

SERFF Tracking Number: GHPI-126397219 State: Arkansas
Filing Company: Coventry Health and Life Insurance Company State Tracking Number: 44182
Company Tracking Number: SOBIND09
TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)
Product Name: ARSOBI09
Project Name/Number: /

Filing at a Glance

Company: Coventry Health and Life Insurance Company

Product Name: ARSOBI09

SERFF Tr Num: GHPI-126397219 State: Arkansas

TOI: H16I Individual Health - Major Medical

SERFF Status: Closed-Approved-
Closed State Tr Num: 44182

Sub-TOI: H16I.005A Individual - Preferred
Provider (PPO)

Co Tr Num: SOBIND09 State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor

Authors: Geneva Clark, Anita
Carter

Disposition Date: 12/01/2009

Date Submitted: 11/24/2009

Disposition Status: Approved-
Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile:

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type:

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 12/01/2009

Explanation for Other Group Market Type:

State Status Changed: 12/01/2009

Deemer Date:

Created By: Anita Carter

Submitted By: Anita Carter

Corresponding Filing Tracking Number:

Filing Description:

(314) 506-1928

acarter@cvty.com

November 25, 2009

Rosalind Minor

SERFF Tracking Number: GHPI-126397219 State: Arkansas
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(PPO)

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Sr. Certified Rate & Form Analyst
Arkansas Insurance Department
Life and Health Division
1200 West Third Street
Little Rock, Arkansas 72201

Re: Co Tracking #: SOBIO9
Form #: AR_SOBIND09_CHL
Schedule of Benefits

Dear Ms Minor:

I am writing on behalf of Coventry Health and Life Insurance Co. ("CHL") regarding submission of the above referenced document.

The intended market for this document is the individual market. This document is a new, rather than replacement document. This document will be issued to individuals.

In addition, please note the following:

1. A check in the amount of \$40.00 will be sent under separate cover. The check will be for the filing fee for this filing as well SERFF filing GHPI-126397200. Per a conversation with Linda Bird on November 25, 2009, it is acceptable to include both filing fees into one check.
2. In compliance with ACA 23-79-206, a Readability Certificate is attached.
3. In compliance with Rule & Regulation 19, this document does not discriminate on the basis of sex.
4. No rates are filed as this document will not change rates previously filed.

This Schedule of Benefits template will be used with form number AR_PPOCOCIND_08_CHL approved 10/7/08.

Thank you for your assistance with this filing. If you have any comments or concerns, please contact me at (314) 506-1928.

Sincerely,

Anita J. Carter, RN
Manager, Regulatory Compliance

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Product Name: ARSOBI09
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Company and Contact

Filing Contact Information

Anita Carter, Manager of Regulatory Compliance
550 Maryville Centre Drive
Suite 300
St. Louis, MO 63141-5818
acarter@cvty.com
314-506-1928 [Phone]
314-506-1672 [FAX]

Filing Company Information

Coventry Health and Life Insurance Company
6705 Rockledge Drive
Suite 900
Bethesda, MD 20817
(314) 506-1700 ext. [Phone]

CoCode: 81973
Group Code: 1137
Group Name:
FEIN Number: 75-1296086
State of Domicile: Delaware
Company Type:
State ID Number:

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:
Per Company: No

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	12/01/2009	12/01/2009

SERFF Tracking Number: GHPI-126397219 *State:* Arkansas
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(PPO)

Product Name: ARSOBI09
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Disposition

Disposition Date: 12/01/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule of Benefits

This Schedule is part of Your COC but does not replace it. Many words are defined elsewhere in the COC, and other limitations or exclusions may be listed in other sections of Your COC. Reading this Schedule by itself could give You an inaccurate impression of the terms of Your Coverage. This Schedule must be read with the rest of Your COC. [This is a QHDHP. Please see Section 2.10 For additional information regarding Your benefits.] Coinsurance amounts are a percentage of the Plan’s Out of Network Rate (ONR). See the last page of this Schedule of Benefits for further explanation. Prior Authorization may be required for some services. Please refer to Your COC for further details or contact Member Services at the phone number listed in the “Schedule of Important Numbers and Addresses” section of Your COC or on the back of Your ID card.

Member Responsibility	In-Network	Out-of Network
<p>Annual Deductible</p> <p>Total amount a Member is required to pay each calendar or Contract Year before he or she is eligible for certain Health Services. The Annual Deductible need only be met once per Member per calendar or Contract Year.</p> <p>[Pharmacy Services are included in the Deductible.]</p> <p>In some cases, In-network Deductible will not apply.</p>	<p style="text-align: center;">Individual [\$0-\$15,000]</p> <p style="text-align: center;">[Family [\$0-\$45,000]]</p>	<p style="text-align: center;">Individual [\$0-\$45,000]</p> <p style="text-align: center;">[Family [\$0-\$90,000]]</p>
<p>Annual Out-of-Pocket Maximum</p> <p>[Copayments,] [Annual Deductible,] [and] [Coinsurance] apply to the Out-of-Pocket Maximum</p> <p>[Pharmacy Services are included in the Annual Out-of-Pocket Maximum.]</p>	<p style="text-align: center;">Individual [\$0-\$25,000]</p> <p style="text-align: center;">[Family [\$0-\$75,000]]</p>	<p style="text-align: center;">Individual [\$0-\$50,000]</p> <p style="text-align: center;">[Family [\$0-\$150,000]]</p>
<p>[Maximum Annual Benefit</p> <p>Combined total of all benefits each calendar year.</p>	<p style="text-align: center;">Individual [\$10,000-unlimited]</p> <p style="text-align: center;">[Family [\$10,000-unlimited]]</p>	<p style="text-align: center;">Individual [\$10,000-unlimited]</p> <p style="text-align: center;">[Family [\$10,000-unlimited]]]</p>
<p>Maximum Lifetime Benefit</p> <p>Combined total of all benefits.</p>	<p style="text-align: center;">[\$1,000,000-Unlimited]</p>	<p style="text-align: center;">[\$1,000,000-Unlimited]</p>

YOU ARE RESPONSIBLE FOR AMOUNTS IN EXCESS OF OUT-OF-NETWORK RATES (ONR) IN ADDITION TO APPLICABLE COMPAYMENT, COINSURANCE AND DEDUCTIBLES.

<p>Physician Office - Preventive Care</p> <p>Services include routine health assessment, well-child care, child health supervision services, childhood immunizations, hearing test, annual self-referred gynecological examination and pap smear.</p> <p>[No copayment/coinsurance for well child visits or immunizations under the age of 6. Benefit is not subject to preventive care limitation.]</p> <p>[No copayment/coinsurance for well women exams.]</p> <p>[Maximum benefit is an In-Network and Out of Network combined limit.]</p>	<p>For Primary Care Services [\$0-\$250 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [after Deductible] [4-unlimited visits] [Deductible does not apply to the initial \$200-\$1000 of Preventive Care Services per calendar/Contract Year]</p> <p>For Specialty Care Services [\$0-\$250 Copay per visit] [or][then] [0-50% Coinsurance per visit] [after Deductible]</p>	<p>For Primary Care Services [\$0-\$250 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [after Deductible] [4-unlimited visits]</p> <p>[Deductible does not apply to the initial \$200-\$1000 of Preventive Care Services per calendar/Contract Year]</p> <p>For Specialty Care Services [\$0-\$250 Copay per visit] [or][then] [0-50% of ONR Coinsurance per visit] [after Deductible]</p>
<p>Physician Office – Medical Services</p> <p>Services include diagnosis, consultation and treatment, diagnostic tests and radiology services, immunizations and injections, surgery, allergy tests and treatment.</p>	<p>For Primary Care Services [\$0-\$250 Copay per visit] [or][then] [0-50% Coinsurance per visit] [after Deductible]</p> <p>For Specialty Care Services [\$0-\$250 Copay per visit] [or][then] [0-50% Coinsurance per visit] [after Deductible]</p>	<p>For Primary Care Services [\$0-\$250 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [after Deductible]</p> <p>For Specialty Care Services [\$0-\$250 Copay per visit] [or][then] [0-50% of ONR Coinsurance per visit] [after Deductible]</p>
<p>Chiropractic Office Visits</p> <p>Services include treatment that is Medically Necessary, clinically appropriate, and within the chiropractor’s scope of practice.</p> <p>[Visit limitation is an In-Network and Out of Network combined limit.]</p>	<p>[\$0-\$250 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [after Deductible] [10-unlimited visits]</p>	<p>[\$0-\$250 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [after Deductible] [10-unlimited visits]</p>
<p>Emergency Room Services</p> <p>Coverage is provided for worldwide Emergency Health Services as defined in section [1.41] of the COC.</p>	<p>[\$0-\$500 Copay per visit] [or] [then] [0-50% Coinsurance per visit] ([Copay; Coinsurance]</p>	<p>[\$0-\$500 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] ([Copay;</p>

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	waived if the patient is admitted) [after Deductible]	Coinsurance] waived if the patient is admitted) [after Deductible]
Emergency Ambulance Services Coverage is provided for Emergencies as defined in Sections [1.41] and 6 of the COC.	[\$0-\$500 Copay per occurrence] [or] [then] [0-50% Coinsurance per occurrence] [after Deductible]	[\$0-\$500 Copay per occurrence] [or] [then] [0-50% of ONR Coinsurance per occurrence] [after Deductible]
Urgent Care Services Urgent Care Services at Alternate Facilities both in and out of the Service Area are Covered.	[\$0-\$500 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [after Deductible]	[\$0-\$500 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [after Deductible]
Outpatient Services and Diagnostic Procedures and Tests Coverage includes diagnostic procedures and tests, including but not limited to lab and radiology, not performed in the Physician's office. Certain procedures and tests are considered surgery, including but not limited to colonoscopy and endoscopy. Refer to the Outpatient Surgery section.	[\$0-\$500 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [after Deductible] [0-20% penalty for failure to precertify]	[\$0-\$500 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [after Deductible] [0-20% penalty for failure to precertify]
Outpatient Surgery Benefits are provided for Covered Services rendered at an outpatient Hospital and may include an overnight observation stay. Certain procedures and tests are considered surgery, including but not limited to colonoscopy and endoscopy.	[\$0-\$500 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [up to a maximum of \$0-\$2000] [per calendar year; Contract Year] [after Deductible] [0-20% penalty for failure to precertify]	[\$0-\$500 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [up to a maximum of \$0-\$2000] [per calendar year; Contract Year] [after Deductible] [0-20% penalty for failure to precertify]
[Outpatient Surgery Freestanding Facility Benefits are provided for Covered Services rendered at a Freestanding surgery center.	[\$0-\$500 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [up to a maximum of \$0-\$2000] [per calendar year; Contract Year] [after Deductible] [0-20% penalty for failure to precertify]	[\$0-\$500 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [up to a maximum of \$0-\$2000] [per calendar year; Contract Year] [after Deductible] [0-20% penalty for failure to precertify]]
[High Technology Diagnostic Services, Tests, and Procedures Including, but not limited to: MRI,	[\$0-\$500 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [up	[\$0-\$500 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per

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MRA, CT Scans, Thallium Scans, Nuclear Stress Tests, PET Scans, Echocardiograms, Ultrasounds	to a maximum of \$0-\$2000] [per calendar year; Contract Year] [after Deductible] [0-20% penalty for failure to precertify]	visit] [up to a maximum of \$0-\$2000] [per calendar year; Contract Year] [after Deductible] [0-20% penalty for failure to precertify]]
Injectables Includes Injectable medications, allergy and therapeutic injections and chemotherapy. There may be more than one Copayment/Coinsurance charged by the same Provider on the same day.	[\$0-\$500 Copay] [or] [then] [0-50% Coinsurance] [up to a maximum of \$0-\$500] per injection with the exception of immunizations [after Deductible]	[\$0-\$500 Copay] [or] [then] [0-50% of ONR Coinsurance] [up to a maximum of \$0-\$500] per injection with the exception of immunizations [after Deductible]
Self-Injectable Medications Medications considered by the Plan to be Self-Injectable Medications are Covered only under a Pharmacy Rider, if purchased.	Not Covered under the medical policy.	Not Covered under the medical policy.
Inpatient Hospital Services Coverage is provided for Medically Necessary Physician and surgeon services, Semi-private room, operating rooms and related facilities, intensive and coronary care units, laboratory, x-rays, radiology services and procedures, medications and biologicals, anesthesia, special duty nursing as prescribed, short-term rehabilitation services, nursing care, meals and special diets.	[\$0-\$1000 Copay] [or][then] [0-50% Coinsurance] [per admission; per day] [up to a maximum of \$0-\$2000] [per calendar year; Contract Year] [after Deductible] [\$0-\$1000 penalty for failure to precertify]	[\$0-\$1000 Copay] [or][then] [0-50% of ONR Coinsurance] [per admission; per day] [up to a maximum of \$0-\$2000] [per calendar year; Contract Year] [after Deductible] [\$0-\$1000 penalty for failure to precertify]
Transplant Services Services and supplies for certain transplants are Covered when provided at a Designated Transplant Network Facility and by a Designated Transplant Network Physician. Please see Your COC for further details. Donor screening testing is limited to a [\$10,000-\$20,000] benefit maximum per Member per Lifetime. This is a combined in-network and out-of-network limit.	[\$0-\$1000 Copay] [or][then] [0-50% Coinsurance] [per admission; per day] [up to a maximum of \$0-\$2000] [per calendar year; Contract Year] [after Deductible] [\$0-\$1000 penalty for failure to precertify]	Covered only at a Designated Transplant Network Facility by a Designated Transplant Network Physician
Skilled Nursing Facility	[\$0-\$1000 Copay]	[\$0-\$1000 Copay]

YOU ARE RESPONSIBLE FOR AMOUNTS IN EXCESS OF OUT-OF-NETWORK RATES (ONR) IN ADDITION TO APPLICABLE COMPAYMENT, COINSURANCE AND DEDUCTIBLES.

Coverage is provided when approved by the Plan. Coverage is provided on a Semi-private basis. [Maximum benefit is an In-Network and Out of Network combined limit.]	[or][then] [0-50% Coinsurance] [per admission; per day] [up to a maximum of \$0-\$2000] [per calendar year; Contract Year] Limited to [0-150] days per [calendar year; Contract Year] [after Deductible] [\$0-\$1000 penalty for failure to precertify]	[or][then] [0-50% of ONR Coinsurance] [per admission; per day] [up to a maximum of \$0-\$2000] [per calendar year; Contract Year] Limited to [0-150] days per [calendar year; Contract Year] [after Deductible] [\$0-\$1000 penalty for failure to precertify]
Home Health Care Coverage is provided when services are rendered by licensed Providers and Authorized in advance by the Plan. [Maximum benefit is an In-Network and Out of Network combined limit.]	[\$0-\$500 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [Limited to 20-50 visits per calendar year; Contract Year][after Deductible] [0-20% penalty for failure to precertify]	[\$0-\$500 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [Limited to 20-50 visits per calendar year; Contract Year] [after Deductible] [0-20% penalty for failure to precertify]
Hospice Coverage is provided when services are rendered by licensed Providers and Authorized in advance by the Plan. [Maximum benefit is an In-Network and Out of Network combined limit.]	[\$0-\$500 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [Limited to 20-50 visits per calendar year; Contract Year][after Deductible] [0-20% penalty for failure to precertify]	[\$0-\$500 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [Limited to 20-50 visits per calendar year; Contract Year] [after Deductible] [0-20% penalty for failure to precertify]
Durable Medical Equipment (DME), Orthotics and Prosthetics Coverage is provided when services are rendered by licensed Providers and Authorized in advance by the Plan. [Maximum benefit is an In-Network and Out of Network combined limit.]	[0-50% Coinsurance of Covered expenses] [after Deductible] [limited to a benefit maximum of \$1000-\$20,000] [0-20% penalty for failure to precertify]	[0-50% of ONR Coinsurance of Covered expenses] [after Deductible] [limited to a benefit maximum of \$1000-\$20,000] [0-20% penalty for failure to precertify]
[Eyeglasses and Contacts Coverage is provided for the first pair of eyeglasses or corrective lenses following cataract surgery [Maximum benefit is an In-Network and Out of Network combined limit.]	100% of Covered eyewear up to [\$50-\$500]	[0-50% Coinsurance of Covered expenses] [after Deductible]]
[Hearing Aids	[\$0-\$500 Copay per	[\$0-\$500 Copay per

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<p>Coverage is provided for hearing aids.</p> <p>[Maximum benefit is an In-Network and Out of Network combined limit.]</p>	<p>hearing aid] [or] [then] [0-50% Coinsurance per hearing aid] [limited to a benefit maximum of \$250-\$5000] [after Deductible]</p>	<p>hearing aid] [or] [then] [0-50% of ONR Coinsurance per hearing aid] [limited to a benefit maximum of \$250-\$5000] [after Deductible]]</p>
<p>Physical, Occupational, and Speech Therapy</p> <p>Coverage is provided for Medically Necessary inpatient or outpatient physical, occupational, and speech therapy when rendered by licensed Providers and Authorized in advance by the Plan.</p> <p>[Maximum benefit is an In-Network and Out of Network combined limit.]</p>	<p>[\$0-\$500 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [after Deductible] [0-20% penalty for failure to precertify] [Physical therapy: 20-unlimited visits] [Occupational therapy: 20-unlimited visits] [Speech therapy: 20-unlimited visits] [10-60 combined visits]</p>	<p>[\$0-\$500 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [after Deductible] [0-20% penalty for failure to precertify] [Physical therapy: 20-unlimited visits] [Occupational therapy: 20-unlimited visits] [Speech therapy: 20-unlimited visits] [10-60 combined visits]</p>

YOU ARE RESPONSIBLE FOR AMOUNTS IN EXCESS OF OUT-OF-NETWORK RATES (ONR) IN ADDITION TO APPLICABLE COMPAYMENT, COINSURANCE AND DEDUCTIBLES.

OUT OF NETWORK RATE (ONR)

The "Out-of-Network Rate" or "ONR" is the amount the Plan pays for Covered Services rendered by a Non-Participating Provider for Out-of-Network Benefits. When services are rendered by a Non-Participating Provider, benefits may be paid directly to You upon receipt of Your claim submission.

The ONR is the lesser of the Provider's billed charges or 100% of the current Medicare fee schedule. (Please note that the Medicare fee schedule is updated April 1 of each year.) If there is no corresponding Medicare rate noted for a particular service, the Plan will determine the payment to the Provider. .

Please Note: You are responsible for paying any expenses or charges in excess of the ONR.

The examples below illustrate how ONR works:

Assume Your Hospital Coinsurance is 20%, the Hospital bill is \$5,000 (actual charges), and the ONR for the Hospital is \$3,000. In this example, the Plan would not take into account \$2,000 of the \$5,000 Hospital bill, because it exceeds the \$3,000 ONR. The Plan would pay 80% of the \$3,000 ONR, which is \$2,400. You would pay 20% of the \$3,000 ONR, which is \$600, PLUS the \$2,000 of actual charges that exceed the \$3,000 ONR, for a total cost to You of \$2,600. Please note that any payments You make in excess of the ONR do not count towards Your Deductible or Out of Pocket Maximum.

Assume Your Specialist visit Copayment is \$50. The Specialist's bill is \$140 (actual charges) and the ONR for the Specialist is \$80. In this example, The Plan would not take into account \$60 of the Specialist's bill because it exceeds the \$80 ONR. The Plan would pay \$30 (the ONR minus Your Copayment amount). You would pay the \$50 Copayment PLUS the \$60 of actual charges that exceed the \$80 ONR, for a total cost to You of \$110. Please note that any payments You make in excess of the ONR do not count towards Your Deductible or Out of Pocket Maximum.

By way of contrast, the examples below illustrate how In-Network Covered Services would be paid:

Assume Your In-Network Hospital Coinsurance is 20%, the Hospital bill is \$5,000 (actual charges), and the contracted rate for the Hospital is \$3,000. In this example, the Plan would not take into account \$2,000 of the \$5,000 Hospital bill, because it exceeds the \$3,000 contracted rate. The Plan would pay 80% of the \$3,000 contracted rate, which is \$2,400. You would pay 20% of the \$3,000 contracted rate, which is \$600. The amount in excess of the contracted rate would not be Your responsibility.

Assume Your Specialist visit Copayment is \$50. The Specialist's bill is \$140 (actual charges) and the contracted rate for the Specialist is \$80. In this example, the Plan would not take into account \$60 of the Specialist's bill because it exceeds the \$80 contracted amount. The Plan would pay \$30 (the contracted rate minus Your

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Copayment amount). You would pay the \$50 Copayment. The amount in excess of the contracted rate would not be Your responsibility.

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attached is the readability certification for this filing. Attachment: Readability Certificate.pdf	Approved-Closed	12/01/2009
Bypassed - Item: Application Bypass Reason: N/A. This is a Schedule of Benefits for a policy. Comments:	Approved-Closed	12/01/2009
Bypassed - Item: Health - Actuarial Justification Bypass Reason: N/A. There are no changes to the rates for this document. Comments:	Approved-Closed	12/01/2009
Bypassed - Item: Outline of Coverage Bypass Reason: N/A. This is a Schedule of Benefits, not a Certificate of Coverage. Comments:	Approved-Closed	12/01/2009

READABILITY CERTIFICATION

I hereby certify that the following forms comply with the Arkansas minimum Flesch reading ease test scores pursuant to A.C.A. § 23-80-206:

AR_SOBIND09_CHL



(Signature) Assistant Secretary, Coventry Health & Life Insurance Company

Jonathan D. Weinberg

(Print Name)

November 24, 2009

(Date)