Schedule of Benefits

LGIT HEALTH COOPERATIVE –Rates are good through June 30, 2026

Fixed Rate Insured Plan Designs-In Network Benefits								
	Plan D (In-Network)		**Plan F (In-Network)**		**Plan G (In-Network)**		**Plan H (In-Network)**	
Benefit	Single $4.70	Family $11.73	Single $4.92	Family $12.29	Single $7.24	Family $16.39	Single $5.30	Family $12.01
Examination	Covered 100% Once Every 12 Months		Covered 100% Once Every 12 Months		Covered 100% Once Every 12 Months		Covered 100% Once Every 12 Months	
Lenses	Standard Glass or Plastic Covered 100% Once Every 12 Months		Standard Glass or Plastic Covered 100% Once Every 12 Months		Standard Glass or Plastic Covered 100% Once Every 12 Months		Standard Glass or Plastic Covered 100% Once Every 12 Months	
Frame	Covered up to $60 Retail Allowance (20% discount off remaining balance over $60 allowance)*** Once Every 24 Months		Covered up to $60 Retail Allowance (20% discount off remaining balance over $60 allowance)*** Once Every 12 Months		Covered up to $130 Retail Allowance (20% discount off remaining balance over $130 allowance)*** Once Every 12 Months		Covered up to $130 Retail Allowance (20% discount off remaining balance over $130 allowance)*** Once Every 24 Months	
Contact Lenses	(In lieu of Lenses/Frames) Once Every 12 Months Up to $85 Retail Allowance*-Elective (15% discount (Conventional) or 10% discount (Disposable) off remaining balance over $85)**** Medically Necessary – Covered 100%**		(In lieu of Lenses) Once Every 12 Months Up to $85 Retail Allowance*-Elective (15% discount (Conventional) or 10% discount (Disposable) off remaining balance over $85)**** Medically Necessary – Covered 100%**		(In lieu of Lenses/Frames) Once Every 12 Months Up to $130 Retail Allowance*-Elective (15% discount (Conventional) or 10% discount (Disposable) off remaining balance over $130)**** Medically Necessary – Covered 100%**		(In lieu of Lenses) Once Every 12 Months Up to $130 Retail Allowance*-Elective (15% discount (Conventional) or 10% discount (Disposable) off remaining balance over $130)**** Medically Necessary – Covered 100%**	

OUT OF NETWORK BENEFITS

	Plan D (Out-of -Network)	**Plan F (Out-of -Network)**	**Plan G (Out-of -Network)**	**Plan H (Out-of -Network)**
Benefit				
Examination	(Reimbursed Amounts) Up to $32	(Reimbursed Amounts) Up to $32	(Reimbursed Amounts) Up to $52	(Reimbursed Amounts) Up to $52
Lenses	Single Vision Up to $25 Bi-Focal Up to $36 Tri-Focal Up to $46 Lenticular Up to $72	Single Vision Up to $25 Bi-Focal Up to $36 Tri-Focal Up to $46 Lenticular Up to $72	Single Vision Up to $55 Bi-Focal Up to $75 Tri-Focal Up to $95 Lenticular Up to $125	Single Vision Up to $55 Bi-Focal Up to $75 Tri-Focal Up to $95 Lenticular Up to $125
Frame	Covered up to $30	Covered up to $30	Covered up to $57	Covered up to $57
Contact Lenses	(In lieu of Lenses/Frames) Up to $85 $225	(In lieu of Lenses/Frames) Up to $85 $225	(In lieu of Lenses/Frames) Up to $105 $225	(In lieu of Lenses/Frames) Up to $105 $225

* Fitting & Follow-Up Fees are deducted from the Contact Lens Allowance shown above unless otherwise specified.
** Prior Authorization required from NVA
*** Discount does not apply at WalMart/Sam's Club locations.
**** Discount does not apply at WalMart/Sam's Club locations or Contact Fill.

NOTE: If covered participants choose extra options, they are responsible for the additional cost of the options paid directly to the provider.