Understanding
HEALTH INSURANCE TERMS

cayman islands insurance association

Disclaimer: Every effort has been made to make this exhibit as accurate as possible. However, in the event that anything described herein is in conflict with the provisions set forth in the laws and regulations, policies, contracts, and/or plan documents, the legal instrument will prevail.

Allowed/Allowable Charge
See Usual & Customary (U & C). In Cayman, see SHIF.

Appeal
A request for your health insurer or plan to review a decision or a complaint again.

Assignment of Benefits
When you authorise (assign) that the provider can directly receive your benefits from the insurance company. It is recommended to review charges being submitted on your behalf.

Benefit
The services & amounts payable by the insurance company.

Benefit Period (usually Policy Year)
This is a 12 month period and will be detailed in your Policy. Usually the calendar year of 1st Jan to 31st Dec. If your benefit(s) stipulate e.g. 5 visits to a therapist in that period, you will have to pay for the additional visits. If you have the SHIC Plan you have CI$400 for out-patient services in your benefit period.

Claim
A documentation of services provided which you or your service provider submit to your insurance company for consideration of payment.

Co-insurance / coinsurance
Your share of the costs of a covered healthcare service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $80 and you've met deductible (if applicable), your coinsurance payment of 20% would be $16. The health insurance or plan pays the rest of the allowed amount.

Co-pay / co-payment
A fixed flat dollar amount (for example, $10 or $15) that you pay toward a covered healthcare service, usually when you receive the service.

Cost sharing
When you pay some of the costs of your healthcare.

Covered Person
Any person covered under the plan.

Covered Services
Charges for services that your insurance plan will pay for. Not all services billed will be covered. Different plans and different insurance providers cover different services.

CPT
Current Procedural Terminology - a coding system using 5 number codes that providers put on requests or claims to describe the services they are proposing or have done.

Deductible
On some plans and / or benefits: the yearly amount you may owe for healthcare services before your health insurance begins to pay benefits. For example, if your deductible is $300, certain benefits subject to deductible will not have anything paid by insurance until you have met your $300 deductible cost sharing for those covered services. Some plans may not have deductibles, others may have separate or combined deductibles for medical, dental and/or vision benefits. If your plan has a family maximum on the deductibles, once the sums among the covered family members have accumulated and reach the family max, the deductible is deemed met for all family members for the remainder of that Policy year. Remember to submit your claims to your insurance Company so they know you have made the payments which could count toward deductibles.

Dependant
Spouse or children eligible for coverage on an Insurance policy. In Cayman, eligible dependants include: spouses legally married or living together as man & wife for 5 or more years (proof of co-habitation is usually required); children, step-children and adopted children up to age 18 or 19 (depending upon policy), up to age 24 if attending school, and if financially dependent, up to age 30. For over 18 or 19 yr. old children: to remain eligible, it is necessary to provide your insurance company with information on an annual or semi-annual basis. Married and/or employed children do not usually count as eligible dependants and should go on their own policies.

Effective Date
The date on which your coverage begins.

Exclusion or limitation
A specific situation, condition or treatment that a health insurance plan does not cover or limits in coverage. This will be stipulated by the insurance Company.

Explanation of benefits / EOB
A written or electronic statement which gives details about how a claim was paid by the insurer. It will contain information of what was paid to you and/or the provider, and the portion of the costs you are responsible for.

Health Insurance Commission (HIC)
The division of the Cayman Government's Department of Health Regulatory Services which monitors and assists with compliance of the Health Insurance and related Laws & Regulations. Their website is: www.dhrs.gov.ky.

ICD
International Classification of Diseases - a coding system that providers use on claims to describe the problems they are treating.

Insurance (health)
An agreement and sharing of risk in which persons or companies make regular payments to an insurance Company (the insurer). The Company in turn promises to pay money towards specified wellness / preventative services and towards allowed medical services if the covered person becomes ill or injured.

Medically-Necessary
Services, supplies or prescription drugs that are needed to diagnose or treat a medical condition. Your insurer will review the information provided and decide if it is accepted as standard practice, appropriate for the condition, age etc. and that it is not for convenience or cosmetic reasons. Sometimes additional information is required from you or the provider to make that determination.

Non-covered Charges
Charges for services and supplies not covered under your plan.

Non-disclosure
When an applicant fails to provide accurate details about pertinent medical history when they apply for coverage or upgrade. May be cause for retroactive termination or a permanent exclusion to be applied to a Policy.

Out-of pocket cost
Charges for services and supplies not covered under your plan including deductibles, coinsurance and charges which exceed the allowed charges or the maximum benefits of your plan.

Out-of-pocket Cost
The part of the costs which are the patient's responsibility.

Out-of-Pocket (OOP) Limit
Also called "co-insurance limit" or "stop-loss limit": the most you may have to pay during a benefit period (usually a calendar year) before your health insurance or plan begins to pay 100% of the allowed amounts. This limit never includes your premiums or non-covered services. Plans vary as to which coinsurance sums count towards your OOP limits: hospital, surgical, chemo & radiation coinsurance usually always count. Prescription and dental coinsurance & co-pays never count. Medical visits and diagnostics coinsurance may count on some policies. Deductibles and out-of-network coinsurance very rarely count. Always check to determine the definitions and OOP provisions in your Policy.

Policy
The legal contract outlining the full benefits, eligibility and procedures followed by your insurance company for your coverage. A "**benefit grid**" or "**schedule of benefits**" is a brief overview of the Policy, and the Policy has more of the specifics and legal guidelines.

Portability
In Cayman, when a person is covered on a Cayman-compliant plan for 12 or more months with no more than a 3 month break in coverage, the person is said to be portable to their next Cayman-compliant plan up to similar coverage levels which the prior coverage had. Financial accumulators, such as lifetime maximum and annual maximum, and prior exclusions / restrictions may be carried forward by the new insurer. However, no new exclusions or limitations may be placed on the new Policy (unless the applicant fails to disclose). If the person is applying to an upgraded coverage, the insurer may limit the new plan to their prior plan levels.

Portal (also called Member or Web Portal)
An internet service which most insurers offer in which you can sign up to be able to view your Explanations of Benefits (EOBs) and other insurance information on-line.

Pre-Authorisation
Also called coverage determination. A decision by your health plan about whether a service is medically-necessary and covered by the Policy. Often certain types of care or dollar amounts trigger the need for the insurer to pre-authorise services. Note that proposed fees do not have to be submitted by the provider for a pre-authorisation so the patient is advised to ask about the fees vs. coverage levels too.

Pre-existing Condition
A condition that exists before your health insurance went into effect. These may be limited within your coverage depending upon your portability and your Policy provisions.

Preferred Provider Organisation (PPO)
Always in USA and sometimes in other countries: a network of medical providers who are under contract with your insurance company for accepting assignment of covered benefits and usually provide discounts on costs. Be sure to use the PPO when available for best coverage levels.

Premium(s)
Payments that you or your employer pay to the health insurance company to keep you insured.

Providers
Refers to entities (persons or facilities) who provide medical, dental, vision or pharmacy services.

Referral
The process of directing or redirecting (as a medical case or a patient) to an appropriate specialist or agency for definitive treatment. Your health plan may require written referral requests for any overseas care.

SHIC (Standard Health Insurance Contract)
The minimum health plan coverage that each person residing in Cayman must have. A SHIC plan provides (in Cayman dollars): $1,000,000 lifetime maximum; $100,000 per annum maximum (mostly available towards hospitalisation and inpatient or outpatient surgery, dialysis, chemotherapy and oncology radiation). Some other SHIC plan highlights are: $400 per annum for medical visits, labs/x-rays & prescriptions; $200 per annum for wellness services; $15,000 air ambulance; $5,000 emergency and $500 pre/ante-natal care.

SHIF (Standard Health Insurance Fees)
These are the highest amounts your health insurance company will pay a provider for the services you receive. In the Cayman Islands this is set by the Health Insurance Commission: a look-up tool of SHIF can be found at: http://www.dhrs.gov.ky/ - then click on HIC and Standard Fees. Providers may charge you higher than the SHIF and can bill the patient for the additional amounts; thus you are encouraged to verify charges and coverage levels before services are rendered.

Termination
When a Policy ends for an individual enrolee or for an entire group.

Usual & Customary Charge
The Usual & Customary payment levels that the insurance will consider. Also called Usual, Customary & Reasonable (UC&R) or allowable charge – usually based on geographic norms. In Cayman, see: SHIF.

Waiting Period
A period of time beginning with a policy's effective date during which a health plan may not pay benefits for certain benefits or conditions.