GRUPA LUXMED
Jesteśmy częścią Bupa

"FREEDOM OF TREATMENT" Regulations on Reimbursement for LUX MED Clients

Reimbursement limit	PLN 500
Refund Period	Quarter
% of reimbursed costs	70% of costs incurred, however maximally up to the Reimbursement Limit

I. Definitions

The following terms used in the Regulations in singular and plural form mean, respectively:

Reimbursement – a refund of costs incurred by a Beneficiary in relation to Healthcare services provided to a Beneficiary entitled to Reimbursement by a Medical facility, however only in the scope of Healthcare services to which the Beneficiary is entitled under the Agreement, as specified in the Benefitplan;

Medical facility – organisational unit of a therapeutic entity, entitled to provide outpatient Healthcare services, operating in the Republic of Poland and in accordance with the laws in force in the Republic of Poland;

Own Facilities – generally accessible outpatient medical facility of the Contractor, operating under LUX MED and Medycyna Rodzinna brands, listed athttp://www.luxmed.pl;

Partner Facilities – entities providing medical services which cooperate with LUX MED - their current list is available at the Patient Portal and the LUXMED website: www.luxmed.pl/placowkiwspolpracujace_wspolplacenie and http://www.luxmed.pl;

Application – Reimbursement application form (Reimbursement application) consistent with a template specified by LUX MED;

Regulations – document specifying the rights and obligations of parties with regard to Reimbursement;

Agreement – agreement on provision of healthcare services concluded between the Customer (Client) and LUX MED;

Benefitplan – code-specified list of Healthcare services to which a Beneficiary is entitles under the Agreement, along with conditions under which it is performed.

Beneficiary entitled to Reimbursement – natural person entitled to Healthcare services, as well as entitled to Reimbursement under the Agreement in the scope of the Benefitplan, in the period when the said Beneficiary is entitled to that Benefitplan and in the scope specified in the Benefitplan and additional documents;

LUX MED price list – price list in force in the LUX MED Own Facility located closest to the facility providing Healthcare services on the day on which the service was performed, which facility offers the Healthcare service provided to the Beneficiary. The current price list is available at www.luxmed.pl.

Reimbursement Limit – maximal reimbursement amount for Healthcare services provided to a Beneficiary entitled to Reimbursement applicable in a given Reimbursement Period; in the event the cost of Healthcare services reported for Reimbursement in a Reimbursement Period exceeds the Reimbursement Limit, the Beneficiary is entitled to a refund up to the Reimbursement Limit.

Reimbursement period – calendar quarter (i.e.. January-March, April-June, July-September, October-December).

II. Right to Reimbursement

1. The scope of Healthcare services subject to Reimbursement, the amount of the amount of available Reimbursement Limit and the percentage of costs which are subject to Reimbursement are specified in the Agreement.
2. The Beneficiary becomes entitled to reimbursement on the first day on which he/she become eligible for healthcare under the Agreement, specified in the Benefitplan, if the Benefit plan provides for the right to Reimbursement.
3. The right to Reimbursement expires after the last day on which the Beneficiary is covered by the Agreement under which he/she is entitled to a Benefitplan covering Reimbursement.
4. The mode and deadlines for submitting the List of Beneficiaries and changes thereto are specified in the Agreement.
5. In a Reimbursement Period the Beneficiary is entitled to a refund of costs incurred maximally to the Reimbursement Limit amount.
6. The Right to Reimbursement applies to Healthcare services to which a Beneficiary is entitled under the Agreement on the day on which the Healthcare service was provided, performed in Medical facilities in outpatient settings, taking into account the conditions of performing services (including limits), as well as exclusions under the Agreement and General Insurance Conditions, as well as exclusions specified in point VII of these Regulations.

III. Requirements regarding documenting the costs incurred

1. A Beneficiary entitled to Reimbursement covers costs of Healthcare services provided to him/her in the Medical facility in accordance with the price list in force at that Medical facility and requests an invoice or bill for the Healthcare services provided in accordance with the Regulations.
2. The invoice or bill for Healthcare services provided to the Beneficiary should be issued to the Beneficiary entitled to Reimbursement, and in the case of Healthcare services provided to a minor below 18 years of age - the minor's guardian or legal representative.
3. The invoice or bill should include:
    a) data of the Beneficiary entitled to Reimbursement to whom the Healthcare services were provided (the mandatory data are: the name, surname and address). In case of services provided to a minor, when the invoice is issued to the minor's guardian or legal representative, the invoice should include the data of the minor who received the Healthcare services;
    b) the list of Healthcare services provided to the Beneficiary (as part of the invoice itself) or in the form of an annex issued by the Medical facility performing these services along with the name of the Healthcare service,
    c) the number of Healthcare services of a specific kind which was performed.
    d) the date on which the Healthcare service was performed;
    e) the unit price of the Healthcare service performed.
4. In the case of laboratory tests, diagnostic tests and other Healthcare services, if a referral requirement results from the Agreement (Benefitplan), and the referral for that service was issued outside an Own Facility, the Beneficiary should record the receipt of such a referral by making its copy and attaching it to the Application.
5. In the absence of a copy of the referral referred to in paragraph 4 above, the fact that a referral was issued can also be confirmed by a copy of the Beneficiary's medical records including an adequate remark about the referral having been issued.
6. Reimbursement of costs of rehabilitation Healthcare services is possible provided that the Application includes a copy of the rehabilitation referral and, if the referral requirement results from the Agreement (Benefitplan), and the referral for that service was issued outside an Own Facility, the Beneficiary should record the receipt of such a referral.
7. Costs will not be reimbursed in the event when the submitted documents will not make it possible to determine the names of all the Healthcare services provided or the person, to whom the service was provided, e.g.:
    a. on the basis of a receipt which does not constitute personalised proof that the Beneficiary used the Healthcare service in question;
    b. on the basis of an invoice or bill which does not include the list of Healthcare services provided to the Beneficiary or specification referred to in paragraph 3 above (e.g. with a general description of the service, that is: medical service, rehabilitation service, dental service, etc.) which do not make it possible to clearly determine

whether the Beneficiary is entitled to specific healthcare services under the Agreement specified in the Benefitplan.

IV. Reimbursement Calculation

1. Limit periods are calculated on a calendar basis and come in 4 quarters during one year, i.e. January-March, April-June, July-September, October-December – Reimbursement Periods.
2. A Healthcare service which was reimbursed is counted into a Reimbursement Limit in a given Reimbursement Period on the basis of the payment date.
3. If the value of the invoice accompanying the Application exceeds the value of the Reimbursement Limit available in a given Reimbursement Period, the refund is made maximally to the amount of the Reimbursement Limit in the given Reimbursement Period.
4. The cost of Healthcare services provided cannot be counted against future Reimbursement Periods and Reimbursement Limits.
5. A Reimbursement Limit which has not been used in a given Reimbursement Period cannot be transferred to the next Reimbursement Limit.
6. In the case of Healthcare services which involve the Beneficiary's co-payment, expressed as a percentage or lump-sum (e.g. surcharge to a service, rebates resulting from the Agreement - the Benefitplan), the value of the Healthcare service performed which is reimbursed will be decreased by an amount of the Beneficiary's co-payment.
7. If Healthcare services which are subject to Reimbursement are limited under the Agreement (Benefitplan) - e.g.a quantitative limit - this limit applies to Healthcare services performed in Own Facilities, Partner Facilities and Medical facilities covered by Reimbursement, In the event the limit for Healthcare services specified in the Agreement is exceeded, the cost of the service will not be reimbursed, even if the Reimbursement limit is available in the given Reimbursement period.
8. Reimbursement of Joint Healthcare services (e.g. couple's psychotherapy) is possible if all Beneficiaries using the Healthcare services are entitled to such a Healthcare service under the Agreement (Benefitplan); in such a case, the limit with regard to Healthcare services is counted separately for each Beneficiary.
9. In the event that the submitted documents or Applications which are to constitute the basis for Reimbursement do not make it possible to determine the costs of the Healthcare service incurred or there are reasonable doubts with regard to the costs incurred, LUX MED has the right to make the Reimbursement conditional on the Beneficiary submitting additional documents which would help dispel the reasonable doubt or allow to determine the scope of Reimbursement. For the purpose mentioned above, the Beneficiary may authorize LUX MED to request Medical facility to provide a copy of medical records in the scope of the benefit covered by the Application, otherwise or the Beneficiary is obliged to provide a copy of medical record itself.
10. In the event the Beneficiary does not give consent to accessing medical records regarding the Healthcare service or does not provide medical record itself, as referred to in paragraph 9 above, as well as in the event it is decided, based on the documents submitted, as referred to in paragraph 9 above, that Reimbursement is not justified, LUX MED has the right to refuse Reimbursement either in full or in part, about which the Beneficiary applying for Reimbursement will be informed.
11. If the cost of the Healthcare service provided to the Beneficiary entitled to Reimbursement exceeds grossly the cost of that services specified in the LUX MED price list, LUX MED has the right to reduce the Reimbursement amount to the highest price of such a Healthcare service in the LUX MED price list, unless the Beneficiary applying for Reimbursement submits medical records justifying the amount of costs incurred.
12. If, after the costs of Healthcare services had been reimbursed, LUX MED obtains proof that Reimbursement was carried out on the basis of information or invoices/bills which are inconsistent with the facts indicated in the Application or attached documents (e.g. submitting invoices or bills for healthcare services provided to third parties), LUX MED is entitled to the unduly paid out Reimbursement amounts along with interest calculated from the Reimbursement payment date.

V. Payment under Reimbursement

1. Payment of a Reimbursement amount is made on the basis of a Reimbursement Application submitted by the Beneficiary along with attached invoices or bills, as well as copies of referrals submitted within 3 months of the date on which the Healthcare service was provided. .
2. The Application, along with all the supporting documents must be sent to the following address:

LUX MED Sp. z o.o.
ul. Iłżecka 24F, 02-135 Warsaw
With a note: Refundacja (Reimbursement)

3. In case the received Application or accompanying documentation is incomplete or filled in incorrectly, LUX MED will inform the person submitting the Application about the need to supplement data which is necessary for making the reimbursement decision and will indicate what is missing from the Application.
4. LUX MED will refund (reimburse) the costs at the indicated Bank account number within 30 days from the date a complete Application is submitted.

VI. Exclusion of Reimbursement

1. Reimbursement does not cover:
   a. The cost of healthcare services purchased not as a single service, but due as part of services purchased by the Beneficiary for a flat rate under a contract covering medical packages, cards, medical subscriptions and other similar contracts, the subject of which is provision of healthcare services paid at a flat rate;
   b. Hospitalisation services and other services performed in inpatient settings which require the Beneficiary's stay in a hospital department.
   c. Services in the field of occupational medicine, medical certification, sports medicine, tests performed before a driving licence is issued, aviation medicine, home visits;.
   d. Rehabilitation services, with the exception of cases described in point III paragraph 6 of the Regulations.
   e. Healthcare services in the event the Application or invoice/bill constituting the basis for Reimbursement are sent to LUX MED later than 3 months from the date on which the Healthcare service was provided.

Annexes:

- Reimbursement application.