City of Riverside
2025 Blue Shield PPO
Limits and Co-Pays

BENEFITS DESCRIPTION	BLUE SHIELD *Custom Full PPO Split Deductible* *20 - 500 - 80/60* Network Provider	Out of Network Provider
ANNUAL LIMITS		
Deductible: Individual*	$500	$500
Deductible: Family*	$1,500	$1,500
Maximum Out of Pocket: Individual	$3,500	$7,000
Maximum Out of Pocket: Family	$7,000	$14,000
PHYSICIAN SERVICES		
Primary Care Phyisician Office Visits	$20	40%*
Specialist Office Visits	$20	40%*
Preventative Services (schedule applies)	No Charge	40%*
Chiropractic	Chiro: $20*, 30 combined visits/CY Acupuncture: $20*, 30 combined visits/CY	Chiro: 40%*, 30 combined visits/CY Acupuncture: 40%*, 30 combined visits/CY
OUTPATIENT SERVICES		
Basic Lab	$20 *	40% * (Ltd to $350 max/visit)
Basic X-Ray	$20 *	40% * (Ltd to $350 max/visit)
Complex Radiology & Imaging	$20 *	40% * (Ltd to $350 max/visit)
EMERGENCY SERVICES		
Urgent Care	$20	40% *
Emergency Room (True Emergency)	$150 + 20%	$150 + 20%
Ambulance (True Emergency)	20% *	20% *
HOSPITAL SERVICES (Prior Authorization)	***Requires prior authorization for all inpatient stays, both in-network and out-of-network.***	
Inpatient	20% *	40% * up to $600 max/day
Outpatient Surgery	20% *	40% * (limited to $350 max/visit)
PRESCRIPTION DRUGS	**Participating Pharmacies**	
Rx Deductible	$150 Per Member / $450 Per Family (Excluding Generic)	
Generic / Tier 1	$15	
Brand / Tier 2	$40	
Non-Formulary / Tier 3	$60	
Speciality Rx / Tier 4	30% up to $250 Max/Rx after Rx ded.	
MISCELLANEOUS		
Hearing Aid Allowance	20%, $5,000 allowance every 24 months	
Durable Medical Equipment	20%*	40%*

The above information is intended as a benefit summary only. It does not include all of the benefit provisions, limitations and qualifications. If this information conflicts in any way with the contract, the contract will govern rates and benefits.