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Health insurance requirement for the TSS visa

It is a requirement of the TSS visa that all visa applicants hold 'adequate' health insurance. Once the TSS visa is approved, it is subject to 'condition 8501' which requires all TSS visa holders to maintain these adequate arrangements for health insurance for the duration of their stay in Australia.

What do I need to provide?
You will need to provide a certification letter from your health insurer that confirms you are covered by a policy that meets the Department's requirements.

What does the Department consider 'adequate'?
This is outlined on the next page.

Who needs to pay for the insurance?
There is no obligation for the employer to pay health insurance for their TSS visa applicants/holders.

I am not in Australia yet – what should be the start date for my insurance?
If you are lodging your TSS application while you are outside Australia, your health insurance does not need to come into effect until you arrive in Australia on a TSS visa. However, you need to show that you have joined a health insurance policy for your TSS application to be approved. You can provide an estimated start date to your insurance provider, and then change it once you know if you will be arriving in Australia earlier or later than that date. This should mean that you don't have to pay for your health insurance until you arrive in Australia. For further information about this, please speak to your insurance provider.

How do I find a suitable insurance policy?
There are a number of Australian insurers who offer products designed to meet the TSS visa requirements. Insurers generally call this type of insurance 'overseas visitor coverage'. You will need to consider the various products and determine which insurance product is appropriate for your needs. Most insurers will provide access to prices and allow you to purchase the product online.

Can I use an international insurance policy?
An international health insurance policy can be used for the TSS visa application provided it covers you (and any family members included in your TSS visa) for at least AU$1M in medical expenses and emergency services and meets the Department's requirements for 'adequate' coverage (see next page).

Are there any exemptions?
Onshore visa applicants who are enrolled with Medicare in Australia under reciprocal health care arrangements will be considered to meet this requirement and additional insurance is not required.

Visa applicants with passports from the Republic of Ireland are not required to provide evidence of health insurance or Medicare as part of their TSS visa application.

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Who can get Medicare?
The Australian Government has agreements with New Zealand, the United Kingdom, the Republic of Ireland, Sweden, the Netherlands, Finland, Italy, Belgium, Malta, Slovenia and Norway. If an applicant holds a passport from one of these countries, he/she can apply for a Medicare card.

If you are eligible for Medicare and are in Australia at the time your TSS application is lodged, you will need to provide evidence that you currently have (or have at least applied for) Medicare. This will satisfy the insurance requirement for visa grant.

If you are eligible for Medicare and are outside Australia when your TSS application is lodged, you will need to provide evidence of travel insurance to cover the period up until when you can apply for Medicare. This is because you cannot apply for Medicare from outside Australia. Once you arrive in Australia and receive your Medicare card, you are under no obligation to continue with your travel insurance.

Level of cover considered 'adequate' by the Department of Immigration

Insurance benefits at least equivalent to:

a) Public hospital – admitted patient treatment, a benefit equal to the State and Territory health authority gazetted rates for ineligible patients for:

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

Note: for the purpose of clarity this includes all admitted treatments covered by the Medicare Benefit Schedule.

b) Surgically implanted prostheses – no gap prostheses and gap permitted prostheses as listed in the Private Health Insurance (Prostheses) Rules 2007: Benefit at least equal to 100% of minimum benefit amount listed.

c) Pharmacy – all PBS listed drugs that are prescribed according to the 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.

Note: For the purpose of clarity, this definition is intended to include the cost of PBS listed drugs administered post discharge – if they form part of the admitted episode of care.

d) Medical services – admitted medical services with an MBS item number – 100% of the Medicare Benefits Schedule fee, or less if the patient is charged less.

e) **Ambulance services** – 100% of the charge, that is 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 on-site, or inter-hospital transfer for emergency treatment.

Note: For the purpose of clarity, this definition is intended to include 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.

Other minimum health insurance policy features

f) **Informed Financial Consent**
Insurers will make available membership eligibility checking to hospitals to enable the provision of informed financial consent to members on admission.

g) **Waiting periods**
To comply with the minimum level of health insurance, the only waiting periods that maybe imposed are:

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

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

- Assisted reproductive treatments;
- Elective cosmetic treatments;
- Bone marrow and organ transplants;

Insurance policies may also exclude the following:

- Treatment rendered outside of Australia including treatment necessary en route to or from Australia;
  Treatment arranged in advance of the insured's arrival in Australia;
- Services and treatment which are covered by compensation and damages provisions of any kind

Note: insurers are not required to exclude these treatments. A decision to cover them is at the discretion of the insurer.

i) Global annual benefit limits

To comply with the minimum level of health insurance, the per person per annum, benefit must not be less than $1 million dollars.

j) Portability

To comply with the minimum level of health insurance, 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:

a. When transferring between Australian based insurers where the customer has been a member of the previous fund for greater than 12 months, waiting periods of no greater than 12 months will apply to the higher level of benefits.
b. When transferring between Australian based insurers where the customer has been a member of the previous fund for less than 12 months, any unserved waiting periods will need to be completed with the new fund and if increasing the level of cover or benefits, additional waiting periods of no greater than 12 months will apply to the higher level of benefits. These waiting periods are served concurrently.

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

c. grant a member who seeks to transfer between Australian based insurers, continuity of cover for up to 30 days from the date they leave the previous insurer; and
d. provide members, who terminate their policy, with a clearance certificate, approved by the Department of Immigration and Border Protection, within 14 days of the date of termination or the date of notification of the termination, whichever is the later.

k) Buyout clauses

To comply with the minimum level of health insurance, a policy must not contain a buyout clause that has the effect of terminating the insurers liabilities in exchange for a pre-determined lump sum payment.

l) Arrears

To comply with the minimum level of health insurance an insurer will allow for acceptance of premiums for 60 days from the last financial date of membership without terminating the membership. Insurers are not obligated to pay for treatments received during any arrears period until and unless the arrears are paid for the relevant period.