Subclass 457: Health Insurance Standard Template Letter

<Addressed to visa applicant(s)>

On behalf of <*insert insurer here*>, I certify that the following person(s)

<*insert visa applicant biographic details here – name and DOB*>

is/are, or will immediately upon their arrival in Australian be, covered by insurance that is at least as comprehensive as the minimum level of insurance required by the Australian Department of Immigration and Citizenship (DIAC) set out at Attachment A <*insert to allow insurers to offer their most compliant existing product for the first 12 months* 'subject to the following exceptions to 14 September 2010:

- *insert exceptions here*'>.

The premium has been paid up until <*insert date or period (eg. 12 months from the data of arrival) here*>.

<*insert if the premium has be pre paid for less than 12 months* 'At Attachment B, we have prepared a letter you can sign and give to your employer, authorising your employer to make regular deductions from your wages for health insurance premiums.'>

This letter can be provided to DIAC as part of the application process as evidence of the required insurance cover. By doing so, you are also agreeing that the insurer may notify Immigration if you cancel or fail to renew your health insurance policy, or if your health insurance policy is terminated.

This is important because, if you are granted a visa, Immigration will use information provided by your insurer to monitor compliance with visa condition 8501. Condition 8501 requires all visa holders, including accompanying family members, to maintain adequate arrangements for health insurance for the duration of their stay in Australia. Failure to comply with a visa condition may result in your visa being cancelled.

If you have any questions about your health insurance cover, please contact <*insert contact details here*>

<*signed*>

Attachment A

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

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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, regarless of whether or not the condition is a pre-existing.

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:

- 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.
- 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:

- 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
- provide members, who terminate their policy, with a clearance certificate, approved by the Department of Immigration and Citizenship, within 14 days of the date of termination or the date of notification of the termination, whichever is the later.

k) Buy out clauses

To comply with the minimum level of health insurance, a policy must not contain a buy out 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.

‘Attachment B’

<addressed to sponsor>

I authorise <*visa applicant to insert sponsor details here*> to deduct <*insurer to insert $/week/fortnight/month*> from my wages for health insurance premiums and for it to be paid into the following account on my behalf:

<i*nsurer to insert account details*>

<*visa applicant to sign*>