

SERFF Tracking Number: CFAP-127839519 State: District of Columbia
 Filing Company: Group Hospitalization and Medical Services, Inc. State Tracking Number:
 Company Tracking Number: 1636
 TOI: H20G Group Health - Vision Sub-TOI: H20G.000 Health - Vision
 Product Name: Filing #1636 GHMSI DC Small Group Voluntary Vision
 Project Name/Number: DC GHMSI SG Voluntary Vision eff 201204/1636

Rate Information

Rate data applies to filing.

Filing Method: Electronic
Rate Change Type: Neutral
Overall Percentage of Last Rate Revision: 0.000%
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):
Group Hospitalization and Medical Services, Inc.	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

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Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
	1636 DC GHMSI U50 Voluntary Vision Rate Filing	listed in the rate filing	New		1636 GHMSI DC U50 Voluntary Vision Rate Filing.pdf

CAREFIRST BLUECROSS BLUESHIELD

DISTRICT OF COLUMBIA **Employer-Sponsored and Voluntary Vision**

Vision Rates Effective 4/1/2012

GHMSI dba CareFirst BlueCross BlueShield

GHMSI Employer-Sponsored BlueVision Plus Rider

(Option with any GHMSI Medical product when choosing parallel enrollment)

DC/CF/VISION (R. 1/12)

and any amendments

GHMSI Employer-Sponsored BlueVision Plus Non-Rider / Freestanding Forms

DC/CF/EOC/D-V (1/12)

DC/CF/DOCS-V (R. 1/12)

DC/CF/SOB-V (R. 1/12)

DC/CF/GC (R. 8/10)

and any amendments

GHMSI Voluntary BlueVision Plus Non-Rider / Freestanding Forms

DC/CF/EOC/D-V (1/12)

DC/CF/DOCS-V (R. 1/12)

DC/CF/SOB-V (R. 1/12)

DC/CF/GC (R. 8/10)

and any amendments

GHMSI dba CareFirst BlueCross BlueShield

DISTRICT OF COLUMBIA SMALL GROUP

Effective 4/1/2012

Employer-Sponsored BlueVision Plus

PLAN DESIGN SUMMARY*

Individual

Option A: \$0 exam copay/12/12/24 benefit period

\$0 Exam Copay	
\$20 Spectacle Lenses Copay	\$7.00
\$20 CL Fitting Copay	
Non-Collection Frame Allowance: Up to \$130	
Davis Vision Frame: Covered in Full	

Option B: \$10 exam copay/12/12/24 benefit period

\$10 Exam Copay	
\$20 Spectacle Lenses Copay	\$6.00
\$20 CL Fitting Copay	
Non-Collection Frame Allowance: Up to \$130	
Davis Vision Frame: Covered in Full	

Option C: \$0 exam copay/12 month benefit period

\$0 Exam Copay	
\$20 Spectacle Lenses Copay	\$8.00
\$20 CL Fitting Copay	
Non-Collection Frame Allowance: Up to \$130	
Davis Vision Frame: Covered in Full	

Option D: \$10 exam copay/12 month benefit period

\$10 Exam Copay	
\$20 Spectacle Lenses Copay	\$7.00
\$20 CL Fitting Copay	
Non-Collection Frame Allowance: Up to \$130	
Davis Vision Frame: Covered in Full	

* Benefit Period for Exam/Lenses/Frames

GHMSI dba CareFirst BlueCross BlueShield

DISTRICT OF COLUMBIA SMALL GROUP

Effective 4/1/2012

Voluntary BlueVision Plus

PLAN DESIGN SUMMARY*

Individual

Option A: \$0 exam copay/12/12/24 benefit period

\$0 Exam Copay
\$20 Spectacle Lenses Copay \$8.00
\$20 CL Fitting Copay
Non-Collection Frame Allowance: Up to \$130
Davis Vision Frame: Covered in Full

Option B: \$10 exam copay/12/12/24 benefit period

\$10 Exam Copay
\$20 Spectacle Lenses Copay \$7.00
\$20 CL Fitting Copay
Non-Collection Frame Allowance: Up to \$130
Davis Vision Frame: Covered in Full

Option C: \$0 exam copay/12 month benefit period

\$0 Exam Copay
\$20 Spectacle Lenses Copay \$9.00
\$20 CL Fitting Copay
Non-Collection Frame Allowance: Up to \$130
Davis Vision Frame: Covered in Full

Option D: \$10 exam copay/12 month benefit period

\$10 Exam Copay
\$20 Spectacle Lenses Copay \$8.00
\$20 CL Fitting Copay
Non-Collection Frame Allowance: Up to \$130
Davis Vision Frame: Covered in Full

* Benefit Period for Exam/Lenses/Frames

SERFF Tracking Number: CFAP-127839519 State: District of Columbia
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Product Name: Filing #1636 GHMSI DC Small Group Voluntary Vision
Project Name/Number: DC GHMSI SG Voluntary Vision eff 201204/1636

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Actuarial Justification		
Comments:		
Attachment: 1636 GHMSI DC U50 Voluntary Vision Actuarial Memorandum.pdf		

	Item Status:	Status Date:
Satisfied - Item: NAIC Transmittal Doc		
Comments:		
Attachment: 1621 GHMSI NAIC Transmittal Doc.pdf		

Group Hospitalization & Medical Services, Inc. (GHMSI)
NAIC #53007

DISTRICT OF COLUMBIA

Employer-Sponsored and Voluntary Vision

Effective 4/1/2012

Actuarial Memorandum

CareFirst BlueCross BlueShield

Rate Filing Summary (Filing #1636)

This submission pertains to the new product offering for the small group vision business of GHMSI. The proposed effective date is 4/1/2012.

CFBCBS is proposing to launch a new line of BlueVision Plus plans. The 4 new plans (2 with 12/12/12 benefit periods and 2 with 12/12/24 benefit periods for exam/lenses/frames), offered both as employer-sponsored and voluntary plans, will have increased allowances, separate benefits for contact lens evaluation, fitting, follow-up care and additional copayments (as shown in page 5).

Since Davis Vision administers CFBCBS vision plans, they provided the capitation rates for the new plans.

There are no participation or contribution limits for the voluntary plans. If the employer contribution is less than 50% of the cost of the Individual Coverage for enrolled employees, then it will be voluntary.

The rating methodology of these plans will match that of the existing employer-sponsored plans.

These plans will be offered as rider (i.e. with medical) or freestanding (without medical). The current freestanding load will apply.

These plans will not be age rated.

Contract Form Numbers pertaining to this filing:

GHMSI Employer-Sponsored BlueVision Plus Rider

(Option with any GHMSI Medical product when choosing parallel enrollment)

DC/CF/VISION (R. 1/12)

and any amendments

GHMSI Employer-Sponsored BlueVision Plus Non-Rider / Freestanding Forms

DC/CF/EOC/D-V (1/12)

DC/CF/DOCS-V (R. 1/12)

DC/CF/SOB-V (R. 1/12)

DC/CF/GC (R. 8/10)

and any amendments

GHMSI Voluntary BlueVision Plus Non-Rider / Freestanding Forms

DC/CF/EOC/D-V (1/12)

DC/CF/DOCS-V (R. 1/12)

DC/CF/SOB-V (R. 1/12)

DC/CF/GC (R. 8/10)

and any amendments

ACTUARIAL CERTIFICATION

I, Anna Guloy, am a Pricing Actuary with Group Hospitalization and Medical Services, Inc. (GHMSI) doing business as CareFirst BlueCross BlueShield and a member of the American Academy of Actuaries. I have been involved in the development of these rates.

To the best of my knowledge and judgment, this rate filing complies with applicable laws and regulations of the District of Columbia and produces premiums that are reasonable in relation to benefits provided.

Anna Guloy

Digitally signed by Anna Guloy
DN: cn=Anna Guloy, o=CareFirst BlueCross BlueShield,
ou=Actuarial Pricing Department, email=anna.
guloy@carefirst.com, c=US
Date: 2011.11.22 15:14:31 -05'00'

Anna Guloy, ASA, MAAA
Actuarial Associate
CareFirst BlueCross BlueShield
Mail Drop-Point 01-780
Pricing Department
10455 Mill Run Circle
Owings Mills, MD 21117

CareFirst BlueCross BlueShield
Small Group Business
Employer-Sponsored and Voluntary Vision Product
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11	Calculation of Monthly Premiums

**CareFirst BlueCross BlueShield
DC Small Group Business
BlueVision Plus Benefit Comparison**

New Vision Plans 4/1/2012

In-Network Benefits	Option A	Option B	Option C	Option D	Out-of Network Benefit
Frequency-Once Every:					
		Frequencies			
Eye Health Examination inclusive of Dilation (when professionally indicated)	12 months	12 months	12 months	12 months	
Spectacle Lenses	12 months	12 months	12 months	12 months	
Frame	24 months	24 months	12 months	12 months	
Contact Lens Evaluation, Fitting & Follow-Up Care	12 months	12 months	12 months	12 months	
Contact Lenses (in lieu of eyeglasses)	12 months	12 months	12 months	12 months	
Copayments		Member Charges			Reimbursement
Eye Health Examination	\$0	\$10	\$0	\$10	Up to \$45
Spectacle Lenses		\$20			NA
Contact Lens Evaluation, Fitting & Follow-Up Care		\$20			NA
Eyeglass Benefit - Frame		Member Charges			Reimbursement
Davis Vision Tower Collection		\$0			NA
Non-Collection Frame Allowance (retail price, except where noted)		Up to \$130			Up to \$60
Eyeglass Benefit - Spectacle Lenses		Member Charges			Reimbursement
Basic Single Vision Lenses		\$0			Up to \$52
Basic Bifocal Lenses		\$0			Up to \$82
Basic Trifocal Lenses		\$0			Up to \$101
Lenticular Lenses		\$0			Up to \$181
Contact Lens Benefit		Allowances			Reimbursement
Non-Collection Single Vision Contact Lenses: Materials Allowance		Up to \$130			Up to \$112
Non-Collection Bifocal Contact Lenses: Materials Allowance		Up to \$130			Up to \$127
Evaluation, Fitting & Follow-Up Care - Standard Lens Types		Included			Up to \$60
Evaluation, Fitting & Follow-Up Care - Specialty Lens Types		Up to \$60			Up to \$60
Collection Contact Lenses		Included			NA
Medically Necessary Contact Lenses		Included			Up to \$285

DERIVATION OF CONVERSION FACTOR PER MEMBER TO PER CONTRACT GROUP BUSINESS

EQUATION

Individual Per Contract Rate = X
Per Member Per Month Cost = Y

$(IND \% \times 1.0X) + (I\&C \% \times 1.85X) + (I\&A \% \times 2.3X) + (FAM\ 4T \% \times 2.8X) =$
 $(IND \% \times 1.0Y) + (I\&C \% \times 2.48Y) + (I\&A \% \times 2Y) + (FAM\ 4T \% \times 4.06Y)$

4-Tier	<u>% Distribution</u>	<u>Rating Relationship</u>	<u>Average Members</u>	<u>Rating Eq 1/2</u>	<u>Cost Eq 1/2</u>
IND	59.8%	1.00	1.00	0.5985	0.5985
Ind + Child(ren)	5.0%	1.85	2.48	0.0920	0.1233
Ind + Adult	11.7%	2.30	2.00	0.2691	0.2340
<u>FAM</u>	<u>23.5%</u>	<u>2.80</u>	<u>4.06</u>	<u>0.6574</u>	<u>0.9529</u>
Sum	100.0%			1.6170	1.9086

1.6170 * X = 1.9086 * Y

X = 1.1804 Conversion Factor to Go From Per Member Cost to Per Contract Cost

$(IND \% \times 1.0X) + (FAM\ 2T \% \times 2.8X) =$
 $(IND \% \times 1.0Y) + (FAM\ 2T \% \times 3.52Y)$

2-Tier	<u>% Distribution</u>	<u>Rating Relationship</u>	<u>Average Members</u>	<u>Rating Eq 1/2</u>	<u>Cost Eq 1/2</u>
IND	77.8%	1.00	1.00	0.7778	0.7778
FAM	22.2%	2.80	3.52	0.6222	0.7824
Sum	100.0%			1.4000	1.5602

1.4000 * X = 1.5602 * Y

X = 1.1144 Conversion Factor to Go From Per Member Cost to Per Contract Cost

Weighted average factor:

	<u>% Distribution</u>	<u>Factor</u>	
4-Tier	99.9%	1.1804	1.1803 Weighted conversion factor used in calculating rates
2-Tier	0.1%	1.1144	
Sum	100.0%		

Fully Insured Small Group vision business for all legal entities enrollment data from 12 months from 201005 - 201104.

CareFirst BlueCross BlueShield
VISION PRODUCT OFFERING
DISTRICT OF COLUMBIA
DERIVATION OF Individual Rates and Components of Retention
Effective 4/1/2012

New Employer Sponsored BlueVision Plus Plans

	<u>PMPM</u>	<u>Individual Rate</u>	<u>% of Gross Revenue</u>
Davis Capitation (Claims Cost + Davis's Retention)	\$3.10	\$3.66	52.49%
Admin Cost	\$1.17	\$1.38	19.74%
Brokers/Administrators/Wholesalers	\$1.52	\$1.79	25.67%
Contribution to Reserve	\$0.00	\$0.00	0.00%
Invst Income Credit	\$0.00	\$0.00	0.00%
Premium Tax / Community Health Investment	\$0.12	\$0.14	2.00%
Assessment Fees	\$0.01	\$0.01	0.10%
Federal Taxes	\$0.00	\$0.00	0.00%
GROSS COST:	\$5.91	\$6.98	100.00%
Gross Income PMPM =			\$5.91

Individual Monthly Rate Derivation

New Employer Sponsored BlueVision Plus Options:	Capitation PMPM	Step UP Factor	DICR	Calculated Ind Rate	Rounded	Proposed Ind Rates
Option A: \$0 exam copay/12/12/24 benefit period	\$3.13	1.1803	52.5%	\$ 7.04	\$ 7.00	\$ 7.00
Option B: \$10 exam copay/12/12/24 benefit period	\$2.96	1.1803	52.5%	\$ 6.66	\$ 7.00	\$ 6.00
Option C: \$0 exam copay/12 month benefit period	\$3.25	1.1803	52.5%	\$ 7.31	\$ 7.00	\$ 8.00
Option D: \$10 exam copay/12 month benefit period	\$3.07	1.1803	52.5%	\$ 6.90	\$ 7.00	\$ 7.00
Blended Average	\$3.10			\$6.98	\$7.00	\$7.00
Differential to Calculated Rates						0.3%

The derivation of the individual monthly rates is included above. Due to the relatively small size of these rates, and quoting system requirements that base rates be rounded to whole dollars, we have made subjective adjustments to the calculated rates as seen in the column labeled Proposed Ind Rates. In order to create a logical price differential, based on the relative value of the benefit designs, we propose to lower Option B \$1 from it's calculated rate and raise Option C \$1 from it's calculated rate. Assuming an equal distribution among the plans this has the impact of producing the same average premium as the rounded base rates, and is 0.3% above the calculated unrounded base rates.

CareFirst BlueCross BlueShield
VISION PRODUCT OFFERING
DISTRICT OF COLUMBIA
DERIVATION OF Individual Rates and Components of Retention
Effective 4/1/2012

New Voluntary BlueVision Plus Plans

	<u>PMPM</u>	<u>Individual Rate</u>	<u>% of Gross Revenue</u>
Davis Capitation (Claims Cost + Davis's Retention)	\$4.33	\$5.11	60.44%
Admin Cost	\$1.17	\$1.38	16.28%
Brokers/Administrators/Wholesalers	\$1.52	\$1.79	21.18%
Contribution to Reserve	\$0.00	\$0.00	0.00%
Invst Income Credit	\$0.00	\$0.00	0.00%
Premium Tax / Community Health Investment	\$0.14	\$0.17	2.00%
Assessment Fees	\$0.01	\$0.01	0.10%
Federal Taxes	\$0.00	\$0.00	0.00%
GROSS COST:	\$7.16	\$8.46	100.00%
Gross Income PMPM =			\$7.16

Individual Monthly Rate Derivation

New Voluntary BlueVision Plus Options:	Capitation PMPM	Step UP Factor	DICR	Calculated Ind Rate	Rounded	Proposed Ind Rates
Option A: \$0 exam copay/12/12/24 benefit period	\$4.01	1.1803	60.4%	\$ 7.83	\$ 8.00	\$ 8.00
Option B: \$10 exam copay/12/12/24 benefit period	\$3.79	1.1803	60.4%	\$ 7.40	\$ 7.00	\$ 7.00
Option C: \$0 exam copay/12 month benefit period	\$4.89	1.1803	60.4%	\$ 9.55	\$ 10.00	\$ 9.00
Option D: \$10 exam copay/12 month benefit period	\$4.63	1.1803	60.4%	\$ 9.04	\$ 9.00	\$ 8.00
Blended Average	\$4.33			\$8.46	\$8.50	\$8.00
Differential to Calculated Rates						-5.4%

The derivation of the individual monthly rates is included above. Due to the relatively small size of these rates, and quoting system requirements that base rates be rounded to whole dollars, we have made subjective adjustments to the calculated rates as seen in the column labeled Proposed Ind Rates. In order to create a logical price differential, based on the relative value of the benefit designs, we propose to lower Options C and D \$1 from their calculated rates. Assuming an equal distribution among the plans this has the impact of producing an average premium that is -5.4% below the calculated unrounded base rates.

**CareFirst BlueCross BlueShield
DC Small Group Business
BlueVision Plus Capitation PMPM Rates**

PMPM Capitation Rates Effective 4/1/2012		
New BlueVision Plus Options*:	Employer-Sponsored	Voluntary
Option A: \$0 exam copay/12/12/24 benefit period	\$3.13	\$4.01
Option B: \$10 exam copay/12/12/24 benefit period	\$2.96	\$3.79
Option C: \$0 exam copay/12 month benefit period	\$3.25	\$4.89
Option D: \$10 exam copay/12 month benefit period	\$3.07	\$4.63

* The new proposed BlueVision Plus benefits are administered through a capitation arrangement with our vision vendor, Davis Vision. The PMPM capitations based on our arrangement with Davis are shown above and compose the claims component of our rate derivation.

**CareFirst BlueCross BlueShield (BlueChoice & GHMSI)
DISTRICT OF COLUMBIA
TIER AND FREESTANDING FACTORS**

TIER STRUCTURE	CONTRACT TYPE	Currently Effective Tier Factors*
TWO TIER	INDIVIDUAL	1.00
	FAMILY	2.80
FOUR TIER	INDIVIDUAL	1.00
	INDIVIDUAL & CHILD(REN)	1.85
	INDIVIDUAL & ADULT	2.30
	FAMILY	2.80
	Complementary to Medicare Vision	1.00

* Note: Small Group Vision tier factors must follow those of Small Group Medical business approved at the time of rating.

FREESTANDING FACTOR: 1.69

CAREFIRST BLUECROSS BLUESHIELD

DISTRICT OF COLUMBIA

Calculation of Monthly Premiums for Employer-Sponsored and Voluntary Vision Plans

- Step One:* Start with the base (Individual) rate for the corresponding BlueVision Plus Option
- Step Two:* For freestanding products, add a 1.69 load to the rate from step one
- Step Three:* Round the rate to the nearest whole dollar
- Step Four:* Multiply rate from step three by tier factors to develop tiered rates*
- Step Five:* Round the rates to the nearest whole dollar

**Example 1:
Employer-Sponsored**

Option A: \$0 exam copay/12/12/24 benefit period

<i>Step One:</i>	Vision Base Rate	\$7.00
<i>Step Two:</i>	Vision Rate	\$7.00
<i>Step Three:</i>	Rounded Rate	\$7.00
<i>Step Four:</i>	Individual Vision Rate =	\$7.00
	Ind + Child(ren) Vision Rate =	\$12.95
	Ind + Adult Vision Rate =	\$16.10
	Family Vision Rate =	\$19.60
	CtM Vision Rate =	\$7.00
<i>Step Five:</i>	Individual Vision Rate =	\$7.00
	Ind + Child(ren) Vision Rate =	\$13.00
	Ind + Adult Vision Rate =	\$16.00
	Family Vision Rate =	\$20.00
	CtM Vision Rate =	\$7.00

**Example 2:
Voluntary Freestanding**

Option A: \$0 exam copay/12/12/24 benefit period

<i>Step One:</i>	Vision Base Rate	\$8.00
<i>Step Two:</i>	FS Vision Rate	\$13.52
<i>Step Three:</i>	Rounded Rate	\$14.00
<i>Step Four:</i>	Individual Vision Rate =	\$14.00
	Ind + Child(ren) Vision Rate =	\$25.90
	Ind + Adult Vision Rate =	\$32.20
	Family Vision Rate =	\$39.20
	CtM Vision Rate =	\$14.00
<i>Step Five:</i>	Individual Vision Rate =	\$14.00
	Ind + Child(ren) Vision Rate =	\$26.00
	Ind + Adult Vision Rate =	\$32.00
	Family Vision Rate =	\$39.00
	CtM Vision Rate =	\$14.00

* Note: Small Group Vision tier factors must follow those of Small Group Medical business.

Life, Accident & Health, Annuity, Credit Transmittal Document

1. Prepared for the State of	District of Columbia
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2.	Department Use Only
	State Tracking ID

3.	Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #
	Group Hospitalization and Medical Services, Inc. 840 First Street NE Washington, DC 20065	District of Columbia	Hospital, Medical & Dental Service or Indemnity		53007	53-0078070	

4.	Contact Name & Address	Telephone #	Fax #	E-mail Address
	Anna Guloy 10455 Mill Run Circle Owings Mills, MD 21117	(410) 998 - 5098	(410) 998 - 7704	anna.guloy@carefirst.com

5.	Requested Filing Mode	<input checked="" type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____
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6.	Company Tracking Number	1621
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7.	<input checked="" type="checkbox"/> New Submission <input type="checkbox"/> Resubmission Previous file # <u>N/A</u>
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8.	Market	<input type="checkbox"/> Individual <input type="checkbox"/> Franchise
		Group <input checked="" type="checkbox"/> Small <input type="checkbox"/> Large <input type="checkbox"/> Small and Large <input checked="" type="checkbox"/> Employer <input type="checkbox"/> Association <input type="checkbox"/> Blanket <input type="checkbox"/> Discretionary <input type="checkbox"/> Trust <input type="checkbox"/> Other: _____

9.	Type of Insurance	H10G Group Health-Dental
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10.	Product Coding Matrix Filing Code	H10G.000 Health-Dental
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11.	Submitted Documents	<input type="checkbox"/> FORMS <input type="checkbox"/> Policy <input type="checkbox"/> Outline of Coverage <input type="checkbox"/> Certificate <input type="checkbox"/> Application/Enrollment <input type="checkbox"/> Rider/Endorsement <input type="checkbox"/> Advertising <input type="checkbox"/> Schedule of Benefits <input type="checkbox"/> Other
		Rates <input checked="" type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate <input type="checkbox"/> FILING OTHER THAN FORM OR RATE: Please explain: _____ SUPPORTING DOCUMENTATION <input type="checkbox"/> Articles of Incorporation <input type="checkbox"/> Third Party Authorization <input type="checkbox"/> Association Bylaws <input type="checkbox"/> Trust Agreements <input type="checkbox"/> Statement of Variability <input checked="" type="checkbox"/> Certifications <input checked="" type="checkbox"/> Actuarial Memorandum <input type="checkbox"/> Other _____

12.	Filing Submission Date	06/27/2011	
13	Filing Fee (If required)	Amount _____	Check Date _____
		Retaliatory <input type="checkbox"/> Yes <input type="checkbox"/> No	Check Number _____
14.	Date of Domiciliary Approval		
15.	Filing Description:		
<p>This filing contains the rate proposal for the new Group Hospitalization and Medical Services, Inc. dba CareFirst BlueCross BlueShield's Small Group (2-50 contracts) Voluntary Dental plans, with an effective date of October 1, 2011. Please refer to the Actuarial Memorandum (Supporting Documentation) and Rate filing (Rate/Rule Schedule) for more details.</p> <div data-bbox="544 1396 1117 1480" style="text-align: center; border: 1px solid black; padding: 5px; margin: 20px auto; width: fit-content;"> <p>View Complete Filing Description</p> </div>			

16.	Certification (If required)		
<p>I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of <u>District of Columbia</u>.</p>			
Print Name <u>Dwayne Lucado, F.S.A., M.A.A.A.</u>		Title <u>Assistant Actuary</u>	
Signature <u>Dwayne Lucado</u>		 <small>Digitally signed by Dwayne Lucado DN: cn=Dwayne Lucado, o=CareFirst BlueCross BlueShield, ou=Actuarial Pricing Department, email=dwayne.lucado@cedent.com, c=US Date: 2011.06.24 10:42:48 -0400</small>	Date: <u>6/24/2011</u>

17.	Form Filing Attachment
This filing transmittal is part of company tracking number	
This filing corresponds to rate filing company tracking number	

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
02			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	

LH FFA-1

18.		Rate Filing Attachment		
This filing transmittal is part of company tracking number		1621		
This filing corresponds to form filing company tracking number				
Overall percentage rate indication (when applicable)				
Overall percentage rate impact for this filing		0.0 %		
	Document Name	Affected Form Numbers		Previous State Filing Number
	Description			
01	Rate Filing #1621 This filing contains the proposed rates for GHMSI Small Group Voluntary Dental plans.	DC/CF/DO-DOCS (R. 10/11) DC/GRP APP (R. 10/11)	<input checked="" type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
02		and any required amendments	<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	

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