic Accident: Expenses incurred for all kinds of medical and surgical interventions to reconstruct the teeth and jaws damaged only due to a traffic accident shall be covered hereunder subject to the limits and payment percentages specified in the Policy, provided that the event shall be documented with a Traffic Accident Report and a physician's report.

4- WAITING PERIODS

All treatments and complications related with the diseases listed below shall be included in the coverage upon completion of the respective waiting periods, after the health expenses regarding outpatient treatment (except the first medical examination) and inpatient treatment are included in the insurance coverage (excluding the red zone in Triage and Emergency cases).

Waiting periods for this product: 9 months for Inpatient Treatment, 6 months for Outpatient Treatment coverages. Waiting period shall be calculated according to Türk Nippon Sigorta's initial Policy Inception Date for Policies continuing uninterruptedly before 30 days after Policy Expiration Date has expired.

- All types of hernia (umbilical, inguinal, gastrocele, spinal, lumbar, cervical, etc.),
- Anorectal diseases (hemorrhoid, fissure, fistula, sphincterotomy, pilonidal sinus, perianal abcess and bartholin abcess/cyst),
- Uterus, cervix, ovary and tuba diseases (ovarian cysts, myoma, endometriosis, etc.),
- Otitis media, tympanic membrane surgery and tympanic tube placement, auditory surgery (tympanoplasty, stapedectomy),
- Cataract, glaucoma and retinal diseases,
- Joint and connective tissue diseases (cartilage, synovia, connective tissue lesions, coxarthrosis, shoulder, elbow,

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ankle, knee, meniscus, hip, etc.),
- All kinds of rheumatic and autoimmune diseases (multiple sclerosis, SLE-Lupus, etc.),
- Sarcoidosis, diagnosis and treatment expenses,
- Breast diseases,
- Tonsillar and adenoid diseases, nasal polyps, sinusitis, paranasal sinus diseases,
- Thyroid gland, parathyroid gland diseases and goitre,
- Spine and spinal disc diseases (spinal and intervertebral disc diseases),
- Gall bladder and biliary tract diseases, gallstones,
- Pancreatic and splenic diseases, except those emerging as a consequence of an accident,
- Urinary system diseases (kidney, ureter, urinary bladder, urethra, urinary tract diseases; medical expenses regarding dialysis and ESWL treatment),
- Liver diseases (cirrhosis, cyst hydatid, etc.),
- Stress incontinence, cystorectocele, prolapsus uteri and all medical expenses incurred for deformation of female reproductive organs,
- Prostate gland diseases (including TUR),
- Trigger finger, entrapment neuropathy, carpal tunnel syndrome,
- All kinds of chronic diseases, (high blood pressure, chronic obstructive pulmonary disease-COPD, diabetes mellitus, etc.),
- Cardiovascular system diseases (coronary by-pass, angiography, angioplasty, aneurysm, cardiac valve and cardiac pace maker,
- All kinds of varicosis, venous stasis,
- Stomach and esophagus diseases (gastritis, peptic ulcers and esophageal reflux, etc.), small & large intestine diseases, gastrointestinal bleedings, disorders connected with diverticulitis,
- Organ failures, organ transplant diagnosis and treatment expenses,
- All endoscopic and interventional-invasive diagnostic processes (ERCP, laparoscopic, arthroscopic etc. processes),
- All kinds of bulks, lesions /tumor, lipoma, wart, verrucous, nevus, polyp, nodule, etc.), cysts (hygroma, ganglia, cutaneous, subcutaneous, kidney, vaginal, etc.),
- Treatment of all kinds of cancer (chemotherapy, radiotherapy, immunotherapy etc.) and other related expenses,
- Neurological diseases,
- Uvula elongation.

Diseases already existing before Policy Inception (all health expenses incurred for sicknesses and complaints even if already declared or undeclared even if undiagnosed yet) and all diseases included in the exclusions list in the Policy shall be excluded, even if the relevant waiting periods have already been expired.

5- EXCLUSIONS

Following conditions shall be excluded from Policy coverage and shall be paid by the Policyholder. Insurer may modify the list of Exclusions as required. Such changes and modifications shall be applicable as of the Policy renewal date for each invoice issued in the name of Policyholder.

1. Conditions excluded from policy coverage in accordance with the provisions of Health Insurance General Conditions,

2. Expenses regarding diseases and disorders of Policyholder existing before Policy Inception Date (all health expenses incurred for sicknesses and complaints even if already declared or undeclared even if undiagnosed yet), including recurrence of surgeries and treatments implemented during Insurance Period and relevant complications,
3. Expenses for diagnosis, control, treatment and complications regarding all congenital diseases and disabilities (natal anomalies, genetic disorders, genetic disease researches,screening etc.), Scoliosis, Kyphosis and all spinal deformities, keratoconus, pes planus, hallux valgus, surgical interventions on nasal septum and nose, regardless of surgery reason

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(septum deviation, SMR, concha surgeries, nasal valve operations, etc.), obesity, metabolic syndrome, growth and development,

4. Diagnosis and treatment expenses for inguinal hernia before age 18, umbilical cyst, spermatocele, varicosele, hydrocele,
5. Expenses incurred by Policyholder for medical examinations, analysis, laboratory and x-ray etc. applications and treatments performed for diagnostic and/or protection purposes without an actual existing disease, procedures for early diagnosis, check-ups, medication and vaccination expenses,
6. Outpatient treatments exceeding the number of uses and/or coverage limit and/or participation percentage specified and not having a coverage in the Policy;
7. Expenses for analysis and examinations incurred for control purposes without the existence of any actual disease/disorder, expenses for Specialist Physician's Report (document required for marriage, recruitment etc. purposes),
8. Examination, diagnosis, treatment expenses and expenses for relevant complications in every branch of dental, gum, jaw bone, temporomandibular joint and maxillofacial surgery,
9. Expenses made for treatment and complications of ophthalmic refractive error (myopia, etc.) surgery, treatment of strabismus and amblyopia, ophthalmic glasses, glasses frames, contact lenses, lens solutions and other expenses related with the foregoing;
10. Coverages not preferred in the Policy and all kinds of health expenses not included in the explanations specified in the Policy, medication expenses and all kinds of medical expenses incurred in and all kinds of medications to be brought from foreign countries,
11. Coverages for daily incapacity wage amounts which the Policyholder is not able to earn due to sickness, care costs & expenses in case the Policyholder becomes in need of care or daily care costs, rehabilitation, check-up expenses, second hospital attendee costs, luxurious and suite hospital room charge differences, and private expenses,
12. Expenses regarding examinations, analysis and treatment for birth control methods, infertility diagnosis and treatment, assisted reproduction techniques, medical examination for control purposes due to desire for pregnancy (follicle monitoring, hysterosalpingography, spermiogram, adhesiolysis, artificial insemination, in-vitro fertilization, miscarriage investigations, preconception control techniques, embryo reduction, etc.),
13. Examinations & treatments related to circumcision (phimosis etc.) (even if for treatment purposes), sexual disorders, impotence (penile doppler, penile prosthesis, etc.), expenses for gender reassignment surgeries and all kinds of post- & pre-surgery hormonal therapies,
14. Unless another contract exists as otherwise, all kinds of expenses regarding pregnancy, birth and those made for the newborn, Health expenses related with Premature Birth and Low Birth Weight (SGA - Small for Gestational Age),
15. Epidemic and pandemic diseases as announced by World Health Organization (WHO) and/or any country throughout the world or in a specific country or in a specific city or region (e.g. Novel coronavirus (2019-nCoV), SARS, MERS-CoV, Cholera, Malaria, etc.); diseases with an epidemic nature even if not yet announced publicly by WHO and/or any country; test, analysis and treatment expenses regarding the aforementioned diseases; damages which may occur during a trip to a country due to the aforementioned diseases and all loss claims to be made in connection therewith; all diseases which may be caused by the aforementioned diseases; all diseases connected with AIDS, ARCS and HIV virus, diagnosis and treatment expenses for genital herpes, genital and anal papillomatous lesions (warts, condyloma accuminata etc.), genital and anal contagiosum, Human papilloma virus (HPV) andother genital diseases,
16. Expenses for all kinds of Bariatric Surgery methods (gastric by-pass, gastric balloon, gastric tube, adjustable gastric band, weight loss surgery -stomach reduction-, biliopancreatic diversion, jejunoileostomy,colon shortening surgery, etc.) regardless of the reason, including complications thereof,
17. All kinds of aesthetic and plastic surgeries (nose reshaping, rhinoplasty, liposuction, breast reduction, etc.), all interventions, vaccinations, injections and treatments for aesthetic purposes, perspiration treatment, gynecomastia,

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aesthetic and plastic surgeries which may be required due to falling, traumas, impacts, burns or diseases which have occurred before Policy start, including complications thereof,

18. Stem cell transplantation and stem cell procedures for therapeutic purposes, embryo cloning, all kinds of treatment and transplantation procedures made with the cells obtain through such treatment, expenses related to taking and storage of umbilical cord blood and umbilical cord blood bank;
19. For organ transplantations and blood transfusion, expenses incurred for the organ, blood products and the donor and those related to the organ and/or tissue; for bone marrow transplantations, expenses related to storage of materials belonging to the donor and recipient;
20. Deliberate or indeliberate self-injuries and hazards occurring in sane or insane condition, drunk driving, alcohol intoxication, diseases and injuries arising from alcoholism and alcohol abuse; all types of health expenses incurred as a result of use of narcotics and addictive substances such as heroine, morphine etc.,
21. Medical examinations, analysis, treatment of and preparations relating with quitting smoking (nicotine strips, nicotine gums, vaporizer pens etc.),
22. Expenses for examination, neuropsychiatric tests, analysis, treatment (including psychotherapy) and complications of psychiatric and psychological disorders,
23. Geriatric diseases, diseases and disorders related with dementia, all expenses related with other demential diseases,
24. All expenses incurred at nurseries, palliative care centers, thermal springs and baths and similar facilities (including physiotherapy) and all expenses made at other facilities which do not mean "healthcare facility" definition criteria,
25. Expenses related to any kind of alternative therapies (acupuncture, ayurveda, hydrotherapy, hypnosis, arometherapy, healing cures, massage, detox, mesotherapy, reflexology, neural therapy, chiropracty, oxytherapy, CO2, ozonotherapy, PRP (Platelet Rich Plasma) ,
26. Analysis and treatment expenses and all kinds of apparatus used for sleeping disorders, sleep apnea and snoring (polysomnography, sleep EEG),
27. Voice and speech therapy,
28. Expenses for medical examination, analysis, treatment and complications of diseases connected with HIV virus (AIDS) and sexually transmitted diseases, anal and genital herpes, genital & anal papillomatous lesions (warts, condyloma acuminatum, etc.), genital molluscum contagiosum,
29. Expenses related with diseases and/or injuries which may occur due to or during performance of extreme sports such as mountaineering, sky diving, rodeo, paragliding, hang-gliding, rafting, street luge, jumping from heights such as base jumping and bungee jumping, sports performed with a kite such as kiteboarding, kitesurfing, underwater sports, cave diving, mountain biking-motorcycling (bicycle, motor bicycle, electric motorcycle and electric skateboard accepted in bicycle category etc.), injuries due to driving of motor vehicles in violation of legal rules and requirements and all kinds of transportation and treatment expenses incurred for the foregoing, all kinds of expenses related with automobile sports and all kinds of sickness, disease and/or injuries which may occur during sporting events, matches and/or trainings where Policyholder participates as a professional athlete,
30. All expenses not related with medical services (phone calls, transportation, accommodation expenses, customs fees, taxes and costs for medications, etc.),
31. Expenses for private nurses, assisting healthcare professionals (such as physiotherapist, respiratory therapist, caregiver etc.) in all kinds of centers, regardless of whether included in healthcare facility definition or not,
32. Health expenses due to occupational diseases and work accidents,
33. All kinds of expenses related with treatments and/or procedures and/or devices which, on the date of application to

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Policyholder, are not supported with sufficient (i.e. in terms of number and quality) controlled clinical trials proving the necessity, effectiveness and reliability for diagnosis and/or treatment of a disease or which have not been approved or accepted by national or international medical authorities (specialty associations, occupational organizations, US Food and Drug Administration (FDA), disciplinary scientific boards of medical schools, Ministry of Health) and/or for which medical associations and authorities have publications or written announcements stating that such treatment and/or procedure and/or device are still in trail stage or that another person or institution is still performing experimental/trial activities on the relevant treatment and/or procedure and/or device,

34. Immunotherapy and allergy tests (skin tests, quantitative antigen assessment in serum and other analysis),
35. All interventions and treatments for superficial varicose veins (sclerotherapy, laser, radio frequency, etc.),
36. Injuries during driving without a driver's license as referred to in provisions of Highway Traffic Act and all relevant travel, transportation and treatment expenses;
37. Medical devices, leasing and calibration expenses of medical devices (robotic surgery leasing amounts, sleep apnea device and its calibration, holter device, nebulizer, etc.), all expenses related to robotic surgery and robotic organs,
38. All vaccines except for rabies and tetanus,
39. Expenses related with funeral in case of death (morgue expenses in case Policyholder is deceased after hospitalization, transfer of dead body etc.),
40. Expenses for drugs, vitamins and food supplements not having an official drug license but approved by the Ministry of Agriculture and Rural Affairs and imported with the permission of the Ministry of health, medical fruit salts, medical sodas, herbal extenuatives, bran and herbal fibers, artificial sweeteners, nicotine preparations used for quitting smoking, contact lens maintenance preparations, toothpaste, mouth and dental care preparations, medical teas, preparations containing plants and plant elements prepared in medication form and those containing fractions like herbal extract distillate, preparations not licensed by the Ministry of Health, all kinds of soaps and anti-dandruff and anti-hair loss preparations, regular or anti-dandruff shampoos, skin creams, skin soaps, cosmetic products, hot water bottles, thermometers, etc.,

6- GEOGRAPHICAL TERRITORY

Coverages regarding contracts arranged in line with these Special Conditions shall be valid only within the boundaries of Turkish Republic. Diagnosis and treatment expenses incurred in foreign countries shall be excluded. TRNC (Turkish Republic of Northern Cyprus) is considered as a foreign country.

7- IMPLEMENTATION PRINCIPLES

7.1 Coverage Limit Implementation Principles

Policy Coverage shall be valid separately for each Policyholder, subject to the limits, implementation and participation percentages and for cases exceeding these foregoing limits, Insurer shall not make any payments. The Company has two healthcare facility categories: Contractual and Non-Contractual. Coverage limits according to the type of healthcare facility are specified in the Policy. Limits specified for Inpatient and Outpatient Treatment expenses shall be deducted from Inpatient and Outpatient Treatment Coverage limits specified in the Policy. Contractual and Non-Contractual Healthcare Facility limits indicated in the Policy are single common limit.

Remaining limit amount shall be calculated by deduction of the sum of compensation amounts paid by Insurer and participation share amounts paid by Policyholder from the gross limit amount specified in the Policy.

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7.2 Contractual Healthcare Facility Implementation Principles

Contractual Healthcare Facility List is updated as required and announced in Insurer's website at http://www.turknippon.com/ for information purposes.

Insurer may make changes in this Contractual Healthcare Facility List. Applications specific to a Contractual Healthcare Facility shall automatically cease in case the contract between such Healthcare Facility and the Insurer is terminated.

Policyholder must obtain authorization at the relevant facility before obtaining any service from a Contractual Healthcare Facility. Insurer shall make direct payment to the Contractual Healthcare Facility for medical services provided in line with the relevant Network specifications, specified limits and payment percentages.

Türk Nippon does not guarantee in any way the quality of services provided by medical institutions/professionals and related medical consequences. Selected healthcare facility of the person selecting such medical facility and/or healthcare professional shall be responsible from the services selected by Policyholders and the consequences arising therefrom.

8- COMPENSATION PAYMENTS

8.1 Contractual Healthcare Facility:

Medical expenses incurred at Contractual Healthcare Facilities included in the Network as preferred in the Policy shall be covered by direct payment to be made to the said Facility in line with the respective Contractual Healthcare Facility coverage limit and payment percentage.

Health expenses for treatments provided by Non-Contractual Physicians and/or Physicians included in permanent/contractual staff list of the respective Contractual Healthcare Facility who have not accepted Türk Nippon Agreement is determined according to the Medical Services Price List and shall be limited to the minimum fee amount applicable on the event date and shall be covered according to the Non-Contractual Healthcare Facility limit and payment percentage indicated in the Policy.

8.2 Non-Contractual Healthcare Facility:

Expenses related with the medical services received from healthcare facilities not included in the Network which is preferred in the Policy (including emergencies) shall be covered up to the limit and with the participation share specified in the Policy for Non-Contractual Healthcare Facilities.

Health expenses from treatments given by physicians of this healthcare facility are determined by Medical Services Price List and limited to the minimum fee amount applicable on the event date and shall be covered up to the Non-Contractual Healthcare Facility coverage limit and the payment share percentage.

Health expenses for treatments provided by Non-Contractual Physicians and/or Physicians included in permanent/contractual staff list of the respective Contractual Healthcare Facility who have not accepted Türk Nippon Agreement is determined according to the Medical Services Price List and shall be limited to the minimum fee amount applicable on the event date and shall be covered according to the Non-Contractual Healthcare Facility limit and payment percentage indicated in the Policy.

Health expenses incurred in foreign countries shall be excluded.

8.3 Documentation of Medical Expenses

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TÜRK NİPPON SİGORTA SAĞLIĞIM SİZDE HEALTH INSURANCE POLICY

Product Code	: 908	**Inception Date**	: 30/08/2022
Policy / Renewal No	:	**Expiration Date**	: 30/08/2023
Endorsement No	:	**Time**	: 365 Days
Agency Code / Business Title	:		

Following information and documents must be submitted to Insurer for claims made to receive compensation for health expenses. Insurer shall make necessary reviews for compensation assessment within the periods prescribed in policy Special Conditions, General Conditions and Regulations.

For expenses incurred at Contractual Healthcare Facilities:

- Original passport should be submitted,
- Contractual Healthcare Facility must obtain provision for the medical services to be rendered,
- "Private Health Insurance Form" containing diagnosis and treatment details must be filled by the attending physician,
- Analysis results (if any), physician reports, relevant required documents and reports for forensic cases, prescription, detailed procedural documents (e.g. E-State, Treatment Details Inquiry Result, E-Pulse, etc.),
- Accident Report, Alcohol Test Report in case of an incident occurred due to an accident,
- Panoramic x-ray imaging in case of emergency dental treatment after a traffic accident,
- Original copy of paranasal sinus tomography of Policyholder before sinusitis surgeries.

For expenses incurred at Non-Contractual Healthcare Facilities:

- For conditions covered under Article 8.2.:
- Original invoice copy, POS voucher with the name & surname of the person receiving treatment and seal and signature of the attending physician,
- "Private Health Insurance Form" containing diagnosis and treatment details must be filled by the attending physician,
- Analysis results (if any), epicrisis report/medical history for hospitalization/surgery, physician reports, relevant required documents and reports for forensic cases, detailed procedural documents (e.g. E-State, Treatment Details Inquiry Result, E-Pulse, etc.),
- Original prescription copy and medication price tags,
- Analysis request form and results,
- For Physiotherapy and Rehabilitation invoices, report arranged by respective physiotherapist specifying the treatment plan in detail (start, end, procedures etc.),
- Passport copy of Policyholder,
- Accident Report, Alcohol Test Report in case of an incident occurred due to an accident,
- Panoramic x-ray imaging in case of emergency dental treatment after a traffic accident,
- Original copy of paranasal sinus tomography of Policyholder before sinusitis surgeries.
- Account details of Policyholder (IBAN No., Bank Name, Branch Code and Name, Name of Account Owner, Tax. No. or provisional ID No.).

Insurer shall be entitled to perform additional investigation if required, request any information and/or documents from attending physician, relevant healthcare facility or other third parties regarding diagnosis and treatment of Policyholder and have Policyholder get examined by another physician designated by Insurer.

8.4 Subrogation Principle (Assignment of Rights)

Pursuant to the "Right of Subrogation" and in accordance with the applicable relevant legislation, Türk Nippon Sigorta A.Ş shall be entitled to subrogate the Policyholder after realization of an insured risk and payment of the compensation amount to the Policyholder (beneficiary), and claim payment for damages from the person(s) or entity(ies) causing such damage.

Policyholder shall be liable to provide all kinds of information, documents and assistance to Türk Nippon Sigorta A.Ş. to enable the

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Insurer use such right.

Insurer shall have the right to request Policyholder(s) to reimburse any payment (including compensation payments) made by Insurer to Contractual Healthcare Facilities or to the bank account(s) of Policyholder(s) which are later determined to be made on invalid grounds. Tortious payments arising from incomplete or incorrect information provided by the relevant healthcare facility or attending physician or from failure in providing such information at all.

8.5 Entities for Sending Compensation Payment Information

Pursuant to the legal legislations, Insurance Firm shall be liable to disclose and submit, upon request, all information (e.g. damage, compensation details, personal details, etc.) they have obtained from Policyholders during the arrangement stage of the Health Insurance Contract to SSI Information Center, Undersecretariat of Treasury, SAGMER and all similar governmental authorities. Everyone purchasing health insurance shall be deemed to have accepted in advance that such information shall be disclosed to the relevant competent authorities.

9- INSURANCE CONTRACT RENEWAL AND LIFETIME RENEWAL WARRANTY

Policy can be renewed before Policy Expiration Date upon mutual agreement between Insurer and Policy Owner subject to the following conditions: Policy period shall be 1 year unless agreed as otherwise by contractual parties. This product does not provide Lifetime Renewal Warranty.

Insurer shall reserve the right to make changes in product special conditions, coverage content, exclusions list, coverage limits and Policy premium amounts, to make a new risk assessment for such renewal, to renew the Policy automatically or to reject renewal of the Policy. Such changes and modifications shall be applicable as of the Policy renewal date for each invoice issued in the name of Policyholder. Renewal must be made on the Policy Expiry date of the previous Policy at the latest.

In case Policy is not renewed within 30 days following Policy Expiration Date, Policyholder's current vested rights shall be forfeited and Policyholder shall be considered as a new applicant. Additional premium amount can be implemented in connection with the compensation premium rate of the Policy.

In case a loss claim is made for the previous Policy after the renewal premium amount is determined which would change the renewal premium amount, Insurer may charge additional premium or cancel the renewed Policy.

In case Policyholder wants to change their preferences for the renewed Policy (such as Network, plan, product etc.), "Transfer and Vested Rights" section shall apply.

If Insurer prefers automatic renewal, preferred network, plan, product, Contractual Healthcare Facilities data shall be used for the new Policy without any changes. If the Policy preferences are not applicable anymore for the renewal period, most close preferences shall be selected for renewal.

Payment terms applicable to the previous Policy shall be kept the same for the renewed Policy for automatic renewals unless Policy Owner notifies as otherwise in writing before the due date.

10- PREMIUM ASSESSMENT

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10.1 Tariff Premium

Premium amounts are determined according to criteria such as age, gender, residence address of Policyholders, product scope and changes in Medical Services Price List, etc.

Insurer shall update the "Medical Services Price List Premium" periodically, also by taking the performances of each risk profile and the overall performance of the portfolio, inflation rate in medical services, and other general economic changes in the country in consideration.

Increase in "Medical Services Price List Premium" shall be limited to maximum three times the previous period's medical services price list premium within the same category, provided that this increase shall not be less than the inflation rate realized in the relevant medical services.

Insurer shall reserve the right to make reasonable changes in discount rates and/or additional premium rates and relevant criteria during policy renewal periods.

10.2 Additional Sickness Premium:

Additional sickness premium to be applied to the Health Tariff Premium of Policyholder cannot exceed 300% per disease.

10.3 No Claim Discount/Additional Claim Premium

Discount for Uninterrupted Personal Renewal Policies is calculated by taking the "Compensation/Health Net Premium" ("C/P") ratio into account within the current Policy Period of the respective Policyholder. No discount shall be given for new businesses and new Policyholder entries through transfer.

Additional premium for Uninterrupted Personal Renewal Policies is calculated by taking the "Compensation/Health Net Premium" ("C/P") ratio into account within the current Policy Period of the respective Policyholder.

After Policy renewal, in case the outstanding compensation payments belonging to the previous Policy period increases the renewed Policy's premium amount by changing the Policyholder's C/P ratio, then Insurer shall request the premium difference with an endorsement or shall be entitled to deduct the premium difference amount from the payable compensation amount.

10.4 Other

Insurer may change the applicable discounts or discount rates in line with certain rules and campaigns or to cancel the discount in full.

11- NEW ENTRY PROCEDURES

11.1 Entrance Assessment for Policyholder

Unless agreed by Insurer otherwise in writing, citizens of foreign countries residing within the boundaries of Turkish Republic shall be accepted to be covered by this insurance during Policy validity period. Individuals who have applied for a residence permit are considered to be a Turkish resident. Turkish citizens cannot be insured with this insurance product.

Policyholder's age is calculated by subtracting the birth date of Policyholder from Policy Inception Date. Unless stated as otherwise, only the elementary family members can be included within the scope of a single Policy. Elementary family consists of the mother, father and their unmarried children (under 25 years of age), including adopted ones.

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Infants who have completed 15 days after birth and persons who have not turned 65 can be included in the Policy Coverage.

Premium amount which the Insurer has become entitled to for all Policyholder entrance requests (including spouse, newborns, children and adopted children (to be evidenced)) filed after policy Inception date shall be calculated on used/unused days basis, depending on the time between date of inclusion and Policy Expiry date. Such premium amount shall be collected in advance if the Policy payments have been completed, or otherwise by dividing into the remaining number of installments.

All medical expenses incurred for diseases/disorder existing before Policy Inception Date shall be excluded. Additionally, diseases/disorders continuing during Policy Period and determined to be existing before Policy Inception Date may be excluded and/or additional premium may be requested or Policy may be canceled due to such disease/disorder.

11.2 Evaluation of Application and Information Form

Policyholder's filling in the Application and Information Form does not mean that the Policy is initiated. Insurer shall make reviews and examinations according to the risk assessment conditions based on the representations made by Policy Owner/Policyholder within the scope of their liability of representation.

Insurer shall reserve the right to change the scope of the proposed Policy (e.g. Network, coverage), to introduce additional exclusions or additional premium amounts, to make Policyholder subject to medical examination in case Insurer deems as required and to ask for additional medical analysis or to reject the application as a result of this evaluation.

Policy shall enter into effect upon collection of the entire premium amount or the first installment in case application is approved by Insurer.

12- TRANSFER PROCEDURES AND VESTED RIGHTS

No right can be transferred in case Policyholder switches from this product to another health insurance product or vice versa.

12.1 Product/Coverage Change Procedures

Requests for change in product and coverages during Policy renewal shall be evaluated 15 days before or after Policy Expiration Date. Policyholder must be younger than 60 years old for such request to be admitted for evaluation.

Policy Owner/Policyholder may prefer to expand their preferences (product/coverage) in the Policy to be renewed. In such case, Insurer shall request Policyholder's health condition declaration if necessary and shall make a risk assessment based on Policyholder's previous insurance data and other relevant health information.

12.2 Transfer Procedures

Insurer shall review the Candidate Policyholder's representations and the information obtained from other insurers, Group Health Insurance Contract/Protocol conditions, Insurance Information and Monitoring Center (SBGM) and other relevant organizations/authorities to decide, in consideration of the New Entrance Procedures section herein, whether the Policyholder's rights acquired from other insurers shall continue.

For transfers from other insurers, continuation of Policyholder's vested rights shall be subject to Insurer's approval, provided that the

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following requirements shall be met.

- Transfer Form for Policyholder's policy issued by the other insurer should be sent to Insurer.
- Transfer application should be made within maximum 30 days after the expiration date of the previous policy and the Proposal/Policy should be approved.
- Policyholder should have completed minimum one year in the previous insurer's health insurance.
- New entrance applications can be made for newborn babies minimum 15 days old up to individuals 64 years of age (64 included).

13- PRINCIPLES FOR TERMINATION OF INSURANCE CONTRACT

Commitments made to Policyholder by Insurer shall terminate in case Policy is canceled or Policyholder is removed from Policy. For cancellation, Policy Owner should also arrange and send to Insurer a termination request letter, bearing Policyholder's signature and current date to initiate the cancellation procedure, provided that at least one of the requirements stated below shall be met.

- Submission of a new private health insurance policy covering the residence permit period to the Insurer,
- Cancellation of residence permit,
- Submission of a document confirming General Health Insurance coverage in accordance with the Social Security and General Health Insurance Act No.5510,
- Provision of required documents showing the date of departure in case Policyholder leaves the country,
- Death.

Cancellation requests shall be processed in case the above listed requirements are met. Cancellation date of current Policy shall be calculated as of the date when the cancellation request is received by Insurer.

13.1. Cancellation Due to Failure in Premium Payments or upon Request of Policy Owner/Policyholder

Policy Owner shall enter into default in case Policy Owner fails to pay the entire Policy premium (if payment terms is prepayment) until the end of the day when the Policy is delivered to Policy Owner or any one of the installments (in case of installment base payment) until the end of the respective due date specified on the Policy.

In case Policy Owner or Policyholder requests cancellation after Policy Inception Date, the premium amount corresponding to the unused portion of the period where the Insurer's liability still continues shall be calculated on days basis and reimbursed to the Policy Owner, provided that no previous compensation claims have been made and the above explained procedure does not contradict with any liability of Insurer according to the applicable insurance legislation and other relevant laws and regulations.

The amount to be reimbursed to Policy Owner due to Policy cancellation shall be calculated as explained below, in consideration of the portion to which the Insurer has become entitled (i.e. earned) and the total amount of compensation payments.

- In case the compensation payments made to Policyholder do not exceed the Insurer's earned premiums amount, the earned premium amount shall be deducted and the outstanding amount shall be reimbursed, provided that the above explained procedure does not contradict with any liability of Insurer according to the applicable insurance legislation and other relevant laws and regulations.
- In case the compensation payments made to Policyholder exceed the Insurer's earned premiums amount but do not exceed the premium amounts paid by Policy Owner, then the compensation amount shall be deducted from the collected premium amounts and the outstanding amount shall be reimbursed to Policy Owner, provided that the above explained procedure does not contradict with any liability of Insurer according to the applicable insurance legislation and other relevant laws and regulations.
- No premium reimbursement shall be made in case the compensation payments made to Policyholder exceeds both the Insurer's earned premium amount and total premium payments paid by Policy Owner/Policyholder so far.

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- Upon realization of compensation payment, portion of the undue premium installments not exceeding the compensation amount which the Insurer is liable to pay shall become due and payable.

13.2 Death within Policy Period

In case Policy Owner is deceased within Policy Period, the Policy may be continued with a letter of consent by Policy Owner's legal inheritors by changing the name of Policy Owner in the Policy/Insurance Contract. Provisions set forth in Article 13.1 herein shall be applicable in cases where such written approval is not obtained or where legal inheritors of deceased Policy Owner do not accept continuation of the Policy. For enforcements of the aforementioned provisions, legal inheritors of the deceased Policy Owner shall be deemed as the legally valid Policy Owner.

Provisions set forth in Article 13.1 herein shall also apply in case of death of any one of the Policyholders. Certificate of Inheritance and other documents related with the applicable taxes should be submitted to Insurer by the deceased Policy Owner's legal inheritors for payment of any outstanding health expense amount not reimbursed previously to the Policyholder.

13.3 Treatments Ongoing after Policy Expiration Date

In case the Policy is renewed by Türk Nippon or by another insurer while the treatments included in the Policy coverage are still ongoing, portion of the expenses of such medical treatment realized until 12:00 PM on the renewal date shall be covered from the coverage limits of the former Policy and portion realized after this hour of the same date shall be covered from the coverage limits of the newly renewed policy.

For Policies not renewed by Türk Nippon or by another insurer or for Policies where an exclusion is applied for the relevant disease, the period of the coverage to cover these treatments cannot exceed 10 days after the Policy Expiration Date.

14- OTHERS

14.1 Provision and Sharing of Information

Türk Nippon Sigorta is authorized to obtain and share information and/or documents from/with Turkish Undersecretariat of Treasury, Insurance Information & Monitoring Center (SBGM), Insurance Association of Turkey, all healthcare facilities and institutions, physicians, other insurance companies and Public Entities and Institutions in accordance with the legislation regarding Personal Data Protection Act, including but not limited to insurance legislation, regulations on insurance and underwriting and health legislation.

By signing the relevant documents, policyholders or candidate policyholders are considered to have given their consent that their medical information, coverage records and other data can be obtained from Insurance Information and Monitoring Center (SBGM), State Social Security Institution (SGK), Ministry of Health, healthcare institutions and other insurers with the purpose of performing risk assessments and finalizing damage claims; and information in Company's possession can also be shared with SBGM, other insurers and other institutions and authorities as specified in the relevant legislation.

14. 2 Failure in Fulfillment of Liability of Representation

Policy Owner and Policyholder are required to notify Insurer in writing about all the issues, facts and changes which they are aware and they should know about their health condition, both at initial application stage and during the Policy Period.

In case the representations of Policy Owner and/or Policyholder provided at application stage are determined to be misstated, incomplete or wrong or in case Insurer finds out that undeclared diseases/disorders are determined to be existing which Policy Owner

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and/or Policyholder was already aware of or which they should have known such existence, or in case of a change in occupation, Insurer shall be allowed to terminate the Policy or continue the Policy through exclusion of such diseases/disorders and/or charging additional premium amounts. Insurer shall not re-assess such diseases disorders already excluded from insurance coverage for foregoing reasons to reinclude them in the coverage.

Insurer shall be entitled to reclaim the health expense payments made under insurance coverage and cancel the Policy in cases where existence of malicious acts are detected including without being limited to uninsured persons benefiting from insurance coverage, Policyholder family members having their health expense documents issued in the name of other persons covered by the Policy, attempts of insurance abuse for including uncovered expenses in insurance coverage, failure in meeting the respective criteria specified for new entrance procedures.

14.3 Informing of Policy Owner/Policyholder

In cases where Insurer provides general information to Policy Owner/Policyholder as of the Policy Inception Date, and/or information about Policy expiration and renewal, and/or information about premium payments and contract renewal to Policy Owner/Policyholder, and/or information about renewal warranty (if provided with the Policy) to Policyholder, either in electronic environment or by other means in writing, Insurer shall take the current contact information included in Company records at the time of such notifications as basis.

Cell phone number or e-mail address of both Policy Owner and at least one Policyholder specified in the Policy should be provided to the Company in addition to the postal address information to enable the Company fulfill its liability to provide the required Information to Policy Owner/Policyholder(s).

Policy Owner/Policyholder must notify Insurer about any change or missing item or error in the aforementioned contact details included in the Policy.

AGENT	**INSURED CANDIDATES**	**INSURER**
Stamp		
Date / /	**Date / /**	**Date / /**

ACENTE KULLANICI BILGILERI

Acente Levha No :

Personel Ad Soyad :

Personel Sicil No :

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