



Optimum Health Saver

Fixed Benefit Health & Income Protection



Design Your Optimum Plan

Lifetime Maximum Per Policy: \$5,000,000

Calendar Year Max Benefit Per Insured Person

- \$250,000 \$500,000 \$1,000,000

Benefit Level

- Value (One Unit)
- Plus (Two Unit)
- 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

The Confinement Deductible applies to each Insured with a maximum of three deductibles per Calendar Year. The Confinement Deductible only applies to certain inpatient confinement benefits as indicated in the brochure.

HOSPITAL BENEFITS - FACILITY FEES

Inpatient confinement benefits are payable when confined for 24-hours or more. All benefits are paid cumulatively on a calendar year basis.

Value
(One Unit)

Plus
(Two Unit)

Preferred
(Three Unit)

First Day Hospital Admission Benefit

Includes up to 1 day per Calendar Year.

Per Day
\$1,000

Per Day
\$2,000

Per Day
\$3,000

Hospital Confinement as a Result of Covered Sickness Indemnity Benefit:

Includes hospital stay for 24-hours or more.

Per Day

Per Day

Per Day

Days 1-3

\$3,000

\$6,000

\$9,000

Day 4

\$2,250

\$4,500

\$6,750

Days 5+

\$1,500

\$3,000

\$4,500

Deductible Applies

Hospital Confinement as a Result of Covered Injury Indemnity Benefit:

Includes Hospital stay for 24-hours or more.

Per Day

Per Day

Per Day

Days 1-3

\$3,500

\$7,000

\$10,500

Day 4

\$2,750

\$5,500

\$8,250

Days 5+

\$2,000

\$4,000

\$6,000

Deductible Applies

Confinement in Hospital Intensive Care Unit (ICU) Indemnity Benefit:

Includes up to 20 days for Three Unit Plans, up to 16 days for Two Unit Plans, and up to 12 days per One Unit Plan, per Calendar Year

Per Day

Per Day

Per Day

Days 1-3

\$3,500

\$7,000

\$10,500

Day 4

\$2,750

\$5,500

\$8,250

Days 5+

\$2,000

\$4,000

\$6,000

Deductible Applies

Observation Stay Confinement Benefit for Sickness:

Per Day

Per Day

Per Day

Days 1-3

\$3,000

\$6,000

\$9,000

Day 4

\$2,250

\$4,500

\$6,750

Days 5+

\$1,500

\$3,000

\$4,500

Deductible Applies

Observation Stay Confinement Benefit for Injury:

Per Day

Per Day

Per Day

Days 1-3

\$3,500

\$7,000

\$10,500

Day 4

\$2,750

\$5,500

\$8,250

Days 5+

\$2,000

\$4,000

\$6,000

Deductible Applies

Confinement in a Hospital for Mental Illness Indemnity Benefit

Per Day
\$200

Per Day
\$400

Per Day
\$600

Rehabilitation or Skilled Nursing Facility Confinement Benefit

Inpatient confinement benefits are payable when confined for 24-hours or more. Mental illness is covered under a separate 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.

Plan Benefits (continued)

FACILITY FEES (CONTINUED)	Value (One Unit)	Plus (Two Unit)	Preferred (Three Unit)
<i>Additional surgical benefits can be found under Professional Services.</i>			
Outpatient Hospital or Ambulatory Surgical Center Services When Surgery is Performed Indemnity Benefit <i>A Calendar Year Maximum for Surgical Benefits applies.³</i>	Per Day	Per Day	Per Day
Benefit for Surgery Performed Under General Anesthesia	\$1,500	\$3,000	\$4,500
Benefit for Surgery Performed not Requiring General Anesthesia	\$750	\$1,500	\$2,250
Outpatient Radiation Therapy, Chemotherapy and Immunotherapy Benefit <i>Includes up to \$40,000 in benefits payable per Calendar Year.</i>	Per Day \$750	Per Day \$1,500	Per Day \$2,250
PROFESSIONAL SERVICES	Value (One Unit)	Plus (Two Unit)	Preferred (Three Unit)
Inpatient Healthcare Practitioner Benefit (Non-Surgical) <i>Includes up to 20 days for Three Unit Plans, up to 16 days for Two Unit Plans, and up to 12 days per One Unit Plan, per Calendar Year.</i>	Per Day	Per Day	Per Day
	Days 1-6 \$80	Days 1-8 \$120	Days 1-10 \$160
	Days 7+ \$40	Days 9+ \$60	Days 11+ \$80
Surgery Benefit When Performed in a Hospital or Ambulatory Surgical Center <i>A Calendar Year Maximum for Surgical Benefits applies.³</i>	1 X Surgical Schedule ⁴	2 X Surgical Schedule ⁴	3 X Surgical Schedule ⁴
Assistant Surgeon Benefit <i>A Calendar Year Maximum for Surgical Benefits applies.³</i>	1 X Surgical Schedule ⁴	2 X Surgical Schedule ⁴	3 X Surgical Schedule ⁴
Anesthesia Benefit <i>A Calendar Year Maximum for Surgical Benefits applies.³</i>	1 X Surgical Schedule ⁴	2 X Surgical Schedule ⁴	3 X Surgical Schedule ⁴
Inpatient Pathologist or Radiologist Benefit	Per Day \$80	Per Day \$160	Per Day \$240
OUTPATIENT BENEFITS	Value (One Unit)	Plus (Two Unit)	Preferred (Three Unit)
Aggregate Calendar Year Maximum for Outpatient Benefits	\$2,000	\$4,000	\$6,000
Physician Benefit	Per Day	Per Day	Per Day
	Days 1-6 \$80	Days 1-8 \$120	Days 1-10 \$160
	Days 7+ \$40 <i>12 days per year</i>	Days 9+ \$60 <i>16 days per year</i>	Days 11+ \$80 <i>20 days per year</i>
Chiropractor Benefit	Per Day \$80 <i>4 days per year</i>	Per Day \$120 <i>5 days per year</i>	Per Day \$160 <i>6 days per year</i>
Therapy Benefit <i>Including but not limited to physical, speech and occupational therapy. Includes up to 20 days for Three Unit Plans, up to 16 days for Two Unit Plans, and up to 12 days per One Unit Plan, per Calendar Year.</i>	Per Day \$40	Per Day \$60	Per Day \$80

³The Calendar Year Maximum for Surgical Benefits is \$50,000.

⁴The Surgical Schedule can be found in the Policy.

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.

Plan Benefits (continued)

OUTPATIENT BENEFITS (CONTINUED)	Value (One Unit)	Plus (Two Unit)	Preferred (Three Unit)
Aggregate Calendar Year Maximum for Outpatient Benefits	\$2,000	\$4,000	\$6,000
Radiology Benefit for MRI, PET, CAT Scan and Nuclear Testing	Per Day \$240	Per Day \$480	Per Day \$720
Radiology Benefit for X-Ray and Other Diagnostic Testing <i>Includes up to 4 days per Calendar Year.</i>	Per Day \$80	Per Day \$160	Per Day \$240
Surgery Benefit When Performed in a Physicians or Specialists Office <i>Includes up to 2 days per Calendar Year.</i>	Per Day \$100	Per Day \$200	Per Day \$300
Lab Work Benefit <i>Includes up to 4 days per Calendar Year.</i>	Per Day \$40	Per Day \$80	Per Day \$120
Injection Benefit.	Per Day \$10	Per Day \$20	Per Day \$30
Emergency Room or Department Benefit: <i>Maximum of two (2) benefit per Insured person per Calendar Year. Maximum of four (4) benefits combined Emergency Department Benefit/Urgent Care Center Benefit per Insured person per Calendar Year.</i>	Per Day	Per Day	Per Day
Facility Fee	\$50	\$100	\$200
Professional Service	\$50	\$100	\$150
Urgent Care Benefit <i>Maximum of four (4) benefits per Insured person per Calendar Year. Maximum of four (4) benefits combined Emergency Department Benefit/Urgent Care Center Benefit per Insured person per Calendar Year.</i>	Per Day \$150	Per Day \$200	Per Day \$250
Ambulance Indemnity Benefit <i>Includes up to two ground ambulance benefits and up to one air ambulance benefit per Calendar Year.</i>	\$500 (Ground)	Per Day \$1,000 (Air)	
Generic Prescription Benefit <i>Paid per prescription filled.</i>	Per Day \$5	Per Day \$10	Per Day \$15
Brand Name Prescription Benefit <i>Paid per prescription filled.</i>	Per Day \$10	Per Day \$20	Per Day \$30

PREVENTIVE CARE	Value (One Unit)	Plus (Two Unit)	Preferred (Three Unit)
<i>Coverage starts sixty (60) days after the Effective Date of each Insured person. Limit of one of each of the benefits below per person per calendar year. Not subject to the Pre-Existing Conditions Exclusion. Preventative care benefits are subjected to outpatient aggregate calendar your maximum.</i>			
Mammogram Benefit	\$250 Per Calendar Year		
Colonoscopy Benefit Without Finding Any Polyps Policy Years 1-3 <i>If polyps are found, colonoscopies are paid under eligible outpatient surgery benefits.</i>	\$600 Per Calendar Year, Every 3 Years		
Colonoscopy Benefit Without Finding Any Polyps Policy Years 4+	\$750 Per Calendar Year, Every 3 Years		
Preventive Care Services Benefits	\$125 Per Calendar Year		

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.

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 Days 1-3 = \$18,000 (\$6,000 x 3)

Your Three (3) day Hospital Stay Cost = \$7,272*

Hospital Admission Benefit for the First Inpatient Day	\$2,000
Confinement Benefit for Covered Sickness Days 1-3	+ \$18,000
Total Benefits	\$20,000
Deductible	- \$5,000
Net Benefits	\$15,000
Estimated Hospital Stay Cost	- \$7,272
Excess Indemnity Benefit	\$7,728

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

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.

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.



Limitations & Exclusions

This policy provides benefits only for covered benefits identified in the policy. We will not pay benefits for claims resulting, whether directly or indirectly, from events or loss related to or resulting from any of the following:

1. A sickness or injury that is the result of a work-related condition that is eligible for benefits under Worker's Compensation, Employers' Liability or similar laws even when a covered person does not file a claim for benefits. This exclusion will not apply to a covered person who is not required to have coverage under any Worker's Compensation, Employers' Liability, or similar law and does not have such coverage. However, a covered person must receive services in accordance with the benefits section of the policy.
2. War or any act of war, whether declared or undeclared.
3. Participation in the military service of any country or international organization.
4. Treatment, services, or supplies that: (a) are not part of a specifically listed covered benefit shown on the schedule of benefits; (b) are due to complications of a non-covered service; (c) are incurred before a covered person's effective date or after the termination date of coverage, except as provided under the Extension of Benefits provision; (d) are provided in a student health center or by or through a school system; or (e) are provided at no cost to a covered person.
5. Glasses, contact lenses, vision therapy, exercise or training, surgery, including any complications arising therefrom, to correct visual acuity including, but not limited to, lasik and other laser surgery, radial keratotomy services or surgery to correct astigmatism, nearsightedness (myopia) and/or farsightedness (presbyopia), and vision care that is routine.
6. Hearing care that is routine, any artificial hearing device, cochlear implant, auditory prostheses or other electrical, digital, mechanical or surgical means of enhancing, creating or restoring auditory comprehension.
7. Treatment/services for foot conditions including, but not limited to: (a) flat foot conditions; (b) foot supportive devices, including orthotics, and corrective shoes; (c) foot subluxation treatment; (d) corns, bunions, calluses, toenails, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet; or, (e) hygienic foot care that is routine.
8. Dental treatment, dental care that is routine, bridges, crowns, caps, dentures, dental implants or other dental prostheses, dental braces or dental appliances, extraction of teeth, orthodontic treatment, odontogenic cysts, any other treatment or complication of teeth and gum tissue, except as otherwise covered for an accidental injury.
9. Treatment of TMJ and CMJ, any appliance, medical or surgical treatment for malocclusion (teeth that do not fit together properly which creates a bite problem), protrusion or recession of the mandible (a large chin which causes an underbite or a small chin which causes an overbite), maxillary or mandibular hyperplasia (excess growth of the upper or lower jaw) or maxillary or mandibular hypoplasia (undergrowth of the upper or lower jaw).
10. Treatment of substance abuse, whether organic or non-organic, chemical or non-chemical, biological or nonbiological in origin and irrespective of cause, basis or inducement, including, but not limited to, drugs and medicines for inpatient or outpatient treatment of substance abuse.
11. Any treatment, services, supplies, diagnosis, drugs, medications or regimen, whether medical or surgical, for purposes of controlling a covered person's weight or related to obesity or morbid obesity, whether or not weight reduction is recommended by a health care practitioner or appropriate or regardless of potential benefits for comorbid conditions, weight reduction or weight control surgery, treatment or programs, any type of gastric bypass surgery, suction lipectomy, physical fitness programs, exercise equipment or exercise therapy, including health club membership visits or services, and nutritional counseling.
12. Organ, tissue, or cellular material donation by a covered person, including administrative visits for registry, computer search for donor matches, preliminary donor typing, donor counseling, donor identification, and donor activation.
13. Chemical peels, reconstructive or plastic surgery that does not alleviate a functional impairment and other confinement or treatment visits that are primarily for a cosmetic service.
14. Capsular contraction, augmentation or reduction mammoplasty, except for all stages and revisions of reconstruction of the breast following a mastectomy by a health care practitioner, for treatment of cancer, including reconstruction of the other breast to produce a symmetrical appearance and treatment of lymphedemas.
15. Removal or replacement of a prosthesis, durable medical equipment or personal medical equipment, except for internal breast prostheses following a mastectomy by a health care practitioner for treatment of cancer and services are received in accordance with the benefits section.
16. Prophylactic treatment, services, or surgery including, but not limited to, prophylactic mastectomy or any other treatment, services or surgery to prevent a disease process from becoming evident in the organ or tissue at a later date.
17. Treatment, services, and supplies for: (a) home health care; (b) hospice care; (c) custodial care, respite care, rest care, supportive care, homemaker services; (d) phone, facsimile, internet or e-mail consultation, compressed digital interactive video, audio or clinical data transmission using computer imaging by way of still-image capture and store forward; (e) treatment, services, or supplies that are furnished primarily for the personal comfort or convenience of a covered person, covered person's family, a health care practitioner or provider; (f) treatment or services provided by a standby health care practitioner; or (g) treatment or services provided by a masseur, masseuse or massage therapist, massage therapy, a rolfer.
18. Treatment, services, and supplies for growth hormone therapy, including growth hormone medication and its derivatives or other drugs used to stimulate, promote or delay growth or to delay puberty to allow for increased growth other than children 18 years of age or under as long as medically necessary.

19. Treatment, services, and supplies related to the following conditions, regardless of underlying causes: sex transformation, gender reassignment, and treatment to enhance, restore or improve sexual energy, performance or desire.
20. Treatment, services, and supplies related to maternity, pregnancy (except complications of pregnancy), routine well newborn care at birth including nursery care, abortion.
21. Treatment for or treatment use of: (a) genetic testing or counseling, genetic services and related procedures for screening purposes including, but not limited to, amniocentesis and chronic villi testing; (b) services, drugs or medicines used to treat males or females for an infertility diagnosis regardless of intended use including, but not limited to artificial insemination, in vitro fertilization, reversal of reproductive sterilization, any treatment to promote conception; (c) sterilization; (d) cryopreservation of sperm or eggs; (e) surrogate pregnancy; (f) fetal surgery, treatment or services; (g) umbilical cord stem cell or other blood component harvest and storage in the absence of sickness or injury; or (h) circumcision.
22. Treatment for vocational or work hardening programs, transitional living, except for outpatient diabetes selfmanagement training and education for treatment of a covered person with diabetes.
23. Treatment for or through use of: (a) non-medical items, self-care or self-help programs; (b) aroma therapy; (c) meditation or relaxation therapy; (d) naturopathic medicine; (e) family or marriage counseling; (f) inpatient treatment of chronic pain disorders.
24. Sickness or injury resulting from abuse or overdose of any illegal or controlled substance, except when administered in accordance with the advice of a covered person's health care practitioner.
25. Treatment of sickness or injury when a contributing cause of the condition was a covered person's voluntary attempt to commit or participation in or commission of a felony, whether or not charged, or as a consequence of a covered person being under the influence of any illegal or non-prescribed controlled substance while committing a felony.
26. Any amount in excess of the lifetime maximum benefit or any other maximum limitation for covered scheduled benefits.
27. Treatment that does not meet the definition of a covered benefit in this policy including, but not limited to, treatment that is not provided by a health care practitioner.
28. Treatment, services, and supplies for experimental or investigational services.
29. Sickness or injury caused or aggravated by suicide, attempted suicide, or self-inflicted sickness or injury.
30. Treatment, services, supplies, drugs or medicines received outside the territorial United States.
31. Vitamins and/or vitamin combinations even if they are prescribed by a health care practitioner.
32. Any prescription products, drugs or medicines in the following categories, whether or not prescribed by a health care practitioner: (a) herbal or homeopathic medicines or products; (b) minerals; (c) appetite suppressants; (d) dietary or nutritional substances or dietary supplements; (e) nutraceuticals; (f) medical foods; or (g) durable medical equipment/supplies.
33. Drugs or medicines that have an over-the-counter equivalent or contain the same or therapeutically equivalent active ingredient(s) as over-the-counter medication.
34. Drugs or medicines administered at or by the rest home, sanitarium, extended care facility, convalescent care facility, skilled nursing facility or similar institution, or dispensed at or by a hospital, an emergency room, a free-standing facility, an urgent care facility, a health care practitioner's office or other inpatient or outpatient setting for take home by a covered person.
35. Drugs or medicines used to treat, impact or influence: athletic performance, body conditioning, strengthening, energy, slowing the normal processes of aging, dry mouth, excessive salivation, genetic make-up or genetic predisposition, prevention or treatment of hair loss, excessive hair growth or abnormal hair patterns.
36. Unit-dose drugs, drugs or medicines used to treat onychomycosis (nail fungus), botulinum toxin and its derivatives.
37. Drugs or medicines prescribed for treatment of a condition that is specifically excluded under this policy.
38. Drugs, medicines or supplies that are illegal under federal law, such as marijuana, even if they are prescribed for medical use in a state.
39. Duplicate prescriptions, replacement of lost, stolen, destroyed, spilled or damaged prescriptions; prescription refills in excess of the number specified on the health care practitioner's prescription order; prescriptions refilled more frequently than the prescribed dosage indicates, prescriptions refilled after one year from the health care practitioner's original prescription order, any administration for drug injections or any other drugs or medicines obtained other than through a pharmacy.
40. 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.
41. Any facility charges for treatment at a hospital in excess of the indemnity amount specified in the policy schedule of benefits.
42. Drugs or medicines that have an over-the-counter equivalent or contain the same or therapeutically equivalent active ingredient(s) as over-the-counter medication.

Pre-Existing Conditions

There is no coverage for a Pre-Existing Condition, as defined in the policy, for a continuous period of 12 months

Questions? Call Us Toll Free: 1-888-748-3040

Underwritten by:
Philadelphia American Life Insurance Company

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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Benefits, exclusions and limitations may vary by state.*