Administrative Resolution No. (78) of 2022

Issuing the Implementing Bylaw of Law No. (11) of 2013

Concerning Health Insurance in the Emirate of Dubai[1]

The Director General of the Dubai Health Authority,

After perusal of:

Law No. (11) of 2013 Concerning Health Insurance in the Emirate of Dubai;

Law No. (28) of 2015 Establishing the Dubai Statistics Centre;

Law No. (6) of 2018 Concerning the Dubai Health Authority and its amendments;

Law No. (13) of 2021 Establishing the Dubai Academic Health Institution;

Decree No. (17) of 2018 Establishing the Corporations Affiliated to the Dubai Health Authority and Determining their Functions;

Decree No. (2) of 2021 Appointing the Director General of the Dubai Health Authority;

Resolution No. (8) of 2022 Concerning Application of the Health Insurance Law within the Dubai Healthcare City;

Executive Council Resolution No. (7) of 2016 Approving Health Insurance Fees and Fines in the Emirate of Dubai;

Executive Council Resolution No. (6) of 2017 Approving the Health Insurance Implementation Phases in the Emirate of Dubai; and

Executive Council Resolution No. (18) of 2018 Approving the Organisational Structure of the Dubai Health Authority,

Does hereby issue this Resolution.

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[1]*Every effort has been made to produce an accurate and complete English version of this legislation. However, for the purpose of its interpretation and application, reference must be made to the original Arabic text. In case of conflict, the Arabic text will prevail.*

Definitions
Article (1)

The following words and expressions, wherever mentioned in this Resolution, will have the meaning indicated opposite each of them unless the context implies otherwise:

UAE:	The United Arab Emirates.
Emirate:	The Emirate of Dubai.
Government:	The Government of Dubai.
DHA:	The Dubai Health Authority.
DHIC:	The Dubai Health Insurance Corporation affiliated to the DHA.
Law:	Law No. (11) of 2013 Concerning Health Insurance in the Emirate of Dubai.
Concerned Entity:	Any Government entity in charge of the implementation of the Law and the resolutions issued in pursuance thereof.
Health Insurance:	Enjoyment by a Beneficiary of Health Benefits in accordance with the Law and the resolutions issued in pursuance thereof.
Beneficiary:	A natural person who is covered by Health Insurance under the Law.
Health Benefits:	The set of health services a Beneficiary receives from a Health Service Provider pursuant to a Health Insurance Policy.
Coverage Provider:	An entity which bears the cost of Health Benefits that a Health Service Provider provides to a Beneficiary. This includes the Government and any Insurance Companies.
Health Insurance Policy:	A document which determines the rights and obligations of a Beneficiary and a Coverage Provider with respect to Health Benefits.

Basic Coverage:	The minimum Health Benefits to be provided to a Resident under the relevant resolutions issued in pursuance of the Law.
Supplementary Coverage:	The Health Benefits provided to a Beneficiary in addition to the Basic Coverage.
Co-payment:	A fixed lump sum amount or percentage which is stated in the Health Insurance Policy, and which must be paid by a Beneficiary when he receives Health Benefits.
Health Insurance Card:	A document which is issued by a Coverage Provider to a Beneficiary to present to a Health Service Provider, and which proves his enrolment in a Health Insurance scheme for the Coverage Period stated therein.
Coverage Period:	The period extending from the commencement date to the expiry date of a Health Insurance Policy.
Health Service Provider:	A Government or private healthcare facility authorised to provide Health Benefits to Beneficiaries in accordance with the Law and the resolutions issued in pursuance thereof.
Health Service Providers Network:	A list of the names and addresses of the Health Service Providers stated in the Health Insurance Policy.
Insurance Company:	An insurance or *Takaful* insurance company licensed to conduct insurance business in the UAE and authorised by the DHIC to conduct Health Insurance activities in the Emirate.
Claim Management Company:	An establishment licensed to conduct the insurance claim settlement activity in the UAE and authorised by the DHIC to conduct Health Insurance activities in the Emirate.
Insurance Broker:	An establishment licensed to conduct the insurance brokerage activity in the UAE and authorised by the DHIC to conduct the activity of marketing or sale of Health Insurance Policies in the Emirate.

Authorisation:	A document issued by the DHIC authorising the conduct of any activity related to Health Insurance in the Emirate, in accordance with the conditions and requirements stipulated in the Law and the resolutions issued in pursuance thereof.
UAE National:	A natural person holding the UAE nationality.
Resident:	A natural person who does not hold the UAE nationality but holds a valid residence permit issued by the competent entity in the Emirate.
Employer:	A natural person or public or private legal person who operates in the Emirate and hires employees or workers in return for remuneration of whatever nature.
Employee:	A person who works for an Employer in return for remuneration of whatever nature.
Sponsor:	A natural or legal person who sponsors, in accordance with the legislation in force in the Emirate, a non-UAE National natural person for the purpose of visiting or residing in the UAE.
Visitor:	A natural person, including a tourist, who visits the UAE through the Emirate in accordance with applicable legislation.
Emergency Condition:	A case which requires an immediate medical intervention by a Health Service Provider to save, or eliminate a threat to, a person's life.
Actuarial Study:	An analysis through which risks related to Health Insurance funding are identified using statistics and recognised mathematical methods; and proper solutions to minimise these risks and mitigate their adverse effects are proposed.
Low-income Persons:	Any person who receives a monthly total salary that is lower than the minimum monthly salary determined by the DHIC under the resolutions it issues in this respect.

Subscribing Entity:	Any of the entities responsible for enrolling Beneficiaries in Health Insurance schemes in accordance with the provisions of the Law.
Health Insurance Agent:	A natural person assigned to promote or sell Health Insurance Policies on behalf of Insurance Companies; and to advise Beneficiaries on Health Insurance, Health Benefits, and the differences between offered Health Benefits.

Requirements for Issuing Authorisations to Insurance Companies
Article (2)

For an Insurance Company to be issued with an Authorisation to provide Basic Coverage or Supplementary Coverage, the company's legally authorised representative must submit an application for Authorisation to the DHIC on the form prescribed by it for this purpose. The application must meet the relevant requirements and be supported by the information and documents specified on the DHA website.

Obligations of Insurance Companies Authorised to Provide Insurance Coverage other than Basic Coverage
Article (3)

In addition to its obligations under the Law, the resolutions issued in pursuance thereof, and other legislation in force in the Emirate, an Insurance Company authorised to provide insurance coverage other than Basic Coverage must:

1. provide the Beneficiaries with a Health Service Providers Network that is approved by the DHIC and that is distributed in a geographically balanced manner across the UAE;

2. not exercise any form of direct or indirect pressure on any Beneficiary to force him to amend any of the Health Benefits included in the Coverage provided under the contract concluded with him;

3. not pay any commissions or provide any material or moral benefits to Claim Management Companies, Insurance Brokers, or Health Service Providers; or perform any act that may affect their duties or obligations, or that may cause, or raise suspicions as to the existence of, a conflict of interest of any sort whatsoever;

4. use the insurance claim systems prescribed by the DHIC;

5. comply with the pricing rules adopted by the DHIC for Health Insurance Policies;

6. fulfil its responsibilities, even by entering into contract with a Claim Management Company for the purpose of managing the insurance claims related to the Health Insurance Policies it issues;

7. not charge or impose any fees or other amounts in respect of the Health Insurance complaints filed with it;

8. provide Subscribing Entities with proof of the commencement of the Coverage Period and the essential information related to the insurance coverage as per the terms of the Health Insurance Policy and the relevant requirements prescribed by the DHIC;

9. serve notices on Subscribing Entities requesting the renewal of Health Insurance Policies at least thirty (30) days prior to their expiry. A notice must include the premium amount and any changes to be made to the Health Insurance Policy;

10. provide the Beneficiary with insurance coverage and pay all relevant claims arising therefrom before issuing the Health Insurance Card or linking the Emirates Identity Card to the system as an alternative to the Health Insurance Card;

11. provide the DHIC, within the time frames it prescribes, with periodic reports on performance and efficiency levels. These reports must state the time taken to issue prior approvals to provide Health Benefits; the number and percentage of cases that have exceeded the annual coverage limit; the paid settlement amounts; and any other data required by the DHIC; and

12. observe the time frame prescribed by the DHIC for the insurance claim cycles, the insurance approval issuance, and the settlement of payments related to the provision of the Health Benefits.

Obligations of Insurance Companies
Authorised to Provide Basic Coverage
Article (4)

In addition to its obligations under the Law, the resolutions issued in pursuance thereof, and other legislation in force in the Emirate, an Insurance Company authorised to provide Basic Coverage to Low-Income Persons, or any other category specified by the DHIC, must:

1. provide the DHIC with an annual report stating the number of complaints filed with the Insurance Company, the number of resolved and pending complaints, and the reasons for not addressing pending complaints; and with any other details the DHIC may request in respect of these complaints;

2. provide the DHIC, within the time frames it prescribes, with periodic reports on performance and efficiency levels. These reports must state the time taken to issue prior approvals to provide Health Benefits; the number and percentage of cases that have exceeded the annual coverage limit; the paid settlement amounts; and any other data required by the DHIC;

3. submit a quarterly report stating the status of financial settlements with Health Service Providers, in accordance with the guidelines, rules, and procedures issued by the DHIC;

4. provide the DHIC with an annual Actuarial Study indicating the rate of reinsurance for the Health Benefits scheme of each year;

5. provide the DHIC with quarterly financial reports, a final financial report at the end of the financial year, and any other financial reports required by the DHIC for any specific Coverage Period;

6. not reject any request for providing Basic Coverage without a valid reason acceptable to the DHIC;

7. not charge any additional amounts that exceed the amounts prescribed by the DHIC for providing Basic Coverage or for any other services the Insurance Company provides;

8. use the insurance claim systems determined by the DHIC;

9. submit a written request to the DHIC at least thirty (30) days prior to the date on which the Insurance Company wishes to cease providing Basic Coverage. This request must be

reasoned, justified, and accompanied by a written undertaking to continue providing the Basic Coverage under all Insurance Policies issued by the Insurance Company until their respective expiry dates;

10. not pay any commissions or provide any material or moral benefits to Claim Management Companies, Insurance Brokers, or Health Service Providers; or perform any act that may affect their duties or obligations, or that may cause, or raise suspicions as to the existence of, a conflict of interest of any sort whatsoever;

11. comply with the pricing rules adopted by the DHIC for Health Insurance Policies;

12. not change the prices of contracts upon their renewal without first obtaining the relevant approval of the DHIC;

13. where its Authorisation is revoked upon its request, undertake not reapply for Authorisation to provide Basic Coverage before the lapse of five (5) years from the date of revocation;

14. fulfil its responsibilities, even by entering into contract with a Claim Management Company for the purpose of managing the insurance claims related to the Health Insurance Policies it issues;

15. not charge or impose any fees or other amounts in respect of the Health Insurance complaints filed with it; and

16. observe the time frame prescribed by the DHIC for the insurance claim cycles, the insurance approval issuance, and the settlement of payments related to the provision of the Health Benefits.

Assignment of Health Insurance Policies
Article (5)

a. No Insurance Company may assign the Health Insurance Policies it has issued to any other Insurance Company without first obtaining the written approval of the DHIC. This approval will be issued in accordance with the following procedures and rules:

    1. An application for the assignment of Health Insurance Policies will be submitted to the DHIC. The application must include the reasons and grounds for the assignment.

2. Proof that the Insurance Company requesting the assignment has fulfilled its responsibilities in respect of all Health Insurance Policies issued by it must be provided.

3. Upon issuance of the DHIC approval, the Insurance Company must publish, at its own expense, in two local newspapers; one in Arabic and the other in English, its intention to assign the Health Insurance Policies issued by it to another Insurance Company. The announcement must be published twice in each newspaper with an interval of fifteen (15) days between the first and second publication, and must state that the holders of Health Insurance Policies and affected parties have the right to file with the DHIC objections to the assignment within forty-five (45) days from the date of publication of the last announcement.

b. Where no objection to the assignment is filed within the time frame referred to in sub-paragraph (a)(3) of this Article, and upon verifying that the Insurance Company has fulfilled its responsibilities, the DHIC will issue a decision approving the assignment of the Health Insurance Policies. This approval will be announced in the manner determined by the DHIC within one (1) month from the date of the same. The assignment approval decision will be binding on all persons to whom a Health Insurance Policy is issued and on all affected parties. The rights of the Insurance Company requesting the assignment will be transferred to the Insurance Company to whom the assignment of Health Insurance Policies is approved.

c. Notwithstanding the provisions of paragraph (b) of this Article, the DHIC may issue a decision approving the assignment of Health Insurance Policies in respect of which an objection is filed:

1. where a final decision dismissing the objection is issued by the DHIC;

2. where the objector waives the objection for any reason whatsoever; or

3. where the Insurance Company pays an amount equal to its liabilities towards the objector.

Applications for Revocation of Insurance Company Authorisations
Article (6)

a. The procedures and rules stipulated in Article (5) hereof apply to any Insurance Company applying for Authorisation revocation.

b. In considering the application of an Insurance Company for revocation of its Authorisation, the following rules apply:

    1. The Insurance Company must prove that it has fulfilled all its obligations in relation to the Health Insurance Policies issued by it, or that it has obtained the approval of the DHIC to assign these Health Insurance Policies to another Insurance Company.

    2. The Insurance Company will be liable for all the Health Insurance Policies whose contracts have been concluded within the UAE prior to the revocation of the Authorisation. The Insurance Company will remain liable for these policies until the expiry of their terms.

c. Without prejudice to sub-paragraph (4)(13) hereof, an Insurance Company whose Authorisation revocation application is approved may apply for a new Authorisation upon the lapse of one (1) year from the date on which its Authorisation is revoked. The DHIC may waive or shorten that period based on valid grounds provided by the Insurance Company.

d. Non-renewal of an Authorisation upon the lapse of thirty (30) days after its expiry will be deemed as an application for Authorisation revocation.

Authorisations of Claim Management Companies
Article (7)

For a Claim Management Company to be issued with an Authorisation, its legally authorised representative must submit an Authorisation application to the DHIC on the form prescribed by it for this purpose. The application must meet the relevant requirements and be supported by the information and documents specified on the DHA website.

Obligations of Claim Management Companies
Article (8)

In addition to its obligations under the Law, the resolutions issued in pursuance thereof, and other legislation in force in the Emirate, a Claim Management Company must:

1. refrain from performing any act that may undermine the rights of a Beneficiary, including the services covered by the Health Insurance Policy issued to the Beneficiary; or that may cause the Beneficiary's financial burdens to exceed those stipulated under the Health Insurance Policy;

2. not pay any commissions or provide any material or moral benefits to Health Service Providers or Insurance Brokers; or perform any act that may affect their duties or obligations, or that may cause, or raise suspicions as to the existence of, a conflict of interest of any sort whatsoever;

3. use the insurance claim systems prescribed by the DHIC;

4. assume joint liability with the Insurance Company contracted with the Claim Management Company to manage insurance claims,

5. not charge or impose any fees or other amounts in respect of the Health Insurance complaints filed with it; and

6. observe the time frame prescribed by the DHIC for the insurance claim cycles, the insurance approval issuance, and the settlement of payments related to the provision of the Health Benefits.

Authorisations of Insurance Brokers
Article (9)

For an Insurance Broker to be issued with an Authorisation, its legally authorised representative must submit an Authorisation application to the DHIC on the form prescribed by it for this purpose. The application must meet the relevant requirements and be supported by the information and documents specified on the DHA website.

Obligations of Insurance Brokers
Article (10)

In addition to its obligations under the Law, the resolutions issued in pursuance thereof, and other legislation in force in the Emirate, an Insurance Broker must:

1. maintain an electronic register of the names, qualifications, and Health Insurance-related work experience of its employees and contracted Health Insurance Agents;

2. not hire any person to work as Health Insurance Agent unless that person obtains a Health Insurance Agent Authorisation issued by the DHIC;

3. provide Health Insurance Policy buyers with quotations stating the service charges payable to the Insurance Broker and to its company, and the method of payment of these charges;

4. use the insurance claim systems prescribed by the DHIC; and

5. pay all the insurance claims owed by Beneficiaries for the period during which the Insurance Broker is late in enrolling the Beneficiaries in Health Insurance schemes.

Authorisations of Health Insurance Agents
Article (11)

To be issued with a Health Insurance Agent Authorisation, the natural person wishing to obtain the Authorisation must submit an application to the DHIC on the form prescribed by it for this purpose. The application must meet the relevant requirements and be supported by the documents and information specified on the DHA website.

Authorisations of Health Service Providers
Article (12)

To be issued with a Health Service Provider Authorisation, the legally authorised representative of the applicant must submit an Authorisation application to the DHIC on the form prescribed by it for this purpose. The application must meet the relevant requirements and be supported by the documents and information specified on the DHA website.

Obligations of Health Service Providers
Article (13)

In addition to its obligations under the Law, the resolutions issued in pursuance thereof, and other legislation in force in the Emirate, a Health Service Provider must:

1. not change the prices of Health Services without first obtaining the approval of the DHIC. This approval will be issued in accordance with the relevant requirements and procedures adopted by the DHIC;

2. provide Beneficiaries with Health Services in accordance with the Health Insurance system, the relevant standards adopted by the DHA, and the established medical norms recognised in this respect;

3. not cease providing Health Services under the Health Insurance system without first obtaining the approval of the DHIC. This approval will be issued in accordance with the following procedures and rules:

    a. An application for suspending or ceasing the provision of Health Services under the Health Insurance system will be submitted to the DHIC. The application must include the reasons and grounds for the request, and the period of suspension in case of requesting to suspend the services.

    b. Upon issuance of the DHIC approval, the Health Service Provider must publish, at its own expense, in two local newspapers; one in Arabic and the other in English, its intention to suspend or cease the provision of Health Services under the Health Insurance system. The announcement must be published twice in each newspaper with an interval of seven (7) days between the first and second publication, and must include an undertaking to settle all outstanding liabilities.

4. use the insurance claim systems prescribed by the DHIC,

5. not pay any commissions or provide any material or moral benefits to Claim Management Companies, Insurance Brokers, other Health Service Providers, or any party to the Health Insurance system; or perform any act that may affect their duties or obligations, or that may cause, or raise suspicions as to the existence of, a conflict of interest of any sort whatsoever; and

6. not act in any way as a broker to sell or promote Health Insurance Policies.

Contracts between Insurance Companies and Claim Management Companies
Article (14)

A contract concluded between an Insurance Company and a Claim Management Company must clearly and explicitly provide for all the matters regulating the relationship between the parties. In particular, the contract must:

1. specify the Health Services subject of the contract;

2. include an authorisation from the Insurance Company to the Claim Management Company to conclude agreements with Health Service Providers on behalf of the Insurance Company;

3. state the rights and obligations of the Insurance Company and the Claim Management Company in respect of the contracts to be concluded by the Claim Management Company with the Health Service Providers on behalf of the Insurance Company;

4. specify the files, books, and records that must be regularly maintained by the Claim Management Company; grant the Insurance Company the right to access these files, books, and records; and determine the method of obtaining copies of the same;

5. specify the period during which claims must be settled;

6. establish the rules and procedures regulating the management of the property governed by the contract;

7. include the information related to the statistics reports to be submitted periodically by the Claim Management Company to the Insurance Company;

8. state the fees or other amounts allocated by the Insurance Company to the Claim Management Company, including the method of calculating these fees and amounts;

9. specify the entity responsible for handling the complaints submitted by affected parties in respect of the subject matter of the contract;

10. state the obligation of the Insurance Company to settle the financial claims payable to the Health Service Providers on the due dates agreed upon by the Health Service Provider and the Claim Management Company;

11. determine the service levels and performance indicators for the services to be provided by both parties; and

12. include any other information prescribed by the DHIC.

Contracts between Health Service Providers and Insurance Companies or Claim Management Companies
Article (15)

A Contract concluded between a Health Service Provider and an Insurance Company or Claim Management Company must clearly and explicitly state all the matters regulating the relationship between the parties. In particular, the Contract must:

1. establish the procedures and methods for payment of Health Service charges;

2. establish the procedures for verifying the identity of the Beneficiary and for obtaining approval to provide him with Health Services;

3. state the costs of Health Services that must be provided by the Health Service Provider;

4. state the obligation of the Insurance Company to settle the financial claims payable to Health Service Providers in respect of Health Services on the agreed-upon due dates;

5. stipulate that the Insurance Company or Claim Management Company may not charge Health Service Providers any amounts in return for joining its Health Service Providers Network. If the Insurance Company or Claim Management Company wishes to charge any amounts in return for additional services it provides, it must be licensed by the Concerned Entity to provide these services; and

6. include any other information prescribed by the DHIC.

Contracts Between Insurance Companies and Subscribing Entities
Article (16)

a. A contract concluded between an Insurance Company and a Subscribing Entity must clearly and explicitly provide for all the matters regulating the relationship between the parties. In particular, the Contract must:

   1. state the contract value and payment method;

   2. provide the details of the coverage that must be included in the Health Insurance Policy, particularly, the covered Health Services, the Health Service Providers, the geographic coverage, the financial limits of the Health Insurance Policy and Health Services, the Co-payment, and any other benefits to be provided to the Beneficiary;

   3. describe the process for providing the Beneficiary with a proof of his enrolment in the Health Insurance scheme;

   4. state the names of Beneficiaries and the category of Health Insurance coverage of each Beneficiary;

   5. establish the procedures to be followed in case of cancelling the Health Insurance Policy;

   6. establish the procedures for renewing, or amending any of the terms of, the contract;

   7. stipulate that a notice must be served on the Subscribing Entity requesting the renewal of the Health Insurance Policy at least thirty (30) days before its expiry. The notice must include the premium amount and any changes to be made to the policy; and

   8. include any other information prescribed by the DHIC.

b. The Insurance Company must provide the Subscribing Entity with an electronic or paper-based Health Insurance Policy within fourteen (14) days from the date of concluding the contract. Where the Insurance Company fails to provide the Subscribing Entity with the Health Insurance Policy within that period, the Subscribing Entity may cancel the contract; recover any amounts paid by it to the Insurance Company; and hold the Insurance Company liable for any costs incurred by the Subscribing Entity or by the

Beneficiaries for medical treatment during the period of delay in providing the Health Insurance Policy.

c. The Subscribing Entity will be granted a trial period not exceeding fourteen (14) days from the date and time on which the Health Insurance Policy comes into effect. The Subscribing Entity may incorporate in the contract its right to withdraw from the contract without giving any reasons, and to recover any amounts paid by it to the Insurance Company. In that case, upon withdrawal from the contract, the following must be observed:

    1. It must be confirmed that none of the Beneficiaries covered by the Health Insurance Policy subject of the contract has received any benefits under the contract before the withdrawal, otherwise any payments incurred by the Insurance Company must be refunded.

    2. All the Health Insurance Cards must be returned to the Insurance Company upon withdrawal from the contract.

General Information to be Included in Health Insurance Contracts
Article (17)

In addition to the data that must be included in Health Insurance Contacts pursuant to the Law, this Resolution, and other legislation in force in the Emirate, a Health Insurance contract must include the following essential information and provisions:

1. details of the parties to the contract;

2. rights and obligations of the parties to the contract;

3. term of the contract and the cases that require its cancellation or termination;

4. conditions and procedures for termination of the contract;

5. procedures for renewal of the contract;

6. data and information confidentiality provisions;

7. procedures for receiving and determining complaints;

8. procedures for dispute resolution. In this regard, the contract must stipulate that before recourse to the judiciary or to arbitration, all disputes that may arise between the parties must be referred to the DHIC for its determination or for conciliation; and

9. any other information prescribed by the DHIC.

Obligations of Beneficiaries
Article (18)

In addition to his obligations under the Law, the resolutions issued in pursuance thereof, and other legislation in force in the Emirate, a Beneficiary must:

1. inform the Insurance Company of his full and accurate medical history and provide it with any other information or data required for the purposes of issuing him with a Health Insurance Policy;

2. not misuse the Health Insurance services or act in any manner whatsoever to gain a material or moral benefit for himself or for others;

3. not collaborate with any entity to misuse the insurance coverage or manipulate the Health Insurance system;

4. notify the DHA of any misuse, manipulation, negligence, or omission committed against him by any party to the Health Insurance system;

5. disclose, as stipulated by the Law, any other Health Insurance scheme in which he, or any of his family members covered under the Health Insurance system, is enrolled; and

6. not combine any Health Insurance package provided under the Law with any other health insurance package. The DHIC may allow a Beneficiary to hold multiple Health Insurance packages in accordance with the rules and procedures adopted by DHIC in this respect.

Health Insurance Packages
Article (19)

I. The types of Health Insurance packages and the Health Benefits prescribed for each category of Beneficiaries are determined and upgraded as follows:

1. UAE National Package

a. The package covers the therapeutic and preventive Health Services provided by public and private Health Service Providers as approved by the DHIC, in accordance with the Health Insurance policy it adopts in this respect;

b. The package allows benefiting from the government Health Insurance system to cover the gap between the insurance coverage provided to him by his Employer and the government insurance coverage provided to UAE Nationals.

c. A UAE National may upgrade his government Health Insurance package by purchasing, by himself or through the Subscribing Entity, another Health Insurance package that offers other benefits in addition to those provided under his government Health Insurance package.

2. Resident Package

a. The package covers at least the Health Services included in the Basic Coverage prescribed by the DHIC. Additionally, the Subscribing Entity may provide the Resident and his family members with a Supplementary Coverage.

b. A Resident may upgrade his Health Insurance package by purchasing, by himself or through the Subscribing Entity, another Health Insurance package that offers other benefits in addition to those provided under his original package.

3. Visitor Package:

a. The package covers at least the Health Services included in the Basic Coverage prescribed by the DHIC. Additionally, the Subscribing Entity may provide the Visitor and his family members with a Supplementary Coverage.

b. A Visitor may upgrade his Health Insurance package by purchasing, by himself or through the Subscribing Entity, another Health Insurance package that offers other benefits in addition to those provided under his original package.

II. The DHIC will periodically review Health Insurance packages taking into consideration the needs of individuals and the health requirements. This includes reviewing the Health Benefits prescribed for each package.

Health Insurance Policies
Article (20)

a. The following conditions apply to any Health Insurance Policy:

   1. It must be clearly drafted to enable ordinary people to understand its wording; and must contain precise definitions of the used terms, with explanatory examples where necessary.

   2. It must be drafted in the Arabic and English languages. The Arabic version must prevail in any case of discrepancy between the Arabic text and the other texts.

   3. A copy of the policy and all its annexes must be provided to the Beneficiary, and the provision of that copy to the Beneficiary must be evidenced through the relevant method prescribed by the Insurance Company.

   4. In addition to the information stipulated by the Law, the policy must include the following information:

      a. the type of the Health Insurance Policy or the package;

      b. the procedures for cancellation or renewal of the Health Insurance Policy; and

      c. the obligations of the Beneficiary.

b. A Health Insurance Policy may exclude the coverage of any medical conditions discovered before enrolment in the Health Insurance scheme. Except for medical Emergency Conditions, the coverage exclusion period may not exceed six (6) months from the commencement date of the first Health Insurance Policy of the Beneficiary.

c. A Health Insurance Policy issued prior to the effective date of this Resolution will continue in effect until the expiry of its validity, or until the lapse of one year from the effective date hereof, whichever comes first.

d. A Health Insurance Policy will be valid for one year. However, the DHA may issue Health Insurance Policies that are valid for a longer period. Where a Health Insurance Policy is terminated prior to the expiry of its validity and no dispute between the Insurance Company and the Subscribing Entity is pending, the Insurance Company must refund

part of the Health Insurance Policy value as per the equation adopted by the DHIC for this purpose.

Health Insurance Cards
Article (21)

Coverage Providers will issue electronic or paper-based Health Insurance Cards to Beneficiaries. A Health Insurance Card must contain the following information and data:

1. Beneficiary's name;
2. Beneficiary's nationality;
3. Beneficiary's date of birth;
4. Health Insurance Card number;
5. Health Insurance Policy number;
6. Coverage Provider's name;
7. validity date;
8. Health Service Providers Network name; and
9. Health Insurance category;
10. Co-payment; and
11. any other information specified by the DHIC.

Health Insurance Claims
Article (22)

a. Health Service Providers must submit their Health Insurance Claims in accordance with the relevant procedures, instructions, and regulations adopted by the DHIC.

b. Insurance Companies must respond to the Health Insurance Claims in accordance with the relevant procedures, instructions, and regulations adopted by the DHIC.

Procedures for Pricing Health Services
Article (23)

a. Health Service Providers must comply with the price lists they submit when applying for Authorisation, and they may only change these lists after the lapse of at least one year from the date announced by the DHIC for providing price lists. An application submitted to the DHIC for changing the prices must be supported by analytical and statistical data as per the tables prescribed by the DHIC for this purpose. The application will be determined by the DHIC within sixty (60) days from the date of its submission.

b. The DHIC will approve the process for pricing Health Services and circulate the same to Health Service Providers to follow. In developing this process, the following must be observed:

    1. The process must apply to all Health Service Providers, excluding pharmacies and optical service providers.

    2. The process must stipulate that the DHIC approval be obtained before negotiating with Insurance Companies and Claim Management Companies on the annual total increase of prices as per the annual variable percentages. These prices must be determined in cooperation with the DHIC and the Dubai Statistics Centre.

    3. The state of the market must be reviewed from time to time in cooperation with Insurance Companies, Claim Management Companies, and Health Service Providers to develop a suitable pricing model where required.

    4. The procedures adopted by the DHIC for approving and changing Health Service prices must be followed, particularly the following:

        a. an application for increasing prices must be submitted on the form prescribed by the DHIC for this purpose;

        b. the following requirements and procedures must be observed:

            1. registering and following up the application through the systems adopted by the DHIC;

            2. using the medical prescription system adopted by the DHIC;

3. meeting the minimum indicators prescribed by the DHA;

4. verifying that there are no outstanding payments with the DHIC;

5. in case of certain Health Service Providers specified by the DHIC, providing information about the required prices to assist in estimating future prices; and

6. meeting any other requirements and procedures prescribed by the DHIC.

c. An application for increasing the prices of Health Services will be considered, and the applicant will be notified of whether the application is approved or rejected through the relevant systems adopted by the DHIC.

d. Any application that is not submitted as per the procedures, or does not include the information, stipulated in this Article may not be considered.

Procedures for Approving the Prices of Health Insurance Packages
Article (24)

a. Insurance Companies must present their existing and future Health Insurance packages to the DHIC for registration and approval before promoting them in the Emirate.

b. The registered Health Insurance packages must offer the minimum Health Benefits that must be covered under the Basic Coverage as specified by the DHIC.

c. Insurance Companies must, within the time frame prescribed by the DHIC, amend the Health Benefits in all Health Insurance packages issued to Residents before the effective date of the Law in order to ensure that they offer the benefits of the Basic Coverage package.

d. Insurance Companies may specify, on an annual basis, the prices of Supplementary Coverages in Health Insurance schemes. In that case, the following requirements must be met:

1. The conditions established by the DHIC to regulate the prices of various Health Insurance packages must be observed.

2. The prices of the Health Insurance packages may not be increased within a year without first obtaining the approval of the DHIC.

3. The prices in valid Health Insurance Policies may not be increased.

4. The coverage specified in the Health Insurance Policy of any Beneficiary must be renewed in accordance with the rules prescribed by the DHIC.

5. The procedures for making payments for Health Services during the validity of a Health Insurance Policy must not be changed without first serving a thirty-day written notice by the Insurance Company on the Subscribing Entity. The request for changing the procedures must state the reasons and grounds for the change.

e. Residents who do not have an Employer or Sponsor must obtain Health Insurance coverage before the deadline prescribed by the DHIC.

Norms and Rules for Health Insurance Data Protection
Article (25)

a. Without prejudice to the provisions of the legislation in force in the Emirate, the information and data contained in the records related to Health Insurance and to the Health Services provided to Beneficiaries must be kept confidential. These data and information may be accessed by the following persons and entities upon their request:

1. a Beneficiary or his legal representative;

2. the judicial authorities; and

3. the DHA, for the purpose of implementing the provisions of the Law and the resolutions issued in pursuance thereof.

b. The persons and entities referred to in paragraph (a) of this Article must maintain and protect the confidentiality of the information and data contained in the records related to Health Insurance and to the Health Services provided to Beneficiaries, and must use these information and data only for the purpose for which they are requested.

c. The parties to the Health Insurance system must comply with the policies issued by the DHIC for dealing with personal and financial data.

d. Without prejudice to any longer period prescribed under the legislation in force in the Emirate, Health Service Providers must maintain the medical records of Beneficiaries, in electronic or paper format, for a period of not less than twenty-five (25) years from the date of last medical procedure performed on the Beneficiary, or from the expiry date of his last Health Insurance Policy, whichever is later.

e. If a Beneficiary finds any error in his medical file or record, he may request the Health Service Provider to correct this error without paying any amount in return for such correction.

f. The DHIC will determine the types of reports to be submitted to it by Insurance Companies, Health Service Providers, Insurance Brokers, and Claim Management Companies. These entities must provide the DHIC with the required reports on the dates, and using the method, specified by the DHIC.

Revocation or Transfer of Health Insurance Policies
Article (26)

a. The following rules apply to the applications for revocation or transfer of the coverage prescribed under a Health Insurance Policy:

    1. A Resident applying for the revocation of his Health Insurance Policy must provide proof that he is covered by another Health Insurance Policy or that his UAE residence permit is cancelled.

    2. A Sponsor applying for the revocation of the Health Insurance Policy of a Resident he sponsors must provide proof that the sponsored Resident is covered by another Health Insurance Policy, that his residence visa is cancelled or transferred to another Sponsor, or that his UAE residence permit is cancelled.

    3. A worker applying for the revocation of his Health Insurance Policy while he is still employed must provide proof that he is covered by another Health Insurance Policy provided by his Employer. In case the Beneficiary's residence visa is cancelled, the Subscribing Entity must continue to provide him with an insurance coverage for a period of thirty (30) days after cancellation of the visa or until he leaves the UAE, whichever comes first.

b. A Health Insurance Policy will be cancelled upon the Beneficiary's death. In that case, the Insurance Company will continue to be liable for any financial obligations owed under the Health Insurance Policy.

c. The following rules apply to the Health Insurance Policies issued as replacement for cancelled policies under this Article:

   1. The coverage prescribed in the new Health Insurance Policy may not be less than the coverage prescribed in the cancelled policy.

   2. The old Health Insurance Policy may not be revoked or replaced before the commencement date of the new Health Insurance Policy.

   3. Where the Insurance Company wishes to transfer its obligations under a Health Insurance Policy to another Insurance Company, the prior approval of the DHIC must be obtained.

d. An Insurance Company must coordinate with the DHIC in case of cancellation of a Health Insurance Policy for any reason other than an act of fraud committed by the Beneficiary. The Insurance Company must refund part of the Health Insurance Policy value pro rata to the remaining period of the policy validity, in accordance with the rules approved by the DHIC in this regard.

Audit and Inspection
Article (27)

a. The DHIC will issue periodic circulars prescribing the standards that must be observed by the parties to the Health Insurance system, including the standards for creating Health Service Providers' databases.

b. For the purpose of ensuring proper implementation of the Health Insurance system in the Emirate, the DHIC will undertake the audit and inspection of the parties to the Health Insurance system to verify their compliance with the provisions of the Law, the resolutions issued in pursuance thereof, and the circulars issued by the DHIC.

c. In addition to their powers under the applicable legislation, the DHA employees who are granted the law enforcement capacity to record the acts committed in breach of the provisions of the Law will have the powers to:

1. request any information or documents from the persons to whom the provisions of the Law apply to enable the DHA employees to efficiently perform their jobs duties and to ensure the proper implementation, management, and control of the Health Insurance system;

2. investigate any Health Insurance complaints referred to them and take the necessary action in respect of the same;

3. issue violation reports against violators on the forms prescribed for this purpose. In that case, a violation report must contain the following:

    a. name and staff number of the law enforcement officer;

    b. date, time, and location of the reported incident constituting the violation;

    c. statements of the witnesses or expert witnesses on the facts related to the reported violation;

    d. details of the facts related to the committed violation;

    e. signature of the law enforcement officer; and

    f. signatures of the witnesses, expert witnesses, or other persons whose statements are taken, who are interrogated, or whose assistance is sought, including translators. The name, title, age, profession, nationality, place of residence, identification papers, and Emirates Identity Card numbers of these persons must be noted in the report;

4. submit the outcomes of the audit and inspection to the DHIC for information and for issuing the relevant directives as it deems appropriate.

5. maintain the confidentiality of the data and information related to audit and inspection and to complaints, and only allow the legally competent authorities to access these data and information in the cases permitted by the legislation in force in the Emirate; and

6. seek, where required, assistance from the concerned Government Entities, including police personnel.

Complaints and Disputes
Article (28)

a. The DHIC will consider the complaints filed with it regarding the Health Services covered by the Health Insurance system or Health Insurance Policies.

b. A complaint filed with the DHIC must:

   1. contain the personal details of the complainant;

   2. contain the details of the complaint, including a clear and precise description of the complainant's requests;

   3. be accompanied by all the documents that support the complaint;

   4. be written in Arabic or in both the Arabic and English languages; and

   5. meet any other requirements prescribed by the DHIC.

c. Upon filing a complaint with the DHIC by an affected party, the DHIC must:

   1. receive and register the complaint, and notify the complainant of the same;

   2. seek assistance from the DHA employees and other persons, as it deems appropriate, to give opinion on the complaint where required;

   3. take any action it deems necessary, including any inspection, audit, or complaint validity verification;

   4. serve the complaint and its supporting documents on the respondent entity, and require it to provide the DHIC with its response to the complaint within the time frame prescribed by the DHIC;

   5. assign a DHA employee to conduct audit or inspection, where required; and

   6. review the data included in the DHA databases, where necessary, and request any other records or documents from the Health Service Providers, Health Insurance Companies, Claim Management Companies, or Insurance Brokers, as deemed

required for considering the complaint and taking the necessary action in respect thereof.

d. A complaint filed with the DHIC will not be considered in any of the following cases:

   1. where the merits of the complaint have already been determined;

   2. where the merits of the complaint are being heard by a judicial authority, or a definitive judgement has been issued in respect thereof by the competent court;

   3. where one (1) year has lapsed since the dispute subject of the complaint arose;

   4. where it is established that the complainant has no capacity or interest in the complaint; or

   5. where the complaint is not written in Arabic or in both the Arabic and English languages.

e. The Director General of the DHA will issue a resolution forming the following two (2) committees:

   1. the Health Insurance Disputes Settlement and Resolution Committee, and

   2. the Health Insurance Grievances Committee.

The resolution forming the above-mentioned committees must determine their functions and terms of reference.

Emergency Conditions
Article (29)

a. An Emergency Condition will be classified as such based on the Beneficiary's symptoms, rather than on the initial or final diagnosis by the physician. The Beneficiary's symptoms must be extremely severe and require that he receive immediate healthcare. This includes sustaining a sudden illness or trauma, or developing a critical medical condition manifesting itself in acute symptoms of sufficient severity, including severe pain, as established by the assessment of a physician specialised in the relevant health condition. The condition must require immediate medical intervention, so that any negligence or

absence of immediate medical attention could result in the Beneficiary's death; cause the Beneficiary to suffer a serious medical condition, impairment of bodily functions, dysfunction of body organs or parts, or serious deformities; or pose a serious threat to the life of the Beneficiary's foetus.

b. An Emergency Condition will cease to exist in any of the following cases:

1. Stable for Transfer

This means that the Beneficiary's health condition is stable and the Beneficiary can be transferred to another Health Service Provider within the Health Service Providers Network, provided that there is no medical objection to the transfer and that it is established that the transfer would not cause harm to the Beneficiary, endanger the Beneficiary's health; or pose a serious threat to the life of the Beneficiary's foetus.

2. Stable but Not Fit for Transfer

This means that the patient's health condition is stable, as evidenced by the body vital signs, but the patient is not fit enough to be transferred to another Health Service Provider. Subject to the DHIC approval, the patient may be transferred to another specialised Health Service Provider to receive further treatment, provided that there is no medical objection to the transfer and that it is established that the transfer would not cause harm to the patient, endanger the patient's health; or pose a serious threat to the life of the patient's foetus.

c. Where a patient is not enrolled by a Subscribing Entity in a Health Insurance scheme in spite of his eligibility to enrolment, the Subscribing Entity must pay the actual costs of treatment received by the patient in Emergency Conditions.

General Provisions
Article (30)

a. The Beneficiary is liable for all costs arising from his overstay in a Health Service Provider's facility after being discharged by the treating physician from that facility, in which he has received the treatment as per the treatment guidelines adopted in this respect.

b. In an Emergency Condition, the Health Service Provider must provide the Beneficiary with the relevant Health Services until his health condition stabilises even if the Health Service Provider is not a member of the Health Service Providers Network contracted by the Insurance Company. In that case, the Health Service Provider will have recourse against the Insurance Company which has issued the Health Insurance Policy for payment of the costs of the Health Services provided to the Beneficiary in Emergency Conditions.

c. Subject to the relevant rules, requirements, and procedures adopted by the DHIC, the Insurance Company is entitled to be reimbursed for the costs paid by it for the Health Services provided to the Beneficiary where these costs should have been paid by another entity.

d. No Authorisation issued by the DHIC to conduct the Health Insurance business may be renewed or revoked without the payment of all fines prescribed pursuant to the Law and the resolutions issued in pursuance thereof.

e. All the parties to the Health Insurance system in the Emirate must comply with the international standards for issuing medical approvals in order to preserve the patients' health and life, in alignment with the interests and work flow of the Health Insurance system in the Emirate.

Issuance and Publication of Implementing Resolutions
Article (31)

The DHIC will issue the resolutions required for the implementation of this Resolution; and will publish the same on the DHA website. Any of these resolutions will be binding on the persons to whom it applies only thirty (30) days after the date of its publication unless that resolution, as published on the DHA website, stipulates a different time frame.

Publication and Commencement
Article (32)

This Resolution will be published in the Official Gazette and will come into force on the day on which it is published.

Awad Saghir Al Ketbi

Director General

Dubai Health Authority

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Corresponding to 1 Rabi al-Thani 1444 A.H.