City of Riverside
2025 VISION SERVICE PLAN
Limits and Co-Pays

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

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.