CONSOLIDATED EDISON COMPANY OF NEW YORK
CON-ED EPO NETWORK
PLAN DESCRIPTION & FEE SCHEDULE

PLAN DOES NOT ALLOW FOR OUT OF NETWORK BENEFITS

This document is a brief description of the program. In cases of discrepancy the dental program document will control.

ELIGIBILITY	▪ Eligibility is determined according to the definition and requirements outlined in the Con Ed Summary Plan Description. **Eligible dependents** include the lawful spouse and unmarried children to the end of the year in which they reach age 19, unmarried children who are fulltime students to end of year in which they reach 26 or graduate, whichever comes first. ▪ **PLEASE BE ADVISED MEMBERS WITH OPTION 3 ARE REIMBURSED FOR DIAGNOSTIC AND PREVENTIVE SERVICES ONLY. ALL OTHER COVERED SERVICES ARE PROVIDED ON A DISCOUNT FEE FOR SERVICE. PLEASE CALL TO CONFIRM WHICH OPTION THE MEMBER IS COVERED BY.**
PLAN YEAR	▪ January 1 st through December 31 st
ANNUAL MAXIMUM	▪ No Max
DEDUCTIBLE	▪ No Deductible
ORTHODONTIC MAXIMUM	• **Local 3 -** payable at 50% of the maximum charge of $1600 per eligible dependent. • **Local 1-2 FC** payable at 60% of the maximum charge of $1600 per eligible dependent.
PLAN LIMITATIONS	• **Examination** – once every six months • **Prophylaxis** – once every six months • **X-rays- Full Mouth Series or Panorex** – once every 36 months • **Replacement of prosthetics** – not more than once in five years • **Palliative treatment** – no other treatment rendered that same visit • **Fluoride treatment** – to age 19, one application every six months • **Root Scaling, curettage, bite correction; any combination, including prophylaxis** – once every six months • **Periodontal surgery –** charting and x-rays required; 1 in 12 consecutive months • **Periodontal maximum -** $900 per calendar year for all periodontal services. • **Anesthesia –** payable when performed with at least 2 impactions or 7 surgical extractions. • **Rebasing or relining denture** – once in a three year period
PRE-TREATMENT REVIEW	• This process is recommended for your benefit as it will give the dentist and plan member a better understanding of the dental coverage for a proposed treatment plan before the work begins and expenses are incurred. **Please note-** a pre-treatment review estimate is not a promise of payment. Work must be done while the patient is still eligible • Pre-op periapical x-rays required for crowns, veneers, inlays and extractions • Periodontal charting and x-rays are required for surgical periodontal procedures • Pre-op periapical x-rays of the entire arch are required for fixed bridgework and removable bridgework
PERMISSIBLE CHARGES	• **Covered and reimbursable services:** None • **Covered but not reimbursable services:** Schedule allowance • **Non-covered services:** Your usual charge for that service
COORDINATION OF BENEFITS	• If the patient is eligible for benefits under more than one group dental plan, you are entitled to collect benefits available through both plans. The total may not exceed your usual charge and payments from the other plan must first be applied to reduce or eliminate co-payments, deductibles, or charges levied due to maximums.
HOW TO FILE A CLAIM	• **As a participating provider, you must complete all necessary paper work and accept assignment of benefits.** • Complete a Claim Form **(computer generated, ADA, and universal claim forms are accepted)** and provide an itemized bill of services rendered. • Enclose, when appropriate, x-rays, tooth charting, periodontal charting • Mail claims to: Administrative Services Only, Dept 134. P.O. Box 9005 Lynbrook, NY 11563 • File claims electronically: **PAYOR ID: CX076**

For up to date detailed information, including member eligibility, please access our website at:
www.asonet.com
If you have any questions regarding the operation of this program please contact A.S.O. at:
(1877)-632-6633

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CONSOLIDATED EDISON COMPANY OF NEW YORK
SCHEDULE OF ALLOWANCES

	MAXIMUM CHARGE
I-DIAGNOSTIC	
ORAL EXAM	20.00
X-RAYS (FULL MOUTH SERIES)	40.00
PERIAPICAL X-RAY-FIRST FILM	10.00
PERIAPICAL X-RAY-EACH ADDITIONAL	6.00
BITEWING X-RAY-TWO FILMS	12.00
BITEWING X-RAY-FOUR FILMS	20.00
PANORAMIC FILM	25.00
II-PREVENTIVE	
PROPHYLAXIS-Adult	30.00
PROPHYLAXIS-Child	17.00
FLUORIDE EXCL. PROPHY	12.00
SPACE MAINTAINER-FIXED	97.00
SPACE MAINTAINER-FIXED BILATERAL	146.00
SPACE MAINTAINER-REMOVABLE	58.00
SPACE MAINTAINER-REMOVABLE BILATERAL	75.00
III-RESTORATIVE	
AMALGAM - 1 SURFACE	40.00
AMALGAM - 2 SURFACES	60.00
AMALGAM - 3 SURFACES	75.00
AMALGAM- 4+ SURFACES	100.00
RESIN-1 SURFACE	40.00
RESIN-2 SURFACE	60.00
RESIN-3 SURFACE	70.00
PORCELAIN OR METALLIC INLAY-2 SRF	140.00
PORCELAIN OR METALLIC INLAY-3 SRF	170.00
CROWN-PLASTIC TO METAL	340.00
CROWN-PORCELAIN	340.00
CROWN-PORCELAIN TO METAL	400.00
CROWN-FULL CAST	280.00
CROWN-3/4 CAST	280.00
CAST POST AND CORE	100.00
PREFAB POST AND CORE	80.00
RECEMENT CROWN OR INLAY	30.00
IV-ENDODONTICS	
ROOT CANAL THERAPY-1 CANAL	160.00
ROOT CANAL THERAPY-2 CANALS	200.00
ROOT CANAL THERAPY-3 CANALS	280.00
APICOECTOMY - FIRST ROOT	140.00
V-ADJUNCTIVE SERVICES	
PALLIATIVE TREATMENT	17.00
GENERAL ANESTHESIA/IV SEDATION	
Plan pays first 30 minutes only	110.00
SPECIALIST CONSULTATION	60.00

	MAXIMUM CHARGE
VI-PERIODONTICS	
GINGIVECTOMY-PER QUAD	161.00
OSSEOUS SURGERY-PER QUAD	345.00
OSSEOUS GRAFT-Multiple Sites	150.00
CURETTAGE, SCALE\ROOT PLANING-full mouth	140.00
CURETTAGE, SCALE\ROOT PLANING-per quad	40.00
VII-ORAL SURGERY	
SURGICAL EXTRACTION	60.00
IMPACTION-SOFT TISSUE	60.00
IMPACTION-PARTIAL BONY	120.00
IMPACTION-COMPLETE BONY	200.00
REMOVAL OF RESIDUAL ROOTS	40.00
CYST/TUMOR REMOVAL <1.25	58.00
CYST/TUMOR REMOVAL >1.25	60.00
ALVEOPLASTY-PER JAW	
FRENULECTOMY	140.00
INCISION AND DRAINAGE-NO OTHER TREATMENT	50.00
VIII-PROSTHODONTICS	
COMPLETE DENTURE	400.00
IMMEDIATE DENTURE	225.00
PARTIAL DENTURE-ACRYLIC BASE	240.00
PARTIAL DENTURE-CAST BASE	240.00
REPAIR ACRYLIC SADDLE OR BASE	60.00
ADD, REPAIR OR REPLACE CLASP	120.00
REPAIR CAST FRAMEWORK	120.00
REPLC MISS/BRKN TTH-COM DENT	60.00
RELINE COMPLETE DENTURE-CHAIRSIDE	100.00
RELINE PARTIAL DENTURE-CHAIRSIDE	80.00
RELINE COMPLETE DENTURE-LABORATORY	160.00
RELINE PARTIAL DENTURE-LABORATORY	120.00
PONTIC-PORCELAIN TO METAL	300.00
PONTIC-RESIN WITH METAL	240.00
CAST METL RETNR-ACID ETCH	100.00
ABUTMENT-PLASTIC WITH METAL	340.00
ABUTMENT-PORCELAIN WITH METAL	400.00
IX-ORTHODONTICS	
DIAGNOSTIC AND INITIAL INSERTION	
ACTIVE TREATMENT - 24 MONTHS	
MAXIMUM CHARGE	**1600.00**
MAXIMUM PLAN PAYMENT for LOCAL 3	800.00
MEMBER PAYMENT For LOCAL 3	800.00
MAXIMUM CHARGE	**1600.00**
MAXIMUM PLAN PAYMENT for LOCAL 1-2 FC	900.00
MEMBER PAYMENT For LOCAL 1-2 FC	700.00

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