

TABLE OF BENEFITS

MAXIMUM LIFETIME PER INSURED PERSON	B/. 300,000.00
Coverage:	Local
Network Providers:	MEDIRED
<ul style="list-style-type: none"> • Hospitals: <ul style="list-style-type: none"> Panama: All hospitals in network providers Interior and Colon: All hospitals in network providers • Other Providers: Listed in network providers 	
Deductible per Policy Year:	B/.300.00
Stop Loss per Policy Year:	B/.4,000.00

INPATIENT EXPENSES – Preauthorization required

<p>a. Daily Room and Board - Private Room</p> <p>b. Intensive Care Unit</p> <p>c. Hospital Charges (Miscellaneous) Exams greater than B/.200.00 - Preauthorization required</p> <p>d. Surgery: Surgeon Fees Assistant Surgeon – Preauthorization required</p> <p>e. Anesthesia: Anesthesiologist Fees</p> <p>f. Inpatient Visits: Medical Fees</p> <ul style="list-style-type: none"> o Main Physician Visits – 1 visit a day Additional visits requires preauthorization o Additional Specialist - Preauthorization required 	<p style="text-align: center;">HOSPITALS IN PANAMA COPAYMENT PER DAY:</p> <p>San Fernando and Santa Fe B/.150.00 Hospital Nacional and Paitilla B/.200.00 Pacifica Salud B/.250.00</p> <p>Up to 4 days. From the 5th to the 10th day will be covered at 100%. From the 11th day, will be covered at 80%, coinsurance 20%.</p> <p style="text-align: center;">HOSPITALS IN INTERIOR AND COLON COPAYMENT PER DAY</p> <p style="text-align: right;">B/.100.00</p> <p>Up to 4 days. From the 5th to the 10th day will be covered at 100%. From the 11th day, will be covered at 80%, coinsurance 20%.</p>
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OUTPATIENT EXPENSES

Satelite Clinics – General Physician	100% No Copayment
Satelite Clinics – Specialist Physician	Copayment B/.10.00
External Consultation - General Physician in network	Copayment B/.12.00
External Consultation – Specialist Physician in network	Copayment B/.20.00
External Consultation – Sub Specialist Physician in network	Copayment B/.25.00
X Rays and Laboratory Tests – Preauthorization required	Copayment 25%
Exams with total costs greater than B/.100.00	
Special Exams - Preauthorization required	Copayment 30%
Prescription Drugs:	
<ul style="list-style-type: none"> • Innovative or Commercial • Bioequivalent or Generic • Maximum per policy year 	80% after deductible 90% after deductible B/.10,000.00
Acupuncture	Copayment B/.15.00 by session
<ul style="list-style-type: none"> • Maximum per policy year • Maximum lifetime 	Five (5) sessions Twenty (20) sessions
Chiropractic Care	Copayment B/.15.00 by session
<ul style="list-style-type: none"> • Maximum per policy year 	Twenty (20) sessions
Physical Therapy and Rehabilitation – Preauthorization required	Copayment B/.10.00
<ul style="list-style-type: none"> • Maximum per policy year • In excess of anual limit, preauthorization required 	Fifteen (15) session



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Inhaloteraphy and Immunizations	Copayment B/.10.00 by session
Chemotherapy, Radiation Therapy, Hemodialysis Ambulatory Sessions – Preauthorization required	Copayment 30% by session

EMERGENCY ROOM

a. Accident	100%, no limit
b. Detailed Illness (*)	100%, no limit
c. No Detailed Illness	Copayment B/.75.00

AMBULATORY SURGERY– Preauthorization required

a. In hospital facility, clinic or outpatient centers (Miscellaneous Charges and Physician Fees):	
<ul style="list-style-type: none"> • Panama: San Fernando, Santa Fe and outpatient centers • Panama: Hospital Nacional y Paitilla • Panamá: Pacífica Salud • Interior and Colón: Listed in network providers 	Copayment B/.200.00 per event Copayment B/.300.00 per event Copayment B/.350.00 per event Copayment B/.150.00 per event
b. In doctor's office (Miscellaneous Charges and Physician Fees)	Copayment 30% per event

MATERNITY

Waiting Period:	12 month to get pregnant. Maternity will be covered if the pregnancy begins the first day of 13 month
<ul style="list-style-type: none"> • Maximum per event 	B/.3,500.00 per event
Prenatal care and hospitalization:	
<ul style="list-style-type: none"> ○ Prenatal visits - Maximum 8 ○ Ultrasounds – Maximum 3 ○ Laboratories ○ Prescribed drugs and vitamins ○ Hospitalization – Private Room 	Copayment B/.20.00 Copayment 25% Copayment 25% After deductible. Reimbursement 80% or 90% Under hospitalization copayment
<ul style="list-style-type: none"> • Newborn Coverage • Premature Newborn 	B/.5,000.00 to 100% B/.10,000.00 to 100%

NEONATAL CONGENITAL HEREDITARY OR ACQUIRED DISEASE

Only for children born under the policy Applies from the first day of birth	
<ul style="list-style-type: none"> • Maximum lifetime for each child 	B/.30,000.00 to 100%

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

<ul style="list-style-type: none"> • Maximum per policy year • Maximum lifetime 	B/.5,000.00 to 100% B/.25,000.00 to 100%
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NURSING CARE

Preauthorization required	100%, maximum 30 sessions 8 hours each session
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AMBULANCE

a. Ground ambulance	B/.100.00 to 100%
b. Air ambulance – Preauthorization required	B/.1,000.00 to 100%
Private ambulance for emergencies	100% / Membership included in Panama

EMERGENCY ATTENTION OUTSIDE OF PANAMA

This coverage is applied to all benefits detailed in this table, up to the limits indicated for each one.	60% refund will be based on the negotiated costs with Network Providers in Panama
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PREVENTIVE CARE MEDICINE

HEALTHY CHILD CONTROL	
<ul style="list-style-type: none"> • Routine Consultation <ul style="list-style-type: none"> 0 to 12 months Up to 8 visits per year 13 to 24 months Up to 4 visits per year 3 to 6 years Up to 2 visits per year • Vaccines BCG, Diphtheria + Tetanus, DTaP, Hepatitis A, Hepatitis B, Hibiter, MMR, Neumococo, Poly IM, Rotavirus, Varicella 	Copayment 50%
WOMEN (do not apply to dependent daughters)	
<ul style="list-style-type: none"> • Annual Control Visit • PAP Smear Test • Annual Mammography after the age 40 	Copayment 50%
MEN	
<ul style="list-style-type: none"> • PSA test after the age 40 	Copayment 50%

MAXIMUM PARTICIPATION (STOP LOSS)

**Maximum per policy year limit, in respect of coinsurance, of all expenses covered under the policy.
Excess will be pay at 100%**

Not applicable for: Lack of preauthorization or approval of the insurance company, usage of providers outside BCBS network in required cases, or any other indicated in the policy.	Per policy year B/.4,000.00
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TABLE OF BENEFITS

OUT OF NETWORK PROVIDERS

Apply to all benefits indicated in this table	60% refund, based on the negotiated costs with Network Providers
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(*) Detailed Illness:

Medical services in acute cases of: Infarcted myocardium or coronary insufficiency, loss of knowledge or obnubilation, sudden disorientation, acute allergic reactions or anaphylactic, hemorrhages of all type including gynecological and obstetrics, convulsions, intoxications, nephritic colic, hepatic or biliary colic, episodes of chest angina, pulmonary embolism, acute bronchial asthma attack, vomits and severe diarrheas with or without dehydration, acute abdominal pain, state of "shock" and any type of coma, acute urine retention, high fever on infants and any other diseases that endangers health of the insured, must be approved by the company

Note: This information is intended as a brief summary of benefits. For additional information about exclusions, limitations, and terms, please refer to your Policy Contract in Spanish.

