Policy Underwritten By: PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY

AMERICAN ALLY

Health Saver Plus

GOLD EDITION

Fixed Benefit Health & Income Protection

This plan does not meet the requirements of the Affordable Care Act. This form (H-0434 series) meets the exemptions of the Affordable Care Act and is approved by the Department of Insurance in your state.

Design Your Gold Plan

Lifetime Maximum Per Policy: $5,000,000

Calendar Year Max Benefit Per Insured Person		
☐ $250,000	☐ $500,000	☐ $1,000,000

Benefit Level
☐ Gold Value (One Unit)
☐ Gold Plus (Two Unit)
☐ Gold Preferred (Three Unit)

Calendar Year Confinement Deductible
Per insured person with a maximum of three (3) deductibles per Policy.
☐ $5,000
☐ $2,500
☐ $1,000
☐ $500
☐ $100

Calendar Year Maximum and Calendar Year Confinement Deductible options vary depending on the Benefit Level Chosen.

FIRST DAY INPATIENT

Choose a Calendar Year Inpatient Deductible per Insured Person. Higher Deductible plans will pay a First Day Hospital Admission Benefit

	$5,000 Deductible	$2,500 Deductible	$1,000 Deductible	$500 Deductible	$100 Deductible
Hospital Admissions Benefit for First Inpatient Day *One benefit per insured person, per Calendar Year.*	$2,000 per year	$1,000 per year	$0 per year	$0 per year	$0 per year

HOSPITAL INDEMNITY BENEFITS - FACILITY FEES	Value (One Unit)	Plus (Two Unit)	Preferred (Three Unit)
Hospital Confinement as a Result of Covered Injury or Sickness Indemnity Benefit: *Includes Observation Unit stay for 24-hours or more.*	Per Day	Per Day	Per Day
Deductible Applies — Covered Sickness Benefit	$1,500	$3,000	$4,500
Deductible Applies — Covered Injury Benefit	$2,250	$4,500	$6,750
Confinement in Hospital Intensive Care Unit (ICU) Indemnity Benefit: *Up to twenty (20) days per Calendar Year as a result of covered Injury or sickness.*	Per Day	Per Day	Per Day
Deductible Applies — Covered Sickness Benefit	$2,250	$4,500	$6,750
Deductible Applies — Covered Injury Benefit	$2,500	$5,000	$7,500
Confinement in a Hospital for Mental Illness, Alcohol and/or Substance Abuse Dependency Indemnity Benefit	Per Day $200	Per Day $400	Per Day $600
Rehabilitation Facility or Skilled Nursing Facility Confinement Indemnity Benefit *Does not include Mental Illness, Alcohol and/or Substance Abuse Dependency.*	Per Day $750	Per Day $1,500	Per Day $2,250
Outpatient Hospital or Ambulatory Surgical Center Services When Surgery is Performed Indemnity Benefit	Per Day	Per Day	Per Day
Benefit for Surgery Performed Under General Anesthesia	$2,000	$3,500	$5,000
Benefit for Surgery Performed not Requiring General Anesthesia	$750	$1,500	$2,250
Outpatient Radiation Therapy, Chemotherapy, Immunotherapy Indemnity Benefit	Per Day $750	Per Day $1,500	Per Day $2,250

Benefits, exclusions and limitations may vary by state. Regardless of the charge for the inpatient, professional, or outpatient medical services you receive, we pay the listed benefit amount for eligible services. Daily time periods are twenty-four (24) or more consecutive hours. Resource Based Relative Value Scale (RBRVS) is based on provider's geographical location.

Plan Benefits (continued)

PROFESSIONAL SERVICES	Value (One Unit)	Plus (Two Unit)	Preferred (Three Unit)
Inpatient Physicians Care Indemnity Benefit *When medical care is from a physician other than an operating surgeon.*	Per Day $50	Per Day $100	Per Day $150
Surgery Indemnity Benefit for Covered Services When Performed in a Hospital or in an Ambulatory Surgical Center *Per procedure for your provider location.*	Per Day 1X RBRVS	Per Day 2X RBRVS	Per Day 3X RBRVS
Inpatient Pathology/Radiology Indemnity Benefit for Covered Services *Per procedure for your provider location.*	Per Day 1X RBRVS	Per Day 2X RBRVS	Per Day 3X RBRVS
Assistant Surgeon Surgical Services Indemnity Benefit for Covered Services	20% of Surgical Benefits Payable per day		
Anesthesia Indemnity Benefit for Covered Services	25% of Surgical Benefits Payable per day		

ADDITIONAL OUTPATIENT BENEFITS	Value (One Unit)	Plus (Two Unit)	Preferred (Three Unit)
Aggregate Calendar Year Maximum for Outpatient Benefits *Per Insured person.*	Per Year $4,000	Per Year $6,000	Per Year $8,000
Physician Indemnity Benefit *For each day an Insured person sees a Physician in office or at an outpatient clinic.* Maximum of twenty (20) benefit days including six (6) chiropractor and two (2) Specialist Physician visits per Insured person per Calendar Year.	Per Day $80	Per Day $120	Per Day $160
Specialist Physician Indemnity Benefit *Maximum of two (2) benefit days paid at the Specialist Physician rate per Insured person per Calendar Year. After the first two Specialist Physician Benefits are paid at this rate, you will be paid the Physician Indemnity Benefit amount, assuming that you have not met your maximum of twenty (20) benefit days per Insured person per Calendar Year.*	Per Day $100	Per Day $150	Per Day $200
Surgery Benefit in a Physicians/Specialists Office or Outpatient Clinic *Maximum of two (2) benefits per Insured person per Calendar Year.*	Per Day $100	Per Day $200	Per Day $300
MRI, PET, CAT Scan or Nuclear Testing Indemnity Benefit	Per Day $300	Per Day $500	Per Day $700
X-rays or Other Diagnostic Testing Indemnity Benefit	Per Day $80	Per Day $160	Per Day $240

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Plan Benefits (continued)

ADDITIONAL OUTPATIENT BENEFITS *(CONTINUED)*	Value (One Unit)	Plus (Two Unit)	Preferred (Three Unit)
Laboratory Indemnity Benefit	Per Day $40	Per Day $80	Per Day $120
Injection Indemnity Benefit	Per Day $30	Per Day $60	Per Day $90
Emergency Department Indemnity Benefit *Maximum of one (1) benefit per Insured person per Calendar Year. Maximum of two (2) benefits combined Emergency Department Benefit/Urgent Care Center Benefit per Insured person per Calendar Year.*	Per Day	Per Day	Per Day
Facility Fee/Charges	$200	$300	$400
Professional Services	$200	$300	$400
Urgent Care Center Indemnity Benefit *Maximum of two (2) benefits per Insured person per Calendar Year. Maximum of two (2) benefits combined Emergency Department Benefit/Urgent Care Center Benefit per Insured person per Calendar Year.*	Per Day $200	Per Day $300	Per Day $400
Ambulance Indemnity Benefit *Maximum of two (2) ground benefit payments & one (1) air benefit payment per Insured person per Calendar Year.*	Per Day $1,000 (Ground)	$2,500 (Air)	
Generic Prescription Indemnity Benefit *Per Insured person per prescription filled.*	Per RX $10	Per RX $20	Per RX $30
Brand Name Prescription Indemnity Benefit *Per Insured person per prescription filled.*	Per RX $20	Per RX $40	Per RX $60

PREVENTATIVE CARE BENEFITS	Value (One Unit)	Plus (Two Unit)	Preferred (Three Unit)
*Coverage starts **sixty (60) days after the Effective Date** of each Insured person. Limit of one (1) benefit per Insured person per Calendar Year. Not subject to the Pre-Existing Conditions Exclusion.*			
Mammograms	$250 per calendar year		
Colonoscopy Without Finding Any Polyps			
Policy Years One (1) Through Three (3)	$500 every three years		
Beginning the Fourth (4th) Policy Year	$750 every three years		
All Other Preventive Care Services Including but not limited to: *Pap smears, PSA tests, chest X-rays and cholesterol testing.* *Coverage starts sixty (60) days after the Effective Date of each Insured person.*	$250 per calendar year		

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Plan Benefits (continued)

$5,000,000 Lifetime Maximum Per Policy

$0 Copays

Free Telehealth

Use Any Provider OR Save More With The First Health (LBP) PPO Network

OPTIONAL CRITICAL ILLNESS RIDER OR POLICY

Critical Illness Benefits range from $10,000 to $50,000.

By adding a Critical Illness Rider to your Optimum Plan, you could receive a lump sum of cash paid directly to you upon diagnosis of a Covered Condition. You can use your benefit to help pay for: experimental treatments, rehabilitation, mortgage payments, lost income wages, etc.

The benefit for certain Covered Conditions may be reduced. Waiting periods and other restrictions may apply and can vary by state. Refer to your policy for more details. Any Critical Illness Covered Condition diagnosed or treated prior to the Effective Date of the rider or within the Rider Waiting Period will not be payable at any time for that condition.

Exclusions and limitations may vary by state.

Inpatient Benefit Example

This plan pays set benefits for hospital stays. The confinement deductible is deducted from the total confinement benefits payable. **Scenario:** Jill has a Plus (Two Unit) Plan with a $5,000 Hospital Confinement Deductible. She suddenly becomes ill and is confined to an in-network hospital for three days.

Hospital Admission Benefit for the First Inpatient Day	**= $2,000**
Hospital Confinement Benefit for Covered Sickness	**= $3,000**
Your Three (3) day Hospital Stay Cost	**= $7,272***

Hospital Admission Benefit for the First Inpatient Day	$2,000
Confinement Benefit for Covered Sickness x Days Confined	+ ($3,000 x 3)
Total Benefits	**$11,000**
Deductible	- $5,000
Net Benefits	**$6,000**
Estimated Hospital Stay Cost	- $7,272
Excess Indemnity Benefit	**$1,272**

**Approx $2,424 per day based on the United States average Inpatient Day Expense. 2019 Kaiser Family Foundation State Health Facts. Results may vary.*

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Value Beyond Benefits

Optional: American Ally Advocacy Membership

Year-round access to patient advocates who are experts in medical billing and will help you:

- **Pre-price your doctor-ordered procedures**
- **File claims with insurance**
- **Negotiate predatory medical bills…**
  or get them erased entirely!

First Health Network

This plan provides access to the First Health Limited Benefit Plan (LBP) Network for discounts on healthcare services such as doctor visits, hospital stays, labs and more! To search for providers within this network, visit www.firsthealthlbp.com.

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AMERICAN ALLY

SHOP SMART & SAVE

Please call our Healthcare PALs before you receive care. We are here to help guide you on smart healthcare shopping, getting the most out of your benefits, and reducing or eliminating you out-of-pocket medical expenses. .

TOLL FREE: 1-888-748-3040

Renewability: The policy is guaranteed renewable to age 65. Premium rates are subject to change.

Pre-Existing Condition Limitation: Pre-Existing Conditions are excluded for the first twelve months following the effective date of coverage. Pre-Existing Condition is a condition for which medical treatment was rendered or recommended by a physician or for which drugs or medicine was prescribed within twelve (12) months prior to an Insured person's effective date. A condition shall no longer be considered a Pre-Existing Condition after the date a person has been covered under the policy for twelve (12) consecutive months.

Exclusions & Limitations: With respect to all of the benefits provided under the policy, no benefits will be payable as the result of: (a) any service, supplies or treatment that is not a specified benefit; (b) suicide or any attempt thereat, while sane or insane; (c) any intentionally self-inflicted loss; (d) rest care; (e) cosmetic surgery or care or treatment solely for cosmetic purposes, or complications therefrom. This exclusion does not apply to cosmetic surgery resulting from a covered injury if initial treatment of the insured person is begun within 12 months of the date of the injury; (f) immunization shots and routine examinations such as: health exams; periodic check-ups; pre-marital exams; and routine physicals, except as otherwise covered under the policy; (g) routine newborn care, including routine nursery charges; (h) voluntary abortion, except with respect to You or Your covered dependent spouse where such person's life would be endangered if the fetus were carried to term or where medical complications have arisen from an abortion; (i) pregnancy of a d pendent child, unless required by law; (j) an insured person's participation in a riot, civil commotion, civil disobedience, or unlawful assembly. This does not include a loss which occurs while acting in a lawful manner within the scope of authority; (k) an insured person committing, attempting to commit or taking part in a felony, or engaging in an illegal occupation; (l) air travel, except: (1) as a fare-paying passenger on a commercial airline on a regularly scheduled route; or (2) as a passenger for transportation only and not as a pilot or crew member; (m) any loss occurring as a result of the voluntary use of intoxicants, narcotics or hallucinogens unless taken on the written advice of a physician except for treatment of Alcohol and/or Substance Abuse Dependency as provided in the policy; (n) sex changes; (o) any dental care, treatment or service to the teeth, gums or mouth; (p) experimental treatments or surgery; (q) the reversal of tubal ligation or vasectomies; (r) artificial insemination, in vitro fertilization, and test tube fertilization, including any related testing, medications, or physician's services, unless required by law; (s) treatment of weight control; (t) an act of war, whether declared or undeclared, or while performing police duty as a member of any military or naval organization. This exclusion includes loss sustained while in the service of any military, naval or air force of any country engaged in war. We will refund the pro rata unearned premium for any such period the insured person is not covered; (u) injury or sickness arising out of or as the result of any work for wage or profit when coverage is in force for the injury or sickness under Workers' Compensation, employer's liability or similar laws or coverage; (v) any service, supplies or treatment that is not a covered benefit; (w) any facility charges for treatment at a hospital in excess of the indemnity amount specified in the policy; (x) pregnancy, childbirth or voluntary abortion, except for complications of pregnancy as defined; (y) any service or treatment rendered outside the territorial limits of the United States of America; (z) treatment of jaw joint problems including temporomandibular joint syndrome and craniomandibular disorder, or other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to that joint; (aa) voluntary sterilization.

Benefits and availability may vary by state. For more information about policy/plan benefits and limitations, please refer to the outline of coverage or policy as approved in your state. Please refer to your policy for definitions and all other exclusions and limitations.

The purpose of this brochure is solicitation of insurance and contact will be made by an insurance agent or Philadelphia American Life Insurance Company, a subsidiary company of New Era Life Insurance Company.

Underwritten by:
Philadelphia American Life Insurance Company
Houston, TX | Toll Free Number: 1-888-748-3040

New Era Life Insurance Companies

New Era Life Insurance Company
New Era Life Insurance Company of the Midwest
Philadelphia American Life Insurance Company

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