COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT

MARKET CONDUCT
EXAMINATION REPORT

OF

Hospital Service Association
of
Northeastern Pennsylvania

Wilkes-Barre, PA

As of: May 10, 2011
Issued: July 2, 2011

MARKET ACTIONS BUREAU
LIFE AND HEALTH DIVISION

HOSPITAL SERVICE ASSOCIATION

OF NORTHEASTERN PENNSYLVANIA

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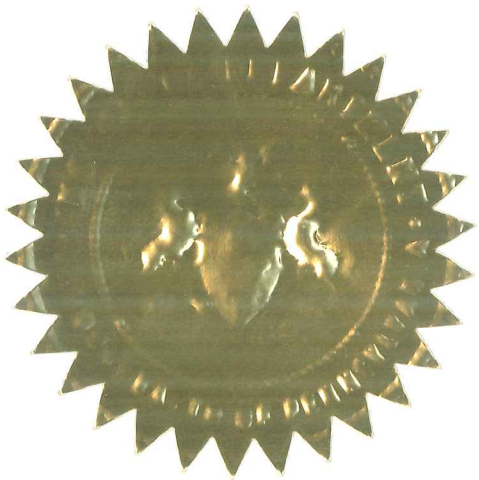
BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

ORDER

AND NOW, this 27th day of April, 2011, in accordance with Section 905(c) of the Pennsylvania Insurance Department Act, Act of May 17, 1921, P.L. 789, as amended, P.S. § 323.5, I hereby designate Ronald A. Gallagher, Deputy Insurance Commissioner, to consider and review all documents relating to the market conduct examination of any company and person who is the subject of a market conduct examination and to have all powers set forth in said statute including the power to enter an Order based on the review of said documents. This designation of authority shall continue in effect until otherwise terminated by a later Order of the Insurance Commissioner.



Michael F. Consedine
Insurance Commissioner

Hospital Service Association of
Northeastern Pennsylvania
Market Conduct Examination as of the
close of business on May 11, 2011

Docket No.
MC11-05-001

ORDER

A market conduct examination of Hospital Service Association of Northeastern Pennsylvania (referred to herein as "Respondent") was conducted in accordance with Article IX of the Insurance Department Act, 40 P.S. §323.1, et seq., for the period January 1, 2008, through December 31, 2008 and was subsequently expanded to include April 16, 2010 through January 18, 2011. The Market Conduct Examination Report disclosed exceptions to acceptable company operations and practices. Based upon the Respondent's response to the Examination Report, the report has been modified as attached.

It is hereby ordered as follows:

1. The attached Examination Report will be adopted and filed as an official record of this Department. All findings and conclusions resulting from the review of the Examination Report and related documents are contained in the attached Examination Report.

2. Respondent shall comply with Pennsylvania statutes and regulations.

3. Respondent shall comply with all recommendations contained in the attached Report.

4. Respondent shall file an affidavit stating under oath that it will provide each of its directors, at the next scheduled directors meeting, a copy of the adopted Report and related Orders. Such affidavit shall be submitted within thirty (30) days of the date of this Order.

The Department, pursuant to Section 905(e)(1) of the Insurance Department Act (40 P.S. §323.5), will continue to hold the content of the Examination Report as private and confidential information for a period of thirty (30) days from the date of this Order.

BY: The Pennsylvania Insurance Department

Ronald A. Gallagher, Jr. June 2, 2011
Ronald A. Gallagher, Jr.
Deputy Insurance Commissioner

I. INTRODUCTION

The Market Conduct Examination was conducted on Hospital Association of Northeastern Pennsylvania; hereafter referred to as "Company," at the Company's office located in Wilkes-Barre, Pennsylvania, initially during February 8, 2010 through May 13, 2010 and subsequently during February 22, 2011 through April 8, 2011. Review and follow-up was conducted in the office of the Pennsylvania Insurance Department.

Pennsylvania Market Conduct Examination Reports generally note only those items, to which the Department, after review, takes exception. A violation is any instance of Company activity that does not comply with an insurance statute or regulation. Violations contained in the Report may result in imposition of penalties. Generally, practices, procedures, or files that were reviewed by Department examiners during the course of an examination may not be referred to in the Report if no improprieties were noted. However, the Examination Report may include management recommendations addressing areas of concern noted by the Department, but for which no statutory violation was identified. This enables Company management to review these areas of concern in order to determine the potential impact upon Company operations or future compliance.

Throughout the course of the examination, Company officials were provided status memoranda, which referenced specific policy numbers with citation to each section of law violated. Additional information was requested to clarify apparent violations. An exit conference was conducted with Company officials to discuss the various types of violations identified during the examination and review written summaries provided on the violations found.

The courtesy and cooperation extended by the Officers and Employees of the Company during the course of the examination is acknowledged.

The following examiners participated in the Examination and in the preparation of this Report.

Yonise Roberts Paige
Market Conduct Division Chief

Frank Kyazze
Market Conduct Examiner

Lonnie Suggs
Market Conduct Examiner

Gary L. Boose
Market Conduct Examiner

Verification

Having been duly sworn, I hereby verify that the statements made in the within document are true and correct to the best of my knowledge, information and belief. I understand that false statements made herein are subject to the penalties of 18 Pa. C.S. §4903 (relating to false swearing).

Gary L. Boose, Examiner in Charge

Sworn to and Subscribed Before me

This 13 Day of December , 2010

Notary Public

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
LINDY McMILLEN, Notary Public
City of Harrisburg, Dauphin County
My Commission Expires March 23, 2014

II. SCOPE OF EXAMINATION

The Market Conduct Examination was conducted pursuant to the authority granted by Sections 903 and 904 (40 P.S. §§323.3 and 323.4) of the Insurance Department Act and initially covered the experience period of January 1, 2008, through December 31, 2008. Subsequent to finalization of the Examination Report, the Department became aware of additional information. This resulted in the examination being re-opened and the experience period relative to claims practices being expanded to include April 16, 2010, through January 18, 2011. The purpose of the examination was to determine compliance with Pennsylvania insurance laws and regulations.

The examination focused on the Company's operation in areas such as: Forms, and Claim Handling Practices and Procedures.

The Company was requested to identify the universe of files for each segment of the review. Based on the universe sizes identified, random sampling was utilized to select the files reviewed for this examination.

During the course of the examination, for control purposes, some of the review segments identified in this Report may have been broken down into various sub-categories by line of insurance or Company administration. These specific sub-categories, if not reflected individually in the Report, would be included and grouped within the respective general categories of the Examination Report.

III. COMPANY HISTORY AND LICENSING

Hospital Services Association of Northeastern Pennsylvania (HSA) was incorporated under a decree of the Court of Common Pleas of Luzerne County Pennsylvania on September 7, 1938 pursuant to provisions of the non-profit Corporation Law of the Commonwealth of Pennsylvania.

The Company received its Certificate of Authority from the Pennsylvania Insurance Department, effective November 23, 1938 and the Company commenced business on December 1, 1938.

On April 8, 1965, HSA filed for approval to use the fictitious name Blue Cross of Northeastern Pennsylvania.

The Company is currently authorized to engage in the business of maintaining and operating a non-profit hospital plan corporation as described in 40 Pa.C.S.A. § 6101 et seq. The Company operates in 13 counties of Northeastern Pennsylvania: Bradford, Carbon, Clinton, Lackawanna, Luzerne, Lycoming, Monroe, Pike, Sullivan, Susquehanna, Tioga, Wayne and Wyoming.

The Company product offerings include guaranteed issue individual products, an individual Medicare supplement, and a Medicare supplement group product for employer groups. The Company also administers group products for federal employees.

The Company's total Pennsylvania earned premium, as reported in their 2008 Annual Statement, was $119,733,101. The total annual member months reported was 1,060,269.

IV. FORMS

The Company was requested to provide a list and copies of all policy and certificate forms used during the experience period. The forms provided were reviewed to ensure compliance with Insurance Company Law, Section 354 and the Accident and Health Reform Filing Act, No.159 (40 P.S. §3803). No violations were noted.

V. CLAIM PROCESSING MANUALS AND CLAIMS

The Company was requested to provide copies of all procedural guidelines used in handling claims during the experience period; including all training manuals, internal audit examination manuals, company memos and any other instructions concerning claims handling. The claim manuals and procedural guides were reviewed for any inconsistencies, which could be considered discriminatory, specifically prohibited by statute or regulation, or unusual in nature. No violations were noted.

The Company provided the following claim manuals and guidelines:

a. UB System Processing Guidelines and References:

1. Traditional In-Patient Admission
2. Out-patient
3. Medicare Secondary Payer, The VA & Other Government Agencies
4. Claim Processing Guidelines
5. Pre-existing Conditions
6. Traditional Indemnity
7. Termination of Coverage
8. Claim Denial
9. Appeals Request

b. SAMM System Processing Guidelines and References

1. Claim Form
2. Rejections
3. Stipulations
4. Allergy Test
5. Ambulance Service
6. Anesthesia Charges
7. Blue Care Comprehensive Reference Coder
8. MM On-Line Coder Manual
9. Emergency Accident Care
10. Immunization
11. Injections
12. Investigations
13. Laboratory Procedures
14. Maternity
15. Nursing Home visits
16. Nutritional Supplements
17. Office Visits
18. Pap Smear
19. Physical Therapy
20. Prosthetics
21. Psychiatric Service & Visits
22. Skilled Nursing Home
23. X Ray Radiology
24. Blue Care Comprehensive Claim Adjustment
25. MM On-Line Reference EBP Enrollment
26. Blue Care Comprehensive On-Line Suspense Manual: B/S Plan

c. OSCAR Claims Processing Manual

1. Claims Overview
2. Preference
3. Institutional Claims Processing
4. Accessing OSCAR
5. Additional Documentation
6. OSCAR Tools
7. Professional Claims Entry
8. Pending Claims Inquiry
9. OSCAR Claims Processing
10. Other Insurance
11. Provider
12. Facility
13. Service
14. Membership
15. Condition, Consult & Disability Dates
16. Anesthesia
17. Benefits
18. Medical Policy
19. Medical Sorts
20. OSCAR Files
21. OSCAR Tools
22. History
23. Pricing
24. Managed Care
25. Return Development
26. DPW Claims
27. Concurrent Processing

d. Claim Administration – Quality Assurance Program

1. Mission/Purpose/Goals/ Objectives
2. Audit Scope
3. Roles and Responsibilities
4. Audit Definitions
5. Performance Measures
6. Sampling Methodology
7. Review Process
8. Findings
9. Reporting

e. Claim Processing Daily Updates

A. Subscriber Submitted Medical Claims (UB SAMM)

The Company was requested to provide a list of all subscriber submitted medical claims received during the experience period. The Company identified a universe of 10,109 claims. A random sample of 50 claim files was requested, received and reviewed. The files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146 – Unfair Insurance Practices. No violations were noted.

B. Provider Submitted Medical Claims (OSCAR)

The Company was requested to provide a list of all claims received during the experience period. The Company identified a universe of 105,956 provider submitted medical claims. A random sample of 75 claim files was requested, received and reviewed. The files were reviewed to ensure the Company claims adjudication process was adhering to the provisions of the policy contract as well as complying with pertinent state insurance laws and regulations. No violations were noted.

C. Provider Submitted Medical Claims (UB-SAMM)

The Company was requested to provide a list of provider submitted medical claims received during the experience period. The Company identified a universe of 7,453 provider submitted medical claims being processed using their Universal Billing (UB) and Shared Application Major Medical (SAMM) systems. A random sample of 50 claim files was requested, received and reviewed. The files were reviewed to ensure the Company claims adjudication process was adhering to the provisions of the policy contract as well as complying with pertinent state insurance laws and regulations. No violations were noted**.**

Department Concern: The Company should make sure that the denial codes on the Explanation of Benefit (EOB) forms reflect the actual reason a claim is not considered for payment at the time of submission. During the files review process, it was determined that the denial/reject code for the noted claims was 05W - Claim for services after January 1, 2008. Charges will be sent to correct area for processing. However, in response to the Department's Initial Summary of findings the Company

provided a different denial reason – The Provider submitted the claims with inaccurate subscriber information based on the coverage at time of service.

D. Provider Submitted Clean Claims Over 45 (OSCAR)

The Company was requested to provide a list of provider submitted clean claims over 45 days received during the experience period. The Company identified a universe of 99 provider submitted clean claims over 45 days and processed using their Optimum System for Claims Adjudication and Reporting (OSCAR) system. A random sample of 25 claims was requested, received and reviewed. The files were reviewed to ensure the Company claims adjudication process was adhering to the provisions of the policy contract as well as complying with pertinent state insurance laws and regulations. No violations were noted.

E. Provider Submitted Clean Claims Over 45 (UB-SAMM)

The Company was requested to provide a list of provider submitted clean claims over 45 days received during the experience period. The Company identified a universe of 40 provider submitted clean claims over 45 days that were processed using their Universal Billing (UB) and Shared Application Major Medical (SAMM) claims system. A random sample of 25 claim files was requested, received and reviewed. The files were reviewed to ensure the Company claims adjudication process was adhering to the provisions of the policy contract as well as complying with pertinent state insurance laws and regulations. No violations were noted.

F. Mammography Claims Denied (SAMM)

The Company was requested to provide a list of mammography claims denied during the experience period. The Company identified a universe of 78 denied mammography claims. A random sample of 10 claim files was requested, received and reviewed. The files were reviewed to ensure the Company claims adjudication process was adhering to the provisions of the policy contract as well as complying with pertinent state insurance laws and regulations. No violations were noted.

G. Mammography Claims Denied (UB)

The Company was requested to provide a list of mammography claims denied during the experience period. The Company identified a universe of 293 denied mammography claims. A random sample of 20 claim files was requested, received and reviewed. The files were reviewed to ensure the Company claims adjudication process was adhering to the provisions of the policy contract as well as complying with pertinent state insurance laws and regulations. No violations were noted.

Department Concern: The Company should make sure that the denial codes on the Explanation of Benefit (EOB) forms reflect the actual reason a claim is not considered for payment at the time of submission. During the files review process, it was determined that the denial/reject code for the noted claims was 05W - Claim for services after 1-1-08. Charges will be sent to correct area for processing. However, in response to the Department's Initial Summary findings the Company provided a different denial reason – The claims were denied because the provider submitted the claims with inaccurate subscriber information based on the coverage at the time of service.

H. Mammography Claims Denied (OSCAR)

The Company was requested to provide a list of mammography claims denied during the experience period. The Company identified a universe of 2,794 denied mammography claims that were processed on the Optimum System for Claim Adjudication and Reporting (OSCAR) system. A random sample of 30 claims was requested, received and reviewed. The files were reviewed to ensure the Company claims adjudication process was adhering to the provisions of the policy contract as well as complying with pertinent state insurance laws and regulations. No violations were noted.

I. Mammography Claims Denied < Age 40 (SAMM)

The Company was requested to provide a list of all mammography claims denied under age 40 during the experience period. The Company identified a universe of 2 denied mammography claims denied. Both claim files were requested, received and reviewed. The files were reviewed to ensure the Company claims adjudication process was adhering to the provisions of the policy contract as well as complying with pertinent state insurance laws and regulations. No violations were noted.

J. Mammography Claims Denied < Age 40 (UB)

The Company was requested to provide a list of all mammography claims denied under age 40 during the experience period. The Company identified a universe of 9 denied mammography claims. All 9 claim files were requested, received and reviewed. The files were reviewed to ensure the Company claims adjudication process was adhering to the provisions of the policy contract as well as complying with pertinent state insurance laws and regulations. No violations were noted.

K. Mammography Claims Denied < Age 40 (OSCAR)

The Company was requested to provide a list of all mammography claims under age 40 denied during the experience period. The Company identified a universe of 70 denied mammography claims under age 40. A random sample of 20 claim files was requested, received and reviewed. The files were reviewed to ensure the Company claims adjudication process was adhering to the provisions of the policy contract as well as complying with pertinent state insurance laws and regulations. No violations were noted**.**

L. Subscriber Submitted Emergency Room Claims Denied (UB SAMM)

The Company was requested to provide a list of subscriber submitted emergency room claims denied during the experience period. The Company originally provided a universe of 49 subscriber submitted emergency claims from their UB-SAMM system. This universe list included paid and $0.00 claims. The Company indicated that the $0.00 paid claims could be considered denied claims in almost every instance. With

that information, the Department extracted all claims that had a $0.00 paid amount and identified them as denied claims. From the new universe of 49 claims, the Department extracted 28 claims that were denied. All 28 denied claim files were requested, received and reviewed. The files were reviewed to ensure that the Company's claims adjudication process was adhering to the provisions of the policy contract as well as complying with pertinent sate insurance laws and regulations. No violations were noted.

M. Provider Submitted Emergency Room Claims Denied (OSCAR)

The Company was requested to provide a list of emergency claims denied during the experience period. The Company originally provided a universe of 4,869 provider submitted emergency claims from their OSCAR system. This universe list included paid and $0.00 claims. The Company indicated that the $0.00 paid claims could be considered denied claims in almost every instance. With that information, the Department extracted all claims that had a $0.00 paid amount and identified them as denied claims. From the universe of 4,869 claims the Department extracted 1,359 claims. From the new universe, a random sample of 100 denied claim files was requested, received and reviewed. The files were reviewed to ensure the Company claims adjudication process was adhering to the provisions of the policy contract as well as complying with pertinent state insurance laws and regulations. No violations were noted.

N. Provider Submitted Emergency Room Claims Denied (UB SAMM)

The Company was requested to provide a list of emergency claims denied during the experience period. The Company originally provided a universe of 676 provider submitted emergency claims from their UB-SAMM system. This universe list included paid and $0.00 claims. The Company indicated that the $0.00 paid claims could be considered denied claims in almost every instance. With that information, the Department extracted all claims that had a $0.00 paid amount and identified them as denied claims. From the original universe of 676 claims, the Department extracted 221 claims that were denied. From this new universe, a random sample of 50 claim files was requested, received and reviewed. The files were reviewed to ensure that the Company's claims adjudication process was adhering to the provisions of the policy contract as well as complying with state insurance laws and regulations. No violations were noted.

Department Concern: The Company should make sure that the denial codes on the Explanation of Benefit (EOB) forms reflect the actual reason a claim is not considered for payment at the time of submission. During the files review process, it was determined that the denial/reject code for the noted claims was 05W - Claim for services after 1-1-08. Charges will be sent to correct area for processing. However, in response to the Department's Initial Summary of findings the Company provided a different denial reason – The Provider submitted the claim with inaccurate subscriber information based on the coverage at time of service.

O. Major Medical Claims Denied

The Company identified a list of major medical claims inappropriately denied from April 16, 2010 through December 17, 2010 due to an upgrade to the OSCAR system. The Company notified the Pennsylvania Insurance Department that beginning April 16, 2010, when a separate major medical claim was created, the system rejected the claim with rejection code S5232 with the message: "In order to process this claim, additional information is needed from your provider. The provider has been contacted and asked to resubmit the claim with the correct information." An automated resolution was implemented on December 18, 2010 to remedy this problem. The Company was requested to provide a list of all major medical claims denied and subsequently upheld from April 16, 2010 through December 18, 2010 to verify the accuracy of the automated resolution. The Company identified a universe of 3,530 denied major medical claims and subsequently upheld during the experience period. A random sample of 50 claims was requested, received and reviewed. The files were reviewed to ensure the Company claims adjudication process was adhering to the provisions of the policy contract as well as complying with pertinent state insurance laws and regulations. No violations were noted.

Department Concern: The Company should make sure that the denial reason on the Explanation of Benefit (EOB) form reflects the actual reason a claim is non-reimbursable. During the file review process it was determined that one inaccurately denied claim was submitted under the original policy and was subject to co-payment by the claimant. Subsequently, the claim was submitted to the major medical policy based on the non-paid benefit (co-payment). The co-payment was ineligible for reimbursement under the major medical policy.

P. Major Medical Paid Claims

The Company identified a list of major medical claims inappropriately denied from April 16, 2010 through December 17, 2010 due to an upgrade to the OSCAR system. The Company notified the Pennsylvania Insurance Department that beginning April 16, 2010, when a separate major medical claim was created, the system rejected the claim with rejection code S5232 with the message: "In order to process this claim, additional information is needed from your provider. The provider has been contacted and asked to resubmit the claim with the correct information." An automated resolution was implemented on December 18, 2010 to remedy this problem. The Company was requested to provide a list of all major medical claims subsequently paid as a result of the December 18, 2010 automated resolution. The Company identified a universe of 8,832 denied major medical claims that were subsequently paid during the experience period. A random sample of 100 claims was requested, received and reviewed. The files were reviewed to ensure the Company claims adjudication process was adhering to the provisions of the policy contract as well as complying with pertinent state insurance laws and regulations. No violations were noted.

Q. Major Medical Duplicate Claims

The Company identified a list of denied major medical claims inappropriately denied from April 16, 2010 through December 17, 2010 due to an upgrade to the OSCAR system. The Company notified the Pennsylvania Insurance Department that beginning April 16, 2010, when a separate major medical claim was created, the system rejected the claim with rejection code S5232 with the message: "In order to process this claim, additional information is needed from your provider. The provider has been contacted

and asked to resubmit the claim with the correct information." An automated resolution was implemented on December 18, 2010 to fix this problem. The Company was requested to provide a list of all major medical claims paid as a result of the December 18, 2010 automated resolution. The Company identified a universe of 8,160 adjudicated claims without a process date because they were duplicative during the experience period. A random sample of 75 claims was requested, received and reviewed. The files were reviewed to ensure the Company claims adjudication process was adhering to the provisions of the policy contract as well as complying with pertinent state insurance laws and regulations. No violations were noted.

R. Major Medical Claims Denied (Post-System Remedy)

The Company identified a list of major medical claims inappropriately denied from April 16, 2010 through December 17, 2010 due to an upgrade to the OSCAR system. The Company notified the Pennsylvania Insurance Department that beginning April 16, 2010, when a separate major medical claim was created, the system rejected the claim with rejection code S5232 with the message: "In order to process this claim, additional information is needed from your provider. The provider has been contacted and asked to resubmit the claim with the correct information." An automated resolution was implemented on December 18, 2010 to remedy this problem. The Company was requested to provide a list of all major medical claims paid from December 18, 2010 through January 18, 2011 to verify the accuracy of the automated resolution post-system remedy. The Company identified a universe of 2,051 denied major medical claims during the experience period. A random sample of 25 claims was requested, received and reviewed. The files were reviewed to ensure the Company claims adjudication process was adhering to the provisions of the policy

contract as well as complying with pertinent state insurance laws and regulations. No violations were noted.

S. Major Medical Claims Paid (Post-System Remedy)

The Company identified a list of major medical claims inappropriately denied from April 16, 2010 through December 17, 2010 due to an upgrade to the OSCAR system. The Company notified the Pennsylvania Insurance Department that beginning April 16, 2010, when a separate major medical claim was created, the system rejected the claim with rejection code S5232 with the message: "In order to process this claim, additional information is needed from your provider. The provider has been contacted and asked to resubmit the claim with the correct information." An automated resolution was implemented on December 18, 2010 to remedy this problem. The Company was requested to provide a list of all major medical claims paid from December 18, 2010 through January 18, 2011 to verify the accuracy of the automated resolution post-system remedy. The Company identified a universe of 3,321 paid major medical claims during the experience period. A random sample of 25 claims was requested, received and reviewed. The files were reviewed to ensure the Company claims adjudication process was adhering to the provisions of the policy contract as well as complying with pertinent state insurance laws and regulations. No violations were noted.

VI. COMPANY RESPONSE

BlueCross
of Northeastern Pennsylvania
Independent Licensee of the Blue Cross and Blue Shield Association
®Registered Mark of the Blue Cross and Blue Shield Association

19 North Main Street, Wilkes-Barre, Pennsylvania 18711-0302

May 25, 2011

Yonise Roberts Paige
Chief, Life and Health Division
Pennsylvania Insurance Department
Market Action Bureau
1321 Strawberry Square
Harrisburg, PA 17120

Re: Examination Warrant Number: 09-M24-019
Hospital Service Association of Northeastern Pennsylvania

Dear Ms. Paige:

This letter is in response to your report of examination received on May 10, 2011, regarding the Pennsylvania Insurance Department's ("Department's") Market Conduct Examination of Hospital Service Association of Northeastern Pennsylvania ("HSA") covering the period January 1, 2008, through December 31, 2008 and subsequent experience period of April 16, 2010, through January 18, 2011 as of the close of business on May 10, 2011.

Thank you for the opportunity to review the Department's report of examination. Enclosed, please find HSA's responses to the Department's recommendations contained in the Market Conduct Examination Report.

If you have any questions or require additional information, please contact me at (570) 200-1650 or trish.savitsky@bcnepa.com. Thank you.

Sincerely,

Trish Savitsky

Trish Savitsky, CIPP, CIA
Vice President, Corporate Assurance & Compliance

Cc: Denise S. Cesare, President & Chief Executive Officer
Brian Rinker, Sr. Vice President - Service Operations

Listed below are Hospital Service Association of Northeastern Pennsylvania's responses to the following Department concerns noted within the report:

Section C. - Provider Submitted Medical Claims (UB-SAMM)

Department Concern: The Company should make sure that the denial codes on the Explanation of Benefit (EOB) forms reflect the actual reason a claim is not considered for payment at the time of submission. During the files review process, it was determined that the denial/reject code for the noted claims was 05W - Claim for services after January 1, 2008. Charges will be sent to correct area for processing. However, in response to the Department's Initial Summary of findings the Company provided a different denial reason – The Provider submitted the claims with inaccurate subscriber information based on the coverage at time of service.

Company Response: Hospital Service Association of Northeastern Pennsylvania recognizes the Department's concern in relation to the section listed above. The Company would like to note that the claims processing systems (UB and SAMM), from which the claims for the audit were drawn, have been decommissioned as of September 1, 2010. Therefore, the noted denial reason code (05W) is no longer in use and thus, will not be reflected on any current Explanation of Benefits (EOB's).

Section G. - Mammography Claims Denied (UB)

Department Concern: The Company should make sure that the denial codes on the Explanation of Benefit (EOB) forms reflect the actual reason a claim is not considered for payment at the time of submission. During the files review process, it was determined that the denial/reject code for the noted claims was 05W - Claim for services after 1-1-08. Charges will be sent to correct area for processing. However, in response to the Department's Initial Summary findings the Company provided a different denial reason – The claims were denied because the provider submitted the claims with inaccurate subscriber information based on the coverage at the time of service.

Company Response: Hospital Service Association of Northeastern Pennsylvania recognizes the Department's concern in relation to the section listed above. The Company would like to note that the claims processing systems (UB and SAMM), from which the claims for the audit were drawn, have been decommissioned as of September 1, 2010. Therefore, the noted denial reason code (05W) is no longer in use and thus, will not be reflected on any current Explanation of Benefits (EOB's).

Section N. - Provider Submitted Emergency Room Claims Denied (UB SAMM)

Department Concern: The Company should make sure that the denial codes on the Explanation of Benefit (EOB) forms reflect the actual reason a claim is not considered for payment at the time of submission. During the files review process, it was determined that the denial/reject code for the noted claims was 05W - Claim for services after 1-1-08. Charges will be sent to correct area for processing. However, in response to the

Department's Initial Summary of findings the Company provided a different denial reason – The Provider submitted the claim with inaccurate subscriber information based on the coverage at time of service.

Company Response: Hospital Service Association of Northeastern Pennsylvania recognizes the Department's concern in relation to the section listed above. The Company would like to note that the claims processing systems (UB and SAMM), from which the claims for the audit were drawn, have been decommissioned as of September 1, 2010. Therefore, the noted denial reason code (05W) is no longer in use and thus, will not be reflected on any current Explanation of Benefits (EOB's).

Section O. - Major Medical Claims Denied

Department Concern: The Company should make sure that the denial reason on the Explanation of Benefit (EOB) form reflects the actual reason a claim is non-reimbursable. During the file review process it was determined that one inaccurately denied claim was submitted under the original policy and was subject to co-payment by the claimant. Subsequently, the claim was submitted to the major medical policy based on the non-paid benefit (co-payment). The co-payment was ineligible for reimbursement under the major medical policy.

Company Response: Hospital Service Association of Northeastern Pennsylvania recognizes the Department's concern in relation to the Section listed above. We will continue to, on behalf of our customers, monitor the accuracy of denial codes/reasons represented on our Explanation of Benefits (EOB's).