

State: Arkansas **Filing Company:** Arkansas Blue Cross and Blue Shield
TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health - Dental
Product Name: Amendment
Project Name/Number: 1-13 General Amendment - Group Dental/23-2680 1/13

Filing at a Glance

Company: Arkansas Blue Cross and Blue Shield
Product Name: Amendment
State: Arkansas
TOI: H10G Group Health - Dental
Sub-TOI: H10G.000 Health - Dental
Filing Type: Form
Date Submitted: 11/05/2012
SERFF Tr Num: ARBB-128757426
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: 23-2680 1/13

Implementation: 01/01/2013
Date Requested:
Author(s): Christi Kittler, Yvonne McNaughton, Frank Sewall, Rita Thatcher, Evelyn Laney
Reviewer(s): Rosalind Minor (primary)
Disposition Date: 11/06/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas **Filing Company:** Arkansas Blue Cross and Blue Shield
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General Information

Project Name: 1-13 General Amendment - Group Dental Status of Filing in Domicile: Pending
 Project Number: 23-2680 1/13 Date Approved in Domicile:
 Requested Filing Mode: Domicile Status Comments: Arkansas is state of Domicile
 Explanation for Combination/Other: Market Type: Group
 Submission Type: New Submission Group Market Size: Small and Large
 Group Market Type: Employer Overall Rate Impact:
 Filing Status Changed: 11/06/2012 Deemer Date:
 State Status Changed: 11/06/2012 Submitted By: Yvonne McNaughton
 Created By: Yvonne McNaughton
 Corresponding Filing Tracking Number:

Filing Description:

Attached please find fomr 23-2680 1/13 for your review and approval if indicated.
 We are deleting "Occlusal Guards/Night Guards" from the covered services and making this an exclusion eff 1/1/13.
 We also have changed the term "x-ray(s) and film(s), to radiographic images as the ADA has made this change to their terms as well.
 We have added codes that are new ADA codes, and deleted some codes that are no longer used.
 Some of the descriptions have also been updated by the ADA, so we have changed our descriptions to match.

Company and Contact

Filing Contact Information

Yvonne McNaughton, Regulatory Compliance Analyst
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Filing Company Information

Arkansas Blue Cross and Blue Shield
 601 S. Gaines Street Little Rock, AR 72201
 (501) 378-2967 ext. [Phone]
 CoCode: 83470
 Group Code:
 Group Name:
 FEIN Number: 71-0226428
 State of Domicile: Arkansas
 Company Type:
 State ID Number: N/A

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: \$50.00 per form, 1 form attached.
 Per Company: No

Company	Amount	Date Processed	Transaction #
Arkansas Blue Cross and Blue Shield	\$50.00	11/05/2012	64590352

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/06/2012	11/06/2012

SERFF Tracking #:

ARBB-128757426

State Tracking #:

Company Tracking #:

23-2680 1/13

State:

Arkansas

Filing Company:

Arkansas Blue Cross and Blue Shield

TOI/Sub-TOI:

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Disposition

Disposition Date: 11/06/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes

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Form Schedule

Lead Form Number: 23-2680 1/13

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved-Closed 11/06/2012	Amendment	23-2680	CERA	Initial		40.200	23-2680 1-13 Group Dental.pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages



**AMENDMENT TO THE
ARKANSAS BLUE CROSS AND BLUE SHIELD
DENTAL GROUP BENEFIT CERTIFICATES**

**AMENDMENT NO. 2680
Form Nos. 304, 307, 309, 310, and 219**

SCHEDULE OF BENEFITS, Diagnostic and Preventive Services (Service Category A.), "X-rays" is hereby amended to read "Radiographic Images".

COVERED SERVICES, "Alternate Treatment, section 6.", is hereby amended to add the code (D2929) and has also been amended to read as follows:

Stainless steel crowns are paid as an alternate benefit to stainless steel crowns with resin windows, prefabricated esthetic stainless steel crowns, prefabricated porcelain/ceramic crown (primary tooth), or prefabricated resin crowns. Stainless steel crowns are covered once per tooth per lifetime for children under age 14. **The Covered Person is responsible for the difference in cost.**

- {D2929 is paid as D2930.
- D2932 is paid as D2930.
- D2933 is paid as D2930.
- D2934 is paid as D2930. ¹}

COVERED SERVICES, "Alternate Treatment, section 7.", is hereby deleted in its entirety. All following sections will be renumbered.

COVERED SERVICES, "Alternate Treatment", is hereby amended to add the following subsection:

If an overdenture is provided, the amount of a removable upper and/or lower denture will be reimbursed to the dentist or Covered Person. **The Covered Person is responsible for the difference in cost.**

- {D5860 is paid as D5213
- D5861 is paid as D5214 ²}

{COVERED SERVICES, Service Category A., is here by amended to replace the term X-rays with radiographic images as follows:

(– Indicates that radiographic images are required upon claim submission. Applicable to non-participating Dental providers ONLY.)³}*

COVERED SERVICES, "Diagnostic and Preventive Services (Service Category A.) ", is hereby amended to add the following covered services:

- | | | |
|----|-------|---|
| A | D0277 | VERTICAL BITEWINGS – 7 TO 8 RADIOGRAPHIC IMAGES |
| {A | D1208 | TOPICAL APPLICATION OF FLUORIDE |

¹ These codes will not appear in section 6 of the 64-219 certificate, however, they will appear in all other certificates.

² These codes will not appear in section 9 of the 64-219 certificate, however, they will appear in all other certificates.

³ Applies to 64-219 **ONLY**.

A	D1352	PREVENTIVE RESIN RESTORATION ^{4}}
A	D2929	PREFABRICATED PORCELAIN CERAMIC CROWN – PRIMARY TOOTH
A	D2981	INLAY REPAIR NECESSITATED BY RESTORATIVE MATERIAL FAILURE
A	D2982	ONLAY REPAIR NECESSITATED BY RESTORATIVE MATERIAL FAILURE
A	D2983	VENEER REPAIR NECESSITATED BY RESTORATIVE MATERIAL FAILURE
A	D3354	PULPAL REGENERATION

COVERED SERVICES, “Diagnostic and Preventive Services (Service Category A.)”, is hereby amended to delete codes D1203 and D1204 in their entirety as they are no longer utilized by the American Dental Association.

COVERED SERVICES, “Diagnostic and Preventive Services (Service Category A.)”, the below services are hereby amended to read as follows:

A	D0210	INTRAORAL – COMPLETE SERIES OF RADIOGRAPHIC IMAGES
A	D0220	INTRAORAL– PERIAPICAL–FIRST RADIOGRAPHIC IMAGE
A	D0230	INTRAORAL– PERIAPICAL–EACH ADDITIONAL RADIOGRAPHIC IMAGE
A	D0240	OCCLUSAL RADIOGRAPHIC IMAGE
A	D0250	EXTRAORAL– FIRST RADIOGRAPHIC IMAGE
A	D0260	EXTRAORAL – EACH ADDITIONAL RADIOGRAPHIC IMAGE
A	D0270	BITEWING– SINGLE RADIOGRAPHIC IMAGE
A	D0272	BITEWINGS – TWO RADIOGRAPHIC IMAGES
A	D0273	BITEWINGS – THREE RADIOGRAPHIC IMAGES
A	D0274	BITEWINGS – FOUR RADIOGRAPHIC IMAGES
A	D0277	VERTICAL BITEWINGS – 7 TO 8 RADIOGRAPHIC IMAGES
A	D0330	PANORAMIC RADIOGRAPHIC IMAGE
A	D1206	TOPICAL FLUORIDE VARNISH
{A	D2980	CROWN REPAIR – NECESSITATED BY RESTORATIVE MATERIAL FAILURE
A	D6980	FIXED PARTIAL DENTURE REPAIR ^{5}}

{COVERED SERVICES, “Special Limitations for Diagnostic and Preventive Services (Service Category A.), sections 1.b., 2.c.,d. and 5.”, are hereby amended to read as follows:

1. One (1) in a calendar year:
 - b. Bitewing radiographic images, one occurrence of two bitewings (D0272), three bitewings (D0273), four bitewings (D0274) or eight vertical bitewings (D0277) for adults over the age of 18.
2. Two (2) in a calendar year:
 - c. Fluoride treatment for dependent children through age 18 (D1208)..
 - d. Bitewing radiographic images (D0272) for dependent children through age 18.
5. One (1) in a five year period:
 - Full mouth radiographic images (D0210 & D0330). ^{6}}

⁴ All added codes apply to 64-219 **ONLY**. Only the codes **D1208** and **D1352**, are being added to 64-304, 64-307, 64-309, and 64-310.

⁵ Applies to 64-219 **ONLY**.

⁶ Applies to all **except** 64-219.

{COVERED SERVICES, "Special Limitations for Diagnostic and Preventive Services (Service Category A.), sections 2. b.,3.d., 6. And 7.d.", are hereby amended to read as follows:

2. One (1) in a calendar year:
 - b. Bitewing radiographic images, one occurrence of two bitewings (D0272) four bitewings (D0274) for adults over the age of 18.
3. Two (2) in a calendar year:
 - d. Bitewing radiographic images (D0272) for dependent children through age 18.
6. One (1) in a five year period:
Full mouth radiographic images (D0210 & D0330).
7. One (1) per tooth per lifetime:
 - d. Prefabricated porcelain crown – Primary tooth (D2929). ^{7}}

COVERED SERVICES, "{Basic ^{8}}{Restorative ^{9}} Services (Service Category B.)", is here by amended to add and/or amend the notation below above the list of covered services to read as follows:

(– Indicates that radiographic images are required upon claim submission. Applicable to non-participating Dental providers ONLY.)*

{COVERED SERVICES, "Basic Services (Service Category B.)", is hereby amended to add the following covered services:

- | | | |
|---|-------|--|
| B | D2929 | PREFABRICATED PORCELAIN CERAMIC CROWN – PRIMARY TOOTH |
| B | D2981 | INLAY REPAIR NECESSITATED BY RESTORATIVE MATERIAL FAILURE |
| B | D2982 | ONLAY REPAIR NECESSITATED BY RESTORATIVE MATERIAL FAILURE |
| B | D2983 | VENEER REPAIR NECESSITATED BY RESTORATIVE MATERIAL FAILURE |
| B | D3354 | PULPAL REGENERATION |
| B | D7321 | ALVEOPLASTY NOT WITH EXTRACTIONS ^{10}} |

{COVERED SERVICES, "Restorative Services (Service Category B.)", is hereby amended to add the following covered services:

- | | | |
|---|-------|--|
| B | D4212 | * GINGIVECTOMY/GINGIVOPLASTY– TO ALLOW ACCESS FOR RESTORATIVE PROCEDURE – PER TOOTH |
| B | D4277 | FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING DONOR SITE SURGERY) – FIRST TOOTH |
| B | D4278 | FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING DONOR SITE SURGERY) – EACH ADDITIONAL CONTIGUOUS TOOTH |
| B | D7321 | ALVEOPLASTY NOT WITH EXTRACTIONS ^{11}} |

{COVERED SERVICES, "Basic Services (Service Category B.)", is hereby amended to add the following covered services:

- | | | |
|---|-------|---|
| B | D2929 | PREFABRICATED PORCELAIN CERAMIC CROWN – PRIMARY TOOTH |
| B | D7321 | ALVEOPLASTY NOT WITH EXTRACTIONS ^{12}} |

⁷ Applies to 64-219 **ONLY**.

⁸ Applies to all **except** 64-219.

⁹ Applies to 64-219 **ONLY**.

¹⁰ Applies to all **except** 64-310 and 64-219.

¹¹ Applies to 64-219 **ONLY**.

¹² Applies to 64-310 **ONLY**.

{COVERED SERVICES, "Basic Services (Service Category B.)", is hereby amended to delete codes D6972 and D6973 in their entirety as they are no longer utilized by the American Dental Association. ^{13}}}

{COVERED SERVICES, "Restorative Services (Service Category B.)", is hereby amended to delete codes D4271, D6970 and D6972 in their entirety as they are no longer utilized by the American Dental Association. ^{14}}}

COVERED SERVICES, "{Restorative ^{15}}{Basic ^{16}} Services (Service Category B.)", is hereby amended to delete D9940 as it is no longer a covered benefit.

{COVERED SERVICES, "Basic Services (Service Category B.)", the below services are hereby amended to read as follows:

- B D2980 CROWN REPAIR – NECESSITATED BY RESTORATIVE MATERIAL FAILURE
- B D6980 FIXED PARTIAL DENTURE REPAIR ^{17}}

{COVERED SERVICES, "Service Category B.", the below services are hereby amended to read as follows:

- B D4210 * GINGIVECTOMY/GINGIVOPLASTY – FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT
- B D4211 * GINGIVECTOMY/GINGIVOPLASTY– ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT
- B D4260 * OSSEOUS SURGERY (INCLUDING FLAP ENTRY & CLOSURE – FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT)
- B D4261 * OSSEOUS SURGERY (INCLUDING FLAP ENTRY & CLOSURE– ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES TEETH, PER QUADRANT) ^{18}}

{COVERED SERVICES, "Special Limitations for Basic Services (Service Category B.), section 4.", is hereby amended to add "f. Prefabricated porcelain crown – Primary tooth (D2929)." as a covered service. The following sections will be re-alphabetized. ^{19}}}

{COVERED SERVICES, "Major Restorative Services (Service Category C.)", is here by amended to replace the term X-rays with radiographic images as follows:

(– Indicates that radiographic images are required upon claim submission. Applicable to non-participating Dental providers ONLY.) ^{20}}*

{COVERED SERVICES, "Major Restorative Services (Service Category C.)", is hereby amended to add the following covered services:

- C D4212 * GINGIVECTOMY/GINGIVOPLASTY– TO ALLOW ACCESS FOR RESTORATIVE PROCEDURE – PER TOOTH
- C D4277 FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING DONOR SITE SURGERY) –

¹³ Applies to all **except** 64-219.

¹⁴ Applies to 64-219 **ONLY**.

¹⁵ Applies to 64-219 **ONLY**.

¹⁶ Applies to all **except** 64-219

¹⁷ Applies to all **except** 64-310 and 64-219.

¹⁸ Applies to 64-219 **ONLY**.

¹⁹ Applies to all **except** 64-219.

²⁰ Applies to all **except** 64-219.

FIRST TOOTH
 C D4278 FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING DONOR SITE SURGERY) – EACH ADDITIONAL CONTIGUOUS TOOTH ²¹}

{COVERED SERVICES, "Major Restorative Services (Service Category C.)", is hereby amended to add the following covered services:

C D2981 INLAY REPAIR NECESSITATED BY RESTORATIVE MATERIAL FAILURE
 C D2982 ONLAY REPAIR NECESSITATED BY RESTORATIVE MATERIAL FAILURE
 C D2983 VENEER REPAIR NECESSITATED BY RESTORATIVE MATERIAL FAILURE
 C D3354 PULPAL REGENERATION
 C D4212 * GINGIVECTOMY/GINGIVOPLASTY– TO ALLOW ACCESS FOR RESTORATIVE PROCEDURE – PER TOOTH
 C D4277 FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING DONOR SITE SURGERY) – FIRST TOOTH
 C D4278 FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING DONOR SITE SURGERY) – EACH ADDITIONAL CONTIGUOUS TOOTH ²²}

{COVERED SERVICES, "Major Restorative Services (Service Category C.)", is hereby amended to delete the following covered services in their entirety:

C D4271 FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING DONOR SITE)
 C D6970 CAST POST & CORE IN ADDITION TO BRIDGE RETAINER
 C D9940 OCCLUSAL GUARD ²³}

{COVERED SERVICES, "Major Restorative Services (Service Category C.)", the below services are hereby amended to read as follows:

C D4210 GINGIVECTOMY/GINGIVOPLASTY – FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT
 C D4211 GINGIVECTOMY/GINGIVOPLASTY– ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT
 C D4260 OSSEOUS SURGERY (INCLUDING FLAP ENTRY & CLOSURE – FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT)
 C D4261 OSSEOUS SURGERY (INCLUDING FLAP ENTRY & CLOSURE– ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES TEETH, PER QUADRANT)
 C D6056 PREFABRICATED ABUTMENT – INCLUDES MODIFICATION AND PLACEMENT
 C D6057 CUSTOM FABRICATED ABUTMENT – INLCUDES PLACEMENT ²⁴}

{COVERED SERVICES, "Major Restorative Services (Service Category C.)", the below services are hereby amended to read as follows:

C D2980 CROWN REPAIR – NECESSITATED BY RESTORATIVE MATERIAL FAILURE
 C D4210 GINGIVECTOMY/GINGIVOPLASTY – FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT
 C D4211 GINGIVECTOMY/GINGIVOPLASTY– ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT

²¹ Applies to all **except** 64-310 and 64-219.

²² Applies to 64-310 **ONLY**.

²³ Applies to all **except** 64-219.

²⁴ Applies to all **except** 64-310 and 64-219.

C	D4260	OSSEOUS SURGERY (INCLUDING FLAP ENTRY & CLOSURE – FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT)
C	D4261	OSSEOUS SURGERY (INCLUDING FLAP ENTRY & CLOSURE– ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES TEETH, PER QUADRANT)
C	D6056	PREFABRICATED ABUTMENT – INCLUDES MODIFICATION AND PLACEMENT
C	D6057	CUSTOM FABRICATED ABUTMENT – INLCUDES PLACEMENT
C	D6980	FIXED PARTIAL DENTURE REPAIR ^{25}}

COVERED SERVICES, "Orthodontic Services and Payment Procedure (Service Category D.)", the below services are hereby amended to read as follows:

D	D0340	CEPHALOMETRIC RADIOGRAPHIC IMAGE
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SPECIFIC BENEFIT LIMITATIONS, "Integral Services, sections 5., 6., and 10.", are hereby amended to read as follows:

5. Periapical radiographic images taken on the same day as a panorex (D0330).
6. Periapical radiographic images and /or bitewings taken on the same day as a full series (D0210).
10. Diagnostic radiographic images taken the same day as the initial root canal therapy is covered. Any other radiographic images 30 days before or after root canal therapy are Integral.

SPECIFIC BENEFIT LIMITATIONS, "The following services are specifically limited with the following conditions:, sections 2., 3., 4., 24., 25., and 28.", are hereby amended to read as follows:

2. Cephalometric radiographic images (D0340) are covered once per lifetime with all others denying as an Integral Service. Cephalometric radiographic images are not covered at all unless your Schedule of Benefits indicates that you have coverage for Orthodontic Services (Service Category D.).
3. If the allowance for the combination of multiple periapicals, bitewings or full series of radiographic images exceeds the allowance for a full series they will be combined to a full series.
4. Vertical bitewing radiographic images (7 to 8 images, D0277) are paid with the same benefit limitations as four bitewing radiographic images (D0274).
- {24.} Surgical extractions (D7210) denied for lack of coverage remain denied if resubmitted as simple extractions (D7111, D7140) unless; on an inquiry basis, radiographic images substantiate that it is a simple extraction.
- {25.} The degree of impaction of teeth is determined via radiographic image review (D7220, D7230, D7240, & D7241).
- {28.} Diagnostic radiographic images are not covered if there is no documentation in the patient's records indicating why the radiographs were ordered and/or what was diagnosed by the dentist upon reviewing the prescribed radiographic images.

SPECIFIC BENEFIT LIMITATIONS, "The following services are specifically limited with the following conditions:", is hereby amended to delete "14. Preventive resins are considered sealants." in its entirety. The following sections will be re-numbered.

SERVICES NOT INCLUDED, "Overdentures (D5860, D5861)" is hereby deleted in its entirety. The following sections will be re-alphabetized.

²⁵ Applies to 64-310 **ONLY**.

SERVICES NOT INCLUDED, the below services are hereby amended to read as follows:

- {AI.} double abutments unless there is evidence of decay noted on radiographic image;
- {AV.} Radiographic and intraoral imaging (D0260, D0290, D0310, D0320, D0321, D0322, D0350);
- {BA.} prefabricated resin crowns, prefabricated esthetic coated crowns, prefabricated porcelain-ceramic crown (primary tooth), or stainless steel crowns or stainless steel crowns with resin windows for a primary tooth for patients age 14 and older.
- {BQ.} treatment and reduction of dislocation and management of TMJ/TMD (Temporomanibular Joint / Temporomandibular Joint Dysfunction) (D7810 – D7899) including diagnostic radiographic images, occlusal appliances, and/or splints;
- {CR.} a panoramic radiographic image or panorex (D0330) is not covered for Children under the age of five.

SERVICES NOT INCLUDED, is hereby amended to add "Occlusal guard (D9940)." as a new exclusion.

This Amendment becomes a part of the Arkansas Blue Cross and Blue Shield Dental Group Benefit Certificate. All other provisions remain in full force and effect.



P. Mark White, President and Chief Executive Officer

ARKANSAS BLUE CROSS AND BLUE SHIELD
601 S. Gaines Street
Little Rock, Arkansas 72201

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Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	11/06/2012
Comments:	See attached Flesch Certification Form.		
Attachment(s):	Flesch Certification Form.PDF		

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	11/06/2012
Bypass Reason:	Not needed		



**Arkansas
BlueCross BlueShield**
An Independent Licensee of the Blue Cross and Blue Shield Association

RE: Arkansas Blue Cross and Blue Shield
Form No. 23-2680 1/13

**FLESCH READING EASE
CERTIFICATION**

This is to certify that the above referenced documents have achieved a Flesch Reading Ease Score average of 40.2 and comply with the requirements of A.C.A. §23-80-201 *et. seq.*, cited as the Life and Health Insurance Policy Language Simplification Act.

Name

Senior Vice President

Title

November 5, 2012

Date