

SERFF Tracking Number: ARBB-128293216 State: Arkansas
 Filing Company: Arkansas Blue Cross and Blue Shield State Tracking Number:
 Company Tracking Number: DB DENTAL AGENT ARTA (04/12)
 TOI: H10I Individual Health - Dental Sub-TOI: H10I.000 Health - Dental
 Product Name: ARTA DentalBlue
 Project Name/Number: ARTA DentalBlue/64-313 ARTA

Filing at a Glance

Company: Arkansas Blue Cross and Blue Shield

Product Name: ARTA DentalBlue

SERFF Tr Num: ARBB-128293216 State: Arkansas

TOI: H10I Individual Health - Dental

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

Sub-TOI: H10I.000 Health - Dental

Co Tr Num: DB DENTAL AGENT State Status: Approved-Closed
ARTA (04/12)

Filing Type: Form/Rate

Reviewer(s): Donna Lambert
Disposition Date: 05/02/2012

Authors: Christi Kittler, Yvonne
McNaughton, Frank Sewall, Rita

Thatcher, Evelyn Laney

Date Submitted: 04/23/2012

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: ARTA DentalBlue

Status of Filing in Domicile: Pending

Project Number: 64-313 ARTA

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: Arkansas is the
state of domicile.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 05/02/2012

State Status Changed: 05/02/2012

Deemer Date:

Created By: Christi Kittler

Submitted By: Christi Kittler

Corresponding Filing Tracking Number:

Filing Description:

Attached please find a new application, form DB Dental Agent ARTA (04/12), an actuarial memorandum and rate set for your review and approval if indicated.

Form DB Dental Agent ARTA (04/12) is a new application form for use with the sale of our previously approved DentalBlue Bronze, Silver and Gold plans approved by your department on August 27, 2010 and the new Vision policy approved on December 28, 2011. This application has been amended for use by the Arkansas Retired Teachers

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Association (ARTA). No previously approved forms will be replaced by this new application.

Also attached is an actuarial memorandum and set of rates to be used solely for Arkansas Retired Teachers Association members.

By way of this letter, I certify that the submission meets the provisions of Arkansas Insurance Department Rule & Regulation 19.

I certify that the Life and Health Guaranty Association Notices required by Arkansas Insurance Department Rule & Regulation 49 is incorporated in the policies in which this application form will be attached.

I further certify that the consumer information notice required by Arkansas Code Annotated §23-79-138 is incorporated in the policies in which this form is used.

If you have any questions, please feel free to contact me at 378-2967.

State Narrative:

Company and Contact

Filing Contact Information

Christi Kittler, Compliance Supervisor cmkittler@arkbluecross.com
320 West Capitol, Ste 211 501-378-2967 [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: \$50.00
Retaliatory? No
Fee Explanation: \$50.00/form
Per Company: No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Arkansas Blue Cross and Blue Shield	\$50.00	04/23/2012	58420092

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/02/2012	05/02/2012

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Donna Lambert	04/25/2012	04/25/2012	Christi Kittler	04/25/2012	04/25/2012
Pending Industry Response	Donna Lambert	04/24/2012	04/24/2012	Christi Kittler	04/24/2012	04/24/2012

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Reviewing Notes	Reviewer Note	Donna Lambert	04/27/2012	
Discuss w/ Dan 5/1/2012	Reviewer Note	Donna Lambert	04/27/2012	

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Disposition

Disposition Date: 05/02/2012

Implementation Date:

Status: Approved-Closed

Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Arkansas Blue Cross and Blue Shield	%	%	\$		\$	%	%

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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	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	ARTA DentalBlue App	Approved-Closed	Yes
Rate	Rate Table ARTA	Approved-Closed	Yes

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 04/25/2012
Submitted Date 04/25/2012
Respond By Date 05/25/2012

Dear Christi Kittler,

Objection 1

- Health - Actuarial Justification (Supporting Document)

Comment: Are the rates submitted an increase or decrease to the approved rates?

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Donna Lambert

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Response Letter

Response Letter Status Submitted to State
Response Letter Date 04/25/2012
Submitted Date 04/25/2012

Dear Donna Lambert,

Comments:

Response 1

Comments: Based on what we filed, the Individual and Individual + Spouse rates are slightly higher and the Individual + Children and Family rates are slightly lower.

Related Objection 1

Applies To:

- Health - Actuarial Justification (Supporting Document)

Comment:

Are the rates submitted an increase or decrease to the approved rates?

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

I hope this helps. Please let me know if I can be of further service to you!

Thanks so much!

Christi

Sincerely,

Christi Kittler, Evelyn Laney, Frank Sewall, Rita Thatcher, Yvonne McNaughton

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 04/24/2012
Submitted Date 04/24/2012
Respond By Date 05/24/2012

Dear Christi Kittler,

This will acknowledge receipt of the captioned filing.

Objection 1

- Health - Actuarial Justification (Supporting Document)

Comment: Do the rates submitted with this filing differ from those submitted with the two previously approved policies?

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Donna Lambert

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Response Letter

Response Letter Status Submitted to State
Response Letter Date 04/24/2012
Submitted Date 04/24/2012

Dear Donna Lambert,

Comments:

Hi Donna!

Response 1

Comments: Yes, these rates are similar but not identical to those submitted originally. They have been revised to reflect the benefit of membership in ARTA.

Related Objection 1

Applies To:

- Health - Actuarial Justification (Supporting Document)

Comment:

Do the rates submitted with this filing differ from those submitted with the two previously approved policies?

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

I hope this answers your question. If you need additional information, please let me know.

Sincerely,

Christi Kittler, Evelyn Laney, Frank Sewall, Rita Thatcher, Yvonne McNaughton

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Reviewer Note

Created By:

Donna Lambert on 04/27/2012 08:36 AM

Last Edited By:

Rosalind Minor

Submitted On:

05/02/2012 02:08 PM

Subject:

Reviewing Notes

Comments:

Roz will discuss this filing with Dan on Monday, May 1, during my absence to KS City, MO.

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Product Name: ARTA DentalBlue
Project Name/Number: ARTA DentalBlue/64-313 ARTA

Reviewer Note

Created By:

Donna Lambert on 04/27/2012 08:37 AM

Last Edited By:

Rosalind Minor

Submitted On:

05/02/2012 02:08 PM

Subject:

Discuss w/ Dan 5/1/2012

Comments:

Roz will discuss this filing with Dan on Monday, May 1, during my absence to KS City, MO.

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Form Schedule

Lead Form Number: DB Dental Agent ARTA (04/12)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed 05/02/2012	DB Dental Agent ARTA (04/12)	Application/ Enrollment Form	ARTA DentalBlue App	Initial			DentalBlue_A gt_ARTA_041 2rev3.pdf



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

Application for DentalBlue[®] and DentalBlue GoldSM Plus Vision Insurance



Complete all sections in black ink (please print) and sign.

1 WHO IS APPLYING

In the RELATIONSHIP box below, please indicate **spouse, son, daughter, stepson or stepdaughter** beside each dependent's name.

First Name	M.I.	Last Name	Suffix	Relationship	Sex	Date of Birth	Social Security No.
				Self			

2 PARENT/GUARDIAN (If policy is only for a child under age 18)

First Name	M.I.	Last Name	Relationship (Check One)
			<input type="checkbox"/> Mother <input type="checkbox"/> Stepmother <input type="checkbox"/> Guardian <input type="checkbox"/> Father <input type="checkbox"/> Stepfather

3 MARITAL STATUS

Single (including divorced or widowed) Married (including separated)

4 RESIDENTIAL ADDRESS (Must be permanent address - No P.O. box, please)

Street _____ City _____ State _____ Zip _____
AR

5 MAILING ADDRESS (Complete only if different from residential address)

Street or P.O. Box _____ City _____ State _____ Zip _____

6 BILLING ADDRESS (Complete only if different from residential address)

Street or P.O. Box _____ City _____ State _____ Zip _____

7 CONTACT INFORMATION

Primary Phone Number () ()	Alternate Phone Number () ()	Best Time to Call AM PM	E-mail Address	How do you prefer we communicate with you? <input type="checkbox"/> E-mail <input type="checkbox"/> Phone

8 HOUSEHOLD INFORMATION

Yes No Do all proposed insureds reside in Arkansas?

If "no," please provide: Name: _____ Address: _____

Reason: _____

9 PREVIOUS COVERAGE

Yes No Have any of the proposed insureds had any other dental coverage within the last 12 months?

If "yes," effective date: ____/____/____ Termination date: ____/____/____

Carrier Name: _____ I.D. #: _____

FOR HOME OFFICE USE ONLY (Do Not Write In This Space)

I.D. No.	Group No.	Effective Date

10 TYPE OF COVERAGE

Individual Individual and Spouse Individual and Child(ren) Individual, Spouse and Child(ren)

11 BILLING MODE

Monthly Bank Draft (Must complete attached bank draft form) Quarterly Invoice Semi-Annual Invoice Annual Invoice

12 PLAN SELECTION

MUST CHOOSE ONLY ONE BOX

Bronze **Silver** **Gold** **Gold Plus Vision**

Note: Waiting periods apply to dental benefits only. The following guidelines must be met in order for waiting periods to be waived:

- Your DentalBlue application must be received within 30 days of the termination date of your prior coverage;
- Your 6-month Minor Restorative Waiting Period can be waived if you have had at least 6 months of prior continuous coverage for minor restorative benefits;
- Your 6-month Minor **and** 12-month Major Restorative Waiting Periods can be waived if you have had at least 12 months of prior continuous coverage for major restorative benefits; and
- You provide us with a copy of your Certificate of Coverage verifying your previous dental coverage within 30 days of your policy effective date.

PLEASE READ BEFORE SIGNING

I UNDERSTAND: (1) This application may be declined. (2) If accepted, the insurance applied for shall not become effective until the date shown on my identification card and the initial premium is paid in full, but in no event will insurance become effective earlier than 10 days after the date of this application. (3) If my application is accepted relying on my representations in this document, any coverage which may be issued to me shall be invalid if based on false information. (4) Arkansas Blue Cross and Blue Shield may phone me for additional information that may help with the timely processing of my application.

In signing below, I: (a) represent that the statements and answers given in this application and any signed and dated addendum to this application (both front and back) are true, complete and correctly recorded; (b) agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me upon request.

I certify that I signed this application in the state of Arkansas.

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.

SIGNATURE SECTION (Please sign appropriate line only)

Proposed Insured OR Parent/Legal Guardian's (if policy for a minor)	X	Date Signed
Spouse (required if applying)	X	Date Signed
Dependent Age 18 or Older (required if applying)	X	Date Signed

This section to be completed by sales representative

Sales Rep License No. (required)	Sales Representative's Name (please print)	Telephone No.
Agency Federal Tax ID No. (if applicable)	Sales Representative's Signature	Date Signed

For Home Office Use Only (Do not write in this space.)

Home Office Endorsements

THIS APPLICATION IS VALID FOR 90 DAYS ONLY WHEN COMPLETED AND SIGNED.

Pre-Authorized Bank Draft

Monthly Program Sign-up Form

Our monthly bank draft service makes premium payments easy and convenient for you. Completing this simple form helps assure your payments are made accurately and timely.

Depending on the health insurance plan you are applying for and the date your application is approved, we may be able to draft your first month's premium. If so, you will be notified in writing prior to the draft. Once the bank draft is in effect, you will not receive a billing statement.

Complete the information below.

Important: Please Read Before Signing

I authorize Arkansas Blue Cross and Blue Shield and the BANK indicated below, to debit my Arkansas Blue Cross premium from my checking or savings account indicated below. 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 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 also will be terminating my Arkansas Blue Cross coverage, UNLESS Arkansas Blue Cross 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.

I understand that an insufficient check fee will be assessed for any payment returned to Arkansas Blue Cross as a result of insufficient funds.

Proposed Insured(s) Information

First Name: _____ Last Name: _____

Address: _____

Street

Apt. No.

City

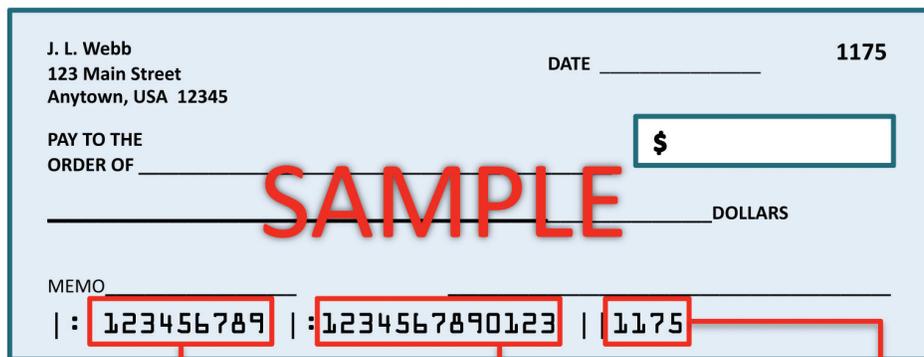
State

Zip

Bank Account Information

Bank Name: _____ Name on Account: _____
(If different than the proposed insured)

Routing Number: _____ Account Number: _____
Type of Account: Checking Savings



Bank Routing Number

Bank Account Number

Check Number

Signature

Signature _____ Date _____
Signature of Bank Account Holder

After Arkansas Blue Cross receives and processes this completed authorization form, you will receive a letter providing the effective date of your first scheduled draft. We hope you find this bank draft service of value. It is our privilege to serve you. Thank you for your business!



**Arkansas
BlueCross BlueShield**

An Independent Licensee of the Blue Cross and Blue Shield Association

For Office Use Only (Please do not write in this space)

ID NO.	EFFECTIVE DATE



**Arkansas
BlueCross BlueShield**

An Independent Licensee of the Blue Cross and Blue Shield Association

Policy Effective Date

All DentalBlue® policies will be issued with a 1st of the month effective date based on the approval date (1st-15th **OR** 16th-31st) of your application. For example, if your application is approved on January 10, coverage will be effective February 1. If your application is approved on January 20, coverage will be effective March 1.

Application Checklist

Have you . . .

- Answered all the questions?
- Signed and dated the application?
- Enclosed a completed Pre-authorized Monthly Bank Draft form signed by account holder (if monthly bank draft is requested)?
- Attached a voided check from account to be charged (if monthly bank draft is requested)?

Please return this application and bank draft form (if completed) in the business-reply envelope provided. If you did not receive an envelope, please mail to:

Arkansas Blue Cross and Blue Shield
ATTN: Individual Underwriting
P.O. Box 2181
Little Rock, AR 72203-2181

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State: Arkansas
 State Tracking Number:
 Sub-TOI: H101.000 Health - Dental

Rate Information

Rate data applies to filing.

Filing Method: Review and approve
Rate Change Type: Neutral
Overall Percentage of Last Rate Revision: %
Effective Date of Last Rate Revision:
Filing Method of Last Filing:

Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Arkansas Blue Cross and Blue Shield	%	%				%	%

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Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved-Closed 05/02/2012	Rate Table ARTA	64-313, 17-278	New		ARTA Rate Table 64-313, 17-278.PDF

Exhibit III

Arkansas Blue Cross and Blue Shield
Proposed Monthly Premium Rates
Effective May 1, 2012

Dental Policy Form: 64-313

Individual	\$28.97
Individual and spouse	\$61.43
Individual and child(ren)	\$57.55
Individual, spouse and child(ren)	\$88.41

Vision Policy Form: 17-278

Individual	\$7.03
Individual and spouse	\$13.18
Individual and child(ren)	\$13.50
Individual, spouse and child(ren)	\$21.17

Combined Dental Plus Vision

Individual	\$36.00
Individual and spouse	\$74.61
Individual and child(ren)	\$71.05
Individual, spouse and child(ren)	\$109.58

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State: Arkansas
State Tracking Number:
Sub-TOI: H101.000 Health - Dental

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	05/02/2012
Bypass Reason:	Not needed for this filing.		
Comments:			
Bypassed - Item:	Application	Approved-Closed	05/02/2012
Bypass Reason:	Not needed for this filing.		
Comments:			
Satisfied - Item:	Health - Actuarial Justification	Approved-Closed	05/02/2012
Comments:	See attached.		
Attachment:	ARTA Actuarial Memo 64-313, 17-278.PDF		
Bypassed - Item:	Outline of Coverage	Approved-Closed	05/02/2012
Bypass Reason:	Not needed for this filing.		
Comments:			