SERFF Tracking Number:	*CFAP-126065477*	*State:*	*District of Columbia*
Filing Company:	*Group Hospitalization and Medical Services, Inc.*	*State Tracking Number:*	
Company Tracking Number:	*1241*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health Dental*
Product Name:	*Filing #1241 GHMSI DC Small Group Dental*		
Project Name/Number:	*DC GHMSI Small Grp Dental eff 200907/1241*		

Rate/Rule Schedule

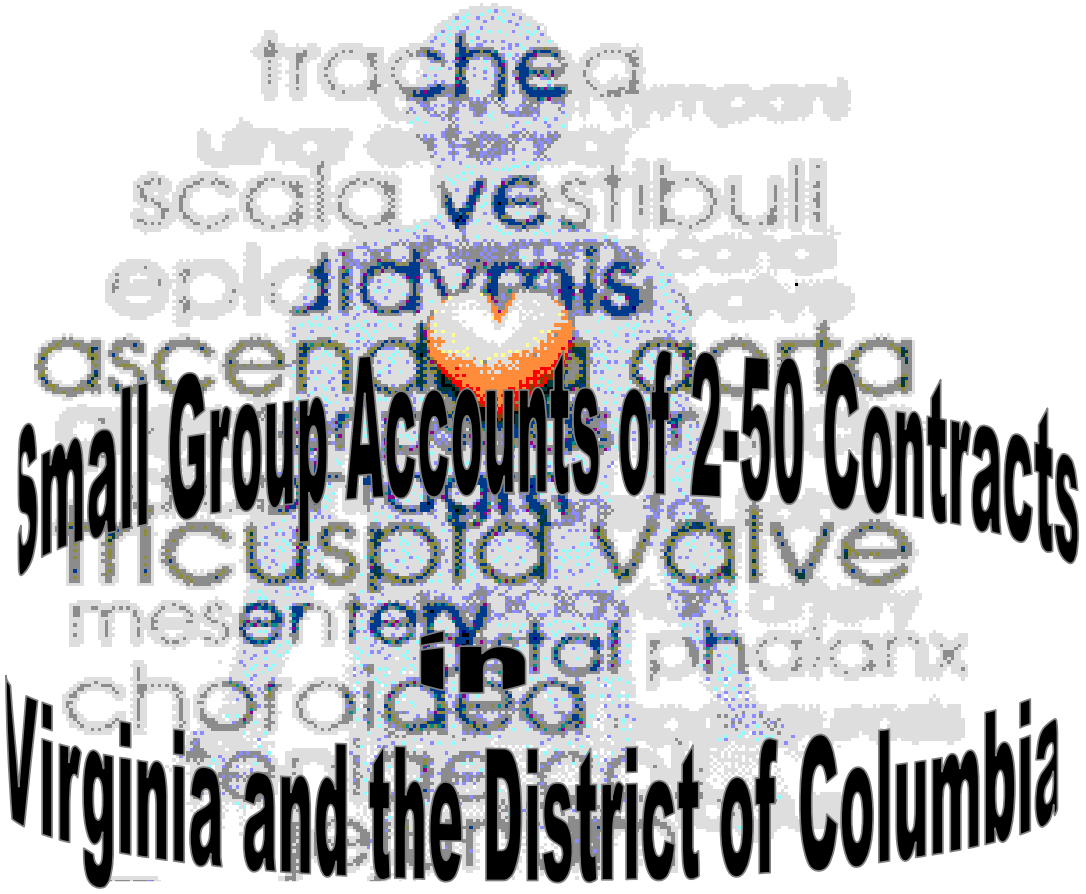
Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:*	Rate Action Information:		Attachments
APPROVED 04/01/2009	Rate Filing #1241 DC GHMSI SG Dental	DC/CF/COC DEN (R. 9/04), DC/CF/DO-DOCS (R. 1/04), DC/CF/DO-SOB (R. 1/04), DC/CF/ELIG (9/04), DC/CF/DENTAL RIDER (R. 1/04), DC/CF/GC-V (9/04)	Revised	Previous State Filing Number: Percent Rate Change Request:	 4.600	1241_DC_GHMSI_Rate Filing.pdf

Group Hospitalization and Medical Services, Inc.
dba CareFirst BlueCross BlueShield

District of Columbia
Small Group Dental Coverage

File # 1241

CareFirst BlueCross BlueShield



Rates to Become Effective 07/01/09

CareFirst BlueCross BlueShield

COMMUNITY RATED GROUP ACCOUNTS OF 2-50 CONTRACTS
JURISDICTION: DISTRICT OF COLUMBIA
REGIONAL RIDER INDEMNITY DENTAL CARE BENEFITS
MONTHLY PREMIUMS EFFECTIVE July 1, 2009

ANCILLARY BENEFITS
Dental Coverage As A Rider
(Not Age Rated But Adjusted for Geography)

Form Numbers: DC/CF/DENTAL RIDER (R. 1/04)

PLAN DESIGN		**Individual**
Individual Annual Deductible		$50
Non-Individual Annual Deductible		$150
Coinsurance	CLASS 1	80%
	CLASS 2	50%
	CLASS 3	50%
	CLASS 4	50%
$1,000 Annual Benefit Maximum per Participant		
OPTION 1		$24
Individual Annual Deductible		$50
Non-Individual Annual Deductible		$150
Coinsurance	CLASS 1	100%
	CLASS 2	80%
	CLASS 3	50%
	CLASS 4	50%
$1,000 Annual Benefit Maximum per Participant		
OPTION 2		$28
Individual Annual Deductible		$50
Non-Individual Annual Deductible		$150
Coinsurance	CLASS 1	100%
	CLASS 2	80%
	CLASS 3	80%
	CLASS 4	50%
$1,000 Annual Benefit Maximum per Participant		
OPTION 3		$29
Individual Annual Deductible		$50
Non-Individual Annual Deductible		$150
Coinsurance	CLASS 1	100%
	CLASS 2	80%
	CLASS 3	80%
	CLASS 4	50%
$1,500 Annual Benefit Maximum per Participant		
OPTION 4		$31

Optional Riders

ORTHODONTICS :	50% Coinsurance	
	$800 Lifetime Benefit Maximum per Participant	$1
	$1200 Lifetime Benefit Maximum per Participant	$2

Class 1: **Preventive and Diagnostic Services**
Class 2: **Therapeutic and Minor Restorative Services**
Class 3: **Periodontic and Endodontic Services**
Class 4: **Prosthodontic and Major Restorative**

Note: The dental group tier structure must match the medical group tier structure. Please refer to page 10 of the actuarial memorandum for instructions on calculating tiered rates.

Deductible Credit will be included in the regional dental benefits. This gives subscribers credit for deductibles paid in the same period to another carrier.

CareFirst BlueCross BlueShield

COMMUNITY RATED GROUP ACCOUNTS OF 2-50 CONTRACTS
JURISDICTION: DISTRICT OF COLUMBIA
REGIONAL FREESTANDING INDEMNITY DENTAL CARE BENEFITS*
MONTHLY PREMIUMS EFFECTIVE July 1, 2009

ANCILLARY BENEFITS **Form Numbers:** DC/CF/GC-V (9/04) DC/CF/DO-SOB (R. 1/04)
FreeStanding Dental Coverage DC/CF/COC DEN (R. 9/04) DC/CF/ELIG (9/04)
(Not Age Rated But Adjusted for Geography) DC/CF/DO-DOCS (R. 1/04)

PLAN DESIGN		**Individual**
Individual Annual Deductible		$50
Non-Individual Annual Deductible		$150
Coinsurance	CLASS 1	80%
	CLASS 2	50%
	CLASS 3	50%
	CLASS 4	50%
$1,000 Annual Benefit Maximum per Participant		
OPTION 1		$28
Individual Annual Deductible		$50
Non-Individual Annual Deductible		$150
Coinsurance	CLASS 1	100%
	CLASS 2	80%
	CLASS 3	50%
	CLASS 4	50%
$1,000 Annual Benefit Maximum per Participant		
OPTION 2		$32
Individual Annual Deductible		$50
Non-Individual Annual Deductible		$150
Coinsurance	CLASS 1	100%
	CLASS 2	80%
	CLASS 3	80%
	CLASS 4	50%
$1,000 Annual Benefit Maximum per Participant		
OPTION 3		$33
Individual Annual Deductible		$50
Non-Individual Annual Deductible		$150
Coinsurance	CLASS 1	100%
	CLASS 2	80%
	CLASS 3	80%
	CLASS 4	50%
$1,500 Annual Benefit Maximum per Participant		
OPTION 4		$36
Optional Riders		
ORTHODONTIC	50% Coinsurance	
	$800 Lifetime Benefit Maximum per Participant	$1
	$1200 Lifetime Benefit Maximum per Participant	$2

Class 1: **Preventive and Diagnostic Services**
Class 2: **Therapeutic and Minor Restorative Services**
Class 3: **Periodontic and Endodontic Services**
Class 4: **Prosthodontic and Major Restorative**

*Individual FreeStanding Indemnity rates determined by applying freestanding factor of 1.15 to individual Rider Indemnity rates and rounding to the nearest whole dollar

Note: The dental group tier structure must match the medical group tier structure. Please refer to page 10 of the actuarial memorandum for instructions on calculating tiered rates.

Deductible Credit will be included in the regional dental benefits. This gives subscribers credit for deductibles paid in the same period to another carrier.

CareFirst BlueCross BlueShield

COMMUNITY RATED GROUP ACCOUNTS OF 2-50 CONTRACTS
JURISDICTION: DISTRICT OF COLUMBIA
REGIONAL RIDER PPO DENTAL CARE BENEFITS*
MONTHLY PREMIUMS EFFECTIVE July 1, 2009

ANCILLARY BENEFITS Form Numbers: DC/CF/DENTAL RIDER (R. 1/04)
Dental Coverage As A Rider
(Not Age Rated But Adjusted for Geography)

		IN-NETWORK	OUT-OF-NETWORK	Individual
Individual Annual Deductible		$25	$50	
Non-Individual Annual Deductible		$75	$150	
Coinsurance	CLASS 1	80%	60%	
	CLASS 2	50%	35%	
	CLASS 3	50%	35%	
	CLASS 4	50%	35%	
$1,000 Annual Benefit Maximum per Participant				

OPTION 1 $19

		IN-NETWORK	OUT-OF-NETWORK
Individual Annual Deductible		$25	$50
Non-Individual Annual Deductible		$75	$150
Coinsurance	CLASS 1	100%	75%
	CLASS 2	80%	60%
	CLASS 3	50%	35%
	CLASS 4	50%	35%
$1,000 Annual Benefit Maximum per Participant			

OPTION 2** $22

		IN-NETWORK	OUT-OF-NETWORK
Individual Annual Deductible		$25	$50
Non-Individual Annual Deductible		$75	$150
Coinsurance	CLASS 1	100%	75%
	CLASS 2	80%	60%
	CLASS 3	80%	60%
	CLASS 4	50%	35%
$1,000 Annual Benefit Maximum per Participant			

OPTION 3 $23

		IN-NETWORK	OUT-OF-NETWORK
Individual Annual Deductible		$25	$50
Non-Individual Annual Deductible		$75	$150
Coinsurance	CLASS 1	100%	75%
	CLASS 2	80%	60%
	CLASS 3	80%	60%
	CLASS 4	50%	35%
$1,500 Annual Benefit Maximum per Participant			

OPTION 4 $25

OPTIONAL RIDERS		IN-NETWORK	OUT-OF-NETWORK	
ORTHODONTICS :	Coinsurance	50%	35%	
	$800 Lifetime Benefit Maximum per Participant			$1
	$1200 Lifetime Benefit Maximum per Participant			$2

Class 1: **Preventive and Diagnostic Services**
Class 2: **Therapeutic and Minor Restorative Services**
Class 3: **Periodontic and Endodontic Services**
Class 4: **Prosthodontic and Major Restorative**

Note: The dental group tier structure must match the medical group tier structure. Please refer to page 10 of the actuarial memorandum for instructions on calculating tiered rates.

Deductible Credit will be included in the regional dental benefits. This gives subscribers credit for deductibles paid in the same period to another carrier.

CareFirst BlueCross BlueShield

COMMUNITY RATED GROUP ACCOUNTS OF 2-50 CONTRACTS
JURISDICTION: DISTRICT OF COLUMBIA
REGIONAL FREESTANDING PPO DENTAL CARE BENEFITS*
MONTHLY PREMIUMS EFFECTIVE July 1, 2009

ANCILLARY BENEFITS
FreeStanding Dental Coverage
(Not Age Rated But Adjusted for Geography)

Form Numbers: DC/CF/GC-V (9/04) DC/CF/DO-SOB (R. 1/04) DC/CF/COC DEN (R. 9/04) DC/CF/ELIG (9/04) DC/CF/DO-DOCS (R. 1/04)

		IN-NETWORK	OUT-OF-NETWORK	Individual
Individual Annual Deductible		$25	$50	
Non-Individual Annual Deductible		$75	$150	
Coinsurance	CLASS 1	80%	60%	
	CLASS 2	50%	35%	
	CLASS 3	50%	35%	
	CLASS 4	50%	35%	
$1,000 Annual Benefit Maximum per Participant				
OPTION 1				$22

		IN-NETWORK	OUT-OF-NETWORK	
Individual Annual Deductible		$25	$50	
Non-Individual Annual Deductible		$75	$150	
Coinsurance	CLASS 1	100%	75%	
	CLASS 2	80%	60%	
	CLASS 3	50%	35%	
	CLASS 4	50%	35%	
$1,000 Annual Benefit Maximum per Participant				
OPTION 2				$25

		IN-NETWORK	OUT-OF-NETWORK	
Individual Annual Deductible		$25	$50	
Non-Individual Annual Deductible		$75	$150	
Coinsurance	CLASS 1	100%	75%	
	CLASS 2	80%	60%	
	CLASS 3	80%	60%	
	CLASS 4	50%	35%	
$1,000 Annual Benefit Maximum per Participant				
OPTION 3				$26

		IN-NETWORK	OUT-OF-NETWORK	
Individual Annual Deductible		$25	$50	
Non-Individual Annual Deductible		$75	$150	
Coinsurance	CLASS 1	100%	75%	
	CLASS 2	80%	60%	
	CLASS 3	80%	60%	
	CLASS 4	50%	35%	
$1,500 Annual Benefit Maximum per Participant				
OPTION 4				$29

OPTIONAL RIDERS		IN-NETWORK	OUT-OF-NETWORK	
ORTHODONTICS :	Coinsurance	50%	35%	
	$800 Lifetime Benefit Maximum per Participant			$1
	$1200 Lifetime Benefit Maximum per Participant			$2

Class 1: **Preventive and Diagnostic Services**
Class 2: **Therapeutic and Minor Restorative Services**
Class 3: **Periodontic and Endodontic Services**
Class 4: **Prosthodontic and Major Restorative**

*Individual FreeStanding PPO rates determined by applying freestanding factor of 1.15 to individual Rider PPO rates and rounding to the nearest whole dollar

Note: The dental group tier structure must match the medical group tier structure. Please refer to page 10 of the actuarial memorandum for instructions on calculating tiered rates.

Deductible Credit will be included in the regional dental benefits. This gives subscribers credit for deductibles paid in the same period to another carrier.

CAREFIRST BLUECROSS BLUESHIELD (GHMSI)
COMMUNITY RATED GROUP ACCOUNTS OF 2-50 CONTRACTS
JURISDICTION: DISTRICT OF COLUMBIA

TIER FACTORS
EFFECTIVE DATE: JANUARY 1, 2005

DEVELOPMENT OF SLOPE ADJUSTMENT FACTOR BASED ON ASSUMED AND DESIRED SLOPES.

TIER STRUCTURE	CONTRACT TYPE	ASSUMED MEMBERS PER CONTRACT	Currently Effective Tier Factors
TWO TIER	INDIVIDUAL	1.00	1.00
	FAMILY	**3.45**	**2.80**
FOUR TIER	INDIVIDUAL	1.00	1.00
	INDIVIDUAL & CHILD(REN)	2.31	1.85
	INDIVIDUAL & ADULT	2.00	2.30
	FAMILY	**3.70**	**2.80**

Note: The tier factors shown above follow those of the DC GHMSI Small Group Medical business.

FREESTANDING FACTOR
Effective Date: January 1, 2008

115.0%

SERFF Tracking Number:	*CFAP-126065477*	*State:*	*District of Columbia*
Filing Company:	*Group Hospitalization and Medical Services, Inc.*	*State Tracking Number:*	
Company Tracking Number:	*1241*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health Dental*
Product Name:	*Filing #1241 GHMSI DC Small Group Dental*		
Project Name/Number:	*DC GHMSI Small Grp Dental eff 200907/1241*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Cover Letter	APPROVED	04/01/2009

Comments:

Attachment:

1241 GHMSI DC SERFF Cover Letter.pdf

		Item Status:	Status Date:
Satisfied - Item:	NAIC Transmittal Doc	APPROVED	04/01/2009

Comments:

Attachment:

1241 NAIC Transmittal Doc.pdf

CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, MD 21117-5559
www.carefirst.com

March 9, 2009

Mr. Laszlo Pentek
Actuary
Government of the District of Columbia
Department of Insurance, Securities and Banking
Insurance Products Division
810 First Street, NE, Suite 701
Washington, DC 20002-8023

Re: Group Hospitalization and Medical Services, Inc. (GHMSI) dba
CareFirst BlueCross BlueShield
NAIC 53007 (GHMSI)
FEIN 53-0078070
Dental Coverage
Rate Filing for DC Small Group (Our Filing #1241)

Dear Mr. Pentek:

Attached for your review is the actuarial memorandum for Group Hospitalization and Medical Services, Inc. dba CareFirst BlueCross BlueShield's (NAIC# 53007) small group dental coverage for a July 1, 2009 effective date. Below is a summary of our proposal:

Product	Proposed Composite Rate Increase vs 1/1/09 Rates
Indemnity Rider	4.6%
Indemnity FreeStanding	4.6%
PPO Rider	4.6%
PPO FreeStanding	4.6%

The complete pricing analysis can be found on page 4 of the actuarial memorandum, and the experience data used in the pricing analysis can be found on pages 6-8.

The form numbers affected by this memorandum are as follows:

DC/CF/DENTAL RIDER (R. 1/04)
DC/CF/GC-V (9/04)
DC/CF/COC DEN (R. 9/04)
DC/CF/DO-DOCS (R. 1/04)
DC/CF/DO-SOB (R. 1/04)
DC/CF/ELIG (9/04)

We appreciate your consideration of this matter. If you have any questions or concerns, please contact me at (410) 998-5716.

Sincerely,

Katheryn Barron

Digitally signed by Katheryn Barron
DN: cn=Katheryn Barron, o=CareFirst BlueCross BlueShield, ou=Actuarial Pricing Department, email=katheryn.barron@carefirst.com, c=US
Date: 2009.03.09 08:05:41 -04'00'

Katheryn Barron
Actuarial Assistant

Effective January 1, 2009

Reset Form

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	Prepared for the State of	District of Columbia

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
	Katheryn Barron 10455 Mill Run Circle Owings Mills, MD 21117	(410) 998 - 5716	(410) 720 - 5946	katheryn.barron@carefirst.com

5.	Requested Filing Mode	☑ Review & Approval ☐ File & Use ☐ Informational ☐ Combination (please explain): _____ ☐ Other (please explain): _____

6.	Company Tracking Number	1241
7.	☑ New Submission ☐ Resubmission	Previous file # 1159
8.	Market	☐ Individual ☐ Franchise Group: ☑ Small ☐ Large ☐ Small and Large ☑ Employer ☐ Association ☐ Blanket ☐ Discretionary ☐ Trust ☐ Other: _____
9.	Type of Insurance	H10G Group Health-Dental
10.	Product Coding Matrix Filing Code	H10G.000 Health-Dental
11.	Submitted Documents	☐ **FORMS** ☐ Policy ☐ Outline of Coverage ☐ Certificate ☐ Application/Enrollment ☐ Rider/Endorsement ☐ Advertising ☐ Schedule of Benefits ☐ Other **Rates** ☐ New Rate ☑ Revised Rate ☐ **FILING OTHER THAN FORM OR RATE:** Please explain: _____ **SUPPORTING DOCUMENTATION** ☐ Articles of Incorporation ☐ Third Party Authorization ☐ Association Bylaws ☐ Trust Agreements ☐ Statement of Variability ☑ Certifications ☑ Actuarial Memorandum ☑ Other Cover Letter

12.	**Filing Submission Date**	03/09/2009
13	**Filing Fee (If required)**	Amount _____ Check Date _____ Retaliatory ☐ Yes ☐ No Check Number _____
14.	**Date of Domiciliary Approval**	

15. Filing Description:

This filing contains the rate proposal for Group Hospitalization and Medical Services, Inc. dba CareFirst BlueCross BlueShield's Small Group (2-50 contracts) regional dental coverages, with an effective date of July 1, 2009. Please refer to the cover letter and actuarial memorandum (Supporting Documentation) and rate filing (Rate/Rule Schedule) for more details.

View Complete Filing Description

16. Certification (If required)

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 the District of Columbia.

Print Name Dwayne Lucado, F.S.A, M.A.A.A. Title Assistant Actuary

Signature Dwayne Lucado Digitally signed by Dwayne Lucado DN: cn=Dwayne Lucado, o=CareFirst BlueCross BlueShield, ou=Actuarial Pricing Department, email=dwayne.lucado@carefirst.com, c=US Date: 2009.03.09 08:34:43 -04'00' Date: 03/09/2009

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

	Document Name Description	Form Number		Replaced Form Number Previous State Filing Number
01			☐ Initial ☐ Revised ☐ Other _____	
02			☐ Initial ☐ Revised ☐ Other _____	
03			☐ Initial ☐ Revised ☐ Other _____	
04			☐ Initial ☐ Revised ☐ Other _____	
05			☐ Initial ☐ Revised ☐ Other _____	
06			☐ Initial ☐ Revised ☐ Other _____	
07			☐ Initial ☐ Revised ☐ Other _____	
08			☐ Initial ☐ Revised ☐ Other _____	
09			☐ Initial ☐ Revised ☐ Other _____	
10			☐ Initial ☐ Revised ☐ Other _____	

LH FFA-1

18.	Rate Filing Attachment			
This filing transmittal is part of company tracking number			1241	
This filing corresponds to form filing company tracking number				
Overall percentage rate indication (when applicable)				
Overall percentage rate impact for this filing			4.6 %	
	Document Name **Description**	**Affected Form Numbers**		**Previous State Filing Number**
01	Rate Filing #1241 This filing contains the rate proposal for GHMSI Small Group Regional Dental business.	DC/CF/DENTAL RIDER (R. 1/04), DC/CF/GC-V (9/04), DC/CF/COC DEN (R. 9/04), DC/CF/DO-DOCS (R. 1/04), DC/CF/DO-SOB (R. 1/04), DC/CF/ELIG (9/04)	☐ **New** ☑ **Revised** **Request +** 4.6 **% -____%** ☐ **Other** _____	
02			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other** _____	
03			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other** _____	
04			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other** _____	
05			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other** _____	
06			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other** _____	
07			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other** _____	
08			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other** _____	
09			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other** _____	
10			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other** _____	

LH RFA-1

