Cooperative Health Insurance Policy
(Amended)

As Approved on Session No. (73) dated 08/05/1430H and Sanctioned by
Ministerial Decision No. DH/1/30/6131 dated 08/06/1430H
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Section 1 – Definitions

For purposes of this insurance, the following terms, phrases and expressions, wherever mentioned in the policy or its endorsement or attachments, shall be construed as follows:

1) **Accident**: a sudden injury or a sudden and unforeseen event occurring during the period of insurance.

2) **Disease**: a sickness or illness that occurs to the beneficiary and necessitates medical treatment by a licensed physician during the period of insurance.

3) **Allergy**: the sensitivity a particular person has to certain kinds of food, weather or pollen, or acquires from plants, insects, animals, minerals, elements or other materials causing such person to develop bodily reactions from direct or indirect contact with such materials resulting in conditions like asthma, indigestion, itching, hay fever, eczema or headache.

4) **Beneficiary (Insured person)**: the person (employee or dependent) included under the scheme and listed in the list of beneficiaries attached to this policy.

5) **Benefit**: the costs of providing health services included in the insurance cover within the limits shown in the policy schedule.

6) **Premium (contribution)**: the amount due by the policyholder in consideration of the insurance coverage granted under the policy during the period of insurance.

7) **Congenital Deformity**: the functional, chemical or bodily defect usually existing before birth whether hereditary or resulting from environmental factors.
8) **Insurance Coverage**: the basic health benefits granted to the beneficiary as described in the insurance policy attached to this schedule.

9) **Coinsurance / Deductible (co-payment)**: the part (as determined in the policy schedule) that the beneficiary has to pay for health care received in outpatient clinics.

10) **Employee**: any person actually working for the policyholder and registered as such in his records.

11) **Dependent**:
    a. Husband / wives registered as such in the records of the policyholder and residing legally in the Kingdom of Saudi Arabia.
    b. The employee’s children and/or the children of a spouse and/or children officially sponsored that are residing in the Kingdom of Saudi Arabia, depending upon the employee or their subsistence and registered as such in the records of the policyholder.

12) **Claim Supporting Documents**: all documents proving and establishing the beneficiary’s age, nationality, identity and the validity of the insurance coverage, circumstances of the event giving rise to claim and payment of costs as well as other documents such as police report, invoices, receipts, prescriptions, physician's report, referrals and recommendations and any other original documents that may be required by the Company.
13) **Direct Billing or Company Billing**: the facility of non payment granted to the beneficiary at one or more medical facilities appointed by the Company whereby all such costs are directly billed to the Company.

14) **Inception Date**: the date shown in the policy schedule on which insurance coverage commences.

15) **Effective Date**: the date chosen by the policyholder and approved by the Company to start covering a beneficiary under this policy or to add a beneficiary or delete him from the policy.

16) **Endorsement**: a document issued by the Company on its official forms dated and signed by an authorized employee to establish the validity of any amendment to the policy that does not change the original coverage as requested in writing by the policyholder.

17) **Hospital**: a qualified medical facility approved by the Council and acceptable to the policyholder and the Company and licensed under applicable law to operate as a hospital and to provide treatment for which compensation may be claimed under this policy. The term “hospital” as used in this policy does not include hotels, pensions, guest houses, rest houses, sanatoriums, convalescence homes, quarantine, retirement or nursing homes, mental asylums or any place usually used to shelter and treat drug or alcohol addicts.

18) **Hospitalization**: registering a beneficiary as an in-patient staying overnight in a hospital following a referral from a licensed physician.
19) **Insurance**: proof of validity of the insurance coverage as witnessed by this policy, its schedule, endorsements or attachments.

20) **Licensed Physician**: A medical practitioner having received his qualification and officially licensed to practice medicine and accepted by the policyholder and the Company to provide treatment for which compensation might be claimed under this policy.

21) **Limit of Coverage**: the maximum limit of the Company’s liability as shown in the policy schedule in respect to any beneficiary and before applying the coinsurance/deductible.

22) **Service Provider**: the government/non-government medical facility approved and licensed under applicable law to provide medical services in the Kingdom, such as hospital, diagnostic center, clinic, pharmacy, laboratory, physiotherapy or radiotherapy center.

23) **Pregnancy and Delivery**: Any pregnancy and/or delivery, including natural delivery, caesarean and abortion.

24) **Surgery or Same-Day Treatment**: Surgery or treatment requiring preparation for admission to a hospital or treatment center without necessitating an overnight stay.

25) **Treatment in Outpatient Clinics**: the beneficiary's visit(s) to out-patient clinics for diagnosis or treatment of a disease.
26) **Company**: a cooperative insurance company licensed by SAMA to operate in the Kingdom of Saudi Arabia, and qualified by the Council to practice cooperative health insurance.

27) **Approved Service Providers' Network**: a group of health care providers approved by the Cooperative Health Insurance Council and selected by the insurance company to provide health care to the employer / policyholder and bill the insurance company directly whenever a beneficiary presents his valid insurance card, provided that such network include the three levels of health care:

   - Level 1: Primary health care.
   - Level 2: General hospitals.
   - Level 3: Specialized or referral hospitals.

28) **Grace Period**: the number of days during which the policy remains valid in case of non-payment of the total contribution shown in the schedule.

29) **Period of Insurance**: The period shown in the policy schedule during which insurance remains in force.

30) **Policyholder**: the natural or corporate person in whose name the policy is issued.

31) **Reasonable and Customary Medical Expenses**:

   a. The medical expenses compatible with level of fees charged by the majority of licensed physicians or hospitals in the Kingdom, provided such fees are for the treatment of a similar condition by physicians and hospitals of similar qualifications and standing to those which provided the treatment.
b. The medical treatment that does not differ significantly from what a licensed physician considers acceptable as being usual and customary for any particular disease for which compensation for the costs of its treatment is recoverable under this policy.

32) **Basis of Compensation**: the procedure followed to compensate the policyholder for recoverable expenses paid by the beneficiary and claimed by him, after satisfying the coinsurance/deductible.

33) **Costs of Corpse Repatriation**: all costs of preparation and repatriation of corpse to the home country set forth in the labor contract.

34) **Personal Risks**: Any activities known to involve high risk of exposing a person to an illness or an accident, or is expected to aggravate a previous illness or injury.

35) **Fraud**: Intentional misleading by a person or an entity with the intent to exploit health care and distort facts or the intentional deceit leading to obtaining benefits or offering of privileges that are excluded or exceeding the allowable limits for a person or entity.

36) **Misuse**: Unintentional practices by individuals or entities that may lead to obtaining benefits or privileges they are not entitled to, but without the intention of fraud, misrepresentation or distortion of facts in order to obtain the benefit.

37) **Violent External Means**: Any means resulting in accident or injury to the insured.

38) **Acute Psychological Disorders**: Mental or psychological disorders, such as mood disorder, cognitive disorder, memory disorder or any other mental disorder,
wholly or partially. Such disorder is deemed acute if it causes malfunction in any
two of the following functions:

1. Sound Judgment (Sound reasoning in terms of decision making).
2. Human behavior.
4. Coping with ordinary life responsibilities.

The Cooperative Healthcare Insurance Policy shall cover diagnosis and
treatment of the above disorders during a period extending from one day to
less than three months.

39) Rehabilitation (Physiotherapy): a complementary part of comprehensive health
care service and its applications for rehabilitating a person. The Cooperative
Healthcare Insurance Policy covers diagnostic and treatment procedures and tests
pertaining to rehabilitation cases during the validity of the policy.

40) Detailed Annex to the Policy: An annex is attached to this Policy containing
instructions and procedures relevant to the application of this Policy.

**Section 2 – Recoverable Expenses / Benefits**

For purposes of this policy, recoverable expenses shall mean the actual costs incurred for
services, supplies and equipment, not excluded in Section 3, prescribed by a licensed
physician prescribes for an illness occurring to the beneficiary, provided such expenses
are necessary, reasonable and customary in the time and place of their occurrence.

Accordingly, recoverable expenses shall include:
1. Health benefits
   a. All costs relating to medical consultation, diagnosis, treatment and medicines as shown in the policy schedule.
   b. All costs relating to hospitalization including surgeries, same-day surgeries or treatment as well as obstetrics and delivery.
   c. Treatment of dental and gum diseases.
   d. Preventive measures such as vaccinations including seasonal vaccinations and maternity and child care in accordance with instructions issued by the Ministry of Health (provided for in the Annex attached to this Policy).
   e. Acute psychological disorders within the limits specified in the policy schedule.
   f. Cases of contagious diseases requiring isolation in hospitals as specified by the Ministry of Health.

2. Costs of preparation and repatriation of the corpse of a beneficiary to the home country specified in the labor contract.

Section 3 – Limitations and Exclusions

a. This policy shall not cover claims arising from:

1. Intentional self-inflicted injury.

2. Sicknesses resulting from abuse of some medicines, stimulants or tranquilizers, or from use of alcohol, narcotics and the like.
3. Cosmetic treatment or surgery unless necessitated by a bodily injury not excluded in this section.

4. General checkups, inoculations, drugs or preventive measures not required for medical treatment covered under this policy (excluding preventive measures determined by the Ministry of Health, such as vaccination, maternity and child care).

5. Pregnancy and delivery treatment of a woman identified in her contract as unmarried.

6. Treatment received by a beneficiary free of charge.

7. Rest cures, general health cures and treatment in social welfare institutions.

8. Any illness or injury resulting directly from the beneficiary's profession.

9. Medically recognized venereal or sexually transmitted diseases.

10. Costs of treatment following diagnosis of HIV or any disease related to HIV, including AIDS and its derivatives, alternatives or other forms.

11. All costs related to tooth implant, dentures, fixed or movable bridges or orthodontic treatment, unless resulting from violent external means.

12. Vision or hearing correction tests and visual or hearing aids, unless requested by a licensed physician.

13. The beneficiary's transportation expenses within and between cities in the Kingdom by other than ambulances of the Saudi Red Crescent or licensed ambulances.

14. Hair loss, baldness or artificial hair.
15. Psychological, mental or nervous disorders, unless of an acute nature as specified in the policy schedule.

16. Allergy tests of any nature, unless relating to medicines, diagnosis or treatment.

17. Equipment, means, drugs and procedures, or hormone treatment aimed at regulating reproduction, contraception, fertility, infertility, impotence, secondary sterility, in-vitro fertilization or any other method of artificial fertilization.

18. Any congenital weakness or deformity unless it is life threatening, except for cases requiring treatment in accordance with a medical report issued by the health facility approved by the Council.

19. Any costs or additional expenses incurred by the beneficiary's companion during a hospital stay, except for hospital room and board charges for one companion such as a mother accompanying her child aged up to twelve years or whenever medically necessary as assessed by the attending physician.

20. Treatment of acne or any treatment relating to obesity or overweight.

21. Organ or marrow transplant, or implant of artificial organs to replace any organ of the body.

22. Personal risks set forth in Section – 1 (Definitions) of this Policy.

23. Alternative medicine procedures and medications.

24. Artificial and ancillary limbs except those required by the beneficiary as per a medical decision issued by the health care facility approved by the Council.

25. Natural changes related to menopause, including menstrual disorders.
b. This policy shall not cover medical benefits or corpse repatriation to home country in claims resulting directly from:

1) War, invasion, acts of foreign enemy, acts of aggression (whether or not war is declared) or civil war.

2) Ionizing radiations, pollution from radioactive activity of any nuclear fuel or waist resulting from the combustion of nuclear fuel.

3) Radioactive, toxic, explosive or other hazardous properties of any nuclear plant or any of its nuclear components.

4) Beneficiary’s service or participation in armed forces or police activities.

5) Riots, strike, terrorism or the like.

Section 4 - General Conditions

1. Proof of Validity

This policy represents the basic level of insurance cover granted to beneficiaries and shall not be valid unless confirmed by a schedule duly signed by an employee officially authorized by the Company. Likewise, any addition to this policy shall not be valid unless confirmed an endorsement duly signed by an employee officially authorized by the Company.

2. Records and Reports

The policyholder must maintain a record of all of its employees and their dependents covered under this policy comprising for each person his full name, sex, age, nationality, classification and other basic information that might affect the
administration of this insurance and the determination of its premium rates. The Company shall given the right and opportunity, whenever it so requires, to examine those records and verify the accuracy of the information provided by the policyholder. The Company undertakes, whenever requested, to supply the policyholder with any information concerning the beneficiaries that he might wish to examine.

3. **Eligibility**

   a. *For employees:* any person satisfying the definition of "employee" shall be qualified for insurance in accordance with the policy schedule.

   b. *For dependents:* any person satisfying the definition of "dependent" shall be eligible for insurance in accordance with the policy schedule provided that such person is a dependent of an eligible employee. If a person defined as "dependent" is also eligible for insurance as an employee, his benefits as "dependent" shall be discontinued according to this policy. If both the wife and husband are living permanently together and are insured as employees, their children shall only be eligible for insurance as dependents of the husband.

4. **Payment of premiums**

   a. The policyholder shall pay the insurance premium due on each insured person upon commencement of the insurance coverage or as otherwise agreed upon with the Company.
b. In the event of non-payment of any portion of a premium, the policy will not be valid for a period longer than that covered by the portion paid, and the Company shall be compelled to notify the Cooperative Health Insurance Council accordingly.

5. **Effective Date of Coverage**

   a. *For employees:*

   Cover shall become effective for an employee actively at work from the inception date shown in the policy schedule. For any person joining work at a later date, the effective date of cover shall be the date he started work for the policyholder or the date of his arrival to the Kingdom.

   b. *For dependents:*

   Insurance cover shall become effective for dependents from the date the employee supporting them becomes insured or from the date they first become dependents.

6. **Addition and Deletion of Beneficiaries and Relating Premiums**

   a. The policyholder must immediately notify the Company in writing of all the employees or dependents to be covered by insurance after the inception date of the policy. The Company shall calculate the additional premium due for immediate payment for persons added to the list of insured persons on proportional basis from the date of their inclusion in the cover.
b. The policyholder must advise the Company in writing, within thirty days from the required termination date, of all beneficiaries (employees and/or dependents) whose insurance coverage expires before the end of the period of insurance. The Company shall not refund the proportionate part of the premium relating to such persons for the remaining period of insurance unless the policyholder provides the Company with proof of their leaving the Kingdom on final exit, or proof of their inclusion in another insurance program acceptable to the Cooperative Health Insurance Council, in case of transfer of sponsorship.

7. **Termination of Beneficiaries' Insurance Cover:**

   a. *For employees:* coverage under this policy shall be automatically terminated in the following cases:

      1. If the policy period ends as defined in the policy schedule.
      2. Upon exhaustion of the maximum limit of benefits provided for in the policy.

   b. *For dependents:* coverage under this policy shall be automatically terminated in the following cases:

      1. The dependent no longer qualifies as "dependent" as defined in Section – 1, Definitions, Paragraph 11 (b) of this Policy.
      2. If the policy period ends as specified in the schedule.
3. Upon exhaustion of the maximum limit of benefits provided for in the policy.

c. Payment of recoverable expenses in respect of any illness in progress that leads to continued hospitalization on the date of termination of coverage shall continue for as long as required for such illness, but not beyond 365 days from the date of onset of said illness that led hospitalization and within the limits of cover indicated in the policy schedule.

d. In case this policy is terminated for any reason, the policyholder must immediately return to the Company all health insurance cards issued, relating to direct billing of the company by assigned healthcare providers' network. This also applies to the termination of any beneficiary's cover. The policyholder shall be liable to reimburse the Company for all medical costs and expenses resulting from his failure to comply with this rule.

8. Verification of the Beneficiary's Condition

a. The Company has the right and should be given the opportunity, to have the beneficiary for whom a claim was submitted for recoverable expenses examined by a qualified medical facility at the expense of the Company for up to two times within sixty days following submission of the claim.

b. The policyholder or the beneficiary shall cooperate with the Company and allow all necessary measures that may reasonably be required by and paid for by the Company for the purpose of preserving its rights, recoveries or
legal compensations from third parties. He may not assign such rights except with the Company's explicit or implicit consent.

9. **Non-Duplication of Benefits**

In case of a claim for recoverable expenses due under this policy for a beneficiary also covered for the same expenses under another insurance, plan, program or the like, the Company shall then be responsible to pay such costs and become subrogated in the rights of the beneficiary to claim from others their proportionate share of such claim.

10. **Basis of Direct Billing of the Company by the Assigned Healthcare Providers' Network**

The Company shall issue for each beneficiary a medical insurance card allowing him to receive healthcare at the assigned healthcare providers' network without being asked to pay the costs of such services. The assigned service providers shall send to the Company on a monthly basis all invoices relating to medical expenses incurred in accordance with this policy. The Company will audit and process such expenses and advise the policyholder whenever expenses reach the maximum limit of benefit. In case such limit is exceeded, the Company shall have the right to claim the surplus costs from the policyholder within a period not exceeding (60) days from the date of his notification thereof.
In case the policyholder default in paying such costs to the Company within the specified period, the Company shall have the right to raise the issue to the Cooperative Health Insurance Council to take the necessary measures. The Company has the right to delete or replace any or all of the healthcare providers assigned for purposes of this policy, during its validity, provided it is coordinated with the policyholder, and replacements of the same level are appointed.

11. **Coinsurance / Deductible**

Without prejudice to the facility of direct billing of the Company, a compulsory and binding condition that the beneficiary pay the coinsurance / deductible, if any, at the healthcare center, and any attempt by the beneficiary withhold payment shall be considered breach of the terms and conditions of this policy whose validity shall be suspended in respect of such beneficiary until the deductible is paid.

12. **Reimbursement Basis**

In case of emergency, a beneficiary may obtain urgent medical treatment in centers other than those assigned by the Company on reimbursement basis. In such case, the Company shall compensate the policyholder, in accordance with the policy's terms, conditions, limitations and exclusions, for recoverable costs and expenses on the basis of prevailing prices, provided that it provides the
Company with the supporting documents it requires, within 30 days from incurring such costs.

13. **Cancellation**

The policyholder may cancel this policy at any time by serving a written notice to the Company at least 30 days prior to the date required for cancellation. In such case, the policyholder must provide the Company with proof of:

a. Purchase of another insurance policy from a qualified company, or inclusion of the beneficiary under another health coverage acceptable to the Council whereby the new coverage commences from the day following the cancellation of the former policy in cases of transfer of sponsorship.

b. The beneficiary's leaving the Kingdom on a final-exit visa.

In such case, the Company shall be liable to refund to the policyholder, within 60 days from the cancellation date, the remaining part of the premium for each insured person whose claims did not exceed 75% of the annual premium. The refundable amount shall be calculated on proportional basis:

\[
(Refund = \frac{\text{annual premium}}{365.25 \text{ days}} \times \text{number of the remaining days})
\]

In case the policyholder stops paying the costs exceeding the maximum limit of benefit within the period specified in Article (10) of the General Conditions of the policy and due as a result of the arrangement for direct billing of the Company, the Company shall have the right to withhold refund of premiums, if any, and use
such amounts to compensate for the expenses paid to the service providers which should have been paid to the Company by the policyholder.

14. **Approvals**

The Company's reply to approval requests from service providers to provide health service to beneficiaries shall be within a period not exceeding sixty minutes from the time of receipt of such request.

15. **Gender**

For purposes of this policy, words using the masculine gender are deemed to include the feminine gender.

16. **Notices**

a. Any notice or other correspondence to the Company as required by this policy shall be written or printed.

b. The Company is in no way obliged to notify the policyholder of the expiry date of this policy.

17. **Compliance with Policy Provisions**

As a condition preceding any liability of the company, the policyholder and beneficiaries should strictly comply with and execute all requirements, conditions, obligations and commitments stated in this policy.

18. **Settlement of Disputes**

Any disagreement or dispute arising out of or relating to this policy shall be settled by the Council and committees formed pursuant to a decision by its
chairman for review of violations of the provisions of the Law in accordance with Article (14) of the Cooperative Health Insurance Law.

The policyholder and the insurance company have read and agreed to the provisions of this policy and its schedule.

Date: .................................. Date: ..................................

........................................... ...........................................
Signature, Policyholder Signature, Insurance Company