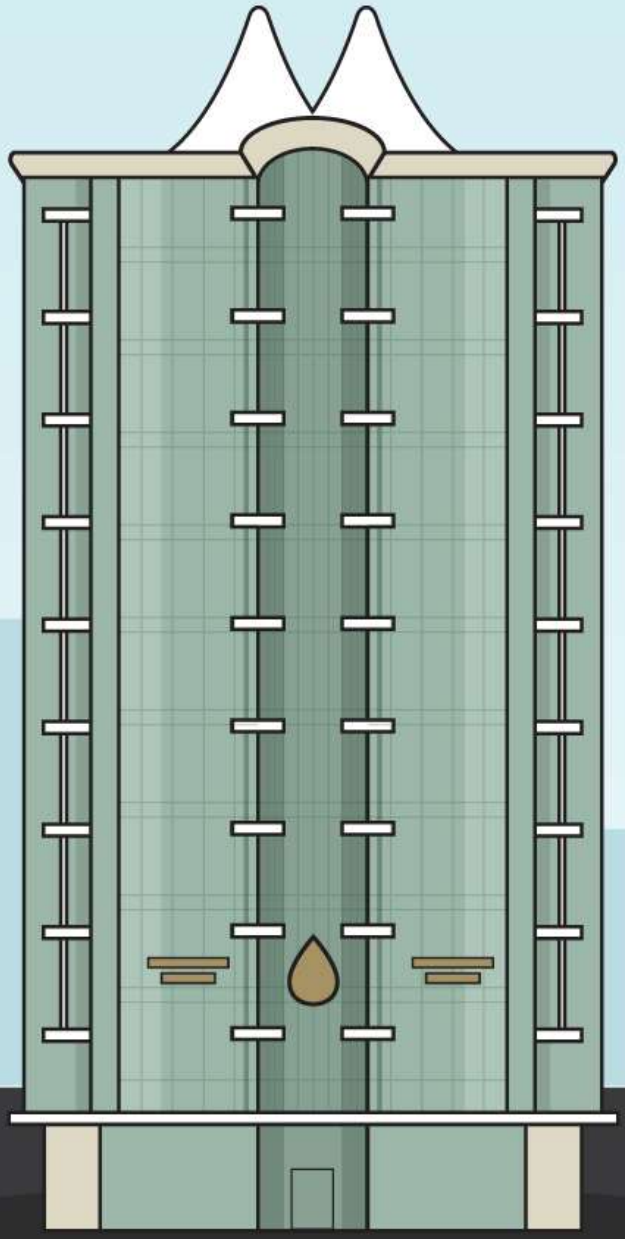
مجلس الضمان الصحي التعاوني
Council of Cooperative Health Insurance



Regulation of Qualification of Health Insurance Claims Management Companies

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Chapter One: Definitions

Article (1): The following terms shall have the meaning ascribed to them:

1. **Law:** means the mandatory Cooperative Health Insurance Law, issued by Royal Decree No. (10/M) on 01/05/1420 A.H (12/08/1999 A.D).
2. **Council:** means the Council of Cooperative Health Insurance (CCHI), which is established under the provisions of Article (4) of the Law.
3. **General Secretariat**: means the executive body of the CCHI.
4. **Authority**: Saudi Arabian Monetary Authority (SAMA).
5. **Social Insurance**: means the applicable insurance under the Social Insurance Law, and shall be implemented by the General Organization for Social Insurance (GOSI).
6. **Employer**: means any natural person or legal entity that uses one or more workers.
7. **Policyholder**: means any natural person or legal entity that the insurance policy is issued with its name.
8. **Dependent / Dependents**: means husband, wives, male children under the age of 18 and unmarried girls.
9. **Insurance Company**: means the cooperative health insurance company, which is licensed by SAMA to operate within the Kingdom of Saudi Arabia and qualified by the Council to exercise the cooperative health insurance works.
10. **Health Insurance Claims Management Company**: Companies that settle insurance claims and are licensed by SAMA to work within the Kingdome of Saudi Arabia and qualified by the Council to manage the cooperative health insurance claims.
11. **Insured (Beneficiary):** means any person who is included by the Law, and insured by an insurance company.
12. **Health Insurance**: means the cooperative health insurance that is referred to in the Law.
13. **Urgent Case**: means the medical treatment, which is required by medical condition of the beneficiary as a result of an accident or urgent health case that requires prompt medical attention.
14. **Insurance Coverage**: means the basic health benefits that are available to the beneficiary and specified by the insurance policy/policies issued by the Council.
15. **Insurance Policy**: is the fundamental cooperative health insurance policy and any other policies acknowledged by the Council, which includes the limitations, benefits, exceptions and general conditions and issued by the Insurance Company according to an insurance application submitted by Employer (Policyholder).
16. **The Premium (Subscription):** means the amount that shall be paid to insurance companies by Policyholders for the insurance coverage that is provided by such insurance policy during the insurance period.
17. **Deductible/Endured Rate (Co-Payment)**: means the amount that shall be paid (specified in the insurance policy schedule) by the beneficiary (the insured) upon visiting a doctor.
18. **Benefit**: means all expenses of providing health services that are included in the insurance coverage within the limits set forth in the table of insurance policy.

19. **Service Provider**: means health facilities approved by the General Secretariat, in accordance with the applicable regulations, to provide healthcare services within the Kingdom of Saudi Arabia e.g. hospital, diagnostic center, clinic, pharmacy, laboratory, physical therapy center or radiation therapy center.
20. **Approved Service Providers Network**: means a group of healthcare service providers accredited by the Council and specified by the health insurance company to provide services to the Employer/ Policyholder. Such services are provided through the direct registration at the expense of the insurance company when the insured present their valid insurance cards. Such network shall include the following three levels of healthcare:
    A) The first level of providing healthcare services (Initial Healthcare).
    B) The second level of providing healthcare services (Public Hospitals).
    C) The third level of providing healthcare services (Specialized/Reference Hospitals).
21. **Fraud**: means the deliberate misleading done by a person or entity to use healthcare illegally through deliberate deception that leads to having benefits, providing exceptional advantages or exceeding the permissible limits for an individual or entity.
22. **Abuse**: practices done by individuals or entities that may lead to having benefits or advantages that are not authorized to them, but without the intention of cheating and fraud or deliberate lying and distortion of facts in order to have a benefit.
23. **Claim:** means a request submitted to the insurance company by the service provider or the beneficiary directly for compensation for healthcare services (covered by the policy).
    Claim Supporting Documents: means all 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 such 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 original documents that may be required by the company.
24. **Claims Beneficiaries**: means the insured that the claim is issued with his/her name by service providers in consideration for having a provided medical service.
25. **Insurance Parties**: means insurance companies, health insurance claims management companies and service provider according to contracts concluded therebetween.
26. **Medical Claim Services Management Contract**: a contract that regulates the relationship between (the insurance company/the health insurance claims management company) and specify the rights and duties of each party. Such contract represents the minimum rights of the insured set forth in the health insurance policy for the purpose of managing and settling health insurance claims.

Chapter Two: Qualification of Health Insurance Claims Management Companies

Article (2): Any health insurance claims management company that desires to work in the field of cooperative health insurance shall be subject to the following requirements:

1. Shall be licensed by SAMA to operate within the Kingdom of Saudi Arabia as limited liability/ joint stock insurance claims settlement companies.

2. Activities of medical claims management shall be separated from the activities of other claims (if any).
3. The qualification period of all health insurance claims management companies shall be 3 Hijri years subject to renewal.
4. The value of qualification application forms for the first time (and/or) qualification renewal forms shall be (SAR 1000).
5. The financial compensation of qualification for the first time shall be SAR (90,000) for 3 Hijri years subject to renewal (the consideration of the first year shall be nonrefundable if the company does not obtain such qualification) and shall be divided by three years as follows:
   - (SAR 30,000) is the qualification value for the first year.
   - (SAR 30,000) is the qualification renewal value for the second year.
   - (SAR 30,000) is the qualification renewal value for the third year.
6. The financial consideration of qualification renewal shall be SAR (90,000) for 3 Hijri years and shall be divided as previously mentioned.
7. Companies shall use integrated accounting systems thereof.
8. The efficiency of the executive and medical body of companies shall have the approval of the General Secretariat.
9. Any financial amounts shall not be collected from the insured directly.
10. An insurance policy shall be concluded to cover the professional liability risks resulting from default, negligence and fault where the insurance coverage shall be at least (SAR 1,000,000).
11. All qualification renewal applications shall be submitted before (30) days at least of the qualification expiry date.
12. All health insurance claims management companies shall saudize related medical jobs, taking into account Saudis employment and qualification plans submitted to SAMA and decisions and instructions issued by the Council.
13. All health insurance claims management companies shall provide the General Secretariat with any required information by the same for the purpose of examining qualification or qualification renewal applications within 30 days.

Article (3): The submission of qualification applications shall be in writing according to the forms designated for such purpose and the following documents shall be attached:

1. Permit issued by SAMA.
2. A copy of the valid commercial register.
3. A copy of Zakat and Tax Certificate (for existing companies).
4. C.Vs of the executive members of the company.
5. A copy of the annual report (for existing companies) approved by the certified accountants and signed by the chairman of the board of directors or the director-general of the company. Such report shall indicate all company works performed during the previous fiscal year regarding the medical claims.
6. A written undertaking stipulates the following:

A) There are no financial obligations on the company (for existing companies) with entities contracted therewith during the past 3 years inside (and / or) outside the Kingdom of Saudi Arabia.
B) Comply with the internationally recognized professional standards in the field of practicing medical claims management.
C) Adhere to quality standards of providing health services, which were issued by the Ministry of Health (MOH) and preserve of the insured's rights including facilitation of service provision and the security and confidentiality of patients and medical facilities information.
D) Notify the General Secretariat of any change that may occur to the continuation of companies' activities (30 business days) before starting to make such change and being committed to paying the financial compensation and any entitlements to the Council on the due dates thereof.

Article (4): After meeting the conditions mentioned in Articles (2 and 3) of this Regulation, the procedures of qualifying health insurance claims management companies shall be done as follows:

First: First Time Qualification Procedures for 3 Hijri Years:

1. Qualification forms shall be received, completed and value thereof which is (SAR 1000) shall be paid according to the form designated for such purpose.
2. The financial consideration of qualification application, which is (SAR 90,000) shall be paid according to the form designated for such purpose.
3. Companies shall submit qualification applications in writing to the Secretary-General of the CCHI according to the form designated for such purpose.
4. Companies shall be notified in writing by the General Secretariat of any uncompleted items (if any) within (15 business days) as from the date of submitting qualification applications.
5. The qualification application shall be considered and decided by the General Secretariat within a maximum of (90 business days) as from the date of "Application Completion".
6. Companies shall be notified in writing by the General Secretariat of the rejection or Postponement of qualification with clarification of the reasons thereof, and companies may submit qualification applications again.
7. Companies' qualification certificates shall be issued, registered and given registration numbers by the General Secretariat.
8. The announcement of companies that are qualified for the first time shall be made by the General Secretariat on the website of the Council.

Second: Procedures of Qualification Renewal for 3 Hijri Years:

1. Qualification renewal forms shall be received, completed and value thereof which is (SAR 1000) shall be paid according to the form designated for such purpose.
2. The financial consideration of qualification renewal application, which is (SAR 90,000) shall be paid according to the form designated for such purpose.

3. Companies shall submit qualification renewal applications in writing to the Secretary-General of the Council according to the form designated for such purpose 30 days prior to the expiry date of the qualification.
4. Companies shall be notified in writing by the General Secretariat of any uncompleted items (if any) within (15 business days) as from the date of submitting qualification renewal applications.

5. The qualification renewal application shall be considered and decided by the General Secretariat within a maximum of (90 business days) as from the date of "Application Completion", and the company shall have the right to practice activities thereof during such period.

6. Companies shall be notified in writing by the General Secretariat of the rejection or Postponement of qualification renewal with clarification of the reasons thereof, and companies may submit qualification renewal applications again after the grounds for rejection or postponement of qualification no longer exist.

7. Companies' renewal qualification certificates shall be issued by the General Secretariat.

8. The announcement of companies' qualification renewal shall be made by the General Secretariat on the website of the Council.

Article (5): The General Secretariat shall withdraw or suspend the qualification of health insurance claims management companies according to the following procedures:

1. Information related to withdrawal or suspending qualification shall be considered.

2. If there are observations on the performance of a health insurance claims management company made by the CCHI, warnings (with maximum of two times) shall be sent in written to the same within (30 days) as from the date of such observations on the performance of such company came to knowledge of and /or received by the General Secretariat. The health insurance claims management company shall respond in writing and meet the requirements of such observations on performance thereof within a maximum of (30 business days) as from the date of the first warning and within (15 business days) as from the date of the second warning.

3. The company's response shall be considered and submitted to the person who has the authority after meeting the conditions of withdrawing and suspending qualification.

4. The suspension period shall be specified in the decision text issued against the company according to volume, type and impact of observations on the performance thereof.

5. In the event of qualification withdrawal, the company shall pay any costs or compensation or consequential rights thereon.

6. All qualified health insurance companies, accredited service providers, SAMA, Ministry of Commerce and Industry, and relevant entities shall be informed in writing of the decision of qualification withdrawal or suspension.

1. The decision of qualification withdrawal or suspension shall be announced on the website of the Council and local newspapers.

Chapter Three: Tasks and Works of Health Insurance Claims Management Companies

Article (6): Health Insurance Claims Management Companies shall exercise the following main tasks:

1. Any works related to health insurance claims, which require the existence of specific specializations to examine and consider claims that arise and result in paying compensation to policyholders by the insurance company.
2. Any works related to managing and/or developing medical programs that are issued by health insurance companies/service providers and subject to the Cooperative Health Insurance Law as a minimum, as well as actuarial studies, training within the company's field of work, research, and/or any works that fall within the company's activity.
3. Estimate compensation resulting from the cost of the service for urgent cases provided outside the network compared to the actual cost of healthcare service provided within the network whether inside (and/or) outside the Kingdom of Saudi Arabia.
4. Perform financial settlement works of received and unreceived claims from service providers (and/or) insurance companies (and/or) policyholders.

Article (7): Follow up the issuance of medical claims by service providers, as follows:

1. Claims shall be received from service provision center (and/or) handed by patients or representatives thereof when having services outside the network.
2. Ensure that the provided service is covered within the insurance policy before issuing any claim.
3. Follow-up the submission of claims by service providers to health insurance claims management companies that are related to all healthcare services provided to the insured.
4. The completion of claims issuance procedures by service providers regarding healthcare services provided to the insured shall be followed up.

Article (8): Medical claims management companies shall have the right to conduct investigations if necessary (such as reviewing patient files in service provision centers) by a settlement technician (and/or) licensed physicians at health insurance claims management companies (and/or) insurance companies by using all possible means including official records of service providers, as stated in the Cooperative Health Insurance Law and Implementing Regulation thereof and instructions issued by the Council.

Article (9): Service providers shall claim dues thereof, which result from the treatment of beneficiaries, as agreed upon with medical claims management companies within a period that shall not exceed 90 days from the due date.

Article (10): if there is a violation committed by one of the parties, the party that is violated shall have the right to notify the General Secretariat thereof.

Article (11): Quarterly, semi-annual or annual statistical reports shall be prepared by health insurance claims management companies. Such reports shall clarify cost containment indicators of providing healthcare services as well as the total paid, postponed and in progress claims and the Council shall be provided with a copy thereof within (15 business days from the date of issuing thereof) and/or at any time the same is requested by the Council.

Chapter Four: Rules of Practicing Works of Health Insurance Claims Management

Article (12): Practice works of health insurance claims management shall be the responsibility of claims management companies, which are authorized to operate in the Kingdom of Saudi Arabia and practice insurance claims settlement under the Cooperative Insurance Companies Control Law and qualified by the Council to practice health insurance claims management works.

Article (13): Any health insurance claims management company shall not be allowed to own (or equity participation) or operate any medical facilities or health insurance companies.

Article (14): Any health insurance claims management company may not sell and/or market health insurance policies, and shall conclude health insurance policies with health insurance companies qualified by the Council to have the insurance coverage stipulated in the policy for employees of health insurance claims management companies.

Article (15): The company shall be responsible for managing medical claims of a third parties regarding any compensation for insurance companies (and/or) beneficiaries from the policy issued by such insurance companies under a contract with health insurance companies.

Article (16): Health insurance claims management companies shall have the right to manage claims resulting from the following:

A) Diagnosis and treatment at service providers, provided that beneficiaries shall bear the deductible/endured amount as stated in the policy (and/or) amounts that exceed the coverage limits.
B) Financial amounts of necessary and urgent medical treatment costs if such costs are paid by a beneficiary directly, on the condition that insurance companies could not make such service available to the beneficiary urgently or refuse to make such service available to the same unfairly. The cost reimbursement to beneficiaries who paid the treatment cost shall be according to the limits stated in the policy and within limits paid by insurance companies to service providers at similar level.

Article (17): Health insurance claims management companies shall have the right to start managing medical claims as from the date of signing medical claims services management contracts (unless contracts specify anther date thereof).

Article (18): For the purposes of applying the Cooperative Health Insurance Law, health insurance claims management companies shall not be responsible for any claim to have healthcare services if such services are provided as a result of an accident happened at the place of work or arising of professional diseases that are included in the definition stated in the Social Insurance Law. If an insurance company provided such services, and turned out that the occupational hazards department at GOSI shall cover thereof, the insurance company shall claim GOSI to pay expenses paid by the same. Further, the health insurance claims management company may settle for the purpose of having such compensation by a written authorization from the insurance company.

Article (19): Health insurance claims management companies shall complete compensation procedures within the limits complied with by insurance companies in providing services that are not included in the Social Insurance Law. If GOSI provides healthcare services to a person who has an insurance contract with an insurance company, although the latter is obliged to provide such services, such insurance company shall compensate GOSI for expenses that arise in this regard.

Article (20): Health insurance claims management companies shall ensure that each beneficiary who benefits from medical services shall pay the deductible and endured amount under a bill of receipt issued by service providers as specified in the policy except in ambulatory cases and hospitalization. Further, medical service providers may not waive the co-payment amount according to the policy type, and health insurance claims management companies shall report any service provider that violates thereof.

Article (21): Qualified health insurance claims management companies shall:

1. Adhere to the insurance coverage and benefits according to the health insurance policy.

2. Conclude medical claims services management contracts with any of qualified health insurance companies and accredited healthcare service providers by the Council for the purposes of managing and settling medical claims only.

3. Provide services in accordance with generally accepted professional and ethical standards that comply with acceptable and recognized modern medical methods, taking into account the progress achieved in medicine field. Health insurance claims management companies may not manage services that do not comply with the above-mentioned.

4. Medical procedures shall be limited to what is required by necessary treatment need to complete the task.

5. Comply with procedures related to maintain quality issued by the Healthcare Services Council when health insurance claims management companies review documents and records related to compensation resulting from accredited service providers' network and contracted with qualified insurance companies.

6. Health insurance claims management companies shall settle any dispute that may arise between the same and contracted parties regarding any medical claim within a maximum of (30 days) from the due date of such claim, provided that the provision of service to the insured shall not be affected. Further, the General Secretariat may be referred to within such period (and/or) at any time.

7. Comply with the procedures of removal, addition and cancelation of the insured by insurance companies, taking into account instructions and decisions issued by the Council in this regard.

Article (22): The obligations of health insurance claims management companies shall end by the expiry (and/or) termination of medical claims services management contracts, (and/or) by the end of insurance coverage and all claims shall be definitively settled even after the expiry

of insurance coverage as set out in the Cooperative Health Insurance Law and Implementing Regulation thereof and provisions of this Regulation.

Chapter Five: Overseeing Health Insurance Claims Management Companies

Article (23): The Council shall be responsible for overseeing the compliance of health insurance claims management companies with the Cooperative Health Insurance Law and Implementing Regulation thereof, and ensuring that such companies as well as all parties to the relationship of health insurance perform tasks and responsibilities assigned thereto in accordance with this Regulation.

Article (24): The Council shall have the right to request (and/or) review any information (and/or) data from health insurance claims management companies regarding all work matters related to health insurance, concerning employers (and/or) beneficiaries (and/or) service providers, as well as concluded contracts with insurance companies.

Article (25): SAMA shall inform the Council in writing of any observations on health insurance claims management companies qualified by the Council or vice versa.

Article (26): The Council shall have the right to make reservation or object to any of officials and CEOs at health insurance claims management companies within the jurisdiction of the Council and notify SAMA and relevant entities of violations.

Article (27): The Council shall be entitled to use the information mentioned in Article (26) of this Regulation where it shall be used for the following purposes only:

1. Examine applications submitted by health insurance claims management companies for the purposes of qualification.
2. Check the compliance with instructions issued by the Council.
3. Pursue any violations of obligations arising from managing and settling medical claims between health insurance claims management companies, service providers and beneficiaries from insurance coverage.
4. Within the framework of examination procedures of complaints submitted regarding a decision taken by a health insurance claims management company.
5. Within the framework of procedures of considering and taking action on violations in accordance with Article (14) of the Law.

Article (28): The Council may suspend or withdraw the qualification of health insurance claims management companies if the same violate the requirements of qualification. In case of qualification suspension or withdrawal, such health insurance claims management companies shall be responsible for paying any costs or compensation.

Article (29): The financial consideration of the CCHI for supervising the application of the Cooperative Health Insurance Law shall be (1%) of the total commission (and/or) company remuneration for each signed contract with health insurance companies according to reviewed financial statements of previous year.

Chapter Six: Regulation of All Relationships between Parties to the Relationship Specified in Article (1)

Article (30): Health insurance claims management companies shall provide insurance companies and service providers with all required data to finish claims and settle dues. If health insurance claims management companies have reasonable justifications to doubt the validity of such information, the same may refer such matter to the Council to verify it.

Article (31): Health insurance claims management companies shall be responsible if any of employees thereof practices fraud, abuse or forgery when performing tasks thereof.

Article (32): Health insurance claims management companies shall, when concluding contracts of medical claims services management with insurance companies and service providers, take into account the following:

1. The insurance company shall be qualified by the Council.
2. The service provider shall be licensed by MOH and accredited by the Council.
3. The health insurance claims management company shall be qualified by the Council.
4. The contract period shall be one year subject to renewal upon the agreement of contracted parties, and health insurance claims management companies shall notify the General Secretariat of the renewal in writing within a maximum of (30 days) from the contract renewal date.
5. All healthcare service rates shall be subject to what is approved by the Healthcare Services Council in the Kingdom of Saudi Arabia.
6. Full compliance with the provisions of the Cooperative Health Insurance Law and Implementing Regulation thereof, Labor and Social Insurance Laws and other relevant laws.

Article (33): Service providers, health insurance claims management companies and insurance companies may terminate health insurance claims management contracts therebetween with being committed to the conditions set out in such contracts and shall notify the General Secretariat of such termination in writing within (7 days from the termination date).

Article (34): Health insurance claims management companies shall hire individually or collectively physicians with specialist degree and above who are licensed by the Saudi Commission for Health Specialties to verify treatment requirements within the limits of cost effectiveness during treatment of one of beneficiaries. Further, the preference in hiring such physicians shall be given to Saudis.

Article (35): The concerned physicians who work for health insurance claims management companies shall be professionally independent and shall, in opinions thereof, only subject to medical requirements in performing oversight tasks. In addition, such physicians may not interfere in medical treatment or treatment of beneficiaries.

Article (36): Service providers, beneficiaries and insurance companies shall provide physicians, who work for health insurance claims management companies, with all required information and make all required documents available to the same in order to perform oversight works according to the provisions of Article (34) of this Regulation. Further, such physicians may have access to hospital wards, medical supervision offices and medical records of licensed hospitals in which beneficiaries had/ still have treatment, when necessary, to perform oversight tasks assigned thereto in coordination with concerned hospitals and the General Secretariat of the Council.

Article (37): Beneficiaries shall be checked on by legally licensed physicians hired by insurance companies or claims management companies accredited by the Council, if necessary, and concerned companies shall bear the cost of examination.

Article (38): Beneficiaries shall review with any of initial healthcare facilities or physicians working within the network of service providers accredited thereof, and the referral to specialists or hospitals shall be by a decision from the general practitioner.

Article (39): Hospitalization compensation shall be limited to cases in which beneficiary's treatment at outpatient clinics is insufficient, and in such case, the same shall benefit from one-day surgeries or treatments. If a beneficiary reviews with a hospital other than the hospital specified in referral papers, the same shall bear the difference in treatment cost.

Article (40): Financial settlements between the contracted parties shall be according to the Cooperative Health Insurance Law, and regulations and instructions issued by the Council, taking into account the following:

1. Procedures of collecting medical claims management dues shall be upon the agreement between insurance companies, health insurance claims management companies and service providers with adherence to decisions and instructions issued by the Council.
2. The insurance company shall pay the dues of health insurance claims management companies and insurance companies shall be primarily responsible for paying such dues according to the agreed payment arrangements with adherence to this Regulation.
3. If the insurance company does not pay the dues of health insurance claims management companies, the latter shall have the right to terminate the medical claims services management contract concluded with such insurance company.
4. All commissions and discount rates agreed upon with insurance companies shall be included within the resources of health insurance claims management companies with adherence to the provisions of the Cooperative Health Insurance Law and Implementing Regulation thereof.
5. Health insurance claims management companies shall complete the procedures of paying dues of service providers in a period that shall not exceed (60 days) from claims receipt date.

Chapter Seven: Penalties and Settlement of Disputes

Article (41): The Committee for Considering the Violations of the Cooperative Health Insurance Law constituted under the text of Article (14) of the Law, shall consider all violations that arise from the relationship between health insurance claims management companies and beneficiaries, policyholders, insurance companies and service providers.

Article (42): Any fine shall be applied to the company by a decision from His Excellency/ the Chairman of the Council according to the following:

1- The fine of not submitting the qualification renewal application within a maximum of (30 business days) from the expiry date of the previous qualification shall be (SAR 25,000), and qualification shall be suspended after (60 business days) from the expiry date of the previous qualification without the submission of the qualification renewal application.

2- In case of submitting the qualification renewal application after a decision of suspending qualification is issued, the fine shall be (SAR 25,000) at least and shall not exceed (SAR 90,000) according to what the Chairman of the Council sees based on the circumstances that lead to the qualification suspension. Further, the qualification suspension decision shall not affect the obligation of the company.

3- The fine due from the company shall be doubled by (100%) if (30 business days) pass from the fine imposition date without being paid by the company.

Article (43): Complaints shall be submitted in writing by health insurance claims management companies or any of parties to the relationship of insurance to the Secretary General of the Council within (90) days as from the date of dispute occurrence, which resulted in complaints subject.
Article (44): The General Secretariat of the Council shall refer complaints to the Committee for Considering the Violations of the Cooperative Health Insurance Law that considers violations of the provisions of such Law.
Article (45): Fines shall be applied by a decision from the Chairman of the CCHI upon the recommendations of the Committee for Considering the Violations of the Cooperative Health Insurance Law. The company may complain about such decision before the Board of Grievances within (60 business days) as from the decision date.
Article (46): If a complaint is proven invalid and not based on permissible grounds, the Committee for Considering the Violations of the Cooperative Health Insurance Law shall take the required regulatory actions or propose the suitable penalty against complainant.

Chapter Eight: Transitional Provisions and Implementation of this Regulation
Article (47): This Regulation shall be issued by a decision from His Excellency the Chairman of the Council and shall be applicable after (30) days from being published in Um Al-Qura Newspaper.
Article (48): This Regulation shall be applicable to health insurance claims management companies according to decisions, instructions and executive plans issued by the Council and the same shall be supplement to this Regulation and binding upon all parties to the relationship of insurance.

God Grants Success