Koç Group

Retirement and Support Fund Foundation
Group Private Health Insurance
User's Guide
2013

Dear Policyholder,

This User's Guide provides information on the Group Private Health Insurance, developed especially for you, the valuable members of the Koç Group Retirement and Support Fund, in cooperation with our Company. We would like to remind you to examine this guide closely and carefully follow the defined procedures to benefit from the services provided in the fastest and most efficient manner.

You can directly contact us via the communication line at (0212) 336 0 700 – created for the members of the Koç Group Retirement and Support Fund – for any requests/questions and for help This same phone number is located on the front of your TELEMED24 card, issued to provide you with ease of service at the Yapi Kredi Insurance's Contracted Healthcare Institutions.

You will receive your TELEMED24 card when our Company takes you under the coverage of insurance and the same card can be used when the policy is renewed. You can receive service at around 2,400 contracted healthcare institutions by showing your photo ID along with your TELEMED24 card. Our current list and constantly extending network of contracted healthcare institutions is available on our website at http://www.yksigorta.com.tr.

We wish you healthy days under the guarantee of Yapi Kredi Insurance and pay our respects to you.

Yapi Kredi Insurance

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COVERAGE AND PREMIUM TABLE BY SENIORITY GROUP
January 1, 2013 to January 1, 2014

	ANNUAL COVERAGE LIMITS (TL)			
COVERAGE	SENIORITY GROUP 1 241 months and over	SENIORITY GROUP 2 121 to 240 months	SENIORITY GROUP 3 37 to 120 months	POLICYHOLDER'S CONTRIBUTION
Inpatient Treatment				
Inpatient Treatment	Unlimited	48,000	38,000	None
Postoperative Physiotherapy	Limited to 20 sessions*			None
Nursing and Follow-Up Care	Limited to 8 weeks*			None
Ambulance	Unlimited	2,900	2,900	None
Chemotherapy, Radiotherapy, Dialysis	Unlimited	19,000	13,000	25%
Examination for Chemotherapy, Radiotherapy, Dialysis	Unlimited	*	*	25%
Prosthesis	26,500	19,000	12,000	None
Outpatient Treatment				
Outpatient Treatment	Unlimited	2,150	1,750	25%
Advance Diagnostic Methods And Medical Observation/Treatment	Unlimited	6,300	5,500	25%
Others				
Dental Treatment after Traffic Accident	Unlimited	None	None	None
Incidental Surgery	Unlimited	3,650	3,350	25%
Medical Equipment	1,500	850	580	25%
Normal Delivery	Unlimited	2,900	2,900	None
Cesarean Delivery	Unlimited	5,300	5,300	20%
Check-up Mammography (for women over 40)	Once a year***			None
Prostate-Specific Antigen (PSA) Test (for men over 40)	Once a year			None
Bone Density Test (for women over 40)	Once a year			None
MONTHLY CONTRIBUTIONS FOR MEMBERS IN THE SENIORITY GROUPS 1, 2 & 3				
Members				TL 72.00
Spouses of members				TL 72.00
Each child of members (< 24 years old)				TL 28.80
MONTHLY CONTRIBUTIONS FOR MEMBERS WITH SENIORITY OF LESS THAN 36 MONTHS				
Members				TL 134.00
Spouses of members				TL 95.00
Each child of members (< 24 years old)				TL 37.00

* Expenses for Nursing & Follow-up Care and Postoperative Physiotherapy are deducted from the annual limit of the Inpatient Coverage.

** Expenses related to the Examination for Chemotherapy, Radiotherapy and Dialysis are paid up to 75% and are deducted from the annual limit of the Coverage for Chemotherapy, Radiotherapy and Dialysis.

*** Check-up Mammography is acceptable only if performed in specially contracted institutions.

1) Seniority Group 1 is provided with Inpatient Treatment Coverage with an annual limit of $1,000 and 75% payment rate for international travels of up to 15 days (retired members excluded).
2) Seniority Group 1 is provided with an annual "Domestic Non-contracted Institution Limit" of net 27,000 Turkish Lira and 75% payment rate for inpatient treatment in any other institutions than the contracted ones.
3) The Seniority Group 1 is provided with an annual limit of 39,750 Turkish Lira and 75% payment rate for international inpatient treatment. Any expenses of up to 27,000 Turkish Lira will be covered under the domestic non-contracted healthcare institution limit.

IMPORTANT REMINDERS

Fair and right management of medical expenses is of great importance for the Company. We accordingly expect our policyholders to show similar sensitivity to ensure sufficient coverage limits and a reasonable increase in the premiums of the following year. The following considerations will guide you in benefiting from your health insurance.

- A TELEMED24 card is issued for each person covered by the policy (you, your spouse and your child (children)) to enable each of you to receive discount and direct payment services from contracted healthcare institutions. The TELEMED24 card must be presented along with a photo ID. When the TELEMED24 card is used at the contracted healthcare institutions, Yapı Kredi Insurance directly pays treatment expenses covered by the policy –minus the policyholder's contribution, if any.

- In any emergency health cases, you may contact Yapi Kredi Insurance TELEMED24 line at 0212 336 0 911 to benefit from the around-the-clock medical advice or ambulance services. The TELEMED24 line number is also located on the back of your TELEMED24 card.

- Information on your coverage and current medical expenses is accessible on our website at http://www.yksigorta.com.tr, under the "Online Policy View" in the "Online Transactions" menu. For first time users, you will need to register by entering required information and retrieving a password.

- The insurance coverage limits are separate for each family member and cannot be transferred interpersonally.

- In your relations with health care institutions, always inspect the institution on behalf of your insurance company and in your best interest. If necessary, please notify Yapi Kredi Insurance. Unnecessary and/or excessively priced transactions will lead to insufficiency of your coverage limits.

- In health cases requiring surgery, it is of great importance for the sufficiency of your coverage limit and balance of your medical expenses to ask your private physician about the surgery costs and compare it with the medical fee at the contracted healthcare institution in which the surgery will be performed, and to question the costs if they are not reasonable.

- Except for the emergency health cases, Yapi Kredi Insurance must be contacted for authorization 24 hours prior to the hospitalization for inpatient treatment.

- Invoices and receipts must be issued to the name of the individual treated and attached to the "Medical Expenses Claims Form" also issued in the name of the same individual. You may either use the Medical Expenses Claims Forms – original or copy – sent when you were taken under the insurance coverage by the Company or print a new form from our website at http://www.yksigorta.com.tr, under the "Online Policy View" display in the "Online transactions" menu. The form may also be requested via the communication line at (0212) 336 0 700, established specifically for the members of the Koç Group Retirement and Support Fund Foundation.

- The Medical Expenses Claims Form and any attached documents of our working policyholders will be drawn up by the related Company departments and will be sent to Yapi Kredi Insurance along with the list. Yapi Kredi Sigorta will, in turn, send the related Company departments the lists containing details of the claims payments, as well as information on the policyholders whose claims are rejected because of missing documents, etc. Therefore, you may access any information on your claims payment from the related department of your company. Invoices sent individually, without the knowledge of your company's representative, will not be processed. Individuals whose volunteer-basis membership continues and who receive retirement pay must send their medical expenses documents attached to the medical Expenses Claims Form to the Medical Expenses Management Department at Yapi Kredi Insurance – the address is located at the back of this guide.

- In cases in which a credit card is used for the payment of medical expenses at a physician's office, if the cardholder is different from the treated policyholder and no receipt/invoice is issued, the name of the treated policyholder must be written on the back of the POS slip, which must also be signed and stamped by the physician in order that the POS slip can be accepted by Yapi Kredi Insurance.

- In case of university hospitals, please attach the detailed list of charges in order to facilitate the acceptance of receipts from the cashiers and in case of foundation-run health centers, always ensure the donation receipts is stamped.

- In any health condition, you must first contact the On-site Physician at your company. Always ensure that medications obtainable from SGK are procured from SGK through the on-site physician at your company.

- In case of any members requiring inpatient treatment as a result of any accident or serious disease, the related company must always ensure that SGK insurance is used at the beginning of the treatment. This will guarantee the payment of temporary incapacity fee by SGK to the member, the assessment of any partial or permanent disability, receipt of related reports, as well as the coverage of the treatment expenses by SGK within the legal limits. Similarly, it is beneficial to give priority to the SGK use in other family members.

  Any health coverage provided under package policies and/or additional health policies other than our Company's Individual or Corporate Health policies cannot be associated with the insurance rights provided by our Company's Individual or Corporate Health policies. This cannot be considered as the beginning, continuation and/or complement of an Individual and/or Corporate health insurance policy.

- Those policyholders who cancel the Group Private Health Insurance for the Koç Group Retirement and Support Fund Foundation (Koç Foundation) may apply to Yapi Kredi Insurance within thirty (30) days following the cancellation date for the continuance of their insurance with one of Yapi Kredi Insurance's private health products, provided that all the family members are included in the application. In individual health insurance applications, certification conditions will apply for those policyholders who have been granted with Lifetime Renewal Guarantee under the Koç Foundation Group Private Health Insurance (see Article 11). Those policyholders who have not been granted with the Lifetime Renewal Guarantee will not be obliged to apply with all the family members but they will be subject to standard risk assessment under the Special and General Conditions of the Individual Health Policy they prefer.

- A medical declaration, a medical examination report, and additional tests may be required, upon assessment, from policyholders who are covered by the Koç Foundation Group Private Health Insurance and who apply for any reason for a second policy, either individual or corporate. Upon the medical assessment performed pursuant to the Yapi Kredi Risk Acceptance Regulations, some diseases of the applicant may be excluded or restricted, additional premium may be asked or the application may be rejected.

- Any policyholders who are detected to have taken abusive actions within the policy year will lose their right to benefit from health insurance for four (4) years along with their family members covered by the Koç Foundation Private Health Insurance.

CODE OF PRACTICE FOR
KOÇ GROUP RETIREMENT AND SUPPORT FUND FOUNDATION
GROUP PRIVATE HEALTH INSURANCE

At the General Assembly of the Koç Group Retirement and Support Fund Foundation, held on October 22, 1996, Article 52 of the Foundation's Formal Contract was amended to include health insurance among the services provided by the Foundation to its members and the Koç Foundation Group Private Health Insurance entered into effect on January 1, 1997. The code of practice for the Koç Foundation Group Private Health Insurance is submitted for your information with its renewed version, and is effective as of January 1, 2012.

1. ELIGIBILITY FOR INSURANCE

1.1 WHO CAN BE INSURED?

All existing and future employees of the Koç Group Companies and their family members can be insured, provided that they are members of Koç Foundation. The Koç Foundation members can benefit from the health insurance as of the beginning of the first month following their membership date, along with their spouses and any single children less than 24 years of age. Spouse and children cannot be covered without the member him/herself.

1.2 SENIORITY GROUPS

Members with seniority exceeding 36 months will be accepted into the health insurance under the coverage types defined for the following seniority groups:

Seniority Group	Membership Duration
Seniority Group 1	241 months and over
Seniority Group 2	121 to 240 months
Seniority Group 3	37 to 120 months

Every year within the policy renewal period, the Foundation Board will determine and notify the Company and the members on the coverage types to be provided to the seniority groups, the related limits and other conditions, as well as monthly contributions to be paid by the members with equal installments and through their related company.

1.3 MEMBERS WITH INSUFFICIENT SENIORITY

Those employees whose membership duration in the Foundation has not passed 36 months will be able to benefit from the same coverage types with the Seniority Group 3 on a voluntary basis, until the 36th month of his/her membership ends. In this case, either the employee him/herself can pay total insurance premium by installments or his/her Company may cover the amount equal to the Foundation contribution.

Seniority Group 3	Membership Duration
Seniority Group 3	Less than 37 months

1.4 IF THE MEMBER'S SPOUSE AND/OR CHILD IS ALSO A MEMBER OF THE FOUNDATION

If both the wife and husband work at Koç Group and are members of the Foundation, the member with the less seniority will benefit from the seniority of the other member in the status of spouse. The child who is

also a member of the Foundation will benefit from the coverage type defined for his/her own seniority group in the status of employee.

2. TAX ADVANTAGE

Pursuant to the amendment in the Articles 4 and 7 in the Act on Amendments in Some Taxation Acts with 4.697 law no and Article 63 and 89 in the Act on Income Tax, contributions of the members and the premium installments of the voluntary policyholders can be deducted from their taxable base related to their monthly gross salaries or from their incomes.
Resettlements are made for the explanations in the articles related with tax deduction and limitations in "Individual Pension Savings and Investment System Law and the Law on the Amendment of Certain Laws and Decree Laws" with 6327 law no that is published in the official gazette with 28338 no on June.29, 2012 .

AS of January.01,2013, such contributions/installments are limited to 15% of the gross salary of the month in which they are paid for the salaried policyholders and to 15% of the declared gross income for the taxpayers. Furthermore, such contributions/installments should not exceed the annual minimum wage in both cases.

Since the income tax deduction will thus decrease, the part of the contribution that represents the member's income tax bracket rate will be returned back as a net wage increase.

3. ACCEPTANCE/CANCELLATION OF THE POLICY AND CHANGES IN THE STATUS OF MEMBERSHIP

3.1 CHANGES IN SENIORITY

When members that receive Koç Foundation Group Private Health Insurance (under the seniority groups according to the duration of their membership) reach adequate seniority within a policy period, their upgrade to a higher seniority group will commence in the next policy period.

3.2 INCLUSION OF NEWBORNS INTO THE INSURANCE COVERAGE

The policy acceptance requires that insured members notify the Foundation within three (3) months following the birth of a newborn. In this case, newborns of members will be included in the policy as of their birth date. If the three-month period has exceeded, newborns will be included into the policy in the next renewal period.

3.3 POLICY ACCEPTANCE AND CANCELLATION

Policy acceptance and cancellation will only take place as of the policy start date (policy renewal period), except for the following transactions occurring within the year.

If the following cases occur within the year, policy acceptance/cancellation will take place as of the beginning of the month following the date of change.

A. New affiliation to the Foundation, as well as admission of those individuals whose membership duration has exceeded 36 months in seniority group 3;
B. Change of status from active to voluntary or retired membership;
C. Transfer to another company within Koç Group;
D. Cancellation due to withdrawal from Foundation membership;
E. Cancellation due to military service;
F. Spouse acceptance due to marriage;
G. In the case of marriage between two members;

The spouse with less seniority will continue in the seniority group of the other and in the status of spouse. If two Foundation members with children from previous marriage(s) get married, each will benefit from health service along with their own child(ren) under his/her own seniority group and via the company at which he/she is working, as far as his/her contract of employment is effective. If the employment contract of one of the members terminates, the member who lost his/her job will continue to receive service via his/her spouse; however, his/her child(ren) from previous marriage(s) will not be able to benefit from the health insurance.

H. Cancellation of children who turn 24 years old, who marry or who enter military service;
I. Cancellation due to divorce;
J. Cancellation due to death of the member;
   If a member dies, the insured spouse and child(ren) will continue to be covered for ninety (90) days without premium payment.
K. Cancellation due to death of spouse/child.

3.4. TERMINATION OF THE RIGHT TO BENEFIT FROM HEALTH INSURANCE

USE OF THE POLICY IN CONTRAVENTION OF THE INSURANCE CONDITIONS

If any policyholders are detected to use or to cause others to use the benefits in contravention to the insurance conditions, they will lose their right to benefit from health insurance for the following four (4) years, along with their spouse and child(ren).

WAIVER OF HEALTH INSURANCE BY WORKING MEMBERS

Members who benefit from the health insurance cannot waive their health insurance coverage before the policy renewal period ends, unless they withdraw from Foundation membership. Those members who waived the health insurance coverage and left the system at the end of a policy period upon a written declaration to their Company will be able to benefit once again from health insurance only after four (4) yearly policy periods have elapsed.

3.5. UTILIZATION OF HEALTH INSURANCE BY MEMBERS WHO RECEIVE RETIREMENT PAY, WHOSE MEMBERSHIP CONTINUES ON VOLUNTARY BASIS, AND WHO LEAVE THE FOUNDATION

MEMBERS WHO RECEIVE RETIREMENT PAY FROM THE FOUNDATION

Members entitled to receive retirement pay from the Foundation will benefit from the “Koç Foundation Group Private Health Insurance" along with their spouse, within the age limits specified on the Foundation Formal Contract, provided that the insurance contributions are defrayed by the members and will continue within the same seniority group in which they had been prior to retirement. If they wish, these members can include their single children less than 24 years of age into the “Koç Foundation Individual Health Insurance,” provided that the total policy fees are defrayed by the members.

Retired members who receive retirement pay from the Foundation and benefit from the Koç Foundation Group Private Health Insurance cannot waive their health insurance coverage before the policy renewal period, unless they leave the Foundation. The retired members who waived the Koç Foundation Group Private Health Insurance coverage can be insured once again only after four (4) yearly insurance periods have elapsed. Members are entitled to waive and then reenter the health insurance coverage once only.

The health insurance coverage of those members whose relation with the Foundation continues through retirement pay applies to the existing family members who are covered by the Koç Foundation Group Private Health Insurance on the date of status change (changes in the marital status and newborns are excluded).

Among the members who receive retirement pay, those who claimed the total payment of their accumulated pensions and terminated their relation with the Foundation will also conclude their Koç Foundation Group

Private Health Insurance. However, those members can apply within thirty (30) days following their termination date to the Yapi Kredi Insurance for the Koç Foundation Individual Health Insurance coverage.

VOLUNTARY MEMBERS OF THE FOUNDATION

As indicated in the Formal Contract of the Koç Group Retirement and Support Fund Foundation, a member whose seniority surpasses 180 months or more and who have not met the age requirements to receive retirement pay are entitled to maintain their membership on a voluntary basis in the case they resign from their company or their company concluded with the Foundation. Upon request, these members may benefit from the Koç Foundation Group Private Health Insurance along with their spouses and children (covers single children aged 24 or younger) until they meet the effective age limit to receive retirement pay, provided that the insurance contributions are defrayed by themselves and they continue within their last seniority group.

Members that benefit from health insurance cannot waive their health insurance coverage until the policy renewal period, unless they withdraw from voluntary membership. Those members who waived the health insurance coverage and left the system at the end of a policy period cannot be accepted into the health insurance coverage once again unless four (4) yearly policy periods have elapsed. Members are entitled to waive and then reenter the health insurance coverage once only.

The health insurance coverage of those members whose relation with the Foundation continues applies to existing family members who are covered by the Koç Foundation Group Private Health Insurance on the date of status change (changes in the marital status and newborns are excluded).

Among the voluntary members, who claimed the total payment of their accumulated pensions and terminated their relation with the Foundation and thus culminated their privileges with the Koç Foundation Group Private Health Insurance, these members are eligible to apply within thirty (30) days following their termination date to the Yapi Kredi Insurance for the Koç Foundation Individual Health Insurance coverage.

MEMBERS WHO LEAVE THE FOUNDATION

A) MEMBERS WHO ARE UNDER THE RETIREMENT PAY STATUS PURSUANT TO THE FORMAL CONTRACT ARTICLE 45-I, AMENDED ON JANUARY 1, 2007 (NEW SYSTEM)

Among the Foundation members who have been benefiting uninterruptedly from the Koç Foundation Group Private Health Insurance for the last four (4) years, those who prefer receiving total payment and leaving the Foundation even though they have both met the age (55 years old in men, 50 years old in women) and seniority requirements (at least 180 months) may be accepted upon request into the "Koç Foundation Individual Health Insurance" by Yapi Kredi Insurance as of their termination date. The health insurance coverage of those members who will benefit from the Koç Foundation Individual Health Insurance applies to the existing family members on date of the status change. (Spouses to be included because of change in the marital status and newborns will not be covered by the Koç Foundation Individual Health Insurance.) To benefit from this service, members must apply to Yapi Kredi Insurance within thirty (30) days following the termination date of the Foundation membership.

Similarly with those (children included) who benefit from Article 45, paragraph 1, subparagraph (j) and paragraph 2, subparagraph (g) of the Koç Group Retirement and Support Fund Foundation's Formal Contract (amended version of January 1, 2007), the abovementioned members are entitled to continue to benefit from the insurance coverage without age limit and under the same conditions offered to the working members, provided that they continue to remain within the same seniority group and they themselves defray the total insurance premiums set for the related coverage group.

If members who are within the Seniority Group 1 do not apply to Koç Foundation Individual Health Insurance within the set period, they will not benefit from the special rights provided under the Koç Foundation Group Private Health Policy (such as acceptance of existing diseases). If members have

exceeded the 30-day period but applied within three (3) months, they may be insured under the status of Koç Foundation pensioner, but only able to select from seniority groups 2 or 3.

B) MEMBERS UNDER RETIREMENT PAY STATUS PURSUANT TO THE FORMAL CONTRACT ARTICLE 45-I EFFECTIVE BEFORE JANUARY 1, 2007 (PREVIOUS SYSTEM)

Among the Foundation members who have been benefiting uninterruptedly from the Koç Foundation Group Private Health Insurance for the last four (4) years, those who prefer receiving total payment and leaving the Foundation even though they have met both the age (50 years old in men, 45 years old in women) and seniority requirements (at least 180 months) may be accepted upon request into the Koç Foundation Individual Health Insurance by Yapi Kredi Insurance as of their termination date. The health insurance coverage of those members who will benefit from the Koç Foundation Individual Health Insurance applies to the existing family members on date of the status change. (Spouses to be added because of change in the marital status and newborns will not be covered by the Koç Foundation Individual Health Insurance.) To benefit from this service, members must apply to Yapi Kredi Insurance within thirty (30) days following the termination date of their Foundation membership.

Similarly with those (children included) who benefit from Article 45, paragraph 1, subparagraph (g) and paragraph 2, subparagraph (g) of the Koç Group Retirement and Support Fund Foundation's Formal Contract (version effective before January 1, 2007), those abovementioned members are entitled to continue to benefit from the insurance coverage until the age of 70 years old under the same conditions offered to the working members, provided that they remain within the same seniority group and they themselves defray the total insurance premiums set for the related coverage group.

If members within the Seniority Group 1 do not apply to Koç Foundation Individual Health Insurance within the set period, they will not benefit from the special rights provided under the Koç Foundation Group Private Health Policy (such as acceptance of existing diseases). If members have exceeded the 30-day period but applied within three (3) months, they may be insured under the status of Koç Foundation pensioner, but only able to select from seniority groups 2 or 3.

C) MEMBERS WITH SENIORITY OF LESS THAN 180 MONTHS

If members have less than 180 months of seniority at the termination date of their Foundation membership, the Koç Foundation Group Private Health Insurance is also terminated as of the same termination date. If those members who left the Foundation and whose policies are cancelled apply to Yapi Kredi Insurance within thirty (30) days following the termination date, their acceptance into the individual health insurance policy will be assessed.

3.6. EMPLOYEES WORKING ABROAD

In cases in which the Foundation members working abroad cannot benefit from the Koç Foundation Group Private Health Insurance policy, their family members who are still residing in Turkey will continue to be insured (except for those with less than 36 months of seniority who themselves pay the total of their insurance premiums).

4. NOTIFICATION OF CHANGES AND PAYMENT OF PREMIUMS

If members benefiting from health insurance culminate with the Foundation within a month, their membership termination details will be immediately (not later than the following day) submitted to Yapi Kredi Insurance.
As members will benefit from medical services until the end of the month, regardless of the exact date of membership termination, their insurance premium of this month must be deducted from their allowance and paid to Yapi Kredi Insurance.

In cases of delayed notification, the membership termination will be processed as of the notification date and the insurance premium of the related member will be collected from the companies. If the termination details of a member are not submitted to Yapi Kredi Insurance on the following day at the latest, the medical expenses incurred on the termination date or the following days in the healthcare institutions with direct payment contract will be revoked to the related companies.

Additionally other changes of the members conditions (marriage, divorce, birth…etc) should be notified to the Foundation by the related departments of the companies.

Companies should submit all their notifications by the sixth (6^{th}) workday of each month. Any notifications submitted after the sixth (6^{th}) workday will be processed the following month. Notifications should be submitted via Portal of Foundation

At the beginning of each month, Yapi Kredi Insurance will issue the additional policy (endorsement) necessary for the changes (marriage, divorce, birth) notified through the Foundation and send the documents to the related companies. These documents will indicate the discrete contributions of the Foundation, the policyholders, and the companies.

After having pay-rolled the necessary deductions and tax advantage arrangements according to the endorsements issued by Yapi Kredi Insurance and the insured employee list, Companies must deposit the total monthly insurance premium contributions of the policyholders/companies no later than the tenth (10^{th}) of the following month into the bank account no TR04 0006 7010 0000 0069 7733 87 of Yapi Kredi Insurance in Main Branch of Yapi Kredi Bank.

For instance, following the notification of changes occurring within the month of January via the Foundation, Yapi Kredi Insurance will send the endorsements to the related companies, which will validate the notified changes as of February 1^{st}. The companies will issue the payroll for the month of February and will deposit the total insurance contributions of the policyholders (also adding the contributions of the company, if any) into the bank account of Yapi Kredi Insurance no later than March 10^{th}.

5. DEFINITIONS

5.1. HEALTHCARE INSTITUTIONS

Pursuant to law, a healthcare institution is defined as a private or government institution, which offers inpatient or outpatient diagnosis and treatment services, as authorized and controlled by the Ministry of Health.

5.2. CONTRACTED HEALTHCARE INSTITUTIONS (TELEMED24 SERVICE NETWORK)

The contracted healthcare institutions are any hospitals, clinics, diagnosis centers, pharmacies, laboratories, and private physician's offices, which have special financial agreements with Yapi Kredi Insurance and at which the policyholders can receive medical services using their TELEMED24 cards without paying any fees, within their coverage types/limits/payment percentages.

The contracted fees of Yapi Kredi Insurance apply in cases in which the policyholders have to defray their own medical expenses in contracted healthcare institutions due to reasons of exclusions or limit excess. As indicated in the list of Contracted Healthcare Institutions, some institutions have no agreement for all coverage types. Contracted institution practices will apply only to coverage types agreed in these institutions.

The most current list of our network of contracted healthcare institutions is available on our website at http://www.yksigorta.com.tr.

5.3. NON-CONTRACTED HEALTHCARE INSTITUTIONS

Non-contracted healthcare institutions are any natural or legal entities, such as hospitals, laboratories, clinics, and private physician's offices, pharmacies, which do not have any contract with Yapi Kredi Insurance and are not included in the TELEMED24 Service Network. Furthermore, this category also includes those physicians who provide service within a contracted healthcare institution but do not accept the contractual terms between the institution and Yapi Kredi Insurance and or those who issue their own invoices.

5.4. DIRECT PAYMENT

Yapi Kredi Insurance directly pays the Contracted Healthcare Institution medical expenses covered by the policy, within the coverage limit and at payment percentage, provided that the policyholder presents his/her TELEMED card and photo ID to the Contracted Healthcare Institution.

5.5. REIMBURSABLE PAYMENT

Medical expenses are first defrayed by the policyholder to the healthcare institution or the physician and are then claimed from Yapi Kredi Insurance through documents specified in the section titled "Documentation of medical expenses." These medical expenses are assessed by Yapi Kredi Insurance according to the policy terms, coverage limit, and payment percentage and are then transferred into the policyholder's bank account.

5.6. PAYMENT PERCENTAGE AND POLICYHOLDER'S CONTRIBUTION

Payment percentage is the percentage of the claims amount, which the Insurer is liable to pay within the coverage limit. The difference in percentage that completes this payment percentage to 100% is called policyholder's contribution.

For instance, for a coverage type with 100% payment percentage with no policyholder's contribution, Yapi Kredi Insurance defrays all the medical expenses, which remain within the coverage limit. In a coverage type with 25% policyholder's contribution and 75% payment percentage, the policyholder defrays 25% of medical expenses while Yapi Kredi Insurance defrays 75% of the part remaining within the annual coverage limit (the payment is to be made within the annual coverage limit is based on the VAT included invoice amount).

5.7. COVERAGE LIMIT

This refers to the maximum annual amount defrayable for medical expenses under each coverage type. The net medical expense amount defrayable under each coverage type is calculated by multiplying the coverage limit by the payment percentage (Net limits also indicate the maximum annual medical expense amount defrayable, calculated by multiplying the "Domestic Non-Contractual Healthcare Institution" and "International Inpatient Treatment" limits by payment percentage).

5.8. DOMESTIC NON-CONTRACTED HEALTHCARE INSTITUTIONS LIMIT

This refers to the maximum annual amount defrayable for medical expenses under the coverage of Inpatient Treatment, Chemotherapy/Radiotherapy/Dialysis, Ambulance, and Dental Treatment after Traffic Accident, and Examination for Chemotherapy/Radiotherapy/Dialysis. This limit applies only to Seniority Group 1.

5.9. INTERNATIONAL INPATIENT TREATMENT LIMIT

This refers to the maximum annual amount defrayable for medical expenses incurred abroad under the coverage of Inpatient Treatment, Chemotherapy/Radiotherapy/Dialysis, and Examination for Chemotherapy/Radiotherapy/Dialysis. Such medical expenses are firstly defrayed by being deducted from the Domestic Non-contractual Healthcare Institutions Limit. This limit applies only to Seniority Group 1.

The content of this coverage type and the details on the international medical expenses for Seniority Groups 2 and 3 are explained in Articles 9 and 12.

5.10. TURKISH MEDICAL ASSOCIATION MINIMUM FEE TARIFF (TMA TARIFF)

This refers to the units list issued to set the minimum fees, which the physicians can claim for examinations/treatments/tests, according to the Law no 6023 of the Turkish Medical Association Central Council. These fees are set by multiplying the units by a coefficient (which is determined by the Medical Chambers of the related provinces and which periodically changes), and then by adding the VAT. The TMA units can be calculated based on reports submitted after the procedure or by the related physician him/herself before the procedure.

5.11. TELEMED24 LINE

This refers to the telephone line that the policyholders can request ambulance service for emergency cases. The policyholder can also receive emergency medical consultancy service via this line, which is located on the back of TELEMED24 card, the TELEMED24 line number is (0212) 336 0 911.

6. COVERAGE TYPES

INPATIENT TREATMENT

6.1. INPATIENT TREATMENT COVERAGE

This coverage includes expenses for inpatient treatment of at least 24 hours and surgeries, within the related coverage limit and payment percentage, provided that they are medically required and that the physician specifies the hospitalization reason in his/her detailed report.

This coverage applies to expenses incurred during the inpatient treatment in relation with standard single-bed hospital room, food, attendant, physician, medications, required medical examinations, surgery room, surgeon, assistant, anesthetist, intensive care, materials, and postoperative physiotherapy.

The hospitalization duration covered within a policy year is 180 days for Seniority Group 1 for which the Inpatient Treatment Coverage is limitless. From the total hospitalization duration of 180 days, one day is deducted for each day of stay in regular rooms while two days are deducted for each day of stay in intensive care units.

6.1.1. SURGERY

This coverage includes the surgical interventions of 150+ units in the TMA Tariff, which the physician has verified to be necessary for the treatment.

If more than one procedure is performed within the same session, the coverage for each procedure is determined separately, based on their section and unit in the TMA Tariff.

If the Policyholder has undergone more than one surgery under the same anesthesia and if any one of these surgeries is not covered in the policy, the relevant hospital and surgical expenses are defrayed on weighted proportion of separate TMA units for each surgery, provided that the total invoice or the invoice of uncovered expenses is also separately submitted.

Expenses for coronary angiography, Extracorporeal Shock Wave Therapy Lithotripsy (ESWL), Extracorporeal Shock Wave Therapy (ESWT), as well as the related anesthetist’s and physician’s fees, are defrayed under the Inpatient Treatment Coverage, regardless of whether they are inpatient or outpatient procedures.

6.1.2. NON-SURGICAL TREATMENT

This coverage includes expenses incurred for inpatient treatment of at least 24 hours, provided that the physician and/or hospital's reports verify that the treatment of the policyholder requires hospitalization in regular or intensive-care rooms, without any need for surgery.

6.1.3. POSTOPERATIVE PHYSIOTHERAPY

The Inpatient Treatment Coverage limit and payment percentage apply to expenses for physiotherapy sessions scheduled in relation with a surgery accepted by Yapi Kredi Insurance, provided that the sessions are held within 60 days following the discharge date of the policyholder, regardless of whether this is an inpatient or outpatient treatment.

The postoperative physiotherapy expenses are limited to a total of twenty (20) sessions and to procedures specified under the "Physical Medicine and Rehabilitation" section of the TMA Tariff, provided that the treatment plan and report of the physiotherapist is approved by Yapi Kredi Insurance. If the therapy is performed on more than one part of the body, every part is considered as a separate session.

This coverage type does not apply to international cases for Seniority Group 1.

6.1.4. NURSING AND FOLLOW-UP CARE

Expenses related to nursing services, provided to the policyholder as of the discharge date following inpatient treatment, are defrayed for up to eight weeks within a policy year under the Inpatient Treatment Coverage limit and payment percentage, provided that the nursing plan is sent to and approved by Yapi Kredi Insurance on discharge date.

This coverage type is not applicable for international cases.

6.2. AMBULANCE COVERAGE

Expenses related to land or air ambulance services, provided by Yapi Kredi Insurance to the policyholder for transportation to the nearest healthcare institution in a life-threatening emergency case caused by an illness or injury occurring within the policy period, are defrayed under Ambulance Coverage. They are defrayed under the limit and payment percentage of Inpatient Treatment Coverage for Seniority Group 1 and of the related coverage type for Seniority Groups 2 and 3.

The policyholder should first call the Yapi Kredi Insurance TELEMED24 line at 0212 336 0 911 for land ambulance service. The abovementioned conditions also apply to cases in which the policyholder cannot call TELEMED24 line and receives land ambulance service from another provider because of the emergency of his/her case. For Seniority Group 1, expenses for land ambulance services received without obtaining the approval of Yapi Kredi Insurance will be defrayed under the limit and payment percentage of the Domestic Non-contractual Healthcare Institutions as specified in the policy. For Seniority Groups 2 and 3, the expenses will be defrayed under the limit and payment percentage of the related coverage type.

In cases in which the policyholder can neither be transported by land to the nearest healthcare institution because of a life-threatening emergency case nor undergo medical intervention in place, then written medical details of the policyholder must be submitted to Yapi Kredi Insurance and its approval must be obtained to provide air transportation. Air transportation provided without proper authorization will not be accepted by the insurer. All expenses related to private or scheduled air transportation are excluded from this coverage.

Expenses related to land and air ambulance services provided because of a life-threatening emergency case are defrayable only within the borders of the Republic of Turkey.

Yapi Kredi Insurance will not be held responsible for any failures or delays caused especially by the existing practice restrictions in Turkey and by the services of the ambulance company.

6.3. CHEMOTHERAPY/RADIOTHERAPY/DIALYSIS COVERAGE

All expenses related to chemotherapy, radiotherapy, and dialysis (hospital, medications, physicians fee) are defrayed under the limit and payment percentage of this coverage type, regardless of whether inpatient or outpatient procedures are performed, and provided they are approved by Yapi Kredi Insurance.

If such expenses are incurred in Non-contractual Healthcare Institutions, they will be defrayed under the limit and payment percentage of the Domestic Non-Contractual Healthcare Institutions Coverage for Seniority Group 1.

6.3.1. EXAMINATION FOR CHEMOTHERAPY/RADIOTHERAPY/DIALYSIS

Medical expenses related to laboratory examinations, X-rays, and advance diagnostic methods required during the planning and follow-up stages of chemotherapy, radiotherapy, or dialysis treatment for malignant diseases approved by Yapi Kredi Insurance, are defrayable under the limit and payment percentage of the Chemotherapy/Radiotherapy/Dialysis Coverage, regardless of whether they are inpatient or outpatient procedures.

If such expenses are incurred in Non-contractual Healthcare Institutions, then they will be defrayed under the limit and payment percentage of the Domestic Non-Contractual Healthcare Institutions Coverage for Seniority Group 1.

6.4. PROSTHESIS COVERAGE

The following medical expenses incurred by a policyholder as a result of an accident or disease occurring within the policy period, are defrayable under the annual limit and payment percentage of Prosthesis Coverage, provided that their necessity is certified by the physician's report and they are approved by Yapi Kredi Insurance:

- Expenses related to finger, hand, arm, leg or other body implant devices, which are not of an aesthetic nature and used to restore the functions of an impaired organ;
- Prosthetic expenses related to post-breast cancer treatment;
- Expenses related to pacemakers, ICD, cochlear implants, and body-implanted pumps.

OUTPATIENT TREATMENT

6.5. OUTPATIENT TREATMENT COVERAGE

In cases in which diagnosis and treatment do not require hospitalization, medical expenses related to medical examinations, medications, testing/X-rays, and physiotherapy (as detailed below) are defrayable under the limit and payment percentage of this coverage.

6.5.1. MEDICAL EXAMINATION COVERAGE

Expenses related to outpatient examinations performed by physicians working at hospitals and clinics with work permits from the Turkish Ministry of Health or who are authorized to open a private office or emergency examination at home are defrayable under the limit and payment percentage of the Outpatient Treatment Coverage.

6.5.2. TESTING AND X-RAY COVERAGE

Expenses related to any analyses (blood and urine), tests (hearing test), and diagnostic methods (X-rays, mammography, intravenous pyelography, ultrasonography, ECG, EEG, EMG), which are considered by the

physician to be medically necessary for diagnosis and treatment are defrayable under the limit and payment percentage of Outpatient Treatment Coverage.

Medical expenses related to the aforementioned tests and diagnostic methods must be documented by attaching copies of report results to the original invoices or receipts. Periodic repetition of the same tests and examinations for check-up purposes are excluded from the coverage, even if they are requested by the physician.

This coverage also includes all expenses related to tests and examinations, which the policyholder has undergone as inpatient procedures although there is not any need for inpatient treatment.

6.5.3. MEDICATIONS COVERAGE

Expenses related to medications licensed by the Turkish Ministry of Health are defrayable under the limit and payment percentage of Outpatient Treatment Coverage, provided that their necessity for treatment is certified with a prescription.

Expenses related to medications must also be certified by the original prescriptions, pharmacy invoices/cash vouchers, price tags, and barcodes/2d-codes. Price tags must be clipped to ensure that medication names and prices are legible. Medications deemed necessary by the physician could be prescribed as a maximum of five (5) items and one (1) box of each item. If a box of medication does not meet the dosage of 10-day treatment, the required quantity can be prescribed. However, medications, which the report by the attending physician indicates to be used continuously, can be prescribed in 90-day dosage, provided that they are used within the policy term and approved by Yapi Kredi Insurance.

Expenses related to prescribed medications will be covered upon consideration of the dosage and duration.

Expenses related to medications, which have no equivalents in Turkey yet are vital for treatment, are defrayable under the relevant coverage, provided that they are used within the policy term and are approved by Yapi Kredi Insurance.

Medications prescribed by the on-site physician will be procured from SGK. In any health condition, it is of great importance that you first contact the on-site physician at your company. Always ensure those medications obtainable from SGK are procured from SGK through the on-site physician at your company.

Routine vaccines for pre-school children aged 0 to 6 years old: 4 doses each for Polio, Diphtheria, Pertussis, Tetanus, Haemophilus Influenzae B; 3 doses for Hepatitis B; 2 doses each for Measles, Rubella, Mumps; 1 dose for Varicella, BCG (tuberculosis); 3 doses for Hepatitis A;

Routine vaccines for children aged 0 to 9 years old: 4 doses for Pneumococcus;

Routine vaccines for children aged 0 to 1 years old: 2 doses for Rotavirus;

Additionally, vaccines for rabies, tetanus and, and allergies in all ages are defrayable under the limit and payment percentage of Outpatient Treatment Coverage.

6.5.4. PHYSIOTHERAPY COVERAGE

In cases that require physiotherapy and rehabilitation, expenses related to physiotherapy and rehabilitation are defrayable under the limit and payment percentage of Outpatient Treatment Coverage, regardless of whether they are performed on an inpatient or outpatient basis, provided that the treatment plan and report by the physiotherapist is approved by Yapi Kredi Insurance before the treatment starts.

For Seniority Group 1, physiotherapy and rehabilitation expenses, which are defrayable within a policy year, are limited to 20 sessions and the TMA Tariff. If the therapy is performed on more than one part of the body, every part is considered as a separate session.

For Seniority Groups 2 and 3, physiotherapy and rehabilitation expenses are defrayable under the limit and payment percentage of Outpatient Treatment Coverage. This coverage type does not apply to international cases for Seniority Group 1.

6.6. ADVANCE DIAGNOSTIC METHODS AND MEDICAL OBSERVATION TREATMENT COVERAGE

Computerized tomography, exertion ECG, Holter, Doppler ultrasonography examinations, MR, nuclear medicine, any types of biopsy (smear, punch or piercing methods; direct or endoscopic-radiological biopsies from thyroid, breast, prostate, testicles, lymph glands, arteries and veins, skin and all other tissues or internal organs) are defrayable under this coverage, if deemed necessary for diagnosis and treatment and expressly asked by the physician. However, expenses related to liver biopsies and excision biopsies, if lesions are completely removed, are defrayable under the Inpatient Treatment Coverage or Minor Surgery Coverage, based on their respective units in the TMA Tariff.

Furthermore, expenses related to angiography (only conventional cardiac angiography is defrayable under the Inpatient Treatment Coverage); amniocentesis; pain treatment, regardless of its respective units in the TMA Tariff (pain treatment for spinal and disc diseases is defrayable under the Minor Surgery Coverage); and endoscopic procedures such as gastroscopy, cystoscopy, bronchoscopy (including the biopsy itself, as well as necessary medications and medical materials) are defrayable under the limit and payment percentage of this coverage, regardless of whether they are inpatient or outpatient procedures.

Medical treatment of less than 24 hours' (observation or monitoring) is also defrayable under the limit and payment percentage of this coverage.

Medical expenses related to diagnostic methods not mentioned above are defrayable under the limit and payment percentage of the Outpatient Treatment Coverage.

This coverage type does not apply to international cases for Seniority Group 1.

OTHER COVERAGE TYPES

6.7. COVERAGE FOR DENTAL TREATMENT AFTER TRAFFIC ACCIDENT

Expenses related to any treatments and surgeries, that are required upon a traffic accident certified by accident report and which are performed by dentists and maxillofacial surgeons, are defrayable under the limit and payment percentage of this coverage. Expenses related to precious metal coating and prostheses are excluded.

If such expenses are incurred in Non-contracted Healthcare Institutions, then they are defrayable under the limit and payment percentage of Domestic Non-contracted Healthcare Institutions Coverage.

This coverage applies only to domestic cases for Seniority Group 1.

6.8. MINOR SURGERY COVERAGE

Expenses related to surgical procedures, which are defined as minor surgeries with up to 150 units in TMA Tariff (procedures performed with a single incision), as well as interventions on incisions, fracture reductions, plaster casting, extraction of foreign objects, nasal tampons, biopsies with full lesion excision, electro cauterization, cryotherapy, nail extraction, abscess/hematoma drainage, stomach irrigation, and burn debridement and dressing are defrayable under the limit and payment percentage of this coverage, regardless of the type of anesthesia administered or whether they are inpatient or outpatient procedures.

Expenses related to the aforementioned procedures' applications of 150 units and more are defrayable under the limit and payment percentage of Inpatient Treatment Coverage.

Expenses related to the pain treatment for spinal and disc diseases (such as facet denervation, radiofrequency thermocoagulation, transforaminal epidural injection) are defrayable under the limit and payment percentage of this coverage, regardless of their unit value in the TMA Tariff or their inpatient or outpatient status.

Expenses related to medical materials/medications and the operating room (including preoperative blood test), which will be used during procedures are defrayable under the Minor Surgery Coverage, in addition to the related surgeon's fees, are also defrayable under the limit and payment percentage of this coverage.

Even if related to the aforementioned procedures, any laboratory or radiology examinations and/or prescribed medications, as well as their related injection costs, if any, or any other individual medication injections (intra-articular injections), which may be performed or administered before, during, or after the procedure (except for those performed/administered in the operating room), are defrayable under the limit and payment percentage of the relevant coverage types.

If more than one procedure is performed within the same session, the coverage type for each procedure is determined separately, based on their section and unit value in the TMA Tariff.

If more than one surgical procedure is performed with the same or separate incision within the same session and if one of them is an excluded procedure, the amount defrayable is calculated by pro-rating the total invoice (including materials, medications, operating room's and surgeon's fees) with the TMA Tariff.

This coverage type does not apply to international cases for Seniority Group 1.

6.9. MEDICAL EQUIPMENT COVERAGE

Expenses related to medical materials or equipment, which are used only for medical purposes and to support the body from the outside, as a part of the policyholder's treatment upon an accident or a disease within the policy period, such as portable personal splints, elastic bandages, orthopedic boots, sole pads, corsets, varicose stockings, neck supports, knee-guards, wrist supports, arm slings, seat pads, aero chambers, hearing aids (device maintenance and supplies excluded), as well as expenses related to covering materials used in burn or wound treatment, are defrayable under the limit and payment percentage of this coverage.

6.10. DELIVERY COVERAGE

Expenses related to normal delivery, caesarean section,and all inpatient treatments for pregnancy and puerperant complications (including expenses related to the newborn) and expenses related with mastitis are defrayable under the limit and payment percentage of this coverage. Delivery coverage does not incur a waiting period and also applies to existing pregnancies.

Delivery Coverage includes expenses related to inpatient treatment for complications occurring throughout the pregnancy period while any expenses related to the outpatient pregnancy follow-up procedures are defrayable under the limit and payment percentage of the coverage types of Outpatient Treatment, Advanced Diagnostic Methods, Medical Observation/Treatment, and Minor Surgery.

Delivery Coverage applies to all of the female policyholders in the policy, except for those who are of the child status.

Separate coverage limit and payment percentage applies to normal delivery/caesarean section expenses for Seniority Groups 2 and 3. Delivery Coverage is valid worldwide for Seniority Groups 2 and 3. However, 75% of the payment percentage will apply to medical expenses incurred in the U.S.A., Canada, or Israel (the policyholder's liability is limited to 60% of the related limit for caesarean section expenses with 80% payment percentage).

For Seniority Group 1, expenses related to treatments for delivery and/or pregnancy complications are defrayable limitlessly and at the related payment percentage under this coverage, provided that they are administered only in the Contracted Healthcare Institutions. Such expenses incurred in Non-contracted Healthcare Institutions are excluded. If the delivery or pregnancy complications are followed up and treated

by the policyholder's own physician (who is not contracted with Yapi Kredi Insurance), the physician's fees cannot exceed the physician's fees agreed between the Insurer and the Contracted Healthcare Institution preferred by the policyholder.

In Seniority Group 1, Limitless Delivery Coverage is valid only domestically and in Contracted Healthcare Institutions.

6.11. CHECK-UP MAMMOGRAPHY COVERAGE

This coverage applies to expenses related to check-up mammography, which can be performed once a year on female policyholders aged 40 years old or more, in any Contracted Healthcare Institutions List.

6.12. PSA (PROSTATE-SPECIFIC ANTIGEN) TEST COVERAGE

This coverage applies to expenses related to PSA (Prostate-Specific Antigen) test, which can be performed once a year on male policyholders aged 40 years old or more, in any Contracted Healthcare Institution.

6.13. BONE DENSITY TEST COVERAGE

This coverage applies to expenses related to bone density test, which can be performed once a year on female policyholders aged 40 years old or more, in any Contracted Healthcare Institution.

7. TELEMED24 CARD

As of the policy start date, the member and his/her family members will each receive a TELEMED24 card, issued to their name and attached to this guide. TELEMED24 card must be presented to the healthcare institution along with a photo ID, in order to receive discount and direct payment services in the Contracted Healthcare Institutions. When the Contracted Healthcare Institutions are used, treatment expenses covered by the policy – minus the policyholder's contribution, if any – are directly paid by Yapı Kredi Insurance. Especially for expenses under the Outpatient Treatment Coverage, use of TELEMED24 card through POS will expedite the transactions.

TELEMED24 card will remain effective as far as the Koç Foundation Group Private Health Insurance is renewed. If the card is unusable because of loss, theft or a problem on its magnetic strip, a new TELEMED24 card will be sent immediately upon contacting the Communication Line at (0212) 336 0 700.

8. GUIDELINES ON MEDICAL EXPENSE CLAIMS

8.1. MEDICAL EXPENSE CLAIMS PERIOD

For the policyholder's medical expenses claims to be valid, claims must be filed to the Insurer within sixty (60) days following the diagnosis or treatment date.

8.2. 8.2 TREATMENTS EXTENDING THE POLICY TERM

If, on the policy renewal date, the policyholder is under inpatient treatment for an accident or disease, which occurred before the policy renewal date, medical expenses incurred before midday are defrayable under the respective coverage of the expired policy while medical expenses incurred after midday are defrayable under the respective coverage of the new policy. However, if the policy is not renewed, such inpatient treatment duration cannot exceed seven (7) days after the policy end date. For policyholders who are excluded from the policy in the interim period, the coverage will terminate as of the exclusion date.

8.3. GUIDELINES FOR ADDITIONAL POLICIES TO THE KOÇ FOUNDATION GROUP PRIVATE HEALTH INSURANCE

If the policyholder has a second health policy in Yapi Kredi Insurance, the Koç Foundation Group Private Health Policy is first used. If the medical expenses claims exceed the coverage limit, the second policy actuates and the exceeding part is covered under this policy. However, if the policyholder's contribution exists in the coverage type used, this amount is defrayed by the policyholder. The policyholder's contribution is not covered under the second policy.

The policyholders can first use their second policy if they have completed the wait period in this policy only for inpatient treatment expenses related to normal delivery/caesarean section and pregnancy complications. However, all the medical expenses (hospital, physician, etc.) are fully defrayed under the coverage of the preferred policy and cannot be divided between two policies, except when the coverage expires.

8.4. DOCUMENTATION, DELIVERY AND REIMBURSEMENT OF MEDICAL EXPENSES

8.4.1. "Health Expenses Claims Forms," issued for the insured Foundation members and their family members, must be completed with medical expense details and enclosed with treatment documents. Photocopies of the claims forms are accepted. Please note that the policyholder's identification on the Form and the documents sent must match.

8.4.2. In cases in which medical expenses are incurred in Non-contracted Healthcare Institutions and are defrayed by the policyholder, the invoice details must be recorded on the Medical Expenses Claims Form and the original invoices must be stapled to the Medical Expenses Claims Form, the complete documents must be delivered to the related department of the company.

8.4.3. Medical Expenses Claims Forms and attached documents collected at the related department of the companies, upon revision, are sent collectively to reach Yapi Kredi Insurance Head Office on a certain workday within the week, (predetermined separately for each company). Yapi Kredi Insurance performs the necessary controls and deposits the approved amounts to the policyholders' bank accounts on the same workday of the following week. Any forms that Yapi Kredi Insurance did not receive on the specified workday, will be held over to the following week and processed as such. Any forms sent without the knowledge of the company officer, are not accepted and returned. Individuals whose volunteer-basis membership continues and who receive retirement pay must send their medical expenses documents attached to the Medical Expenses Claims Form to the Yapi Kredi Insurance Health Expenditure Management Department, the address is located at the back of this guide.

8.4.4. Lists containing reimbursement details and any medical expenses claims not reimbursed due to missing documents, etc. will be sent by Yapi Kredi Insurance to respective departments of the companies. Policyholders will be able to obtain information on their reimbursement status from the respective departments at their company.

8.4.5. Invoices or self-employment receipts for medical examinations must bear the physician's seal and specialty. If the medical examination fee is paid via credit card and the POS slip bears the statement, "this document substitutes a self-employment receipt pursuant to Tax Procedure Law," such slips substitute receipts. However, if the credit cardholder and the policyholder are different persons, the policyholder's name must be written on the back of the slip, sealed and signed by the physician, in order that the slip be accepted by Yapi Kredi Insurance.

8.4.6. Health institutions must be asked to provide invoices issued to the name of the policyholder rather than cash voucher and in cases in which invoice cannot be obtained, the cash voucher must be sent along with the diagnosis and treatment reports.

8.4.7. The following reports and documents are required along with the original invoices for the diagnosis and/or treatment expenses, attached to the Medical Expenses Claims Form. Yapi Kredi Insurance can thus expedite the medical expense assessment and ensure timely reimbursement.

- Epicrisis, anamnesis, surgery and pathology reports, along with a detailed hospital invoice, for treatments and interventions performed in the hospital, even if the policyholder has not been hospitalized;

- In medical examinations, an Anamnesis report, if necessary;

- For physiotherapy and rehabilitation, a detailed report issued by the physician indicating the precise treatment plan, along with test results, if any;

- For diagnostic procedures, the physician's referral and results;

- For medications, the original prescriptions, along with price tags clipped to ensure that the drug names and barcodes/2d-codes are legible;

- Medical report for ongoing medications;

- In judicial cases (including traffic accidents), any documents issued by judicial authorities (incident scene investigation report, alcohol report, forensic report, traffic accident investigation report, non-prosecution decision) must be submitted.

- For the expenses that are ocurred in abroad, copy of passport that shows entry/exit dates, payment documents and credit card receipts.

8.4.8. Yapi Kredi Insurance is entitled, if deemed necessary to make further investigations, to request the physician, health institutions or third parties who treated the policyholder to provide any information, reports, or other documents related to diagnosis and/or treatment, and to have a specialist examine the policyholder.

8.4.9. Original invoices must be submitted for treatments covered by the policy. If the original of the invoices got lost, Medical expenses will be reimbursed with a copy of invoice, including "same as the original." statement and decleration of the insured.

8.4.10. Detailed list of charges must be attached to the cashier receipts from the university hospitals, in order to be processed. Medical expenses cannot be reimbursed against "credit card slip" therefore, invoices must be issued in such cases. The donation receipts from the foundation-run hospitals must be sealed and attached with a detailed list of charges.

9. INTERNATIONAL TREATMENT

International treatment expenses are reimbursed in Turkish Lira, based on the Turkish Central Bank's selling rate effective on the reimbursement date of Yapi Kredi Insurance. Reports and invoices pertaining to international treatments must either be in English, German, or French language. If not, they must be forwarded with their certified Turkish translations.

For Seniority Group 1;

- International medical expenses under the Inpatient Treatment Coverage (Postoperative Physiotherapy, Nursing and Follow-up, Prosthesis, Ambulance excluded) are reimbursed by 75% and deducted from the Domestic Non-contracted Healthcare Institutions Coverage Limit of net 27,000 Turkish Lira. When international medical expenses exceed the Domestic Non-contracted Healthcare Institutions Coverage Limit, International Inpatient Coverage is used with an additional net limit of 12,750 Turkish lira and 75% payment percentage. The sum of two limits cannot exceed net 39,750 Turkish Lira. (Prosthesis Coverage is also valid for international cases within the domestic coverage limit and 75% payment percentage.)

- International Outpatient Treatment expenses (Physiotherapy, Advanced Diagnostic Methods, and Medical Observation/Treatment Coverage are excluded) are reimbursed by 75% and within an annual limit of $1,000 (except for pensioners). This coverage is valid only in international travels of up to fifteen (15) days and does not apply to longer travels.

- Medical Materials Coverage limit also applies to international cases with the same payment percentage. However, the coverage types other than the Medical Materials Coverage, defined under the "Other Coverage Types," are not valid abroad.

For Seniority Groups 2 and 3;

- Domestic coverage types are also valid abroad within the respective limits, payment percentages and practices (coverage types of Nursing and Follow-up, Ambulance, Check-up Mammography, PSA and Bone Density Test excluded). Coverage types of Inpatient Treatment, Chemotherapy/Radiotherapy/Dialysis (including related examinations), and Outpatient Treatment are also valid abroad within their domestic limits, payment percentages and practices.

- 75% of the payment percentage will be valid only for medical expenses incurred in the U.S.A, Canada or Israel (for instance, 75% of the medical expenses will be defrayed within the limit of the Inpatient Treatment Coverage with no policyholder's contribution. 56% of the medical expenses will be defrayed for coverage types with a policyholder's contribution of 25%).

10. DOMESTIC NON-CONTRACTED HEALTHCARE INSTITUTIONS LIMIT

This refers to the limit valid for medical expenses incurred in the Domestic Non-contracted Healthcare Institutions under the coverage of Inpatient Treatment, Chemotherapy/Radiotherapy/Dialysis, and Examinations for Chemotherapy/Radiotherapy/Dialysis, Ambulance, and Dental Treatment after Traffic Accident. This limit is set as net 27,000 Turkish Lira for the policy term of 2013-2014 with the payment percentage of 75%. This means that the policyholder will pay 25% of the medical expenses and the maximum reimbursable amount will be 27,000 Turkish Lira.

11. TERMS OF LIFETIME RENEWAL GUARANTEE

Under the following terms, Yapi Kredi Insurance agrees and declares to renew life policies of those policyholders who have been party to the Koç Foundation Group Private Health Insurance Policy for four full years without interruption and who wish to continue with one of the "Wellness Insurance" plans. In fulfilling this guarantee, the Insurer reserves all rights stated in the General Conditions of the Health Insurance and Special Conditions of the Wellness Insurance, which are effective on the application date.

- The Lifetime Renewal Guarantee certificate states that only the Wellness Insurance policy of the policyholder will be renewed for life. The risk assessment of the policyholder will be performed on the initial application date for this individual policy.

- Yapi Kredi Insurance reserves the right to investigate the policyholder's medical history and to assess whether the annual net health premium paid for four full years on behalf of the policyholder and the annual medical expense rate paid and/or to be paid exceed 100%, before granting a Lifetime Renewal Guarantee.

- Lifetime Renewal Guarantee is effective, provided that it has been claimed within a month following the cancellation date of the Koç Foundation Group Private Health Insurance and that all the family members covered by the group insurance policy have applied collectively.

- In order that the Lifetime Renewal Guarantee granted for the Wellness Insurance is effective, the Foundation member must apply to Yapi Kredi Insurance for individual health insurance within a month from the cancellation date of the Koç Foundation Group Private Health Insurance due to retirement, resignation, or dismissal (at the end of the policy term in which this incidence occurs at the latest) or due to a decision by the relevant company not to take out an insurance policy.

- The medical risk assessment will be performed on the application date of the Wellness Insurance, taking into account the applicant's medical history up to the date on which a Lifetime Renewal Guarantee is granted. An illness exemption and/or supplementary premium may be applicable, depending on the applicant's medical history.

- When switching to the individual health insurance policy, if the policyholder wishes that conditions considered risky by the insurer be excluded, the illness exemption applied at the policyholder's request remains effective for life and cannot be included again into the policy at a supplementary premium during renewal periods. Furthermore, health conditions excluded (deemed to be out of coverage) as a result of the medical risk assessment cannot be included again into the policy during policy renewal periods and the exemption remains effective for life.

- Health conditions occurring after the issuance date of the Lifetime Renewal Guarantee certificate will not be excluded from the policy during renewal periods and no supplementary premium rate will be applied to these conditions.

- If the policyholder is detected to be guilty of false declaration, underreporting, or misrepresentation or to have used policy terms in bad faith, the Lifetime Renewal Guarantee will be terminated. In such a case, the relevant article of the General Conditions for Health Insurance will apply.

- In cases of risks or health conditions, which occurred before the issuance date of the Lifetime Renewal Guarantee certificate and are known to the policyholder but not to Yapi Kredi Insurance, Yapi Kredi Insurance reserves the right to terminate the Lifetime Renewal Guarantee or to maintain the policy by applying illness exemption and/or supplementary illness premium as of the disclosure date. The policyholder must notify Yapi Kredi Insurance on any risks or health conditions he/she is exposed within eight (8) days.

- In the initial application to an individual health product by the policyholder granted with the Lifetime Renewal Guarantee, the product, coverage, and coverage limits he/she chooses are subject to the approval by Yapi Kredi Insurance.

- If the policyholder wishes to expand his/her coverage during renewal periods, Yapi Kredi Insurance will revise the renewal guarantee. Coverage expansion is subject to the approval by Yapi Kredi Insurance. Yapi Kredi Insurance may request the policyholders who wish to expand their coverage to submit a recent medical declaration, may put them through a medical examination or additional tests, or may exclude some diseases from the policy.

- On the renewal period of the individual policies, the coverage, coverage limits, and respective premiums are set according to special policy terms. Yapi Kredi Insurance may amend the special policy terms, such amendments become effective as of the start date of the new policy.

12. PAYMENT TERMS FOR MEDICAL EXPENSES BY SENIORITY GROUP

12.1. SENIORITY GROUP 1

12.1.1. Medical expenses related to the coverage types of Surgery, Nonsurgical Treatment, and Chemotherapy/Radiotherapy/Dialysis;

A. Medical expenses incurred in Contracted Healthcare Institutions and approved in advance by Yapi Kredi Insurance are defrayable limitlessly and at the payment percentage of the respective coverage, under the direct payment system.

B. Out of the medical expenses incurred in the Contracted Healthcare Institutions and approved in advance by Yapi Kredi Insurance, the portion belonging to persons or institutions, which do not fit the description of contracted healthcare institutions (the policyholder's private physician and/or a physician who does not accept the agreement terms although practicing at a contracted healthcare institution) is defrayable through deduction from the Domestic Non-contracted Healthcare Institutions Coverage Limit at the payment percentage of 75%, under the reimbursable payment system.

C. Medical expenses related to procedures performed by persons or institutions defined as Non-contracted Healthcare Institutions are defrayable through deduction from the Domestic Non-contracted Healthcare Institutions Coverage Limit at the payment percentage of 75%, under the reimbursable payment system. However, in life-threatening emergencies, medical expenses are defrayable limitlessly and at the payment percentage of the respective coverage, under the reimbursable payment system, provided that the treatment reports are submitted to and accepted by Yapi Kredi Insurance. In domestic provinces in which there are no Contracted Healthcare Institutions, medical expenses related to treatment methods under the policy and incurred in any existing healthcare institutions are defrayable limitlessly and at the payment percentage of the respective coverage. In such cases, policyholders must first defray the medical expenses to the related healthcare institution and then submit the required documents to Yapi Kredi Insurance to make a claim.

D. Medical expenses incurred in public hospitals under the Ministry of Health or in public university hospitals are defrayable limitlessly and at the payment rate of the respective coverage, under the reimbursable payment system.

12.1.2. Medical expenses related to the coverage types of Outpatient Treatment, Minor Surgery, Advanced Diagnostic Methods, and Medical Observation/Treatment;

A. Medical expenses incurred in Contracted Healthcare Institutions and approved in advance by Yapi Kredi Insurance are defrayable limitlessly at the payment percentage of 75%, under the direct payment system.

B. Out of the medical expenses incurred in the Contracted Healthcare Institutions and approved in advance by Yapi Kredi Insurance, the portion belonging to persons or institutions, which do not fit the description of contracted healthcare institutions (the policyholder's private physician and/or a physician who does not accept the agreement terms although practicing at a contracted healthcare institution) is defrayable limitlessly at the payment percentage of 75%, under the reimbursable payment system.

C. Medical expenses related to procedures performed by persons or institutions defined as Non-contracted Healthcare Institutions are defrayable limitlessly at the payment percentage of 75%, under the reimbursable payment system.

D. Medical expenses incurred in public hospitals under the Ministry of Health or in public university hospitals are defrayable limitlessly at the payment rate of 75%, under the reimbursable payment system.

E. The policyholders (except for pensioners) are granted with additional international outpatient treatment coverage with an annual limit of $1,000 and a payment percentage of 75% for medical expenses incurred upon the policyholder's own wish or in the case of an emergency, to be used only in international travels of up to fifteen (15) days. Coverage types of Minor Surgery, Advanced Diagnostic Methods, and Medical Observation/Treatment are not effective abroad.

F. Medical expenses incurred in pharmacies included into the network of Contracted Healthcare Institutions in accordance with the payment terms specified for medications and vaccines are

defrayable limitlessly at the payment percentage of 75%, under the direct payment system. If there is a time period of more than 10 days between the prescription date and the purchase date of the medications, then the related medication expenses are considered under the reimbursable payment system.

12.2. SENIORITY GROUPS 2 AND 3

12.2.1. Medical expenses related to the coverage types of Surgery, Nonsurgical Treatment, and Chemotherapy/Radiotherapy/Dialysis;

A. Medical expenses incurred in Contracted Healthcare Institutions and approved in advance by Yapi Kredi Insurance are defrayable through deduction from the annual limit at the payment percentage of the respective coverage, under the direct payment system.

B. Out of the medical expenses incurred in the Contracted Healthcare Institutions and approved in advance by Yapi Kredi Insurance, the portion belonging to persons or institutions, which do not fit the description of contracted healthcare institutions (the policyholder's private physician and/or a physician who does not accept the agreement terms although practicing at a contracted healthcare institution) is defrayable through deduction from the annual limit at the payment percentage of the respective coverage, under the reimbursable payment system.

C. Medical expenses related to procedures performed by persons or institutions defined as Non-contracted Healthcare Institutions are defrayable through deduction from the annual limit at the payment percentage of the respective coverage, under the reimbursable payment system.

D. International medical expenses incurred upon the policyholder's own wish or in the case of an emergency are defrayable through deduction from the annual limit at the payment percentage of the respective coverage, under the reimbursable payment system. However, 75% of the payment percentage of the respective coverage will apply to medical expenses incurred in the U.S.A, Canada or Israel (75% of medical expenses is defrayable for Inpatient Treatment Coverage. 56% of medical expenses is defrayable for Chemotherapy/Radiotherapy/Dialysis Coverage).

12.2.2. Medical expenses related to the coverage types of Outpatient Treatment, Minor Surgery, Advanced Diagnostic Methods, and Medical Observation/Treatment;

A. Medical expenses incurred in Contracted Healthcare Institutions and approved in advance by Yapi Kredi Insurance are defrayable through deduction from the annual limit of the respective coverage at the payment percentage of 75%, under the direct payment system.

B. Out of the medical expenses incurred in the Contracted Healthcare Institutions and approved in advance by Yapi Kredi Insurance, the portion belonging to persons or institutions, which do not fit the description of contracted healthcare institutions (the policyholder's private physician and/or a physician who does not accept the agreement terms although practicing at a contracted healthcare institution) is defrayable through deduction from the annual limit of the respective coverage at the payment percentage of 75%, under the reimbursable payment system.

C. Medical expenses related to procedures performed by persons or institutions defined as Non-contracted Healthcare Institutions are defrayable through deduction from the annual limit of the respective coverage at the payment percentage of 75%, under the reimbursable payment system.

D. International medical expenses incurred upon the policyholder's own wish or in the case of an emergency are defrayable through deduction from the annual limit of the respective coverage at the payment percentage of 75%, under the reimbursable payment system. However, 75% of the payment percentage of the respective coverage will apply to medical expenses incurred in the U.S.A, Canada or Israel (for medical expenses covered with a payment percentage of 75%, 56% are defrayable within the respective limit). Coverage types of Minor Surgery, Advanced Diagnostic Methods, and Medical Observation/Treatment are effective abroad.

E. Medical expenses incurred in pharmacies included into the network of Contracted Healthcare Institutions in accordance with the payment terms specified for medications and vaccines are defrayable within the limit of the Outpatient Treatment Coverage at the payment percentage of 75%, under the direct payment system. If there is a time period of more than 10 days between the prescription date and the purchase date of the medications, then the related medication expenses are considered under the reimbursable payment system.

13. USE OF CONTRACTED HEALTHCARE INSTITUTIONS

Policyholders must present their TELEMED24 cards to receive service from Contracted Healthcare Institutions. TELEMED24 card must be presented along with a photo ID to be effective. Otherwise, the medical expenses must be defrayed by the policyholder and the invoices or supplementary documents must be delivered to Yapi Kredi Insurance for assessment under the reimbursable payment system. Policyholders by submitting their TELEMED24 cards and obtaining approval of Yapi Kredi Insurance, can receive medical services in Contracted Healthcare Institutions without making any payment, as long as their medical expenses remain within their respective limits and after the policyholder's contribution has been deducted according to the insurance coverage and terms (for instance, the policyholders will pay their contribution of 20% and/or 25%, as well as the amount exceeding the coverage limits).

In cases in which the policyholder will undergo inpatient treatment in a contracted healthcare institution, the Disclosure Form (provided by the healthcare institution prior to the hospitalization) must be submitted to Yapi Kredi Insurance for approval within 24 hours before hospitalization in order that the invoice is paid directly. Therefore, the policyholder must confirm on the day of hospitalization that the healthcare institution has faxed the Disclosure Form to Yapi Kredi Insurance. This 24-hour requirement does not apply to emergency cases. The policyholder him/herself defrays the medical expenses, which are not approved in the Contracted Healthcare Institutions and are incurred in the Non-contracted Healthcare Institutions. If the contract is terminated between a Contracted Healthcare Institution and Yapi Kredi Insurance, benefits (direct payment of invoices, discounts, etc.) special to Contracted Healthcare Institutions will be automatically terminated.

The Contracted Healthcare Institution system is a supplementary benefit provided by Yapi Kredi Insurance to its policyholders with the aim of fast and affordable service under the contracts executed with healthcare institutions and physicians. The policyholders are completely free to choose these persons or institutions. This service does not constitute advice, referral, or guarantee by Yapi Kredi Insurance, the institutions and persons are solely responsible for the performance and results of any diagnosis, treatment, post-treatment assessment, and controlling or screening test.

14. EXCLUSIONS

The following cases, treatments, and expenses are not covered by this insurance policy:

14.1. Check-ups, coronary artery calcium scoring or EBT performed periodically or for controlling purposes; noninvasive cardiac angiographies (EBT angiography, multi-slide coronary angiography, etc.) and related examinations and tests, as well as preventive vaccines and medications;

14.2. The following medications, even if prescribed:

- Any vitamin and mineral combinations, minerals, and preparations containing other natural nutritional supplements, which are not licensed by the Turkish Ministry of Health and are permitted to be sold without prescription to satisfy the daily physical needs and/or protect general well-being;

- Preparations, which cannot be classified as medication or do not contain active agents;

- Preparations and medications, which are not licensed by the Turkish Ministry of Health;
- All kinds of soaps and shampoos;
- Contraceptive medications;
- Preparations to prevent dandruff or hair loss;
- Medicinal fruit salts or drinks;
- Herbal weight-loss products, bran or herbal fibers, weight-loss preparations, artificial sweeteners;
- All kinds of medicinal teas, herbs and herbal elements in the form of medications, as well as those containing fractions such as herbal extracts or distillates;
- Water or seawater prepared in the form of medication, which does not contain any active agent;
- All kinds of toothpaste, as well as oral and dental care preparations;
- Contact lens care products;
- Nicotine preparations used for smoking cessation;
- All kinds of cosmetic preparations (creams, lotions, hand creams);

14.3. Expenses related to all kinds of cure, balneotherapy, rehabilitation and physiotherapy at hot springs, thermal facilities, hotels, and similar facilities, even if performed under the supervision of a physician;

14.4. Expenses related to diagnosis, testing, treatment and complications of psychiatric or geriatric diseases, dementia syndrome (senile dementia, Alzheimer), and other cases requiring psychotherapy, as well as related psychologist's and consultant's fees;

14.5. Expenses related to diagnosis, treatment, complications and follow-up of congenital anomalies or diseases, genetic diseases and all kinds of tests for assessment of genetic disease/status (except for the follow-up of pregnancy), developmental disorders, inguinal hernia in individuals under the age of 18, existing disabilities and related complications, all kinds of spinal curvatures (kyphosis, scoliosis, etc.), structural disorders (septum deviations, nasal valve deficiency, hallux valgus; etc.), and obesity, even if diagnosed after the start date of the policy;

(Medical expenses related to septum deviation and inguinal hernia in individuals under the age of 18 are defrayable under the respective coverage, if the policyholder has been granted with Lifetime Renewal Guarantee after having completed four full policy terms consecutively and provided that these diseases are diagnosed within the policy period and no exception/exemption applies to them. Furthermore, medical expenses related to arteriovenous malformation are defrayable under the relevant coverage, provided that it is diagnosed after the policyholder has completed four full policy terms consecutively and has been granted with Lifetime Renewal Guarantee.)

14.6. Expenses related to surgeries performed to treat strabismus or optical fractures (including laser treatment);

14.7. Expenses related to all kinds of reconstructive and cosmetic treatments and surgeries, as well as related follow-up examinations and complications (except for reconstructive post-mastectomy surgeries for breast cancer, which is accepted under this policy); related gynecomasty, hemocystein

and DHEA performed for anti-aging purposes, as well as all other related tests, treatments, follow-up examinations, complications, medications or materials; weight-loss tests, treatments, exercises, massages or acupuncture; dietician's, private nurse's or physiotherapist's fees; superficial varicosis treatments (sclerosant laser treatment); mesotherapy; neural therapy, PERTH (Pulsating Energy Resonance Therapy); sound or speech therapies; tests and treatments for sleep disorders, sleep apnea, snoring (polysomnography, sleep EEG); and alternative medicine methods;

14.8. Expenses related to phimosis performed for any reason; assisted reproductive techniques (diagnosis and treatment of infertility, IVF, ovulation monitoring and any other infertility diagnosis/treatment methods and/or related complications); contraceptive methods (including abortion), as well as related medications and materials; gender reassignment surgeries; diagnosis, treatment, follow-up and complications of genital herpes, genital and anal papillomatous lesions (warts, condyloma acuminatum, etc.), genital and anal molluscum contagiosum, Peyronie's disease, sexual dysfunctions, and menopausal osteoporosis;

14.9. Expenses related to follow-up tests, laboratory examinations or required treatment for HIV and any other diseases caused by HIV;

14.10. Expenses related to the treatment of addiction to alcohol, heroin, morphine, stimulants or similar drugs and intoxication and diseases resulting from such addiction; as well as diagnosis, treatment, follow-up, and complications of diseases, injuries, or accidents of policyholders who have been tested positive for any of these substances;

14.11. Expenses related to injuries or disabilities suffered during competitions and speed/resistance races of professional and/or extreme sports (mountain climbing, parachuting, traveling on non-tariff flights with a position other than the passenger, underwater sports, rally, motocross, etc.);

14.12. Expenses related to all kinds of sanitary materials such as diapers, baby formulas, feeding bottles, pacifiers, thermophores, and thermometers; slippers; devices for sleep apnea; equipment and devices such as wheelchairs and crutches; breast and penile prostheses; as well as expenses not directly related to treatment (telephone and TV); room fees other than standard single-bed room with one attendant;

14.13. In cases in which a policyholder with more than one year of policy term is hospitalized, continuously or at intervals, for more than 365 days for the same disease, expenses related to the exceeding period;

14.14. Except for emergencies, inpatient treatment, which has not been notified to the insurer at least 24 hours in advance;

14.15. Expenses, which fall under any coverage type, not indicated in the policy, as well as treatment expenses incurred at any healthcare institutions that do not fall under the policy's definition of healthcare institution;

14.16. In cases in which treatment consists of domestic and international stages, travel expenses and accommodation costs at hotels or similar places connected to the treatment centre;

14.17. In organ transplantations and blood transfusions, expenses related to donor, as well as to organ and organ transfer;

14.18. Expenses related to spectacles (frame and glass) and contact lenses;

14.19. Expenses related to dental, periodontal, temporomandibular, and oral-maxillofacial examinations, tests, treatments, surgeries and complications (medical expenses arising from a traffic accident are covered, as specified in the respective section);

14.20. Fee of a physician who has kinship by blood or marriage with a policyholder who applies to him/her for diagnosis and treatment;

14.21. Policyholder's contribution and/or exemption amount related to medical expenses covered by a policy issued by Yapi Kredi Insurance or any other insurer;

14.22. The unearned daily salary and all the incurred expenses of daily care in case he/she needs healthcare are not covered under the policy,

14.23. All treatments that, there is not enough published documents regarding to their necessarity for the related illness, effectiveness, reliability and quality; and not approved by the authorities such as medical specialty associations, Ministry of Health, Medical Institutions, USA Food&Drug Administration or experimental studies by the authorities that are not proved yet, or an identified information of an individual/ Corperation's on going experimental studies related with the same illness at the time that the insured having treatment.

14.24.Exclusions specified in Articles 2 and 3 of General Terms for Health Insurance:

General Terms, Article 2:

a) War and warlike operations, revolutions, rebellions, insurrections, and civil commotions arising thereof,

b) Committing or attempting to commit a crime,

c) Policyholder's willful acts, which would seriously endanger him/herself, except when undertaken for rescuing people and goods in danger,

d) Abuse of drugs such as hashish and heroin,

e) Nuclear risks or use of nuclear, biological and chemical weapons, as well as any kind of sabotage and attack, which may cause exposure to biological and chemical substances,

f) All damages caused by biological and/or chemical pollution, contamination or poisoning as a result of terrorist acts specified in the Anti-Terrorism Law No. 3713 and related sabotages or of operations undertaken by authorized bodies to prevent such acts and lessen their effects,

g) Diseases and injuries caused by the suicide attempt of the policyholder, and

h) Other excluded cases, which will be set forth under the special policy terms.

General Terms, Article 3:

Unless otherwise agreed, illnesses and/or accidental injuries suffered by the policyholder within the insurance period as a result of the following cases are not covered by the policy:

a) Earthquakes, floods, volcanic eruptions, and landslides,

b) Except for the damages specified in General Terms, under Article 2, paragraph (f), terrorist acts and sabotages specified in the Anti-Terrorism Law No. 3713, as well as operations undertaken by authorized bodies to prevent such acts and lessen their effects.

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