City of Riverside
2024 Benefits

BENEFITS DESCRIPTION	VISION SERVICE PLAN Plan B 12 / 12 / 24 *with PEC-Primary Eye Care* Self-Funded Plan Participating Provider	Non-Participating Provider
DEDUCTIBLE Individual/Family	None	None
COMPREHENSIVE EYE EXAM	$10 Copayment	Up to $50 Reimbusement
Primary EyeCare	$20 Copayment	In Network Only
Frequency	12 Months	12 Months
LENSES	Single, Bi-Focal, Tri-Focal, Standard Progressive: $25	Single: $50, Bi-Focal: $75, Tri-Focal: $100, Standard Progressive: $75
Frequency	12 Months	12 Months
FRAMES	$150 Allowance, 20% off amount over your allowance	$70 Reimbursement
Frequency	24 Months	24 Months
CONTACT LENSES **(In Lieu of Lenses/Frames)**	12 Months	12 Months
Elective Contact Lenses	$150 Allowance	$105 Reimbursement
Necessary Contact Lenses	No Charge w/Authorization	$210 Reimbursement