

SERFF Tracking Number: DDAR-127798933 State: Arkansas
Filing Company: Delta Dental of Arkansas State Tracking Number: 50201
Company Tracking Number: DDARIN-2011-W
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: DDARIN-2011-W
Project Name/Number: /

Filing at a Glance

Company: Delta Dental of Arkansas

Product Name: DDARIN-2011-W

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Filing Type: Form

SERFF Tr Num: DDAR-127798933 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 50201

Co Tr Num: DDARIN-2011-W

State Status: Approved-Closed

Author: Sara Farris

Reviewer(s): Rosalind Minor

Date Submitted: 11/07/2011

Disposition Date: 11/07/2011

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile:

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type:

Individual Market Type: Individual

Overall Rate Impact:

Filing Status Changed: 11/07/2011

State Status Changed: 11/07/2011

Deemer Date:

Created By: Sara Farris

Submitted By: Sara Farris

Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

This is our individual dental/vision brochure and application. It has been reformatted for our website.

Company and Contact

Filing Contact Information

Sara Farris,

sfarris@ddpar.com

1513 Country Club

501-992-1662 [Phone]

Sherwood, AR 72120

501-992-1663 [FAX]

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Filing Company Information

Delta Dental of Arkansas
1513 Country Club Rd.
Sherwood, AR 72120
(501) 992-1662 ext. [Phone]

CoCode: 47155
Group Code:
Group Name:
FEIN Number: 71-0561140

State of Domicile: Arkansas
Company Type:
State ID Number:

Filing Fees

Fee Required? Yes
Fee Amount: \$0.00
Retaliatory? No
Fee Explanation:
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Delta Dental of Arkansas	\$50.00	11/07/2011	53533934

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/07/2011	11/07/2011

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Disposition

Disposition Date: 11/07/2011

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form	DDARIN-2011-W	Approved-Closed	Yes

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Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 11/07/2011	DDARIN-2011-W	Application/ DDARIN-2011-W Enrollment Form	Initial		0.000	DDARIN-2011-W.pdf

Dental and Vision Benefits Information

Individual and family plans at a price that will make you smile.

Call 1-800-814-3451 for Information on
Dental and Vision Coverage from Delta Dental.

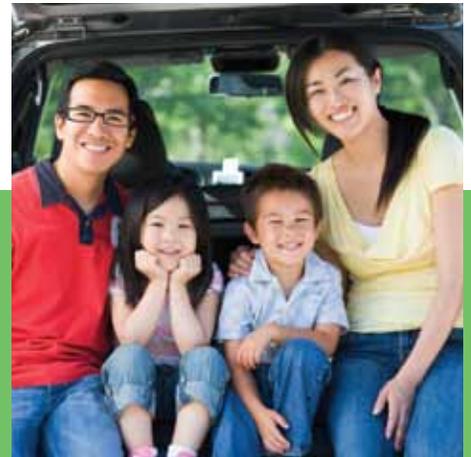


Delta Dental of Arkansas
P.O. Box 6140
Sherwood, AR 72124
www.DeltaDentalAR.com



Delta Dental is the largest dental benefits provider in the state and that means you get all the services you deserve at a price you can afford.

- Freedom to choose your own dentist
- Affordable monthly rates
- All the benefits you need
- Online access to your claims & benefits



It's as easy as **1 – 2 – 3**

- 1) Select from the following Delta Dental Premier + PPO
- 2) Return the attached enrollment form
- 3) Enjoy excellent benefits at affordable rates!

Basic Dental Plan

Services*

- Two periodic exams, per member per benefit period
- Two cleanings, including scaling and polishing, per member per benefit period
- Two topical applications of fluoride per benefit period for covered dependents up to 19th birthday
- X-rays
- Sealants (one every 60 months for dependents up to 16th birthday)

Coverage

100%
No Waiting Period

Monthly Premiums

Individual	\$11.33	Individual & Child(ren) ...	\$21.77
Individual & Spouse	\$22.68	Family	\$29.66

*One-time annual deductible of \$50 per individual which applies to all services. Annual Maximum Benefits: \$500 per individual. Benefits are covered through participating dentists only. Limitations apply. See schedule of benefits for this policy for a comprehensive explanation of services and benefits.

Basic Dental + Vision Plan

Services*

Basic Dental Plan Services

100%

Plus! In-Network Vision Benefits

Vision Examination

Covered in Full After Co-Pay(s)

Frame (within plan allowance)

Spectacle Lenses: Standard Single Vision, Standard Bifocal, Standard Trifocal, Standard Lenticular

Contact Lenses: Elective (up to plan allowance), Medically Necessary (prior authorization required)

No Co-Pay for Contacts

Lens Options

Up to 20% off

Laser Vision Correction

5% - 25% off

Additional Purchases

Up to 20% off on non-covered items

Monthly Premiums

Individual	\$18.64	Individual & Child(ren) ...	\$34.81
Individual & Spouse	\$34.64	Family	\$49.04

*Vision Plan 976. Vision examination co-pay: \$10. Materials co-pay: \$25. Out of network vision benefits are limited - see schedule of benefits for details. Dental benefits are covered through participating dentists only. Limitations apply. See schedule of benefits for this policy for a comprehensive explanation of services and benefits.

Comprehensive Dental Plan

Services*

PREVENTATIVE

Initial and Periodic Exams, Routine Prophylaxis (cleaning), Fluoride Treatments, X-rays, Sealants

Coverage

100%
No Waiting Period

BASIC RESTORATIVE SERVICES

Emergency Treatment, Fillings, Simple Extractions, Space Maintainers

80%
6 Month Waiting Period

MAJOR RESTORATIVE SERVICES

Endodontics (root canals); Oral Surgery; Surgical Extractions; Inlays, Onlays and Crowns; Bridges; Partial and Dentures; Periodontics (gum disease)

50%
12 Month Waiting Period

Monthly Premiums

Individual	\$29.12	Individual & Child(ren) ...	\$55.99
Individual & Spouse	\$58.34	Family	\$85.54

*One-time annual deductible of \$50 per individual which applies to all services. Annual Maximum Benefits: \$1,000 per individual. Coverage will be reduced by 10% for work done by non-participating dentists. Limitations apply. See schedule of benefits for this policy for a comprehensive explanation of services and benefits.

Comprehensive Dental + Vision Plan

Services*

Comprehensive Dental Plan Services

100%/80%/50%

Plus! In-Network Vision Benefits

Vision Examination

Covered in Full After Co-Pay(s)

Frame (within plan allowance)

Spectacle Lenses: Standard Single Vision, Standard Bifocal, Standard Trifocal, Standard Lenticular

Contact Lenses: Elective (up to plan allowance), Medically Necessary (prior authorization required)

No Co-Pay for Contacts

Lens Options

Up to 20% off

Laser Vision Correction

5% - 25% off

Additional Purchases

Up to 20% off on non-covered items

Monthly Premiums

Individual	\$36.43	Individual & Child(ren) ...	\$69.03
Individual & Spouse	\$70.30	Family	\$104.91

*Vision Plan 976. Vision examination co-pay: \$10. Materials co-pay: \$25. Out of network vision benefits are limited - see schedule of benefits for details. Dental coverage will be reduced by 10% for work done by non-participating dentists. Limitations apply. See schedule of benefits for this policy for a comprehensive explanation of services and benefits.

Delta Dental of Arkansas
 P.O. Box 6140
 Sherwood, AR 72124
 Toll-free fax 877-992-1854

**Application for Individual Dental Plans
 & Individual Dental + Vision Plans**

Rates effective through 3/31/2012

Requested Effective Date		
Month	Day	Year

Applicant Name _____ Date of Birth _____ Sex _____
 Street Address _____ City _____ State _____ Zip _____
 Social Security # _____ E-mail _____ Phone # _____

Plan Selection (Choose one) **Basic Dental Plan ONLY** **Basic Dental + Vision** **Comp. Dental ONLY** **Comp. Dental + Vision**
 Individual Individual & Spouse Individual & Child(ren) Individual, Spouse & Children

List all dependents to be enrolled

Spouse's Name _____ Date of Birth (DOB) _____ Sex _____
 Child's Name _____ DOB _____ Sex _____
 Child's Name _____ DOB _____ Sex _____
 Child's Name _____ DOB _____ Sex _____

Will this replace existing dental coverage? Yes No **If Yes, submit copy of current coverage & effective dates.

Do all proposed insureds reside in Arkansas? Yes No If no, provide reason: _____

Payment Method **Payment is made via Electronic Funds Transfer ONLY, DO NOT SEND A LIVE CHECK**

Bank Draft (EFT): Monthly Annually Bank Account Type: Checking Savings
 Bank Routing Number: _____ Bank Account Number: _____

(Please attach a voided check to application)

I authorize Delta Dental of Arkansas (DDAR) and the BANK* indicated above to debit my DDAR premium from my checking or savings account indicated above. This authority is to remain in full force and effect until my BANK has received written notification from me of the Pre-Authorized Bank Draft Program termination in such time and such manner as to afford the BANK a reasonable opportunity to act on it, or until the BANK has sent me ten (10) days' written notice of the bank's termination of this agreement.

I understand that by revoking the Pre-Authorized Bank Draft Program after I have agreed to it, I will also be terminating my DDAR coverage, unless DDAR has received written notice from me of my desire to continue coverage at least twenty (20) days prior to the next Pre-Authorized Bank Draft Program withdrawal date.

Signature of Applicant _____ Date _____

*BANK also applies to Savings and Loan

Credit Card: Monthly Annually Credit Card Type: Visa Mastercard
 Credit Card Number: _____ Expiration Date (MM/YYYY): _____
 Credit Card Holder's Name: _____

Credit Card Billing Address

Street Address _____ City _____ State _____ Zip _____
 CV2 Number (last 3 digits located in signature block on back of card): _____

Policy Effective Date

All Delta Dental policies will have an effective date of the first of the month following receipt of complete application and subsequent to the initial premium amount due being drafted from applicant's checking/savings account or credit card payment. Application must be received in our offices by the 15th of the month prior to the requested effective date. (Example: Received by January 15th to be effective February 1st.) Applications received after the 15th of the month will be made effective on the 1st of the following month. (Example: Received on January 16th, will be effective March 1st.)

Authorization

I authorize dentists, dental office personnel, and other health care professionals and entities to disclose to Delta Dental of Arkansas, its agents and employees (including, without limitation, its claims and customer service personnel) all information necessary to determine (1) eligibility for coverage and (2) covered benefits. This authorization is made for each individual to be enrolled or affected by this change. The authorization is valid for 30 months from the date this form is signed for the purpose of collecting information in connection with enrollment, coverage reinstatement, or requests to change benefits. The authorization is valid for the term of coverage for the purpose of collecting information in connection with claims for benefits. The applicant or the applicant's authorized representative is entitled to receive a copy of the authorization form.

Applicant Signature _____ Date _____

City in which application was signed: _____, Arkansas

Certification

I certify that the information supplied by me on this form is accurate to the best of my knowledge. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Applicant Signature _____ Date _____

Correspondence

NOTICE - All correspondence regarding this plan will be conducted electronically unless applicant requests to be contacted via mail. Correspondence will be sent to the e-mail address listed on the front of this application. If applicant wishes to receive correspondence at a different e-mail address, please provide it here.

E-Mail Address: _____ Check box to opt out of electronic correspondence

This section to be completed by sales representative

Agent Name (please print) _____ Agency Name _____
 DDAR Vendor ID# _____ Phone Number _____

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Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	11/07/2011
Bypass Reason:	N/A		
Comments:			
		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	11/07/2011
Bypass Reason:	N/A		
Comments:			
		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	11/07/2011
Bypass Reason:	N/A		
Comments:			
		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	11/07/2011
Bypass Reason:	N/A		
Comments:			
		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	11/07/2011
Bypass Reason:	N/A		
Comments:			