The Standard Insurance Policy of the compulsory health insurance for domestic workers and their equivalent who are more than (4)

Introduction

ARTICLE ONE

This policy specifies the minimum mandatory health insurance for domestic workers and their equivalents whose number exceeds (4) based on Cabinet Resolution No. (724) dated 10/26/1444 AH, and in accordance with the terms, conditions and exceptions contained therein or attached to it. The insurance company agrees to provide the coverage shown below as the approved compensation limits during the insurance coverage period, in exchange for the employer's agreement to pay the agreed upon premium. The insurance company and the employer are prohibited from reducing the limits of liability for what is stated in this document, and they may agree to add significant coverage shown in this document.

Definitions

ARTICLE TWO

The following words and phrases, wherever they occur herein, shall have the meanings assigned thereto, unless the context requires otherwise.

- **Policy:** The Standard Insurance Policy of the compulsory health insurance for domestic workers and their equivalent who number are more than (4)
- **The Company:** The Insurance Company licensed by the Insurance Authority that conducting health insurance activities.
- **Kingdom:** Kingdom of Saudi Arabia.
- **Authority:** Insurance Authority
- **Council:** Council of Health Insurance
- **Employer:** Every natural person who recruited a domestic service worker himself, or through a licensed recruitment agency, to perform a domestic service, or to whom the services of a domestic service worker were transferred.
- **Domestic service worker:** Every natural person who performs domestic service directly for the employer or any member of his family, and during the performance of the service he is under the supervision and direction of the employer, or someone acting in his place, even if he is away from his supervision. The competent authority determines the professions of the worker. Home service.
- **The insured:** the domestic worker who benefits from insurance coverage according to the provisions stated in the policy.
- **Policyholder:** the employer in whose name the policy was issued.
- **Policy schedule:** The schedule attached to the policy. It contains the data of the employer and the domestic worker and also contains the coverage limits for the benefits included in the insurance coverage.
- **Appendix:** An agreement between the insurance company and the employer subsequent to the issuance of the policy, for the purpose of adding, amending, or canceling additional coverages.
- **Premium:** the amount paid by the Insurance Applicant on behalf of the Employer to the Insurer for its acceptance to indemnify the Insured for the damage directly caused by a risk covered under the Policy.
- **Claim:** a request submitted to the insurance company or its representative from a service provider, the insured, or the policyholder, for the purpose of replacing the value of health services expenses included within the policy's coverage, and which is accompanied by the financial and medical documents supporting it.
- **Service Provider:** The health facility (governmental and non-governmental) that is legally qualified or licensed to provide health services in the Kingdom in accordance with the relevant regulations and rules, and approved by the Health Insurance Council, and for example but not limited to: a hospital, a general medical complex, a complex Specialized medical, diagnostic center, clinic, pharmacy, laboratory, physical therapy center or radiation therapy center.
- **Approved service provider network:** A group of health service providers approved by the Council and designated by the insurance company to provide the service to the insured. These services are credited directly to the insurance company's account, this network includes the following levels of health services:
  - Primary health care
  - Secondary (general hospitals).
  - Tertiary (specialized or referral hospitals).
  - Centers providing other complementary health services (such as: day surgery centers, pharmacies, physical therapy centers, optical stores, telemedicine, and home care).
- **Emergency cases:** emergency medical treatment required by the insured's medical condition following the occurrence of an event, accident, or emergency health condition that requires rapid medical intervention, according to the following levels of urgent medical care triage levels (1- Resuscitation, 2- Emergency, 3 - An urgent situation that could lead to the loss of life, the loss of one or more organs, or the occurrence of a temporary or permanent disability) as stated in the private health institutions system and its executive regulations.
- **Hospitalization:** Registering the insured person as an admitted patient in the hospital until at least the next morning, including a patient who is admitted based on this reason and leaves the hospital for any reason without spending the night.
- **Expenses for returning the remains of the deceased to his country of origin:** All expenses for preparing and returning the body of the insured person to his country of origin.
- **Emergency medical evacuation:** Transferring the patient to the nearest medical center inside and outside the Kingdom that provides the health service the patient needs.
- **Traffic accident:** Any accident that results in serious or minor damage or partial or total material loss to property without intention, as a result of using the vehicle while it is in motion, as stipulated in the relevant and relevant regulations.
- **Material Fact:** any information requested by the Insurer from the Insurance Applicant when concluding the Policy that may affect the Insurer's decision to accept or reject the insurance coverage request, or accept it under different conditions.
- **Basis for compensatory compensation:** The method used to compensate the policyholder for the compensable expenses incurred by the insured and for which a claim is submitted, after applying the payment participation rate.

Insurance Coverage

ARTICLE THREE

Section One: The insurance company is obligated to compensate the policyholder according to the compensations set forth in this article and according to the limits set forth in the policy schedule in the following cases:

- **Health benefits (reimbursable expenses), which include:**
  - Actual expenses for medical examination, diagnosis, treatment and medications, according to the policy schedule.
  - Actual expenses for hospitalization.
  - Actual expenses for emergency dialysis cases.
  - Actual expenses for emergency medical evacuation.
  - Actual expenses for injuries resulting from traffic accidents.
- **Death of the domestic worker:**
  - Actual expenses for preparing and returning the body of the domestic worker to his home country.

Section Two: The insurance coverages mentioned in (Section One) of this Article shall apply as follows:

In the case that a residence permit is issued/renewed for a domestic worker by an employer whose number of domestic service workers registered with him exceeds (4).

Section Three: One insurance policy will be concluded for each employer that includes all domestic service workers registered with it whose number exceeds (4).

Policy Effective Date

ARTICLE FOUR

Taking into account the provisions of the beginning of insurance coverage in (Section Two) of Article Three of this document, the policy begins from the date of issuance/renewal of residency for the (fifth) domestic worker registered with the employer and the rest of the other domestic service workers registered with him, whose number exceeds (4).

Compensation Limits

ARTICLE FOUR

The company's maximum liability for insurance coverage - for a single insured - during the policy's validity period will not exceed a total amount of 100,000 riyals (one hundred thousand Saudi riyals) as a maximum of the company's liability according to the attached policy schedule. Insurance coverage also ends in one of the following cases:

- If the policy period expires as specified in the policy schedule.
- When the maximum benefit specified by the policy has been exhausted.
- When the insured leaves the Kingdom permanently.
- If the document is canceled in cases where this is permitted.

Health benefits also continue to be paid for any ongoing illness whose treatment began before the expiration of the policy period and led to continued hospitalization on the expiry date of coverage, until the maximum policy coverage limit is exhausted.

The Exclusions

ARTICLE SIX

The insurance coverage of the Policy does not include the following:

- Diseases that arise as a result of the intentional misuse of certain medications, stimulants, or tranquilizers, or as a result of the abuse of alcohol, drugs, or the like.
- Surgery or cosmetic treatment unless necessitated by accidental physical injury not excluded in this section.
- Comprehensive examinations and vaccinations, drugs or preventive methods that do not require medical treatment stipulated in this document.
- Treatment that the insured person receives without compensation.
- Recreation, convalescence, beauty, general physical health programs and treatment in social care homes.
- Any illness or injury that arises as a direct result of the insured person's profession and personal risks.
- Treating medically recognized venereal or sexually transmitted diseases.
- Treatment expenses for the period following the diagnosis of human immunodeficiency virus (HIV) or illnesses related to HIV, including AIDS (acquired immunodeficiency virus), its derivatives, synonyms, or other forms.
- All costs related to dental implants, installation of artificial teeth, fixed or removable bridges, or braces.
- Costs of glasses, headphones, vision or hearing correction tests and operations, and visual or hearing aids.
- The expenses of transporting the insured person within and between the cities of the Kingdom by unlicensed means of transportation (ambulance).
- Hair loss, baldness, or wigs.
- Treating psychological conditions, mental or neurological disorders.
- Allergy tests, whatever their nature, other than those related to prescribing treatment medications.
- Devices, methods, drugs, procedures, or hormone treatment for the purpose of birth control, preventing pregnancy, infertility, impotence, decreased fertility, in vitro fertilization, or any other means of artificial insemination.
- Cases of weakness or congenital deformity unless they pose a danger to the life of the insured.
- Any additional costs or expenses incurred by a companion of the insured during his hospitalization or stay in the hospital, other than the expense of accommodation and subsistence in the hospital for one companion of the insured, such as a mother accompanying her child until the age of twelve, or whenever medical necessity requires that at the discretion of the treating physician.
- Treating pimples (acne) or any treatment related to obesity or obesity, other than covered medications.
- Cases of transplantation of transferred organs and bone marrow, or transplantation of alternative artificial organs that replace any organ in the body, completely or partially.
- Prosthetics and auxiliary limbs.
- The natural changes of menopause for the insured woman, including menstrual changes.
- Treatment with herbs or natural medicines and any other methods of alternative medicine.
- Illegal abortions (according to the laws of the Kingdom of Saudi Arabia), or cases of pregnancy, childbirth, or legal abortion (not disclosed) in the insurance application.
- Suicide or intentional physical or psychological harm to oneself.
- The insured's resistance, refusal, or non-compliance with the medical directions provided by the company doctor and the treating physician.
- A medical evacuation or return the insured to his home country in the following cases:
  - If the insured is not medically authorized to do so.
  - B. If the insured suffers from mental or nervous disorders unless he is hospitalized.
  - T. Returning the remains of the deceased insured to a country other than his original country.

  Th. If the insured suffers from minor wounds, minor injuries such as sprains, simple fractures, or a moderate illness that can be treated by doctors in the country of arrival and does not prevent the participant from continuing his travel journey or being returned to his homeland.

- Health benefits and the return of the body to the place of origin in the event of claims arising directly from the following:
  - War, invasion, acts of (foreign) aggression, whether war is declared or not.
  - Ionic radiation or radioactivity contamination from any nuclear fuel or any nuclear waste resulting from the combustion of nuclear fuel.
  - The radioactive, toxic, explosive or any other dangerous properties of any nuclear assemblies of any of their nuclear components.
  - The insured person's practice or participation in the service of the armed forces or police or their operations.
  - Riots, strikes, terrorism or similar acts.

  Epidemics, accidents, or chemical, biological, or bacteriological reactions, if these accidents or reactions result from work-related injuries or occupational hazards.

Procedures for Addressing Claims and Paying Indemnities

ARTICLE SEVEN

- **The basis for direct debiting the company's account with the service provider network:**
  - The insured has the right to receive health services from the network of service providers agreed upon with the company and without being asked to pay the expenses of those services.
  - The Company's appointed service providers shall forward all medical expenses incurred under this policy within a period not exceeding 30 days, and the Company shall evaluate and process such expenses, and notify the Insured when the expenses reach the maximum benefit limit.

  The company has the right to delete or replace any and/or all of the service providers designated for the purposes of this policy, during the period of its validity, provided that the insured is notified of this and appoints a replacement for them at the same level.

- **Basis for Compensation:** The insurance company, in accordance with the terms, conditions, limitations and exceptions of the policy, will compensate the insured within a period not exceeding 15 working days from the date of submitting the claim according to the prevailing prices. The insured must submit the claim to the company within a period not exceeding (30) days from the date of incurring that claim. expenses, taking into account the following:
  - The compensation will be paid after the company agrees that the expenses are covered by insurance, after completing the insurance application form and submitting it to the company, attaching the necessary invoices in addition to any other relevant documents, such as medical information documents.
  - Under no circumstances will the amount of compensation exceed the maximum coverage.
  - Compensation amounts shall be limited to usual, familiar and acceptable expenses in the Kingdom of Saudi Arabia.
  - The company must be notified immediately in the event of death, hospitalization, emergency return to the homeland, medical evacuation, or escort, and this notification must include medical information related to illness or injury.
  - Notification should be made by any mean such as phone or smart Apps or email to the company's 24-hour emergency service.
  - The policyholder or insured person must cooperate with the company and notify it immediately regarding any request for compensation or the right to take action against any other party.

Cancelation

ARTICLE EIGHT

- **The company or employer does not have the right to cancel this Policy during its validity period except in the following cases:**
  - Issuing a final discharge for the domestic worker (the insured)
  - Transferring the services of a domestic worker to another employer, provided that there is a valid health insurance policy for the other domestic worker.

  And only the employer has the right to cancel the Policy if the number of domestic workers decreases below the minimum domestic workers' number of this Policy.

  In this case, the company is committed to the following:

  - The company is committed, within a period not exceeding (60) working days from the date of the company's knowledge of the occurrence of any of the cases mentioned in the introduction to the paragraph, to return to the employer by depositing the remainder of the subscription in the employer's bank account via the international bank account number (IBAN), the remaining part of the subscription for each insured person whose claims do not exceed 75% of the value of the annual subscription, so that the refunded part of the subscription is calculated on a pro rata basis: (the refunded part = annual subscription ÷ 365.25 days x the number of remaining days).

    The company is excluded from the obligation to pay the remaining subscription if there is any claim - related to the policy to be canceled - whose value exceeds the value of the amount supposed to be returned according to the above calculation method.

    In the event that the employer refrains from refunding expenses that exceeded the maximum benefit limit during the period specified in Article No. (7) (Basis for direct restriction on the insurance company's account with the network of service providers) of the general conditions of the policy resulting from the method of direct restriction on the insurance company's account, he has the right to The insurance company refrains from refunding the refundable subscriptions (if any) and using them to compensate for expenses paid to service providers that the policyholder should have paid to the insurance company.

  - The company shall inform (by official notice) the Authority, the Council and the network of service providers immediately upon receiving the employer's notice of cancellation of the policy.

- Despite the above, the company and the insured remain committed to the provisions of this document regarding the obligations arising before its cancellation.

General Conditions

ARTICLE NINE

- The employer must submit a medical disclosure form for each insured to the company.
- The employer must notify the company within (20) days of any change in the fundamental fact, and the company must notify the employer if it wishes to increase an additional amount on the insurance premium as a result of that, and the company does not notify the employer within (5) working days. This means her agreement to continue coverage at the same insurance premium agreed upon upon contracting.
- In the event that a claim is made for compensable expenses payable to the insured under this policy, and he is also covered, for those expenses, under any other plan, program, insurance, or the like, in this case the health insurance company will be responsible for covering those expenses. It takes the place of the insured in demanding that others pay their relative share of that claim.
- The rights arising from this policy shall be forfeited if the claim submitted involves fraud, or the use of fraudulent methods or means by the insured, those on their behalf, or third parties in order to obtain a benefit from this policy, or if liability or damage results as a result of an intentional act on the part of the insured or Whoever represents them or a third party, and the company has the right to resort to any party found responsible for this fraud, whether a participant or an accomplice, provided that the company is committed to compensating the third party if it is in good faith.
- **Jurisdiction and applicable system:**
  - Any dispute over this document is subject to the laws and regulations in force in the Kingdom of Saudi Arabia, and the committees for resolving insurance disputes and violations stipulated in the Cooperative Insurance Companies Control System are responsible for adjudicating it.
  - No lawsuit arising from this policy shall be heard after five years have passed since the occurrence of the incident from which the lawsuit arose and the interested parties became aware of its occurrence unless there is an excuse that the committees for settling insurance disputes and violations are convinced of.
- Approvals: The request for approvals shall be responded to by the insurance company to service providers to provide health services to beneficiaries within a period not exceeding sixty minutes from the time of requesting approval.

APPENDIX

SR 100,000

The maximum benefit limit - for each insured - for the duration of the policy, including the minimum limits stated in this policy

Insurance Coverage	حد التغطية التأمينية	نسبة المشاركة بالدفع
Expenses for examining and treating emergency cases	Up to the maximum limit of this policy	No Copayment
Hospital admission expenses	Up to the maximum limit of this policy The patient's daily accommodation and subsistence limit (shared room) is a maximum of 600 SAR/day It includes: bed fees, nursing services, visits, medical supervision, and subsistence services. This does not include the cost of medicines and medical supplies that are dispensed by the doctor's order. The daily accommodation and subsistence limit for a companion (shared room) is a maximum of 150 SAR/day	No Copayment
Ambulance transportation expenses	Up to 1,000 SAR	No Copayment
Outpatient treatment expenses	Maximum of 4 visits	Primary care centers 0-5% (maximum 25 SAR)
Expenses for vaccinations and examinations	According to the preventive measures determined by the Ministry of Health	No Copayment
Dental treatment expenses	Not Covered	
Eyeglass expenses	Not Covered	
Pregnancy and childbirth expenses	Not Covered	
Expenses for injuries resulting from traffic accidents	Up to the maximum limit of this policy	No Copayment
Emergency dialysis expenses	Up to the maximum limit of this policy	No Copayment
Medication costs	Up to 10,000 SAR	No Copayment
Costs of returning the remains of the deceased to their place of origin	بحد أقصى 10,000ر. س خلال مدة الوثيقة	No Copayment
Range of the Coverage		Kingdom of Saudi Arabia