BlueCross BlueShield of Illinois

Important information regarding Pediatric Dental:

Member Level Attestation

ACA generally requires 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 Illinois (BCBSIL) medical plan(s), ACA requires us to be reasonably assured that all participants (enrolled in the applicable BCBSIL medical plan) have pediatric dental EHB coverage through another policy.

ACA requires that each participant (enrolled in an applicable medical plan) must have pediatric dental EHB coverage even if that participant is not eligible for these services. However, participants who are not eligible for these services will not pay a premium for the coverage of the pediatric dental EHBs.

In order to comply with the requirements described above, all employers are required to complete an attestation form to confirm whether participants (enrolled in the applicable BCBSIL medical plan) have coverage of the pediatric dental EHBs. The dental qualified health plan (QHP) as offered by your employer, which provides pediatric dental essential health benefits, will be included as part of your BCBSIL coverage at an additional premium cost for eligible participants (up to a maximum of three dependents), unless you tell us that you or your dependents (enrolled in the applicable BCBSIL medical plan) have pediatric dental EHBs coverage through another policy. Please use the attestation below to provide us with that confirmation.

Complete, digitally sign, and submit the Pediatric Dental EHBs Attestation Form to your employer's enrollment department, which will then submit your form to: Blue Cross and Blue Shield of Illinois, P.O. Box 805107, Chicago, IL 60680-3625.

Employer Name	
Subscriber Full Name (please print)	
Group number (applicable to existing BCBSIL membership)	
Identification Number or SSN (applicable to existing BCBSIL membership, refer to BCBSIL ID card)	
Employee Signature (e-signature)	Date

Please check one:

☐ I/We already have the necessary coverage. I, and each dependent, (if applicable) have obtained coverage for pediatric dental essential health benefits through another policy. (No need to provide information in the grid below.)

☐ I attest that family members, enrolled in the applicable Blue Cross and Blue Shield medical plan(s) and entered in the grid below, have obtained coverage for pediatric dental essential health benefits through another policy. I have used the grid below to list all family members who should **not** have the BlueCare Dental 4 Kids℠ 1B pediatric dental plan added to their policy.

Name	Identification Number or SSN (refer to BCBSIL ID card for ID number)	Date of Birth (DOB)