Kingdom of Saudi Arabia
Cooperative Health Insurance Council
Secretariat General

No. ..............................................  
Date: .........................................  
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Implementing Regulations of the Cooperative Health Insurance Law in the Kingdom of Saudi Arabia (Amended)

As Approved in Session No. (73) dated 08/05/1430H and adopted pursuant to Ministerial Decision No. DH/1/30/6131 dated 08/06/1430H
Chapter I - Definitions

Article (1): The following terms shall have the meanings assigned to them:

1. **Law**: The Cooperative Health Insurance Law in the Kingdom of Saudi Arabia
2. **Council**: The Cooperative Health Insurance Council formed in accordance with the provisions of Article (4) of the Law.
4. **Agency**: Saudi Arabian Monitory Agency (SAMA).
5. **Social Insurance**: The insurance applied in accordance with the Social Insurance Law and implemented by the General Organization for Social Insurance.
6. **Medical Insurance**: Cooperative Medical Insurance referred to in the Law.
7. **Employer or Sponsor**: A natural or corporate person employing one or more employees.
8. **Policyholder**: A natural or corporate person in whose name the policy is issued.
9. **Insured (Beneficiary)**: A person covered by the Law and insured by an insurance company.
10. **Dependent(s)**: Spouse, sons under 18 years of age and unmarried daughters.
11. **Insurance Company**: A qualified insurance company licensed by the Council to operate in the Kingdom in the field of cooperative health insurance.
12. **Health care Provider**: Government and non-government health care facilities approved by the Council in accordance with applicable laws to provide health care services in the Kingdom, e.g. hospital, diagnostic center, clinic, pharmacy, laboratory, physiotherapy center or radiological treatment center.
13. **Accredited Health care Provider Network**: The group of health care providers accredited by the Cooperative Health Insurance Council and specified by the insurance company to provide health care to the employer / policyholder and bill the cost directly to the insurance company’s account, upon the insured producing of a valid insurance card, provided that the network include the following three health care levels:
   - Level 1: Primary health care services.
   - Level 2: General hospital services.
   - Level 3: Specialist / Referral hospital services
14. **Health Insurance Claims Management Company**: A claim settlement company licensed by SAMA to operate in the Kingdom of Saudi
Arabia and accredited by the Council to engage in health insurance claims management.

15. **Policy:** The basic cooperative health insurance policy annexed to these Regulations, which has been approved by the Council and contains limitations, benefits, exclusions and general conditions. It is issued by an insurance company pursuant to an insurance application submitted by the employer (policyholder).

16. **Premium (Subscription):** The amount to be paid by the policyholder to the Company for the insurance coverage provided by the policy during the insurance term.

17. **Insurance Coverage:** Basic health benefits made available to the beneficiary as specified in the insurance policy attached to these Regulations.

18. **Benefit:** The cost of providing health services included in the insurance coverage within the limits identified in the policy schedule.

19. **Deductible (Burden Sharing):** The amount (specified in the policy schedule) payable by the beneficiary (the insured) on medical visits.

20. **Emergency:** The medical treatment required for an insured person as a result of an accident, or a case requiring prompt medical attention.

21. **Claim:** A host of financial and legal documents submitted by the health care provider (and in some cases the insured or policyholder) to the insurance company for reimbursement for health expenses offered to the insured.

22. **Fraud:** The intentional misrepresentation by an individual or an entity for the purpose of exploiting health care and distorting facts, the intentional manipulation resulting in obtaining benefits or providing privileges excluded or which exceed the allowable limits to an individual or entity.

23. **Misuse:** Unintentional practices by individuals or entities which may lead to realizing privileges or benefits they are ineligible to, without the intent to defraud, deceive, misrepresent or distort facts for the purpose of obtaining the benefit.

24. **Model Health care Insurance Contract:** A labor contract approved by the Council, which may be used by all parties to the insurance policy to regulate the relationship between the company and the health care provider, taking into consideration the provisions of Article 78 of these Regulations.
Chapter 2 - Beneficiaries (the Insured)

Article (2)
The following categories are subject to health insurance:
1. Non-Saudis working for the non-government sector.
2. Persons unemployed in the non-government sector, who are residing in the Kingdom.
3. Family dependents of persons specified in paragraphs 1 and 2 of this Article, who are holding a residence permit in the Kingdom.
4. Saudis working in the private sector and individuals with whom they have labor contracts or proof of employment, regardless of the form of remuneration.1
5. Family members of Saudis referred to in paragraph 4 of this Article as determined by the Cooperative Health Insurance Council.2

Article (3)
The following categories shall be excluded from the health insurance provided for in Article (2) of these Regulations:
1. Non-Saudi employees working for government bodies and those whose work contract do not provide for health care services shall be obligated to obtain insurance coverage in accordance with approved insurance policies.
2. Family dependents of employees specified in paragraph 1 of this Article. The scope of treatment specified in the above paragraph shall at least conform to the provisions of Article (7) of the Law and the quality standard provided for in Chapter 9 of these Regulations.

Chapter 3 - Insurance Coverage under the Law

Article (4)
a. The employer undertakes to obtain a health insurance policy from an insurance company to cover employees under his sponsorship in the Kingdom or new employees under his sponsorship as well as other employees subject to this Law.
b. Owners of companies and sole proprietorships that own private medical facilities are not exempted from subscribing to the cooperative health insurance, and they shall, as a minimum, obtain the insurance coverage

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1 As per Council of Ministers Resolution No. 206 dated 15/08/1423 H.
2 As per Council of Ministers Resolution No. 206 dated 15/08/1423 H.
stipulated in the cooperative health policy through health insurance companies accredited by the Council.

c. Insurance companies accredited by the Council may not deny any cooperative health insurance application, whether directly or indirectly.

d. The insurance company providing insurance coverage to employees of companies and sole proprietorships owning accredited private medical facilities shall contract with such facilities to provide treatment to employees of said companies and sole proprietorships within the scope of approved health care services provided by such facilities.

Article (5)
The insurance company shall issue a binder to the employer (policyholder) as proof of insurance for its employees to present to authorities concerned with the issuance and renewal of residence permits. The Council shall determine the content of such binder.

Article (6)
Where a beneficiary is not granted a residence permit, his name shall be stricken off the cooperative health insurance policy as of the date of his final exit. The premium for the term of insurance shall be calculated on the basis provided for in the policy.

Article (7)
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 (8)
The employer may change the insurance company contracted to provide insurance coverage, provided that it notifies the insurance company in writing at least one month prior to the requested date of cancellation, with a copy thereof provided to the Council. The amount of the insurance premium to be refunded shall be calculated on a pro rata basis. The employer (policyholder) shall return the insurance cards 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 (9)
If a person covered by cooperative health insurance transfers to work for another employer, the new employer shall provide such person with insurance coverage from the date of transfer and present the insurance binder as a supporting document for the transfer of sponsorship.
Article (10)
The cooperative health insurance coverage shall include the benefits provided for in Article (7) of the Law as well as the scope of provisions stipulated in Chapter IV of these Regulations. The policy shall specify the duration of treatment, maximum limit of insurance coverage, limitations, benefits, exclusions and general conditions of the insurance coverage.

Article (11)
The benefits of the insurance coverage shall include pregnancy and delivery for employees of the status “married” contracts, within the limits specified in the policy.

Article (12)
The mandatory cooperative health insurance coverage shall be limited to services provided in the Kingdom of Saudi Arabia by approved health care providers’ network contracted by the insurance company to provide health care.

Article (13)
The employer undertakes to provide insurance coverage for a beneficiary from the date of the beneficiary’s arrival to the Kingdom and to give him the insurance card within ten working days from the date of his arrival.

Article (14)
The insurance coverage shall terminate upon the beneficiary’s death, expiration or cancellation of the policy or his final exit from the Kingdom.

Chapter 4- Benefits (Benefits In-Kind and Indemnification)

Article (15)
The beneficiary shall be entitled to the benefits indicated in the policy as follows:
1. Diagnosis and treatment by the approved health care providers, provided that the beneficiary pays the deductible specified in the policy, if any.
2. Expenses of necessary and emergency medical treatment paid directly by the beneficiary, provided that the insurance company fails to provide such services urgently to the beneficiary or unjustifiably refuses to provide the service. The person bearing the expenses shall indemnified in accordance with the limits provided for in the policy and within the limits paid by the company for a health care provider of a similar standard.
**Article (16)**
The right to claim benefits shall commence from the beginning of the insurance coverage, in accordance with the provisions of Article (13) of these Regulations.

**Article (17)**
There shall be no undue delay in availing the benefits at the commencement of the insurance coverage. The provision of benefits upon commencement of the insurance policy shall include cases originating prior to the commencement of the insurance coverage.

**Article (18)**
The right to receive benefits shall cease with the end of the insurance coverage in accordance with the provisions of Article (14) of these Regulations. This includes insurance cases which have not been decided, where the deciding factor on the insurance company's obligation shall be the date of the beneficiary's receiving health care from the health care provider.

**Article (19)**
Insurance benefits shall cover basic inoculations and vaccinations for children up to school age in accordance with the decisions of the Ministry of Health, as well as illnesses requiring hospital isolation which have to be provided by a contracted health care provider.

**Article (20)**
Health care and medical treatment shall be provided by a network of approved health care providers specified on the list attached to the insurance policy which is delivered to the beneficiaries and approved by the insurance company and policyholder.

**Article (21)**
Insurance coverage shall include cost of hospital stay and meals for one person accompanying the beneficiary, 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 (22)**
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 licensed ambulances or by ambulances of the Saudi Red Crescent Society.
Article (23)
Each beneficiary, upon receiving health care service shall pay the deductible amount, if any, to the health care provider in accordance with the policy's schedule, except for emergency cases and hospitalization.

Article (24)
If the contract provides for contribution to the payment and deduction, the health care provider may not waive the contribution.

Article (25)
The deductible shall be paid by the beneficiary to the health care provider against a receipt.

Article (26)
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 Cooperative Health Insurance Law.

Article (27)
Health care services may not be claimed in case of an illness if such services are provided due to a workplace accident, or to the occurrence of occupational illnesses that fall within the definition stated in the Social Insurance Law.

Article (28)
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), then said company may apply to GOSI for indemnification.

Article (29)
If GOSI provides health care 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.

Article (30)
GOSI and the insurance company may conclude a joint contract which provides for taking specific procedures to provide the services stated in Articles (28) and (29) of these Regulations.
**Article (31)**
The insurance company shall have the right to subrogation against a third party causing the damage for which it compensated the beneficiary.

**Chapter 5- Controls of Financial Liabilities**

**Article (32)**
(a) An insurance company shall comply with the decisions of SAMA, with regard to technical allocations commonly recognized by the insurance industry.
(b) SAMA shall brief the Council in writing of any remarks concerning the performance of the health insurance companies or health insurance claims management companies accredited by the Council.

**Article (33)**
(a) The health insurance premium shall be determined by agreement between the insurance company and the employer.
(b) The insurance company, when determining insurance premiums, shall observe the following:
   - Prices must be fair and not exorbitant.
   - Prices must be in accordance with subscription rules, causing no increase or decrease in prices of products of the insurance company beyond technically acceptable standard.
   - SAMA shall be furnished with the basis used in determining prices. The insurance company may not rely only on prices applied by other companies.
(c) The maximum benefit for each beneficiary shall be two hundred and fifty thousand Saudi Riyals.

**Article (34)**
An employer shall undertake to pay the premiums for his contracted employees and their dependents to the relevant insurance company. This provision shall also apply to non-working persons and their dependents. The employer shall be solely liable for premiums payable at the beginning of each insurance year unless agreed otherwise.

**Article (35)**
If premiums are not paid on the time agreed upon, the insurance company may cancel the policy. The insurance company shall notify the General Secretariat and the approved health care providers’ network of such an action.
**Article (36)**
Charges collected by the Cooperative Health Insurance Council for overseeing the application of the Cooperative Health Insurance Law shall be 1% of the total health insurance premiums collected by the accredited insurance companies in accordance with the audited financial statements of the previous year, provided that this percentage be reviewed in coordination with SAMA three years after the application to determine its suitability and the possibility of reducing it.

**Article (37)**
A Cooperative Health Insurance Fund shall be established to cover all expenses exceeding the insurance coverage specified under the insurance policy. Affiliation of said fund as well as its procedures and controls of its activities including its financing and determining beneficiaries thereof shall be determined in coordinated between the Council and SAMA.

**Article (38)** The Council shall be funded from the following sources:

1) Charges for accreditation and annual renewal of insurance companies.
2) Charges for accreditation and annual renewal of Health Insurance Claims Management Companies.
3) Charges for annual approval of government and non-government health care providers.
4) Charges collected by the Cooperative Health Insurance Council for overseeing the application of the Cooperative Health Insurance Law equivalent to 1% of the premiums collected by the accredited insurance companies in accordance with audited financial statements of the previous year.
5) Other fines due to the Council and those imposed by the Committee of Violations of Health Insurance Law specified in Article 101 of these Regulations..
6) Donations, grants and investment revenues.
7) Revenues collected from other sources such as magazines, booklets, training and consultations provided by the Council.

**Chapter 6 - Health Insurance Practice**

**First – Insurance Companies**

**Article (39)**
Health insurance shall be practiced by cooperative insurance companies authorized to operate in KSA in accordance with the Cooperative Health Insurance Companies Control Law and its Implementing Regulations.
Article (40)
Insurance companies may not practice health insurance unless accredited by the Council. Accreditation shall be limited to a period of three years renewable for similar periods.

Article (41)
Cooperative insurance companies licensed to practice insurance in the Kingdom shall be accredited to practice health insurance through an application submitted for the purpose. The Council may specify the details it deems necessary regarding the nature and scope of particulars required to be included in the applications. The Council shall decide on the accreditation application within ninety days from the date of submission.

Article (42)
The Council may select from among applying companies those possessing the following:
1. License to practice insurance.
2. Technical, administrative and medical staff as well as procedures for approvals, handling and settlement of claims. Such tasks may be outsourced to a claims management company accredited by the Council.

Article (43)
An insurance company shall include the following documents in its accreditation application:
1. Company’s name and address.
2. Articles of incorporation or memorandum of association.
3. Names of the chairman, members of the board of directors, managing director and the executive management.
4. Annual statements audited by a certified accountant for the three years preceding the submission of application (for existing companies).
5. Written statement from SAMA verifying absence of any reservations on the performance of the insurance company (existing companies).

Article (44)
The health insurance company shall inform the Council in advance of any substantial amendment to the company’s action plan regarding health insurance.

Article (45)
Accreditation of an insurance company may be denied pursuant to a letter stating 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 preserve the beneficiaries’ interests, or to continually fulfill its obligations.

3. If the company fails to pay the accreditation or renewal fees specified in Article (46) of these Regulations.

**Article (46)**

a. The Council shall charge a fee of SR150,000 for accreditation of insurance companies.

b. The Council shall charge an annual fee of SR 50,000 for renewal of the accreditation of cooperative health insurance companies. After the elapse of the first three-year period, reaccreditation is required.

**Article (47)**

The insurance policy shall be deemed effective from the date of payment of the insurance premium unless stated otherwise in writing.

**Article (48)**

The insurance company shall be directly liable before the employer for any obligations or fines incurred due to the insurance company's non-compliance with provisions of Articles 47 and 50 of these Regulations.

**Article (49)**

The insurance company may not submit the names of the insured to the National Health Insurance Network prior to ensuring payment of the insurance premium referred to in the policy.

**Article (50)**

The insurance company shall submit the names of the insured to the National Health Insurance Network within forty eight hours from the effectiveness date of the policy and upon fulfilling the requirements provided for in Article 49 of these Regulations.

**Article (51)**

The insurance coverage for the beneficiaries is not conditional on the issuance of cards to them. The insurance company shall be liable for all medical claims from the effectiveness date of the health insurance policy. The insurance company shall issue insurance cards within five business days from the effectiveness date of the policy at the latest.
Second – Health care Providers

Article (52)
The Council shall approve government/non-government health care providers according to the following conditions:

1) The health care facility in the private sector is licensed by the Ministry of Health.
2) Medical staff are registered with the Saudi Commission for Health Specialties.
3) The government/non-government health care facility meets quality standards in accordance with resolutions and instructions issued by the Central Council for Approval of Health Facilities.

Article (53)
Health care providers shall be approved pursuant to a written notice issued by the Secretariat of the Council. The annual fee shall be paid according to the schedule approved by the General Secretariat specified in the Annex attached to these Regulations.

Article (54)
The Council shall determine the fee for each case in accordance with Article (53) as well as the fee for other health care providers, such as diagnostic centers, pharmacies and laboratories.

Article (55)
The Council may withdraw the approval of a health care provider in any of the following cases:

1) Revocation or withdrawal of the license by the MOH.
2) Inability of the health care provider to provide proper health care.
3) Fraud or misuse by the health care providers.
4) Noncompliance with quality standards provided for in Chapter Nine of these Regulations.
5) Failure to pay approval/renewal fees.
   In such case, the Council shall notify the insurance company of the same.

Article (56)
If the approval expires and re-approval is requested by the health care provider after the lapse of one or more years, the Council may require payment for the past period regardless of its duration, unless the health care provider officially establishes, through a certified accountant, that it has no relation with health insurance companies nor income therefrom within the said period, provided that the General Secretariat verifies the same in the manner it deems fit. The General Secretariat may reject any report whose integrity is in question.
Chapter 7- Overseeing Insurance Parties: Objectives and Scope

Article (57)
The Health Insurance Council shall oversee the comprehensiveness of the health insurance coverage and ensure that the health insurance parties are fulfilling their duties in accordance with these Regulations.

Article (58)
The Council may request SAMA, insurance companies and other concerned parties to provide information and data on all matters related to health insurance. The Council may, in individual cases, especially with regard to general provisions of health insurance, request forms and other printed matters used by health insurance companies in their correspondence with employers, beneficiaries and health care providers, as well as contracts concluded with the health insurance claims management company.

Article (59)
The Council or designee may, at regular intervals or at any time, verify procedures and controls for provision of insurance coverage by all insurance companies in the health field within the powers of the Council.

Article (60)
The Council may express reservations towards officials and executive managers of insurance companies within the powers of the Council, in coordination with SAMA and agencies concerned with violations.

Article (61)
The Council may withdraw the accreditation of a health insurance company that violates any of the accreditation requirements. The company shall fulfill its standing obligations. The same shall apply if the insurance company discontinues its business activities, without its accreditation being withdrawn.

Article (62)
The Council may also withdraw the accreditation of a health insurance company if it fails to utilize its accreditation within twelve months, or expressly relinquishes the accreditation or discontinues its business activities for a period of six months without justification acceptable to the Council.

Article (63)
With exception to cases referred to in Articles (61) and (62), coordination shall be made with the authorities concerned with regard to withdrawal of accreditation.
Article (64)
The General Secretariat may rescind the approval of a health care facility in case of noncompliance with controls of accreditation or renewal, or if fraud or misuse is established.

Article (65)
The Council shall make available basic statistical information and data regarding health insurance companies. It may also provide for a charge additional statistical information and data regarding cooperative health insurance.

Chapter 8 - Relations among Insurance Parties

Article (66)
The Council shall determine the requirements for designing the health insurance card and its content by joint agreement with insurance companies and health care providers.

Article (67)
Insurance companies, health insurance claims management companies, government and nongovernment health care providers and self-employed persons in the field of cooperative health insurance shall observe the following:

1. Provide health care in accordance with generally accepted professional and ethical standards conforming to recognized and accepted modern medical practices, taking into consideration medical advances. Health care 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 (68)
Insurance parties, i.e. policyholders, health insurance companies, health care providers and health insurance claims management companies shall, each in their own capacity, observe recognized professional standards in carrying out the following:

1. Payment of premiums on time by policyholders to insurance companies.

2. Prompt approvals by insurance companies to health care providers to provide treatment to beneficiaries, and prompt settlement of health care providers’ claims.

3. Prompt and smooth provision of treatment services by health care providers to beneficiaries, and prompt submission of claims to insurance companies by health care providers for settlement of dues.
4. Follow-up and settlement of medical claim by insurance claims management companies accredited by the Council in accordance with applicable rules adopted by the Council for this purpose.

Article (69)
Insurance companies and health insurance claims management companies may not own or operate facilities for purposes of providing health care to the insured, nor can private health facilities own health insurance companies.

Article (70)
Contractual parties to the insurance policy are the policyholder (employer) and the insurance company.

Article (71)
An 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 required documents and grant the Council’s representatives access to such documents at the employer’s place of business.

Article (72)
Employers shall explain the policy and coverage limits to beneficiaries.

Article (73)
Without prejudice to laws and directives, an employer shall impose penalties against a beneficiary proven to have committed fraud or misused the service.

Article (74)
A health care provider shall be liable for any fraud, misuse or forgery committed by any of its employees or staff when providing the service.

Article (75)
An employer shall return the insurance cards to the insurance company upon termination of a beneficiary’s employment or expiry of the insurance policy. The employer shall be liable for any expenses arising from non-compliance with this provision.

Article (76)
In fulfilling its obligations to provide benefits, an insurance company shall conclude health care service contracts with service providers accredited by the Council.
Article (77)
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 health care providers with no health care service contracts concluded with the insurance company. In case the insurance company disapproves of the continuation of treatment at that particular facility, the patient, upon stabilization of his health, shall be transferred to one of the health care providers network facilities.

Article (78)
Parties to the insurance may use the model health care service contract approved by the Council which regulates the relationship between the parties concerned, provided that the contract includes the following at a minimum.
   1. Mutual rights and obligations and penalties for breach.
   2. Compliance of health care providers with the quality standard in accordance with the conditions and procedures provided for in Articles (98) and (99) of these Regulations.
   3. Compliance of health care providers with the cost-effective requirements in accordance with the provisions of Article (67) of these Regulations, and with the provision of treatment and prescriptions offered accordingly.
   4. Fees, settlement procedures and settlement of amounts due for the prescriptions dispensed.
   5. Preconditions and deadlines for notices.

Article (79)
A health care provider shall verify the beneficiary’s identity. If it provides treatment to a non-beneficiary, it shall bear the expenses incurred.

Article (80)
A health care provider shall claim its dues for providing treatment to beneficiaries as agreed upon with the insurance company within a period not exceeding (90) days.

Article (81)
Parties to the insurance contract shall comply with the Council’s Coding System (NDC/ AR-DRG/ICD-10 AM) in describing cases, treatment, cost and claims of dues and compliance therewith in accordance with the timing specified by the Council.

Article (82)
A service provider may terminate the health service contract with the insurance company, taking into consideration the termination conditions in case of default in payment of dues or if the refusal exceeds the allowable limit agreed upon by the two parties. In this case, the insurance company shall notify the employers accordingly.

Article (83)
An insurance company shall, upon commencement of the insurance coverage, provide the policyholder with insurance cards for beneficiaries and explanatory booklets including the policy, coverage and exclusions as well as the accredited health care providers’ network. The employer shall officially hand over the same to the beneficiaries upon commencement of the insurance coverage. The insurance company shall notify the accredited health care providers’ network of the enrollment of the policyholder to the insurance coverage as well as any additional coverage, if any.

Article (84)
The insurance company and policyholder shall take into consideration the interest of beneficiaries when providing a network of health care providers that suits the needs of beneficiaries and their work places so that they are not compelled to seek health care from a health care provider outside the network.

Article (85)
A health care provider shall, as soon as possible, apply to the insurance company for approval of the medical procedure, if necessary.

Article (86)
Except for emergency cases an insurance company shall respond to a “request for approval to bear treatment expenses” within sixty minutes.

Article (87)
Insurance companies shall individually or collectively hire physicians (specialists or above) licensed by the Saudi Commission for Health Specialties to ensure compliance with treatment requirements within the cost-effectiveness provided for in Article (67) of these Regulations when treating a beneficiary. Priority shall be given to Saudis.

Article (88)
Physicians hired to work for insurance companies shall be professionally independent. In carrying out their monitoring tasks, physicians shall base their
opinions solely on medical considerations. They may not treat beneficiaries or interfere with medical treatment.

**Article (89)**
Health care providers or the insured shall provide physicians working for insurance companies with all required information, and make available all documents necessary for monitoring in accordance with Article (87) of these Regulations. Physicians may access hospital wards, offices of medical supervision and medical records of any licensed hospital where a beneficiary was or is being treated when necessary for monitoring, in coordination with the parties concerned.

**Article (90)**
All physicians working for insurance companies shall be subject to the Law of the Saudi Commission for Health Specialties.

**Article (91)**
The insurance company shall pay health care providers’ dues within a period not exceeding sixty days from the date of the claim.

**Article (92)**
In case of inadequate service on the part of the health care provider, the insurance company may, in coordination with policyholder, revoke the health service contract with the health care provider, taking into account the specified grace period as well as the revocation terms provided for in the contract.

**Article (93)**
The insurance company may request the beneficiary or health care provider to provide details regarding emergency cases and obligations arising therefrom.

**Article (94)**
The beneficiary shall, upon the company's request, agree to be re-examined by a duly licensed physician designated by the insurance company. In such case, the company shall bear the expenses of the re-examination.

**Article (95)**
When seeking treatment, a beneficiary shall present his insurance card and proof of identity to the health care provider who shall return the same to him after recording the data necessary for treatment.
Article (96)
   a. The beneficiary shall visit any approved primary care facility or physician. Referral to a specialist or consultant shall be authorized by the general practitioner.
   b. If the beneficiary needs to be followed up by a specialist or consultant for the same illness for which he was previously referred, he may do so without further referral from the general practitioner.
   c. The beneficiary shall incur the difference in the examination fees if he directly visits the specialist or consultant as provided for in the policy.

Article (97)
Recommendation for hospitalization shall be limited to cases where treatment offered by outpatient clinics is not sufficient. Same-day surgery or treatment, where appropriate, shall be utilized. If a beneficiary visits a hospital other than that specified in the referral documents, he shall bear the difference in the cost of treatment.

Chapter 9 – Ensuring Quality of Services

Article (98)
The Council may ensure compliance with standards and conditions to be met by health care providers in accordance with standards of the Central Board for Approval of Health Facilities.

Article (99)
The Council’s measures for maintaining quality shall cover the following, at a minimum:
   1. Standards of examination rooms of approved health care providers.
   2. Regular inspection of approved hospitals, clinics and polyclinics on location, without prior notice by the Council or qualified designee from outside the Council.
   3. Evaluation of health care contracts in respect to their commitment to quality assurance.

Article (100)
Health care providers approved by the Council shall submit to the Council a report every three years indicating their level of compliance with quality assurance in accordance with the standards set forth by the Council of Health Services in the Kingdom of Saudi Arabia. In case of non-compliance with such condition, the Council may revoke the approval.
Chapter 10 – Dispute Resolution and Penalties

Article (101)
A committee or more, named the “Committee for Violations of the Cooperative Health Insurance Law” shall be formed, pursuant to a decision by the Chairman of the Council as per Article 14 of the Law, to review violations of the provisions of the Law and decide on the appropriate penalty. Said penalty shall be imposed pursuant to a decision by the Chairman of the Council. An appeal may be filed against such decision before the Board of Grievances within sixty days from the date of notification.

Article (102)
The party concerned shall file a written complaint with the General Secretariat of the Council 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 this period.

Article (103)
The Council’s General Secretariat shall refer the complaint to the committee reviewing violations of the provisions of this Law, in accordance with its jurisdiction.

Article (104)
The Council shall draft regulations for procedures of the committee reviewing violations of the provisions of this Law.

Article (105)
Fines collected for violations of the provisions of the Law as well as fines specified in Articles (101) and (106) shall be deposited with the Council, in accordance with financial regulations.

Article (106)
If it becomes evident to the Committee that the complaint is invalid and not based on reasonable grounds, it may take the necessary legal measures or propose an appropriate penalty against the complainant.

Article (107)
Insurance companies shall set up a unit for reviewing and handling complaints of beneficiaries. If this is not possible, they shall be submitted to the Insurance Dispute and Violation Resolution Committee.4

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4 As per Ministerial Resolution # 222 dated 25/07/1429 H
Chapter 11 - General Provisions

Article (108)
Council members or employees of the General Secretariat may not disclose confidential information obtained in the course of their employment during or after membership or employment. This provision shall apply to any other person obtaining such information from official reports.

Article (109)
The Council may use the information referred to in Article 108 above for the following purposes alone:

1) Examination of application submitted by the insurance company for accreditation and renewal thereof.
2) Instructions issued by the Council.
3) Pursuing violations of the insurance policy as per Article 14 of the Law.
4) In the context of reviewing complaints filed regarding a decision of an insurance company.
5) In the context of reviewing and deciding on violations as per Article 14 of the Law.

Article (110)
These Regulation shall apply to employers as per the Council's resolutions, instructions and executive plans in this regard.

Article (111)
All insurance companies shall, at a minimum, comply with the insurance policy approved by the Cooperative Health Insurance Council.

Article (112)
The Council shall review and make amendments to these Regulations every three years or when necessary. A decision to this effect shall be issued by the Chairman of the Council.

Article (113)
These amended Regulations shall be issued pursuant to a decision by the Chairman of the Council and shall take force 30 days after its date of publication in the Official Gazette.
Chapter 12 – Annexes

Article (114)
This Annex comprises the following documents referred to in some articles of these Regulations:

1. Council of Ministers’ Resolution No. 206 dated 15/08/1423 H for the implementation of the Cooperative Health Insurance Law on Saudis working in the private sector and their dependents.
2. Council of Ministers’ Resolution No. 222 dated 25/07/1429 H for approval of re-formation of Insurance Dispute Resolution Committee.
3. Criteria of eligibility for getting medical services.
4. Model health care service contract.
5. Annual fee for approval of health care providers by the Council.