Dear Insured,
We would like to thank you for choosing us as your Insurance Firm. The detailed information, which we consider may be informative for you, regarding your Health Insurance policy is provided below. Furthermore, you can also call us at the phone number printed on the back side of your health insurance card, on any matter regarding which you would like more information. We would like to recommend you to call us first upon any medical problem, to obtain information on how you can benefit from the coverage provided in your policy.
We would also like to remind you that you can access the list of medical institutions included in our network, at the address www.anadolusigorta.com.tr or by calling our company; and wish you a healthy life.

I. SPECIAL TERMS AND CONDITIONS REGARDING COVERAGE THE SCOPE OF MEDICAL INSURANCE POLICIES

The policy hereby covers the minimum coverage structure determined with the Notice Regarding Private Health Insurances to be Made for Residence Permit Requests numbered 9 and dated 6/6/2014.

Only foreign nationals can be insured within the scope of this policy. T.C. citizens cannot be insured within the scope of this policy.

Anadolu Anonim Türk Sigorta Şirketi (Anadolu Sigorta) covers the costs of examination, diagnosis and treatment of the insured for the conditions occurred after the insurance commencement date within the framework of the General Terms and Conditions of Medical Insurance and Special Terms and Conditions of Anadolu Sigorta Foreign Nationals Medical Insurance within the scope and limits of the coverage specified in the policy. The payments within the framework of this policy require that the examination, diagnosis and treatment of the insured must be effected in the policy period. No expenses regarding conditions of which symptoms/findings or diagnosis and/or the beginning of treatment predates the insurance commencement date, as well as complications to arise in relation thereof shall be covered by the policy.

The insurance coverage provided to the insured is limited to the matters specified as covered in the policy and the general and special terms and conditions of the insurance. No cases other than those explicitly stipulated as under coverage shall ever be construed as within the insurance coverage, even if such are not specified individually among the exceptions of coverage.

IMPORTANT MATTERS TO BE CONSIDERED

Procedures carried out by the non-staff physicians in the contracted health providers
To be valid for all coverages, the amounts to be paid to the physicians and their teams (assistant, anesthesiologist) for the diagnosis and treatment procedures of the insured to be carried out by the non-staff physicians at the domestic contracted health providers shall be deducted from the limit of the non-contracted institutions within the scope of the payment rates specified in the policy and be as much as the fees specified in the contract signed by Anadolu Sigorta with the health provider. If the amount demanded by the non-staff physician is more than the amount to be paid to a staff physician, the exceeding portion shall be paid by the insured to the physician. Therefore, the insured who are not

treated by staff physicians at the contracted health providers are advised to speak to the representatives of our Company prior to the operation and find out the amount to be paid for a staff physician by our Company and compare the fees demanded by the physicians to the fees of the staff physicians.

Procedures carried out by the physicians in the non-contracted health providers
Fees to be paid to the physicians and their team (assistant, anesthesiologist) in relation to the procedures for the purpose of treatment (minor medical attention, operation, radiotherapy, chemotherapy, dialysis etc) and procedural tests for the purpose of diagnostics (colonoscopy, gastroscopy, cystoscopy, biopsy, biopsy with USG, angiography, angiography with MR etc) done outside the contracted health providers or surgeries shall be deducted from the limit of the non-contracted institutions within the scope of payment rates specified in the project and be as much as the fees specified in the Turkish Physicians Association Minimum Fee Tariff. Therefore, if the insured is to be treated in a non-contracted health provider, it is important for them to call our Company and make queries about the physician fees prior to the treatment. If the physician fees for the procedures specified above and carried out by the non-contracted health providers are more than the fees specified in the Turkish Physicians Association Minimum Fee Tariff, the difference in between shall be paid by the insured.

Treatment abroad
This policy is valid only within the borders of the Republic of Turkey (T.C.) and it will not be valid outside Turkey. Turkish Republic of Northern Cyprus is regarded as abroad.

Classification of operations
Turkish Physicians Association Minimum Fee Tariff shall be taken as basis in the classification of operations specified in the coverage list in the policy. However, operations, the rate of which are 2500 or over individually are considered within the Extra Major Operations class which is not included in the tariff but is covered by the Policy Coverage Tables.

Benefiting from the discounts of the contracted providers
People insured with our Foreign Nationals Health Insurances will pay their outpatient treatment expenses outside the scope of the policies of contracted health institutions and they will have an advantage by making payments over the discount prices on which Anadolu Sigorta reached an agreement.

Qualities of the Foreign Nationals Health Insurance
The following health providers and new health providers which will be owned in future by the same companies which own such health providers shall not be regarded as contracted health providers for the insured who are covered by the Foreign Nationals Health Insurance.

Acıbadem Health Group
Alman Hospital Group
Amerikan Hospital Group
Florence Nightingale Group
International Hospital Group
Liv Hospital Group
Other: İntermed Medical Centre, İntermed Maslak Policlinic, İntermed Infants Laboratory

DESCRIPTION OF COVERAGE

Descriptions of the coverage for health insurance products of our Firm is provided below. The insured shall be able to benefit from the coverage described below, if such coverage is included in their policies. The insured shall not be able to benefit from the coverage if such is not included in their policies.

A. Outpatient treatment coverage:

Expenses for outpatient physician examination, prescription drug, diagnosis and treatment and minor operations unit of which alone is less than 150 in the Turkish Physicians Association Minimum Fee Tariff (plasters for broken limbs, stitches on the skin, removal of foreign substances from the eye, etc) are assessed in the Outpatient Treatment Coverage. Diagnosis expenses for the cases where the treatment period does not exceed 24 hours and/or the observation is approved shall be covered under Outpatient Treatment Coverage.

Expenses regarding all examinations, inspections and treatments within the scope of outpatient treatments are covered up to 60% until the limit specified in the policy in all contracted and non-contracted health institutions.

1. Physician examination expenses:

Expenses relating to examinations to be performed by physicians employed at hospitals and clinics licensed by the Ministry of Health of the Republic of Turkey and/or physicians eligible to open private practices are payable within the limit and rate specified in the policy. However, expenses of lenses and eye examinations performed in optical centers and dentist examination bills are not covered. Expenses relating to the diagnostics performed by the physicians themselves during examination in aid of diagnosis will be covered as medical examination coverage.

Expenses relating to the examinations performed by the same doctor within 10 days relating to the diagnosis in the initial examination are outside coverage.

Routine physician examinations of children in 0-6 age group are paid using the relevant coverage.

2. Drug expenses (Outpatient):

Drug expenses regarding pharmaceutical products (with drug qualities) written in the prescription made up by a physician in Turkey after an examination and for which relevant drug license was obtained from the Ministry of Health in Turkey will be covered by this coverage according to the rate and limit specified in the policy within the framework of the agreement. For each prescription, only drug expenses corresponding to maximum 1 month dosage will be paid. For payment of drug expenses, self-employment invoice or receipt of the physician examination fees, cashier's slips for drug expenses, drug packing clippings cut so that the name of drug is legible, drug barcodes matrix codes and physician's prescription must be produced. Furthermore, it is mandatory that the date of the bill or cash register slip for the drugs is within the validity period of the policy.

In the prescriptions prescribed subsequent to physician examination should include the protocol number in the "Patient Register Book" which is mandatory for the physicians or health providers to have and the diagnosis of the insured and also should bear the seal and signature of the physician indicating the physician's diploma number and medical specialty. Prescriptions not adhering to such format will not be accepted. Drugs should be purchased within ten days as of the prescription date. If ten days period is exceeded, the prescription shall be deemed invalid and no action shall be taken.

Drugs injected in the joints shall be covered under this coverage.

Preventive inoculations for the children in 0-6 age group are covered within the scope of this coverage.

Expenses for the drugs approved by a physician to be used continually shall only be paid if the insured documents this by a physician's report (the report should be issued to cover maximum 6 months), Anadolu Sigorta approves and the use of drugs are within the period of the policy.

Plants and plant products formulated as drugs and drugs containing fractions like plant extract and distillates and drugs prescribed by a dentist are excluded from coverage.

3. Diagnosis units expenses (Outpatient):

Expenses for all diagnosis units required by a physician to diagnose a disease (laboratory, radiology, cardiology, nuclear medicine etc) shall be covered within the limit and rate of the policy.

Procedural tests for the purpose of diagnosis (Colonoscopy, gastroscopy, cystoscopy, biopsy, biopsy with USG, angiography, angiography with MR etc) shall be covered under this coverage. Expenses in relation to radiological tests (USG etc) shall only be paid if the said tests are conducted by the relevant specialists. Expenses in relation to radiological tests (USG etc) done by the physician, who is not a radiology specialist, during the examination shall not be covered.

Expenses for hepatitis markers shall only be paid if the liver enzyme values are above the normal values.

Fees to be paid to the physician in relation to the procedural tests for the purpose of diagnostics done outside the contracted health providers shall be deducted from the non-contracted institutions limit according to the payment rates specified in the policy and be covered up to the amount of the fees specified in the Turkish Physicians Association Minimum Fee Tariff.

If the procedural tests for the purpose of diagnostics carried out by the non-staff physicians at the contracted health providers, the fees to be paid to such physicians shall deducted from the non-contracted institutions limit according to the payment rates specified in the policy and be up to the amount of the fees specified in the agreement signed between Anadolu Sigorta and the health provider.

Drugs and material expenses used during the radiological procedures shall be paid out of the diagnostics coverage (outpatients).

It is mandatory that the insured apply to the health providers they call for examination with the referral form to be completed by the examining physician and the claim form. Treatment expenses for the tests without a claim form and/or physicians report shall not be paid.

4. Physiotherapy expenses:

Expenses of physiotherapy administered by physicians licensed to administer physiotherapy and any pain treatments will be paid within limits of physiotherapy coverage, session limits and rates specified in the policy regardless of whether treatment is given on outpatient or inpatient basis. Expenses such as room-meal-attendant, doctor follow-up, etc. billed during the administration of physiotherapy shall not be included in the physiotherapy coverage.

The fees to be paid to the physicians for the examinations to be made during physiotherapy in non-contracted domestic health institutions shall be deducted from the limit of the non-contracted institutions according to the payment rates specified in the policy and shall be covered up to the amount of the fees specified in the Turkish Physicians Association Minimum Fee Tariff.

If the physiotherapy is carried out by the non-staff physicians at the contracted domestic health providers, the fees to be paid to such physicians shall be deducted from the limit of the non-contracted institutions according to the payment rates specified in the policy and be limited to the fees specified in the agreement signed between Anadolu Sigorta and the health provider.

For physiotherapy expenses to be payable, the results of imaging which makes treatment necessary (MR, tomography, ultrasound, etc.) and detailed doctor's report (how many sessions of physiotherapy are needed, detailed breakdown of therapy which must be administered in one session) must be furnished to Anadolu Sigorta.

5. Rehabilitation expenses:

All expenses of the insured for functional training (rehabilitation) provided to him so that he can gain life function activities (walking with or without crutches, eating, drinking, dressing, undressing, sitting at toilet, going up or downstairs) he has lost after neurological diseases, severe trauma or extremity amputation, etc. will be paid within the coverage limits specified in the policy and the special and general terms of the policy provided that the treatment is on inpatient basis and the situation is approved by the Insurer. Moreover, other benefits like room-meal-attendant, physician's follow-up will not go into effect.

6. Minor medical attention (minor operation) expenses:

Any expenses in relation to procedures (plasters for broken limbs, stitching, removal of foreign substances from the eye, stomach irrigation, etc.) carried out for the treatment under general or local anesthesia or without anesthesia at the hospital or the doctor's practice, regardless of whether administered by the domestic outpatient or inpatient departments and the expenses regarding any kind of examinations like laboratory and radiology procedures to be made before and after procedures and drugs that will be prescribed, up to 150 units as specified in Turkish Physicians Association Minimum Fee Tariff, shall be paid within the limits and rates specified in the policy, excluding expenses for the physician examination and diagnostics. Expenses of materials, drugs, pre-op blood analysis and physician fee of the relevant physician in the procedures to be carried out under Minor Medical Attention Coverage shall be covered under this coverage.

Several interventions within one session shall be considered within the minor medical attention coverage even the total of units is 150 or more, provided that one intervention only does not exceed 150 or more.

The fees to be paid to the operating physician in the minor medical interventions in doctors' offices or non-contracted domestic health institutions shall be deducted from the non-contracted institution limit according to the payment rates specified in the policy and be covered up to the amount of the fees specified in the Turkish Physicians Association Minimum Fee Tariff.

If the medical attention is carried out by the non-staff physicians at the contracted domestic health providers, the fees to be paid to such physicians shall be deducted from the non-contracted institution limit according to the payment rates specified in the policy and be up to the fees specified in the agreement signed between Anadolu Sigorta and the health provider.

The fee to be paid for the operations made outside the contracted domestic health providers and not specified in the Turkish Physicians Association tariff shall be deducted from the non-contracted institution limit according to the payment rates specified in the policy and be limited to the amount stated in the agreement executed by our company and an equivalent hospital among the contracted health providers.

B. Inpatient treatment coverage:

Expenses for the surgical or medical treatments which require staying in the hospital and the surgical and orthopedic operations which do not require the insured to stay in the hospital and the rate of which is over 150 according to the Turkish Physicians Association Minimum Fee Tariff shall be considered under inpatient treatment coverage. However,

- Expenses for the non-operational treatments, duration of hospital stay of which does not exceed 24 hours shall be covered under Outpatient Treatment Coverage..
- Hospital stay for the purpose of tests is regarded outside the Inpatient Treatment Coverage.

Pre-op tests required by the anesthesiologist are paid under the Inpatient Treatment Coverage.

Hospital stay approvals granted by the contracted health providers are not for an indefinite period of time. Hospital stay approval is valid on the condition that it is practiced within seven days and the policy is in force. If hospital stay is required for a longer period of time than the specified, the insured and the health provider should make an application again to receive provision.

A new report form should be sent and approval of the Insurer should be acquired in all hospital stays that exceed fifteen days so that expenses within the scope of the coverage incurred after fifteen days can be paid.

All diagnoses and treatable expenses within the scope of inpatient treatments will be covered in non-contracted health institutions by 80% payment rates up to the annual limit specified in the policy.

1. Surgery expenses:

Surgical expenses such as operating room cost, equipment and drugs cost during the operation, fees of surgeon and the operating team (Assistants and anesthesiologists) shall be paid within the limits specified in the list of covered procedures and the special and general terms and conditions of the policy, provided that the insured needs a surgical operation for the treatment is proven with a physician report and the operation is done at the health providers.

Pre-approval of operation: Except for emergencies, the Insured should notify the Insurance Company of their operation a few days prior to the operation, by faxing the “Inpatient Treatment Information Form” available at contracted hospitals which is to be filled out by the surgeon who will perform the surgery. It is important that the insured should take confirmation from our Company officers whether the expenses shall be covered or not prior to the inpatient treatment so that they would not be kept waiting during their hospital admittance procedures.

Fee payable to surgeon and the team: Another important issue the insured should consider is to find out the operating surgeon’s fee prior to the operation and confirm with the insurer whether that will be covered under the policy. This point is particularly important for the insured that are operated by a non-staff surgeon of a contracted health provider instead of a staff physician.

If the insured is operated at a contracted health provider by an outside physician and their team (Assistant, anesthesiologist), the fee payable to the non-staff surgeon and the team shall be deducted form the limit of the non-contracted institution according to the

payment rates specified in the policy and be at most in the amount of the staff physician fees specified in the contract entered into between the health provider where the operation was performed and the insurer. If the fee asked by the non-staff physician is more than the amount to be paid to the health provider by the insurer for the staff physician and the team, the difference should be paid by the insurer.

Fees to be paid to the surgeon in relation to the operations made outside the contracted health providers or at the physician's practices shall be deducted from the non-contracted institution limit according to the payment rates specified in the policy and covered up to an amount of the fees specified in the Turkish Physicians Association Minimum Fee Tariff.

If more than one operation is carried out in one clinic and if some of the operations are not covered under the insurance policy, the expenses regarding the operation or operations that are not covered herein shall not be paid; Expenses for the operation or operations covered under the insurance shall be paid in proportion with all operations carried out in the same clinic to the total rate of the operation or operations specified in the Turkish Physicians Association Minimum Fee Tariff.

Coronary Angiography with catheter procedure, ectopic pregnancy operation and ESWL (breaking kidney stones) expenses which are carried out in hospital conditions shall be paid under the operation coverage.

The fee to be paid for the operations made outside the contracted domestic health providers and not specified in the Turkish Physicians Association tariff shall be deducted form the non-contracted institution limit according to the payment rate specified in the policy and be limited to the amount stated in the agreement executed by our company and an equivalent hospital among the contracted health providers.

2. Hospital room - meal - attendant fees:

If the Insured is treated on inpatient basis, expenses for room-meal-attendant for each full day shall be paid within the limits specified in the policy and the special and general terms and conditions of the policy for each admission to inpatient treatment in health providers. In case of lodging in luxury rooms or suites, the payment for bed, meal and hospital attendant expenses shall be limited to the amount for the single private room in the hospital where the treatment is received. The difference in between shall be paid by the insured.

The time to stay in a hospital is limited to 180 days for an annual policy period. Treatment expenses exceeding 180 days will not be covered by our Company.

3. Intensive care expenses:

In the cases causing an insured person to stay in the intensive care unit of a hospital, intensive care expenses are paid within the scope of the special and general terms and conditions of the policy and the limit specified in the policy up to 90 days at most by being deducted from 180 days, which is the total limit to stay in a hospital.

4. Physician follow-up expenses:

The expenses regarding the physician follow-up incurred by the insured during the inpatient treatment at the health provider shall be paid within the limit specified in the policy, and the special and general terms and conditions of the policy. Physician follow-up expenses should be specified as a separate item in the health provider's invoice.

If an outside physician is consulted for follow-up and medical consultation in the contracted health providers, the fee to be paid to that physician shall be deducted form the non-contracted institution limit according to the payment rate specified in the policy and be equal to the staff physician's fee specified in the contract entered by and between

the hospital and the insurance company. If the outside physician asks for a higher fee, the difference in between shall be paid by the insured.

Physician follow-up expenses of the insured in the non-contracted health institutions will be deducted from the non-contracted institution limit according to the payment rate specified in the policy and will be covered up to an amount of the fees specified in the Turkish Physicians Association Minimum Fee Tariff. If the amount in the invoice is more than the physician follow-up fees specified in the Turkish Physicians Association Minimum Fee Tariff, the difference in between shall be paid by the insured.

5. Drug expenses (Inpatient):

The expenses of drugs prescribed during the inpatient treatment of the insured at the health providers shall be paid within the limit specified in the policy, and the special and general terms and conditions of the policy.

6. Diagnosis units expenses (Inpatient):

Diagnosis clinic expenses during the inpatient treatment of the insured shall be paid within the limit specified in the policy, and the special and general terms and conditions of the policy.

Fees to be paid to the physician in relation to the procedural tests for the purpose of diagnostics done outside the contracted health providers shall be deducted from the non-contracted institutions limit according to the payment rates specified in the policy and be covered up to the amount of the fees specified in the Turkish Physicians Association Minimum Fee Tariff.

If the procedural tests for the purpose of diagnostics carried out by the non-staff physicians at the contracted health providers, the fees to be paid to such physicians shall deducted from the non-contracted institutions limit according to the payment rates specified in the policy and be up to the amount of the fees specified in the agreement signed between Anadolu Sigorta and the health provider.

7. Chemotherapy and radiotherapy expenses:

Expenses of chemotherapy and radiotherapy (physician, room-meal-attendant, drug, opening of venous port) and blood tests required for performance of these two procedures prior to chemotherapy and radiotherapy, blood test done for evaluation of complications which may occur post radiotherapy and chemotherapy and treatment of complications are included in this coverage in accordance with the special and general terms of the policy.

Drugs with "interferon alpha" active ingredient used in treatment of hepatitis C outside cancer treatments (Roferon-A or Intron-A) and drugs with "peginterferon alpha" active ingredient (Pegasys or Pegintron) used in treatment of hepatitis outside cancer treatments will be paid out of chemotherapy coverage.

Expenses for examinations and tests performed to evaluate the course of this disease after chemotherapy and radiotherapy will be paid out of the relevant coverage. It will not be paid out of the chemotherapy coverage.

For chemotherapy/radiotherapy performed at a contracted health provider by an outside doctor who is not a staff physician of that health provider, the fee payable to the non-staff physician will be deducted form the non-contracted institution limit according to the payment rates specified in the policy and be up to the amount of the staff physician fees specified in the agreement entered into between the health provider where the procedure was performed and the insurer. If the outside physician asks for a fee higher than that fee, the difference in between shall be paid by the insured.

Fees to be paid to the physician in chemotherapy and radiotherapy treatments performed at the non-contracted domestic health providers will be deducted from the non-contracted institution limit according to the payment rates specified in the policy and be up to the amount of the fee specified in the Turkish Physicians Association Minimum Fee Tariff.

8. Dialysis related expenses:

Dialysis related expenses – including physician, room-meal-attendant, drug, diagnostics, shunt opening, etc. will be paid within the limits specified in the special and general terms of the policy.

If dialysis is performed on the insured at a contracted health provider by an outside doctor who is not a staff physician of that health provider, the fee payable to the non-staff physician will be deducted form the non-contracted institution limit according to the payment rates specified int he policy and be at most up to the fees received by the staff physician specified in the agreement entered into between the health provider where the procedure was performed and the insurer. If the outside physician asks for a fee higher than that fee, the difference in between shall be paid by the insured.

In dialysis treatments performed outside the domestic contracted health providers, the fee to be paid to the physician will be deducted from the non-contracted institution limit according to the payment rate specified in the policy and be up to the fee specified in the Turkish Physicians Association Minimum Fee Tariff.

C. Other coverage:

1. Home care expenses:

Expenses of medical care and treatments administered at home only by medical staff for continuation of the said treatment after the insured's being treated on inpatient basis at a health provider will be covered out of this coverage within the limits specified in the policy and the special and general terms of the policy. For the insured to be able to make use of this coverage, it is mandatory that the insured or the treating doctor notifies the insurer that the treatment of the insured must be continued at home accompanied by health care staff with a report when the insured is discharged from the hospital and the insurer approves the situation.

Conditions such as the insured not being able to perform daily vital activities on its own, being incontinence or immobilized, needing help in eating, taking oral drugs, not being able to take a bath on its own or taking bath with the help of others, needing urinary catheter care, living on its own at home and having a chronicle disease which requires social support are not covered under the Home Care Services coverage.

2. Artificial limb expenses:

If an artificial limb is required for the treatment of an organ which lost its functions due to an accident or a disease during the term of the policy, artificial limb expenses (artificial hand, arm, leg and prosthesis outside the scope of aesthetical purposes) shall be paid within the limits of coverage and the special and general terms of the policy. Artificial limb coverage shall only cover the apparatus (Material) used. Artificial limbs to be used for the disability and renewal of the existing artificial limbs occurred prior to the commencement date of the insurance and dental prosthesis are not covered under the policy.

All expenses relating to the reconstruction surgery carried out after mastectomy for breast cancer covered by the policy will be paid within the limits of this coverage. Other coverage such as further surgery, room-meal-attendant, physician's follow-up, inpatient

drug, inpatient diagnosis, etc. will not go into effect. The expenses for breast prostheses to be used by the insured for breast cancer covered by this policy will also be paid under this coverage.

3. Auxiliary medical equipment:

As a part of the treatment applied to the insured as a result of a disease or accident that occurred after the starting date of the insurance, medical equipments such as personal splints (orthesis, braces, active ankle, bone spur pad) orthopedic sole plate, walker, elastic bandage, sling, corset, varsity sock, nebulizer, hearing aid, cervical collar, kneepad, wristguard, seating cushion and crutch to be used as external support for the body only for medical purposes will be covered out of this coverage according to annual limit and payment rate specified in the policy. Auxiliary medical equipments other than the above-mentioned equipments are outside the insurance coverage.

4. Dental treatment expenses as a result of traffic accident:

This coverage shall only apply to the insured whose policies cover dental treatment expenses which occur as a result of traffic accident..

Expenses relating to dental treatment of the insured provided as a result of a traffic accident will be paid within the limit specified in the policy and the policy special and general terms, provided they are performed by hospitals, clinics licensed by the Ministry of Health and/or dentists licensed to open private practices. All expenses for the dental treatment required as a result of traffic accident (including dental and dental gum surgeries) are outside the scope of the other coverage. For treatment expenses of dental disorders occurring as a result of traffic accidents, the insured must get treatment within 90 days from the accident and the judicial report stating that the teeth were damaged is produced to the insurance company alongside with the invoice. Other expenses relating to dental treatments other than curing of damage sustained by teeth as a result of traffic accidents are not paid.

Invoice or self employment receipt for dentist fee relating to dental treatments as a result of traffic accidents and the graphic scheme of the mouth displaying which tooth is being treated should be submitted. The insurance company may also require a dental x-ray and the detailed report of the dentist treating.

5. Ground ambulance coverage:

In cases of “Emergencies” specified herein below, the insured may, free of charge, make use of ground ambulance services in the company of a doctor, and receive consultancy services, by calling the alert center in Istanbul at the phone number printed on the back side of their insurance cards, where doctors employed by the firm which provides such services for Anadolu Sigorta are available on the basis of 7 days a week and 24 hours a day. The firm which provides such services for the Insurance Firm shall also provide such services in provinces and districts other than Istanbul, where it has a local organization. As a response to calls from insured persons outside Istanbul, the Alert Centre shall direct the closest ambulance to the location of the insured, in the company of a doctor. The arriving team may either treat the insured at home or will take him to a suitable health provider. The insured will not pay any fee for this service provided by the contracted health provider of the Insurance Company in case of “Emergency Situations” specified herein below.

In case, in an emergency, the insured makes use of another ambulance other than those provided by the contractor of the Anadolu Sigorta, the ambulance fees for each case shall be reimbursed within the limit specified in the policy, and the Special and General Terms of the policy.

Cases to be considered as “Emergencies” within the policy are specified in the following list:

Drowning, traffic accident, falling down from height, loss of limb, electric shock, frostbite, cold and heat stroke, severe burns, eye injuries, poisoning, anaphylactic reactions, broken bones, myocardial infarction, hypertensive encephalopathy, acute cerebrovascular attack, sudden strokes, diabetic and urea coma, acute massive hemorrhages, acute kidney failure, meningitis, encephalitis, brain abscess, foreign substance in respiratory passage, high fever (39.5 degrees and over).

II. SPECIAL TERMS AND CONDITIONS REGARDING IMPLEMENTATION

1. Policy issuance:

a. Maximum age for being insured is 64.

One person can not be insured under more than one Foreign Nationals Health Insurance policy of Anadolu Sigorta.

b. Before providing coverage for the child(ren) in families with child, the co-insurance request of the parents shall be accepted. Moreover, all the children younger than 18 should be included in the insurance coverage, if any of them are to be included at all.

Family discounts are not applied for family policies. Children under the age of 18 cannot be insured on their own within the scope of this policy. It is necessary for children under the age of 18 to be insured together with one of their parents within the scope of the policy. Newborns can be included to the scope of the policy as of the 14th day after their birth at the earliest.

c. The insurance company may request the following before approving the coverage;

- For the candidates at or over 55,

- Height- weight index (height-Weight Index=Weight(kg)/Height^2(m)), for the candidates at or over 35,

-although not included in the above two categories, candidates who are required by our Company physicians to have some tests, all shall be requested to have the tests which are specified by the Company to be carried out before they are accepted under the insurance coverage.

The health provider which will carry out the tests shall be determined by the insurer and the test expenses shall be paid by the insurer to the health provider. Whether the candidate shall be approved under an insurance coverage or not or the conditions of such coverage shall be determined by the insurer upon the review of the pre- test results.

As a result of the tests, if some test results of the candidate are above the normal levels, the insurer may ask the candidate to have more tests done in order to understand the seriousness of the health problem. Expenses of such tests shall also be paid by the insurer.

d. If number of dependants increase after the commencement date of the policy; a new application form should be filled out for each dependant and if the dependant is a new born baby then a detailed physician report reflecting the health condition of the new born baby and if the dependant is a spouse then the official documents such as marriage certificate should be submitted to the insurer. Family members who are entitled as a dependant at a later date should be included in the insurance coverage within 30 days at the latest as of they are entitled to become a dependant. Premiums to be paid for the dependants who are taken under the policy after the commencement date of insurance are to be paid on the basis of the days acquired.

e. The insured's age is determined by subtracting the birth date of the person in question as day/month/year from the issuance date of the policy.

2. Commencement of the policy:

Medical Insurance policy coverage shall commence on the condition that, upon the approval of the acceptance form and conduct of the risk assessment done by the insurer, the policy is drawn up and the premium is paid in full.

3. TERM OF THE INSURANCE CONTRACT:

The contract term for medical insurance shall be 1 year. The medical expenses incurred by the insured on the commencement date specified on the policy, regardless of the time of the day, shall be paid within the limit specified in the policy, and the special and general terms and conditions of the policy. However, the medical expenses incurred by the insured on the expiry date of the insurance, regardless of the time of the day, shall not be paid under the policy.

For a medical insurance policy to be accepted as renewal, new policy should become effective on the expiry date of the previous policy. Loss of rights may occur for the policies which have expired but the term has not been renewed. Policies must be renewed within 30 days at the latest following expiration.

Inpatient treatment cover accepted by the insurer prior to expiration of the insurance, in case contract term is expired and no new contract has been signed, shall continue for only an additional ten days on the condition that duration and cover limit specified in special terms are not exceeded. In case the private policy is renewed, medical expenses for the relevant treatment shall be paid within the limit and according to payment rates specified in the policy, and the special and general terms and conditions of the policy.

4. Renewal of Foreign Nationals Private Medical Insurance Policy

Anadolu Sigorta has the initiative renew the policy in the next year for the foreign nationals within the scope of the Law on Foreign Nationals International Protection numbered 6454.

Anadolu Anonim Türk Sigorta Şirketi may require the insured to get certain controls done during the renewal of the policy whenever it deems obtaining information about the health condition of the insured necessary.

We do not have a "Renewal Guarantee" in our foreign nationals health insurance policy.

Vested interests in Foreign Nationals Health Insurance policy are not transferable to personal or corporate health insurance policies of Anadolu Sigorta.

Practices in relation with transfers from other insurance companies

Earned rights of the people who were insured with other insurance companies but who wanted to have Foreign Nationals Health Insurance by Anadolu Sigorta in the new period by not renewing their then current insurances will not be taken over by Anadolu Sigorta.

5. Discount and additional premium implementation:

Family deductions, no-claim bonus, extra claim premium, member and associated institution deductions are not included in the Foreign Nationals Private Medical Insurance Policy.

- The important diseases of insured people, which emerged during the period of their insurance within the scope of the Foreign Nationals Health Insurance, may be a cause for taking additional premiums while their insurance policy is being renewed for the next year. Additional premium rate which will be effective for each renewal year shall not exceed 50% for each illness.
- Any expenses regarding conditions of which symptoms/findings or diagnosis and/or the beginning of treatment predates the insurance commencement date, as well as complications to arise in relation thereof shall be covered by the policy, if deemed fit as a result of a risk assessment provided that illness premium is applied. An illness premium at the rate of maximum 200% of the base premium shall be applicable per illness. It is at the discretion of the Insurer.
- Base tariff premiums, which are to be actuarially calculated, of the policyholders shall be increased at the rate of maximum 50% in policy renewal period. The maximum increase rate, which is 50%, has been determined based on the assumption that inflation rate would not exceed 15% and, in case inflation rate exceeds this rate, the difference in between shall be added to the rate of 50%.

6. Termination of policy due to undeclared illnesses or leaving illnesses outside the scope of insurance:

a. This policy has been issued considering that any information given in the approval form of the insured are complete and true. In case the declaration by the policy holder/insured is incorrect or incomplete, the insurer reserves the right to decline or cancel the contract.

b. The policies of all insured covered under the policy shall be terminated immediately, in case any one of the insured covered under the policy acts in violation of general terms and conditions of the policy or implementation principles, or attempts to willingly benefit from the insurance, and the premiums shall not be revoked or the policy shall continue on the condition that the illnesses known by the insured and not declared in the health report but identified by the insurer at a later date are left outside the policy coverage.

7. Automatic termination of the policy:

The policy of a dependent covered under the medical insurance coverage shall be terminated automatically if any of the following occur;

a. If policy of an insured is terminated due to incomplete and wrong declaration or an ill-intentioned act, policies of other members of the family shall also be terminated as of the same date.

b. If the contract expires,

c. If dependant is no longer a dependant. Policy of the spouse of an insured divorced shall be canceled as of the date of divorce. Policies of married children shall be canceled as of the date of marriage. In the year single children become 31 shall be excluded in the family policy during the policy renewal period. The above-mentioned persons, if they wish to, may continue their insurance by purchasing any other policy without any interruption for more than 1 month.

8. Right of recourse of the Insurer:

In case the Insurer becomes obliged to make payments in violation of the special and general terms and conditions of the policy due to provision of incorrect and/or incomplete information by the insured or the physician, it shall collect the figures paid as such through subrogation from the insured. Moreover, this practice shall also apply for the payments the insurer is obliged to make on behalf of the insured to "Contracted Health Provider" in accordance with the "Outpatient Direct Payment Agreement" in relation to the expenses in breach of the special and general terms and conditions of the policy.

Any payment by the Insurance Company of any amounts which are not covered by the policy shall not vest a right to the insured.

9. Pre-Approval before inpatient treatment:

The Insured should notify the Insurer a few days prior to any admittance to a health provider where the Insured should receive inpatient treatment in order to facilitate the procedures, except for the emergency cases where the Insured should be admitted immediately to a health provider. Moreover, submitting the claims to the Insurer within 10 days as of the invoice date shall speed up the procedure.

10. Subjection of the insured to physician's examination and tests:

Upon its discretion, the insurer may also require the insured to undergo an examination by a doctor to be appointed by the insurer, during the processing of the indemnity request. Prior to paying health expenses of the insured or when the insured is to receive inpatient treatment, the Insurer, if deems necessary, may require some examinations prior to its approval for inpatient treatment. Furthermore, with the insured's written approval, it shall also be entitled to request information and copies of records regarding the medical history of the insured, from all doctors, health providers, Social Security Institution, Insurance Information and Monitoring Center (SBM), public institutions, and third persons involved in the treatment of the insured before and after the insurance period. Anadolu Sigorta may transfer any and all details in relation to insured's health information to Insurance Information and Monitoring Center (SBM) and third persons involved in insurance services.

11. Wrong treatments Applied:

All liability for wrong treatments of the insured by the health providers or physicians shall be of the health provider physicians that applied the treatment.

12. Indemnity procedures:

In case the insured applies to a contracted provider for treatment, the contracted health provider receives a provision from our Company and the insured checks out the contracted health provider after paying the patient share within the coverage limits and signing a waiver.

If treatment is provided by a non-contracted provider, the insured is required to submit the invoice against the treatment expenses and other documents to our Company. Treatment expenses are assessed in accordance with the special and general terms and conditions of the policy and the indemnity amount to be paid is paid into the account of the insured.

For the payment of indemnity against the treatment expenses, the following documents should be submitted to the insurer:

a. Indemnity Claim Form (relevant fields of the Claim Form should be filled and signed by the insured, doctor, or the health provider where the treatment was received.),
b Original invoices for all expenses and invoice statements,
c. Operations report and/or patient release epicrisis for inpatient treatments,
d. Results of analyses for the diagnosis of the condition,
e. Alcohol report, judicial report and traffic accident report, in case the treatment is necessitated by a traffic accident; alcohol report, judicial report and statement of the insured, in case of any other kinds of accident.
f. Original prescription, drug packing clipping cuts and receipt or invoice from the pharmacy, (attaching to the prescription and submitting of drug tags),
g. Original of paranasal sinus tomography before sinusitis surgeries,
h. For physiotherapy expenses to be payable, the results of imaging making treatment necessary (MR, tomography, ultrasound, etc.) and detailed physician's report (how many sessions of physiotherapy are needed, detailed breakdown of therapy which must be administered in one session),
i. Translations in Turkish of the reports and examinations carried out abroad, documents proving payment was made (credit card statement, credit card slip, remittance slip)
J. Chemotherapy treatment schema.

The insurer makes the indemnity payments online into the bank account of the insured within 15 (fifteen) business days.

Information on the indemnity payment shall be transferred to Insurance Information Centre.

13. Death of the insured:

Upon the death of the insured while under treatment for a condition or injury, the expenses incurred for his/her treatment, provided that such are covered in the policy and coverage, shall be paid to legal heirs which submit the required paperwork for indemnity claim. The insurer shall be relieved of all its obligations as of the date on which the indemnity is paid. The policy shall then be terminated, and any unaccrued premium shall be returned on the basis of remaining days in the policy term. In case of family policies, the dependents shall benefit from the insurance coverage till the end date of insurance. On the insurance end date, a new family policy shall be drawn up for the dependants.

14. Changes in the policy terms and conditions:

The insurer is free to effect changes in the Special Terms of the Policy and the Scope of the Policy. However, such changes shall take effect on the renewal date of the insured's contract and in case the policy is renewed.

15. Premium payments, default in premium payments, and cancellation upon the request of the insured:

The full insurance premium shall be paid immediately after the agreement is executed and at latest against the delivery of policy.

Unless otherwise agreed, the liability of the insurer does not commence in the event that the insurance premium is not paid even if the policy has already been delivered.

Insured people can pay for their premiums only by using their credit cards. Payments made with methods other than credit cards will not be subtracted from the premium debt.

The insured, who fails to pay the premium required in compliance with article 1431 shall lapse into default as per article 1434 of Turkish Commercial Code. If the premium, the entire amount of which should be paid at once, has not been paid in due time, the insurer may withdraw from the contract within three months during the period in which the payment is not made. This period shall start with the date of maturity. If the premium receivable is not claimed by suit or through execution proceedings within three months following the date of maturity, the contract shall be deemed to have been withdrawn from. If the premium amount is not paid in due time, the insurer shall warn the insured through the channel of a notary public or by registered mail by giving him/her a period of ten days to fulfill his/her obligations and states that otherwise, the contract shall be deemed to have been terminated at the end of this period. If the subject debt is not paid by the end of this period, the contract shall be deemed to have been terminated. The other rights of the insurer arising from the Turkish Code of Obligations due to the default of the insured shall be reserved. If two warnings were sent to the insured within one insurance term, the insurer may terminate the contract to be effective at the expiry of the insurance term.

In case the insured requests in writing the cancellation of the policy;

According to "the Notice Regarding the Private Health Insurances to be Made for Residence Permit Requests" numbered 9 and dated 6.6.2014, the following conditions must be fulfilled in order to finalize the policies issued in accordance with the Law on Foreign Nationals and International Protection with the demand of the insured.

*Upon submittal of a new private insurance policy to the Company which covers the period of the residence permit,

*Upon cancelation of residence permit,

*Upon submittal of the document evidencing the coverage of a General Health Insurance as per the Law No.5510 on Social Insurance and General Health Insurance

The policy cannot be canceled otherwise.

a. In case the premium paid by the insured is more than the premium earned by the Insured on the basis of days, the Insurer shall return the difference to the insured.

b. In case the premium paid by the insured is less than the premium earned by the Insured on the basis of days, the insured shall pay the difference to the insurer.

c. In case there are outstanding back charges, unpaid despite recourse from the insured, the back charges figure shall be deducted from any returnable premium upon the cancellation of the policy, and the remainder shall be returned to the insured.

16. Treatments, inspection and examination expenses of the disorder emerging after the starting date of the insurance and the expenses regarding the treatments, examinations and inspections for the complications to result from such disorders, all of which are specified below, will be outside the scope of the policy for 1 year after the starting date of the insurance. A waiting period of one year will also apply in emergencies to occur in relation to the diseases given below.

1. Wart, lipoma, cyst sebaceous (wen),

2. Varicotomy, anorectal (Hemorrhoids, anal fissure, fistule, anal abscess, etc), pilonidal sinus (sacral dermoid cyst), hydatic cyst, hernia (inguinal etc), gall blader, thyroid and breast diseases,
3. All expenses regarding nose, nostrils and adenoid, sinusitis, hearing impairment surgery and ear ventilation tube, thympanoplasty, etc,
4. Cataract surgery, glaucoma,
5. Uterus, ovaries, cystorectocele, cyst of bartholin gland,
6. Knee surgery (meniscus lesion, rupture etc), trigger finger, neuropathy and ganglion, cystic hygroma, morton neuroma,
7. Urinary system stone diseases, hydrocele and prostate,
8. Spinal diseases and disc diseases, facet denervation, nerve blockage,
9. Any organ transplantation
11. Diseases in connection with blood pressure,
12. Diabetes,
13. Heart diseases,
14. All endoscopic and invasive diagnosis procedures,
15. All kinds of cancer,
16. Ulcer, gastroesophegal reflux,
17. Physiotherapy,
18. Rehabilitation

17. Circumstances not covered by the policy:

Any expenses (physician's examination, tests, etc) in relation to the following conditions, regardless of reason of occurrence shall be outside the scope of the policy:

1. Exclusions provided in the General Terms and Conditions of the Medical Insurance.
2. Expenses regarding existing conditions of the insured, as specified in the policy and hence exempted, as well as expenses regarding the complications of such diseases,
3. Any expenses in relation to conditions of which symptoms/findings or diagnosis and/or the beginning of treatment predates the insurance commencement date, as well as complications to arise in relation thereof.
4. Costs of treatments of alcohol and narcotic addiction, expenses relating to disorders and accidents occurring as a result of alcohol and narcotics, any medical expenses incurred as a result of accidents caused by the insured who have no driver's licenses when driving, expenses relating to treatments incurred due to taking part in a fight, or willing and unwilling self inflicted injuries.
5. Officially declared epidemics,
6. Any aesthetic surgery save those required by accidental injury to the insured, sclerosing treatment of varicose (sclerotherapy), treatments for cosmetic purposes, alopecia (hair loss), hair transplantation, hirsutism, gyneacomastia tests and treatments, etc., breast enlargement and reduction; orthopedic treatment, skin moisturizer and cleaning formulations, sweeteners, obesity tests and treatment, medicine etc. used for dietary purposes, asthenia, spa regimes, mud baths, quarantine, acupuncture, massage, mesotherapy, magnetotherapy, voice and speech therapies, etc.; bills received from nursing homes, sanatorium, spas, fitness and beauty salons, foot care centers and institutions which do not fit the "Health Provider" definition prescribed in the policy; alternative medicine treatment expenses, treatments which are not scientifically proven, experimental treatments and tests and treatments which have not been approved by American Food and Drug Administration (FDA) or which are still in experimental stage, gene therapy, anti-aging, any examination, test and treatment costs of health providers and/or physicians applying balanced nutrition and person specific diet, exercise plans,

any test, follow-up, procedure and drug costs of anti-aging applications, PERTH (Pulsating Energy Resonance Therapy), any examination, test and treatment expenses relating to metabolic syndrome diagnosis and expenses of any complications arisen in relation to such treatments, expenses of hyperhidrosis (excessive sweating),

7. All expenses for treatment and care provided by persons who do not meet the definition of "Doctor" as defined in the policy (physiotherapists, dietitians, private nurse etc.),

8. Expenses for infertility tests and treatment (Ovulation monitoring, HSG, adhesiolysis, tobuplasty etc.), any medical or surgical artificial insemination, structural defects relating to reproductive organs, sexual dysfunctions, sex change operation, circumcision (even for the treatment of phimosis), voluntary abortion, castration, expenses regarding the birth control methods,

9. Whether or not they are related to infertility, expenses regarding all kinds of varicosele examinations and treatments and expenses regarding the diagnosis and treatments of spermatocell, cord cysts and epididymis cysts,

10. Expenses for phantom pregnancy (psychological pregnancy),

11. Expenses for motor and mental development disorder, growth and development retardation,

12. Expenses for doctor's examination for general medical controls and check-ups, periodical controls and analyses requested by a doctor to diagnose a condition, yet which are unrelated to the condition in question,

13. Diagnosis and treatment at psychiatry clinics and/or by psychiatrists and psychologists, psychiatric conditions, psychotropic medicine, regardless of their connection with the treatment of a psychiatric condition,

14. Medical materials such as baby formulae, baby diapers, feeding bottle and pacifiers; all kinds of soap, shampoo and solution, alcohol and cologne; cotton wad, thermometer, ice pouch, hot water bottle etc.; supporting medical materials such as sleep apnea device, wheel chair, dental prosthesis etc. and phone and TV expenses, materials which are not required for treatment, and various administrative costs,

15. Inoculations other than the routine inoculations of the children in 0-6 age group and the test expenses regarding these inoculations,

16. Expenses for all kinds of allergy tests and allergy vaccines,

17. Hepatitis markers (except for infants at the age of 0-6),

18. All doctor, medicine, diagnosis, room-meal-hospital attendant expenses and all other expenses for any condition regarding which the operation and birth coverage payments are not made due to exemption from coverage,

19. Conditions to occur in connection with AIDS and HIV virus, and venereal diseases,

20. In case of organ and tissue transplants, the expenses of donor, organ and tissue costs and transport expenses of organ and tissue,

21. Expenses relating to disorders which may occur due to participation in dangerous sporting activities (riding, driving, mountain climbing, climbing, canoe, rafting, parachute jumping, sky diving, bungee jumping, civil aviation, delta plan, zeppelin, balloon, etc.).

22. All diseases and disabilities to occur due to participation in all kinds of competition and/or training as a professional or amateur licensed athlete,

23. Medication costs bought without prescription, invoice and clippings and other expenses without invoice,

24. Transportation and accommodation etc. costs incurred by the insurer when filing for claims or during treatment,

25. All expenses regarding examination, diagnosis, dental and gingival treatments and jaw treatments carried out by dentists and jaw surgeons, regardless of the cause (However, dental expenses of the insured that are covered by dental treatment after a

traffic accident in their policy, which occurred after a traffic accident shall be paid within the limits of coverage),

26. Glasses, frames, lenses; operations to eliminate refractive defects in the eye (myopia etc.), and expenses regarding strabismus,

27. All kinds of diagnosis and treatment costs regarding coverage not included in the policy,

28. Expenses regarding acne, folliculitids, comedo, veneral wart and condyloma, nevus, epilepsy, snoring and sleep apnea syndrome,

29. Geriatric disorders, dementia related to old age and Alzheimer disease, Parkinson

30. Expenses related to ingunial hernia of infants up to 24 months (except for children with inborn diseases coverage)

31. All expenses regarding septum deviation, concha hypertrophy and hallux valgus diseases

32. Coronary Artery Calcium Scoring Test, Coronary VCT Angiography and any tests listed under the heading EBT (Electron Beam Tomography) in Turkish Physicians Association Minimum Rate Schedule, virtual angiography and virtual colonoscopy, and expenses of similar screening tests.

33. Examination, test and treatment expenses given by individuals who have first or second degree blood relation to the insured.

34. Any expenses relating to taking cord blood and stem cell, transplant and processing thereof.

35. Costs of any equipment, device which can not be considered as medical supplies and supporting medical supplies and regardless of name and title, cost of use of such instruments, rental of devices-equipment (e.g. Robotic surgery usage – rental fee).

36. Expenses incurred for health committee report obtained for causes like pre-marriage, pre-job start and pre-sporting activities, etc.

37. Suite and luxury room price difference in case of accommodation in rooms other than normal rooms,

38. Funeral expenses in case of death (morgue, transportation of the body etc.),

39. All kinds of spinal curvature (kyphosis, scoliosis, etc.),

40. Expenses regarding screening for family-related risk factors,

41. All expenses regarding diseases the formation of which were affected by congenital (natal), structural or genetic faults (e.g. AVM Accessory Pathway/WPW syndrome, ASD etc.) notwithstanding whether or not their existence is known and genetic tests

42. Expenses of prescription drugs and/or tests for the spouse and/or children of the employees prescribed by the occupational physicians

43. Patient shares that the insured are liable to pay pursuant to Article 98/2 of the Social Security and General Medical Insurance Law No 5510 shall not be paid.

44. “Daily incapacity allowance determined for the earnings that can not be obtained by the insured due to inability to work as a result of illness" which should be paid pursuant to subparagraphs c and d of paragraph 1 of Article 1513 of the Turkish Commercial Code and “expenses arising as a result of care or daily care allowance determined if the insured becomes in need of care” are not covered herein.

45. Diagnoses and treatment expenses regarding Menopause, Pre-Menopause, Osteoporosis and Andropause and their complications,

46. Otosclreosis diagnosis and treatment,

47. Expenses for normal delivery, cesarean expenses, pregnancy routine controls and complications due to pregnancy and labor (Compulsory abortion, miscarriage, miscarriage risk, pregnancy induced vomiting, postnatal complications, etc.) shall be covered within the limit of

48. Incubator expenses.

III. DEFINITION OF TERMS

Insurer: Anadolu Sigorta.
Insured: It refers to the person who filled out an approval form in order to become insured in accordance with articles of this policy and whose application is confirmed by Anadolu Sigorta and a policy has been drawn up.
Dependent: Refers to the spouse, children and step children and legally adopted children up to age 30 of the insured, who are included in the insurance coverage as per the articles of this contract.
Spouse: Refers to the person with whom the insured is legally married.
Medical institution: The institution to which operating license was given by the Ministry of Health of Turkey and which

- Provides patient care for 24 hours per day,
- Is qualified for diagnosis, treatment, and surgical operation,
- Where one or more physicians are available for operation at all times,

The term "Health Provider" shall not be interpreted in a manner to include also hotels, nursing homes, convalescent hospitals, orphanages, poorhouses, places dedicated primarily for the isolation and treatment of substance and alcohol addicts, sanatoriums, spas, medical hydrosis, and weight loss resorts.
Contracted health provider: Refers to health providers with which Anadolu Sigorta has entered into direct payment contracts with, for the medical services to be provided to those who have medical insurance. The insurer is entitled to effect changes in the "Contractor Medical Institutions List" during the policy term.
Physician: Refers to qualified persons who have graduated from Medical School, who is licensed for all kinds of diagnosis and treatment, and to whom the patients apply for diagnosis and treatment of conditions.
Treatment: Refers to procedures carried out at health providers (hospital, clinic, polyclinic) which were granted operation license by the Ministry of Health of the Republic of Turkey or authorization certificate by the Ministry of Health of the Turkish Republic of Northern Cyprus, or at private practices, by physicians qualified to work, with the purpose of treating diseases. Expenses regarding self-treatment by a doctor who is also an insured before Anadolu Sigorta shall not be paid.
Inpatient treatment at health provider: Refers to the treatment of the insured at a "Health Provider" as defined above, on an in-patient basis, through the accrual of room and meal costs.
Outpatient treatment: Refers to medical treatment provided at health providers, private practices, and polyclinics, without providing of room and meals.
Expenses required for treatment: Refers to expenses for treatment, service, or use of equipment with regards to a disease or injury.
Coverage: Refers to the guarantees provided to the insured in accordance with the General Terms and Conditions of Medical Insurance and Special Terms and Conditions of Anadolu Sigorta Foreign Nationals Health Insurance.
Conditions predating insurance commencement date: Conditions of which symptoms/findings or diagnosis and/or the beginning of treatment predates the insurance commencement date, as well as complications to arise in relation thereof.
Payment limit: Refers to the upper limit specified in the policy, regarding the payments to be made by Anadolu Sigorta in relation to the expenses incurred by the insured.

Insurance end date: Refers to the expiry date mentioned on the policy for the insurance coverage. The medical expenses incurred by the insured on that date are not covered under the policy.
Renewal: Refers to the continuation of the insurance at the policy expiry date, through the payment of the premium for the policy for the new term, provided that Anadolu Sigorta approves so.
Turkish Physicians Association (TTB) Minimum Fee Tariff: Refers to the booklet where the minimum rates for medical services provided to patients (physician's fee, diagnosis fee) are determined for each 6 months period, and the operations are classified.
Insurance Premium: Premiums for private medical insurance products are determined on the basis of age, gender, coverage limit for the product of choice, coverage structure and payment rates, medical institutions where the product applies (network), and the rate of increase of treatment costs.

GENERAL TERMS AND CONDITIONS OF MEDICAL INSURANCE

SCOPE OF COVERAGE

Article 1:

The present insurance pays the expenses required for treatment, and daily damages, if any, within the framework of the present general terms and conditions, and special terms and conditions, if any, up to the figures specified in the policy, in case the insured persons fall ill and/or incur any injuries throughout the term of the insurance.

EXCLUSIONS

Article 2:

The illness and/or injury due to any accident, of the insured during the term of the insurance, in the cases described below, shall be excluded from coverage under the insurance.

a. War or any operation having the nature of war, revolution, rebellion, riot or any civil disturbances arising thereof;

b. Criminal acts or attempts at crime,

c. Except from the intention of saving persons and goods in danger, insured's taking actions that would put him/herself in great danger,

d. Use of substances such as heroin and drugs,

e. Any kind of assaults and sabotages that would lead to a nuclear risk or use of nuclear, biological and chemical weapons or release of nuclear, biological or chemical substances,

f. All the damages that would arise from terrorist actions stated in the Anti-Terror Law No.3713 and any consequential sabotages or biological and/or chemical contamination or intoxications occurred as a result of interventions made by authorized bodies in order to prevent such actions or mitigate the effects thereof.

g. Illness or injuries that may come to occur due to attempted suicide by the insured

h. Other exclusions to be provided in the special terms and conditions of the policy.

EXCLUSIONS UNLESS PROVIDED OTHERWISE IN CONTRACT

Article 3

The illness and/or injury due to any accident, of the insured during the term of the insurance, in the cases described below, shall be excluded from coverage under the insurance, unless provided otherwise in the contract.

a. Earthquake, flood, volcanic eruption and land slide.

b. Acts of terror and sabotage defined in Anti-Terror Law No.3713 or operations by authorities in order to prevent such actions or mitigate the effects thereof, excluding the damages specified in sub-paragraph (f) of article 2.

TERRITORIAL LIMITS OF INSURANCE

Article 4
The territorial limits of the insurance shall be specified in the policy.

COMMENCEMENT AND END DATE OF INSURANCE
Article 5
The insurance starts at 12:00 at noon according to Turkey time and ends at 12:00 at noon according to Turkey time unless decided otherwise on such days as prescribed to be the starting and ending dates in the policy.
DECLARATION OBLIGATION OF THE POLICY HOLDER AT THE TIME OF EXECUTION OF THE CONTRACT
Article 6
The insurer has agreed to this insurance relying on the representations of the insuring party written in the proposal and if there is no proposal in the policy and endorsements thereof.
The policy holder/insured is under obligation to respond accurately to questions asked in the proposal and complementary documents, and to declare his/her knowledge regarding the issues which constitute the subject matter of the risk or which may affect the assessment of the risk. In case the declaration by the policy holder/insured is incorrect or incomplete, and in cases which require the insurer to refrain from executing the contract or which require harsher terms;
a. The insurer may withdraw from the contract within one month of coming to learn the facts, and may not pay indemnity to the insured in case the policy holder/insured has acted with mal-intent.
The insurer shall still earn the premium in case of withdrawal.
b. In case the policy holder/insured had not acted with mal-intent, the insurer shall terminate the contract within 1 month following the date it became aware of the facts, or may maintain the contract in force by collecting additional premium.
In case the policy holder/insured provides notification to refuse to pay the additional premium, within 8 days, the contract shall be deemed terminated.
The termination notice served by the insurer via return registered mail or notary public shall become valid at 12:00 on the fifth work day following the notification date of the policy holder/insured.
The premium for the time until the effective date of the termination shall be calculated on a daily basis and the excess shall be returned.
a. The right to withdrawal, termination, or request additional premium shall lapse unless exercised within the period specified.
b. In case the policy holder/insured had not acted with mal-intent, upon the occurrence of the risk:
1. Before the insurer becomes aware of facts, or
2. Within the period in which the insurer may serve notification of termination, or
3. Within the period required for the notification to be valid;
The insurer shall affect a discount on the indemnity to the rate of the difference between the actually accrued premium and the premium that should have been accrued.
OBLIGATION TO REPORT WITHIN THE INSURANCE PERIOD
Article 7
In case of any change after the execution of the contract, in the matters specified in the proposal, or in the policy and its annexes if no proposal is present, the policy holder shall be under obligation to report the case to the insurer, within a maximum period of 8 days.
Upon learning about the change, the insurer, should the change require the insurer to refrain from executing a contract or to impose harsher terms, may, within 8 days;
1. Terminate the contract, or

2. Keep the contract in force by demanding additional premium.

In case the policy holder provides notification to refuse to pay the additional premium, within 8 days, the contract shall be deemed terminated.

The termination notice served by the insurer via return registered mail or notary public shall become valid at 12:00 on the fifth work day following the notification date of the policy holder.

The premium for the time until the effective date of the termination shall be calculated on a daily basis and the excess shall be returned.

The right to terminate or ask for a premium difference, which is not exercised within the specified period, shall lapse.

In case the insurer, upon learning about the change, does not terminate the contract within eight days, or acts in a manner to confirm its consent to maintain the insurance contract as is, such as collecting insurance premium, its right to termination or demand additional premium shall lapse.

PAYMENT OF INSURANCE PREMIUM, COMMENCEMENT OF THE LIABILITY OF THE INSURER, AND DEFAULT BY THE POLICY HOLDER

Article 8

The full insurance premium or the first installment (advance payment) if payment of the premium in installments is accepted, shall be paid immediately after the agreement is executed and at latest against the delivery of policy. Unless otherwise agreed, the liability of the insurer shall not commence in the event that the insurance premium or advance payment is not paid even if the policy has already been delivered, and this matter shall be specified on the cover of the policy. In case the policy holder does not pay the insurance premium or the advance payment on the premium if payment in installments is accepted, before the end of the day on which the insurance policy was delivered, it shall be considered in default. In case the premium obligation is not paid even in the 30 days period following the date of default, the insurance contract shall be terminated without any further notice. In cases where it is accepted that the liability of the insurer shall commence with the delivery of the policy, even if the premium is not paid, the liability of the insurer shall remain in effect in the first fifteen days of the abovementioned one month period.

The final payment dates for installments in case installment payments are accepted, as well as the consequences of non-payment on the specified dates shall be noted on the policy, and the policy holder shall be informed of such in writing, along with the policy. The policy holder shall be in default in the event that it fails to pay any premium installments before the end of the due date which had been specified on the policy or notified to itself in writing. The insurance coverage shall be suspended in case the policy holder does not pay the premium obligation within fifteen days following the default. The coverage shall commence from the date of suspension, in case the premium obligation is paid during the suspension of the coverage, provided that the risk has not occurred yet.

In case the premium obligation is not paid within 15 days following the suspension of insurance coverage, the insurance contract shall be terminated without further notification.

If provided for on the cover of the policy, the premium installments yet to become due, shall become due upon the occurrence of the risk, to the amount not exceeding the indemnity to be paid by the insurer.

In case the insurance contract is considered terminated in accordance with the present article, the premium corresponding to the term for which the insurer had been under insurance obligation shall be calculated on the basis of days, and any excess payments shall be returned to the policy holder.

OBLIGATIONS OF THE INSURED UPON OCCURRENCE OF THE RISK

Article 9

A. Risk occurrence notification:

I. The policy holder / insured shall be under obligation to report in writing to the insurer, within eight days after becoming aware of the risk occurrence, or in any case after becoming able to report.

II. The policy holder / insured shall be under obligation to state in the said report, the place, date, and causes of the accident or illness, and also obtain and submit to the insurer a report by the physicians that apply the treatment, attesting the state of the accident or illness, and potential results thereof.

B. Commencement of treatment and taking necessary measures:

It is obligatory to commence treatment immediately after the accident or illness, and to take measures required for the recovery of the injured or patient.

The insurer shall be entitled to have the injured or patient examined or checked for his/her health at all times, and it is mandatory to allow the execution of such examinations or controls.

It is also mandatory to comply with the recommendations, which may directly affect the results of the accident or illness, by the physician of the insurer on the recovery of the injured or patient.

Upon failure to abide by the obligations specified in paragraphs (A) and (B) above;

a. willfully, the rights to arise out of the policy shall disappear.

b. due to negligence, and in case the results of the accident get more severe because of said negligence, the insurer shall not be held liable for the excess.

c. Delivery of required documents

The policy holder or the insured are under obligation to deliver with the firm notification and treatment forms to be filled out by the physician or hospital that carries out the treatment, the originals or copies beyond doubt of the documents which attest the examination, treatment, medicine and hospital expenses required to be paid due to the accident or illness.

DETERMINATION OF EXPENSES

Article 10

The present insurance shall provide coverage up to the limits specified in the policy for expenses incurred by the policy holder due to the occurrence of the covered risks, along with the daily damages, if any.

In the following cases, the insurer shall not fulfill the demands regarding the expenses:

a. Expenses which were not called for as part of the work, and claims exceeding reasonable figures on the basis of a special agreement,

b. Expense claims in breach of special terms and conditions of insurance,

In case the parties do not concur on the expense figures, the figure shall be established by persons to be appointed by the professional organizations of physicians, if any, or elected among experts, and which will be called arbitrator-expert, on the basis of the following provisions.

a. In case both parties fail to agree on the appointment of a single arbitrator-expert, both shall appoint its own arbitrator-expert, and shall notify the other about the event via the notary public. Within seven days following the appointment of arbitrator-experts, and before commencing review, the parties shall elect a third and neutral arbitrator-expert, and establish the event in a minute. The third arbitrator-expert is authorized to decide only on matters where the arbitrator-experts appointed by parties cannot agree on, and within the limits and scope of the said disagreement. The third arbitrator-expert may submit his/her decision in a separate report, or may incorporate it in a report with other arbitrator-experts.

The reports by arbitrator-experts shall be simultaneously notified to the parties.

b. In case a party does not appoint its arbitrator-expert within 15 days following the notification by the other party, or in case the arbitrator-experts of parties fail to agree on the election of the third arbitrator-expert within a period of seven days, the arbitrator-expert

of the party or the third arbitrator-expert shall be elected by the chief justice of the court with jurisdiction over commercial cases at the place of treatment, among impartial experts.

c. Both parties are entitled to request the election of the third arbitrator-expert from a place other than the residence of the insurer or the insured, or the place where the treatment took place, regardless of whether the said person is elected by the arbitrator experts of parties or by the chief justice of the court with jurisdiction. Requests in this respect should be fulfilled.

d. Upon the death, resignation, or refusal of an arbitrator-expert, the replacement for the previous arbitrator-expert shall be elected in accordance with the same principles, and the determination shall resume from its existing stage. The death of the insured shall not relieve the appointed arbitrator-expert from his/her duty.

The right to raise objections against arbitrator-experts on the grounds of non-qualification shall lapse unless exercised within seven days after learning about the relevant person.

e. The arbitrator-experts may request evidence, records, and documents they shall deem necessary for determining the expenses, and may carry out investigations on the site of the treatment.

f. The decisions by the arbitrator-expert(s) or the third arbitrator-expert on the matter of expense shall be final and binding for the parties. Claims shall not be demanded from the insurer, and the insurer cannot be sued without an arbitrator-expert decision.

Objections against arbitrator-experts and their decisions may be raised only in case it is clear that the decisions are substantially incompatible with the facts at hand, and the annulment of decisions may be requested from the court with jurisdiction over commercial cases at the place of treatment, within one week following the notification about the report.

g. Unless the parties agree on the indemnity figure, the damages shall become due only through a decision of arbitrator-experts, and the statutory limitations shall not apply before the delivery of the final report to parties. provided that two years has not passed between the appointment of arbitrator-experts and the notification period as stipulated in article 1446 of Turkish Commercial Code.

h. The parties shall pay for the remunerations and expenses of the arbitrator-expert they appoint.

The remunerations and expenses of the third arbitrator-expert shall be shared equally among the parties.

ı. The determination of the expense shall not affect the provisions and terms and conditions specified in the present policy and regulations, on the risks covered, sum insured, insurance amount, commencement of liability, causes to lapse or reduce rights, as well as the claiming thereof.

RESULTS OF INDEMNIFICATION AND THE SUBROGATION BY THE INSURER

Article 11

The insurer shall subrogate the insured before any liable third parties, to the amount it has paid for treatment costs.

CO-INSURANCE

Article 12

In case treatment costs are guaranteed by more than one insurer, such expenses shall be shared among the insurers, to the rate of the coverage each provides.

CONFIDENTIALITY

Article 13

The insurer shall be liable for the damages to arise due to not keeping confidential the secrets it may come to learn about the policy holder/insured.

NOTIFICATION AND NOTICES

Article 14
The notifications and notices by the policy holder shall be sent in writing or through notary public, to the headquarters of the Insurance Company or to the agent which serves as the broker for the insurance contract.
The notices and notifications of insurer firm shall be made to the address of policy holder stated in the policy; in the event that this address changes, then to the headquarters of the insurance company or the address last notified to the agency acting as the broker to the insurance agreement.
JURISDICTION
Article 15
The competent court for the lawsuits to be initiated against the insurer firm for disputes arising out of the present policy shall be the court with jurisdiction over commercial cases at the place where the registered office of the insurance firm is or the domicile address of the agency acting as an intermediary for the insurance agreement, or at the place of damage, and for the lawsuits to be initiated by the insurer firm, shall be the court with jurisdiction over commercial cases at the domicile address of the defendant.
STATUE OF LIMITATIONS
Article 16
All claims to arise out of the insurance contract shall be subject to a statue of limitations of two years.
SPECIAL TERMS
Article 17
The policies may also incorporate special terms and conditions which do not conflict with the present general terms and conditions and clauses regarding thereof.