

BALSAM Cooperative Health Insurance Policy



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In implementation of the cooperative health insurance BALSAM Cooperative Health Insurance Policy In implementation of the cooperative health insurance Policy approved by Ministerial Decision No. 8/14/1R and dated 12/05/1439 H. Whereas the policy holder has submitted to (name of insurance company) (referred to hereinafter as the «Company») a written application (which will be deemed a basis and an integral part of this policy) for the purposes of insuring the policy holder and his dependants or his employees and their dependants whose names are listed in the schedule attached to this policy and who are referred to hereinafter as the «insured», and has paid the premium or agreed to pay it.

Therefore, the company agrees based on the above - with the policy holder to cover the costs of providing health care to the insured under this. Policy, to the extent and in the manner shown therein, through a network of service providers appointed by the insurance. company provided always that such insurance shall subject to the conditions, definitions, designations and limits of coverage incorporated this policy any additional schedules (already approved by the cooperative health insurance council) or those that will be agreed upon later.

Section 1 – Definitions

The following terms, wherever mentioned in the policy, its annexes or endorsements, shall have the meanings assigned thereto:

1. **“Insurance”** : Proof of insurance coverage under the policy with its schedule, annexes or endorsements.
2. **“Insurance Term”** : The period stated in the policy schedule during which the insurance is valid.
3. **“Grace Period”** : The number of days during which the policy remains valid in case of non-payment of the total premium shown in the schedule.
4. **“Inception Date”** : The date stated in the policy schedule on which insurance coverage commences.
5. **“Effective Date”** : The date chosen by the policyholder and approved by the company to commence coverage of an insured individual under the policy or to add or remove an insured person from the policy.
6. **“Benefit”** : The costs of providing health services included in the insurance coverage within the limits specified in the policy schedule.

7. **"Insurance Coverage"** : The basic health benefits available to the beneficiary as specified in the policy
8. **"Coverage Limits"** : The maximum amount of the company's liability as specified in the policy schedule with respect to any insured person before applying the deductible.
9. **"Insurance Parties"** : Policyholders, health insurance companies, TPAs and health service providers.
10. **"Insurance Company"** : A cooperative insurance company licensed by SAMA to operate in the Kingdom and accredited by the Council to provide cooperative health insurance.
11. **"Policyholder"** : The natural or corporate person in whose name the policy is issued.
12. **"The Insured" (Beneficiary)** : The natural person (or persons) covered by the policy.
13. **"Worker"** : Every natural person employed, managed or supervised by an employer in return for consideration even if not directly supervised by the employer.
14. **"Dependent"** : Husband, wife, sons up to the age of twenty five and unmarried daughters.
15. **"Service Provider"** : A health facility (governmental / nongovernmental) licensed to provide health services in the Kingdom in accordance with relevant laws and rules and accredited by the Council, such as: hospitals, diagnostic centers, clinics, pharmacies, laboratories, and physiotherapy or radiotherapy centers.
16. **"Preferred Provider Network (PPN)"** : A group of healthcare service providers accredited by the Council and designated by the insurance company to provide healthcare to the insured and bill the insurance company directly whenever an insured individual presents a valid insurance card, provided that said network includes the following levels of healthcare services:
 - First Level (Primary healthcare).
 - Second Level (General hospitals).
 - Third Level (Specialized or referral hospitals).
 - Other supplementary healthcare centers (such as: same-day surgery centers, pharmacies, physiotherapy centers and optical stores).
17. **"Hospital"** : A health facility approved by the Council and acceptable to the policyholder and the company and licensed under applicable laws to operate as a hospital and to provide health services for which compensation may be claimed under the policy. The term "hospital" as used in the policy shall not include hotels, lodging houses, guest houses, rest houses, sanatoriums, convalescence homes, quarantine, nursing homes, mental institutions or any place used primarily to shelter and treat drug addicts or alcoholics.

18. **"Licensed Physician"** : A medical practitioner holding an appropriate qualification licensed to practice medicine by the Saudi Commission for Health Specialties and is accepted by the policyholder and the company to provide treatment for which compensation may be claimed under the policy.
19. **"Illness"** : A sickness or disease suffered by the insured which necessitates medical treatment by a licensed physician before and during the insurance term.
20. **"Accident"** : A sudden and unforeseen event occurring in the course of life during the insurance term.
21. **"Traffic Accident"** : Unintentional collision of a private or public mechanical or electric vehicle, whether a car or bus, with another vehicle, whether stationary or moving, or with a fixed object such as a building, barrier, post, tree or the like or with a pedestrian, on any road or street, leading to bodily injuries ranging from minor to serious injuries and may lead to physical disability, death or partial or total loss of property.
22. **"Violent External Means"** : Any means resulting in an accident or injury to the insured.
23. **"Personal Risks"**: Any activity known to involve the risk of exposing a person to an illness or an accident, or is expected to aggravate a prior illness or injury.
24. **"Emergency"** : The urgent medical treatment necessitated by the medical condition of the insured as a result of an accident or an urgent health condition requiring prompt medical intervention.
25. **"Outpatient Treatment"** : Visits by the insured to outpatient clinics for diagnosis or treatment.
26. **"Same-Day Surgery or Treatment"** : Surgery or treatment requiring pre-arrangement for admission to a same-day treatment center without necessitating an overnight stay.
27. **"Hospitalization"** : Registering an insured individual as an in-patient staying overnight in a hospital following a referral from a competent physician.
28. **"Allergy"** : The sensitivity of a person to certain types of food, medicine, weather or pollen or any allergens of plants, insects, animals, minerals or other elements or 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.
29. **"Congenital Deformity"** : The functional, chemical or metabolic defect usually existing before birth, whether hereditary or due to environmental factors as commonly known in the medical community.
30. **"Pregnancy and Delivery"** : Any pregnancy and/or delivery, including natural delivery, caesarean section and abortion.

31. **"Acute Psychological Disorders"** : Intellectual, mood, cognitive or memory or total or partial mental disorder. Such disorder is deemed acute if it causes malfunction in any two of the following functions:
 1. Sound Judgment (sound reasoning, not in terms of right or wrong but in terms of decision making)
 2. Human behavior.
 3. Sense of reality.
 4. Coping with ordinary responsibilities of life.Diagnosis and treatment of such cases shall be covered during the validity of the policy.
32. **"Disability Cases"** : A term covering all forms of organ malfunction/dysfunction, limited activity and restricted participation.
33. **"Rehabilitation" (Physiotherapy)** : A complementary part of comprehensive healthcare service and its applications for rehabilitating a person suffering from constant weakness to the highest level of performance in family and social life which, in turn, would enhance the healthcare system as measured by cost-benefit analysis. The policy covers diagnostic and treatment procedures and tests pertaining to rehabilitation cases during the validity of the policy.
34. **"Premium" (Subscription)** : The amount payable by the policyholder to the insurance company in return for the insurance coverage provided by the policy during the insurance term.
35. **"Deductible" (co-payment)** : The part paid by the insured upon receiving treatment services in outpatient clinics as provided for, if any, in the policy schedule, excluding emergencies and hospitalization cases.
36. **"Basis of Direct Billing or Company Billing"** : The nonpayment facility granted to the insured at one or more service providers designated by the company whereby all costs are directly billed to the company.
37. **"Basis for Compensation"** : The procedure followed to compensate the policyholder for recoverable expenses paid and claimed by the insured after applying the deductible.
38. **"Recoverable Expenses"** : Actual expenses incurred for services, supplies and equipment not excluded under section three of the policy, attached to this Regulation, provided they are prescribed by a licensed physician as a result of an illness suffered by the insured. Said expenses shall be necessary, reasonable and customary in the relevant time and place.
39. **"Claim"** : A request presented to the insurance company or representative thereof by a service provider, an insured person or a policyholder to recover the expenses of healthcare services covered by the policy. Claims shall be accompanied by supporting financial and medical documents.

40. **"Claim Supporting Documents"** : Documents proving the insured's age, nationality and identity, as well as the validity of the insurance coverage, circumstances of the event giving rise to a claim and payment of relevant costs, in addition to other documents such as police reports, invoices, receipts, prescriptions, physician reports, referrals and recommendations and any other documents that may be required by the company.
41. **"Reimbursement of Expenses Relating to Traffic Accidents"** : A medical claim resulting from a traffic accident to cover a person injured in said accident, whether such person was the cause of the accident or otherwise. If such claimed expenses are recoverable by the injured person (i.e. they are covered under any other insurance plan, scheme or the like), the insurance company that is first notified shall be liable to cover the injured person, provide him with medical treatment and reimburse such expenses, and shall subrogate the insured, injured person, in recourse to third parties to pay their proportionate share of said claim.
42. **"Reasonable and Customary Medical Expenses"** :
 - a. Medical expenses agreed upon by the insurance company and service provider which are in line with fees charged by the majority of licensed physicians or hospitals in the Kingdom and are common in the market.
 - b. The medical expenses which do not differ significantly from what a licensed physician considers acceptable as being usual and customary for a similar illness. Such medical expenses may be claimed under the policy.
43. **"Costs of Corpse Repatriation to Home Country"** : Costs of preparation and repatriation of a corpse to the home country set forth in the employment contract.
44. **"Fraud"** : Intentional deceit by an insurance party leading to obtaining benefits, funds or privileges which are excluded or exceed the limits for a person or entity.
45. **"Abuse"** : Practices by an insurance party that may lead to obtaining benefits or privileges they are not entitled to, but without the intent of deceit, fraud, misrepresentation or distortion of facts in order to obtain such benefit.
46. **"Misleading"** : Practices by persons or entities that do not fall within the definition of fraud.
47. **"Endorsement"** : A document issued by the company, upon a written request from the policyholder, on the company's official forms dated and signed by an authorized employee to establish the validity of any amendment to the policy in a manner that does not affect the basic coverage.
48. **"Policy Annex"** : An annex is attached to the policy containing instructions and procedures relevant to the application of the policy.

Section 2 – Recoverable Expenses / Benefits

For purposes of the policy, recoverable expenses shall mean actual expenses incurred for services, supplies and equipment which are not excluded under section three of the policy, provided they are prescribed by a licensed physician as a result of an illness suffered by the insured. Said expenses shall be necessary, reasonable and customary in the relevant time and place.

Recoverable expenses shall include:

1. Health benefits

- a. Expenses of medical examination, diagnosis, treatment and medicine as shown in the policy schedule.
- b. Expenses of hospitalization, including surgeries, same-day surgeries or treatment and pregnancy 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, as provided for in Annexes 1 and 2 attached to the 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.
- g. Alzheimer cases.
- h. Autism cases.
- i. Acquired valvular heart disease.
- j. National Newborn Screening Program (NBS) to prevent disabilities, including tests set forth in Annex 3 attached to the policy.
- k. Costs of organ harvesting procedures.
- l. Disability cases.

2. Costs of preparation and repatriation of the corpse of an insured individual to the home country specified in the employment contract.

Section 3 – Limitations and Exclusions

A. The policy shall not cover claims arising from :

1. Intentional self-inflicted injury.
2. Illness resulting from abuse of some medicines, stimulants or tranquilizers, or from substance abuse.
3. Cosmetic treatment or surgery unless necessitated by a bodily injury not excluded in this section.
4. General examinations, inoculations, drugs or preventive measures not required for medical treatment provided for in the policy (excluding preventive measures determined by the Ministry of Health, such as vaccination and maternity and child care.).
5. Treatment received by the insured free of charge.
6. Recreational therapy, general physical health programs and treatment in social welfare institutions.
7. Any illness or injury directly resulting from the insured's profession.
8. Medically recognized venereal or sexually transmitted diseases.
9. Costs of treatment following diagnosis of HIV or any disease related to HIV, including AIDS and its derivatives, alternatives or other forms.
10. Costs related to tooth implant, dentures, fixed or movable bridges or orthodontic treatment, unless resulting from an accident.
11. Vision or hearing correction tests and visual or hearing aids, unless ordered by the attending physician.
12. The expenses of the insured's transportation within and between cities of the Kingdom by other than licensed means of transportation.
13. Hair loss, baldness or artificial hair.
14. Psychological, mental or nervous disorders, other than acute cases as specified in the policy schedule.
15. Allergy tests of any nature, unless relating to prescribed medicine.

16. 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.
17. Any congenital weakness or deformity unless it is life threatening.
18. Any costs or additional expenses incurred by the insured's companion during hospitalization, except for hospital room and board charges for one companion, such as a mother accompanying a child up to the age of twelve or if medically necessary as assessed by the attending physician.
19. Treatment of acne or any treatment relating to obesity or overweight, excluding covered medicines.
20. Organ or marrow transplant, or implant of artificial organs to wholly or partially replace any organ of the body.
21. Personal risks set forth in Section One (Definitions) of the Policy.
22. Alternative medicine procedures and medications.
23. Artificial and prosthetic limbs except those required by the insured pursuant to a medical decision issued by the health facility approved by the Council.
24. Natural changes related to menopause, including menstrual disorders.

B. The policy shall not cover health benefits or corpse repatriation to home country in claims resulting directly from :

1. War, invasion, acts of foreign aggression; whether or not war is declared.
2. Ionizing radiations, pollution from radioactivity of any nuclear fuel or waste 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. The insured's service or participation in armed forces or police operations.
5. Riots, strike, terrorism or the like.
6. Chemical, biological or bacteriological incidents or reactions resulting from work injuries or occupational hazards.

Section 4 – General Conditions

1. **Proof of Validity :** The policy represents the basic level of insurance coverage granted to beneficiaries and shall not be valid unless confirmed by a schedule duly signed by an employee officially authorized by the company. Any addition to the policy shall not be valid unless confirmed by an endorsement signed by an employee officially authorized by the company.
2. **Records and Reports :** The policyholder must maintain a record of all its employees and their dependents covered under the policy, comprising each person's 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 be given access to such records to verify the accuracy of the information provided by the policyholder. The company shall, when requested, provide the policyholder with any information concerning the beneficiaries.
3. **Eligibility :**
 - a. **For employees:** any person satisfying the definition of "worker" shall be eligible 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.

If a person defined as "dependent" is also eligible for insurance as a worker, benefits enjoyed by said person as a dependent shall be discontinued according to the policy. If both the husband and wife are permanently living together and are insured as workers, their children shall only be eligible for insurance as dependents of the husband.
4. **Payment of Premiums (Subscriptions) :**
 - a. The policyholder shall pay the insurance premium due on each insured person as agreed upon with the company upon commencement of the insurance coverage.
 - b. In the event of non-payment of any portion of a premium, the policy shall not be valid for a period longer than that covered by the portion paid, and the company shall notify the Council accordingly.
5. **Effective Dates of Coverage :**
 - a. **For workers:** Coverage shall become effective for an active employee from the inception date shown in the policy schedule. For any person joining work at a later date, the effective date of coverage shall be the date said person joins the policy.
 - b. **For dependents:** Insurance coverage shall become effective for dependents from the date the worker supporting them becomes insured or from the date they become dependents.

6. Addition and Deletion of Insured Persons and Related Premiums :

- a. The policyholder must immediately and formally notify the company of all the employees or dependents to be covered by insurance upon commencement of the validity of the policy. Said policyholder may add a beneficiary on proportional basis upon proof of said employee's employment, or request the deletion of a beneficiary in the event said employee transfers to work for another employer.
- b. With respect to additions not falling under Paragraph (a) above, new beneficiaries shall be added as of the issuance date of the policy and their coverage shall be deemed effective as of the date of addition.

7. Termination of Beneficiaries' Insurance Coverage :

- a. **For employees:** coverage of any worker under the policy shall automatically terminate in the following cases:
 1. If the policy period ends as defined in the policy schedule.
 2. Upon exhaustion of the maximum benefit limit provided in the policy.
- b. **For dependents:** coverage under the policy shall automatically terminate in the following cases:
 1. The dependent no longer qualifies as "dependent" as defined in Paragraph (14) of Section One (Definitions) of the policy.
 2. If the policy period ends as specified in the schedule.
 3. Upon exhaustion of the maximum benefit limit provided in the policy.
- c. Payment of recoverable expenses in respect of any illness that requires continued hospitalization on the date of termination of coverage shall continue for the period necessary for treatment of such illness provided that such period shall not exceed 365 days from the date of onset of said illness and within the maximum amount of coverage provided for under the policy schedule.
- d. In case the 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 the assigned PPN network. This shall also apply to the termination of any insured's coverage. The policyholder shall be liable to reimburse the company for all medical costs and expenses resulting from his failure to comply with this condition.

8. Verification of the Insured's Health Condition :

- a. The company may have the insured, for whom a claim was submitted for recoverable expenses, examined by an accredited medical facility at the expense of the company for up to two times within a period not exceeding 60 business days following submission of the claim.
- b. The policyholder or the insured shall cooperate with the company and allow all necessary measures that may be reasonably required by and paid for by the company for the purpose of supporting its liabilities, claims or compensations from third parties to which the insured or policyholder is deemed liable. The policyholder or the insured may not waive such rights without the company's explicit or implicit consent.

9. **Non-Duplication of Benefits :** In case of a claim for recoverable expenses due under the policy for an insured who is also covered for the same expenses under another insurance plan, scheme or the like, the company shall be liable for the coverage of such expenses and shall subrogate the insured in his claims against third parties for payment of their proportionate share of such claim.
10. **Basis of Direct Billing of the Company by the PPN :**
- The company shall issue each insured individual a health insurance card entitling him to receive healthcare from the PPN agreed upon with the company without being required to pay the costs of such services other than the deductible specified in the policy schedule.
 - The service providers, assigned by the company, shall, on a monthly basis, send all invoices relating to medical expenses incurred in accordance with the policy. The company shall assess and process such expenses and advise the policyholder whenever expenses reach the maximum benefit limit.
 - In case such limit is exceeded and already incurred by the company, the company shall have the right to recover such expenses within a period not exceeding 60 business days from the date of notification of the policyholder.
 - In case the policyholder defaults in paying such expenses to the company within the specified period, the company may refer the matter to the Council for action.
 - Upon coordination with the policyholder, the company may delete any service provider assigned for purposes of the policy during its validity and appoint substitutes of the same level.
11. **Deductible (Co-payment) :** Without prejudice to the facility of direct billing of the company, the insured shall pay the deductible, if any, specified in the policy schedule at the healthcare center under the agreement between said healthcare service provider and the company. Any attempt by the insured to withhold payment shall be considered breach of the terms and conditions of the policy whose validity shall be suspended in respect of such insured until the deductible is paid.
12. **Reimbursement Basis :** In cases of emergency, the insured may obtain urgent medical treatment in centers other than the PPN agreed upon with the company on reimbursement basis. In such case, the company shall, in accordance with the policy's terms, conditions, limitations and exclusions, compensate the policyholder within a period not exceeding 15 business days 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 business days as of the date of incurring such expenses.
13. **Cancellation :** The policyholder may cancel the policy at any time by serving a notice to the company at least 30 business days prior to the date required for cancellation. In such case, the policyholder and the company shall undertake the following:
- The company shall notify (pursuant to a notice) the General Secretariat and PPN as soon as it receives the relevant notice from the policyholder (employer/insured) regarding cancellation of the policy.
 - The employer shall purchase another insurance policy from a qualified company or include the beneficiaries in another insurance coverage scheme approved by the Council. The new coverage shall commence as of the day following the date of cancellation of the previous policy, in case of transfer of employment.

- c. The employer shall provide the insurance company with proof of the beneficiaries' departure from the Kingdom if one or more workers are to be deleted from the policy. In such case, the company shall be liable to reimburse the policyholder, within 60 business days from the date of cancellation, for the remaining part of the premium for each insured individual whose claims did not exceed 75% of the annual premium. The recoverable amount shall be calculated on proportional basis: (Refund = annual premium ÷ 365.25 days X number of remaining days).

In case the policyholder defaults in paying the expenses that have exceeded the maximum benefit limit within the period specified in Condition 10 of the General Conditions of the policy and resulting from direct billing of the company, the company shall have the right to withhold refund of recoverable premiums, if any, and use such amounts to compensate for the expenses paid to service providers which should have been paid to the company by the policyholder.

14. **Approvals :** The company shall respond to approval requests from service providers to provide health service to beneficiaries within a period not exceeding 60 minutes.
15. **Gender :** For purposes of the policy, words denoting the masculine gender shall be deemed to include the feminine gender as well.
16. **Notices :**
- All notices or correspondences between the insurance parties shall be formal.
 - The company shall notify the policyholder of the dates of renewal or expiry of the policy 30 business days prior to said dates.
 - The insured (policyholder) shall notify the company of any changes to contact details thereof or those of his affiliates.
17. **Compliance with Policy Provisions :** As a precondition to any liability of the company, the policyholder and beneficiaries shall strictly comply with and execute all requirements, conditions, obligations and commitments stated in the policy.
18. **Penalties :** Any disagreement or dispute arising out of or relating to the policy shall be settled in accordance with Section 14 of the Law.

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

* The insurance products provided by Tawuniya Insurance Company are subject to Value Added Tax (VAT), except life insurance (Takaful). A 5% of the premiums and administrative fees are added to all policies issued starting from 1 January 2018.



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