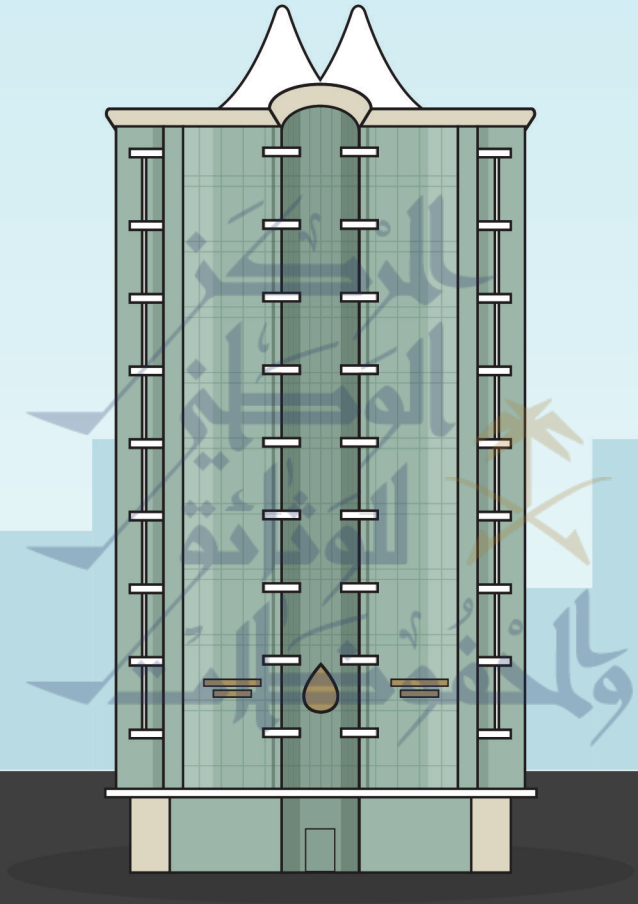
مجلس الضمان الصحي التعاوني
Council of Cooperative Health Insurance



Implementing Regulations of the Cooperative Health Insurance Law

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Chapter One
Definitions

Article (1):

The following terms shall have the meanings ascribed thereto:

1. **Kingdom:** Kingdom of Saudi Arabia.
2. **Law:** The Cooperative Health Insurance Law in force in the Kingdom.
3. **Council:** Council of Cooperative Health Insurance.
4. **Chairman of the Council:** Minister of Health.
5. **General Secretariat:** Executive body of the Council.
6. **SAMA:** Saudi Arabian Monetary Agency.
7. **Social Insurance:** Insurance applied by the General Organization for Social Insurance in accordance with the Social Insurance Law.
8. **Health Insurance:** Health insurance established by the Law and its Implementing Regulation and practiced by cooperative insurance companies licensed to operate in the Kingdom in accordance with the Insurance Companies Control Law.
9. **Policy:** Basic cooperative health insurance policy approved by the Council)attached hereto (Annex 1)(that includes limitations, benefits, exclusions and general conditions and is issued by insurance companies by virtue of an insurance application submitted by the employer (policyholder).
10. **Insurance Coverage:** Basic health benefits made available to the beneficiary as specified in the policy.
11. **Benefit:** Cost of providing healthcare services included in the insurance coverage within the limits set forth in the policy schedule.
12. **Insurance Parties:** Policyholders, insurance companies, third-party administrators (TPAs) and service providers.
13. **Policyholder:** A natural or corporate person in whose name the policy is issued.
14. **Employer:** A natural or corporate person employing one or more employees.
15. **Employee:** Every natural person working for and under the management and supervision of an employer in return for a wage, even if the employee is not under his immediate supervision.
16. **Insured (Beneficiary):** A natural person (or persons) to whom coverage is

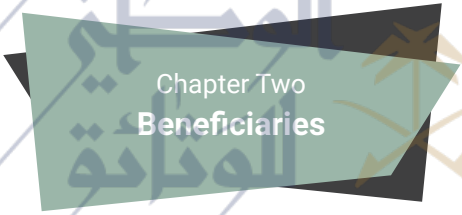
provided under the policy.

17. **Dependent(s):** Spouse, sons up to the age of twenty five and unmarried daughters.
18. **Citizen's Husband:** A non-Saudi husband of a Saudi citizen.
19. **Citizen's Wife:** A non-Saudi wife of a Saudi citizen.
20. **Basic Information:** Information relating to policyholders or beneficiaries as specified by the General Secretariat, such as national identification or residence permit (Iqama) information.
21. **Insurance Company:** A cooperative insurance company licensed by SAMA to operate in the Kingdom and accredited by the Council to provide cooperative health insurance.
22. **Third-Party Administrator (TPA):** A company licensed by SAMA to operate in the Kingdom and accredited by the Council to process cooperative insurance claims.
23. **Service Provider:** healthcare facilities (governmental / non-governmental) licensed to provide healthcare services in the Kingdom pursuant to relevant laws and rules and approved by the Council, such as hospitals, diagnostic centers, clinics, pharmacies, laboratories, physiotherapy or radiotherapy centers.
24. **Preferred Provider Network (PPN):** A group of healthcare service providers accredited by the Council and designated by the insurance company to provide healthcare services to the insured. Said services are charged directly to the insurance company upon presenting a valid insurance card by the insured.
25. **Rejection of Accreditation Applications:** A procedure applied during the accreditation application stage when any of the information provided by a service provider, in order to obtain accreditation, is determined false by the Council (such as forging documents or licenses and providing false information or the like).
26. **Revocation of Accreditation:** A decision made due to a serious violation of the Law and its Implementing Regulation committed by a service provider.

27. **Emergency:** Urgent medical treatment required by the medical condition of the insured as a result of an accident or a case requiring prompt medical attention.
28. **Saudi Health Insurance Bus (SHIB):** A program implemented under the supervision of the Council aimed at sharing health insurance information, data and transactions between service providers, insurance companies, TPAs and the Council according to insurance data standards in a safe and reliable electronic manner.
29. **SHIB Regulatory Rules:** Rules regulating the exchange of health insurance information, data and transactions between service providers, insurance companies, TPAs and the Council through SHIB program for the Saudi health insurance market approved by the Council. These rules are deemed an integral part of the Regulation and are attached hereto (Annex 8).
30. **Policy Record:** The record dealt with or circulated by the National Health Insurance Network, and includes the following cases:
    1. **Active:** A record with a valid date.
    2. **Inactive:** A record with a validity date following its activation date or has not been used yet in an issuance or renewal of a residency permit.
    3. **Expired:** A record with an expired validity.
    4. **Suspended:** A record suspended by the Council or insurance company for a reason.
31. **National Network for Cooperative Medical Insurance (NNCMI):** Entities, programs and persons connected by NNCMI to transfer information and data related to cooperative health insurance.
32. **Premium (Subscription):** Amount paid by the policyholder to the insurance company for the insurance coverage provided by the policy during the insurance term.
33. **Deductible (Co-payment):** Amount, if any, payable by the beneficiary upon receiving outpatient treatment as specified in the policy schedule, excluding emergencies and inpatient treatment.
34. **Reimbursable Expenses:** Expenses paid in return for services, materials

and equipment not excluded under Section 3 of the policy attached hereto (Annex 1) that are prescribed by a licensed physician due to the illness of the insured, provided such expenses are necessary, reasonable and normal in the relevant time and place.

35. **Claim:** A request, accompanied by supporting financial and medical documents, submitted to the insurance company or representative thereof by the service provider, the insured or the policyholder for indemnification of expenses of healthcare services covered by the policy.
36. **Supervisory Field Visits Regulation:** The Regulation attached hereto (Annex 7) that aims at regulating the activities of the teams of supervisory field visits to insurance parties in order to verify compliance of all parties with the Law, its Implementing Regulations and the Standard Policy.
37. **Supervisory Field Visit Team:** A team composed of the General Secretariat staff to perform field supervisory visits to insurance parties.
38. **Fraud:** Intentional deceit by any insurance party leading to obtaining benefits or funds, or providing privileges which exceed the allowed limits to the relevant individual or entity.
39. **Abuse:** Practices by any insurance party which may lead to obtaining benefits or privileges they are not eligible to receive; without the intent to defraud, deceive, misrepresent or distort facts for the purpose of obtaining such benefits and privileges.
40. **Misleading:** Behavior carried out by an individual or entity not covered by the definition of fraud.
41. **Model Contract for Healthcare Services:** A contract approved by the Council that may be used by all insurance parties to regulate the relationship between the company and the service provider, subject to the provisions of Article 95 of this Regulation.



Chapter Two
Beneficiaries

Article 2

The following categories shall be subject to mandatory health insurance:

1. Non-Saudi employees in the non-government sector.
2. Non-Saudi residents in the Kingdom who do not work in the public or private sectors, excluding those of a Saudi mother and a non-Saudi father, whether they are under their father or mother employment contract, and non-Saudi wives of Saudi citizens.
3. Family members holding a residence permit who are dependents of persons subject to health insurance as specified in paragraphs 1 and 2 of this Article.
4. All Saudis working in companies, private institutions and the like under employment contracts, regardless of the type of remuneration. This provision shall apply to the categories set forth in paragraph 2 of this Article.
5. **Family members of Saudis referred to in paragraph 4 of this Article as follows:**
    1. For male employees, the health insurance shall cover his wife (wives), sons under the age of twenty five and unmarried daughters.
    2. For married female employees, the health insurance shall cover her husband who works in a government sector exempted from mandatory health insurance or in another sector that does not provide mandatory health insurance or is unemployed. The health insurance shall also cover the working wife, her sons up to the age of twenty five and unmarried daughters.

Article 3

An applicant for insurance who is not covered by the Law shall be entitled to health insurance.

Article 4

Subject to the categories provided for in Article 2 of this Regulation, all non-Saudi employees in government agencies as well as their family members shall

be exempted from mandatory health insurance, unless healthcare services for non-Saudi employees and their families are provided for in the employment contract or the Regulations of said agencies.

Chapter Three

Insurance Coverage under the Law

Article 5

1. The employer shall undertake to obtain a health insurance policy from an insurance company to cover all employees thereof who are subject to this Law, as well as their family members referred to in Article 2 of this Regulation.
2. Owners of companies and establishments with private medical facilities shall be subject to the Law and shall, as a minimum, obtain the insurance coverage provided for in the policy for their employees through health insurance companies.
3. Insurance companies may not reject any health insurance application which complies with the Law and its Regulation.
4. The insurance company providing insurance coverage to employees of companies and establishments owning accredited private medical facilities shall contract with such facilities to provide treatment to employees of said companies and establishments within the scope of approved healthcare services provided by such facilities.
5. The employer shall provide the insurance company with necessary data for registration with the National Information Center of his employees who are under contract upon the policy›s entry into effect. The insurance company may not add any insured person with a different registration number after the issuance of the policy, except those employed by the relevant employer after the issuance of the policy.
6. The employer shall provide the insurance company with proof of the insured's final exit from the Kingdom, transfer of the employment contract or death to be excluded from the policy.

Article 6

The insurance company shall, upon request, issue a binder to the employer (policyholder) as proof of insurance for his employees to present to authorities concerned with the issuance and renewal of residence permits. The Council shall determine the content of such binder.

Article 7

When a beneficiary is not granted a residence permit, his name shall be stricken off the policy as of the date of his final exit from the Kingdom. The premium for the term of insurance shall be calculated on the basis provided for in the policy.

Article 8

The beneficiary shall be given a copy of the insurance policy of which the health insurance coverage shall not be less than the basic coverage provided for by the Law.

Article 9

The employer may change the insurance company contracted to provide insurance coverage, provided that he notifies the insurance company at least 30 business days prior to the requested date of cancellation and sends a copy thereof to the Council. The employer shall be entitled to recover part of the premium paid to the insurance company which shall be calculated on a pro rata basis. The employer shall return the insurance cards to the company on the date of cancellation and obtain another insurance policy to provide insurance coverage starting on the day following the date of cancellation of the previous policy.

Article 10

If a person covered by this Law transfers to work for another employer, the new employer shall provide said person with insurance coverage from the date of transfer. In this respect, consideration shall be given to the date of the employment contract in the case of Saudi employees and residents belong to a Saudi mother or wife, and to the employment contract transfer date in the case of other non-Saudis.

Article 11

The insurance coverage shall include the benefits provided for in Article 7 of the Law as well as the provisions stipulated in Chapter 4 of this Regulation. The policy shall specify the duration of treatment, maximum amount of insurance coverage, limitations, benefits, exclusions and general conditions of the insurance coverage.

Article 12

The benefits of the insurance coverage shall include pregnancy and delivery for contracted employees (regardless of the form of the employment contract) and shall be within the limits specified in the policy.

Article 13

The insurance coverage shall include treatment of children born through artificial insemination or ovulatory stimulants, and shall not include treatment of sterility, impotence, infertility or artificial insemination.

Article 14

The mandatory cooperative health insurance coverage in the Kingdom of Saudi Arabia shall be limited to services provided by the PPN network in contract with an insurance company to provide healthcare services, in accordance with policy terms. In case of emergencies, the insured may receive treatment outside the PPN network.

Article 15

The employer shall undertake to provide insurance coverage for a beneficiary from the date of his arrival to the Kingdom and to give him the insurance card within ten business days from the date of arrival.

Article 16

The insurance coverage shall terminate upon reaching the maximum benefit

limit of the policy, the beneficiary's death, expiration or cancellation of the policy, the beneficiary's final exit from the Kingdom or transfer to work for a new employer.

Article 17

The insurance coverage of a non-Saudi employee who is absent from work may not be cancelled except upon termination of the relationship between said employee and his employer.

Article 18

The beneficiary shall be entitled to the benefits specified in the policy as follows:

1. Diagnosis and treatment by service providers, provided that the beneficiary pays the agreed upon deductible, if any.
2. The cost of necessary and emergency medical treatment paid directly by the beneficiary, provided that the insurance company fails to urgently provide such service to the beneficiary or unjustifiably refuses to provide the service. The person bearing the expenses shall be indemnified in accordance with the limits provided for in the policy and the limits paid by the company to a service provider of a similar level.

Article 19

The right to claim benefits shall commence from the beginning of the insurance coverage, in accordance with the provisions of Article 15 of this Regulation.

Article 20

There shall be no delay in availing the benefits at the commencement of the insurance. The provision of benefits upon commencement of the insurance coverage shall include cases originating prior to the commencement of the insurance coverage.

Article 21

The right to receive benefits shall cease with the end of the insurance coverage in accordance with the provisions of Article 16 of this Regulation. This includes the approvals of valid insurance coverage.

Article 22

Insurance benefits shall cover the costs of the Saudi Newborn Screening Program for Disability Prevention, and basic inoculations and vaccinations for children as approved by the Council of Health Services as well as communicable

diseases requiring quarantine which shall be provided by a contracted service provider.

Article 23

Healthcare services and medical treatment shall be provided by service providers of the PPN Network specified on the list attached to the insurance policy which is delivered to the beneficiaries and approved by the insurance company and policyholder, provided that the policyholder is notified of any amendments to the policy and list attached thereto.

Article 24

Insurance coverage shall include cost of hospitalization and meals for one companion, such as a mother accompanying her child up to the age of twelve, or as medical necessity dictates, at the discretion of the attending physician.

Article 25

Cost of transporting ill or pregnant beneficiaries to the nearest appropriate facility for treatment shall only be covered in cases of emergency. Transportation shall be provided by a licensed ambulance.

Article 26

Upon receiving healthcare services, every beneficiary shall pay the agreed upon deductible amount, if any, in accordance with the policy›s schedule, except for emergency cases and hospitalization.

Article 27

Where the contract provides for payment of a deductible amount, the service provider may not relieve the beneficiary from payment of such amount.

Article 28

The deductible, if any, shall be paid by the beneficiary to the service provider against a receipt.

Article 29

Beneficiaries may not claim benefits under the policy unless such benefits are part of the basic coverage provided for in the policy or part of the additional coverage obtained in accordance with Article 8 of the Law.

Article 30

Healthcare services may not be claimed if such services are provided as a result of a workplace accident or occupational illnesses as defined in the Social Insurance Law.

Article 31

If the insurance company provides such medical services that should have been provided by the Occupational Hazards Branch of the General Organization for Social Insurance (GOSI), said company may apply to GOSI for indemnification.

Article 32

If GOSI provides healthcare services to a person holding an insurance policy with a health insurance company obligated to provide such services, the insurance company shall indemnify GOSI for expenses incurred within the limits of the policy, taking into consideration the rates approved by the Ministry of Health.

Article 33

GOSI and the insurance company may conclude a joint contract which provides for taking specific procedures to provide the services stated in Articles 31 and 32 of this Regulation.

Article 34

The insurance company may recourse to the third party responsible for the damages against which the beneficiary was indemnified under the principle of subrogation whereby the company may subrogate the insured in all the rights relating to said damages upon proof of payment of the relevant amounts by

the company, without the need to obtain any authorization or power of attorney from the insured.

Chapter Five

Financial Liabilities Regulations

Article 35

SAMA shall brief the Council in writing of any observations concerning the performance of the accredited health insurance companies or TPAs, including observations relating to license revocation or suspension.

Article 36

1. The health insurance premium shall be determined by agreement between the insurance company and the employer.
2. **The insurance company, when determining insurance premiums, shall comply with the following:**
    1. Rates must be in line with average health insurance market rates.
    2. The policy rate must not cause any decrease or increase in the rates of products of the insurance company as approved by SAMA.
    3. The policy value must be technically justifiable on objective bases and may not in any case be less than the actual cost of the policy and associated ordinary or possible treatment costs.
    4. The insurance company may not rely solely on rates applied by other companies to determine the insurance premium.
3. The maximum benefit under the policy for each beneficiary shall be five hundred thousand Saudi riyals only.

Article 37

An employer shall undertake to pay the insurance company he selected the premiums for his employees and their dependents. The employer shall be solely responsible for the payment of premiums at the beginning of each insurance year unless there is an agreement on scheduling the premiums. Individuals residing in the Kingdom who do not meet the definition of “employee” shall be responsible for the payment of health insurance premiums for themselves and their dependents.

Article 38

If premiums are not paid on the dates agreed upon, the insurance company may cancel the policy and shall notify the General Secretariat, PPN Network and policyholder accordingly.

Article 39

Charges collected by the Council for overseeing the application of the Law shall be one percent (%1) of the total subscribed health insurance premiums collected by the accredited insurance companies in accordance with the audited financial statements of the previous year, provided that such percentage be reviewed in coordination with SAMA.

Article 40

A cooperative health insurance fund shall be established to cover expenses exceeding the insurance coverage specified under the insurance policy. Affiliation of said fund as well as its procedures and controls including its financing and determination of beneficiaries thereof shall be determined in coordination between the Council and SAMA.

Article 41

Expenses of the Council shall be financed by revenues generated from the application of the Law in accordance with Article 6 of the Law. Such revenues shall be as follows:

1. Charges for accreditation and annual renewal of accreditation of insurance companies.
2. Charges for accreditation and annual renewal of accreditation of TPAs.
3. Charges for annual accreditation of governmental and non-governmental healthcare service providers.
4. Charges collected by the Council for overseeing the application of the Law at the rate of one percent (%1) of total premiums collected by the accredited insurance companies in accordance with the audited

financial statements of the previous year.

5. Fines payable to the Council which are imposed by the Committee for Violations of the Cooperative Health Insurance Law as specified in Article 14 of the Law.
6. Donations, grants and investment revenues.
7. Revenues collected from other sources such as the issuance of magazines, booklets as well as training and consultation services provided by the Council.

Chapter Six

Provision of Health Insurance Services

First: Insurance Companies

Article 42:

Cooperative health insurance shall be provided by cooperative insurance companies licensed to operate in the Kingdom by SAMA.

Article 43:

Insurance companies may not provide cooperative health insurance unless accredited by the Council. Accreditation shall be limited to a period of three years renewable for similar periods.

Article 44:

Cooperative insurance companies shall be accredited to provide health insurance pursuant to an application submitted for such purpose. The Council may specify the details it deems necessary regarding the nature and scope of data to be included in the application. The Council shall decide on such application within 90 days from the date of submission.

Article 45:

The Council may accept a company›s application for accreditation upon satisfying the following requirements:

1. A license to provide health insurance services.
2. Availability of Technical, administrative and medical staff as well as systems for approvals, processing claims and settlement of entitlements. Such tasks may be outsourced to a TPA company accredited by the Council.

Article 46:

Insurance companies shall include the following documents and data in their applications for accreditation or renewal thereof:

1. Name and address of the company.
2. Copies of articles of incorporation and memorandum of association.

3. Names of the chairman, members of the board of directors, managing director and members of the executive management.
4. The health insurance action plan of the company.
5. Annual accounts audited by a certified accountant for the last three years preceding the submission of application (for existing companies).

Article 47:

An insurance company shall notify the Council prior to any amendment to the company›s work procedures regarding health insurance.

Article 48:

An insurance company shall notify the Council of any policy (policies) not subject to any claims for a period equal to or exceeding three months from the date of issuance.

Article 49:

Accreditation or renewal of accreditation of an insurance company may be denied pursuant to a letter providing grounds for such denial in the following cases:

1. If the Council receives information from SAMA indicating incompetence of the company's executive managers and lack of necessary professional requirements.
2. If the Council receives information from SAMA indicating the company's inability to adequately protect the beneficiaries' interests, or to continually meet its obligations.
3. If the company fails to pay the accreditation or renewal fees specified in Article 50 of this Regulation.

Article 50:

1. The Council shall charge a fee of one hundred and fifty thousand riyals (SAR 150,000) only for accreditation of insurance companies for a period of three years.

2. The Council shall charge an annual fee of fifty thousand riyals (SAR 50,000) for renewal of accreditation of insurance companies.

Article 51:

The policy shall be deemed effective as of the date of payment of the agreed upon insurance premium.

Article 52:

The insurance company shall be directly liable to the employer for any obligations or fines incurred by the employer due to the insurance company›s non-compliance with the provisions of Articles 51 and 53 of this Regulation

Article 53:

The insurance company shall submit the names of the insured persons to the National Health Insurance Network within 48 hours after verifying the payment of the premium referred to in the policy.

Article 54:

Without prejudice to the provisions of Article 36(b) of this Regulation, a policy may not be directly entered into the national network system of the Council if the amount of the premium is not technically justifiable or in line with average rates in the health insurance market until the insurance company provides the criteria and grounds for determining said amount. The Council may accept said criteria and grounds and allow the relevant policy to be processed through such system or refuse the same.

Article 55:

In the contract concluded between the insurance company and the service provider, the rates agreed upon shall be in line with the rates approved by the Ministry of Health.

Article 56:

The insurance coverage for the beneficiaries shall not be conditional on the issuance of insurance cards thereto. The insurance company shall be liable for all medical claims from the effective date of the policy and shall issue insurance cards within a period not exceeding five business days from said effective date.

Article 57:

The accreditation of any insurance company proven to have deliberately issued, allowed, facilitated or contributed directly or indirectly in the issuance of a health insurance policy that does not entail real healthcare services shall be revoked. The revocation decision shall be issued by the Chairman of the Council, based on grounds provided by the General Secretariat. Said decision may provide for the suspension of the relevant company for a specific period.

Second: Healthcare Service Providers

Article 58:

The Council shall approve (governmental/non-governmental) healthcare service providers in accordance with the following:

1. The service provider in the private sector is licensed by the Ministry of Health.
2. The service provider meets quality standards in accordance with decisions and directives issued by the Central Board for Accreditation of Healthcare Institutions.
3. The service provider satisfies the electronic transactions' controls and requirements adopted by the Council.

Article 59:

The PPN network shall comprise the following levels of healthcare services:

- First level (primary healthcare)
- Second level (general hospitals)
- Third level (specialized or referral hospitals)

- Other supplementary healthcare centers (e.g. same-day surgery centers, pharmacies, physiotherapy centers and optical stores).

Article 60:

The fee adopted by the Council for the accreditation of a service provider shall be applied in each case in accordance with Article 61 of this Regulation.

Article 61:

Service providers shall be accredited pursuant to a notice issued by the General Secretariat. The relevant due fee shall be paid in accordance with the schedule adopted by the General Secretariat for this purpose and attached to this Regulation (Annex 3).

Article 62:

The Council may suspend the accreditation of a service provider if the officer of said service provider so requests. In such case, the service provider shall retain its registration number with the Council and settle any prior financial liabilities payable thereby to the Council.

Article 63:

The Council may revoke the accreditation of a service provider pursuant to a decision by the Chairman of the Council, in the following cases:

1. Revocation or withdrawal of the license issued by the Ministry of Health.
2. Establishment of a violation of accreditation requirements.
3. Providing the Council with false information or data.
4. The Council obtains information indicating the service provider's inability to provide the beneficiaries with proper healthcare.
5. Committing, participating in or facilitating fraud or abuse or proven gross negligence or default.
6. Failure to submit proof of compliance with quality standards provided for in Chapter Nine of this Regulation.

7. Failure to pay accreditation renewal fees.
8. Failure to comply with electronic transactions' controls and requirements adopted by the Council.
9. If the service provider prevents or obstructs the supervisory field teams from performing their duties.

If accreditation is suspended or revoked, the Council shall notify the insurance companies and TPAs accordingly.

Article 64:

If a service provider fails to apply for renewal of accreditation within the following year and applies to the General Secretariat for accreditation after the lapse of one year or more, the Council may demand payment of fees payable for the previous period regardless of its duration, unless it is officially established that no relation existed during said period with health insurance companies; in such case, the General Secretariat shall verify the same and may reject any report proven false.

Article 65:

If there is verified information establishing violations committed by any accredited service provider, the Council may report said violations to the Committee of Violations of Healthcare Institutions at the Ministry of Health.

Chapter Seven

Overseeing Insurance Parties

Article 66

The Council shall oversee the comprehensiveness of the health insurance coverage and ensure that the health insurance parties are fulfilling their duties and responsibilities in accordance with this Regulation.

Article 67

The Council may request SAMA, insurance parties and other concerned parties to provide information and data on all matters related to the application of the provisions of the Law.

Article 68

Supervisory field visits to insurance parties shall be conducted in accordance with the controls and standards provided for in the Supervisory Field Visits Regulation approved by the Council and attached to this Regulation (Annex 7).

Article 69

The Supervisory Field Team may visit insurance parties (during official working hours) without a prior notice from the Council. Members of the Supervisory Field Team shall present proof of affiliation with the Council and provide the insurance parties with a notice stating the purpose of their visit. The insurance parties shall undertake to:

1. cooperate with the Supervisory Field Team;
2. provide the Team with required information and data; and
3. promptly respond to enquiries and comments, if any, as specified by the General Secretariat.

Article 70

The Council may express reservations regarding any officials or executive managers of insurance companies within the scope of the Council's jurisdictions and in coordination with SAMA and relevant entities.

Article 71

The Council may revoke the accreditation of any health insurance company or TPA pursuant to a decision by the Chairman of the Council in the following cases:

1. Revocation or withdrawal of the license by SAMA;
2. Establishment of a violation of accreditation requirements;
3. Deliberate provision of false information or data to the Council;
4. Failure of the insurance company to use the accreditation within twelve months or if it relinquishes such accreditation;
5. Discontinuation of activities of the insurance company for six months without justification acceptable to the Council;
6. The Council receives information indicating the inability of the insurance company to provide the insured with proper healthcare services;
7. Involvement in fraud or abuse;
8. Failure to pay charges for overseeing the application of the Law;
9. Failure to pay charges for the insurance company's re-accreditation or renewal of accreditation;
10. Failure to pay charges for the TPA's renewal of accreditation;
11. Noncompliance with electronic transactions' controls and requirements adopted by the Council; or
12. Preventing or obstructing the Supervisory Field Team from carrying out its supervisory duties by the insurance company or TPA. The Council shall notify service providers accordingly.

Article 72

Except for cases referred to in Article 71 of this Regulation, coordination shall be made with relevant agencies regarding revocation of accreditation.

Article 73

In case of violations committed by any insurance party, the Council may suspend said party from providing cooperative health insurance services for

a specific period, subject to provisions of Article 14 of the Cooperative Health Insurance Law.

Article 74

The Council shall make available basic statistical information and data on health insurance. It may also provide, for a charge, additional statistical information and data.

Article 75

If the applicant is a company or establishment, the insurance company shall, prior to approving an insurance request, verify the following:

1. the company or establishment has a commercial registration, a copy of which is provided to the insurance company;
2. the insurance application is signed and sealed by the employer;
3. proof of contractual relationship in accordance with relevant laws;
4. a list of persons to be insured, provided the insurance company verifies the validity of the basic data provided by the employer; and
5. payment of agreed upon premium prior to entering the names into the National Health Insurance Network System.

Article 76

If the applicant is not legally required to register with the commercial register, the insurance company shall, prior to approving an insurance application, verify the following:

1. the validity of identification data of the employer and employees sought to be insured and setting of necessary procedures;
2. the company maintains records of client data obtained;
3. insurance application forms are completed and signed by the applicant; and
4. payment of agreed upon premium prior to entering the names into the National Health Insurance Network System.

Article 77

The insurance company shall undertake to:

1. verify the basic data provided by applicants prior to providing insurance;
2. monitor compliance of insurance broker or agent with the health insurance requirements and conditions provided for in the Implementing Regulation and Standard Policy;
3. If no fraud is attributed to the insured or policyholder, the insurance company may not refuse to provide coverage due to inaccuracy or invalidity of the insured's basic data; and
4. an insurance company may not deal with any insurance broker or agent for the purpose of selling and marketing health insurance policies unless said broker or agent is licensed by SAMA. Notwithstanding any action taken by SAMA with respect to breach of this obligation, the insurance company shall be liable before the Council for health insurance policies concluded through persons or parties not licensed to sell health insurance policies.

Article 78

The insurance company may use the databases maintained by specialized companies, such as the Information Security Company (ELM) and the Saudi Credit Bureau (SIMAH), to verify any required information.

Article 79

The employer shall be liable for any damages resulting from concluding health insurance policies issued by unlicensed entities, and the Council may take legal action where such practices are established.

Article 80

All insurance parties shall undertake to notify the Council of any internal violations, if any, within 15 business days as of the date of discovery of such violations.

Article 81

Insurance companies and service providers shall set up a unit to receive and address complaints filed by beneficiaries and policyholders. If a complaint is not addressed and it relates to violation of the provisions of the Law, the complainant may file the complaint with the Council.

Chapter Eight

Insurance Parties Relations

Article 82

The parties to an insurance policy shall be the policyholder and the insurance company.

Article 83

The employer shall obtain health insurance for his employees by concluding a health insurance policy with an insurance company accredited by the Council.

Article 84

The employer shall provide the insurance company with the basic data required to conclude the policy as provided for in the medical disclosure form attached to this Regulation (Annex 6). The insurance company may request additional data and may waive the requirement to complete all or part of said data.
In all cases, the data provided for in the disclosure form or waived shall suffice to meet the disclosure requirement to conclude the policy, and the disclosure form shall be used to meet the requirement under this Article.

Article 85

The employer shall provide all information requested by the insurance company. If the insurance company has reasonable grounds to doubt the accuracy of such information, it may refer the matter to the Council, along with supporting evidence. The employer shall, upon the Council's request, submit all necessary documents.

Article 86

The employer shall explain the policy and coverage limits to relevant beneficiaries through appropriate means such as:
pamphlets, direct explanation and websites.

Article 87

Without prejudice to laws and directives, the competent authorities shall impose penalties stipulated by law on a beneficiary proven to have abused the service or committed fraud.

Article 88

The insurance parties shall meet the design and content requirements of the health insurance card as per the form attached to this Regulation (Annex 5).

Article 89

Insurance companies, TPAs, healthcare service providers and self-employed professionals in the field of cooperative health insurance shall comply with the following:

1. Provide services in accordance with generally accepted professional and ethical standards conforming to recognized and accepted modern medical practices. Service providers may not submit claims to insurance companies for providing services not in conformity with the above.
2. Medical procedures shall be limited to necessary treatment.

Article 90

Insurance parties shall, in accordance with their jurisdiction, undertake the following:

1. Without prejudice to Article 36 of this Regulation, premiums shall be paid to insurance companies as agreed.
2. Prompt provision of treatment by service providers to beneficiaries.
3. The service provider shall file a request to bear the cost of providing treatment to beneficiaries to the insurance company not later than 15 minutes from the time the attending physician completes the request, subject to criteria for requesting approval to bear treatment costs attached to this Regulation (Annex 2).

4. Insurance companies shall reply to service providers' request to provide treatment to beneficiaries not later than 60 minutes from the time of receiving such request; in case of denial, grounds shall be provided.
5. Service providers shall reply to enquiries and remarks sent by the insurance company, if any, regarding the request for approval not later than 30 minutes from the time of receiving such request.
6. If a service provider does not receive a reply to an approval request within the specified time period, said request shall be deemed approved upon confirmation that the insurance company has received the approval request within such period.
7. The service provider shall file claims to the insurance company directly or through a TPA within a period not exceeding 45 business days from the date claims are due, unless a longer period is directly or indirectly approved by the insurance company or is due to an acceptable justification.
8. The insurance company shall settle claims submitted by service providers within a period not exceeding 45 business days from the date of receiving such claims.
9. The policyholder shall submit claims regarding reimbursable expenses to the insurance company or TPA within a period not exceeding 30 business days as of the date the relevant claims become due; unless a longer period is reasonably justified.
10. The policyholder shall provide the insurance company with the documents supporting the claims requested by the company within a period not exceeding 30 business days from the date of such request.
11. The insurance company shall indemnify the policyholder for reimbursable expenses in accordance with prevailing prices within a period not exceeding 15 business days from the date of completion of the request.
12. Accredited TPAs shall follow up and settle medical claims with the Council in order to ensure payment is made within the period specified

in the above paragraph in accordance with rules approved by the Council for this purpose.

Article 91

Insurance companies and service providers shall be liable for any fraud, abuse or forgery committed by their employees upon providing services.

Article 92

The employer shall, upon termination of a beneficiary's employment, return the insurance cards to the insurance company and shall be liable for any expenses arising from incompliance with this condition.

Article 93

In fulfilling its obligations to provide the benefits under the policy, the insurance company shall conclude healthcare service contracts directly with service providers accredited by the Council. This requirement may not be substituted by contracts concluded between TPAs and service providers.

Article 94

In emergency cases only, treatment may be provided by specialists and hospitals without referral from a primary care facility. This provision shall also apply to treatment provided by service providers with no healthcare service contracts concluded with the insurance company. In case the insurance company disapproves of the continuation of treatment at that particular facility, the beneficiary, upon stability of his health condition, shall be transferred to one of the PPN centers. In non-emergency cases, referral must be obtained through a general practitioner or primary healthcare facility.

Article 95

Parties to the insurance contract may use the model healthcare service contract approved by the Council (attached to this Regulation (Annex 4))

which regulates the relationship between the relevant parties, provided that such contract covers the following as a minimum:

1. Mutual rights and obligations and penalties for any breach.
2. Compliance of service providers with quality standards in accordance with conditions and procedures provided for in Articles 120 and 121 of this Regulation.
3. Compliance of service providers with cost-effective requirements in accordance with the provisions of Article 89 of this Regulation. Provision of treatment and prescriptions shall also comply with the same.
4. Amount of fees, settlement procedures and settlement of amounts due for prescriptions dispensed.
5. Preconditions and deadlines for notices.
6. Method of settlement of disputes arising from healthcare service contracts.

Article 96

A service provider shall verify the beneficiary's identity. The insurance company shall not bear the cost of treatment provided by a service provider to a non-beneficiary.

Article 97

A service provider shall claim its dues for providing treatment to beneficiaries as agreed upon with the insurance company within a period not exceeding 45 business days; unless a delay is reasonably justified.

Article 98

The insurance company shall pay the dues of a service provider within a period not exceeding 45 business days from the date the company receives acceptable complete claims.

Article 99

Parties to the insurance contract shall comply with the Medical Coding System (NDC/AR-DRG/ICD10- AM Version 6) approved by the Council in diagnosis of cases, treatment and cost, claims of dues as per the timing specified by the Council. They shall also comply with rules of the SHIB program adopted by the Council and attached to this Regulation (Annex 8).

Article 100

A service provider may terminate the health service contract with the insurance company in accordance with the termination conditions set forth in the relevant contract in the event said service provider does not wish to maintain such contract or if the insurance company defaults in payment of dues or if the refusal by the insurance company exceeds the limit agreed upon by the two parties; in such case, the insurance company shall notify the employers accordingly.

Article 101

An insurance company shall, upon commencement of the insurance coverage, provide the policyholder with insurance cards and explanatory booklets covering the policy, insurance coverage limit and the PPN Network. The employer shall formally deliver the same to the beneficiaries upon commencement of the insurance coverage. The insurance company shall notify the PPN Network of the enrollment of the policyholder to the insurance coverage as well as any additional coverage, if any.

Article 102

The insurance company and policyholder shall provide a PPN network that takes into consideration the needs of beneficiaries and proximity of their workplaces so that they do not seek healthcare from a service provider outside the network.

Article 103

A service provider shall promptly provide services in emergency cases without

the need to seek the approval of the insurance company, provided that the company is notified accordingly within (24) hours of receiving the case.

Article 104

An insurance company shall, individually or collectively, hire physicians at the level of specialist or higher, licensed by the Saudi Commission for Health Specialties to ensure that medical intervention complies with cost-effectiveness provided for in Article 89 of this Regulation. Priority shall be given to Saudi physicians.

Article 105

Physicians hired by insurance companies shall be independent. When performing their supervisory duties, they shall only observe medical requirements and may not interfere in medical treatment of beneficiaries.

Article 106

Service providers or the insured shall provide the physicians hired by insurance companies with required information and grant them access to documents necessary for performing their supervisory duties in accordance with Article 104 of this Regulation. When necessary, and in coordination with the relevant entity, such physicians shall have access to hospital wards, medical supervision offices and medical files in any licensed hospital where a beneficiary received or is receiving treatment.

Article 107

Physicians hired by insurance companies shall be subject to the Law of the Saudi Commission for Health Specialties.

Article 108

In the event of inadequate service on the part of a service provider, the insurance company may, upon coordination with the policyholder and subject

to the specific notice period and termination terms provided for in the relevant contract, terminate the healthcare contract concluded with said service provider.

Article 109

The insurance company may request the beneficiary or the service provider to provide details of emergency cases and obligations arising therefrom.

Article 110

The beneficiary shall, upon the insurance company›s request, agree to be re-examined by a licensed physician designated by the insurance company. In such case, the company shall bear the expenses of such examination.

Article 111

When seeking treatment, a beneficiary shall present his insurance card and proof of identity to the service provider for the purpose of recording data necessary for treatment.

Article 112

When seeking healthcare services, the beneficiary shall observe the following:

1. The beneficiary shall visit any primary care facility or physician within the PPN network. Referral to a specialist or consultant shall be made by the general practitioner.
2. If a beneficiary referred by the general practitioner needs to be seen by a specialist or consultant for the same illness for which he was referred, said beneficiary may do so without further referral from the practitioner.
3. The beneficiary shall bear the difference in examination fees if he directly visits a specialist or consultant as provided in the policy.

Article 113

Recommendation for hospitalization shall be limited to cases where treatment

offered by outpatient clinics is not sufficient. Same-day surgery or treatment, depending on the medical condition, may be utilized. If a beneficiary visits a hospital other than that specified in the referral document, said beneficiary shall bear the difference in the cost of treatment.

Article 114

A direct contract between a TPA company and a policyholder for the provision of health insurance services shall be prohibited.

Article 115

Insurance companies shall cover the costs of organ harvesting procedures from the donor.

Article 116

Insurance companies may not contract with the employer's in-house clinics unless said clinics are licensed by the Ministry of Health and have a valid accreditation from the General Secretariat.

Article 117

Insurance companies and health insurance claims management companies are not allowed to own or operate facilities for purposes of providing health care to the insured, nor can private health facilities own health insurance companies.

Article 118

Employers may not explicitly or implicitly require insurance companies to return any amounts resulting from a decrease in or reduction of health service costs borne by said companies.

Article 119

Insurance companies shall notify the General Secretariat prior to contracting with any TPA.

Chapter Nine

Health Services Quality Assurance

Article 120

The Council may ensure compliance with the conditions and standards to be met by healthcare service providers in accordance with standards of the Central Board for Accreditation of Healthcare Institutions and electronic transaction standards, requirements and controls adopted by the Council.

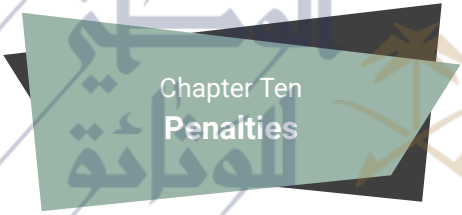
Article 121

The Council's measures for maintaining quality shall, as a minimum, cover the following:

1. Standards for examination rooms of accredited service providers;
2. Regular onsite inspection of approved hospitals, clinics and polyclinics, without prior notice, by Council personnel or persons hired by the Council;
3. Assessment of healthcare contracts in terms of commitment to quality assurance; and
4. Electronic transactions requirements and controls adopted by the Council.

Article 122

Service providers accredited by the Council shall submit to the Council a report every three years indicating the level of their compliance with quality assurance in accordance with standards set by the Central Board for Accreditation of Healthcare Institutions in the Kingdom. In case of non-compliance with such condition, the Council may revoke the accreditation.



Chapter Ten
Penalties

Article 123

One or more committees, named the "Committee for Violations of the Cooperative Health Insurance Law" shall be formed pursuant to a decision by the Chairman of the Council in accordance with Article 14 of the Law, to consider violations of the provisions of the Law and to recommend appropriate penalties. Said penalties shall be imposed by a decision of the Chairman of the Council and may be appealed before the Board of Grievances within sixty days from the date of notification thereof.

Article 124

The relevant party shall file a written complaint with the General Secretariat within ninety days from the date of the occurrence of the dispute subject of the complaint, unless reasonable circumstances prevent the filing of the complaint within such period.

Article 125

The General Secretariat of the Council shall refer the complaint to the Committee and notify the complainant within 15 work days from the date of deciding on the complaint in accordance with the Regulations of the Committee for Violations of the Cooperative Health Insurance Law (attached (Annex 9)).

Article 126

Financial penalties collected for violations of the provisions of this Law as well as fines specified in Articles 123 and 127 shall be deposited with the Council in accordance with the financial regulation.

Article 127

If it becomes evident to the Committee for Violations of the Cooperative Health Insurance Law that a complaint is malicious, it may take the necessary legal actions.

Chapter Eleven

General Provisions

Article 128

Council members or General Secretariat staff may not disclose confidential information during or after their membership or employment. This provision shall apply to any person obtaining such information from official reports.

Article 129

The Council may only use the information referred to in Article 128 for the following purposes:

1. Examination of application submitted by the insurance company or TPA for accreditation and renewal thereof, or by a service provider for accreditation or renewal thereof.
2. Examination of complaints submitted to the Council.
3. Reviewing and deciding on violations under Article 14 of the Law.
4. Directives issued by the Council.

Article 130

This Regulation shall apply to employers in accordance with the resolutions, instructions and executive plans issued by the Council.

Article 131

All insurance companies shall comply with the issuance of insurance policies with minimum coverage as approved by the Council to provide coverage for beneficiaries subject to the Law.

Article 132

The Council shall review and amend this Regulation every three years, or when necessary. A decision to this effect shall be issued by the Chairman of the Council.

Article 133

The amended Regulation shall be issued pursuant to a decision by the Chairman of the Council and shall enter into force 30 days after the date of its publication in the Official Gazette in accordance with the controls stipulated in the decision of approval.

Chapter Twelve

Annexes

Article 134

This Chapter comprises the following set of annexes which shall be deemed an integral part of this Regulation:

1. **Annexes including documents referred to in certain articles of this Regulation:**
   - A. **Annex No. (1):** The Standard Policy for Cooperative Health Insurance approved by the Council.
   - B. **Annex No. (2):** Standards of Treatment Cost Approval.
   - C. **Annex No. (3):** Table of annual fees for approval of healthcare service providers by the Council.
   - D. **Annex No. (4):** Model Healthcare Service Contract.
   - E. **Annex No. (5):** Standard Insurance Card Template approved by the Council.
   - F. **Annex No. (6):** Medical Disclosure Form regarding the health information of the insured.
   - G. **Annex No. (7):** Supervisory Field Visit Regulations approved by the Council.
   - H. **Annex No. (8):** SHIB Regulatory Rules for the Saudi Health Insurance Market.
   - I. **Annex No. (9):** Regulations of the Committee for Violations of the Cooperative Health Insurance Law.

2. **Annexes used as further reference material:**
   - A. **Annex No. (10):** Royal Decree No. (M/32) dated 1424/6/2H approving the Law on Supervision of Cooperative Insurance Companies.
   - B. **Annex No. (11):** Council of Ministers Resolution No. (240) dated 1432/10/26 H approving the Law of Private Health Institutions.
   - C. **Annex No. (12):** Council of Ministers Resolution No. (40) dated 1427/2/27H on implementing government electronic transactions.
   - D. **Annex No. (13):** Council of Ministers Resolution No. (165) dated 1432/5/28H approving the Statute of the National Anti-Corruption Commission.