İHSAN DOĞRAMACI BİLKENT UNIVERSITY AND AFFILIATED ORGANIZATIONS
GROUP HEALTH INSURANCE CONTRACT

This Contract (Policy) is comprised of the two inseparable sections called the "Administrative Section" and the "Technical Section".

ADMINISTRATIVE SECTION

A -) PARTIES

Between
(Insurer) : MAPFRE Sigorta A.Ş.
Yenişehir Mah. Irmak Cad. No:11
34435 Beyoğlu /İstanbul
and
(Company) : İhsan Doğramacı Bilkent University and Affiliated Organizations
Bilkent 06800, Ankara

a Group Health Insurance Contract, which covers the outpatient and inpatient treatment expenses of company employees, their spouses and children, has been prepared in accordance with the Healthcare Insurance General Conditions and the conditions of this contract. Children under 24 years of age and children between 24-29 (including 29) years of age documented to be continuing their education and under dependent status will be covered by this insurance.

B -) THE SUBJECT AND TERM OF THE CONTRACT

The Insurer hereby undertakes to cover the personnel of the company of which the name and address has been written above, for the diagnosis and treatment expenses in the attached list in accordance with the "Turkish Commercial Code", "Healthcare Insurance General Conditions", and the these "Special Conditions".

Policy start date : August 05, 2016 00:01 (midnight)

If there are ongoing treatments after the coverage is expired, the term will be extended due to any compensation amounts due to these treatments.

Unless one of the parties notifies the other 1 month before a year has gone by as of the contract start date, this contract will be automatically extended for one year increments taking into account the following premium calculation principles.

This contract will end without being renewed at the end of year 05/08/2017 as long as there is no other agreement between the parties.

At the renewal period the Company's ratio of total compensation amount (total use based on day) to earned premium (the premium paid to the insurer by the group based on days) and medical inflation will be taken into account to prepare a renewal proposal to be presented for the group's approval. The renewal premium will be provided throughout mutual agreement.

Total Compensation Amount: The total compensation amount paid by the Insurance Company.

C -) PAYMENT OF THE INSURANCE PREMIUM :

The policy premiums have been specified below.

Type of Insured	Premium Amount (TL)
Individual	**2.325,00**
Family (Including unmarried children under 24)	**4.650,00**
Unmarried children between 24 and 29 continuing education	**1.960,00**

The insurance premium will be paid in 12 equal installments in TL. Each installment will be paid by the 5th of that month. If the 5th coincides with a holiday or weekend, the payment will be made on the first business day following the 5th. The liability of the Insurer will start once the first premium has been paid. If the insurance premium is not paid, the provisions of the Turkish Commercial Code shall apply. Premiums for added individuals will be collected from and refunds for departed individuals will be made to the Company.
If the installments are not paid within 15 days at the latest from the due date, the Insurance Company will cease all compensation until the Company pays the due premiums.

D -) CUSTOMER SERVICES AND REPORTING

a. Customer representative: The Insurer will appoint a Customer Representative to answer the questions and complaints of Insured Customers and set up a Customer Service Line. The name and telephone number of the representative will be included in the Insurance Booklet given to Insured customers. Insured complaints will be resolved within 5 business days. Any complaints and how they have been resolved will be kept on record.

b. Monthly Report: The Insurer will submit a report to the Company every month on the (i) compensation/premium ratio that occurs in the scope of the contract, (ii) Complaints that are submitted to the Customer Representative and (iii) (whether there is the subject of a complaint or not) the rejected compensation requests with the reasons for their rejection.

c. Survey: When it is 3 months left until the expiration of the policy period, the Insurer will conduct a "Customer Satisfaction Survey" and submit the results to the Company. The Company will assist in the distribution and collection of survey forms.

E -) ACCEPTANCE TO INSURANCE, DEPARTURE FROM INSURANCE AND NOTIFICATION OF PERSONNEL RESIGNING FROM THE COMPANY TO THE INSURANCE COMPANY:

The existing personnel who wish to join the Group Insurance must apply by October 5, 2016 at the latest. Newly employed personnel may be included in the insurance if they apply within 1 month as of their employment date with an approved letter from the company confirming that they have just been hired.

In the event of a change in marital status, the Insured may transfer from a Family Policy to an Individual Policy or from an Individual Policy to a Family Policy at any time.

The Group Health Insurance of personnel leaving the company will end as of the date of their resign and their policy and the policy of dependents, if any, will be cancelled by day calculation. The Company is required to inform the Insurer in writing that the insured personnel has left the company and that their policy needs to be cancelled on the date of their leave.

Any unfair compensation that the Insurance Company has to pay to the insured directly or to in-network institutions for the healthcare expenses of the departed personnel and their dependents after they have left the company due to their departure being informed late to the Insurance Company, will be paid by the Company to the Insurance Company.

If after the insurance start date the Insured wishes to cancel their policy, the paid compensation as of the exit date and earned premiums based on day calculation will be compared. If the paid compensation is more than the earned premiums based on day calculation, that is to say, if the compensation to premium ratio is over 100%, no premium refund is made, if it is under 100% the premium is calculated per day and refunded.

F -) ARBITRATION BOARD:

1. The parties have established an arbitration board under the following conditions and based the resolution of conflicts on the following conditions. The board will be comprised of 3 people appointed by Bilkent University and 3 people appointed by the Insurer. The parties can call the board to meet at any time within 7 days.
2. Rejected compensation demands, if complained about, can be brought to the board.
3. The problems of all Insured in the scope of the Contract will be handled by this board.
4. If the situation of the insured presents a characteristic not seen before or an extraordinary situation arises, the board will produce a reasonable solution. In cases that cannot be resolved with a majority vote, the opinion of one specialist working at the university will be obtained.

G -) RESOLUTION OF CONFLICTS

The parties will act according to the Arbitration Board provisions in resolving conflicts and issues that are not included in the Contract. If a peaceful solution cannot be found for the conflict, the Ankara Courts and Execution of Debts Offices will be authorized.

I -) FORCE MAJEUR

Situations that develop outside of the control of the parties which prevent and/or delay the Parties being able to carry out the obligations they have undertaken with this Contract shall be considered force majeur (for example strike, lockout, war (declared or not) civil war, terror acts, earthquake, fire, flood, similar natural disasters, decisions and acts of the government, etc.). The parties shall not be held liable for not being able to carry out their obligations completely or on time due to force majeur.

If the force majeur situation continues for 30 (thirty) days, the parties will meet to discuss the continuation, suspension, terminations or other forms of liquidating this Contract. If the parties cannot reach an agreement in this period, any one of the parties has the right to unilaterally terminate the Contract at any time.

J -) TERMINATION

Excluding the Force Majeur Situations specified in the contract, if one of the parties fails completely or partially to fulfill their obligations in the scope of this Contract and its Annexes, or does not carry them out as defined in the Contract and its Annexes or violates their obligations, the other party may send a written notice 1 month in advance demanding that they fulfill their obligations. If the obligations are not fulfilled, the party sending the notice will include in their notice that they have the right to terminate this Contract immediately and unilaterally without the requirement of any warning or notification.

Also, if they wish, the parties may cease the service that is the subject of the contract in the event of the above mentioned violation/contradiction and by notifying the other party in writing, may ask for the contradiction in question to be amended or the obligations to be fulfilled within 3 (three) days.

If the Party violating the Contract does not fulfill its obligations within the period specified above or rectify the violation, the other Party will have the right to unilaterally terminate this contract without requirement of a warning, notification or court order.

In the following situations the Contract will automatically lapse into termination without requirement of a warning, notification or court order:

1. If the COMPANY goes bankrupt, declares bankruptcy;
2. If the COMPANY's legal entity ends, all or some of its asset are sold, transferred or seized.
3. If debt pursuit, levy and custody actions are filed against the COMPANY.

TECHNICAL SECTION

A -) SUBJECT OF THE INSURANCE:

Policy Coverage:

The Insurance Company will compensate the insured individual's outpatient doctor examinations, diagnosis and treatment expenses and inpatient treatment expenses with or without surgery for health issues arising from accidents or illnesses in their private or professional life that occur in the contract term; within the framework of the Healthcare Insurance General Conditions and the conditions of this Contract in accordance with the scope and coverage of this policy.

Policy start date : August 05, 2016, 00:01 (midnight)

If there are ongoing treatments on the coverage expiration date the term will be extended up to 15 days only for compensation costs related to this treatment.

First Insurance Start Date and Earned Rights:

On the condition that there has been no interruption in the group health insurance terms of the Company they are still working in, individuals who have a health insurance policy with another insurer but wish to join the Bilkent University or its affiliates within 30 days as of the expiration date, will have all earned rights including Lifelong Renewal Guarantee maintained by only having a risk analysis for illnesses that fall under the 1st Degree risk group. The first insurance start date will be the start date of their policy which has been continuing uninterrupted.

Lifelong Renewal Guarantee:

Personnel and their dependants, who have remained within the insurer structure for two (2) years without interruption, whose T/P ratio (total compensation amount/gross premium amount) is under 100% each year and who have acted in accordance with the 'Maximum Good Intention Principle' will be given a Renewal Guarantee in the scope of this group health insurance without their illnesses, which emerged after the insurance start date, being excluded from scope and no additional premiums being charged for these illnesses.

The insured who earn a Renewal Guarantee in the assessment at the end of the year, will be considered for a Renewal Guarantee again each year at the policy renewal period according to their T/P ratios for the last 2 years. If insured members who were 60 and under by year, when they first became insured, have not earned a Renewal Guarantee according to the assessments done at the end of the first 2 years and by considering the past 2 years in subsequent years, they will not be considered for a Renewal Guarantee at 64 and over and will not earn a Renewal Guarantee.

A renewal guarantee is given individually to the insured. A Renewal Guarantee being given to one member who is covered under the group insurance as a Family member shall not mean that the other members have been given a Renewal Guarantee.

Conditions for Transferring to Individual Policy:

If an insured member who has been given a Renewal Guarantee while under the group insurance as a family member wishes to obtain an Individual Policy, all other family members under the same group insurance policy, whether they have earned a Renewal Guarantee or not, must be in the scope of the same Individual Policy. If family members, who have not earned a Renewal Guarantee while under the group policy, do not want to get individual insurance and only the family members who have earned a Renewal Guarantee wish to get individual insurance, the family members who have earned a Renewal Guarantee cannot be insured under the individual policy. A risk analysis will be done on family members who have not earned a Renewal Guarantee under the Group structure when they are transferring to an individual policy.

If it is determined that the insured has acted dishonestly and made an incomplete or incorrect declaration or abused insurance compensation, the Insurer may, as of the date that they become aware of the situation,

apply an exemption or additional premium for the illness in question and change the conditions of the Renewal Guarantee, may take recourse against the insured for compensation that has been paid in connection with the illness, remove the Renewal Guarantee or cancel the policy.

In order for the RG to be valid when transferring from a Group Policy to an Individual Policy, if the individual has left the policy by retiring, resigning or being dismissed from the Insurant's company or after the Insurant decides not to get health insurance from any insurance company, they must apply within one (1) month at the latest as of the date that the policies are cancelled. In this situation it is the principle that the Insured along with all dependants in the scope of the Group Health Insurance and as of their coverage under the insurance switch to an equivalent product that is specified by the Insurer.

If the above conditions cannot be met a new risk analysis will be done.

When individuals are departing from the group due to retirement after working for at least 10 years with the company, they will be given a 50% discount on the MAPFRE Insurance individual health current premiums when transferring to individual insurance.

The individual health insurance policy that the Insurer presents to insured members who have been given RG, will be subject to the individual Special Conditions in the term that the policy is in force (applicable to the whole portfolio). Even if the Insured has been given RG the Insured's discount and/or additional premium application right for the Insured uses will continue depending on the Insurer's compensation/premium ratio.

The rights (exemption, limit, additional premium, waiting period, etc.) including Renewal Guarantee of the existing insured, who were entered into the group policy before 05.08.2016, will be maintained.

There is no age limit in group insurance entries.

THE SCOPE AND COVERAGE OF THE POLICY

MAIN COVERAGE TABLE			
INPATIENT TREATMENT	**TYPE OF COVERAGE**	%	**COVERAGE LIMITS (TL)**
Operation		100	UNLIMITED
Room-Meals-Companion		100	UNLIMITED
Intensive Care (Max. 90 days per incident)		100	UNLIMITED
Doctor Monitoring		100	UNLIMITED
Medication (Inpatient)		100	UNLIMITED
Diagnosis (Inpatient)		100	UNLIMITED
Coronary Angiography		100	UNLIMITED
Chemotherapy		100	UNLIMITED
Radiotherapy		100	UNLIMITED
Dialysis		100	UNLIMITED
Small Procedures		100	UNLIMITED
OUTPATIENT TREATMENT	**TYPE OF COVERAGE**	%	**COVERAGE LIMITS (TL)**
Doctor Examination		70	UNLIMITED
Medication (Outpatient)		70	UNLIMITED
Diagnosis (Outpatient)		70	UNLIMITED
Physical Therapy	(Yearly Limit)	70	5.060,00
Check-Up Mammogram +US	(1 Time Per Year)	100	Valid for women 40 and over
PSA (Free PSA)	(1 Time Per Year)	100	Valid for men 40 and over
Routine Pregnancy Check-Ups		100	May be paid from maternity coverage.
OTHER COVERAGE	**TYPE OF COVERAGE**	%	**COVERAGE LIMITS (TL)**
Home Care	(Yearly Limit)	100	38.500,00
Rehabilitation	(Yearly Limit)	100	38.500,00
Physical Therapy After Surgery	(Yearly Limit)	100	3.080,00
Artificial Limb	(Per Incident)	100	15.400,00
Emergency Service Coverage		100	UNLIMITED
Ambulance	(Per Incident)	100	3.080,00
Domestic Air Ambulance	(Per Incident)	100	20.900,00
Foreign Air Ambulance	(Per Incident)	100	41.800,00
Auxiliary Medical Materials	(Yearly Limit)	70	770,00
Hearing Aid	(Yearly Limit)	70	4.785,00
Maternity	(Yearly Limit)	100	6.160,00

- The above coverage is valid without distinction of In-Network/Non-Network institutions.

- In coverage with a Yearly Limit and in which the Insurer participation is 70%, the amount to be paid to the Insured is limited to 70% of the coverage limit.

- The In-Network institutions where check-up **Mammography**, **Breast Ultrasounds**, **PSA** and **Free PSA** can be done are provided in ANNEX-1.

- The coverage that is given as limited on the above MAIN COVERAGE TABLE is valid within the same limit and payment rate in the country and abroad. The coverage that is given as unlimited on the above MAIN COVERAGE TABLE is only valid domestically. Foreign added coverage has been organized in Section 4.

B.1 INPATIENT TREATMENT COVERAGE

Expenses related to surgical or medical treatment that takes place while admitted in the hospital and surgical or medical treatment that does not require hospital admission and the unit is over 150 units according to the Turkish Physicians Association (TPA) Minimum Fee Tariff are considered to be in the scope of Inpatient Treatment. However expenses related to nonsurgical treatment with a hospitalization period not exceeding 24 hours in which no surgical or orthopedic procedure is done, are compensated in the scope of Outpatient Treatment.

Hospitalization for tests is excluded from Inpatient Treatment Coverage.

If the treatment requires surgery the expenses related to the operating room, operator, anesthesiologist, assistants, anesthetics, medication and consumable materials in addition to coronary angiography, PTCA, pacemaker, heart valve and pre-operation tests will be covered by the inpatient treatment coverage.

All expenses related to HIV virus infections, AIDS and its complications are excluded from coverage. However, HIV and Hepatitis tests that are run pre-op in inpatient surgery are paid by the relevant coverage.

B.1.1 Operation Expenses : On the condition that a surgical procedure is required for the insured is documented with a doctor report and the surgical procedure is done in a healthcare institution, the Operation Expenses including the cost of using the operation room, the cost of the materials and medications used during the operation, the operator doctor and staff (Assistant and anesthesiologist) fees; are paid within the limits that are specified in the coverage table and the policy general and special conditions.

Pre-Inpatient Treatment Approval: In planned inpatient treatment, it is important that the Insurance Company be informed at least 48 hours in advance, an authorization is applied for and it is clear whether or not the admission authorization is going to be granted by the Insurance company before being admitted to the hospital to avoid waiting at the hospital and being left in a difficult situation during admission.

Fee to be Paid to the Operator Doctor and Staff: The fee to be paid to non-staff operator doctors and their team (Assistant and anesthesiologist) for an operation in an in-network hospital shall be limited to 2 times the TPA rate. (If the doctor fee that is determined between the In-Network Healthcare Institution and the Insurer is higher than the amount in question, it will be paid in the amount that is applied by the In-Network Healthcare Institution.)

The fee to be paid to the operator doctor and team (Assistant and anesthesiologist) for an operation in domestic non-network hospitals is limited to 3 times the TPA rate.

Classification of Operations: If more than one operation is done in a session and some of these operations are not in the scope of the insurance, the uninsured operation and expenses related to it will not be paid. Insured operations and related expenses will be paid according to the ratio of the total unit of the operation or operations specified in the Turkish Physicians Association Minimum Wage Tariff to its weight among all of the operations done in the same session. The operations will be classified according to the principles that are specified in the Turkish Physicians Association Wage Tariff Booklet.

Coronary Angiography with Catheter – Ectopic Pregnancy Operation and ESWL (Breaking Kidney Stones) Expenses: Expenses for coronary angiography with catheter, ectopic pregnancy operations and eswl done in hospital conditions are paid from the operation coverage.

In dental and mouth injuries that occur in traffic accidents, any kind of operation on the mouth, jaw or teeth performed by dental and oral surgeons will be paid from the operation coverage on the condition that the accident report is presented.

What class operations are in is determined based on the Turkish Physicians Association Tariff. However, operations that are 2500 units and over on their own are classified as “Extra Large Operations” under the policy coverage.

B.1.2 Hospital Room-Meal-Companion Expenses: If the insured is being treated inpatient, the full day room-meal-companion expenses for each admission to a health institution are paid within the limit specified in the policy and the special and general conditions.

Since the room-meal-companion expenses coverage is unlimited, if a luxury room or suite is used the payment will be according to a single private room's bed, meal and companion expenses. The difference will be paid by the insured.

In inpatient treatment for insured, the bed fee for the companion will be paid 100% daily within the limits specified in the policy.

B.1.3 Intensive Care Expenses: The maximum 90 days "per incident" intensive care stays of the insured will be paid within the limit specified in the policy and the special and general conditions.

B.1.4 Doctor Monitoring Expenses: The expenses of the insured concerning doctor monitoring during inpatient treatment at the health institution will be paid within the limit specified in the policy and the special and general conditions. Doctor monitoring must be listed as a separate item in the health institution's bill.

B.1.5 Medication Expenses (Inpatient): The expenses for medications used during inpatient treatment at health institutions will be paid within the limit specified in the policy and the special and general conditions.

B.1.6 Diagnosis Units Expenses (Inpatient): The expenses for all diagnosis units deemed necessary by the doctor to diagnose the illness during inpatient treatment at health institutions are in the scope of Diagnosis Unit Expenses (Inpatient) coverage. The expenses for diagnosis units during inpatient treatment at health institutions will be paid within the limit specified in the policy and the special and general conditions.

B.1.7 Chemotherapy Expenses: Expenses concerning chemotherapy – including all doctor, room-meal-companion, medication, diagnosis unit expenses – regardless of whether they are inpatient or outpatient, will be paid within the limit specified in the policy and the special and general conditions.
Other than in cancer treatment, the "interferon alpha" (Roferon-A or Intron-A) active ingredient "peginterferon alpha" (Pegasys or Pegintron) used in the treatment of Hepatitis C will be compensated from the chemotherapy.

The examinations and tests to determine the course of the illness after chemotherapy and radiotherapy are paid from the relevant coverage.

B.1.8 Radiotherapy Expenses: Expenses concerning radiotherapy – including all doctor, room-meal-companion, medication, diagnosis unit expenses – regardless of whether they are inpatient or outpatient, will be paid within the limit specified in the policy and the special and general conditions.

B.1.9 Dialysis: Expenses concerning dialysis – including all doctor, room-meal-companion, medication, diagnosis unit expenses – regardless of whether they are inpatient or outpatient, will be paid within the limit specified in the policy and the special and general conditions.

B.1.10 Small Procedure Expenses: All expenses related to procedures done in the hospital or doctor's office under general or local anesthesia or no anesthesia towards treatment of the condition (placing casts on fractures, abscess drainage, stitches, oxygen, anesthesia, cast and stitch application; materials for plasma, nail extraction, dressings and injections) including the doctor examination and diagnosis expenses to be considered under the relevant coverage; will be paid within the limit specified in the coverage table and the special and general conditions. The operator doctor fees for small procedures that are performed outside of network institutions are limited to 2 times the TPA Minimum Wage Tariff.
PUVA treatment (treatment of dermatological illnesses with ultraviolet rays) will be paid from small procedures coverage.

B.2 OUTPATIENT TREATMENT COVERAGE

When the treatment of a medical condition does not require being admitted to a hospital, the doctor examination, medication, diagnosis, etc. expenses are considered to be in the scope of Outpatient Treatment. Diagnosis expenses related to treatment not exceeding 24 hours for which observation is approved are compensated in the scope of Outpatient Treatment.

The first doctor examination, first diagnosis and laboratory tests required by these for uninsured conditions, are covered no matter what the results are.

B.2.1 Doctor Examination Expenses: Expenses for examinations by doctors on duty at hospitals or clinics licensed by the T.R. Ministry of Health and/or authorized to open private clinics and for examinations done by doctors abroad are paid within the limit specified in the policy and the special and general conditions.

B.2.2 Medication Expenses (Outpatient): Expenses related to the medications on the prescriptions written out by doctors after an examination and belonging only to pharmaceuticals licensed by the Ministry of Health and expenses related to the medications on the prescriptions written out by doctors abroad will be paid from the Medication Expenses (Outpatient) in the framework of contract provisions.
In order for medication expenses to be paid the freelance professional receipt or bill showing the fee paid for the doctor examination, the cashier receipt for the medication, the print from the medication box showing the medication's name and the doctor prescription must be presented. Also the date on the bill or cashier receipt for the medication must be within the policy term.
The payment of medications that the doctor decides must be used continuously will only be made if the Insurance Company doctor approves and the medication use is within the policy period. The prescriptions made out to our Insured must have the doctor's diploma number, signature and stamp, protocol number, diagnosis and specialty of doctor. (A Compensation Request Form will be sought for prescriptions with no protocol number). Medications that do not match this criteria and prescription format will not be paid by our Company. The expenses for medications that are critical for treatment, do not have an equivalent in Turkey and must be imported from abroad are covered on the conditions that the Insurance Company approves them.

All protective vaccinations (children's vaccinations, rabies, hepatitis, flu, tetanus) are paid from this coverage.

Blood and plasma expenses are covered by the medications coverage.

B.2.3 Diagnosis Unit Expenses (Outpatient):
Diagnosis Units and Interventional Testing For Diagnosis: The expenses for all manner of diagnosis units (laboratory, radiology, cardiology, nuclear medicine, scintography, angiography etc.) that the doctor deems necessary for making a diagnosis are paid within the limit specified in the coverage table and the policy special and general conditions. Interventional Testing For Diagnosis (colonoscopy, gastroscopy, cystoscopy, biopsy, biopsy accompanied by USG, angiography, angiography accompanied by MR) is provided from the Diagnosis Unit Expenses (Outpatient) Coverage.

In-network Healthcare Institutions make their request for compensation directly to the Insurance Company on behalf of the Insured and if there is a sum to be paid by the insured, this will be notified to the insured. If non-network institutions are the provider of services, the insured must first pay for the services and submit payment documents, a detailed report from the doctor, an original detailed bill issued by the institution, results of any tests conducted, the Expense Notification Form filled out and signed by the doctor, prescriptions and medication box clippings to the Insurance Company. In the event of all judicial incidents (including traffic accident) the documents issued by judicial departments (alcohol report, incident scene investigation report, forensic report, traffic accident investigation report) must be submitted with the request for compensation (even if a network healthcare institution is used) to the Insurance Company. If the information is incomplete the Insurance Company's Compensation Department may ask for additional documents. The portion of the bill that is in accordance with the policy conditions will be deposited in the bank account of the insured. In situations when the insured is no longer using this account or wants the reimbursement to be paid to another account they must write the new account on the expense notification form.

The expenses for medications used during radiological procedures will be paid from the diagnosis units.

Hepatitis markers are provided from this coverage.

B.2.4. Physical Therapy Expenses: Physical Therapy expenses are covered by outpatient treatment coverage. Regardless of whether the treatment is done inpatient or outpatient, all expenses are paid within the Physical Therapy Expenses coverage limit specified in the policy. Additional expenses like room-meal-companion and doctor monitoring shall not be in effect.

B.2.5. Check-Up Mammography and PSA Expenses: On the condition of being done in an institution set forth by the Insurance Company check up mammography and breast ultrasounds for women over 40 are covered 100% once a year.
On the condition of being done in an institution set forth by the Insurance Company check up PSA and Free PSA tests for men over 40 are covered 100% once a year.

No payment is made for PSA and mammography expenses at non-network institutions. The list of in-network Institutions for PSA and mammography is included in Annex-1.

B.2.6 Special Provisions to Outpatient Treatment

The diagnosis and treatment of allergenic diseases is under coverage. However immunotherapy treatment (allergy vaccinations) expenses are excluded. Allergic asthma treatment is included in coverage. The fees for classification tests after allergy diagnosis will be paid.

For expenses related to menopause and its complications, if the first diagnosis is after the insurance start date, the diagnosis and treatment expenses will be paid in the scope of outpatient treatment compensation within the policy special and general conditions.

Routine eye exams 1 time per year are covered.

The copayment for procedures in the scope of outpatient treatment done at the Bilkent Healthcare Center will be 20%.

B.3 OTHER COVERAGES

B.3.1 Homecare Coverage: The expenses of the insured in connection with medical care and treatment provided in their home only by a medical professional for the continuation of treatment after inpatient care at a health institution is paid within the limit specified in the policy and the special and general conditions from this insurance for a period of two months after being discharged from the hospital. In order for the insured to be able to benefit from this coverage, the doctor treating the insured must notify the Insurance company that the treatment of the insured needs to be continued at home under the supervision of health personnel and this situation plus the estimated treatment period must be approved by the Insurance Company. All expenses incurred during homecare (USG; laboratory) will be provided from this coverage.

B.3.2 Rehabilitation Expenses: All expenses related to functional training (rehabilitation) the insured receives to regain the functions (like walking with or without crutches, eating, drinking, putting on and taking off clothes, going to the bathroom, going up and down stairs) that they have lost after neurological disorders, serious trauma, hand-arm-leg amputations, etc. will be paid, on the condition that the treatment is done inpatient and is accepted by the insurer, within the rehabilitation coverage limits specified in the policy. Additional coverage like room-meals-companion etc. are not in application.

B.3.3 Post – Operation Physical Therapy: After treatment that requires intensive care, the expenses for physical therapy that takes place within two months and is of a nature that completes the initial treatment, will be paid from the 'Post – Operation Physical Therapy' coverage specified on the coverage table within the policy special and general conditions, regardless of whether it is done outpatient or inpatient.

B.3.4 Artificial Limb Expenses: If the insured's treatment as the result of an accident or illness requires an artificial limb within the policy period, the expenses connected to the artificial limb (hand, arm, leg prostheses that are not for cosmetic purposes) are paid within the limit specified in the policy table and the special and general conditions. The artificial limb coverage is only for the apparatus (material) being used. Artificial limbs that are to be used for pre-existing disabilities, the renewal of pre-existing artificial limbs and dental prostheses are excluded from the policy coverage.

B.3.5 Ambulance Coverage: If an insured uses the services of an ambulance for a life-threatening emergency to reach a health establishment, the ambulance expenses and are paid within the limit specified in the policy table and the special and general conditions per case.

B.3.6 Emergency Service Coverage: The Insured will be able to call the "24/7 Emergency Assistance" line at 444 4 505 in "Emergency Situations" to receive consultation and request a doctor accompanied land ambulance. The team that arrives can treat the insured at home or take them to a healthcare establishment if they deem it necessary. The Insured shall not pay any additional fees for this service that they will receive in "Emergencies".

B.3.7 Air Ambulance (Domestic and Foreign): When the Insured needs an Air Ambulance they will call the Insurance Company's 444 4 505 "24/7 Emergency Assistance" line. In domestic and foreign emergency cases if it is not possible for the insured to get treatment where they are and it is not possible to transport them by land ambulance to the nearest equipped ambulance the insured will be transported by air ambulance and/or air transportation on the condition that the insurance company approves. MAPFRE Sigorta A.Ş. shall not be liable for any problems or delays that occur during this service that is provided by third parties.

The MAPFRE Sigorta A.Ş. ambulance expenses will be paid within the limits that are specified in the policy. In cases where an air ambulance is necessary, obtaining the air ambulance is the responsibility of the insurant. MAPFRE Sigorta A.Ş. will provide every contribution to the insurant on the subject of obtaining an air ambulance.

B.3.8 Auxiliary Medical Materials: Expenses related to the medical materials like portable, customized, elastic bandages, corset, varicose stockings, neck brace, knee brace, wrist brace, seating cushion and crutches used only for medical purposes to provide outside support to the body as part of treatment applied to insured as the result of an accident or illness that has occurred after the insurance start date, will be paid in the scope of this coverage within the annual limit and payment percentage. Other foreign medical auxiliary materials outside of what is listed above are excluded.

B.3.9 Hearing Aid: In cases that occur after the insurance start date the expenses related to hearing aids will be paid within the limit specified in the coverage table and the policy special and general conditions.

B.3.10 Maternity Expenses: The routine expenses (doctor, examination, diagnosis) related to check-up examinations during pregnancy and expenses related to ailments caused by pregnancy and miscarriages will be paid in the scope of this coverage if the pregnancy occurs 3 months after the insured joins this Group Health Insurance.

Expenditures related to maternity coverage are handled as a whole. Additional room-meal-companion, diagnosis unit, medication, doctor and other coverage shall not be in effect. Maternity expenses are paid up to the limit that is specified in the coverage table as the most.

Maternity related expenses for women who are married but covered under the insurance individually (without family members) shall not be paid. Unmarried insured (even if they are widows or divorced) will receive maternity coverage even individually.

Expenses related to complications that develop in the mother after birth are paid from the relevant coverage, not maternity coverage.

Expenses related to routine check-ups during pregnancy (doctor exam, diagnosis) and problems caused by the birth and pregnancy (danger of miscarriage, morning sickness, post delivery hemorrhaging, etc.) are covered by being deducted from the maternity coverage.

There is no insured co-payment in routine maternity check-ups.

The pre-op jaundice tests done during pregnancy are under maternity coverage.

In the event of compulsory abortion and situations that endanger the mother and baby's health during pregnancy, expenses are paid from the maternity coverage on the condition that this is documented by a doctor report and USG.

Also expenses related to researching why a previous miscarriage was experienced to find out if complications will occur in a future pregnancy before becoming pregnant, is not covered by this policy.

Expenses Related to Baby: Immediately after the birth, in a healthy newborn the first doctor examination, first vaccination and medications, the blood sugar, thyroid screening, phenylketonuria and blood type identification tests for checking the baby's health are paid within the limits that are specified on the coverage table. Hip USG, Vision and Hearing tests are in the scope of the baby's policy.

Expenses related to the congenital conditions that develop in the baby within 15 days after birth (Congenital diseases, prematurity, low weight, blood incompatibility, etc.) and incubator expenses related to these conditions are paid from the coverage limit left on the maternity coverage.

Including the baby in the policy: The baby will be included in the insurance once the parents submit all medical documents related to the baby to the Insurer as soon as the baby is born, the application form is completed accordingly and the Insurer accepts the application. The baby will be examined by an Insurer appointed physician within the first 15 days and the necessary exceptions will be entered on the policy. The insurance coverage will not be delayed due to an infection the baby could contract from the outside. The waiting periods that are specified in the special conditions shall not apply (other than the operation waiting period) for conditions that develop in the baby after being accepted under the insurance.

Individuals insured under child status and children continuing their education between the ages of 24 and 29 may not use the maternity coverage. The individual policy does not cover maternity.

All infertility diagnosis and treatment, artificial insemination, sterilization, contraceptive methods, circumcision (phimosis), abortion, venereal diseases, spiral applications and complications related to previous applications are excluded from the scope of this insurance. However a medical abortion documents with a case report where the mother's life is at risk is covered.

B.3.11 Orthopedic supports*:* Crutches, wheelchairs, orthopedic shoes, insoles, and corsets are excluded from coverage. However corsets, any type of knee brace, crutches, slings, foam casts, splints, neck braces, walkers and bandages used as the result of an accident are paid unlimited per case.

B.4 COVERAGE OUT OF THE COUNTRY

The coverage that is provided with limit in the above MAIN COVERAGE TABLE applies to both in the country and outside of the country within the same limits payment rates.

The coverage that is given as unlimited on the MAIN COVERAGE TABLE also applies outside of the country. If this treatment takes place outside the country an annual total 120,000 $ global limit shall apply for outside inpatient treatment. However, this global limit will be available to use in 2 stages with different payment rates. The first stage will be 100% paid foreign 1 global coverage and when this coverage is depleted the foreign 2 global coverage will automatically be activated for the difference with a payment rate of 70% by our company. Regardless of whether treatment is obtained in Turkey or not, all healthcare expenses will be paid in the framework of policy general and special conditions.

INPATIENT TREATMENT OUTSIDE THE COUNTRY		
TYPE OF COVERAGE	**PAYMENT RATE**	**COVERAGE LIMITS ($)**
Operation Room-Meal-Companion Intensive Care Doctor Monitoring Medication (Inpatient) Diagnosis (Inpatient) Chemotherapy Radiotherapy Dialysis	**%100**	**50.000 $** **(YEARLY LIMIT)**

Annex: Foreign 2 global

INPATIENT TREATMENT OUTSIDE THE COUNTRY		
TYPE OF COVERAGE	**PAYMENT RATE**	**COVERAGE LIMITS ($)**
Operation Room-Meal-Companion Intensive Care Doctor Monitoring Medication (Inpatient) Diagnosis (Inpatient) Chemotherapy Radiotherapy Dialysis	**%70**	**50.001 $-120.000 $** **(YEARLY LIMIT)**

- The maximum amount to be paid in Outside Inpatient Treatment is up to 50,000 USD 100%, 70% paid for up to 50,001-120,000 USD.

OUTPATIENT TREATMENT OUTSIDE THE COUNTRY		
Doctor Exam Medication Outpatient Diagnosis Outpatient	**%70**	**5.000 $** **(YEARLY LIMIT)**

- Coronary angiography outside the country will be paid according to class from operation coverage.
- The maximum amount that will be paid in Outside Outpatient Treatment is limited to 70% of $5,000 which is $3,500.

Outside Network

The authorization transactions for inpatient treatment for our foreign coverage insured will be conducted with the approval of MAPFRE Insurance. The solution of problems that may be encountered by our insured at healthcare institutions, enabling our insured to benefit from possible discounts and authorization prior to relevant treatment will only be possible by calling our center.

In order to organize inpatient treatment outside of the country our insured must call our 24 hour MAPFRE Insurance Authorization Center at 0212 334 62 72 to provide information.

C -) THE SCOPE OF THE POLICY AND EXCLUDED SITUATIONS

Scope of the Policy:

The Group Healthcare Insurance covers the diagnosis and treatment of individuals covered by the insurance for health problems that occur after the insurance start date. The insurance does not cover conditions that the insured were aware of and/or being treated for before the insurance start date and related complications.

However, in policies that have continued without interruption for 2 years and the Insured has not gone to a doctor, taken medication or gotten any treatment for an illness that had occurred previously, this disease will be covered under the insurance. Heart diseases, cancer, mental diseases and long term chronic diseases (like diabetes, high blood pressure, etc.) are excluded from the scope of this article.

Coverage Subject to Waiting Periods:
On the condition that the diagnosis is made after the insurance goes into effect **meniscus, gall bladder and kidney stones, hernia, hemorrhoids, adenoid, tonsil, varicosele (varicosele related to infertility is excluded), verruca (wart) (other than anogenital warts) , varicose, thyroid gland, myoma, ovary cist, enlarged prostate, cataract, duodenal ulcer and stomach ulcer, anal fissure-fistula, lipoma excision, laser lithotripsy, sinus procedures** are excluded from coverage for 9 months as of the policy start date. On the condition that these conditions, which are subject to operation waiting periods, are discovered after the policy start date, the related outpatient treatment expenses will be paid within the special and general conditions without a waiting period.

Other than due to an accident, **septum deviation** is not covered. However if the policy continues for more than 24 months, in the case of diagnoses after the 24th month and only as deemed necessary by a ENT specialist and on the condition of not being cosmetic, if the operation indications are accepted by the Insurance Company it will be paid within the limits and coverage.

On the condition that the first diagnosis is made 9 months after becoming insured, sebaceous cists are paid within the limit and coverage.

Chronic Diseases:
On the condition that the first diagnosis is made after becoming insured, **chronic blood pressure disorders, cardiovascular diseases, cancer, diabetes, asthma, migraine, rheumatic diseases, renal diseases that require dialysis, Alzheimer, multiple sclerosis and Parkinson** disease treatment expenses are paid within the policy special and general conditions without a waiting period.

Conditions Excluded from Coverage:

1. Conditions that are excluded in the "Disease Insurance General Conditions" (health care expenses resulting from Terror and Natural Disasters are covered by the Insurance Policy and Limits for the whole Group limited to 270,000-TL per year),
2. The Excluded Special Conditions that are specified in the insurance policy,
3. Health expenses for conditions that the insured was aware of before the policy start date and/or that they got tests and/or treatment for,
4. Alcohol and drug addiction treatment, expenses for disorders and accidents that occur as the result of alcohol and drug use, expenses related to getting involved in fights or self inflicted injuries as the result of alcohol and drug use,
5. Officially announced epidemics,
6. Other than procedures necessary for accidental injury of the insured, all manner of aesthetic and plastic surgery procedures, sclerosant varicose; treatment for cosmetic purposes, hair loss, alopecia, hirsutism, tests and treatment, etc.; skin moisturizers and cleaning preparations, sweeteners, obesity testing and treatment; healing mixtures, mud baths, quarantine, acupuncture, massage, mesotherpy, hydrotherapy, voice and speech therapy, nursing homes, sanatoriums, spas, gyms and beauty salons, foot care centers and bills from establishments that do not match the "Health Institution" definition specified in the policy; alternative medicine treatment expenses and treatments that have not been scientifically proven,
7. Expenses related to treatment and therapy by individuals who do not match the definition of "doctor" in the policy (physiotherapist, dietician, special nurse, etc.),
8. Expenses related to infertility testing and treatment (ovulation monitoring, HSG, HSG, adhesiolysis, tuboplasty, etc.), all artificial insemination both medical and surgical, structural defects related to reproductive organs, sexual dysfunction, sterilization, contraceptives, birth control methods, abortion that is not medically required and all manner of circumcision (even if it is due to phimosis),
9. Expenses related to disabilities before insurance and treatment, surgery and organ transplants required by these and congenital anomalies and diseases, growth and development deficiency,

10. Psychotropic medications (antidepressants, etc.), psychiatric diseases, tests and treatments in psychiatric clinics and/or psychiatric doctors and psychologists,
11. Baby food, diapers, bottles and pacifiers, all kinds of soap, shampoo and solutions, alcohol and colognes; medical supplies like hydrophile cotton, thermometer, ice bag and hot water bottle; medical aid supplies and devices like sleep apnea devices, wheelchairs and dental prostheses, telephone, TV expenses, materials that are not required for treatment and miscellaneous administrative expenses,
12. All doctors examinations and testing for check-ups, periodic checkups,
13. Immunotherapy
14. Diagnosis and treatment of illnesses related to AIDS and HIV and venereal diseases,
15. The donor's expenses in organ and tissue transplants, organ and tissue transplant fees and organ and tissue transport expenses,
16. Any expenses related to diseases and injuries that happen due to dangerous sports activities (horseback riding, race car driving, mountain climbing, diving, parachute diving, etc.) and to professional or amateur licensed athletes during official club competitions and/or practice are excluded. Otherwise the injuries that are sustained by professional or a club's amateur athlete during unofficial competitions are covered by the insurance.
17. Fees for medication purchased without a prescription, receipt or label clipping and other expenses without receipts,
18. Expenses related to the transportation of insured when applying for compensation, preparation of the documents required by the Insurance Company, etc.,
19. No matter what the cause is all expenses related to jaw surgery including dental and oral treatment,
20. Glasses, lens, frame and contact lens expenses,
21. Expenses related to correcting Myopia, etc. and relevant treatment, glasses, lens, frame and contact lens are outside the scope of the insurance. Cataract operations and the lens to be used in this procedure are covered.
    (**All exams related to vision (including diffraction defects) are covered)**
22. All expenses related to acne other than the first diagnosis,
23. All expenses related to nevus (mole removal), epilepsy, snoring and sleep apnea syndrome testing and treatment,
24. The collective examination and testing expenses that are required for all or a portion of the personnel or deemed necessary by the Company and examination and testing expenses related to disease symptoms in the area,
25. All diagnosis and treatment expenses related to coverage not included in the policy. If operation and maternity coverage is not paid due to a situation excluded from coverage all doctor, medication, diagnosis, room-meal-companion and other expenses related to the unpaid situation will be excluded.

D -) SPECIAL ARTICLES:

1 – The Policy Going into Effect:

The health insurance coverage will go into effect when the application is accepted by the Insurance Company, the policy is issued and the whole premium or specified first installment is made.

2 – The Coverage of Spouses and Children:

The deadline for applying for the Bilkent University and Affiliated Companies Group Health Insurance is 05.10.2016. After this date, only newborns with parents insured under this policy, spouses of newly married insured personnel and newly hired personnel insurance applications will be accepted.

a) In groups where insuring the company employee family members is voluntary and all or a portion of the insurance premiums are deducted from their salary, the request of parents to be insured without insuring their children will be accepted. Also if the children are to be included with the mother and father, all of the children must be insured. The request of employees to insure all of their children without insuring their spouse will be accepted. In groups where insurance coverage is voluntary no entries will be accepted after 05.10.2016, only newborns with parents insured under this policy, spouses of newly married insured personnel and newly hired personnel insurance applications will be accepted after this date.

b) If the number of dependents under the insured increases after receiving the policy, a new acceptance form must be submitted for the dependents being insured, a doctor's report detailing the health status of the newborn or official documents like marriage licenses must be submitted to the Insurance Company. Family members that become subsequent dependents must be insured under the health insurance within 30 days at the latest of gaining dependent status. If those who gain dependent status within the insurance period are not insured, they must be insured when renewing the policy at the insurance expiration date.

3 – Cancellation of the Policy or Exclusion of Health Conditions From Coverage:

a) This policy has been prepared assuming that all of the information provided by the insured in the acceptance form is complete and correct. If the insurant and/or insured declaration is untrue or incomplete the Insurance Company has the right not to issue a policy or to cancel the policy.

b) If the insured intentionally abuses the policy general conditions and application principles, their policy will be cancelled immediately and the premium that has been paid will not be refunded; or if the insured does not mention a health condition in their health declaration that they were previously aware of and it becomes apparent after the insurance goes into effect, this condition will be excluded from coverage.

c) The Insurance Company will apply Article 7 (Annex Article) of the Healthcare Insurance General Conditions for premiums that are not paid when due.

4 – The Automatic Termination of the Policy:

The insurance of a dependent under health insurance coverage will be automatically terminated when any one of the following occurs:

a) The employee's policy is cancelled due to resignation or death. The policy of the insured they are a dependent of becomes terminated,

c) The contract expires,

d) The insured does not pay their premiums on time,

e) The dependent loses their dependence status (The policy belonging to a spouse of a Company employee who has been divorced is cancelled as of the divorce date. The policies of children who get married are cancelled as of the marriage date. The policy of children who enter 24 years of age by year regardless of the month, and whose single and student status end will be cancelled as of the new year. The policy of children whose single and student status end between 24-29 years of age will be cancelled as of the date that their single/student status ends. Regardless of whether they are single/student, the policy of children who enter their 30th year is cancelled at the beginning of the new year).

5 – Pre-Approval for Inpatient Treatment at In-Network Healthcare Institutions:

Other than situations in which the insured must be admitted to a healthcare institution urgently, it is important for the insured to fax the "Inpatient Treatment Information Form", which is to be filled out by the doctor conducting the treatment and which is available at in-network institutions, to the Insurance Company to inform them of the treatment 3-4 days in advance and wait to find out if it is improved before being admitted to the hospital to avoid waiting and difficulties in the hospital.

6 – Treatments Received Outside the Country:

The expenses for treatments received by the insured outside of the T.R. borders will be paid in the scope of the policy's coverage and limits.

The expenses for treatments received by the insured outside of the T.R. borders will be paid based on the T.R. Central Bank Foreign Currency purchase rate on the date of the foreign country bill in Turkish Lira, within the conditions and limits specified in the policy.

7 – The Insurance Company's Right of Recourse:

If the Insurance Company is forced to make payments that are in violation of the policy's special and general conditions due to the misinformation of the insured and/or doctor, the insurance company will take resource against the insured for the payments made outside of the coverage.

8 – Requiring Doctor Examinations and Inspections:
When there is a question of the insured receiving inpatient treatment at a healthcare facility, the Insurance Company may have the insured undergo examination before giving its approval; also, the insurance company has the right to ask all doctors, health facilities and third parties for information and copies of the insured's health history before and after the insurance period.

9 – Applied Incorrect Treatments:
All liability for incorrect treatment of the insured by health institutions or doctors, belong to the health institutions or doctors.

10 – Death of the Insured:
In the event of the insured's death during treatment for an illness or injury, the expenses for their treatment will be paid within the scope of the policy and coverage if the insured's heirs complete the necessary documents for compensation. If the insured dies outside of the T.R. borders the expenses necessary for the body to be transported to Turkey are covered with a limit of $10,000.

11 – Prescriptions Written by the Workplace Physician:
The 'Patient Record Ledger' protocol number and diagnosis as the result of an examination, doctor's diploma number must be written on the prescriptions filled out for personnel by the Health Insurance Insurant Company workplace physician and it must include a company physician stamp containing the title and address of the workplace.

Prescriptions written for spouses and children by the workplace physician will also be accepted.

12 – Pre-testing Application in Policy Acceptance:
There is no pre-testing.

E -) DEFINITIONS OF SOME OF THE TERMS IN THE POLICY:

The Insurance Company: MAPFRE Sigorta A.Ş.
Insured: The individual who has filled out an acceptance form in accordance with the articles of this policy to become insured, who has been accepted by the Insurance Company and has been issued a policy.
Dependent : The spouse, children up to 24 years old and children who are between 24-29 (included) who are not married and continuing their education, step children and legally adopted children of insured who are covered under this insurance in accordance with this contract's articles.
Spouse: The person to whom the insured is legally married.

Health Institution: A "Hospital" and/ or "Clinic" which has a license from the Ministry of Health which;
- provides 24 hour patient care,
- has the ability to diagnose, treat and operate,
- has one or more physicians that are ready to do a procedure,
- is a special obstetric facility where medical care and treatment for delivery of babies is provided.

The term "Healthcare Institution" shall not be interpreted to cover hotels, nursing homes, convalescent homes, orphanages, hospices, places where principally substance and alcohol abusers are rehabilitated, sanatoriums, spas, health hydros and weight loss centers.
Doctor : Specialty doctors and surgeons who have no blood or in-law relation to the patient seeking treatment and diagnosis, who have completed Medical School and are licensed for any kind of diagnosis and treatment. Where there are no specialist doctors (Local Health Clinics) the expenses for treatment and diagnosis applied by practicing physicians are also in the scope of the policy.
Treatment: Procedures carried out in health institutions (hospital, clinic, polyclinic) that are licensed by the Ministry of Health, in private doctor offices by authorized and licensed doctors to treat acute health conditions. "Treatment" shall not include chronic illnesses and the measures to relieve illnesses that are medically in their last stage. Expenses related to a doctor, who is under the Insurance Company coverage, treating themselves is not covered.

Inpatient Treatment in a Health Institution: The insured receiving treatment in facility matching the "Healthcare Institution" definition provided above as an admitted patient incurring room and meal expenses.
Outpatient Treatment: The medical treatment that is provided in health institutions, private doctor offices and polyclinics without room and meal expenses.
Expenses Necessary for Treatment: The expenses that are incurred in the scope of the policy to cure a medical condition.
Coverage: The commitment that the Insurance Company makes to the insured as a requirement of the General Health Insurance general and special conditions.
Conditions Before the Insurance Start Date: The insured's congenital genetic diseases and the diseases that they were aware of and/or had tests for and/or received treatment for before the first day they became insured.
Payment Limit: The upper limit for the expenses incurred by the Insured to be paid by the Insurance Company, which is specified in the policy.
Insurance Start and Finish Date: The coverage of the policy starts on the start date specified on the policy and ends on the expiration date specified on the policy. The health expenses incurred by the insured on the insurance start date (even if they are before 12:00) are covered within the policy special conditions. However the health expenditures made by the insured on the date that the policy expires (even if before 12:00) are not covered by the policy. Since the health expenditures before 12:00 on the date that the policy starts are included the health expenses incurred by the insured on the policy expiration date before 12:00 will not be paid.
Renewal: When the policy is expired enabling the continuation of the policy with the payment of the new term's premium.
Accident: Diseases or injuries that occur due to an outside factor not under the control of the insured.
Expenses Related to Conditions Not Covered: No matter what the reason is, all manner of expenses that are excluded from the policy (doctor exams, tests, etc.).
Expense Notification Form: The breakdown of expenses that the bills or receipts of expenses incurred in non-network establishments will be attached to.

F -) COMPENSATION PAYMENTS:
The compensation payments will be paid to the individuals authorized by the Insurance Company at the headquarters of the Insurance Company in Istanbul as per the insured's wishes or to the bank account of the insured by wire transfer.
When the insured has notified their bank account number and the payment is deposited in their account the Insurance Company will be released from all liability.
Compensations are conveyed to the Insurance Company at certain periods according to the agreement made between the Insurance Company and the insured. The Insurance Company shall have the right to make the insured be examined by any doctor they wish if necessary during the processing of compensation demands. Also the Insurance Company may ask for information and records about the insured's treatment from all of the concerned doctors, health institutions and third parties. When treatment is provided outside the country the insured must present a document (Passport copy) showing that the insured was in that country at the time of the treatment to the Insurance Company.
The Insurance Company will not cover expenses that should not be incurred as a requirement of the process and amounts that exceed what is reasonable and generally accepted.
If the insured should become deceased their compensation payments will be made to their legal heirs.
The following documents must be presented for payments related to coverage :
For Payments Related to Inpatient Treatment:
1. The Hospital Inpatient Treatment Information Form, which has to be filled out before being admitted to hospital,
2. The itemized hospital bill and other bills related to the expenses under coverage,
3. The patient epicrisis and/or Operation report
4. Observation file (When necessary),
5. Pathology report (When necessary),
6. If diagnosis methods were used a report showing the results.

For Payments Related to Doctor Examinations:
1. A bill or freelance professional receipt for the doctor fees,
2. Compensation Request Form.

For Payments Related to Medication Coverage:

1. A doctor's prescription and a freelance professional receipt of hospital bill showing the fee paid for the examination by the doctor who gave the prescription

2. Medicine box label clippings,

3. Bill or cashier receipt for medication expenses.

4. Compensation Request Form

For Payments Related to Diagnosis Unit Coverage:

1. The transfer slip or report that the doctor has written out specifying the diagnosis or suspected condition,
2. Bill for the expenses under coverage,
3. Copy of the results for the diagnosis units.
4. Compensation Request Form

For Payments Related to Maternity Coverage:

1. The itemized hospital bill and other bills related to the expenses under coverage,
2. Observation file (When necessary),
3. If diagnosis methods were used a report showing the results,
4. Relevant doctor's report.
5. Detailed doctor's report on the health of the newborn

Special Situations:

1. When treatment is provided outside the country the insured must present a document (Passport copy) showing that the insured was in that country at the time of the treatment to the Insurance Company,

2. If the condition that needs treatment was the result of a traffic accident an accident report and alcohol report from official authorities

3- In judicial cases – a judicial report, police station record, alcohol report, etc.

İHSAN DOĞRAMACI BİLKENT UNIVERSITY
AND AFFILIATED ORGANISATIONS **MAPFRE SİGORTA A.Ş.**

LIST OF EMERGENCY SITUATIONS *

1 - Drowning
2 – Traffic accident
3 –Rape (*judicial report required).*
4 – Falling from an elevation
5 – Serious work accidents, loss of limbs
6 – Electrical shock
7 – Freezing, hyperthermia
8 – Heat stroke
9 – Serious burns
10 – Serious eye injuries
11- Poisoning
12 – Serious allergies and anaphylactic conditions
13 – Spinal and lower extremity fractures
14 – Decompression illness (caisson disease)
15 – Heart attacks, arrhythmia, hypertension attacks
16 – Asthma attacks and acute respiratory distress
17 – Any situation that leads to loss of consciousness
18 – Sudden stroke
19 – Serious general condition deterioration
20 – *For children under 6 years old* a fever above 39.5 degrees
21 – Diabetic and uremic coma
22 – Dialysis disease accompanied by general condition deterioration
23 – Acute abdomen
24 – Acute massive hemorrhaging
25 – Meningitis, encephalitis, brain abscess
26 - Renal colic
27 – Migraine and/or headaches with vomiting and loss of consciousness
28 – Newborn coma
29 – Already begun birth process (this means water has been broken).

** An official report is required for all judicial cases.*

Annex-1

In-network facilities where check-up Mammography, Breast Ultrasound, PSA and Free PSA can be taken;

PROVINCE	DISTRICT	NAME OF ESTABLISHMENT
ANKARA	ÇANKAYA	ÖZEL MEMORIAL ANKARA HOSPITAL
ANKARA	KAVAKLIDERE	ANKARA GÜVEN HOSPITAL
ANKARA	KAVAKLIDERE	BAYINDIR HOSPITAL-KAVAKLIDERE
ANKARA	KAVAKLIDERE	LİV HOSPITAL ANKARA
ANKARA	SÖĞÜTÖZÜ	BAYINDIR HOSPITAL-SÖĞÜTÖZÜ
ANKARA	SÖĞÜTÖZÜ	ÖZEL MEDICANA INTERNATIONAL ANKARA HOSPITAL