Schedule of Benefits

MARYLAND LOCAL GOVERNMENT HEALTH COOPERATIVE –Rates are good through June 30, 2022

Fixed Rate Insured Plan Designs-In Network Benefits								
	Plan A (In-Network)		Plan C (In-Network)		Plan D (In-Network)		Plan F (In-Network)	
Benefit	Single $2.60	Family $6.75	Single $3.61	Family $9.01	Single $4.70	Family 11.73	Single $4.92	Family $12.29
Examination	Covered 100% Once Every 24 Months Once Every 12 Months for Children under age 19		Covered 100% Once Every 24 Months Once Every 12 Months for Children under age 19		Covered 100% Once Every 12 Months		Covered 100% Once Every 12 Months	
Lenses	Standard Glass or Plastic Covered 100% After Co-Payment Once Every 24 Months Once Every 12 Months for Children under age 19		Standard Glass or Plastic Covered 100% Once Every 24 Months Once Every 12 Months for Children under age 19		Standard Glass or Plastic Covered 100% Once Every 12 Months		Standard Glass or Plastic Covered 100% Once Every 12 Months	
	$24 Co-Payment (Single Vision) $36 Co-Payment (Bi-Focal) $46 Co-Payment (Tri-Focal) $72 Co-Payment (Lenticular)							
Frame	Covered up to $60 Retail Allowance Once Every 24 Months		Covered up to $60 Retail Allowance Once Every 24 Months		Covered up to $60 Retail Allowance Once Every 24 Months Once Every 12 Months for Children under age 19		Covered up to $60 Retail Allowance Once Every 12 Months	
Contact Lenses	(In lieu of Lenses/Frames) Once Every 24 Months Once Every 12 Months for Children under age 19 Up to $48 Retail Allowance*-Elective No Coverage-Medically Necessary		(In lieu of Lenses/Frames) Once Every 24 Months Once Every 12 Months for Children under age 19 Up to $85 Retail Allowance*-Elective Covered 100%**-Medically Necessary		(In lieu of Lenses/Frames) Once Every 12 Months Up to $85 Retail Allowance*-Elective Covered 100%**-Medically Necessary		(In lieu of Lenses/Frames) Once Every 12 Months Up to $85 Retail Allowance*-Elective Covered 100%**-Medically Necessary	

OUT OF NETWORK BENEFITS

	Plan A (Out-of-Network)	**Plan C (Out-of-Network)**	**Plan D (Out-of -Network)**	**Plan F (Out-of -Network)**
Benefit				
Examination	(Reimbursed Amounts) Up to $32	(Reimbursed Amounts) Up to $32	(Reimbursed Amounts) Up to $32	(Reimbursed Amounts) Up to $32
Lenses	Single Vision Up to $24 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 $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
Frame	Covered up to $24	Covered up to $30	Covered up to $30	Covered up to $30
Contact Lenses	(In lieu of Lenses/Frames) Up to $48 No Coverage	(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 $85 $225

* Fitting & Follow-Up Fees are deducted from the Contact Lens Allowance shown above unless otherwise specified.
** Prior Authorization required from NVA
NOTE: If covered participants choose extra options, they are responsible for the additional cost of the options paid directly to the provider.