# Dubai Health Insurance Emergency Coverage Policy Directive

## Dubai Health Insurance Corporation (DHIC)

| ID | Issue# | Issue Date | Effective Date | Revision Date | Page# |
|---|---|---|---|---|---|
| DHIC/HIR-002/2024 | 01 | 07/10/2025 | 27/10/2025 | 07/10/2027 | 1 |

**ACKNOWLEDGMENT**

The Dubai Health Insurance Corporation (DHIC), under the supervision of the Dubai Health Authority (DHA), acknowledges the valuable contributions of subject matter experts and professionals who provided technical expertise, regulatory insights, and practical guidance in the preparation of this Regulation. Their input ensured that the framework is comprehensive, enforceable, and aligned with Dubai's broader vision for a transparent and sustainable health insurance ecosystem.

The Authority further recognizes the commitment and diligence of all contributors in reviewing existing practices, benchmarking against international standards, and shaping provisions that strengthen beneficiary protection, enhance compliance, and promote service excellence across the health insurance sector in the Emirate of Dubai.

**Dubai Health Insurance Corporation**

**Dubai Health Authority**

# Table of Contents

# 1 Legal Authority

This Regulation is issued pursuant to Dubai Health Insurance Law No. (11) of 2013, Administrative Resolution No. (78) of 2022 (Implementing Bylaw), Board Resolution No. 9 of 2011, Executive Council Resolution No. 16 of 2013 – Health Insurance for Dubai Government Employees and Executive Council Resolution No. (7) of 2016 on Health Insurance Fines and Fees. It is further supported by the Dubai Health Insurance Corporation's (DHIC) mandate to issue directives, circulars, manuals, and regulatory guidelines for ensuring compliance, transparency, and market integrity across all parties governed by the health insurance framework in the Emirate of Dubai.

# 2 Purpose

To define mandatory insurance coverage requirements, claims protocols, and payment obligations related to Emergency Conditions within the Emirate of Dubai, and to ensure that all eligible Beneficiaries receive uninterrupted and timely emergency medical care.

# 3 Scope of Application

This regulation applies to all DHA-licensed Insurance Companies, Third-Party Administrators (TPAs), Health Service Providers, Employers, and Sponsors operating within the Emirate of Dubai. It outlines the mandatory obligations, minimum service standards, and claims processing requirements related to Emergency Medical Conditions, as defined under Dubai Health Insurance Law No. (11) of 2013, Executive Council Resolution No. (7) of 2016, and supporting policy directives issued by the Dubai Health Insurance Corporation (DHIC).

# 4 Regulatory Requirements

An Emergency is a sudden onset of an illness, injury or medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) requiring immediate and unscheduled medical care, and if left untreated could result in placing the person's life and/or health in serious jeopardy;

serious impairment to bodily functions; serious dysfunction of a bodily organ or part; serious disfigurement; or in the case of a pregnant woman, serious jeopardy to the health of the fetus. Determined by a physician specialized in the relevant condition.

An Emergency Condition is deemed resolved when the patient is:

- **Stable for Transfer**: This means that the Beneficiary's health condition is stable and the Beneficiary can be transferred to another Health Service Providerwithin 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.
- **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.

## 4.1 Emergency coverage responsibilities:

### 4.1.1 Obligations of Insurance Companies:

- Must cover all Emergency Conditions regardless of network affiliation.
- Must not reject or delay claims based on network, location, or pre-authorization status.
- Must settle Emergency Claims **within 7 working days for non-network providers**.

### 4.1.2 Obligations of Health Service Providers:

- Providers are required to deliver **immediate medical care** to any Beneficiary presenting with an Emergency Condition, without delay and regardless of the Beneficiary's insurance status or provider network affiliation. Emergency services must be rendered immediately and

subsequently reported to the insurer or TPA within 24 hours, in accordance with DHA regulations and the Unified Provider Contract.

- Providers must continue providing emergency care until the Beneficiary's condition is stabilized, irrespective of the Health Service Provider's network status with the Insurance Company. In such cases, the Health Service Provider shall retain the right to claim reimbursement from the Insurance Company that issued the Health Insurance Policy, for the full cost of emergency services rendered during the Emergency Condition.
- Claims must be supported by clinical records validating the emergency status and a complete service record of interventions performed.

## 4.2 Emergency Claims Settlement and standard Negotiation Factor

### 4.2.1 Standardized Emergency Claims Pricing Protocol

To ensure consistency and fairness in the settlement of emergency medical claims across the Emirate of Dubai, the Dubai Health Insurance Corporation (DHIC) mandates the application of a unified negotiation factor for emergency room claims.

The standard negotiation factor for emergency claims is fixed at 1.3 (excluding public hospitals under the government of Dubai). This rate shall cover the following scenarios:

- Admission of an emergency case to a **non-network healthcare provider**.
- Admission of an emergency case to a **network healthcare provider**, followed by transfer to a **non-network provider** due to:
    - Unavailability of the required service or specialty, or
    - Any other justifiable reason such as lack of capacity at the initial provider.
- This factor must be used exclusively for claims related to services classified as emergency care under the Unified Health Insurance Policy.

**4.2.2 Compliance Obligations**

- All **permitted insurance companies** operating under the Dubai Health Insurance Law shall apply the above negotiation factor in the adjudication and settlement of eligible emergency claims.
- All **permitted healthcare providers** delivering emergency medical services shall bill such claims using the standardized rate and maintain full compliance with DHIC's emergency pricing framework.

## 4.3 Exceptions to waiting periods and exclusions:

Health Insurance Policies may not impose blanket exclusions on pre-existing medical conditions. Any exclusion shall be strictly confined to chronic conditions that were medically established, documented, and disclosed prior to the Beneficiary's first enrollment under a Health Insurance Policy within the Emirate of Dubai.

- Emergency Medical Conditions are expressly excluded from the scope of such waiting periods or exclusions. Coverage for all Emergency Medical Conditions must be provided immediately and without restriction.
- The exclusion period for eligible pre-existing chronic conditions shall be applied only once, at the inception of the individual's initial policy in Dubai and shall not exceed a maximum duration of six (6) consecutive months from the effective date of that policy.
- No insurer shall extend, renew, or reapply such exclusion beyond this prescribed limit under any circumstances.

## 4.4 Emergency Coverage by Non-network providers:

Insurance Companies shall fully settle the cost of emergency healthcare services provided by out-of-network Health Service Providers, within seven (7) working days from the date of service, where such services were necessary to stabilize the Beneficiary. All such cases shall be recorded and processed through the eClaimLink system to ensure compliance, traceability, and regulatory oversight.

## 4.5 Coverage in Absence of Insurance:

### 4.5.1 Financial Liability for Uninsured Beneficiaries

Employers and Sponsors who fail to enroll eligible individuals under their sponsorship in a DHA-compliant Health Insurance Policy shall be fully liable for the entire cost of health services and emergency medical interventions provided to those individuals.

### 4.5.2 Scope of Financial Responsibility

This obligation includes all actual treatment costs incurred during the Emergency Condition, regardless of:

- The cause of the medical emergency (including road traffic accidents, work-related injuries, or excluded conditions)
- The location or timing of the incident; or
- The individual's enrollment status at the time of service.

### 4.5.3 Enforceability

This financial liability remains fully enforceable even in instances where an individual was eligible for coverage but was not enrolled in an insurance policy by the sponsor or employer. Failure to issue a policy does not absolve the Sponsor of their payment obligations.

## 4.6 Post-Stabilization obligations and Continuity of care

### 4.6.1 Continuity of Care Following Stabilization

Following stabilization of an Emergency Condition, the Healthcare Provider, whether in-network or out-of-network, must ensure that the Beneficiary receives appropriate ongoing treatment in accordance with the terms, limits, and prior authorization requirements of the Health Insurance Policy. This obligation applies regardless of whether the Beneficiary remains in the same facility or is transferred.

### 4.6.2 Insurer Responsibilities for Transfer

Where an Insurance Company notifies its intent to continue treatment at a network facility, and the treating provider has classified the patient as Stable for Transfer, the following rules apply:

- The insurer must arrange the transfer within twenty-four (24) hours of receiving the transfer notification.
- Failure to complete the transfer within this period shall result in the continuation of treatment by the current provider, and all costs incurred from the point of transfer eligibility until discharge shall be borne by the insurer.
- Charges shall be billed according to the standard Emergency Coverage tariffs until physical transfer is completed.

### 4.6.3 Emergency Care Overrides to standards Exclusions

- Health Insurance Policies must provide coverage for all emergency conditions up to stabilization, irrespective of the underlying cause, including but not limited to:
    - Road Traffic Accidents (RTAs),
    - Work-related injuries,
    - Other excluded causes under standard policy terms.
- Where another line of insurance is applicable (e.g., motor insurance or workmen's compensation), the health insurer must cover all emergency care up to stabilization, Thereafter the health insurer has the right to subrogate against the claims from the applicable insurer.
- If no alternate insurance exists, the health insurer remains financially liable to bear all the costs incurred up to stabilization.

## 4.7 Emergency Medical Transport and Cost Recovery

### 4.7.1 Coverage for DCAS Ambulance Services

- Ambulance services rendered by Dubai Corporation for Ambulance Services (DCAS) for medical emergencies or accident-related transfers shall be billable to the appropriate insurance provider.
- Insured non-Dubai residents treated or transported by DCAS in the Emirate shall also be subject to the standard ambulance charges.
- Dubai Corporation for Ambulance Services (DCAS) is required to establish formal contracts with all payers and apply payment terms in accordance with the respective contractual agreements. For payers with whom no contract exists, claims must be settled within seven (7) calendar days from the date of receipt.

### 4.7.2 Pre-Authorization Waiver and Costing

- Insurance Companies and Third-Party Administrators (TPAs) shall not reject claims for emergency medical services or patients transferred through DCAS on the grounds of lack of pre-authorization.
- Insurers and Third-Party Administrators (TPAs) may request additional supporting documentation to validate claims; however, such requests shall not delay or obstruct the timely processing of claims.

## 4.8 Timely Settlement of Emergency Claims:

### 4.8.1 Timelines of Emergency Claims

Insurance Companies and Third-Party Administrators (TPAs) shall ensure full and timely settlement of all expenses incurred for health services rendered by licensed Health Service Providers for Emergency Conditions.

Payments must be made in strict accordance with the contractual deadlines and financial obligations as stipulated in the respective provider agreements.

### 4.8.2 Justified Payment Delays

Any delay or deferral in payment beyond contractual terms must be justified in writing and recorded, and subject to DHIC review.

### 4.8.3 Claims dispute resolution and beneficiary communication:

a) Payers shall establish and maintain clear internal protocols for resolution of disputes raised by Beneficiaries regarding the adjudication of emergency claims and its outcomes.

b) Payers shall ensure transparent communication with Beneficiaries by clearly outlining the status of their claims, specific reasons for any denial, available appeals procedures in accordance with procedures defined by DHIC, DHA.

# 5 Monitoring and Enforcement

## 5.1 Oversight Authority:

The Dubai Health Insurance Corporation (DHIC) reserves the right to conduct audits, inspections, investigations, and reviews to assess compliance with the provisions of this Regulation. These reviews may include, but are not limited to, examination of:

- Policy documentation and filings.
- Financial and pricing arrangements.
- Product structures and benefit schedules.
- Claims practices and reimbursement methodologies.
- Operational procedures and data management systems.

## 5.2 Enforcement action:

Any regulated entity or individual found in violation of this Regulation may be subject to one or more of the following administrative enforcement actions:

- Financial penalties in accordance with the severity and nature of the violation.

- Suspension or restriction of the entity's permit or license to operate (not product registration, as enforcement applies to regulatory authorization).
- Temporary or permanent revocation of the operating permit.
- Public listing or reporting of non-compliant entities, if deemed necessary for transparency.

## 5.3 Violations framework:

To support consistent and transparent enforcement, the table below outlines key regulatory violations under this Regulation, the responsible entity type, and indicative enforcement actions. All penalties and administrative measures shall be applied in accordance with the provisions of **Executive Council Resolution No. (7) of 2016 – Concerning the Implementation of Dubai Health Insurance Law No. (11) of 2013 and Executive Council Resolution No. (16) of 2013 Concerning Health Insurance of Government of Dubai Employees.** Failure to comply with any other data governance standards not explicitly specified in this Regulation shall constitute a violation subject to appropriate regulatory action.

| SN | Violation | Penalty (AED) |
|---|---|---|
| 7 | Failure, by an **Employer or Sponsor**, to pay the cost of health services and/or medical intervention in Emergency Cases for his employees or the persons he sponsors whom he has failed to enrol in a Health Insurance scheme as required | 1,000.00 |
| 19 | Failure, by an Insurance Company, to pay the cost of the Health Benefits provided in an Emergency Case by a Health Service Provider that is not part of its Health Service Provider Network within seven (7) working days from the date of provision of such benefits | AED 5,000.00, plus payment of the cost of treatment |
| 16 | Failure, by an Insurance Company or a Claim Management Company, to pay the cost of Health Benefits provided by a Health Service Provider, or its default in the payment of such cost beyond the deadline specified in its contract with the Health Service Provider | AED 20,000.00 per incident |

| | | |
|---|---|---|
| 48 | Failure by a Health Service Provider, even if it is not part of the relevant Health Service Provider Network, to provide health services to a Beneficiary in an Emergency Case until the Beneficiary's life is no longer threatened | AED 10,000.00 per incident |
| 56 | Failure by an Insurance Company, a Claim Management Company, an Insurance Broker, or a Health Service Provider, to comply with the rules, conditions, and procedures approved under the Law, or under the instructions, bylaws, and resolutions issued by the DHA | 10,000.00 |
| **Executive Council Resolution No. (16) of 2013 Concerning Health Insurance of Government of Dubai Employees (Schedule 1)** | | |
| 12 | Failure to perform an obligation stipulated in this Resolution or the resolutions issued hereunder. | 20,000.00 |
| **Executive Council Resolution No. (16) of 2013 Concerning Health Insurance of Government of Dubai Employees (Schedule 2)** | | |
| 6 | Failure to perform an obligation stipulated in this Resolution or the resolutions issued hereunder | 25,000.00 |

# 6 Effective date and legal applicability

This Regulation shall come into effect twenty (20) calendar days following its official publication by the Dubai Health Insurance Corporation (DHIC). All regulated entities are required to achieve full compliance with their provisions within this implementation period. Non-compliance beyond the effective date shall be deemed a regulatory violation and will be subject to enforcement measures under **Executive Council Resolution No. (7) of 2016 – Concerning the Implementation of Dubai Health Insurance Law No. (11) of 2013 and Executive Council Resolution No. (16) of 2013 Concerning Health Insurance of Government of Dubai Employees**.

# 7 References

The following legislative and regulatory instruments, policy directives, and guidance documents were consulted in the drafting of this Regulation:

1. **Dubai Health Insurance Law No. (11) of 2013** – Concerning the Regulation of Health Insurance in the Emirate of Dubai.
2. **Executive Council Resolution No. (7) of 2016** – On Health Insurance Fines and Fees.
3. **Executive Council Resolution No. (16) of 2013** – Concerning Health Insurance of Dubai Government Employees.
4. **Administrative Resolution No. (78) of 2022** – Implementing Bylaw for Dubai Health Insurance Law.
5. **Dubai Health Insurance Corporation (DHIC) Circulars and Directives**
    - PD 01-2016 - Insurance coverage for emergency cases and DHA price list
    - PD 02-2017 - Emergency Definition
    - PD 01-2018 - Patients treated or transferred by Ambulance
    - PD 03-2019 - Settlement of Payment for Emergency Services
    - PD 04-2020 - Co-Payments of emergency cases transferred by ambulance
    - PD 01-2021 Updated TOB for Essential Benefit Plan
    - PD Insurance coverage of Emergency cases_24-11-2020
    - GC 04-2022 - Excluding Public Hospitals under the Government of Dubai form Emergency Factor 1.3.

6. **Dubai Corporation for Ambulance Services (DCAS) Service Agreements and Tariffs** – As formally recognized under the Dubai Health Insurance regulatory framework.
7. **Benchmarking Against International Best Practices** – World Health Organization (WHO) standards on emergency medical care, and OECD health system financing and beneficiary protection frameworks.