CAYMAN ISLANDS

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HEALTH INSURANCE LAW

(2016 Revision)

HEALTH INSURANCE REGULATIONS

(2017 Revision)

Revised under the authority of the Law Revision Law (1999 Revision).

The Health Insurance Regulations, 1997 consolidated with the Health Insurance (Amendment) (Indigent Persons) Regulations, 1999 (sic), the Health Insurance (Amendment) Regulations, 2001, the Health Insurance (Amendment) Regulations, 2003, the Health Insurance (Amendment) Regulations, 2004, the

Health Insurance (Amendment) Regulations, 2005 the Health Insurance (Amendment) Regulations, 2012 and the Health Insurance (Amendment) (No. 2) Regulations, 2016.

Made	Approved by Legislative Assembly
Regulations, 1997 - 19th August, 1997	5th September, 1997
Regulations, 1999 - 2nd December, 1998	12th April, 1999
Regulations, 2001 - 4th September, 2001	26th September, 2001
Regulations, 2003 - 22nd July, 2003	24th July, 2003
Regulations, 2004 - 1st June, 2004	10th June, 2004
Regulations, 2005 - 25th February, 2005	2nd March, 2005
Regulations, 2012 - 18th September, 2012	21st November, 2012
Regulations, 2016 – 8th March, 2016	22nd April, 2016
Regulations 2016 – 30th August, 2016	24th October, 2016.

Consolidated and revised this 1st day of May, 2017.

Note (not forming part of the Regulations): This revision replaces the 2013 Revision which should now be discarded.

HEALTH INSURANCE REGULATIONS

(2017 Revision)

ARRANGEMENT OF REGULATIONS

HEALTH INSURANCE REGULATIONS

(2017 Revision)

1. These Regulations may be cited as the Health Insurance Regulations (2017 Revision). Citation

2. (1) In these Regulations - Definitions and Interpretation

"ambulant service" means service that is performed in a facility approved under the Health Practice Law (2017 Revision) on a patient who enters and leaves the facility after recovery, within twenty-four hours and includes outpatient radiation, chemotherapy and surgical services and procedures conducted in an ambulant facility; 2017 Revision

"Commission" means the Health Insurance Commission established under section 3 of the Health Insurance Commission Law (2016 Revision); 2016 Revision

"Current Procedural Terminology" (CPT) means a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians, which terms and codes are published by the American Medical Association;

"episode of illness" includes any period during which a person receives medical treatment for an illness within sixty days of any previous treatment for the same illness;

"fees" include any fees or charges prescribed to be paid by patients of health care facilities for treatment, nursing, accommodation, attendance, food, dressings, drugs, medicines or other supplies or services rendered to such patients by the health care facilities; and

"International Classification of Diseases" (ICD) means a statistical classification system that arranges diseases and injuries into groups according to established criteria, and which system is published by the World Health Organisation;

(2) For the purposes of the Standard Health Insurance Contract set out in Schedule 1 the following provisions apply - Schedule 1

A "network" is a collection of medical practitioners, hospitals and other providers of medical care ("medical providers") that:

(a) are under contract with an approved insurer and the contracts provide-

(i) for adequate notice requirements for termination by the approved insurer and medical providers;

(ii) that the medical provider maintain a minimum level of service to the approved insurer's subscribers (e.g. office hours per week for a physician) or other specified availability;

(iii) that the medical provider maintain operating licences in good standing with regulatory authorities;

(iv) that the medical provider agree to charge the approved insurer's subscribers only those cost sharing features (deductibles, copayments, etc.) provided for in the approved insurer's contracts with employers and individuals even if the approved insurer fails to pay the medical provider the balance required for services covered by the approved insurer; and

(b) collectively, can provide the bulk of the services covered under the approved insurer's policies.

Services are considered to be "in-network" when they are provided by a network medical provider.

Services are considered to be "out-of-network" when provided by a medical provider not in the network. If the network cannot provide certain services required by the contracts (e.g. transplants), the approved insurer is obligated to identify a qualified medical provider to provide them. If the approved insurer cannot, the approved insurer is obligated to consider the medical provider selected by the insured person as "in-network". For emergency services, all medical providers are considered "in-network". For the Cayman Islands, a portion of the network would need to be located outside of the islands.

If an approved insurer does not have a network, all services would be considered to have been provided on an "in-network basis".

Prescribed health care benefits

3. (1) The prescribed health care benefits to be covered by a standard health insurance contract are specified in Schedule 1.

(2) An employer shall offer to his employees insurance coverage no less than the standard health insurance contract as set out in Schedule 1.

(2A) An application for the issue of the standard health insurance contract shall be made to an approved insurer in the form set out in Schedule 4 and the approved insurer shall, within ten working days of receipt of the application, advise the applicant and his employer, if any, whether the standard health insurance contract will be issued.

(3) Subject to regulation 9, where -

(a) a compulsorily insured person is required to receive treatment at an overseas health care facility and two registered medical practitioners have provided written confirmation that such treatment cannot be provided at a health care facility in the Islands and that such person requires the treatment as alleged; and
(b) the approved insurer of the compulsorily insured person has given its prior written consent for the overseas treatment,

the compulsorily insured person shall be entitled to claim and receive such usual and reasonable costs for any in-patient benefits received.

Insurance for high risk insurance persons

4. (1) Where a person applies to an approved insurer to obtain insurance under the standard health insurance contract for a high risk insurance person, the approved insurer shall -

(a) provide insurance cover under the standard health insurance contract at the standard premium; or
(b) subject to the following provisions of this regulation, provide insurance cover under the standard health insurance contract -
  (i) at an increased premium that does not exceed two hundred percent of the standard premium, to take into account the increased risk being assumed by the approved insurer; or
  (ii) at an increased premium that exceeds two hundred percent of the standard premium, to take into account the increased risk being assumed by the approved insurer.

(2) Where, after consideration of an application for the issue of the standard health insurance contract for a high risk insurance person, an approved insurer decides to provide insurance cover for the high risk insurance person under the standard health insurance contract at an increased premium that does not exceed two hundred percent of the standard premium, the approved insurer shall, within fifteen days of making the decision, notify the Commission of the decision and provide the Commission with such documents and information as the Commission considers necessary, including an actuarial assessment.

(3) Where, after consideration of an application for the issue of the standard health insurance contract for a high risk insurance person, an approved insurer decides to provide cover for the high risk insurance person under the standard health insurance contract at an increased premium that exceeds two hundred percent of the standard premium, the approved insurer shall, within fifteen days of making the decision, apply to the Commission for approval of the decision and provide the Commission with such documents and information as the Commission considers necessary, including an actuarial assessment.

(4) Where the Commission is of the view that a decision made by an approved insurer pursuant to subregulation (2) or (3), is unreasonable, the

Commission shall, within fifteen days of receipt of the decision, order such variation of the decision as the Commission considers appropriate and the approved insurer shall give effect to the decision as varied.

(5) An order made by the Commission under subregulation (4) shall take effect on the tenth day after the date on which the order was made.

(6) A person aggrieved by an order of the Commission under subregulation (4) may, within ten days of the date on which the order was made, appeal to the Grand Court in accordance with rules made by the Rules Committee for the purposes of this regulation.

(7) On an appeal under subregulation (6), the Grand Court may confirm or discharge the order of the Commission.

(8) A person who fails to provide information or documents under subregulation (2) or (3) commits an offence and is liable on summary conviction to a fine of ten thousand dollars.

Insurance for uninsurable persons

4A. (1) Where, after consideration of an application for the issue of the standard health insurance contract, an approved insurer decides to deem a person unacceptable for cover under the standard health insurance contract, the approved insurer shall, within fifteen days of making the decision, apply to the Commission for approval of the decision and provide the Commission with such documents and information as the Commission considers necessary, including an actuarial assessment.

(2) Where the Commission is of the view that a decision made by an approved insurer pursuant to subregulation (1), is unreasonable, the Commission shall, within fifteen days of receipt of the decision, order such variation of the decision as the Commission considers appropriate and the approved insurer shall give effect to the decision as varied.

(3) An order made by the Commission under subregulation (2) shall take effect on the tenth day after the date on which the order was made.

(4) A person aggrieved by an order of the Commission under subregulation (2) may, within ten days of the date on which the order was made, appeal to the Grand Court in accordance with rules made by the Rules Committee for the purposes of this regulation.

(5) On an appeal under subregulation (4), the Grand Court may confirm or discharge the order of the Commission.

(6) A person who fails to provide information or documents under subregulation (1) commits an offence and is liable on summary conviction to a fine of ten thousand dollars.

Health care for indigent persons

5. (1) The Commission on behalf of the Government shall, in order to cover medical costs for indigent persons, collect from-

(a) each approved insurer other than the Cayman Islands National Insurance Company, ten dollars per month of each premium charged by the approved insurer under each standard health insurance contract effected by that insurer in respect of an insured person with no dependants;

(b) each approved insurer other than the Cayman Islands National Insurance Company, twenty dollars per month of each premium charged by the approved insurer under each standard health insurance contract effected by that insurer in respect of an insured person with dependants;

(c) the Cayman Islands National Insurance Company, ten dollars per month of each premium charged by that Company under each standard health insurance contract effected by that Company in respect of an insured person with no dependants, other than an insured person who is specified in section 5(3)(a) to (i) or (4)(a) to (e) of the Law; and

(d) the Cayman Islands National Insurance Company, twenty dollars per month of each premium charged by that Company under each standard health insurance contract effected by that Company in respect of an insured person with dependants, other than an insured person who is specified in section 5(3)(a) to (i) or (4)(a) to (e) of the Law.

(2) Where the Commission considers it necessary and in the public interest, it may, after giving three months' notice in writing to the approved insurers of its intention so to do, vary the amount to be paid under subregulation (1), and such variation shall be set out in a notice published in the Gazette.

(3) Payments collected under subregulation (1) shall be paid to the Commission for payment into the segregated insurance fund established under the Health Insurance Commission Law (2016 Revision).

2016 Revision

Premiums

6. (1) An approved insurer shall, not less than thirty days prior to first effecting a standard health insurance contract, notify the Commission of its standard rate for such contract and provide the Commission with -

(a) the minimum expected loss ratio of claims to premiums;

(b) a review of projection assumptions; and

(c) such other information as the Commission considers relevant.

(2) An approved insurer shall, not less than thirty days prior to first effecting an increase to its standard rate for a standard health insurance contract, notify the Commission of its intent to increase the standard rate and provide the Commission with such documents and information as the Commission considers necessary, including -

(a) the minimum expected loss ratio of claims to premiums;
(b) a detailed history of premiums and claims; and
(c) a review of projection assumptions.

(3) Where the Commission determines that the rate, or the proposed rate, of a standard premium is excessive, inadequate, unfairly discriminatory or unreasonable, the Commission -

(a) shall notify the relevant approved insurer accordingly; and
(b) after conducting an inquiry, may order such adjustment to be effected within fifteen working days to the rate, or the proposed rate, as the Commission considers appropriate.

(4) An order made by the Commission under subregulation (3) shall take effect on the tenth day after the date on which the order was made.

(5) A person aggrieved by an order of the Commission under subregulation (3)(b) may, within thirty days of the date on which the order was made, appeal to the Grand Court in accordance with rules made by the Rules Committee for the purposes of this regulation.

(6) On an appeal under subregulation (5), the Grand Court may confirm or discharge the order of the Commission.

(7) A standard premium shall become due on the first day of the month for which it is payable.

(8) The part of the employee's premium payable by the employee under sections 7 and 8 of the Law shall be paid at regular weekly or monthly periods during his employment.

(9) A person who fails to comply with subregulation (1) or (2) commits an offence and is liable on summary conviction to a fine of ten thousand dollars.

(10) In this regulation -

"projection assumptions" means conditions or circumstances that may affect a premium rate.

Cover

7. (1) Subject to these Regulations, the minimum period of cover provided under any standard health insurance contract shall be three months or the period for which premiums have been paid, whichever is less.

(2) Where a premium is paid by the employer in respect of any insured person, that insured person and his dependants, if any, shall be covered under the standard health insurance contract for the month for which the premium is paid notwithstanding that, during the course of that month, the insured person's employment may be terminated or he otherwise ceases to be compulsorily insured.

(3) Where an insured person takes up employment in the course of a month the effective day for the purpose of determining liability of his employer under section 5 of the Law shall be the first day of employment, except that, where the insured person is already insured for the month in which the employment begins under a contract of insurance effected by his previous employer, the effective day shall be the first day of the month next following the first day of employment.

(4) Cover under a standard health insurance contract ceases on the first day of the month next following the date of the termination of employment except that, in accordance with section 15 of the Law, if the insured person does not become insured under any other employer, cover under the contract shall continue to be made available for a period of three months from the date of termination of employment or until he becomes employed, whichever is earlier.

(5) This regulation shall apply with the necessary changes in respect of the dependants of the insured person.

(6) Where an insured person changes his approved insurer and, prior to that change, the insured person had been insured continuously for a period of not less than one year under one or more other health insurance contracts effected by an approved insurer, with breaks in insurance cover not exceeding three months in the aggregate, then -

(a) the new approved insurer for the insured person shall provide health insurance cover to the insured person and his dependants -

(i) under a plan of benefits which is favourably comparable to the plan of benefits provided by the previous approved insurer; or

(ii) where there is no favourably comparable plan of benefits, under a plan of benefits which is offered by the new approved insurer for the insured person and which is as similar as possible to the supplemental plan of benefits provided by the previous approved insurer;

(b) the insurance cover so provided to the insured person and his dependants shall not contain, with respect to the medical condition of the insured person or his dependants, any exclusions or limitations of cover that were not specified by the previous approved insurer;

(c) the insurance cover so provided to the insured person and his dependants may be provided at an increased premium; and

(d) for the purpose of applying any pre-existing condition requirements for the insurance cover, the insurance cover of the insured person and his dependants shall be deemed to have begun on the date that it was deemed to have begun under the respective previous health insurance contracts effected by the previous approved insurer.

(7) Where an employer changes his approved insurer -

(a) the new approved insurer shall not refuse to provide insurance cover to any employee insured under the previous health insurance contract effected by the previous approved insurer;

(b) the insurance cover so provided to the employee shall not contain, with respect to the medical condition of the employee, any exclusions or limitations of cover that were not specified by the previous approved insurer;

(c) the insurance cover so provided to the employee may be provided at an increased premium; and

(d) for the purpose of applying any pre-existing condition requirements for the insurance cover, the employee's coverage shall be deemed to have begun on the date that it was deemed to have begun under the previous health insurance contract effected by the previous approved insurer.

(8) An approved insurer shall not refuse to renew a contract of insurance on the ground that a compulsorily insured person has contracted an illness.

(9) In this regulation -

"pre-existing condition", in relation to an employee or insured person, means a medical condition known to the employee or insured person prior to the date of a health insurance contract or a medical condition for which treatment was given or recommended or drugs taken or prescribed or of which symptoms were or had been manifest during the period of twelve months prior to the date of the health insurance contract and of which the insured person should have been aware.

Claims

8. (1) Any claim in respect of a prescribed health care benefit provided to a compulsorily insured person by a health care facility or a registered medical practitioner -

(a) shall be made by the health care facility or the registered medical practitioner in a form published from time to time by the American Medical Association; and

(b) shall be submitted by the health care facility or the registered medical practitioner no later than one hundred and eighty days after providing the prescribed health care benefit to that person.

(2) A claim submitted by a health care facility or a registered medical practitioner under this regulation shall be accompanied by -

(a) detailed documentation from the health care facility or the registered medical practitioner showing the payment that is due to the health care facility or the registered medical practitioner from the insured person or other proof of the costs incurred by that person; and

(b) such information relating to the benefits received by the insured person as the approved insurer may reasonably require for the purpose of determining the claim.

Payment of claims

9. (1) Where a health care facility or a registered medical practitioner has submitted a claim form and any other documents required under regulation 8 and there is no dispute as to the claim made, an approved insurer shall process and respond to or pay (as the case may be) the claim no later than thirty working days after receiving the claim.

(2) The claim form to be used by a registered medical practitioner, a health care facility and an approved insurer shall be a form introduced and published by the Centres for Medicare and Medicaid Services (CMS) and the National Uniform Billing Committee and shall include CPT codes and ICD codes and such other approved diagnosis and treatment codes as may be applicable.

(2A) All new CPT codes which are introduced and published from time to time by the American Medical Association (CPT Code Book Professional Edition) due to changes in procedures, treatments, services, technology or other reasons shall be accepted and utilized, for claims processing, by registered medical practitioners, health care facilities and approved insurers.

(2B) Registered medical practitioners and health care facilities shall file the new codes as an Individual Report with the Commission, and the fee for a new code shall be determined and communicated to the relevant medical practitioner, health care facility and approved insurer within sixty days of filing and the new CPT code and fee shall be published in accordance with the Law.

(3) Where a health care facility or a registered medical practitioner makes claims for benefits which appear to the approved insurer to be medically

unnecessary or frivolous the approved insurer shall not be obligated to settle such claims.

(4) In determining whether a claim is medically unnecessary or frivolous, the approved insurer shall have regard to current medical practice.

(5) Where a health care facility or a registered medical practitioner has, without reasonable excuse, submitted a claim form later than one hundred and eighty days after providing a prescribed health care benefit the approved insurer shall not be obligated to deal with such claim.

(6) Where an approved insurer fails to pay a claim in accordance with the time limit set out in subregulation (1) and there is no dispute as to that claim, the approved insurer shall be liable to pay interest on the money owed from the thirty-first day after the claim has been submitted to the date on which payment is made to the health care facility or the registered medical practitioner.

(7) The rate at which interest is payable under subregulation (6) is at the rate of two percent above the US prime interest rate in force from time to time.

Maximum benefits

10. Under the Standard Health Insurance Contract set out in Schedule 1, an approved insurer shall be liable to pay on behalf of each compulsorily insured person -

(a) during each calendar year, not more than $100,000 in medical fees; and
(b) during the life of an insured, not more than $1,000,000 in medical fees.

Renewal of contract

11. (1) Subject to subregulation (2), a standard health insurance contract shall provide that it continues in force for a period not exceeding twelve months provided that the premium is paid.

(2) Subregulation (1) is without prejudice to an approved insurer's right to terminate a standard health insurance contract in accordance with section 15 of the Law.

Insurer ceasing to be approved

12. If-

(a) the licence of an approved insurer is revoked or suspended for any reason by the Cabinet under the Insurance Law, 2010; or

Law 32 of 2010

(b) an approved insurer withdraws from the provision of health insurance,

the approved insurer shall not be relieved of any liability in respect of any standard health insurance contract in force at the date of such revocation, suspension or withdrawal.

Records

13. (1) An approved insurer shall keep a record in respect of each person insured by that approved insurer under a standard health insurance contract.

(2) A record kept in accordance with subregulation (1) shall be produced to the Commission upon request.

Documents to be submitted to the Commission

14. An approved insurer shall submit to the Commission at least once every twelve months a certificate signed by an auditor stating-

(a) the amount of premium collected under each standard health insurance contract effected by that provider; and
(b) that the approved insurer has complied with regulation 5.

Identification card

15. (1) An approved insurer shall, within two weeks of the making of a standard health insurance contract, issue an identification card to each person insured by the approved insurer under that standard health insurance contract.

Schedule 3

(2) An identification card shall contain such minimum information as is specified in Schedule 3.

(3) An approved insurer who fails to provide an identification card in accordance with subregulation (1) commits an offence and is liable on summary conviction to a fine of two thousand dollars.

(4) Where a person shows his identification card to a health care facility or a registered medical practitioner in relation to a medical benefit that is covered by a contract of health insurance and provided to him by the health care facility or the registered medical practitioner, the health care facility or the registered medical practitioner shall -

(a) accept the identification card; and
(b) verify that there is in existence a contract and benefits therein issued by an approved insurer to provide cover in relation to that person,

and, where such a contract exists, any claim under the contract in respect of the covered medical benefit so provided shall be deemed to be assigned to the health care facility or the registered medical practitioner, as the case may be.

(5) A health care facility or a registered medical practitioner shall not be required, except in the case of an emergency, to provide any medical benefits to a person who fails or refuses to show his identification card.

Inspectors

16. (1) The Cabinet may, by notice in the Gazette, appoint officers of the Commission to be inspectors for the purposes of the Law for such periods of time as it considers appropriate.

(2) Each inspector shall be issued with an identification card prepared and signed by the Permanent Secretary of the ministry responsible for health insurance or his nominee, and the identification card shall contain a photograph of the inspector.

Powers of inspectors

17. (1) An inspector shall, for the purpose of performing his functions under these Regulations, have power -

(a) without previous notice and at all reasonable times, to enter and have access to, through and over any premises, where the inspector has reasonable grounds to believe any book, paper, document, thing or electronically stored data are kept that relate to any matter under the Law or these Regulations;
(b) to make examinations, investigations and inquiries, and require the production of any book, paper, document, thing or electronically stored data that relate to any matter under the Law or these Regulations;
(c) to make, take, remove or require the making, taking or removal of copies or extracts that relate to any such examination, investigation or inquiry; and
(d) to exercise such other powers as may be reasonably necessary.

(2) An inspector shall not, under subregulation (1), enter a private residence without the consent of the occupier, and, on entering any premises or place for the purposes of the Law or these Regulations, shall produce the identification card issued to him under regulation 16.

(3) An inspector may, for any purpose specified under this regulation, upon giving a receipt, remove any, books, papers, documents or electronically stored data respecting health insurance, and may copy such books, papers or other documents within a reasonable period of time and return them as soon as reasonably practicable after the copying is completed.

(4) A copy of any book, paper, document or electronically stored data respecting health insurance, made under this regulation by an inspector in the course of any investigation, examination or inquiry and certified by the Commission, is admissible in evidence in any action for all purposes for which the original would have been admissible.

(5) Where an owner or occupier of premises -

(a) denies entry or access to, through or over premises to an inspector;
(b) instructs the inspector to leave the premises;
(c) obstructs the inspector; or

(d) refuses to comply with a request for the production of any book, paper, document or electronically stored data the production of which is requested for the purpose of examination and investigation or inquiry or for a purpose mentioned in subregulation (1),

he commits an offence and is liable on summary conviction to a fine of ten thousand dollars.

(6) Where any documents are held in or kept by means of a computer, the powers of the inspector to require the supply of information and production of documents shall include powers -

(a) to require any person having charge of, or otherwise concerned with the operation of a computer or associated apparatus which is or has been in use in connection with such information or documents, to afford to the inspector such assistance as he may reasonably require; and
(b) to require the information or documents to be produced or copied in any form which the inspector may reasonably request.

(7) In this regulation -

"document" includes any information or document held or kept by means of a computer.

Employer to maintain records

18. Every employer shall maintain employment and earnings records relating to each employee showing-

(a) the name, address, sex and date of birth of each such employee;
(b) the dates of commencement and termination of employment;
(c) if such employee is married and has children, the name and address of his spouse and children and if the spouse is employed, the name and address of the employer of the spouse;
(d) the name of the approved insurer with whom a standard health insurance contract has been effected; and
(e) the amount deducted monthly from the wages, salary or other remuneration of each employee in respect of health insurance.

Offences

19. (1) An employer who fails to maintain records in accordance with regulation 18 commits an offence and is liable on summary conviction to a fine of five hundred dollars.

(1A) A person who fails to comply with regulation 13 or 14 commits an offence and is liable on summary conviction to a fine of ten thousand dollars and if the offence is a continuing one to a fine of five hundred dollars for every day or part of a day during which the offence has continued.

(2) A person who-

(a) wilfully delays or obstructs an inspector in the exercise of any power under these regulations; or

(b) refuses or neglects to answer any question or to produce any document or record when required to do so by an inspector,

commits an offence and is liable on summary conviction to a fine of five thousand dollars.

Duty of approved insurer

20. (1) An approved insurer, with whom an employer has effected a contract of health insurance, shall report to the Commission any failure on the part of the employer to pay the required premiums on the date such premiums were due, and the approved insurer shall make the report no later than forty-five days after such due date.

(2) An approved insurer who fails or refuses to comply with subregulation (1) commits a procedural offence and, subject to a right of appeal to a summary court, shall pay to the Commission a fine not exceeding five thousand dollars and a further fine not exceeding one hundred dollars for each day or part of a day during which the contravention has continued; and the fines collected by the Commission under this regulation shall be paid into the revenue of the Islands.

Government employees

21. (1) The Government may, in respect of each employee and his dependants in the following categories, effect, with an approved insurer, a health insurance contract which shall provide benefits not less than those provided by the Government in accordance with Chapter 18 of General Orders prior to the 31st January, 1998-

(a) officers in pensionable offices or on probation to such offices;

(b) officers serving under local and overseas contracts; and

(c) *repealed by regulation 14 of the Health Insurance (Amendment) Regulations, 2012*

(d) public office pensioners.

(2) In respect of any other government employee or any other person specified under section 5(3) of the Law, the Government may effect with an approved insurer in respect of each such person and his dependants a standard health insurance contract.

Seamen and veterans

22. (1) The Government may effect with an approved insurer in respect of-

(a) a seaman fifty-five years of age or older or his unemployed spouse or his children;

(b) a widow of a seaman;

(c) a veteran or his unemployed spouse or his children; or

(d) a widow of a veteran,

a health insurance contract which shall provide benefits similar to those available to the persons specified in regulation 21(1) provided that such benefits shall be available only at a government health care facility.

(2) A person specified under subregulation (1) shall, prior to obtaining any health care service at a government health care facility, present proof of his membership or the membership of her spouse of either the Veterans' and Seamen's Society of Cayman Brac and Little Cayman, the Cayman Islands Seafarer's Association or the Cayman Islands Veterans' Association.

Determination of disputes

23. (1) Where a person disputes a matter under a standard health insurance contract including a claim to a benefit, he may apply to the Commission by notice in writing requesting a determination of the matter, and such application shall state briefly the nature of the matter.

(2) On receipt of a notice under subregulation (1), the Commission may request such further information and documents as it deems necessary to assist it in determining the matter.

(3) Where the Commission disallows a claim under a standard health insurance contract or determines a question adversely to the applicant, it shall notify the applicant in writing of its decision, the reasons for the decision and the right of appeal under section 23 of the Law.

Savings and transitional provisions

24. A contract of health insurance that is in force immediately before 1st March, 2013 shall, on the first annual renewal date of the contract of health insurance after 1st March, 2013, be converted into a contract of health insurance similar to the Standard Health Insurance Contract contained in Schedule 1, to the principal Regulations, at a fair and reasonable rate determined in accordance with the same methodology as used in rating the contract of health insurance.

SCHEDULE 1

regulation 3

PRESCRIBED HEALTH CARE BENEFITS

Part 1

Standard Health Insurance Contract

COVERAGE LEVELS IN CI$	
Individual Lifetime Maximum **Individual Annual Maximum**	$1,000,000 $100,000
In-patient Benefits:	
Coinsurance Individual Maximum (applies to hospitalization, surgery, chemotherapy and radiation therapy only)	20% of the first $5,000 of eligible charges up to $1,000 per annum
In-patient Hospital (including physician, surgical, room and board and ancillary expenses) Out-patient Surgery in an ambulatory surgical centre or hospital Chemotherapy or Radiation Therapy (in-patient or out-patient) Maternity-labour and delivery, major maternity procedures and hospitalization Post-Natal (Newborn Care)	80% to coinsurance maximum, then 100% to Individual Annual Maximum ($100,000)
In-patient Benefits - Mental Health	80% to coinsurance maximum, then 100% up to $25,000 per lifetime
Out-patient Benefits:	

Doctor Office Visits and other physician fees including office procedures Diagnostics including radiology/laboratory Physiotherapy with physician referral only Prescription Drugs including contraceptives and contraceptive devices available by prescription only	80% within the annual $400 out-patient benefit
Wellness Benefits: Routine Physicals, Annual Exams, Wellness Services Well Child Care Nutrition counselling with physician referral only One Dental examination/check-up and prophylaxis annually	80% within the annual $200 wellness services
Maternity Benefits: Antenatal (pre-natal)	80% within the $500 per pregnancy benefit
Emergency Medical Services (Including medication, drugs, ground ambulance for "threat to life or limb", sudden onset conditions)	100% of the first $4,000 out-patient services then as per applicable benefit category
Haemodialysis	100% up to Individual Annual Maximum
Air Ambulance Air Ambulance for "life or limb"	**Based upon medical necessity**. 100% up to $15,000 per annum

threatening emergency Medical Airfare for "life or limb" threatening emergency	
Repatriation of remains	$2,000

In-patient Benefits and Ambulant Service Benefits

1. Accommodation and meals up to thirty days in a semi-private room or, where medically necessary, in an intensive care unit.

2. Physicians', specialists' and surgeons' services including ambulant services.

3. Anaesthesia, use of operating room and recovery rooms.

4. Use of all in-patient services of any health care facility.

5. Full nursing service up to thirty days.

6. Standard surgical supplies including oxygen, surgical appliances and implants.

7. Medication and drugs.

8. Use of physiotherapy, inhalation and other rehabilitative therapy facilities.

9. Radiology and Diagnostic Services.

10. Laboratory and pathological studies (including overseas referrals of such studies by registered medical practitioners).

11. Post-natal care for a newly-born dependent child for a period of thirty days from the dependent child's birth to be provided under the mother's benefit until other or alternate coverage is arranged.

Note: Where the Chief Medical Officer/Medical Director and one other registered medical practitioner other than the attending medical practitioner certify that a patient must receive the said benefit for more than thirty days maximum, such patient may claim payment for the cost or part of the cost of the benefit in excess of thirty days.

Part 2

Out-patient benefits

1. Visits to a registered medical practitioner including routine physicals, annual exams, routine laboratory and radiology tests, antenatal services, physiotherapy, prescription drugs, dental check-up and prophylaxis every twelve months, dental surgery for the excision of impacted teeth or a tumour or cyst or treatment for injury to sound natural teeth subject to a limit as prescribed in the plan.

2. Haemodialysis.

3. Emergency medical services, including medication, drugs and ambulance services, subject to a maximum as prescribed in the plan.

Note: In this Part -

"emergency" means a sudden or unexpected occurrence or event causing a threat to life or limb.

Part 3

Benefits which may be excluded under the standard health insurance contract

Benefits will not be provided in connection with -

1. The treatment of any episode of illness or injury which occurred prior to the commencement of the standard health insurance contract, unless the episode of illness or injury or other pre-existing condition was fully disclosed in writing.

2. Consultations in connection with, and treatment for, infertility including in-vitro fertilisation, artificial insemination and other experimental services.

3. Consultations in connection with and treatment for, sexual dysfunction or sex change procedures.

4. Sterilisation.

5. Treatment for any illness caused by or injury sustained in a war (declared or undeclared) or while a person was in active military service in any country.

6. Treatment for injury sustained during hazardous activities, including hang-gliding, sky-diving, parachuting, ballooning, flight in ultra-light aircraft and non-certified scuba diving.

7. Treatment for obesity or weight reduction.

8. Treatment for illness or injury arising from or associated with drug or alcohol abuse, self-inflicted injuries, and sexually transmitted diseases.

9. Treatment for any illness or injury arising from or connected with the Human Immunodeficiency Syndrome.

10. Treatment which, in the opinion of a registered medical practitioner or a health care facility, is not medically necessary.

11. The supply or fitting of eye glasses, contact lenses or hearing aids.

12. Marital counselling, including therapy for marital difficulties and family counselling.

13. Occupational therapy or speech therapy, except where medically necessary.

14. Charges for -

(a) rest cures;
(b) custodial, hospice or geriatric care;
(c) periods of legally enforced quarantine or isolation; or
(d) services received in hydros, or nature cure clinics.

15. Home nursing.

16. Services of an intern or resident doctor unless billed by a health care facility.

17. The rental or purchase of orthotic devices or appliances except where those devices or appliances are required to be permanently fastened to an orthopaedic brace.

18. Cosmetic surgery unless deemed medically necessary by two independent registered medical practitioners.

19. Rental or purchase of exercise equipment or similar non-medical equipment and other items for personal comfort.

20. Charges which the insured has no legal obligation to pay or for which no charge would have been made if the insured had no health insurance cover.

21. Treatment, medicine or other supply which is experimental.

In this Part -

"cosmetic surgery" means surgery performed primarily to improve a person's physical appearance or to restore to normal state through change in the body's appearance, other than surgery for the repair or treatment of an injury or a congenital bodily defect to restore bodily functions;

"experimental" -

(a) in relation to treatment, medicine or other supply, means treatment, medicine or other supply which is still a part of a research programme and which has not been approved by the Health Practice Commission established under section 3 of the Health Practice Law; and
(b) in relation to medicine or other supply, means medicine or other supply which is not included in the British National Formulary or the Physician's Desk Reference unless it has been approved for use in the Islands by the Chief Medical Officer;

"injury" means any wound, trauma, damage, shock or other physical damage or pain that is inflicted on the body and produced by a sudden physical event such as any violence, fall, collision, laceration, fracture, blow or accident or by an external physical cause, such as burn injury, drowning, poisoning or other toxin;

"medically necessary" in relation to treatment, medicine or other supply, means treatment, medicine or other supply which is-

(a) appropriate to the diagnosis or treatment of the insured's illness;
(b) consistent with accepted medical or professional standards of practice;
(c) not primarily for the personal comfort or convenience of the insured, his family, his physician or other health provider; and
(d) the most appropriate level of treatment or medicine that can safely be provided to the insured and which, in the case of in-patient care, cannot be provided safely on an out-patient basis;

"pre-existing condition" means a medical condition known to the compulsorily insured person prior to the date of a health insurance contract or a medical condition for which treatment was given or recommended or drugs taken or prescribed or of which symptoms were or had been manifest

during the period of twelve months prior to the date of the health insurance contract and of which the compulsorily insured person should have been aware; and

"semi-private room" means a room in a health care facility that is equipped to accommodate two to four persons.

Part 4

1. The in-patient benefits and ambulant service benefits specified in Part 1 may be provided at a health care facility in the Islands or at an overseas health care facility.

2. The out-patient benefits specified in paragraph 1 of Part 2 shall be limited to out-patient benefits provided in a health care facility in the Islands.

3. Subject to paragraph 5, a compulsorily insured person shall be required to pay, for any benefit in Part 1 received by him at a health care facility or a registered medical practitioner -

(a) twenty per cent of the published fee for that benefit where applicable up to an annual maximum of $1,000 during each calendar year; and
(b) any fees which are charged for that benefit and which are in excess of the published fee.

4. An approved insurer shall pay, in respect of each person insured compulsorily with that insurer for any benefit in Part 1 received by that person at a health care facility or registered medical practitioner, eighty per cent of the published fee for that benefit where applicable up to $4,000 during each calendar year.

5. Notwithstanding paragraphs 3 and 4, an approved insurer shall be liable during each calendar year to pay all fees charged after the first $5,000 for any benefits to an insured person under Part 1 subject to the annual limit specified in regulation 10.

6. An approved insurer shall be liable to pay eighty per cent of the published fee for the benefits specified under paragraph 1 of Part 2 up to the maximum of the costs for such benefits specified in that paragraph.

SCHEDULE 2

Repealed by regulation 4 of the Health Insurance (Amendment) (No. 2) Regulations, 2016.

SCHEDULE 3

regulation 15

MINIMUM INFORMATION REQUIRED TO BE INCLUDED IN THE HEALTH INSURANCE IDENTIFICATION CARD

Name of insured:

Policy number:

Certificate number:

Name of employer:

Name of dependant:

Hospital registration number (where applicable):

This card is issued as a means of identifying the Insured's Health Insurance Policy. For verification of coverage and questions on benefits, please contact the following insurance company-

Name of insurance company:

Mailing address, street address, fax and telephone number:

SCHEDULE 4

regulation 3(2A)

STANDARD HEALTH INSURANCE CONTRACT
HEALTH INSURANCE APPLICATION FORM

NOTE THE INFORMATION ON THIS FORM IS TREATED AS CONFIDENTIAL

Please check the appropriate boxes:
❒ Individual Coverage ❒ Group Coverage

❒ Employed ❒ Unemployed ❒ Self Employed ❒ Retired

Proposed Effective Date of Policy _____

PART A: Applicant Information

	Last First Middle	Date of Birth	Sex M/F	Height Feet/Inches	Weight Lbs/Oz	Immigration Status
Applicant						

Postal Address: _____ Email Address:_____

Physical Address: _____

Telephone: _____ Fax: _____

Beneficiary _____ Relationship: _____

Date of Birth_____

Postal Address: _____ Telephone: _____

PART B: Employer Information

Name of Employer: _____ Employer #: _____

Postal Address: _____ Email Address:_____

Physical Address: _____

Telephone: _____ Fax: _____

Employer's signature:_____Date:_____

PART C: Eligible Dependents

Relationship	Family Members Names Last First Middle	Date of Birth	Sex M/F	Height Feet/Inches	Weight Lbs/Oz	Immigration Status
Spouse						
Child1/ Dependent Offspring						
Child2/ Dependent Offspring						
Child3/ Dependent Offspring						

Is your spouse employed? Y / N. If yes, please provide name of employer: _____

Are medical benefits available from any other approved insurer to any person listed above (Part A &/or Part C)? Y / N. If yes, please provide name of approved insurer and telephone information:

Approved Insurer: _____Telephone: _____

Has any person listed above (Part A &/or Part C) had continuous coverage for a period of not less than one year? Y/N. If yes, please state the name of the approved insurer: _____

Part D: Medical Questionnaire
Must be completed by all persons

In the last twelve months has any person listed above (Part A &/or Part C) ever been advised to or received medical consultation, care, treatment or taken medication in relation to any of the following:

1. Y / N Heart or circulatory system (including but not limited to infarction, heart attack, angina, rheumatic fever, cardiac defect, arrhythmias, diseases of veins,

arteries or valves, stroke) and/or any other symptom regarding circulatory system or heart.

2. Y / N Sexually transmitted diseases or Human Immunodeficiency Virus (HIV) or Acquired Immuno Deficiency Syndrome (AIDS) or ARC (AIDS related complex).

3. Y / N Neurological System (including but not limited to convulsions epilepsy, paralysis, Multiple Sclerosis, cerebral infarction(stroke), Alzheimer's disease, dementia) and/or any other symptom regarding the neurological system, which if referred to a doctor would result in a diagnosis.

4. Y/ N Liver disorders (including but not limited to fatty liver, cirrhosis, hepatitis) and/or any other symptom regarding the liver, which if referred to a doctor would result in a diagnosis.

5. Y/ N Kidney/Renal disease or failure

In the last twelve months has any person listed above (Part A &/or Part C) ever:

6. Y/ N Been treated for Cancer, if yes, please explain:

   _____

7. Y/ N Been treated for Diabetes(sugar)/Hypertension(high blood pressure) , if yes, please explain: _____

8. Y/ N Been treated for Respiratory conditions, if yes, please explain:

   _____

9. Y / N Had an organ Transplant, if yes please explain:

   _____

10. Y/ N Had major surgery, if yes please explain:

    _____

11. Y/N Are you currently on medications? Please specify.

    _____

12. Females only: Are you pregnant, if yes please specify the number of weeks gestation: _____

Has any approved insurer within the last twelve months:

13. Y/N Declined an application for health insurance?

14. Y/N Required an increased premium or imposed special condition?

15. Y/N Cancelled or refused to renew an existing health insurance policy?

Declaration

I hereby declare that the answers given and recorded herein are, to the best of my/our knowledge, complete and true as at this date.

I hereby authorize any registered medical practitioner, healthcare facility or approved insurer which has copies of my health records to release such information to _____ (name of approved insurer). A photocopy of this signed authorization shall be as valid as the original.

I understand and agree that any injury that occurred within twelve months before the date of this application or any sickness, the signs of which first appeared on or before the date of this application, are not covered by this contract unless fully disclosed on this application. Failure to disclose such information could result in denial of a claim and the cancellation of coverage.

I understand and agree that coverage shall not become effective until accepted by the approved insurer.

I understand that any changes in my health status after submission of application and prior to approval of coverage must be reported to the approved insurer.

Signature of Applicant: _____Signature of Dependent (if applicable)
_____ Date: _____
DD/MM/YY

THIS APPLICATION WILL BE VALID FOR 3O DAYS FROM THE DATE OF SIGNATURE.

For Office Use Only
Comments from Approved Insurer

FAILURE TO DISCLOSE RELEVANT DETAILS OR GIVING MISLEADING INFORMATION MAY CAUSE YOUR APPLICATION TO BE DEEMED NULL AND VOID

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Clerk of Cabinet

(Price $6.40)