

State: Arkansas **Filing Company:** Arkansas Blue Cross and Blue Shield
TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health - Dental
Product Name: Dental GMC Amendment and Application
Project Name/Number: Amendment and Application/23-2695 12/12, NGrpDenApp R12/12

Filing at a Glance

Company: Arkansas Blue Cross and Blue Shield
 Product Name: Dental GMC Amendment and Application
 State: Arkansas
 TOI: H10G Group Health - Dental
 Sub-TOI: H10G.000 Health - Dental
 Filing Type: Form
 Date Submitted: 12/18/2012
 SERFF Tr Num: ARBB-128818167
 SERFF Status: Closed-Approved-Closed
 State Tr Num:
 State Status: Approved-Closed
 Co Tr Num: 23-2695 12/12, NGRPDENAPP R12/12

 Implementation: 12/01/2012
 Date Requested:
 Author(s): Christi Kittler, Yvonne McNaughton, Frank Sewall, Rita Thatcher, Evelyn Laney
 Reviewer(s): Rosalind Minor (primary)
 Disposition Date: 12/18/2012
 Disposition Status: Approved-Closed
 Implementation Date:

 State Filing Description:

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General Information

Project Name: Amendment and Application	Status of Filing in Domicile: Pending
Project Number: 23-2695 12/12, NGrpDenApp R12/12	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	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: 12/18/2012	Deemer Date:
State Status Changed: 12/18/2012	Submitted By: Evelyn Laney
Created By: Evelyn Laney	
Corresponding Filing Tracking Number:	

Filing Description:

Attached please find forms 23-2695 12/12 and NGrpDenApp R12/12 for your review and approval if indicated. Form 23-2695 removes the contributions required by the group for Subscribers on K-1. The application has also been revised to reflect these changes, as well.

Flesch Reading Ease score certification signed by an officer of the company as required by Arkansas Code Annotated §23-80-206(d).

I certify that the submission meets the provisions of Arkansas Insurance Department Rule & Regulation 19. I further certify that the Life and Health Guaranty Association Notices required by Arkansas Insurance Department Rule & Regulation 49 and the consumer information notice required by Arkansas Code Annotated §23-79-138 are incorporated in the certificates to which these amendments will be attached.

Please feel free to contact me at 378-2165 with any questions you may have.

Company and Contact

Filing Contact Information

Evelyn Laney, Senior Compliance Analyst	exlaney@arkbluecross.com
320 West Capitol, Ste 211	501-378-2165 [Phone]
Little Rock, AR 72201	501-378-2975 [FAX]

Filing Company Information

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

Filing Fees

Fee Required?	Yes
Fee Amount:	\$100.00
Retaliatory?	No
Fee Explanation:	\$50.00 per form
Per Company:	No

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Company	Amount	Date Processed	Transaction #
Arkansas Blue Cross and Blue Shield	\$100.00	12/18/2012	65869513

State: Arkansas Filing Company: Arkansas Blue Cross and Blue Shield
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	12/18/2012	12/18/2012

SERFF Tracking #:

ARBB-128818167

State Tracking #:

Company Tracking #:

23-2695 12/12, NGRP DENAPP R12/12

State:

Arkansas

Filing Company:

Arkansas Blue Cross and Blue Shield

TOI/Sub-TOI:

H10G Group Health - Dental/H10G.000 Health - Dental

Product Name:

Dental GMC Amendment and Application

Project Name/Number:

Amendment and Application/23-2695 12/12, NGrpDenApp R12/12

Disposition

Disposition Date: 12/18/2012

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
Form	Application	Approved-Closed	Yes

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Form Schedule

Lead Form Number: 23-2695 12/12									
Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data		Readability Score	Attachments
1	Approved-Closed 12/18/2012	Amendment	23-2695 12/12	CERA	Initial			44.000	23-2695 12-12Dental GMC Amendment.pdf
2	Approved-Closed 12/18/2012	Application	NGrpDenApp R12/12	AEF	Revised	Previous Filing Number:	ARBB-128668221		NGrpDenApp R12-12.pdf
						Replaced Form Number:	NGrpDenApp R12/12		

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



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

**AMENDMENT TO THE
ARKANSAS BLUE CROSS AND BLUE SHIELD
DENTAL GROUP MASTER CONTRACTS**

**AMENDMENT NO. 2695
Form No. GMC-4**

COVENANTS OF THE POLICYHOLDER, Contributions is hereby amended to read as follows.

Contributions: The Group agrees to contribute toward the cost of the Company's premium an amount no less than 50% of the total monthly premium for the Employees. *This minimum contribution requirement does not apply to K-1 recipients.*

This Amendment becomes a part of the Dental Group Policy. All other provisions of the Dental Group Policy remain in full force and effect.

P. Mark White

P. Mark White, President and Chief Executive Officer

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

[Renewal] APPLICATION by:

(hereinafter called "Policyholder")

for a Group Policy covering the employees of the Policyholder and the eligible dependents of such employees. The Policyholder intends hereby to establish and maintain an employee benefit plan (the "Plan") for the Policyholder's employees and eligible dependents, to contribute to the cost of the Plan, and to actively promote the Plan to the Policyholder's employees.

[SECTION 1.] GROUP INFORMATION

Legal Name of Business:

D/B/A:

Street Address:

City, State, Zip:

County:

Mailing Address: (if different from Street)

City, State, Zip:

Telephone #:

Fax #:

Fed. Tax I.D. #:

Business Type: [Sole Proprietorship] [Legal Partnership]
[Corporation] [Government Entity]

Exec. Contact:

E-Mail:

Group Administrator:

E-Mail:

Primary SIC Code:

SIC Description:

Agent:

Agent's Lic #:

Agent's Company:

Agent's Tax Id:

[SECTION 2.] POLICYHOLDER AS PLAN ADMINISTRATOR

The Policyholder, as Plan Administrator, assumes responsibility for the accuracy of information presented to Arkansas Blue Cross and Blue Shield ("ABCBS"), including all information on the employment status and eligibility of individuals to be covered under the Plan, as well as medical information provided with respect to each such individual. The Policyholder agrees that if misrepresentations are made in any of the information provided for rating or in this Group Application or any of the materials submitted with it, including, but not limited to, individual applications and medical information, then ABCBS may cancel or rescind this Group Policy. The Policyholder further agrees that if misrepresentations or false or misleading information is presented in filing of any claims hereunder ("improper claims"), ABCBS may cancel or rescind the coverage of any individual involved in presenting such a claim. Further, ABCBS may cancel or rescind the entire Group Policy if the Policyholder or any representative of the Policyholder knew or should have known of the improper claims, or if the Policyholder's action or inaction contributed to presentation of improper claims.

[SECTION 3.] COBRA ADMINISTRATION

COBRA - Group dental plans for employers with 20 or more employees on more than 50% of the business days in the previous calendar year are subject to Cobra. Employers are required to provide qualified beneficiaries an election period during which the beneficiary can elect to continue coverage under the guidelines. We offer the services of a vendor, "Ceridian", to assist you in administering Cobra (no additional cost). Both full time and part time employees are counted to determine if a plan is subject to Cobra. Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours worked divided by the number of hours used to determine full time status.¹

(Yes __)(No __) As an employer, are you currently obligated by law to comply with COBRA?

(Yes __)(No __) Do you want to use the services of Ceridian?

(Yes __)(No __) If yes, are you currently contracting directly with Ceridian?

[SECTION 4.] BENEFIT SELECTION

[DENTALBLUE PLAN:]

REQUESTED EFFECTIVE DATE, PENDING APPROVAL IS: _____

Effective Date is [first of the month][fifteenth of the month] following the Waiting Period

[Is Waiting Period for Initial Enrollment Waived? [Yes][No]] [Date of Open Enrollment _____]

[If a month is not specified, the Group's Open Enrollment will be the month prior to the Group's renewal date.]

Class	Class Description	Waiting Period	Contribution
		[0 – 12 months] [other]	Employee % Dependent %

Note: *The Employer must pay a minimum of 50% of the Employee premium. This Policy may be terminated by the company if the Policyholder fails to contribute the percentage or fixed amount of Employees' premium specified above. [This minimum contribution requirement does not apply to K-1 recipients].*

Maximum Dependent Age [0-27]

Deductible: Individual [\$25 - \$100] Family [\$XX - \$XX]

Annual Maximum: [\$750 - \$5,000]

Diagnostic & Preventive Services: [80% - 100%] **Basic Services:** [50% - 100%]

Major Services: [0% - 100%] **Orthodontic Service:** [0% -50%]

Orthodontic Lifetime Maximum: [\$0 - \$5,000]

Optional Benefit: Posterior Resins: Yes No

[Roll Over Balance from Previous Carrier Yes No]

[Out-of-State Non-Contracted Provider Reimbursement Rate: [95% - 50%]]

Basic Services Waiting Period [None – 6 months] | **Major Services Waiting Period [None – 12 Months]**

Minimum Number of Insured Employees. [To meet small group enrollment guidelines a group must have at least [two] [five] full-time enrolled employees, of which no more than 50% may reside in the same household.] [To meet large group enrollment guidelines a group must have at least fifty-one full-time enrolled employees. Groups whose enrollment subsequently drops below fifty-one enrolled must be rated as a small group upon renewal]

Minimum Participation Requirements. 75% of all eligible employees without waivers must be insured, and no less than 50% of the full-time employees must enroll.

[Rates]

If there is an agent or broker involved in this coverage transaction they may receive compensation from Arkansas Blue Cross and Blue Shield, or one of its affiliates, for his or her services related to the placement of this coverage. Any such compensation is included in the premium paid by the covered person. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker.

[TRADITIONAL DENTAL]

REQUESTED EFFECTIVE DATE, PENDING APPROVAL IS: _____

Effective Date is [first of the month][fifteenth of the month] following the Waiting Period

[Is Waiting Period for Initial Enrollment Waived? [Yes][No]] [Date of Open Enrollment _____]

[If a month is not specified, the Group's Open Enrollment will be the month prior to the Group's renewal date.]

Class	Class Description	Waiting Period	Contribution
		[0 – 12 months] [other]	Employee % Dependent %

Note: *The Employer must pay a minimum of 50% of the Employee premium. This Policy may be terminated by the company if the Policyholder fails to contribute the percentage or fixed amount of Employees' premium specified above. [This minimum contribution requirement does not apply to K-1 recipients].*

Maximum Dependent Age [0-27]

Deductible: Individual [\$25 - \$100] [Deductible Applies to Preventive]

Annual Maximum: [\$1000 - \$1,500]

Diagnostic & Preventive Services: [80% - 100%]

Restorative Services: [0% - 80%] **Orthodontic Service:** [0% -50%]

Orthodontic Lifetime Maximum: [\$0 - \$1,500]

Minimum Number of Insured Employees. [To meet small group enrollment guidelines a group must have at least five full-time enrolled employees, of which no more than 50% may reside in the same household.] [To meet large group enrollment guidelines a group must have at least fifty-one full-time enrolled employees. Groups whose enrollment subsequently drops below fifty-one enrolled must be rated as a small group upon renewal]

Minimum Participation Requirements. 75% of all eligible employees without waivers must be insured, and no less than 50% of the full-time employees must enroll.

[Rates]

If there is an agent or broker involved in this coverage transaction they may receive compensation from Arkansas Blue

[SECTION 5.] EMPLOYEE INFORMATION

MINIMUM NUMBER OF INSURED EMPLOYEES & MINIMUM PARTICIPATION REQUIREMENTS.

Full-Time = means an active employee with a minimum of 30 hrs/week & 48 weeks/year	In State	OUT OF STATE	TOTAL
Full-Time Employees enrolling (including those satisfying their waiting period within 3 months after the effective date):			
Full-Time Employees waiving (including those satisfying their waiting period within 3 months after the effective date):			
COBRA Continuees (Enrolling)			
Total Enrolling and Waiving			
[New Full-Time Employees who will NOT satisfy the Waiting Period within 3 months after the eff. Date:]			
Part Time / Seasonal / Temporary Employees			
Total # of Employees			

This Policy may be terminated by the Company if the number of insured Employees falls below the minimum number of insured Employees specified above or if the percentage of eligible Employees of the Policyholder covered by the Policy becomes less than the percentage of Employee participation specified above

[Special Group Considerations Form # _____, Description _____]

[SECTION 6.] PROXY

The Policyholder hereby appoints the Board of Directors (“Board”) of Arkansas Blue Cross and Blue Shield (“ABCBS”), as its proxy to act on its behalf at all meetings of members of ABCBS. This appointment shall include such persons as the Board may designate by resolution to act on its behalf. This proxy gives the Board, or its designee, full power to vote for the Policyholder on all matters that may be voted upon at any meeting. The annual meeting of Members is held each year at the home office of ABCBS located at 601 S. Gaines Street, Little Rock, Arkansas, on the third Monday of March, at 1:00 p.m. If the third Monday of March is a legal holiday, then the meeting will be at the same time and place on the next day after, which is not a legal holiday. A special meeting may be called upon notice mailed not less than ten (10) or more than sixty (60) days prior to such meeting. This proxy, unless revoked, shall remain in effect during the Policyholder’s membership in ABCBS. The Policyholder may revoke this proxy in writing by advising ABCBS, attention Legal Division, of such at least five (5) days prior to any meeting. The Policyholder may also revoke its proxy by attending and voting in person at any Members’ meeting.

[SECTION 7.] [SECURED EMPLOYERS WEBSITE]

[Our records indicate that you are currently utilizing the Secured Employer Web Site and we hope that site is useful in the administration of your group health plan. We are always looking for feedback and to assist you with the site if needed, our email address is ewssupport@arkbluecross.com or call us toll free at 1-800-800-5641.

Web Administrator: _____ Email Address: _____]

[Our records indicate that you signed up for the Secured Employer Web Site but have not visited the site and registered to utilize the web functionality. If you need assistance activating your registration, lost the link or need to change the web administrator we can help. Our toll free phone number is 1-800-800-5641 and our email address is ewssupport@arkbluecross.com.

Web Administrator: _____ Email Address: _____]

[Yes No

We have a web site for our small group customers who wish to utilize a “secured” web site which has been very well received by the current users. The site is password protected and all that is required of the group is to have email capability. If you have internet access and wish to utilize the site please mark the “yes” box above, please mark the “no” box if you do not wish to utilize the site at this time.

If you have selected to use the site, please fill in the name of the person who you are designating as “Web Administrator” along with their email address. We will automatically forward a link to this individual shortly after processing this renewal. The link will allow the person to set up their log-on ID and password. In addition to the link, they will receive a guide with detailed instructions on how to use the website.

[SECTION 8.] SIGNATURES

This Application is made and delivered in the State of Arkansas and is governed by the laws of Arkansas and the United States of America. This Application is incorporated in and made a part of the Group Policy and Benefit Certificate.

[I hereby apply for the above referenced coverage and agree the group insurance, subject to the terms and conditions of the policies applied for, will take effect as of the next available effective date after approval, provided this application is approved and the premium is received by the home office of Arkansas Blue Cross and Blue Shield. **I also understand that my signature below represents my agreement and acceptance of the premium rate schedule.**]

[I hereby renew the above referenced coverage and agree the group insurance, subject to the terms and conditions of the policies renewed, will take effect as of the renewal date, provided this application is approved and the premium is received by the home office of Arkansas Blue Cross and Blue Shield. **I also understand that my signature below represents my agreement and acceptance of the premium rate schedule.**]

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in connection with an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

1. Policyholder

Signed at _____, this _____ day of _____ 20____
(City, State)

[full legal name of Policyholder]

By: _____

Authorized Signature	Printed Name
Title or Position	

2. Agent

I hereby certify that all of the information contained in this employer application is correct to the best of my knowledge, and I know nothing unfavorable about this firm or any individual proposed for coverage (except as noted on the employee applications). I have complied with the underwriting rules and regulations and have explained in detail the coverage to the member firm and its employees including the preexisting condition limitations and the qualifications of the effective date provisions. I understand that Arkansas Blue Cross and Blue Shield will have no liability until this application has been approved and the premium is received.

Agent Signature	Insurance License #/Agency Fed. Tax ID#
Agent Printed Name	Date

SERFF Tracking #:

ARBB-128818167

State Tracking #:**Company Tracking #:**

23-2695 12/12, NGRPDENAPP R12/12

State:

Arkansas

Filing Company:

Arkansas Blue Cross and Blue Shield

TOI/Sub-TOI:

H10G Group Health - Dental/H10G.000 Health - Dental

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Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	12/18/2012
Comments:	This certification is for the amendment only. It is not for the application.		
Attachment(s):			
Flesch Certification 23-2695 12-12.pdf			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	12/18/2012
Bypass Reason:	Already attached.		



**Arkansas
BlueCross BlueShield**

An Independent Licensee of the Blue Cross and Blue Shield Association

**RE: Arkansas Blue Cross and Blue Shield
Amendment No. 23-2695 12/12**

**FLESCH READING EASE
CERTIFICATION**

This is to certify that the above referenced document has achieved a Flesch Reading Ease Score average of 44.0 and complies with the requirements of A.C.A. §23-80-201 *et. seq.*, cited as the Life and Disability Insurance Policy Language Simplification Act.

Name

Vice President
Title

December 18, 2012
Date