ADEQUATE LEVELS OF HEALTH INSURANCE FOR TSS VISA HOLDERS

Bupa

LAW INSTITUTE OF VICTORIA ACCREDITED SPECIALIST

HT Hannan Tew Lawyers

ADEQUATE HEALTH INSURANCE

All applicants for TSS visas must make adequate arrangements for health insurance during the period of their intended stay in Australia. In general, adequate levels of health insurance is considered:

1. if the applicant provides a letter or policy document from an Australian based insurance provider that indicates that the applicant and their dependants will be covered by insurance that meets this standard immediately upon visa grant or arrival in Australia;
2. evidence that the visa applicant has lawfully enrolled with Medicare (the Australian Government has Reciprocal Health Care Arrangements (**RHCA**) with the governments of the United Kingdom, Sweden, the Netherlands, Finland, Norway, Malta, Italy, Belgium, the Republic of Ireland and New Zealand);
3. evidence that the main applicant and any accompanying family members immediately upon visa grant or their arrival in Australia, are, or will be, covered by insurance that is at least as comprehensive as the adequate level of cover required under Department policy, with the understanding that the applicants will either enrol with Medicare under a RHCA or enrol in a private insurance arrangement after arrival; or
4. for citizens from the Republic of Ireland, evidence that they hold an Irish passport.

The onus is on the visa applicant to ensure that they have adequate levels of health insurance during their stay in Australia, and failure to do so would result in a breach of visa conditions.

For specific details on the level of insurance, refer to the “Minimum Cover” on Page 4.

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HANNAN TEW CAN REFER YOU TO DISCOUNTED RATES WITH BUPA HEALTH INSURANCE

REFERRAL TO BUPA HEALTH INSURANCE

Bupa provides a range of tailored health cover plans for overseas visitors with a TSS visa. Hannan Tew have an existing agreement with Bupa Health Insurance to provide you with a 5% discount on all premiums. To utilise this discount and apply for Department compliant overseas visitor cover, please follow the instructions below:

1. Click on the following direct link https://migration.bupa.com.au/?txtUsername=HannanTew&txtCorpID=OVChealth
2. Click “Overseas Visitor” and choose between the options: Single, Couple, Family - State – Country of citizenship – Visa – Quick Quote;
3. Choose your desired level of cover (Working visitors must obtain Essential, Essential Plus, Gold, or Platinum);
4. Add extras (optional);
5. Click “View Details” and then “Join now”;
6. Online Application from will appear – Follow Steps 1 - 3;
7. Provide personal information and their payment details;
8. Click “Pay & Send my application form now”.

A confirmation letter will be emailed to the email address provided on application form. You will need to keep a copy of this as evidence of your adequate level of health insurance. This health insurance is acceptable by the Department.

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DISCLOSURES

As part of Hannan Tew's agreement with Bupa please note:

1. Hannan Tew provides this referral as a benefit to you but fully discloses that Hannan Tew will be receiving 5% of your premium as a referral fee (**referral fee**);
2. You have the right to refuse to accept the Hannan Tew referral to Bupa in its entirety and without any prejudice from Hannan Tew;
3. You have the right to use the services of an alternative service provider without any prejudice from Hannan Tew and its delivery of immigration service to you; and
4. You have the right to obtain independent legal advice before using the Hannan Tew referral to Bupa.

QUESTIONS?

Should you have any questions or concerns in relation to the referral program, please do not hesitate to contact your direct Hannan Tew representative or our office using any of the following contact details:

E: info@hannantew.com.au

W: www.hannantew.com.au

T: +61 3 9016 0484

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MINIMUM COVER

You should get cover that provides benefits at least equivalent to the following:

Public hospital

For admitted patient treatment, a benefit equal to the state and territory health authority gazetted rates for ineligible patients for:

1. overnight and day only hospital accommodation (all costs including: all theatre, intensive care, labour wards, ward drugs)
2. emergency department fees that lead to an admission
3. admitted patient care and postoperative services that are a continuation of care associated with an early discharge from hospital

This includes all admitted treatments covered by the Medicare Benefit Schedule (MBS).

Surgically implanted prostheses

For no-gap prostheses and gap-permitted prostheses as listed in the Private Health Insurance (Prostheses) Rules 2007, a benefit at least equal to 100 per cent of the minimum benefit amount listed.

Pharmacy

For all PBS-listed drugs, prescribed according to PBS-approved indications, that are administered during and form part of an admitted episode of care, a benefit equal to the PBS-listed price in excess of the patient contribution.

This includes the cost of PBS-listed drugs administered post-discharge if they form part of the admitted episode of care.

Medical services

For admitted medical services with an MBS item number, 100 per cent of the Medical Benefits Schedule fee or less if the patient is charged less.

Ambulance services

100 per cent of the charge not otherwise covered by third-party arrangements for transport by ambulance provided by, or under an arrangement with, a government-approved ambulance service when medically necessary for admission to hospital, emergency treatment onsite, or inter-hospital transfer for emergency treatment.

This includes inter-hospital transfers that are necessary because the original admitting hospital does not have the required clinical facilities. It does not extend to transfers due to patient preferences.

Informed financial consent

The insurer will allow hospitals to check members' eligibility so members are able to give informed financial consent when they are admitted.

Waiting periods

To comply with the minimum level, the only waiting periods that can be applied are:

1. 12 months for pregnancy related conditions
2. 12 months for pre-existing conditions applied in a way that is consistent with Section 75-15 of the Private Health Insurance Act 2007
3. 2 months for psychiatric, rehabilitation and palliative care, whether or not the condition is pre-existing

Excluded treatments

To comply with the minimum level of health insurance, the only admitted patient treatments that may be excluded are:

1. assisted reproductive treatments
2. elective cosmetic treatments
3. stem cells, bone marrow and organ transplant

Insurance policies may also exclude:

1. treatment provided outside Australia, including necessary treatment en route to or from Australia
2. treatment arranged in advance of the insured's arrival in Australia
3. services and treatment which are covered by compensation or damages provisions of any kind

Insurers don't have to exclude these treatments. They can choose to cover them or not.

Global annual benefit limits

To comply with the minimum level of health insurance, the per-person, per-annum benefit must not be less than AUD1,000,000.

Out-of-hospital cover

For treatment that relates to medical services with an MBS item number, cover up to the Medical Benefits Schedule fee.

Except where otherwise stated, the insurer can decide whether to provide cover for out-of-hospital treatment. The insured person can choose to purchase this additional cover or not.

Excess, co-payment or patient contribution

The insurer can decide to charge an excess, co-payment or patient contribution. Excess, co-payment and patient contributions can be charged on either an annual or per-separation basis.

Portability

When determining waiting periods, insurers must recognise previous length of membership on a policy held with another Australian insurer that meets the minimum standards.

That is:

1. when transferring between Australia-based insurers where the customer has been a member of the previous fund for more than 12 months, waiting periods of no longer than 12 months will apply to the higher level of benefits
2. when transferring between Australia-based insurers where the customer has been a member of the previous fund for less than 12 months, any unserved waiting periods must be completed with the new fund. If increasing the level of cover or benefits, further waiting periods of no longer than 12 months will apply to the higher level of benefits. These waiting periods are to be served concurrently

To comply with the minimum level of health insurance, the insurer must agree to:

1. grant a member who transfers between Australia-based insurers continuity of cover for up to 30 days from the date they leave their previous insurer
2. provide members who terminate their policy with a clearance certificate, approved by the Department of Home Affairs, within 14 days of the termination date or the date they were notified of the termination, whichever is later

Buy-out clauses

To comply with the minimum level of health insurance, a policy must not contain a buy-out clause that would have the effect of terminating the insurer's liabilities in exchange for a predetermined lump sum payment.

Arrears

The insurer will allow the insured person 60 days from the last financial date of membership to pay a premium without terminating the membership.

Insurers do not have to pay for treatment received during any arrears period until and unless the arrears are paid for the relevant period.