



BlueCross BlueShield of Texas

Important information regarding Pediatric Dental for new accounts with a plan year beginning on or after 1/1/2014

In 2014, ACA will generally require non-grandfathered insured small group benefit plans to include coverage for pediatric dental services that are considered essential health benefits (“EHBs”). For applicable small group coverage sold “off-exchange,” pediatric dental EHBs may either be embedded in the medical plan, or provided through a stand-alone dental plan that has been certified by an exchange (also known as a health insurance marketplace) called “Dental Qualified Health Plans” or “Dental QHPs.” If these benefits are not embedded in your Blue Cross and Blue Shield of Texas medical plan(s), ACA requires us to be reasonably assured that all your employees/dependents (enrolled in an applicable medical plan) have pediatric dental EHB coverage through another policy.

ACA requires that each employee and dependent (enrolled in an applicable medical plan) must have pediatric dental EHB coverage even if that employee or dependent is not eligible for these services. However, employees or dependents who are not eligible for these services will not pay a premium for the coverage.

In order to comply with the requirements described above, Low Child Only Dental Plan, our limited dental qualified health plan (QHP), which provides pediatric dental essential health benefits, **will be added to your Blue Cross and Blue Shield of Texas coverage at an additional premium cost** for any participants under age 21 (up to a maximum of three dependents) unless you tell us that all your employees/dependents (enrolled in an applicable medical plan) have pediatric dental EHB coverage through another policy. Please use the following attestation form to provide us with that confirmation.

IMPORTANT: This can be returned along with your new account submission.



Small Group Pediatric Dental EHB Attestation Form

IMPORTANT: Unless we receive this attestation form along with your new group submission, Low Child Only Dental Plan, our limited dental qualified health plan (QHP), will be added to your coverage at an additional premium cost.

Effective Date ____ / ____ / ____ (MM/DD/YYYY)

Please check one:

ATTESTATION: I/We attest that ALL members/dependents enrolled in our applicable Blue Cross and Blue Shield medical plan(s) have (for the applicable plan year) coverage for Pediatric Dental EHBs through a policy issued by Blue Cross and Shield or another entity.

ATTESTATION: I/We attest that ALL the members/dependents **LISTED IN THE TABLE on PAGE THREE** enrolled in our applicable Blue Cross and Blue Shield medical plan(s) AND have (for the applicable plan year) coverage for Pediatric Dental EHBs through a policy issued by Blue Cross and Shield or another entity.

Please add Low Child Only Dental Plan, to those members/dependents not listed in the grid below who are enrolled in our applicable Blue Cross and Blue Shield medical plan(s). Once those members/dependents not listed in the grid below are enrolled in Low Child Only Dental Plan, ALL member/dependents enrolled in our applicable Blue Cross and Blue Shield medical plan(s) will have (for the applicable plan year) coverage for Pediatric Dental EHBs through a policy issued by Blue Cross and Shield or another entity.

(Please use the table on page three to list employee/dependent names.)

Company Name
Date
Signature (e-signature)
Your Full Name (please print)
Title

