

Essential Pediatric Dental Coverage Group Attestation Form

For small groups

Please note: If pediatric dental is a voluntary benefit, you should not complete this form.

In an effort to make health care more accessible, the Affordable Care Act (ACA) requires that all small group health plans provide coverage for a range of core services known as Essential Health Benefits (EHBs), one of which is pediatric dental care. This form may be submitted to membership@cdphp.com.

Enrollment and Billing

CDPHP® is helping to ensure our members with small group health plans have this essential coverage. If you select a Delta Dental group plan through CDPHP, we will enroll your employees and their covered dependents in the Delta Dental Pediatric Dental Plan. You will be billed for all enrolled individuals (subscribers and dependents) who are 18 years of age or younger.

Optional Attestation

If you are providing your employees the essential pediatric dental coverage from another plan not offered by CDPHP, you have the option to opt out from the Delta Dental Pediatric Dental Plan through CDPHP on behalf of your employees. By signing below, you are attesting that you are already meeting the essential pediatric dental coverage requirements through another plan, and you are disenrolling your employees from the CDPHP pediatric dental coverage through Delta Dental.

Group Name: _____ CDPHP Group ID #: _____

Name of the company issuing the standalone dental coverage: _____

Effective date of standalone dental plan: _____

Agreement

I certify that I, as an authorized designee of the above-named employer group, have obtained standalone dental coverage that provides a pediatric dental essential health benefit to my employees and their dependents through a NY State of Health™-certified standalone dental plan offered outside NY State of Health.

I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation.

Signature _____ Date: _____

Name: _____ Title: _____

If you have questions about this form, contact your CDPHP account representative at (518) 641-5000, or toll-free at 1-800-993-7299.

