Executive Regulation of the Cooperative Health Insurance and Cooperative Health Insurance Policy
Issued by the Decision of The Minister OF Health NO. 460/23/T Dated 27/3/1423H(1)
Umm AlQura issued No.3896 dated 10/4/11423H

Executive Regulation of the Law of Cooperative Insurance in the Kingdom of Saudi Arabia

Chapter (1)
Definitions

Article (1)

The following terms shall have the meanings stated before each:

(1) Law: The Cooperative health insurance law in the Kingdom of Saudi Arabia.

(2) Council: The cooperative health insurance council established by virtue of article (4) of the law.

(3) Secretariat General: The Council executive body.

(4) Monitory Authority: Cooperative Health Insurance Council and other authorities specified by the state for monitoring insurance activities.

(5) Social Insurance: Insurance applicable by virtue of Social Insurance Law and which Social Insurance Public Corporation executed.

(6) Employer: National or corporate body who recruits one or more employee.

(7) Policy holder: The natural or corporate body under the name of which the policy is issued.

(8) Sustained: Husband, wives, male children below eighteen years of age, and unmarried daughters.

(9) Insurance Company: Insurance Company authorized to work in the Kingdom and was adapted to practice the cooperative health insurance activities by the Council.

(10) Insured "Beneficiary": The person covered by the law and insured at insurance company.

(11) Health Insurance: Cooperative health insurance mentioned in the law.

(12) Emergency case: Medical treatment required by the beneficiary's medical

necessity subsequent to the occurrence of an accident or an emergency case necessitates immediate medical intervention.

(13) Insurance Coverage: The basic health benefits available for the beneficiary and specified in the insurance policy attached hereto.

(14) Policy: The basic cooperative health insurance policy which the council sanctioned and attached hereto and which contained limitations, benefits, exceptions, and general conditions issued by the insurance company by virtue of insurance application to be presented by the employer [the holder of the policy.]

(15) Premium “subscription”: The amount of money due for the company and to be paid by the policy holder against the insurance coverage provided the policy through the insurance period.

(16) Deduction Rate/Bearing “Share in payment”:
The due portion [specified in the policy table] to be paid by the beneficiary [insured] when visiting the doctor

(17) Benefit: Expenses for the provision of health service included in the insurance coverage within the limits showed in the policy table.

(18) Service provider: The authorized or sanctioned person or health facility, according to the effective laws, to present health services in the Kingdom such as a hospital, Diagnostic center, clinic, and pharmacy.

(19) Sanctioned Net: The group of health service providers sanctioned by Cooperative Health Insurance Council and specified by health insurance company for providing the employer/ Policy holder with the service and such was done through direct debit with the insurance company, provided that such net shall include the three health levels which are:

- The first level of health services presentation [First Aid.].

- Second level of health care presentation [Public governmental hospitals].

- Third level of health care presentation [Specialized or reference hospitals].

Chapter (2)
The Beneficiaries [The Insured Persons]

Article (2)

All the following categories shall be subject to health insurance:

(1) All non Saudi persons working for wage whether for others or for their own account regardless to their income levels, nature of their work, and term

of their offices.

(2) All non Saudi persons residing in the Kingdom without work

(3) Family members depending in their living on persons specified in paragraph (1) and (2) of this article and holding residence licenses [Iqamah] in the Kingdom.

Article (3)

The following shall be exempted from health insurance stipulated in article (2) of this regulation:

(1) All non Saudi employees working at governmental authorities, and establishments the laws of which do not allow concluding contracts with private hospitals to treat their employees, since the employees are under the sponsorship of such establishments and committed with such authorities by contracts provided that their contracts stipulate medical treatment in a governmental hospital, and he whose labor contract is not stipulating providing of health service, shall be obliged to obtain special insurance coverage that covers his basic health needs.

(2) All non Saudi employees working for the private sector by virtue of labor contracts stipulating the provision of medical treatment in the qualified health facilities possessed by the employer and in case the treatment in such facilities is not available, as for the emergencies, the employer shall be obliged to provide the integral insurance coverage.

(3) Family members whom the employees their capacities specified in paragraphs (1) and (2) of this Article are sustained. The scope of treatment mentioned in the paragraphs herein above shall, at least, be in conformity with the provisions of article (7) of the law and coincident with the quality standard set out in this regulation.

Article (4)

The Council shall accord to article (3) , specify the following:

(1) Governmental authorities and establishments.

(2) Employers who recruit persons shall be exempted from health insurance based on application they submit.

The Council shall decide the compatibility of the medical treatment provided by governmental institutions and establishments and by the employers, to the range and standard of the health services to be provided by virtue of this regulation.

(3) The council shall, basing on a request by the employer, take the appropriate decision in cases where the applicability of the provision of article

(3) on any of the employees or the accompanying persons are not decisively clear.

(4) Justifications in removal of the exception of the provisions of paragraph (2) of this article, in this case, employees and the persons depending on them in their living shall be subject to the provisions of the law within the limitations herein above.

Chapter (3)
The Prescribed Insurance Coverage

Article (5)

(a) The employer shall oblige to conclude health insurance policy with one of the companies covering the beneficiaries existing in the Kingdom or any other new recruits subject to this law.

(b) Qualified insurance companies shall not be allowed to reject any request for conducting [executing] cooperative health insurance since such was within the limits of their financial capability.

Article (6)

The insurance company shall issue a certificate for the employer [policy holder] approving that his employees were covered with the insurance, to be presented to the competent authority that issues and renews residence licenses [Iqamah] and the council shall determine the content of such certificate.

Article (7)

In case no residence license is issued for the beneficiary, his name shall be deleted from the cooperative health insurance policy as from the date of his final exit and the due premium for the insurance term shall be calculated according to bases stipulated in the policy.

Article (8)

The beneficiary shall be given [furnished with] a copy of the insurance policy in whish health coverage shall not be less than the basic cover stipulated in the law.

Article (9)

The employer may change the insurance company with which he is contracting to provide the insurance coverage, provided that he shall write a letter of such one month at least before the date of cancellation of the contract, the paid back [refunded] part of the insurance premium shall be calculated on proportional basis, and the employer [the policy holder] shall be bound to reinstate the insurance policies of the date of cancellation and conclude another insurance policy providing insurance coverage to be commenced as of the day following the cancellation of the policy.

Article (10)

When a person subject to cooperative health insurance moves to work for another employer, such employer shall be obliged to insure him as from the date of his movement, and shall present the insurance certificate as one of the supporting document for transferring the sponsorship.

Article (11)

Health insurance coverage shall cover the benefits stipulated in article (7) of the law and the range of the provision set out in chapter four of this regulation, and the policy shall specify the period of treatment and the maximum limits of the insurance coverage amount, and the limitations, benefits, exceptions, and the general conditions of insurance coverage.

Article (12)

Insurance coverage benefits shall include pregnancy and delivery for those whose contracts are concluded on the basis of [contract of a married person] within limits specified in the policy.

Article (13)

Insurance coverage of health insurance shall be restricted to the services rendered in the Kingdom of Saudi Arabia by the sanctioned net of the services donators with which the insurance company is connected through valid service contracts.

Article (14)

The employer shall commit to the insurance coverage to the beneficiary as from the date of his arrival in the Kingdom and shall give him insurance policy within a period not exceeding ten working days from the date of his arrival, as for children born in the Kingdom of Saudi Arabia during the validity period of the policy, the insurance coverage for such shall extend to effect retroactively on them as from the date of their birth.

Article (15)

Insurance coverage shall terminate upon the death of the beneficiary or on the termination of the policy duration or such being cancelled, or when the beneficiary leaves the Kingdom for good.

Chapter (4)
Benefits
[In- Kinds & Cost Reimbursements]

Article (16)

The beneficiary shall obtain the benefits specified in the policy as follows:

(1) Diagnosis and treatment at the donator of the service provided that the beneficiary shall bear the deduction sum/bearing, specified in the policy sharing in payment or the amounts exceeding coverage limits.

(2) Financial sums regarding the emergency and necessary medical treatment in case he is directly bearing such costs, provided that insurance company fails to provide this service and makes it available at the hand of the beneficiary soon, or that insurance company refuses to provide him with such services without reasonable justification, and the costs drawback for the one who bears treatment expenses shall be made within the limits stipulated in the policy and within the limits that paid to the donator of the service of similar quality.

Article (17)

The right of claiming the benefits shall come into being as from the commencement of the insurance coverage according to the provisions of article (14) of this regulation.

Article (18)

There shall be no waiting period at the beginning of the insurance free from benefits thereof, and including rendering the benefits after commencement of the insurance coverage, and in case the beneficiary comes to the Kingdom for treatment and not for work, the insurance coverage shall not extend to cases prior to the commencement of the insurance coverage.

Article (19)

The right to profit from the benefits shall terminate by the termination of the insurance coverage according to the provisions of article (15) of this regulation, such shall include undecided insurance cases, and the decisive factor in providing service by the insurance company is the date of profiting by the service donator.

Article (20)

Insurance benefits shall cover basic vaccinations and vaccines for children up to the age of joining school according to decisions of the Ministry of Health which shall be provided by a contractor with whom the Ministry is contracted.

Article (21)

Providing health services and medical treatment shall be done by the net of service donators listed in the list attached to the insurance policy delivered to the beneficiaries and sanctioned by the insurance company and the policy holder.

Article (22)

Insurance coverage shall include residence and living expenses in the hospital for one accompanying person for the beneficiary such as accompaniment of a mother to her female child till attains twelve years old when medical necessity requires such, according to the discretion of the treating doctor.

Article (23)

Expense of transporting of disease or pregnant beneficiaries to the nearest appropriate centre for receiving treatment shall only be covered in emergency cases. Such transport shall be made by authorized ambulances or Saudi Red Crescent Organization.

Article (24)

Every beneficiary benefited from medical services shall be obliged to contribute in paying treatment expenses in the service centers according to what stated in the policy save in aid and anesthetization cases.

Article (25)

Medical service donator may not cede the sum participated with in the payment and such was made either by adding it to the final amount to be paid by the insurance company or granted it to the beneficiary in term of a deduction.

Article (26)

The contribution in the payment shall be paid by the beneficiary to the donator of the service against [in return for] the obtainment of a receipt.

Article (27)

Beneficiaries shall have no right in claiming for benefits by virtue of the policy except when such benefits of the basic coverage stipulated in the policy or of the additional coverage they acquired according to article (8) of the Cooperative Health Insurance Law.

Article (28)

There shall be no claim of health services in case of illness if such services have been rendered following the accident been occurred in the place of work [occupational or industrial accident] or arising of vocational diseases according to the definition set out in the Social Insurance Law.

Article (29)

In case the insurance company provides the health services and was later on discovered that the department of vocational risks [hazards] at the Social Insurance Public Corporation shall cover such services, Social Insurance Public Corporation Shall commit to compensate the expenses being paid by the company.

Article (30)

In case the Social Insurance Public Corporation provides health services for a person contracted with an Insurance Company despite the later being obliged to provide such services, the said insurance company shall commit to compensate the expenses that

arises thereto to the Social insurance Public Corporation, and such compensation shall be within the limits abided by the insurance company in providing services uncovered under the Social Insurance Law.

Article (31)

Social Insurance Public Corporation and Insurance Company may conclude joint contract stipulating undertaking of certain procedures to satisfy the services set out in articles (29 and 30) .

Article (32)

If any of the beneficiaries has any claim on (at) the others concerning compensations of damages caused by a disease or an accident, the beneficiaries rights shall, in this case, transfer to the insurance company, regarding the costs and expenses fall upon the insurance company as a result of rendering the service to the beneficiary.

Chapter (5)
Insurance Companies Finance

Article (33)

Premiums, additional fees, and the investment returns shall be entered in the insurance companies' resources.

Article (34)

Every insurance company shall abide by what the council, in coordination with other monitory authorities, decides, concerning the customary [established] technical appropriations in the insurance sector.

Article (35)

(a) Insurance premium (Subscription) shall be determined by mutual consent of insurance company and the employer.

(b) In case the premium value differs from what the company was submitted in the work plan [action plan], it shall abide by the agreement of the Council Secretariat General on the premium value, and the Council may review [revise] the premium form time to time.

(c) The benefit maximum limit for every beneficiary shall be (SR250,000) Saudi riyals only.

Article (36)

The employer shall commit to pay the premiums for his contracted employees and for persons they sustained to the insurance company which he chooses for such purposes, such shall be applicable on unemployed person or those whom they sustained. The

employer alone shall be responsible for the payment of the premiums to be paid in the beginning of every insurance year unless otherwise agreed upon.

Article (37)

In case of non payment of the premiums on the agreed date, the insurance company may cancel the policy after termination of period of the validity of the policy and reinstate the insurance cards and collect the due premium. The insurance company shall notice the Insurance Council and the sanctioned net of the service donators.

Article (38)

Part of the insurance operations surplus shall be transferred to the cooperative health insurance fund according to the principles of cooperative insurance. This part shall be calculated on the light of the insurance company operations result after agreement of the other monitory authorities.

Article (39)

Health Insurance Council shall issue the regulation specifying the objectives of the Fund and regulating its works according to article (38) .

Chapter (6)
Practicing Health Insurance Activities

Article (40)

Insurance companies authorized to practice insurance activities in the Kingdom shall undertake the practice of health insurance activities. The provisions of the companies Act and other Laws completed in the Kingdom shall be valid for any unstipulated provisions in this regulation and in any subsequent regulations approved in the future.

Article (41)

Insurance Companies may not be permitted to practice health insurance activities save after rehabilitated by the council, such rehabilitation shall be limited by three years renewable for similar period.

Article (42)

(a) The council shall receive financial return for rehabilitation of the cooperative health insurance companies amounted to one hundred fifty Saudi riyals only.

(b) The council shall receive financial return for annual renewal of the cooperative health insurance companies' amount to fifty thousand Saudi riyals only.

Article (43)

Insurance companies working in the field of health insurance may have the right to practicing other insurance activities provided that such shall be obliged to the

separation of financial aspects from health insurance activities and according to what is decided by the monitory authority.

Article (44)

Insurance companies [authorized to practice insurance activities in the Kingdom] shall be rehabilitated to practice health insurance based on a request to be submitted for such purpose, and the council may determine whatever details it thinks related to the nature and scope of the data to be included in the applications in the required limits for evaluation. The Council shall decide on the rehabilitation application within a period of one hundred eighty days [180 days] of the date of application.

Article (45)

The insurance company shall commit to present the following documents together with its application for rehabilitation:

(1) Company's name and address.

(2) The statute of the company or its articles of Association.

(3) Names of the Chairman and members of the Board of Directors and the delegated member and the executive Board.

(4) Annual accounts audited by a certified [chartered] accountant for the last three years of presenting the plan of action for the new companies.

(5) Name of the independent automatic expert or the company specialized in the auditing studies.

(6) Names of the certified [chartered] auditors.

Article (46)

The plan of action shall include a statement which in turn includes estimation of revenues and expenditures and technical appropriations and the anticipated results of the three years subsequent to the submission of the application according to the form prepared by the Council specially for such purpose and so design of reinsurance arrangements.

Article (47)

The insurance company shall commit to attach a statement from the monitory authority certified [in witness of] the commitment of the company to maintain level of financial capability.

Article (48)

The Council may choose a company that satisfies the following:

(1) Authorization of practicing insurance activities

(2) Medical, administrative, and technical staff and acceptances systems, treatment of claims, and payment of dues, such can be executed through contracting with the company of medical claims management authorized by the Council.

Article (49)

Abstention from rehabilitating the insurance company may be made by virtue of a letter stating the reasons for such abstention in the following cases:

(1) The Council being obtaining information from the other monitoring authority declaring non- efficiency of the executive managers of the company, and such are not satisfying the necessary vocational requirements.

(2) The Council being obtaining information from the other monitory authority indicating inability of the company to maintain the interests of the beneficiaries in the appropriate manner or incapability of the company to fulfill its commitments and obligations.

(3) In case of non payment of the prescribed fees of granting or renewing the rehabilitation specified in article (42) of this regulation.

Article (50)

Every insurance company shall commit to seek the help of auditing expert or a company specified in the auditing services according to what the other monitory authority decides in order that he presents an auditing report on the company's health insurance activity to the monitory authority in which the sufficiency of appropriation and pricing policy are indicated.

Article (51)

The independent auditing expert shall verify the abidance by the insurance methods in the calculation of the insurance subscriptions and the technical appropriations, and he shall, in the course of this activity, check the financial issues of the company specially his being sure- at all times, that the company is satisfying its commitments rising from and stemming from the insurance policies and that the company possesses at its dispose sufficient financial assets within the margin determined by the monitory authority, and when such appropriations are no longer sufficient he shall promptly notify the monitory authority.

Article (52)

Every insurance company shall commit to prepare accounts audited by two offices of the certified accountants authorized to work in the Kingdom, and a report of their activities cover the course work during the previous years to be submitted to the council within the first three months following the end of the fiscal of the insurance company.

Article (53)

Every licensed insurance company shall submit statement to the council by virtue of which it shall abide by the following:

(1) Having an ordinary free capital equal to its capability margin at least.

(2) Capability margin was calculated in a manner that shows the ability of the company to satisfy its commitments and fulfill its obligations continuously.

(3) Presenting a letter of credit to the Cooperative Health Insurance Council equal to one third of the capability margin provided that such shall not be less than twenty five million Saudi riyals.

Article (54)

The Council shall sanction the non governmental donators of health care services within the limits of the following conditions:-

(1) The health care facility shall be licensed by the Ministry of Health.

(2) Personnel in charge of providing health care services shall be registered by the Saudi Authority for Health specializations.

(3) The health care facility shall satisfy the minimum limit of the quality requirements according to articles (109) and (110) of this regulation.

Article (55)

Donators of health care services shall be sanctioned by virtue of a written notice issued by the council and the annual financial consideration for such purpose shall be paid to the council as follows:

(1) 2____0000 Saudi riyals for one doctor clinic.

(2) 5000____10,000 Saudi riyals for a dispensary.

(3) 10,000______20,000 Saudi riyals for one day operation centers.

(4) 20,000______50,000 Saudi riyals for the hospital according to the number of beds.

Article (56)

The council shall determine the financial payment (return) prescribed in each case in accordance with article (55) , and the council also shall determine the financial return [consideration] for the rest of service donators such as diagnostic center—pharmacy and laboratory.

Article (57)

The license of the health facility shall be cancelled if the Ministry of Health draws the license of such facility, and the council shall notify all insurance companies of such.

Chapter (7)
Supervision over the Insurance Parties Relationship
(Objectives and Scope of Supervision)

Article (58)

Health Insurance Council shall undertake supervision on the comprehensive health insurance coverage and verify the execution and implementation of the parties of the health insurance relationship in accordance with this regulation.

Article (59)

The monitory authority shall undertake the responsibility of supervision over the insurance companies practicing health insurance activity in a manner that includes verification of the company financial capability and sufficiency of the capital and soundness of its assets and technical appropriations and its ability to satisfy and fulfill its commitments and obligations towards the beneficiaries benefiting from health insurance services it renders. The Monitory Authority shall inform the council of any defect occurred in the position and status of any insurance company according to what was indicated herein before.

Article (60)

The council may request the amendment of the plan of action of any of the health insurance companies before concluding new insurance policies and in accordance with what the council deemed necessary for the protection of the beneficiaries' interests in a manner that such effects shall extend to the existing insurance policies or unconcluded policies.

Article (61)

The Council may request data and information on all issues related to health insurance from the monitory view, and the council may in single cases specially these related to the general items of health insurance ask or request the patterns [forms] and other publications used by health company in its correspondences with the employers, beneficiaries donators and also the contracts signed with the company of the health insurance claims management.

Article (62)

The council or the persons it appoints shall have the right to conduct auditing and verification on all insurance companies within the jurisdictions of the council during regular periods or at any time, and the same also shall have the right to ask the other monitory authority to undertake such job and provide the council with a report of such.

Article (63)

The council shall have the right to reserve on any of the executive officials in any of the insurance companies and notifying the other monitory authority of such.

Article (64)

Members of the council or persons recruited by the council shall not be permitted to disclose secret information they obtained in the course of the execution of the provisions of this regulation, and such shall be valid for any other person happened to obtain such information within the course of the official reports, but the same shall not be valid on the disclosure of information in terms of general expressions in such a manner that no certain company of the insurance companies is undertaken to be meant.

Article (65)

The council may use the information mentioned in article (64) restrictedly for the following purposes:

(1) Inspection of the application presented by the insurance company for obtaining or renewing rehabilitation

(2) Guidance issued by the council.

(3) Pursuing any violation of the obligations [commitments] arising from insurance contract according to article (14) of this law.

(4) Within the frame of the inspection of complaints submitted against a decision taken by one of the insurance companies.

(5) Within the framework of the examining or deciding on violations according to article (14) of this law.

Article (66)

Safekeeping and preservation of the secretness of the information set out in article (64) shall not prevent the delivery of the following information specially:-

1- To the Judicial authorities, Courts, or other integrated authorities

2- To the authorities responsible for the enforcement of the law, in accordance with its provisions, or the other related laws, since such authority requested the information to perform their duties provided that they abide by the rules and controls of the secrecy set out in article (64) of this regulation.

Article (67)

The other Monitory authority shall have the right to supervise the settlement of issues related to the existing insurance policies in case of prohibition [banning] of the activities of the insurance company, or ceased working or in case of drawing the

license of the company, and it shall coordinate with the Cooperative health Insurance Council.

Article (68)

The council may draw the rehabilitation of practicing health insurance activities if the insurance company violates the rehabilitation conditions, in such a case the subordination of the beneficiaries to the company shall be transferred to an insurance company selected by the employer, and such shall be valid if the insurance company ceased to practice its activities without the rehabilitation being drawn.

Article (69)

The council also may draw the license of practicing health insurance activities if the insurance company does not effect [use] such license within twelve months or it openly declare abandonment of such license or ceased its activities for a period of six months.

Article (70)

With exception of the cases stated in articles (68) and (69) coordination shall be made with the concerned authorities on the draw of the license.

Article (71)

The council shall be financed through the following:-

(1) The financial return of the license and annual renewal of insurance companies.

(2) Financial return of the annual appropriation of non governmental health service donators [providers].

(3) Financial return of the supervision and control over insurance companies against one percent [1%] of health insurance premium according to the audited financial statements of the previous years.

(4) Financial return the council obtains in return of exempting the authorities possessing medical facilities from insurance coverage or part thereof against financial return or consideration to be determined by the council.

(5) Other financial fines due for the council and the fines adjudicated by Cooperative Insurance Law Violates Committee specified in article (111) of this regulation.

(6) Contributions, gifts (donation, endowments) and investment returns.

(7) Financial amounts collected from any other sources such as issuance of magazines and booklets or consultative or training works the council may perform.

Article (72)

The council shall publish general [common] information on the activities of the insurance companies which were licensed [rehabilitated] by the council. The council may coordinate with the other monitory authorities in such, and the council shall, when need be, interpret the executive regulation of the law.

Article (73)

The council shall publish any tables and statistic data which the same deems has relation to insurance for every working year without specifying certain insurance companies.

Chapter (8)
Insurance Relationships

Article (74)

The council shall specify the conditions of the design and the content of the health insurance policy [card] with joint agreement of insurance companies and the donators of health services.

Article (75)

Insurance companies and donators [providers] of the services shall observe the following:- -

1- Presentation [rendering] of services shall be made according to the accepted moral and vocational standards which are in consistent with the established and acceptable modern medical field, and the donators may not claim in insurance companies for rendering services contracting a fore said.

2- Medical procedures shall be restricted to what the necessary treatment requires to accomplish the job.

Article (76)

Parties to the insurance relationship, who are holders of the policies, insurance companies, and the donators, shall, each within his competencies, follow the established vocational standards in executing [performing, implementing] the following:

1- Paying the premiums on due dates by the holders of the policies to the insurance companies.

2- Prompt approvals by insurance companies to services providers to treat the beneficiaries, and set their claims as soon as possible

3- Quickness and easiness of treatment service provision by the donators and

providers to the beneficiaries and the rapidity of the claiming for settlement of the dues.

Article (77)

Insurance companies shall not be permitted to possess, operating facilities with the purpose of health care for the insured persons, and private health facilities shall not be permitted to possess or own health insurance companies.

Article (78)

The Insurance document two contracting parties are the document bearer the employer- and the insurance company.

Article (79)

The employer shall provide the insurance company with all the information required by company, if the company acquired reasonable justification for doubting the trueness of such information it shall submit the matter to the health Insurance Council for verification, and the employer shall, based on the request of the Council, commit to present all the request documents and access the Council representatives to such documents in his site.

Article (80)

The employer shall explain and clarify the policy, and the scope of coverage for the beneficiaries under such coverage.

Article (81)

Without prejudice to the requirement of the laws and instructions, the employer shall execute [inflict] the penalties on the beneficiary legally proven service misuse.

Article (82)

The employer shall reinstate the insurance Cards [policies] to the insurance company when the beneficiary leave him or upon the termination of the insurance policy term, and the same shall be responsible for any expenses arise as a result of non abidance by such condition.

Article (83)

The insurance company shall, in seeking to fulfill its commitments as of providing the beneficiary, conclude health services contracts with the sanctioned service donators [grantors] governmental hospitals and health care facilities accessible by the public may treat the beneficiaries in return to financial consideration born by insurance companies.

Article (84)

Receiving treatment at specialists in hospitals without reference from primary health care center shall only be permissible in emergency cases, such shall be applicable to the treatment by health services donators other than those contracted with insurance company, and case the insurance company disagree to continue treatment with such donators or grantors in such center, the beneficiaries shall, after stability of their health statue, by transferred to one of the service not centers.

Article (85)

Responsibility shall be rested with the donators or grantor of the services in case one of his officials or donators practices deception, forgery, or misrepresentation.

Article (86)

Health services contract shall, at least, contain the following elements, and the Council may propose guidance service contract regulating the concerned parties:

(1) Joint right and obligations and the due penalties in case of violation.

(2) Donators of service abidance by the quality according to the conditions and procedures set out in articles (109) and (110) of this regulation.

(3) Service donators shall abide by the observance of the requirements of cost efficiency according to the provisions of article (75) of this regulation and the same shall prepare the presented treatment and recipe in conformity with such cost efficiency.

(4) Amount of wages and settlement procedures, and settlement of the amounts due for the recipe been delivered.

(5) Prerequisites conditions concerning forwarding warnings and the graces therein.

(6) Method of setting disputes arising from the health services contract.

Article (87)

Service donator shall verify the identity of the beneficiary, and in case the same has treated a person other than the beneficiaries, he shall bear the costs of such treatment.

Article (88)

The employer shall claim his dues arising from treatment of the beneficiaries in a manner agreed upon with the insurance company within a period not exceeding 90 days of the date of maturity.

Article (89)

The employer shall abide by the law of system, to be issued by the Council as per prescribed due amounts

Article (90)

Service donator may cancel the contract of the presentation of health service with the insurance company considering the cancellation conditions in case of payment delay, in such a case the insurance company shall notify the employer of such.

Article (91)

The insurance company shall, upon the commencement of the validity of the insurance coverage, furnish the policy holder with the beneficiaries insurance cards, and illustrative books inclusive of the policy, range and limits of the insurance coverage, and the sanctioned net of the service donators and the employer shall officially and effectively deliver them to the beneficiaries on the commencement of the insurance coverage. The insurance company shall inform the sanctioned net of service donators of the joining of the holder of the policy to the insurance coverage and the additional coverage if any.

Article (92)

Both the insurance company and the policy holder shall consider beneficiaries, circumstances by presenting a net of service donators that is in conformity with the beneficiaries' needs and their working places in order not to be compelled to obtain the service from a donator off net.(out the net).

Article (93)

The insurance company shall not be committed to conclude health services contract with every donator approved by the Council, and the same may choose [select] from amongst the sanctioned donators the one it thinks to be the best in rendering such service.

Article (94)

The insurance company shall not commit to use all the contracted donators.

Article (95)

The insurance company shall answer the request for approval of bearing the charge [cost] of treatment within sixty minutes; in case of non approval the same shall state the reasons thereof in writing. The Council shall lay [set] the standards of the service in this concern.

Article (96)

Insurance companies may- individually or collectively- appoint Saudi doctors to supervise the abidance of the beneficiaries by respectability the treatment conditions within the limits of effectiveness of the cost prescribed in article (75) of this regulation during the treatment of one of the beneficiaries, and in case of impossibility of such, insurance companies may ask for exception to contract with non- Saudi doctors, as for distinguished medical efficiencies such shall be the Saudi specialists

and consultants and in case of requesting Part- time consultations the insurance company shall seek the help of Saudi specialists and consultants working in public sector.

Article (97)

Doctors appointed to work at insurance companies shall enjoy vocational independence and shall- in their opinion- be subject but to medical requirements in their performance of the supervision functions and they shall not intervene in the medical beneficiaries' treatment.

Article (98)

Both service donators and the beneficiaries shall commit to furnish the doctors working in insurance companies with all the required information and at their dispose all the necessary documents to undertake supervision work according to the article (96) of this regulation, doctors may enter the hospital ward and medical supervision offices and the medical files of an authorized hospital in which one of the beneficiaries is treated [cured] or treatment is conducted therein when necessity required such, for the accomplishment of supervision duty vested on them in coordination with the concerned hospital.

Article (99)

The insurance company may object whoever proved medically incapable or violate the profession ethic.

Article (100)

Insurance company shall pay the due amounts of the service donators within a period not exceeding sixty days of the claim.

Article (101)

Both the insurance company and the service donator shall agree on the settlement of the amount of the claims, in case of non agreement either of them shall refer such to the Cooperative Health Insurance Council.

Article (102)

Insurance company may cancel the health service contract concluded with one of the donators taking into consideration the specified warning grace period and cancellation conditions stipulated in the contract concluded between them, if it noticed total or partial violation in rendering the service after consent of the policy holder, and a substitute of same quality shall be appointed in lieu of him.

Article (103)

The beneficiary shall commit to furnish (provide) the insurance company with all the information needed by the insurance company to determine the details of the

emergency cases or the commitments and obligations incurred on the insurance company and the scope of such obligations.

Article (104)

The beneficiary shall commit to being checked by the legally authorized doctor approved and sanctioned by the Council and appointed by the insurance company if the company so desired and the same shall, in this case bears the charges (fees) of checked.

Article (105)

The beneficiary shall when request treatment- commit to present insurance card and the identity card (ID) to the service donator who shall return such to the beneficiary after registering the necessary data for treatment.

Article (106)

The beneficiary shall be obligated to check one of the primary care facilities or one of the doctors working within the donators sanctioned net. Reference to the specialist or hospital shall be made by a general practitioner doctor.

Article (107)

The beneficiary shall bear the balance of the check up in case he directly checks a specialist or consultants as mentioned in the policy.

Article (108)

Recommendation of hospitalization shall be restricted only to cases in which clinic treat is not suffice, in such a case it shall be permissible to benefit from the one – day surgery or treatments, and in case a beneficiary check a hospital other than that specified in the reference documents (papers) such shall bear the balance.

Chapter (9)
Rendered Services Quality Assurance

Article (109)

The Council shall, in collaboration with the financially capable governmental health institutions specified the prerequisite conditions for service, in regard to the execution of the provisions of article (16) of the law, and in the course of specifying the conditions shall, particularly, consider the following:-

1- Availability of the minimum limit for the requirements of the specific quality the donators shall abide by.

2- Sanctioning diagnostic and therapeutic services to be provided or which insurance company will provide on its own account.

3- Doctors observance of the procedures guaranteeing quality.

Article (110)

Procedures concerning maintaining and preservation of the specific quality shall include the following:-

(1) Standards concerning medical check up rooms for sanctioned donators.

(2) Regular Inspection over approved [sanctioned] hospitals, clinics and dispensaries at their locations and without pre warning by the Council officials or by those appointed from outside the Council.

(3) Evaluation of Health services contracts for maintaining quality controls.

(4) Services providers shall commit to contract, every three years on their own account to, through the Council with specialized Advisory office to evaluate and reassure the abidance of the donators by the requirements of the specific quality and to furnish the Council with a copy of the special report thereof, in case the donator violates this condition the Council may cancel the sanctioning.

Chapter (10)
Penalties and Disputes Settlement

Article (111)

A committee or more shall be formed by a decision of the president of the Council comprised of six members from the authorities specified in Article (14) of the law, such committee shall be cited as The Cooperative Health Insurance Law Violations Committee and such shall examine the violations of the provisions of the law and approve the appropriate penalty which shall be inflicted by a decision of the president of the Council, and complain against such decision may be made before the Board of Grievances within sixty (60) days of the date of notification.

Article (112)

Such committee shall examine the violations that arise between beneficiaries policy holders, insurance companies, and donators of services.

Article (113)

Complaint of the parties to the relations shall be presented, in writing, to the Council Secretary General within ninety days of occurrence of dispute upon which the content of complaint is resulted.

Article (114)

The Council Secretariat General shall refer the complaint to the committee that examines the violations to the provisions of this law.

Article (115)

The value of the financial penalties of the violations of the provisions of this law and the fines specified in Articles (111) and (116) shall be accrued to the Council according to the stipulation of the financial regulation.

Article (116)

If it is proved to the committee that the complaint is false and has no acceptable justification, it may took the necessary legal procedures or propose the appropriate legal procedures or propose the appropriate penalty another complainant.

Article (117)

The committee shall convene session wherever need be, and the Council shall pay a reward a mounting one thousand Saudi riyals for every member for each session provided trade such shall not exceed twenty thousand Saudi riyal a year for every member.

Article (118)

The Council shall prepare the detailed procedures for submitting complaints to the committee.

Chapter (11)
The Transitional Provisions and Enforcement of the Regulation

Article (119)

Commencement of rehabilitation procedures for health insurance companies as well as sanctioning the donators of services included by the provisions of this law shall start after the issuance of this regulation.

Article (120)

This regulation shall be applicable to the employers according to the following table:-

(1) Individual companies and establishments of foreign employment therein exceeding five hundred persons, within one year of the issuance of the regulation

(2) Companies and establishments of foreign employment exceeding one hundred persons, - within two years of the date of issuance of this regulation

(3) All employers and individuals covered by the law, - within three years of the date o issuance of this regulation.

Article (121)

In case of conclusion of insurance policies prior to the execution of the law, parties to the contract shall be responsible for termination of their obligations within one year of the date of issuance of this regulation, taking into consideration the provisions of Article (120) of this regulation and they may continue with the same obligations if they obtained the consent of the Council to continue in their previous arrangements, in this case the insurance company shall be licensed, qualified and rehabilitated and the donator of service shall be sanctioned and they shall be able to continue their obligations in accordance with the provisions of the law and the executive regulation.

Article (122)

The Council shall deem competent in proposing amendment to this regulation, and decision of such shall be issued by the Minister of Health.

Article (123)

This regulation shall be issued by a decision of the Minister of Health, and shall be published in the official Gazette and shall come into force as from the date of the execution of the law after ninety days of the date of its issuance.

Cooperative Health Insurance Policy

In execution of the Cooperative health insurance law, issued by the royal decree No M/10 dated 1/5/1420 H, and its executive regulation issued by the decision of the Minister of Health No ….. Dated ….. in this …., and whereas the holder of the policy has applied for the company ….. Name of the insurance company ……. [Herein after referred to as the company] in writing [shall constitute abase of policy and part and parcel thereof] with the purpose of conducting the insurance described later upon himself and upon his dependents, his officials and their dependants whom their names the name of which are listed in the list attached herein with, and herein before referred to as the insured, and has paid the subscription or agreed to pay such, the company agree, by virtue of the above mentioned, with the policy holder to cover the expenses of the providing of health care for the insured by virtue of this policy and to the extent and in the manner showed therein through the net at service donators appointed by the insurance Company always being subject to the Conditions, definitions, limitations, and the additional appendixes [supplements] [approved by the Cooperative Health Insurance Council] to be a greed upon later on.

Section (1)
Definitions

For the purpose of this insurance the following words, expressions, and terms wherever they appear in the policy or appendixes [supplement] and enclosures thereto shall be interpreted according to the following definitions:

(1) Accident: Casual accident [case] or casual and unexpected event occurs during the period of the insurance.

(2) Disease: Sickness or illness afflicted the insured person and necessarily required

medical treatment by an authorized doctor during the period of the insurance.

(3) Sensitivity: A person being sensitive especially towards certain types of food, whether, pollen or any other causatives of plants, insects, animals, minerals and other elements and materials where the individual suffers physical [bodily] reactions caused by direct or indirect contract with such materials causing cases like asthma, allergy, itching, fever, eczema, and headache.

(4) Beneficiary [the insured person]: A person covered by the law [employee or sustained listed in the insured person table herein attached.

(5) Benefit: Expenses for providing health care service included in the insurance coverage within the limits stated in the policy table.

(6) Premium [subscription]: A mount of money to be paid by the policy holder against the insurance coverage the policy provide, during the insurance period.

(7) Congenital deformity: Structural, chemical, or parental functional defects either through heredity or stimulated by environmental factors.

(8) Insurance coverage: Basic health benefits available for the beneficiary and specified by insurance policy herein attached.

(9) Deduction rate/Bear/Participation in payment: The part to be paid [specified in the policy table] by the beneficiary- the insured- in case of medication in a clinic.

(10) Employee: Any person actually practicing work at the holder of the policy and being registered of such capacity in to registry and attaining- at the time when he joins insurance coverage- sixty five years of age.

(11) Sustained:

> (a) Husband/wives registered with such capacity in the records of the policy holder and legally reside in the Kingdom of Saudi Arabia.
>
> (b) Sons (Family) of the employee or the sons of either the husband or the wives or the sons legally sponsored and residing in the Kingdom of Saudi Arabia and totally depend in their living on the employee and registered with such capacity in the records of the policy holder.

(12) Documents leading to claim: All the documents prove and verify the age of the insured, his nationality his identity card and the insurance coverage and the circumstances of the occurrence of the accident such claim is resulted of, paying the expenses, and the same shall include other documents such as police report, invoices receipts and recipes, medical report, reference and recommendation and any other original documents the company may required.

(13) Basis of direct registration or on the Company’s account: on- payment facilities available for the insured persons at the service donators appointed by the Company and the registration of all expenses shall be directly made on the Company’s account

accordingly.

(14) Date of commence: The date stated in the policy table on which insurance coverage commences.

(15) Date of validity: The date specified by the policy holder and accented to by the Company for the commencement of the person's coverage by virtue of such policy or for the addition or omission of a person insured in the policy.

(16) Supplement: A document issued by the Company on an official form dated and signed by an authorized official as a proof confirming any amendment in the policy provided that such amendment shall not violate the basis coverage, based on a written request from the policy holder.

(17) Hospital: Sanctioned health facility accepted by both policy holder and the Company and authorized to work as a hospital according to the valid laws for the presentation of treatment the expenses of which may be claimed to be compensated by virtue of this policy. The word hospital in this policy shall not include hotels, inns, guest house, rest house, recovery house, sanatoriums, infirmaries, or any other place basically used for harboring and treating alcohol or drug addicted persons.

(18) Hospital admission [hospitalization]: Registering an insured person for hospitalization (hospital admission) until the next morning based on an authorized doctor referral.

(19) Insurance: Evidence indicating the establishment of the insurance coverage by virtue of policy tables, supplements and enclosures thereto.

(20) Authorized doctor: A medical practitioner after obtaining a license and legal authorization to practice the profession as being qualified and accepted by both policy holder and company to present the treatment against expenses that may be claimed by virtue of this policy

(21) Coverage limits: The maximum limit of company's responsibility as stated in the policy table for any insured person before any deduction/bearing.

(22) Service donator: Person or health facility sanctioned and authorized, according to the established and valid laws, to present medical services in Kingdom examples are; hospital, diagnostic center clinic, pharmacy, laboratory, and radio therapy center.

(23) Pregnancy and delivery: Any pregnancy or delivery case resulting from legal marital relation.

(24) One day surgery or treatment: Surgery or treatment necessitates pre- arrangement for putting the patient to sleep in a hospital or treatment center but not required the patient to stay in hospital for the next day.

(25) Treatment in outpatient clinic: Frequent visits to the outpatient clinics by the patient for diagnostic or medical treatment.

(26) Net of service donators: A group of health service donators sanctioned by Cooperative Health Insurance Council Service and specified by the insurance company to provide service for the employer/policy holder and directly debited the Company's account on the presentation of a valid insurance card by the insured person provided that such net includes the three levels of health care:

- First level of health service presentation [Primary health care].

- Second level of health service presentation [public governmental hospitals].

- Third level of health service presentation [Reference or specialized hospitals].

27- Validity period: Number of days during which the policy is deemed valid in case of non payment of the full subscription stated in the table.

28- Insurance Period: Means the period stated in the policy table during which the insurance remains valid.

29- Policy holder: Natural or legal person which the policy was issued in his name.

30- Customary or reasonable medical expenses:

(a) Medical expenses in conforming to charges collected by the majority of the authorized doctors or hospitals in the Kingdom provided that such shall be against similar case and such doctors and hospitals shall be similar prestige and qualifications.

(b) Medical treatment which is not completely different from what the authorized doctor considers acceptable as it is common and normal for any specific disease the expenses of which is claimed by virtue of this policy.

(31) Basis of Equivalent Indemnity: The adopted method to indemnify the policy holder for the substitution able expenses born and claimed by the insured person after deduction.

Section (2)
Refundable Expenses / benefits

For the purpose of this policy the substitution expenses shall mean the actual expenses paid in return of services material and apparatus not exempted by virtue of section three as prescribed by an authorized doctor for a sick insured person, provided that such expenses be necessary, reasonable, and customary in the time and at the place where insured [happened].

Basing on such the refundable expenses shall include:-

1- Health facilities:

a- All the expenses of medical check up, diagnosis, therapy medical [drugs] according to the policy table.

b- All the expenses of a patient admission to the hospital inclusive of surgical operations, one day surgery or treatment and delivery.

c- Treatment of gum and dental diseases.

d- Preventive measures specified by the Ministry of health such as vaccinations, infancy and Maternity care.

2- Expenses of bringing back [returning] the corpse of the insured person to his native country.

Section (3)
Limitations and Exceptions

(a) This policy shall not cover claims arising from the following:-

(1) Injury intentionally caused by the person himself.

(2) Diseases arising from misuse or the use of tonics and tranquilizers or by virtue of taking drugs or alcohol or otherwise

(3) Cosmetic surgery or treatment except when necessitated by casual body injury unexempted in this section.

(4) Comprehensive check up vaccines, medicines or the preventive methods not required by medical treatment stipulated in this policy [with the exception of preventive measures specified by the Ministry of Health such as vaccinations and infancy and maternity care].

(5) Treatment of pregnancy and delivery for a woman contracted as unmarried woman.

(6) Treatment received freely [free of charge] by an insured person.

(7) Recreation [relaxation], general physical health programs, and treatment provided in social care houses.

(8) Any disease or injury arising as direct result of the profession of the insured person

(9) Treatment of venereal diseases or diseases conveyed through sexual intercourse and medically recognized.

(10) Treatment expenses for the period followed the diagnostic of HIV or the related diseases including ADIS, derivatives, synonyms or other forms thereof.

(11) All the expenses related to teeth transplantation and dentures mobile and fixed dental bridge [bridge work] and orthodontic with the exception of what was caused by violent external means.

(12) Audition or sight adjustment test and the audiovisual aids unless it was required by an authorized doctor.

(13) Insured person movement expenses with transportation means other than the authorized local ambulances or those of the Saudi crescent organization.

(14) Alopecia, baldness [loss of hair], or wig

(15) Psychological treatment or psychopath, neuropathy except in acute cases

(16) Sensitivity tests whatever its nature is with the exception of that related to medicines, diagnostic, or treatment.

(17) Equipment [apparatus], means. Medicines, and procedures or treatment by the use of hormones with the aim of birth planning or birth control or contraception, sterility, impotency, loss of fertility, fertilization trough tables on other means and other methods of artificial pollination.

(18) Asthenia or congenital deformity existed before the validity of the policy which does not theater life.

(19) Any additional expenses born by the person accompanying the insured person during hospitalization on staying in hospital except insured person during hospitalization or staying in hospital except that of accommodation or staying in hospital for one accompanying person for the insured such as a woman being accompanying her child till the age of twelve, or wherever medical necessity requires such, as the treating doctor deems.

(20) Treatment of comedo, acne, or any treatment related to fatness and obesity.

(21) Cases of oranges transplantation bore marrow or transplantation of artificial limbs to replace natural ones.

(b) This policy shall not cover health benefits and bringing back the corpse to his native country in cases of claims directly arising from:-

(1) War, invasion, operations of foreign enemy, aggression operation [whether a state of war is declared or not] and civil war.

(2) Ionic radiation or radiation pollution or pollution caused by nuclear fuel or any nuclear dross resulted from combustion of nuclear fuel.

(3) Radioactive, toxicant, and explosive peculiarities or any other hazardous peculiarities of nuclear collections.

(4) Practicing or participation of the insured person in armed forces or polices or operation thereof.

(5) Riots – strikes – terrorism or the like.

Section (4)
General Conditions

(1) Verification [proving] of validity:-

This policy shall represent the basic limit of insurance coverage presented for the insured persons, and such shall not be valid unless such is registered in a supplement [appendix] signed by legally delegated official by the company.

(2) Records and reports:-

The policy holder shall keep a registry [record] for all the employees and their sustained insured by virtue of this policy inclusive for every person his full name, sex, age nationality and ranking or categorization and other basic information which shall have effect on management of this insurance and on the decision concerning the subscription rate, full chance shall be available for the company, whenever it wishes, to have access of such records and verifying the information therein presented by the holder of the policy. The company shall whenever required so, furnish the holder of the policy with any data concerning the insured persons which he wants to access.

(3) Persons qualified for insurance:-

a- Officers: any person on whom the definition of officer is applicable, shall be qualified for the insurance in accordance with the stipulation of the policy table.

b- Sustained persons- Any person on whom the definition of the sustained is applicable shall be qualified for the insurance in accordance with the stipulation of the policy table provided that such person shall be sustained by a qualified officer.

If any person defined as sustained and at the same time qualified for insurance in his capacity as an officer, his enjoyment of insurance in his capacity as sustained shall be finished and ceased by virtue of his policy, and when husband and wife are both residing permanently, and they both enjoy insurance coverage in their capacity as officers, their sons shall be qualified as sustained by the husband only.

4- Payment of subscription:-

a- Holder of the policy shall commit to pay insurance subscription to be paid for every insured person at the beginning of the insurance coverage or according to the agreement reached with the company.

b- In case of non payment of any part of the subscription the policy shall not remain valid for a period longer than that covered by the paid part of the subscription, in such a case the company shall be obliged to inform the Cooperative Health Insurance Council of such.

5- Dates of the termination of coverage:-

a- Officers:

Termination of coverage for the officer who is actually existing on work shall start as from the commencement date stated in the policy table, and any person joins the work in subsequent date his coverage shall start as from the date on which he joins the work at the policy holder or from the date of his arrival in the Kingdom.

b- Sustained Persons:-

Termination of insurance coverage for the sustained persons shall start as from the date on which the officer responsible for them becomes insured or as from the date on which they obtain the capacity of sustained for the first time.

6- "Addition or omission of the insured persons" and "subscription" thereof:

a- Holder of the policy shall promptly declare to the company in writing of all the offices and sustained person to be covered by insurance after the commencement of the policy, and the company shall promptly calculate the due additional subscription for the persons to be listed in the insured person table on the proportioned base from the date of their coverage.

b- Policy holder shall notice the company in writing within thirty days of the date of the required termination of all the insured persons [officers –sustained] whom their insurance coverage terminates before the elapse of the insurance period, and the company shall not payback the proportional part of subscription concerning such persons for the remaining period of the insurance unless the holder furnish [provide] the company with a proof of the departure of such person the Kingdom for good or a proof that such person was included with another insurance coverage program approved by the Cooperative Health Insurance Council in case of transference of sponsorship.

7- Termination of the insurance coverage of the insured persons:

(a) Officers: Insurance of any officer shall terminate automatically, by virtue of this policy, in the following cases:-

(1) On the termination of the policy of the policy period as stated in the table.

(2) In the date on which the age of the officer becomes 65 years of old.

(3) Upon the reduction of the maximum benefit limit stipulated in the policy.

(b) Sustained persons:-

The sustained coverage shall automatically terminate, by virtue of policy, in the following cases:-

(1) Loss of the capacity as sustained according to the provisions of item 11 (b) of the definitions by virtue of section one of the policy.

(2) On the termination of the duration of the policy as specified in the

table.

(3) In the date on which the age of the sustained reached 65 years old.

(4) Upon the depletion of the maximum benefit limit stipulated by virtue of this policy.

(c) Paying the refundable expenses for any current diseases causes the continuation of staying in hospital shall continue on the date of the termination of coverage for the period necessitated by such disease, provided that such period shall not exceed (265) two hundred sixty five days of the date of the beginning of such disease and within the limits of the coverage amounts set out in the policy table.

(d) In case of termination of this policy for whatever reason the policy holder shall promptly reinstate all the issued health insurance cards concerning the direct registration or debiting the company's account at the note of the appointed donators, to the company, the same shall be applicable on any insured person whose coverage is terminated. The policy holder shall be responsible for compensating [indemnifying] the company of all medical charges and expenses arising due his negligence of such.

8- Subrogation in Rights:-

a- The company – which shall be given full chance – shall have the right to check the insured person whom a claim of the refundable expenses concerning him is presented through sanctioned medical authority, on its own account twice as maximum within a period of sixty days of the date of receiving the claim.

b- The policy holder or the insured person shall cooperate and permit undertaking the necessary works the company may require on the company's expense within the reasonable limits with the purpose of enhancement of any rights or claims or legal compensations [indemnities] from the other.

9- Non Double Benefits:

In case of claim of refundable expenses payable to an insured person by virtue of this policy and at the same time such person was also covered for such expenses by virtue of any other plan, program or insurance or the like, then the insurance company shall be responsible for the covering of such expenses and shall replace – subrogate the insured in claiming the other of paying their proportioned share in such claim.

10- Basis of Direct Debiting of the company's Account at the Appointed Net of Donators:-

Every insured person, by virtue of which, such person shall have the right to receive health service at the appointed net of donators without being asked to bay the expensive for such services.

The appointed donators shall send to the company, on monthly basis, all the medical expenses sustained by virtue of the policy. The company shall evaluate and process such expenses and shall notify the holder of the policy when such reached the maximum benefit limit, the company shall have the right to claim refund of such

expenses within a period not (zid) "set such in the origin Umm- Al Qura" exceeding sixty days of the date of notification. In case the holders of the policy not refund such expenses to the company within the specified period, the company may submit the matter to the Cooperative Health Insurance Council to decide on it.

The company may have the right to omit or substitute any or all of the appointed donators for the purposes of this policy during its validity provided that the policy holder gives his agreement, and may appoint a substitute of the same level and quality.

11- Deduction – Bearing:-

Without prejudice to the facilities granted by virtue of direct entry on the company's account, the insured person shall compulsory pay the deduction amount at the service center, any attempt by the insured presort to refuse or abstain from payment shall be deemed violation of the provisions of the policy and the terms thereto which cancels it for such person until the payment of the deduction amount.

12- Basis of substitute Indemnity [compensation]:-

In emergencies the insured person may obtain emergency medical treatment from authorities other than centers and hospitals sanctioned by the company on the basis of substitute compensation [indemnity], in such a case the company shall, according to the provisions, terms, limitations, and exemptions of the policy, compensate [compensation], in such a case the company shall, according to the provisions, terms, limitations, and exemptions of the policy, compensate [indemnify] the policy holder of the refundable charges and expenses, provided that, the comp[any shall be furnished [provided] with the conforming documents it asks for within (30) thirty days.

13- Cancellation:-

Policy holder may terminate this insurance at company (30) thirty days at least before the required date of the termination, and the policy holder shall, in this case, be obliged to furnish [provide] the insurance company with proof of:-

a- Conclusion of another insurance policy with a qualified company, or that the insured persons were included under health coverage by virtue of another insurance coverage program approved and accepted by the Cooperative Health Insurance Council provided that the new coverage starts as from the date following the date of cancellation the previous policy in case of transference of sponsorship.

b- The insured person/persons being leaving the Kingdom for good.

In such a case the company shall be obliged within (60) sixty days of the date of termination to pay back top the holder the remaining part of the subscription for every insured person the claims thereof not exceeding 75% of the value of the annual subscription, and the paid back part shall be calculated on a proportioned base.

(Paid back part= Annual subscription ÷ 365.25 day x number of the days remain) and in case policy holder cases refused the expenses exceeding the maximum benefit limit within the period specified in the condition No. (10) of the Policy General Conditions originated due to the direct entry on the company's account [direct debiting the account of the company] the company shall have the right to abstain from paying back subscription liable for such if any, and use such, in the first place, to compensate the expenses paid to the donators of the treatment, such was principally have to be paid by the policy holder for the company.

14- Approvals:

Answering the approval requests shall be made by the insurance company to the donators within a period not exceeding sixty minutes of the time of request for such.

15- Sex:

For the purposes of this policy, words used in masculine shall also be used in feminine.

(16) Notices:-

a- Any other notice or address for the company required by this policy shall either be hand written or typed.

b- The Company shall not, in any case, be obliged to notify the policy holder of the termination date of this policy.

(17) Abidance by the policy provisions:-

The conditions in any obligation of the company that the policy holder and the insured person shall execute and completely abide by all the conditions, duties and obligations set out in this policy.

(18) Dispute settlement:-

Any conflict or dispute arise from or concern to this policy shall be settled through the Cooperative Health Insurance Council or through committees formed by the Council to examine the violations of the provisions of the law according to the article (14) of the cooperative Health Insurance Law.

Policy holder has read the provisions of this policy and the table thereto and a greed thereof.

Date …………….

Signature of the holder of the policy
Date
Signature of Insurance Company

(1) 8 Jun 2002.